

**SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARNERSHIP**

**DOMESTIC HOMICIDE REVIEW**

**into the circumstances**

**of the death of a woman aged 73 years**

**on 20th January 2014**

**Case No DHR 6**

**Independent Author:**

**Malcolm Ross M.Sc.**

**13th July 2015**

**LIST OF ABBREVIATIONS**

**AAFDA** Action After Fatal Domestic Abuse

**BPSD** Behaviour Psychological Symptoms of dementia

**CPA** Care Programme Approach

**CPN** Community Psychiatric Nurse

**CT Scan** Computerised Tomography Scan

**DASH** Domestic Abuse, Stalking and Harassment Risk Assessment Tool

**DHR** Domestic Homicide Review

**DVPN** Domestic Violence Prevention Notice

**EIDS** Early Identified Dementia Services

**GP (VTS)** General Practitioner (Vocational Training Scheme)

**HAU** Harm Assessment Unit – West Mercia Police

**HM Coroner** Her Majesty’s Coroner

**IDVA** Independent Domestic Violence Advisor

**IMR** Individual Management Review

**MAPPA** Multi-Agency Public Protection Arrangement

**MARAC** Multi-Agency Risk Assessment Conference

**MDT** Multi-Disciplinary Team

**NHS** National Health Service

**OAMHS** Older Adult Mental Health Services

**SIO** Senior Investigating Officer - Police

**SWCSP** South Worcestershire Community Safety Partnership

**WFADA** Worcestershire Forum Against Domestic Abuse

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**DOMESTIC HOMICIDE REVIEW**

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1. **Introduction**
   1. This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 73 year old woman on 20th January 2014. The woman’s husband, the Perpetrator, has been arrested and charged with her murder. He appeared before the Crown Court on 26th January 2015 where he was deemed unfit to plead. On 9th February 2014 he was made subject of a Hospital Order under Section 37 Mental Health Act 1983 together with a Section 41 Restriction Order, he is not to be released without the permission of the Home Secretary for public protection considerations.

## 1.2 Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victim's Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[[1]](#footnote-1) on 13th April 2011. Under this section, a domestic homicide review means a review “*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

*(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

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

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[[2]](#footnote-2), which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

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

* *psychological*
* *physical*
* *sexual*
* *financial*
* *emotional*

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

* + - * Establish what lessons are to be learned from the 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 the policies and procedures as appropriate; and
    - Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.

## Process of the Review

1.3.1 West Mercia Police notified South Worcestershire Community Safety Partnership (SWCSP) of the homicide on 21st February 2014. The Worcestershire Forum against Domestic Abuse and Sexual Violence acting on behalf of the Community Safety Partnership convened a DHR sub group meeting and considered the circumstances as known at that stage, and decided not to hold a domestic homicide review. A letter was sent to the Home Office to this effect on 18th June 2014. The Home Office replied that there should be a review and the sub-group of the SWCSP met on 8th July 2014 and commissioned a DHR. The Home Office were informed on 10th July 2014 of the intention to commission a DHR.

1.3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.

1.3.3 Home Office Guidance[[3]](#footnote-3) requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

**1.4 Independent Chair and Author**

1.4.1 Home Office Guidance[[4]](#footnote-4) requires that;

*“The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant”, and “…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review.”*

1.4.2 The Independent Chair and Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years experience in writing over 80 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

**1.5 DHR Panel**

1.5.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Members of the panel and their professional responsibilities were:

Martin Lakeman Worcestershire County Council Domestic Abuse Co-ordinator

Tom Currie National Probation Service West Mercia

Damian Petitt West Mercia Police

Ellen Footman Designated Nurse Safeguarding Worcestershire

Karen Reese Worcestershire Health and Care Trust

Sarah Cox Worcestershire County Council Quality & Safeguarding Services Manager

Lyn Mills Worcestershire County Council Health and Wellbeing (Administrator)

1.5.2 None of the Panel members had direct involvement in the case, nor had line management responsibility for any of those involved.

1.5.3 The Panel was supported by the DHR Administration Officer, Lyn Mills. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.5.4 The full Panel met on three occasions and the Author, Domestic Abuse Co-ordinator and Administrator met on an additional two occasions. At an IMR Author’s briefing the Co-ordinator invited an expert on dementia from the University of Worcester and a senior member of staff from Accident and Emergency. Together they were able to enlighten the Panel regarding the effects of dementia on individuals and families as well as the developing problems the carers face as dementia progresses.

**1.6 Parallel proceedings**

1.6.1 The Panel were aware that the following parallel proceedings were being undertaken:

* Her Majesty’s Coroner opened an Inquest on 23th January 2014 and on 7th July 2014, he adjourned the Inquest to a date to be fixed. Following the criminal trial HM Coroner closed the Inquest on 12th January 2015 recording ‘not resumed after criminal proceedings’.
* The DHR Panel Chair advised HM Coroner on 21st July 2014 that a DHR was being undertaken, and the Coroner has been updated on a regular basis.
* The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with an awareness of the issues of disclosure that may arise.

**1.7 Time Period**

1.7.1 It was decided that the review should focus on the period from 1st July 2000 (the time the Perpetrator first came to the notice of the police) to the date of the Victim’s death on 20th January 2014.

**1.8 Scoping the review**

1.8.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

1.8.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.

1.8.3 The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Perpetrator and their adult children where concerns may have been escalated by agencies.

**1.9 Individual Management Reviews**

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

* + - * West Mercia Police
      * Worcestershire Acute Hospitals Trusts
      * Worcestershire County Council Adult Social Care

**1.10 Summary**

1.10.1 The Victim in this case was 73 years of age at the time of her death. She was a retired lady who was married to the Perpetrator for 43 years. The Victim and the Perpetrator had 3 children all of whom are now mature adults and all of them are married and live away from the family home. The children consist of 2 female and 1 male (S1, S2 and S3 respectively). The Victim suffered from breast cancer and had extensive treatment.

1.10.2 Following a career in the Merchant Navy, the Perpetrator was employed as an Engineering Manager with a well-known national company in Worcestershire. He had been there from 1982 – 1996 when he was made redundant. According to S1, this affected his mental stability; he felt rejected and didn’t work after 1996.

1.10.3 The Victim had a part-time job working for a National Charity within a local hospital albeit she was absent on the day of her death. It is known that a work colleague spoke to the victim during the day of her death. He was probably the last person to speak to her other than the Perpetrator. The work colleague asked why she wasn’t at work that day and the Victim stated that she had trouble with her car, which is thought to be an excuse rather than the real reason for her absence. Both the Victim and the Perpetrator were known drink excessive amounts of alcohol and the Perpetrator often walked or drove to a local public house near the family home and drank over the lunchtime period.

1.10.4 It is known that for a number of years prior to the death of the Victim that the Perpetrator’s mental health was deteriorating and he was diagnosed with dementia. This illness progressively worsened and life became difficult for both the Perpetrator and the Victim who was the sole carer for him.

1.10.5 In March 2013, the Victim reported to her GP that she had fallen and had broken her wrist. She was referred to and treated at hospital. It was some 9 to 11 months later that she disclosed to a Community Psychiatric Nurse that the cause of the fracture was not a fall but some sort of assault.

