SAFER CORNWALL

Kernow Salwa

# Executive Summary

## Safer Cornwall

## Adult A

Year of Death 2018.

Author: Paul Northcott

Date the review report was completed: January 2020.

## Contents

## 1.0 The Review Process

1.1 This summary outlines the process undertaken by the Safer Cornwall Partnership domestic homicide review panel in reviewing the death of Victim A who was resident in their area.

1.2 The following pseudonyms have been used in this review to protect the identities of the relevant people who were involved;

Adult A – Victim
Adult B – Perpetrator
Adult C – Son of perpetrator

1.3 Adult A who was aged eighty-one years at the time of the incident had been living with Adult B, aged sixty-nine, at their home address in Cornwall since 2017. Both were white British nationals.

1.4 The decision to commission a review was taken by the Chair of the Safer Cornwall Partnership on the 13th August 2017. The review commenced on 14th September 2018.

1.5 All agencies that potentially had contact with Adult A prior to the point of her death were contacted and asked to confirm whether they had involvement with them.

1.6 Of the ten agencies that were initially contacted seven confirmed that they had interaction with Adult A and Adult B were asked to secure their files. All but one of these (Police) were Health services.

## 2.0 Contributors to the Review

2.1 The contributors to the DHR were;

- Devon and Cornwall Police– Police logs, Prosecution file, statements.
- Cornwall Partnership NHS Foundation Trust (CFT) – Information/advice.
- South West Ambulance Service Trust (SWAST) – Information.
- Adult Social Care – Information/advice.
- GP Services- Information via interview.
- Consultant Neurologist - Information via interview.
- Consultant Forensic Psychologist - Information via interview.
- First Light – Information/Advice.
- Plymouth NHS – Information via interview.
- NHS Kernow – information/advice.

2.2 Specialist domestic abuse advice and scrutiny was provided by the members from First Light[1].

[1] First Light is a charity supporting people in Cornwall, Devon and Wiltshire who have been affected by domestic abuse and sexual violence.

2.3 The GP Clinical Lead in Cornwall for dementia assisted the panel with advice and oversight in terms of the Health services that are available to the elderly in the County. This individual was independent to any of the services delivered in respect of Adult B and has a special interest in older persons.

2.4 Age UK provided independent advice and guidance in relation to dementia and the elderly.

## 3.0 The Review Panel Members.

3.1 The panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair.
- Detective Sergeant Chris Cowd – Devon and Cornwall Police.
- Detective Inspector Ben Beckerleg - Devon and Cornwall Police.
- Chris Rogers - SWAST.
- Jane Wilkinson – Head of Safeguarding - Cornwall Partnership NHS Foundation Trust (CFT) CFT.
- Detective Constable Kevin Gosling - Devon and Cornwall Police.
- Detective Sergeant Esther Gould - Devon and Cornwall Police.
- Helen Boardman – First Light
- Mel Francis – First Light
- Ann Smith – Cornwall Council Adult Social Care.
- Allison Hibbert – GP Clinical Lead for Dementia NHS Kernow.
- Louise Southwell – Safeguarding Lead, Age UK (Cornwall)

3.2 The panel met on three occasions. Independence and impartiality are fundamental principles of delivering Domestic Homicide Reviews. None of the panel members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved.

## 4.0 Author of the Overview Report

4.1 The Safer Cornwall Partnership appointed Paul Northcott as Independent Chair and author of the overview report on 2nd March 2018.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews (critical incidents, investigations, serious case reviews and safeguarding adult reviews) and currently delivers training in all aspects of safeguarding, including domestic abuse.

## 5.0 Terms of Reference for the Review

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

5.2 Safer Cornwall commissioned a DHR in accordance with a) above with a view to ascertaining whether the relationship between Adult A and Adult B had been abusive and whether this had contributed to her death.

The purpose of the review was therefore set to;

- Establish the facts that led to the death of Adult A and whether there was learning in the way in which local professionals and organisations carried out their responsibilities and duties, and worked together to safeguard Adult A;

- Identify clearly the learning, how this will be acted upon, and what is expected to change as a result;

- Apply the learning to service responses including changes to policies, procedures and practice of individual agencies, and inter-agency working, with the aim to better safeguard victims of domestic abuse in Cornwall;

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve single agency and inter-agency responses to all domestic abuse victims and their children through improved partnership working;

- Identify, on the basis of the evidence available to the review, whether the death of Adult A was foreseeable and avoidable, with the purpose of creating a joint strategic action plan to address the gaps and improve policy and procedures in Cornwall and across the Southwest Peninsula;

- Identify from both the circumstances of this case, and the review process adopted in relation to it, any learning which should inform policies and procedures in respect to national reviews and make this available to the Home Office.

5.3 In addition to the above, the following terms of reference were set by the DHR panel and there was a requirement that these needed to be addressed in the overview report;

1. To provide an overview report that articulates the victim's life through her eyes, and those around her, including professionals.

