Approved for publication 2015

Cheshire West and Chester Community Safety Partnership

Domestic Homicide Review
Executive Summary

Report into the death of Adult A in September 2012

Glossary

CAADA	Coordinated Action Against Domestic Abuse. CAADA is a national charity supporting a strong multi-agency response to domestic abuse
CAADA – DASH	Risk assessment checklist focussed upon risks associated with Domestic Abuse, Stalking and 'Honour'-Based Violence.
CAADA Leading Lights	A status awarded by CAADA. Leading Lights status is the mark of quality for domestic abuse services.
DHR	Domestic Homicide Review. Became law from 13th April 2011. They do not replace but will be in addition to the inquest or any other form of inquiry. They consider what happened and what could have been done differently
G.P.	General Practitioner
IMR	Independent Management Review. Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made. To identify how those changes will be brought about. To identify examples of good practice within agencies.
MARAC	Multi Agency Risk Assessment Conferences. Regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies.
SIO	Senior Investigating Officer

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1.0 INTRODUCTION

1.1 This is an executive summary of the overview report which has been completed following the death of Adult A (F) and the subsequent domestic homicide review, which was commissioned by Cheshire West and Chester Community Safety Partnership.

1.2 The death of Adult A (F) took place between the 5th and 7th September 2012 during an incident involving her husband Adult B (M) at their home address in Winsford, Cheshire.

1.3 On 26th September 2013 Adult B (M) pleaded guilty to the manslaughter on the grounds of diminished responsibility of Adult A (F) and has been sentenced to a period of five years imprisonment.

1.4 The criminal trail encountered a total of six adjournments, for reasons largely concerned with obtaining of expert medical opinion in respect of Adult B (M), which prevented this case coming to trial.

1.5 This in turn delayed the work of the Domestic Homicide Review Panel as, at the request of the Senior Investigating Officer in the criminal case, witnesses who were family and friends of the victim were not interviewed until the conclusion of the criminal trial. The impact has been a delay in completion of the Review within the timescales contained in paragraph 6.1 of the Statutory Guidance.

2.0 TERMS OF REFERENCE

2.1 The circumstances surrounding the death of Adult A (F) met the criteria of the Act and required the establishment of a Domestic Homicide Panel and the completion of a Domestic Homicide Review into the incident.

2.2 The following agencies formed the Domestic Homicide Review Panel and each representative from those agencies completed an Independent Management Review.

- Cheshire West and Chester Council, Prevention and Wellbeing
- Cheshire Police
- Mid Cheshire Hospitals NHS Foundation Trust
- Cheshire Probation Trust
- South and Eastern Cheshire Clinical Commissioning Group
- Cheshire and Wirral Partnership NHS Foundation Trust
- Vale Royal Women's Aid

2.3 The terms of reference which the Panel followed when undertaking this work, and completing the Independent Management Reviews, included the following key lines of enquiry.

1. Communication and co-operation between different agencies involved with Adult A (F) and Adult B (M).

2. Were opportunities for agencies to identify and assess domestic abuse risk missed?

3. What were the Agency responses to any identification of domestic abuse issues?

4. Do organisations have access to specialist domestic abuse agencies in Cheshire West and Chester?

5. The training available to the agencies involved on domestic abuse issues.

6. Review the care and treatment, (including risk assessment and risk management of the couple), in relation to their primary and secondary mental health care.

2.4 The key dates for the Domestic Homicide Review were 7th September 2010 and the date of Adult A's (F) death in 2012. However, the work of the panel included reference to issues dating back to 1998 involving both Adult A (F) and Adult B (M).

2.5 In addition to the Independent Management Reviews, family and friends of Adult A (F) and Adult B (M) contributed to the Review through interviews with the Chair of the Panel.

3.0 SUMMARY OF EVENTS LEADING TO THE DEATH OF ADULT A (F)

3.1 Adult A (F) and Adult B (M) had lived in the same house within a small and close knit community since their marriage 45 years before. In September 2012 friends identified a change in the routine of the couple, and called at the home where, having been granted entry into the house by Adult B (M,) they discovered the body of Adult A (F) in one of the bedrooms.