1.10.6 West Mercia Police were involved with the Victim and the Perpetrator on a couple of occasions in 2013, responding to calls from the Perpetrator on one occasion and a neighbour on another which resulted in a record of minor domestic abuse between them caused by excess alcohol. Neither the Victim of the Perpetrator had criminal convictions.

1.10.7 During the early hours of Tuesday 21st January 2014, Police were called by a neighbour who reported that the Perpetrator had woken the neighbour stating that the Victim had stopped breathing. The Victim was found in the hallway with extensive bruising. Police Officers and Ambulance attended and it was clear that the Victim was dead. A subsequent post mortem examination found extensive bruising consistent with a sustained assault and other injuries which were consistent with a fall down the stairs that there were other significant historical injuries which amounted to some 65 in number.

1.10.8 The Perpetrator was arrested at the scene. Officers determined that he was confused. Initially he was assessed under MHA and was found not to be detainable. He was left in police custody with no alternative to admission. Adult Social Care arranged for him to be placed in hospital where he was detained. He was returned to the Midlands where he was subsequently detained under Section 2 of the Mental Health Act 1983 in a secure unit within a hospital in the South West of England. Following consultation with the Crown Prosecution Service the Perpetrator has been charged with the Victim’s murder. He appeared before the Crown Court on 26th January 2015 where he was deemed unfit to plead. On 9th February 2014 he was made subject of a Hospital Order under Section 37 Mental Health Act 1983 together with a Section 41 Restriction Order, he is not to be released without the permission of the Home Secretary for public protection considerations.

1.10.9 HM Senior Coroner for the County of Worcestershire opened the inquest and adjourned until after the Criminal proceedings, when, on 12th January 2015, he recorded ‘not resumed after criminal proceedings’ and closed the Inquest.

**1.11 Terms of Reference**

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

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

1.11.2 The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim’s wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

1.11.3 In addition to the above, the following agencies are asked to respond specifically to individual questions:

* Worcester Health and Care Trust
  + Was the Mental Health Care Programme approach (CPA) Policy followed and were the decisions made about the care programme approach used in line with this policy?
  + What assessments of the Perpetrator's mental capacity were undertaken and at what stage? How did these assessments, if undertaken, inform assessments, risks and actions?
  + Is there evidence that appropriate care assessment was made and offered?
  + Was the victim spoken to alone as part of any assessment?
* Worcestershire NHS Acute Trust
  + Was the victim spoken to alone as part of any assessment?
  + NHS England
  + What assessments of the Perpetrator's mental capacity were undertaken and at what stage? How did these assessments, if undertaken, inform assessments, risks and actions?
  + Is there evidence that appropriate care assessment was made and offered?
  + Was the victim spoken to alone as part of any assessment?

1.11.4 On 3rd September 2014 the Overview Report Author visited family members who were in the company of a representative of AAFDA (Advocacy After Fatal Domestic Abuse) who requested consideration be given to amending the Terms of Reference to read

“This review seeks to examine the circumstances surrounding the tragic death of the Victim at the hands of her husband following a long history of domestic abuse. It also seeks to examine the interaction between agencies involved.”

## 1.12 Individual Needs

## 1.12.1 Home Office Guidance[[5]](#footnote-5) requires consideration of individual needs and specifically:

* “Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the Victim, the Perpetrator and their families? Was consideration for vulnerability and disability necessary?”

1.12.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

* Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
* Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
* Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.12.3 The review gave due consideration to all of the Protected Characteristics under the Act. 1.12.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.12.4 The perpetrator and the Victim are white European Roman Catholics. The Victim had suffered breast cancer and was under the care of a Breast Care Nurse. They were both pensioners in their 70’s.

**1.13 Lessons Learned**

1.13.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Adult Safeguarding reviews and appropriate and relevant research.

**1.14 Media**

1.14.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the South Worcestershire Community Safety Board.

**1.15 Family Involvement**

1.15.1 Home Office Guidance[[6]](#footnote-6) requires that:

“members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim’s experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator’s networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances”, and:

“Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.”

1.15.2 The views of the family members and any family friends identified by the family will be taken into consideration. The family members will be invited to participate in the review process. (See section re Views of the Family)

1.15.3 These Terms of reference were considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended accordingly as necessary.

**1.16 Persons involved with the Review process**

1.16.1 The following genogram identifies the family members in this case, as represented by the following key:

|  |  |
| --- | --- |
| Victim | Female – Aged 73, Wife of Perpetrator |
| Perpetrator | Male – Aged 77, Husband of Victim |
| S1 | Female – Oldest Daughter of Victim and Perpetrator |
| S2 | Female – Younger Daughter of Victim and Perpetrator |
| S3 | Male – Son of Victim and Perpetrator |
| N1 | Neighbour of Victim and Perpetrator |
| N2 | Neighbour of Victim and Perpetrator |
| BCN1 | Breast Care Nurse |
| AN1 | Admiral Nurse |
| E1 | Gas Engineer |

**GENOGRAM**

P

V

Deceased

S1

S3

S2

**Key Female Male V – Victim P - Perpetrator**

**2.0 Summary of Key Events**

2.1 The Perpetrator was born in 1936. He married the Victim in 1979 and they had 3 children (S1, S2 and S3) all of whom are married adults. S3 lives and works in the USA. The Overview Author has had contact with the family throughout this review process and the family’s views are reflected throughout this report.

2.2 After serving in the Merchant Navy, the Perpetrator lived with his family in Yorkshire but in 1982 he moved to Worcestershire as an Engineering Manager for a National Company. His family remained in Yorkshire for 14 months before they moved to Worcestershire. He was made redundant in 1996 and didn’t work again.

2.3 At the time of her death, the Victim volunteered with a Voluntary Organisation in a local hospital. There is nothing to suggest that the Victim made any disclosures to any of her work colleagues regarding problems at home with the Perpetrator.

2.4 It was revealed by the family members that the Victim had suffered breast cancer in 2008 and was under the care of a breast cancer nurse. The family also stated that for quite some time the Victim had been concerned about the Perpetrator’s mental condition. His memory was beginning to fade and he was becoming more aggressive in his words and actions. S2 was firm in her memory that during 2007, just after the Victim had been discharged from having her mastectomy and was receiving treatment by the District Nurse, S2 was pregnant and S1 was also recovering from surgery, the Perpetrator announced that he thought he was not receiving sufficient attention from the family. He lost his temper and attempted to strike the Victim, but S1 stood between them and prevented the assault. The Victim moved out of the house to live with S1, taking pictures from the walls and intending to live separately from the Perpetrator. She lived with S1 for two weeks before she moved back home. This incident was 5 years before he was diagnosed with Early Dementia.

2.5 The Perpetrator and Victim first came to the notice of the Police on 23rd July 2000 when they responded to a domestic abuse incident between the couple. The Victim had run from the house to a neighbour in fear of her husband. The Police had been called by a neighbour who heard an argument between the Perpetrator and the Victim in their front garden. The neighbour witnessed the Perpetrator with his hands on the Victim and the Victim repeatedly saying ‘No,’ and calling the Perpetrator’s name. The neighbour thought the Victim was going to be hurt and summoned the Police.

2.6 As this was the first incident involving the Police, it was recorded as emotional domestic abuse and letters were sent from the Police to the Perpetrator and his wife that indicated independent agencies that were available to them should they so desire.

2.7 The first time the Health Services were aware of a problem with the Perpetrator was on 24th January 2012 when the Perpetrator’s GP referred him to the Early Dementia Service (EIDS) who see people at a very early stage of their diagnosis with Dementia. The Perpetrator had been sent a leaflet explaining what the EIDS service does and details of a contact number.

2.8 During the course of this review, and in order to gain an appreciation of the signs and symptoms of Dementia, the DHR Panel received a presentation about dementia from an expert on dementia from University of Worcester and the senior Matron from A&E was in attendance to contribute to the review and provide insight where appropriate.

2.9 It was explained that as we grow older, our brains change, and we may have occasional problems remembering certain details. However, Alzheimer’s disease and other dementias cause memory loss and other symptoms serious enough to interfere with life on a day-to-day basis. These symptoms are not a natural part of getting older.

2.10 In addition to memory loss, symptoms include:

* Trouble completing tasks that were once easy.
* Difficulty solving problems.
* Changes in mood or personality; withdrawing from friends and family.
* Problems with communication, either written or spoken.
* Confusion about places, people and events.
* Visual changes, such trouble understanding images.
* A gradual decline in the ability to carry out day-to-day activities
* Past events and memories feel more present than recent ones.
* Present events will trigger past memories

2.11 Family and friends may notice the symptoms of progressive dementias before the person experiencing these changes. The Behaviour Psychological Symptoms of Dementia (BPSD) include:

“Delusions, hallucinations, agitation, depressed mood, anxiety, apathy, irritability and euphoria, and often a lack of identification of pain that is expressed in behaviour.”

**February 2012 - November 2012**

2.12 On 9th February 2012 an EIDS Nurse made a home visit and saw both the Perpetrator and the Victim.

2.13 The role of the EIDS was explained to the Perpetrator and during a brief history it was revealed that the Perpetrator’s cognitive ability had gradually declined over the previous 2 years. This included repetition of questions, inability to sustain conversations in crowds, and disorientation to time, for example the year.

2.14 An EIDS Assessment was completed which identified that the Perpetrator had capacity and was able to make an informed decision about continuing with the EIDS process. The Perpetrator signed a consent form for information to be shared with the Multi-Disciplinary Team (MDT), the Perpetrator’s wife, daughter and GP. No risks were identified at that stage.

2.15 The couple explained that they regularly went to Spain for several weeks every April, and this year had an 11 week holiday booked from April. The Perpetrator was able to attend to all his activities of daily living unassisted but was reliant upon the Victim to assist him with his medication. He was fully mobile and able to drive and planned routes whilst on holiday.

2.16 The couple described their family as being close and in regular contact.

2.17 The Perpetrator declared that he drank socially up to 5 times a week, consuming 18 pints of lager a week, as well as wine whilst at home. He also smoked up to 14-15 cigarettes a day which he had done since he was in the Navy.

2.18 On 5th March 2012 the Perpetrator was seen by a Lead Consultant (DR1) at the Older Adult Mental Health Services (OAMHS). The Victim was with him at the time. DR1 informed the Perpetrator he would arrange for him to have a CT scan to clarify his diagnosis.

2.19 The Victim said that she had noticed that the Perpetrator would forget recent events or conversations which were clearly not explained by poor hearing.

2.20 During an examination by DR1, the Perpetrator became puzzled about the need for the assessment and had no recollection of the EIDS nurse visiting the family home on 5th February. The Perpetrator scored 75/100 on the Adenbrooke Cognitive Examination which is below the usual cut off of 82 and was suggestive of mild dementia. He had scored only 9/28 on the memory test and had no recollection of being asked to remember things in the first place. The Perpetrator was assessed for his Care Programme Approach (CPA) status and was recorded as Non-CPA.

2.21 The Worcestershire Health and Care NHS Trust IMR explains that everyone in receipt of Mental Health Services should have as a minimum a documented plan of care of which there is 2 types:

* Non-care programme approach consisting of a Mental Health Assessment and a Care Plan – a brief and concise document of care, often written in a narrative format
* Care programme Approach care plan

2.22 On 23rd March, the Perpetrator attended for his CT scan.

2.23 On 28th June 2012 the Perpetrator and the Victim were seen by DR1 at an outpatient clinic at OAMHS. The CT scan had shown some small vessel diseases which indicated mild dementia caused by a mixture of Alzheimer’s disease and Vascular disease. It was explained that his Dementia was very mild and would have very little impact on his day to day life. He was prescribed medication and it was considered that this was a good opportunity for the EIDS Nurse to carry out a period of post diagnosis support to help the couple carry on with their lives. There were no concerns recorded regarding his over-active, aggressive, disruptive or agitated behaviour, which were identified within the Assessment.

2.24 On 13th July 2012, the EIDS Nurse made a home visit and details of support networks including a 24 hour help/advice line was explained to both the Perpetrator and the Victim.

2.25 On 17th July 2012 the EIDS Nurse made a referral to the Worcestershire Association of Carers for the Victim. The referral requested a handbook, general information, a carer’s emergency card and other helpful information to be sent to the Victim.

2.26 On 26th July 2012, the EIDS Nurse made another home visit with a Dementia Advisor. The Victim wasn’t present and the Perpetrator said that she had forgotten about the appointment. There are no details recorded as to where the Victim was.

2.27 On 7th September 2012, the EIDS Nurse and the Dementia Advisor made a planned return visit to the family home and saw both the Perpetrator and the Victim. The Dementia Advisor explained her role and left contact details for future reference. The Victim stated that she had recently stayed overnight with her daughter and disclosed that the Perpetrator had repeatedly forgotten where the Victim was and had been concerned that she was not safe. The EIDS Nurse explained that unless further needs were identified at his forthcoming review, the plan would be to discharge him from the EIDS.

2.28 On 20th September 2012, DR1 and the EIDS Nurse saw the Perpetrator and Victim at an outpatient’s clinic and it was stated by the Victim that she felt that the Perpetrator was calmer and less frustrated by his memory difficulties. The Perpetrator was told he was to be discharged from the EIDS but County guidelines suggested that an annual review should be undertaken in Primary Care and if the Perpetrator needed specialist treatment for his dementia, this could be requested, which according to S2, indicates the onus was put on the Victim to identify when the Perpetrator required more specialist treatment.

2.29 On 12th November 2012, a letter was sent to the Perpetrator explaining this course of action and it was noted that the Victim had registered with the Worcestershire’s Carer’s Association.

**January 2013 - 20th December 2013**

2.30 On 26th January 2013, the Victim dialled 999 for the Police. The call was answered by the Emergency Services operator, but the caller (the Victim) did not speak. The Operator could hear shouting in the background before the phone was put down. The call was traced to the home address. The call was passed to the Police who attempted initially to ring the number but the call went to answer phone. The Perpetrator had smashed the telephone.

2.31 The Police attended the address and found that both the Victim and the Perpetrator had been drinking heavily. They had consumed 3 bottles of wine between them and both were deemed to be drunk. It was explained that a verbal argument had taken place which stemmed from anxiety and worry caused by the Perpetrator's recent diagnosis and he had been verbally abusive towards the Victim. She had become upset and called the Police.