3.2 The Home Office pathologist documented in excess of 60 injuries to the head and body of Adult A (F), and the fracture of her spine in two places. The cause of death of Adult A (F) was recorded by the Pathologist as blunt trauma to the head caused by multiple blows.

3.3 The injuries had been caused by Adult B (M) who punched his wife several times as she lay in bed, and further whilst she lay on the floor of her bedroom. Adult A (F) tried to fend off Adult B (M) using her walking stick, but was then subjected to a sustained assault, which included Adult B (M) striking Adult A (F) with her own walking stick.

4.0 INDEPENDENT MANAGEMENT REVIEWS

4.1 Prior to the fatal attack of Adult A (F) in September 2012, with the exception of a small number of occasions when Adult A (F) and Adult B (M) had contact with Health Professionals, this couple maintained a closed relationship rejecting support and contact from all but a small number of family, and friends each of whom they had known for over 40 years.

4.2 Lack of evidence of engagement with organisations, both public and voluntary, underlines family and friend's description of the relationship as being very private.

4.3 The majority of Independent Management Reviews were returned indicating that there had been no contact between the agency or organisation and either Adult A (F) or Adult B (M).

4.4 South and Eastern Clinical Commissioning Group

4.5 The Independent Management Review details the effective information sharing which existed between the Accident and Emergency Services and the G.P. of Adult A (F).

4.6 This followed two incidents of Adult A (F) requiring the assistance of the Ambulance Service. Firstly following a collapse at a bus stop due to an acute spell of dizziness which did not result in admission to hospital, but did result in a follow up visit to the home of Adult A (F) by the Ambulance crew, who noted no safeguarding issues being present but a concern for Adult B (M) by his wife who identified to them that she was Adult B's (M) carer.

4.7 The second incident (in 2012) was a call received by the Ambulance Service from Adult A (F) who was suffering from acute back pain. Adult A (F) was taken to the Accident and Emergency Department of a local hospital where she was examined prior to being discharged with pain relief medication.

4.8 Once in receipt of information regarding the second incident her G.P. visited Adult A (F) at her home. The G.P. noted poor mobility in Adult A (F) and the challenge this presented to her care of Adult B (M). However clinical notes indicate that Adult A (F) refused the offer of a referral by the G.P to support agencies indicating that friends and family would help.

4.9 Mid Cheshire Hospitals NHS Foundation Trust

4.10 This Independent Management Review details the examination which took place involving Adult A (F) following her transfer to the Hospital by ambulance suffering from acute back pain. The cause of the back pain was diagnosed as the result of degenerative changes which were age related.

4.11 The Review also details the alert system which exists within Accident and Emergency Departments to alert clinicians of existing safeguarding concerns for the patient and the admission process and examination, during which further signs or symptoms of domestic abuse are looked for.

4.12 Together the Clinical Commissioning Group and NHS Trust Independent Management Reviews also detail interventions undertaken by the Elderly Mental Health Team within Secondary Mental Health Services following a referral by the G.P. of Adult B (M) in 1998.

4.13 Records indicate the referral by his G.P. of Adult B (M) resulted from a urinary flow obstruction which was making Adult B (M) very agitated. Adult B (M) did not respond to usual treatment to reduce anxiety and his G.P. then referred Adult B (M) to the Elderly Mental Health Unit in Secondary Mental Health Services.

4.14 Diagnosis following the first visit to Secondary Mental Health Services was that Adult B (M) was suffering from an anxiety state, with underlying depression, associated to problems with his prostate.

4.15 During the second half of 1999 Adult B (M) commenced treatment with anti-depressant medication; initially his psychiatrist noted responded "remarkably well" to the medication. As a result he was taken off the treatment, but Adult B (M) regressed

and medication was reinstated. Adult B (M) finally ceased taking this medication in 2004.