2.32 Although officers tried to arrange an overnight accommodation in a local hotel, it is recorded that the Victim chose to stay with a neighbour. She explained that the Perpetrator was capable of looking after himself but she didn’t want to be too far away from him.

2.33 The Police recorded this incident as an Emotional Domestic Abuse Incident which should have resulted in the completion of a Public Protection Investigation Guidance Booklet (PPIG) at the time.

2.34 On 5th March 2013, the Victim presented at the emergency department at the local hospital with an injury to the right wrist reporting that she had tripped over that morning. On examination she had sustained an un-displaced fracture to the distal radius. There was no evidence of any inconsistency of her explanation. There is also no record of anyone attending with her and consideration must be given to the fact, that although she was able to drive, how did she arrive at the hospital with a fractured wrist? It is unclear if the Perpetrator went with her. There was no routine enquiry about the possibility of domestic abuse. However, since this date there has been considerable training and IDVAs have been placed in Emergency Departments of local Hospitals.

2.35 The following day she was seen at the Fracture Clinic and requested that the cast be removed early so she could go on holiday as planned. The cast was not removed and she went on holiday with her wrist in plaster.

2.36 On 6th August 2013, the Perpetrator’s GP sent a letter to the Locum Consultant in Older Age Psychiatry (DR2) asking for a review of the Perpetrator to be made as the Victim had stated that his memory was getting significantly worse and he was getting disorientated and agitated at times. The GP also asked if an Admiral Nurse could make contact with the Victim. The decision to categorise the Perpetrator as a non-CPA patient was by now 18 months ago and during that time, there does not appear to there have been any re-assessment of his CPA Status despite his deterioration and his increased agitation.

2.37 As a result of the letter on 8th August 2013 the CPN arranged for a blood test to be taken from the Perpetrator. The CPN spoke to the Victim over the telephone and during the conversation, the Victim described the Perpetrator as being physically aggressive at times and that he was responsible for breaking her wrist in February 2013. She also described how she had to call the Police about 9 months previously (22nd February 2013) when the Perpetrator had been threatening her. She told the CPN that she had

“learnt to agree with him as this helps him to remain calm”.

2.38 She went on to describe how he was very repetitive, and his short term memory was impaired.

2.39 The CPN recorded that the Perpetrator would need a Domiciliary Visit and that the Admiral Nurse would contact the Victim to arrange to see her the following week.

2.40 The CPN who shares an office with the Admiral Nurse recalls how she imparted the information about the broken wrist to the Admiral Nurse. The CPN, during an interview with the IMR Author, does not recall the Victim giving any further details regarding her broken wrist or the incident with the Police and that as the Victim had said that she had learnt to agree with the Perpetrator, the CPN considered this an indication that the Victim was learning to manage his behaviour. Although the CPN documented the conversation she had had with the Victim, apart from discussing it with the Admiral Nurse, she did not share the information with anyone else. There was no referral made and no risk assessment re-visited because neither the CPN nor the Admiral Nurse linked the Victim’s explanation with domestic abuse.

2.41 On 13th August, the Perpetrator was discussed at a Team Referral meeting. A brief summary of the Perpetrator’s case is recorded as well as the fact that the Admiral Nurse and the Locum Consultant in Older Adult Psychiatry (DR2) were to see the Perpetrator. There is no mention in the minutes of that meeting about the Victim’s disclosure that the Perpetrator was either physically aggressive or that he was responsible for the wrist injury.

2.42 It is considered that these were important facts missed from the Team Referral Meeting. The Overview Author has raised this issue with the IMR Author for clarification. In reply it is stated that only limited notes were taken at the Team Referral meeting and the CPN does not recall whether the wrist injury was mentioned at that meeting or not. An additional question was raised by the Overview Report Author as to whether the fact the Victim stated she had “learnt to agree with the Perpetrator” was taken as she was coping or an indication that the Perpetrator was controlling her even to the point of bullying The response was there is no evidence to suggest this was considered as the disclosure was not seen as domestic abuse. In addition, staff felt that the Victim was “in charge” and that she was a forthright character and she had chosen the degree of involvement from services that she wanted.

2.43 On 14th August 2013, the Admiral Nurse contacted the Victim by telephone regarding an appointment for an Initial Assessment. During that conversation, the Victim informed the Admiral Nurse that she felt that the Perpetrator had deteriorated since his contact with the EIDS and that she, the Victim, was finding it difficult to adjust.

2.44 Two days later, on 16th August 2013, an Admiral Nurse visited the home address for the purposes of conducting the initial assessment with the Victim. Records indicate that both the Perpetrator and the Victim were present. The Admiral Nurse documented that the Victim was finding it difficult to accept that dementia was a progressive deterioration and the Admiral Nurse felt that the Victim was looking for treatment to reduce this. It appears there was no mention of the injury caused to the Victim in February and it also appears that no one confronted the Perpetrator about the injury.

2.45 The Needs Assessment Schedule was completed by the Admiral Nurse in respect of the Victim and in doing so the following questions were asked:

* “Is there any evidence of abuse or the Patient with Dementia (PWD) needs are not being met in any of the following areas? (Physical; Psychological; Financial; Sexual; Social)”

The answer recorded was No.

* “Is there any evidence that the PWD is at risk of harming others?” The answer recorded was No.

2.46 In the narrative of the assessment the Admiral Nurse recorded that the Victim felt that the Perpetrator’s skills had deteriorated more recently and there had been an increase in his irritability, he shouts at her and he has limited patience with his grandchildren. She also recorded that the Victim did not have a good understanding of dementia and she was uncertain about how much she wanted to know. The Victim accepted an offer to attend a Psycho Educational Group to be run in October 2013. The Victim stated she found it difficult to talk about the future and how that might look.

2.47 In the GP IMR it is stated that in the Autumn of 2013 the Perpetrator was seen by the GP and a Consultant Psychiatrist. In a letter dated 14th January 2014 from the Consultant in Old Age Psychiatry, it is stated;

“Other than the occasional increased irritability and being a bit more short-tempered, there has been no significant aggression or behavioural disturbance. His wife reports no management difficulties and maintains feeling extremely well supported by the team at [Support Establishment]”.

2.48 On 12th September 2013, DR2 and a GP VTS Trainee Doctor visited the Perpetrator at home and it is recorded that the Perpetrator appeared to be less given to frustrations or episodes of increased irritability and agitation on his current dose of medication, and that the Victim had confirmed that he had been calmer.

2.49 On 2nd October 2013, the Victim attended the Psycho Educational Group where topics of understanding dementia and the brain and behaviour were covered. There is no evidence of the Victim disclosing anything about the Perpetrator’s responsibility for her injury or his aggression at this or any of the subsequent attendances at group meetings. The victim attended the Psycho Educational Group on 16th and 30th October but there is no record of her disclosing any information about her wrist injury on either of those occasions. S2 recalls that a friend of the Victim was also present at the meetings and she would have found it embarrassing to disclose her problems in front of her friend.

2.50 The family describe their mother’s attendance at these group meetings and said that initially the Victim got a lot out of the meetings and meeting other people in the same situation as her. Indeed she decided to take a friend, whose husband was in the same situation as the Perpetrator, but on this occasion there were too many people there, and both the Victim and her friend felt it was pointless and didn’t go again. The family make the point that whilst they appreciate that their mother who was the principal carer for their father was offered the courses, they were not offered any courses and knew relatively little about dementia or Alzheimer’s disease. They found it very difficult to deal with their father who was getting progressively worse.