4.16 The Panel also had access to a Joint Health and Social Care Report produced at the request of the Crown Court prior to sentencing Adult B (M). This report identifies that whilst on remand Adult B (M) was diagnosed as suffering from Frontal Temporal Dementia with accompanying symptoms of emotional detachment.

5.0 SUMMARY OF KEY FACTS

5.1 The death of Adult A (F) took place sometime between the 5th and 7th September 2012. The catalyst for this homicide was a disagreement between Adult A (F) and Adult B (M) over operation of the house central heating system and financial matters.

5.2 At the time of her death Adult A (F) was an eighty two year old female who had been married to Adult B (M) for 45 years and they had lived as a married couple in the same house which they owned in Winsford, Cheshire from the date of their marriage in 1967. In the later years of their marriage Adult A (F) filled the role as the main carer for her husband.

5.3 Adult B (M) is a seventy nine year old male who worked until his retirement 21 years previously at the age of 58 years.

5.4 Adult A (F) and Adult B (M) lived the whole of their married life within a settled community and restricted contact with anyone outside of their marriage to a small group of people. This included family and friends. This small group of contacts had each known the couple, Adult A (F) and Adult B (M), for at least 40 years.

5.5 As a married couple Adult A (F) and Adult B (M) were described by all who had contact with them as being very private, independent and very loyal to each other. One person described the relationship between Adult A (F) and Adult B (M) as a "close marriage until 2000 then Adult B's (M) behaviour changed and he became anxious". Another described the relationship as "both could be short with each other." However, even in recent years, it was said that "both had their wits about them".

5.6 Following treatment by his G.P. for a physical condition which was making Adult B (M) very agitated, Adult B (M) was referred to the Elderly Mental Health Unit in Secondary Mental Health Services since Adult B's (M) anxiety did not respond to usual treatment.

5.7 Diagnosis by Secondary Mental Health Services was that Adult B (M) was suffering from an anxiety state, with underlying depression, associated to problems with his prostate. Adult B (M) remained on medication for this anxiety between 1999 and 2004.

5.8 Adult B's (M) psychiatrist noted that he had initially responded "remarkably well" to the medication. As a result he was taken off the medication but late in 1999 friends of Adult A (F), at her request, contacted Adult B's (M) Doctor requesting a home visit to treat Adult B (M) who had become very agitated.

5.9 The G.P. who treated Adult B (M) that evening noted that he was "very agitated and wide eyed and his wife was frightened." Adult B (M) was immediately placed back on his medication but no records or further description can be found relating to Adult

B (M) "frightening his wife." There is no record of a referral to another agency, or domestic abuse risk assessment being completed following the home visit by a colleague from the same surgery as Adult B's (M) G.P.

5.10 Further analysis of medical notes record that Adult B's (M) G.P. states during surgery visits Adult B (M) "came across as always mild mannered and quiet, and I would have thought that they enjoyed a good relationship." Additionally, notes from Secondary Mental Health Services include observations made by Adult A (F) who reported "she was managing very well and she has no problem in his behaviour and his mood" and later that "she has no problems with him at home and he is enjoying life."

5.11 In February 2012 the North West Ambulance Services attended to Adult A (F) following her collapse at a bus stop. Adult A (F) complained to Ambulance Officers that she had suffered an acute episode of dizziness, but declined any further support and made her way home on foot. Despite the rejection of support the Ambulance staff followed up the incident by visiting Adult A (F) at her home. No safeguarding or domestic abuse issues were identified during the home visit.

5.12 In June 2012 Adult A (F) called for an ambulance because of the pain she was suffering in her lower back. Having been examined within the Accident and Emergency Department of a local hospital Adult A (F) was not admitted to hospital but later discharged with pain relief medication.

5.13 During her time in hospital Adult A (F) underwent a comprehensive clinical assessment and investigation. Notes show that the diagnosis was Adult A (F) was experiencing back pain as the result of degenerative changes (age related). There was no evidence of trauma, no additional injuries, and no concerns identified regarding the well-being or welfare of Adult A (F), including from issues of domestic abuse.