2.51 On 19th December, the Victim told the Admiral Nurse that she had found the Psycho Education Sessions useful and also that the home situation had settled. The Admiral Nurse decided there was no further role for her and the Victim was discharged from the service but with the offer to contact the Admiral Nurse at any time should she so wish.

2.52 On 20th December 2013, the Victim was sent a letter asking her to attend a Carers and Relatives Monthly Report Group which she attended on 15th January 2014. Again there is no record of any disclosure by the Victim.

**21st January 2014**

2.53 It is known that during the 21st January 2014, the Victim and the Perpetrator were seen by a gas fitter who had attended at the home address to repair a gas cooker. All appeared well between them. It is also known that later that day a work colleague contacted the Victim and she made no disclosures of anything untoward.

2.54 Just before midnight on 21st January 2014, neighbours of the Victim, N1 and N2 were in bed when their doorbell rang at about 11.45pm. They found the Perpetrator at their door asking them “how do you get 999” and stating that he couldn’t rouse the Victim and she was asleep in the chair. The Perpetrator was wearing normal day time clothes which were described as smart with a green jacket.

2.55 The neighbours went to his assistance and went to the Perpetrator's house where they found the Victim lying on the floor in the hallway and not in a chair as the Perpetrator had described.

2.56 N1 saw that she was injured and thought that she was dead. The ambulance service was summoned and the police attended. Both N1 and N2 asked the Perpetrator what he had done but the Perpetrator didn’t seem to know. It was noticed that he had a bruising injury to his hand, which he could not explain.

2.57 Ambulance personnel declared the Victim dead at the scene, and the Perpetrator was arrested and detained.

2.58 A subsequent post mortem was conducted by Forensic Pathologist who found there were numerous significant injuries to her head, neck and face, as well as fractures to her ribs and deep bruising to both sides.

2.59 The cause of death was recorded as multiple injuries including blunt head injury.

2.60 The Perpetrator was detained in a secure mental hospital until his appearance before the Worcester Crown Court on 26th January 2014 where after a hearing of fact, the jury concluded that he was responsible for the death of the Victim but the court accepted that he was unfit to plead The case was adjourned until Friday 9th January 2015 when, at Worcester Crown Court, he was made subject to a Hospital Order under Section 37 Mental Health Act 1983, with further restrictions for public safety under Section 41, should his release ever be considered.

**Views of the Family**

2.61 The Author of the Overview Report visited the eldest daughter of the Victim and Perpetrator on 3rd September 2014. She was being supported at that time by a senior member of AAFDA. She expressed the views of herself and her sister and brother in that the Victim was a private person and would be reluctant to openly share her matrimonial problems with anyone. The daughter did however explain the history of the family from when her and her siblings were youngsters. Their father, the Perpetrator, was a very strict disciplinarian and she described Sunday lunch after a Roman Catholic Church service in the morning, as being a tense time when the Perpetrator eventually arrived home from the Public House. Any minor infringement such as talking or dropping food would result in physical chastisement. She described how her brother was hit and bruised and their mother told the sisters to tell his school he had fallen off a slide. She also stated that the mother would also inflict physical chastisement.

2.62 In relation to her father, the daughter explained how he was often physically violent towards the children and his wife, and would take pleasure during the church service when the congregation shake hands during the “sign of peace”, he would squeeze other members of the congregations hands so tight to hurt them. She summed up her father as;

“He was not a man who became violent due to dementia. He was a violent man who got dementia.”

2.63 The daughter explained that during the period her father had left Yorkshire and moved to Worcestershire to work, he left the family behind and would travel home at weekends on occasions. She described that period of 18 months as;

“the best 18 months of her childhood”.

2.64 The daughter explained how she tried to get her mother to see a different GP because her mother had told her GP that the Perpetrator was becoming more aggressive and she was dissatisfied with the GP’s lack of appreciation of the situation. The mother at that time reported being depressed which the GP dismissed and said she could see another GP if she wanted. The daughter spoke to her mother about taking the father into care but the mother replied that she wouldn’t do that.

2.65 Apart from the daughters and a CPN, no other person was fully aware of the actual details of the Perpetrator’s increased aggression.

2.66 In relation to her mother, the daughter stated that her mother and her own 3 siblings were all beaten by the grandmother and considered such behaviour as learned behaviour. The other daughter also stated to the Police that she was concerned about the amount of alcohol her mother consumed and it had got to the stage that she would only telephone her mother in the morning when she knew she would be sober. She describes how her mother’s drinking caused a barrier between her and her mother.

2.67 On 10th June 2015, the Overview Author visited S1 to inform her of the findings of the review process. The Overview Author went through went through the report with her in great detail as well as the recommendations and action plan. S1 confirmed that she was content with the report and the findings and she thought it was a good representation of the life her Mother lived with the Perpetrator. She requested that it be included in the report, that her Father was a violent man who did not need alcohol to fuel his aggression or violence. She considered him to be a bully. She was particularly anxious for the report to illustrate that the Victim wanted to change GPs from a male GP, who in her opinion, was not empathetic towards her Mother’s depression, to a female GP in the same practice who had dealt with the victim during her breast cancer treatment. The surgery told the Victim that she could not change GP and had to stay with the male Doctor. S1 is of the opinion that her Mother was prepared to disclose details of her life with the Perpetrator to the female Doctor and was prevented from doing so by not being allowed to change GPs.

2.68 On 19th June 2015, the Overview Author saw S2 for the first time during this review and the contents of the report discussed. Like her sister, she was content with the report and the finding but stressed that the following points should be included.

2.69 S2 was concerned that her Mother’s GP was not mentioned in any significant detail and she had some strong thoughts about the conduct of the GP in relation to her parent’s needs. She described that to her knowledge both her Mother and Father would make almost weekly trips top their GP. They always went together whoever was the patient on any particular day. She described the many blood samples both of them had taken during the course of their respective treatments but she also described that how she was aware that the GP was aware that both of her parents drank alcohol. Her argument is that the GP must have been aware that both parents, especially the Perpetrator was drinking to excess and the GP appeared to have failed to reconcile any link between medication, alcohol in excess and dementia as a risk of potential Domestic Abuse. There was no suggestion of either Parent being given or referred for advice on their drinking habits.

2.70 One hypothesis S2 considers is the fact that the Perpetrator liked to give the impression that he was a devout Roman Catholic and busied himself in Church during Mass to be popular. She is also aware that the GP concerned was part of that congregation and wonders is there is anything of significance there.

2.71 About the report, S2 is of the opinion that the GP was under represented within the report and considers that the GP appears defensive with regard to the action of himself and the practice with regard to the Perpetrator, and there is a reluctance on behalf of the GP to accept that the GP and practice could have done better. In response to those comments the GP’s surgery has been invited to comment and have done so by submitting significant information that contradicts the views of the family. However, the family being supplied with the surgery’s view (with permission) have now conceded that their mother and father did receive adequate medical attention from the GPs.