5.14 Adult B (M) has acknowledged during completion of the Joint Health and Social Care Report that he caused physical harm on one occasion, prior to the fatal assault to Adult A (F), without a trigger whilst Adult A (F) sat knitting.

5.15 In July 2012 friends and family recall visiting the house and seeing bruising on the face of Adult A (F). Independently all sought an explanation from Adult A (F) as to how she had come by those injuries.

5.16 Adult A (F) responded to these questions by stating that she had slipped and fallen. Whilst another friend also noted that Adult B (M) had bruising to his face and to his wrists, Adult A's (F) explanation of the injuries was, due to her recent poor mobility and treatment at hospital, accepted without further question by all enquirers.

6.0 ANALYSIS AND CONCLUSION

The 6 key lines of enquiry which this Review agreed at the outset were all followed;

1. Communication and co-operation between different agencies involved with Adult A (F) and Adult B (M)

Lack of evidence of engagement with organisations, both public and voluntary, underlines family and friend's description of the relationship as being very private and independent.

However, medical records show clear evidence that there was effective information sharing between the Ambulance Service, Accident and Emergency Department and the G.P. of Adult A (F).

2. Were there opportunities for agencies to identify and assess domestic abuse risk?

This Review has been unable to identify any evidence of domestic abuse, or opportunities to establish the presence of domestic abuse within the relationship, that were missed or ignored by agencies, or individuals, who came into contact with either Adult A (F) or Adult B (M).

Independent Management Reviews illustrate the comprehensive safeguarding system of risk assessment which exists within the Accident and Emergency Department which Adult A (F) attended in June 2012.

3. What were the Agency responses to any identification of domestic abuse issues?

Prior to the fatal attack no organisation had any record of supporting either Adult A (F) or B (M) in connection with issues of domestic abuse.

It is worthy of note at this point that all agencies in Cheshire West and Chester use the same model of risk assessment checklist, CAADA – DASH when assessing levels of risk faced by victims of domestic abuse.

4. The training available to the agencies involved on domestic abuse issues.

Domestic abuse training is undertaken on a single and multi agency basis, much of it co-ordinated through the Cheshire West and Chester Domestic Abuse Partnership.

Analysis does identify that whilst a great deal of domestic abuse and risk assessment training takes place within Cheshire West and Chester, there is further development required within the training courses to address the issue of domestic abuse within older persons relationships.

5. Do organisations have access to specialist domestic abuse agencies in Cheshire West and Chester?

The Cheshire West and Chester Domestic Abuse Partnership (CWACDAP) provides a forum for effective multi-agency strategy, action and networking on domestic abuse.

Additionally there is a strong membership of the MARAC which has achieved Leading Lights accreditation from CAADA.

Gateways exist within the Voluntary and Public Sectors for victims of domestic abuse to disclose they are a victim and to seek help.

6. Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.

There is clear evidence of treatment for Adult B (M) at a primary and secondary mental health treatment level prior to his fatal attack on Adult A (F). However no records can be found of mental health treatment required by Adult A (F) during the period reviewed.

The diagnosis, made whilst on remand, that Adult B (M) was suffering from Frontal Temporal Dementia, with accompanying symptoms of emotional detachment, was the first time that medical records included such a diagnosis.

There is clear evidence of information sharing and an effective response to changing medical conditions between the Primary and Secondary Mental Health Services in respect of Adult B (M).

7.0 FURTHER ANALYSIS

7.1 Throughout the last 40 years only a very small group of people, (family, and friends) were allowed access into the lives of a very private relationship, and this group maintained between them almost daily contact with Adult A (F) and Adult B (M).

7.2 Those maintaining close contact with Adult A (F) and Adult B (M) describe the close marriage the couple enjoyed, but one person describes how this changed 10 years ago as Adult B's (M) nerves started to get the better of him and he became withdrawn. The anxiety was described as "nuisance behaviour…not violent and not threatening." Other descriptions of Adult B (M) during this time were that he became highly strung.