2.72 The Overview Report Author has been supplied with a short list of friends and neighbours of the Victim, who, it was thought, could provide useful information to the Review process. West Mercia Police has supplied the Author with the details of the witness statements taken from these people and their views have been incorporated into this review.

**3.0 Analysis and Recommendations**

3.1 The Perpetrator's dementia was clearly becoming a more significant feature affecting the relationship between him and the Victim during the latter part of 2013. He had been assessed in March 2012. The result of the assessment was that his status was recorded as being non-CPA[[7]](#footnote-7), which means that the conditions set out under the policy do not have to be strictly adhered to. For example, everyone in receipt of mental health services should have a documented plan of care. When a patient is recorded as non-CPA that plan of care is a brief and concise document often written in a narrative form.

3.2 However, Section 13.0 of the policy indicates that any care plan should be reviewed as a continual and collaborative process. There is evidence that the Perpetrator was seen on a regular basis but any review of his care plan should have taken account of the comments made by the Victim as time progressed and his dementia deteriorated. Such comments as:

“he is becoming more aggressive” and “I have learnt to agree with him”.

3.3 The Safeguarding Service Manager of the Integrated Safeguarding Team, NHS Trust made a helpful comment about this situation:

“[This] is a case where the information about the victim reporting increased aggression and injury and the deterioration in the dementia [of the Perpetrator] not being effectively shared across the whole care team (to include GP and psychiatrist). This failure then meant that the risk assessment was not an accurate reflection of the current risk and therefore did not prompt the transfer to full CPA. So it was a lack of recognition of risk not leading to CPA policy being followed rather than just the CPA policy wasn’t followed.”

3.4 Commenting about the learning from this event, the Safeguarding Service Manager states:

“In hindsight, of course, [it is] now known that there had been years of domestic abuse. Whether domestic abuse had been recognised by staff or not, the learning for us as an organisation is  that risk must be recognised and information recorded and shared effectively in order that the right care can be delivered to support and protect those at risk.”

3.5 This comment accurately reflects the detail in the recommendations made by the Trust in the IMR recommendations and there is little need to repeat that learning within Overview report recommendations.

3.6 On 8th August 2013, the Victim disclosed to the Community Psychiatric Nurse that her broken wrist from February 2013 had been caused by the Perpetrator. The CPN spoke to the Admiral Nurse about that incident but neither of them recognised that comment to be an indication of domestic abuse. This information was not shared with any other professional or agency. It was recorded in the Team notes.

3.7 Both the CPN and the Admiral Nurse have been spoken to about this conversation and their responsibility once a disclosure is made to that effect. Both recognise, after reflection that they had missed an opportunity and both now realise that by not appreciating the significance of the comment, more should have been done. They both consider this to be valuable learning for themselves and the organisation. The Health IMR reflects this issue in their recommendations which in turn should affect health training both internally and externally. It is also appreciated that at that time the likelihood of their peers asking the questions about domestic abuse in these circumstances would have been very slim.

3.8 The IMR Author rightly points out that the Victim was given the opportunity to be seen alone for her carer’s assessment but chose this to be undertaken at home where the Perpetrator was present. The Admiral Nurse, in undertaking the carer’s assessment is clear that if the Victim had expressed a wish to speak to her alone, this would have been arranged.

3.9 The IMR Author also points out that the Victim attended several Psycho Educational Group Meetings without the Perpetrator being present and this would have afforded her opportunities to disclose should she have so desired.

3.10 In retrospect looking at the pathology report, and the significant injuries that the Victim had suffered, it is clear that the domestic abuse inflicted on her by the Perpetrator had taken place over a considerable period of time. It may be considered that her reluctance to disclose was influenced by her perceived duty as a wife to stand by her husband as described by her daughter. This ingrained duty may have been influenced again by religious beliefs, and her own upbringing, and a sense of what goes on behind doors is no one else’s business.

3.11 There were, however, comments made by the Victim to her GP and other health professionals indicating that the situation at home was worsening and these comments do not appear to have triggered any reaction or consideration that such comments were indicative of domestic abuse happening at home.

3.12 Richardson[[8]](#footnote-8) et al describe findings in 2002, of research into under-identification of domestic violence in Primary Care. Her report states:

“results from GPs show most women experiencing domestic violence are not identified in their medical records.” and

“GPs fail to document a history of domestic abuse in about three quarters of women who have experienced it”, and

“a third of women who had experienced domestic violence reported telling their GP.”

3.13 Mention has been made about a letter in January 2014 from a Consultant in Old Age Psychiatry to the GP. The GP IMR states

“This did not raise any concerns and no concerns were raised with the surgery at any time by any other outside agencies. At no stage did the surgery have any concerns regarding the possibility of domestic violence”.

3.14 There is no evidence that the GP’s practice was complying with the Royal College of General Practitioners Guidance[[9]](#footnote-9) regarding domestic abuse which states that GPs should adopt an assertive approach to questioning patients about the possibility of domestic abuse, that a member of the practice should be considered the single point of contact for information for patients regarding support and voluntary agencies, and that all members of staff, both medical and non-medical should receive training on recognising and dealing with domestic abuse issues.

**Recommendation No 1[[10]](#footnote-10)**

**NHS England should circulate the NICE Guidance 2014 and the RCGP 2012 guidance on Domestic Abuse to all Worcestershire GPs.  NHS England and NHS Redditch and Bromsgrove, NHS Wyre Forest and NHS South Worcestershire Clinical commissioning Groups (CCGs) should support local GPs to implement guidance and offer additional training**

3.15 These recommendations are also commensurate specifically with Recommendation No 16 NICE[[11]](#footnote-11) guidance of 2014. Since the domestic homicide the three Worcestershire CCGs have introduced bespoke domestic abuse training in addition to its coverage in Level 3 Mandatory Training for GPs.

3.16 West Mercia Police had interacted with the Victim and the Perpetrator only on 2 occasions prior to the death of the Victim. Both were for domestic abuse incidents, however, these were separated by 13 years and both incidents recorded as standard risk domestic arguments. Indeed the Victim refused to admit that the incident in January 2013 was a domestic abuse incident.

3.17 The Police IMR Author indicates that on both occasions the Police acted appropriately, albeit that the officer attending in January 2013 failed to submit the necessary Public Protection booklet. This was subsequently identified by the Risk Management Assessor and rectified. Due to both incidents both being recorded as low level domestic arguments, there was no referral to either Health or Adult Social Services.

3.18 Since March 2014 Harm Assessment Units (HAU) have been created in Warwickshire and West Mercia Police areas. These units record the risk assessment and referrals for child protection and domestic abuse incidents

3.19 Staff within the HAU carry out research of Police Intelligence Systems which includes persistent callers, concerns for safety, mental health issues, vulnerable adults, domestic abuse and child incidents. This means that any repeat calls to the same named people or addresses will be identified.

3.20 In this case the Police IMR indicates that the lack of information sharing prevented an accurate intelligence picture being obtained which may have highlighted the increase in the aggressive and violent behaviour of the Perpetrator towards the Victim which may have in turn led to increased support being put in place for both the Victim and the Perpetrator.

3.21 In addition to the HAU’s, Warwickshire and West Midlands Police have introduced significant Mental Health training for all public facing staff and control room staff which included specifically a Mental Health and Dementia Week during May 2014.