7.3 No family or friends recognised any signs of dementia present within Adult B (M), though a number had experience of their own family members who had suffered from this illness.

7.4 Adult A (F) did not disclose she was the victim of domestic abuse to anyone within this close group of friends. Every one of the family and friends spoken to by the Chair of this Review made it very clear that they would have overridden the couples desire for privacy and independence, and would have taken action by reporting the matter if they suspected domestic abuse was happening within Adult A's (F) and Adult B's (M) relationship. The group also had a wide range of knowledge about who they would/could report domestic abuse to. One person had also taken part in a unrelated MARAC meeting in another role.

7.5 Signs of controlling behaviour which may have been exhibited by Adult B (M) towards his wife were discussed by the Chair of this Review with family and friends, but none were identified. All observed Adult B's (M) issue with the home central heating, but reflected that this was a sign, or symptom, of his anxiety linked to finances only.

7.6 In spite of this, in July 2012, when Adult B (M) caused physical harm to Adult A (F) she was able to provide convincing and plausible explanations, aided by the very recent episode for which Adult A (F) received treatment at the local hospital and which left her with poor mobility. Convincing family and friends of how she had slipped and caused the injuries, on two separate occasions and to two different people.

8.0 CONCLUSIONS AND RECOMMENDATIONS

8.1 It is possible to conclude from reviewing all the information available to the Panel that no agency could have anticipated this homicide, and that when information relevant to the well-being of individuals is available it is shared and acted upon by professionals working within Cheshire West and Chester.

8.2 It is possible to conclude that whilst Adult A (F) and Adult B (M) led a very private and independent lifestyle, rejecting professional offers of support and intervention in favour of family and friend support, they did allow a very small and close knit group of family and friends access into their lives.

8.3 This small support group had almost daily contact with Adult A (F) and Adult B (M). Each had known the couple for in excess of 40 years and they each had a good level of knowledge of and a commitment to act against domestic abuse. I believe it is safe to conclude that none of this group ignored signs of domestic abuse within Adults A (F) and B (M) relationship.

8.4 This case does highlight issues also found in research into domestic abuse within elderly peoples' relationships. Namely a cultural reluctance that, in addition to the reasons for non-disclosure, identified with younger women; they are further compounded with older women through generational factors, such as notions of privacy surrounding the home and intimate relationships.

8.5 Analysis of the training of staff within Cheshire West and Chester indicates that the programme should be amended to include learning on, and recognition of, mental health issues and domestic abuse amongst older people. This should be supplemented by changes to the program of education and information sharing which already takes place within Cheshire West and Chester, which should be extended so as to target education and information sharing specifically at older age groups.

8.6 This case also raises the question of whether, in the light of the increases in dementia diagnoses, the CAADA - DASH risk assessment checklist should be reviewed and extended to be more explicit in its questioning over the presence of mental illnesses such as dementia. Currently the question regarding mental health issues within the risk assessment checklist is part of a wider question which includes drugs, and alcohol issues.

9.0 RECOMMENDATIONS

9.1 The following recommendations are aimed at delivering improvements to the existing systems and processes within Cheshire West and Chester to prevent further homicides from taking place:

9.2 Training of staff within Cheshire West and Chester should be amended to include learning on and recognition of mental health issues and domestic abuse amongst older people.

9.3 The program of education and information sharing which already takes place within Cheshire West and Chester should be extended so as to target this provision specifically at older age groups.

9.4 The "marketing" of the domestic abuse services available is undertaken at locations where the age profile of the largest cohort of people accessing these areas is closer to the profile of the victim and perpetrator in this case.

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9.5 Evaluation of CAADA DASH risk assessment checklist to assess if its recognition of the risk presented by mental health is at the appropriate level in light of the increasing diagnosis of dementia within the U.K. population.