3.22 In relation to the Police response to domestic abuse, in September 2013, Her Majesty’s Inspector of Constabulary (HMIC) was commissioned by the Home Secretary to inspect Police forces in relation to domestic abuse and the force's response to “Everyone’s Business – Improving the Police’s response to domestic abuse”[[12]](#footnote-12).

3.23 Since the period of the incident, West Mercia and Warwickshire Police have piloted the use of Domestic Violence Protection Notices (DVPN) which has now been implemented throughout the force. The Police IMR indicates however that there is work needed to ensure that all officers across the force should have knowledge of DVPNs to avoid victims of domestic abuse receiving services which are not the best when prosecution does not take place. This matter is raised in the Police IMR recommendations.

**Recommendation No 2**

**West Mercia Police to confirm with Worcestershire Community Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices has been completed for all officers within the force.**

3.24 Research into Domestic Abuse among older adults and those with dementia find many characteristics of this case to be similar to the results of the research.

3.25 Moulton[[13]](#footnote-13) reported in 2003 that older females experience higher rates of abuse than older males even after accounting for their larger proportion of the aging population Bonomi’s[[14]](#footnote-14) research in 2007 into intimate partner violence in older women, found that over a quarter of the women in the sample with a lifetime partner, encountered domestic *violence.*

3.26 This Review found that the Victim was reluctant to disclose her situation, albeit, she eventually did disclose to her CPN but her disclosure went unrecognised. In 2003, Flannery[[15]](#footnote-15) found that individuals who experience domestic abuse are usually quiet-natured, have a past history of victimisation, limited interpersonal coping skills and excessive denial. Flannery goes on to find that people who have dementia are at risk of perpetrating domestic abuse, especially when those characteristics are present in the caregiving relationship. Flannery adds:

“Domestic Violence can become a way of life for these women, from which, it is difficult to break free”.

3.27 Such was the case with the Perpetrator and the Victim in this case.

3.28 An Australian study of domestic abuse involving Dementia sufferers by Cahill and Shapiro[[16]](#footnote-16) in 2008 found that in a sample of 39 female carers, there was aggression against the carer in 89% of the cases, of which serious violence was found in 26% of the cases, and that unlike other dementia-related behavioural problems, aggression is a relational problem, which,

“seems likely to challenge the very core of the relationship”.

**4. Changes since this incident occurred.**

4.1 It should be noted that in February 2014 NICE issued guidance[[17]](#footnote-17) entitled "Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively’.

4.2 This guidance has been acted upon in Worcestershire and many of the recommendations are being progressed in partnership. An extensive programme of training and awareness raising is being done across health including inputs to F1 and F2 doctors, GP's, A&E professionals, Midwives, Specialist Cancer Teams, Consultants and Physiotherapists.

4.3 As part of this work they have undertaken a pilot within the main Worcestershire hospital (subject of this review) with the co-location of a Specialist Independent Domestic Abuse Advisor, (IDVA) who works across the hospital but with an emphasis of working within A&E, midwifery and alongside mental health professionals.

4.4 In addition the Worcestershire Forum against Domestic Abuse and Sexual Violence has worked with the hospital on a number of campaigns and conferences at the hospital and, most recently, the Hospitals across Worcestershire were fully engaged in the White Ribbon campaign during the International 16 Days of Action.

4.5 The Forum has also worked alongside the Local Safeguarding Children's Board and domestic abuse e-learning is freely available to all health professionals as a part of their ongoing professional development.

4.6 It should be acknowledged that much work has been done to raise awareness of the specialist domestic abuse services across Worcestershire during the last two years and demand as a result of this, has at times, and increased by some 79%. Specialist resources have been developed with the involvement of survivors and these are widely available across the county and promoted through the media.

4.7 On 26th January 2015, the Worcestershire Acute Hospital NHS trust launched its new Cancer Services Holistic Assessment Guidelines and domestic abuse features heavily. An hour's awareness presentation is provided by the domestic abuse strategic coordinator.

4.8 Individual agencies have made recommendations particular to their own agency within their respective IMRs, which are replicated with the Action Plan to this report. All agency recommendations are pertinent to this review and are supported by the Author and the Panel.

4.9 West Mercia and Warwickshire Police are intent on instigating MASH (Multi-Agency Safeguarding Hubs) across both forces areas. Hereford and Telford already have operational MASH units, and the rest of Worcestershire is to follow by April 2015. The purpose of MASH is to ensure that referrals, information and intelligence are immediately shared among agencies and acted upon. Many Police Forces across the country have similar designed units.

4.10 In the IMR from Worcestershire Health and Care Trust, the IMR Author make a recommendation for WFADA to review and update multi-agency procedures. Because it is a multi-agency recommendation it is contained in this overview report.

**Recommendation No 3**

**Worcestershire Forum Against Domestic Abuse to review and update the Multi Agency Procedures to ensure that they are visible to professionals on the website on the ‘Information for Professionals’ page.**

**5. Conclusions**

5.1 There is no doubt that his mental illness contributed significantly to the circumstances that led to the Victim’s death. However, it is clear from evidence from his daughter that the Perpetrator was for the most part of his life an aggressive and violent person, albeit this was unknown to any agency with the exception of one incident disclosed to Worcestershire Health and Care Trust which was not recognised as need for concern,

5.2 The Victim was clearly a woman who was very private but strong willed and was reluctant to admit that her life with her husband was violent and clearly a painful process. Other than the occasional incident such as asking for shelter for one night at the neighbour’s house, there was no indication outside the immediate family of any problems between the Victim and the Perpetrator. Police attended on two occasions for two minor domestic arguments, one if not both of those incidents fuelled by alcohol. It was known that both the Victim and the Perpetrator would drink alcohol, sometimes to excess. Other than that to an outsider they seemed to be a reasonably happy married couple who enjoyed long periods of holiday abroad each year.

5.3 It is clear now that as his dementia deteriorated, life was becoming more difficult for the Victim. She visited the GP on numerous occasions alone and again this would have afforded her the opportunity to disclose if she wished. However, the GP did not pro-actively ask questions regarding Domestic Abuse or consider that any violent behaviour thought to be a symptom of his dementia, was in fact a progression of what we now know was existing violence.

5.4 This was the same for the CPN who did not make the links to DA albeit, in this case, the Victim did disclose DA. There appeared to be a lack of knowledge regarding connecting violent behaviour associated with dementia to domestic abuse. There is much research that focuses on the dementia sufferer as being more likely to be the victim of DA rather than the carer being the victim. According to S1 the victim wanted to change GPs to the female GP at the surgery, who had treated her during her breast cancer problems and it is the opinion of S1 and S2 that she may have disclosed to the female GP. They contend that despite her requests to change the practice would not let her change.

5.5 These comments should have been explored further. They should have raised concerns especially given the known facts, signs and symptoms surrounding the deterioration of dementia patients, which often includes increased aggression at the very least.

5.6 It has been mentioned that both the Perpetrator and the Victim drank alcohol to excess. The role played by alcohol or drug misuse in domestic violence and abuse is poorly understood. Research has indicated that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs (Smith et al. 2012)[[18]](#footnote-18).

5.7 Had all the above comments been recognised, additional support may have been available for both the Victim and the Perpetrator.

5.8 There were missed opportunities to intervene with both the Perpetrator and the Victim and to support the wider family. This may have presented opportunities to mitigate against serious harm, but the Panel are of the view, intervention may not necessarily have prevented the death of the Victim.

**List of Recommendations**

**Recommendation No 1** Page 25

NHS England should circulate the NICE Guidance 2014 and the RCGP 2012 guidance on Domestic Abuse to all Worcestershire GPs.  NHS England and NHS Redditch and Bromsgrove, NHS Wyre Forest and NHS South Worcestershire Clinical commissioning Groups (CCGs) should support local GPs to implement guidance and offer additional training

**Recommendation No 2**  Page 26

West Mercia Police to confirm with Worcestershire Community Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices has been completed for all officers within the force.

**Recommendation No 3** Page 28

Worcestershire Forum Against Domestic Abuse to review and update the Multi Agency Procedures to ensure that they are visible to professionals on the website on the ‘Information for Professionals’ page.

**Bibliography**

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**South Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 6**

**ACTION PLAN**

**Overview Report Recommendations**

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| **Recommendation** | **Action Required by Agency** | **Implementation Lead** | **Target Date for Completion** | **Summary of Action Taken and Date** |
| **Recommendation No 1**  NHS England should circulate the NICE Guidance 2014 and the RCOP 2012 guidance on DA to all Worcestershire GPs.  The named GP for the Worcestershire CCGs should support the local GPs to implement the guidance and offer additional training to practices | NHS England (Worcestershire) circulates NICE guidance of 2014 and RCGP guidance 2012 to all Worcestershire GPs.  CCG | Vikki Tweddle NHSE  Ellen Footman | July 2015  June 2015 onwards | Both NICE guidance and RCGP guidance re-issued to all GP's across Worcestershire.  The principles within the guidance's are being re-enforced through focused training with GP's and health staff commissioned by the CCG.  This training is wider than the guidance and seeks to develop the awareness of health professionals around domestic abuse and the range of specialist support agencies within Worcestershire. The training is being supported by a range of materials for both professionals and service users. |
| **Recommendation No 2**  West Mercia Police to confirm with Worcestershire Community Partnership within 6 months of the date of this report that information regarding the dissemination of the use of Domestic Violence Protection Notices has been completed for all officers within the force.  **Recommendation No 3**  Worcestershire Forum Against Domestic Abuse to review and update the Multi Agency Procedures to ensure that they are visible to professionals on the website on the ‘Information for Professionals’ page. | West Mercia Police  Worcestershire Forum Against Domestic Abuse | Martin Lakeman | September 2015  July 2015 | Policy under review with inclusion of key agencies including both Children's and Adult Safeguarding Boards, Health and voluntary sector. |



**South Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 6**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: Worcestershire Health and Care NHS Trust**

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| **Recommendation** | **Action Required by Agency** | **Implementation Lead** | **Target Date for Completion** | **Summary of Action Taken and Date** |
| **Recommendation No 1**  WH&C NHS Trust will give consideration to making domestic abuse training essential for all staff who have direct contact with patients, particularly those who may be undertaking assessments and involved in delivering interventions that may give opportunity to question concerns more fully in a safe and secure environment as well as being in a position where disclosures may be made. | Worcestershire Health and Care NHS Trust |  | September 2015 | Domestic Abuse training has been promoted at all events and Trust Safeguarding meetings and has been highlighted in reports to Trust Quality and Safety Committee. The Trust runs domestic abuse training sessions for staff and staff have access to online learning via Worcestershire Safeguarding Children Board. So far 116 staff have attended a one day face to face session and 11 staff   have completed the online module |
| **Recommendation No 2**  WH&C NHS Trust will continue to promote all internal and external training that is available in respect of domestic abuse to ensure all staff understand that domestic abuse is a considerable risk for both adults and child victims. | Worcestershire Health and Care NHS Trust |  | September 2015 | As above |
| **Recommendation No 3**  WH&C NHS Trust to run courses regarding Dementia Care. Discussions will take place to see if a section regarding awareness of domestic abuse can become an integral part of this course | Worcestershire Health and Care NHS Trust |  | September 2015 | Conversations have taken place and the course content has been updated to reflect this. |
| **Recommendation No 4**  WH&C NHS Trust will have a Domestic Abuse Policy in place by the end of December 2014. | Worcestershire Health and Care NHS Trust |  | December 2014 | Following some delay, this policy was ratified on 25th March 2015. |
| **Recommendation No 5**  WH&C NHS Trust will ensure that the learning from this review will be shared with all the staff involved in this case and the key learning points will be disseminated to all relevant WH&C NHS Trust staff. | Worcestershire Health and Care NHS Trust |  | September 2015 | This has been undertaken with senior managers and the safeguarding working group.  Once the review is published the staff involved will be contacted and feedback will be arranged. |
| **Recommendation No 6**  The WH&C NHS Trust’s Intranet in relation to Domestic Abuse will be reviewed and updated. | Worcestershire Health and Care NHS Trust |  | September 2015 | This work is underway. |



**South Worcestershire Community Safety Partnership**

**Domestic Homicide Review Case No. 6**

**ACTION PLAN**

**Individual Management Report Recommendations**

**Agency: West Mercia Police**

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| **Recommendations** | **Action Required by Agency** | **Implementation Lead** | **Target Date for Completion** | **Summary of Action Taken and Date** |
| **Recommendation No 1**  West Mercia Police to satisfy themselves that referral processes are robust, irrespective of the complex needs of individuals and how incidents are recorded on Police systems, specifically where Vulnerable Adult & Domestic Abuse cases overlap. | West Mercia Police | DCI Pettit | September 2015 | Immediate HAU and All Front Line Supervisors have undergone Women’s Aid and Police joint training.  Electronic DASH is more explicit to capture children’s details as well as HAU being used to screen and signpost to relevant organisations were overlap is identified. |

1. Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance [↑](#footnote-ref-1)
2. Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office [↑](#footnote-ref-2)
3. Home Office Guidance 2013 page 15 [↑](#footnote-ref-3)
4. Home Office Guidance 2013 page 11 [↑](#footnote-ref-4)
5. Home Office Guidance page 25 [↑](#footnote-ref-5)
6. Home Office Guidance page 15 [↑](#footnote-ref-6)
7. Mental Health Care Planning (CPA) Policy Worcestershire Health and Care NHS Trust March 2013 [↑](#footnote-ref-7)
8. Identifying domestic violence: Cross sectional study in primary care. Richardson J. et al BMJ 2002;324;274 [↑](#footnote-ref-8)
9. Responding to domestic abuse: Guidance for general practices, Royal College of General Practitioners, June 2012 [↑](#footnote-ref-9)
10. A similar recommendation was made in DHR 2 (JH) and work is in progress to improve this situation. See the section of this report ‘Progress since the events.’ [↑](#footnote-ref-10)
11. Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively - NICE February 2014 [↑](#footnote-ref-11)
12. Everyone’s Business – Improving the Police Response to domestic abuse, March 2014, Home Office [↑](#footnote-ref-12)
13. Intimate partner violence and health statue among older women. Moulton C.P. 2003Violence Against Women [↑](#footnote-ref-13)
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17. Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively - NICE February 2014 [↑](#footnote-ref-17)
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