2. Establish the sequence of agency contact with Adult A, the perpetrator (Adult B between the dates of 1st January 2014 and the 19th July 2018); and constructively review the actions of those agencies or individuals involved.

3. Provide an assessment of whether the death of Adult A was an isolated incident

or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies.

4. Seek to establish whether Adult A or Adult B were exposed to domestic abuse prior to adulthood and impact that this may have had on the individuals concerned.

5. Establish whether family or friends want to participate in the review and meet the Review Panel.

6. Provide an assessment of whether family, friends, neighbours, key workers were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).

7. Review of any barriers experienced by the victim/family/friends in reporting any abuse or concerns in Cornwall or elsewhere, including whether they knew how to report domestic abuse.

8. Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the relationship;

9. Establish whether improvements in any of the following have led to a different outcome for Adult A considering:

   (a) Communication and information-sharing between services.
   (b) Communication within services.
   (c) Communication to the general public and non-specialist services in Cornwall about the role services available to victims and perpetrators of domestic abuse.

10. Evaluate the effectiveness of training or awareness raising in agencies to ensure a greater knowledge and understanding of domestic abuse processes and / or services in Cornwall.

11. Establish whether the work undertaken by services in this case is consistent with each organisations:

    (a) Internal policy and professional practices.
    (b) Domestic Abuse policy, procedures and protocols.

    and identify whether these policies and practices are effective to meet the needs of victims and their families.

12. Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.

13. Review any previous concerning conduct or a history of abusive behaviour from

Adult B, his level of risk and whether this was known to any agencies.

14. Consideration of any equality and diversity issues that appear pertinent to Adult A, Adult B or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

15. To review any other information that is found to be relevant.

5.4 The panel chose the time period for the terms of reference to ensure that it covered the deterioration in Adult B's mental health and met the above criteria. The panel hoped that by reviewing this period of Adult A and Adult B's life that they would be able to ascertain if there were critical points where intervention could have taken place by agencies.

5.5 In view of the limited contact that agencies had with Adult A and Adult B and the complexity of Adult B's health condition the commissioning body, report writer and panel members agreed that IMR's were not required. This decision was made following a comprehensive review of chronologies following which it was decided that information could be more effectively gathered through interviewing the appropriate professionals involved in this case.

## 6.0 Summary

6.1 Adult A had been happily married until she lost her husband to natural causes in 2011. Adult A had two sons who, although not living close to her, had regular contact with her. Adult A had been a school teacher prior to retirement and was respected in her community.

6.2 Following the death of her husband Adult A lived alone for six years. Those that knew her described how she would keep herself busy and that she was the head of the local quilting association. Adult A was described by one of her sons in his statement as being young for her age.

6.3 Adult A met Adult B in 2014 via a computer dating website. As the relationship developed Adult B would often stay with Adult A at her home address. Approximately five to six months prior to the death of Adult A , Adult B moved in with her.

6.4 Since meeting Adult B Adult A had, according to her sons, become more insular. Adult A's sons believed that she had lost some of her independence and that Adult B could be controlling. Adult A's sons struggled to form a relationship with Adult B because of the way his presence had changed their mother.

6.5 Adult B had suffered from epilepsy and was being treated by his GP for the condition. He had his first seizure aged twenty-three years old. In the past seven years his epilepsy had increased and he was subsequently being treated by a range of services within Health.

6.6 Adult B had also been referred to a neurologist and a specialist epilepsy nurse. Health services worked constructively together to try and identify the cause of his epilepsy and Adult B was prescribed a variety of medicines to manage his conditions.

6.7 Apart from Health there was very little involvement by agencies with either Adult A or Adult B (Police were aware of Adult B but for minor unrelated issues). Adult A attended the same GP's surgery as her partner but apart from routine appointments there was nothing found in records that was of particular relevance this review.

6.8 At approximately 14.00hrs on Thursday 19th July 2018, one of Adult A's neighbours heard screaming and on looking out of his window saw Adult A running down the street. At that time she was being chased by Adult B. Adult B then caught up with Adult A and pushed her to the ground. The neighbour left his home address and on approaching Adult B he saw that he was assaulting Adult A.

6.9 Police had been called by another of Adult A's neighbours. On arriving at the scene police officers found Adult A lying on a grass verge and she had suffered significant facial injuries. The paramedics who had also attended the scene made an initial assessment that she had suffered life threatening injuries and she was immediately taken to hospital where she later died (0140hrs on the morning of Saturday 4th August 2018).

6.10 Those at the scene describe Adult B as shaking as though he had Parkinson's disease and that he was babbling words almost incoherently. Adult B appeared to be very confused at this time. Adult B was later arrested and taken to a police station.

6.11 On being taken to a custody centre Adult B underwent a mental health assessment by a qualified professional. Adult B was subsequently deemed to be unfit to be detained and was taken to a secure unit for assessment and treatment.

6.12 On Monday 19th November 2018 Adult B was arrested for the murder of Adult A and conveyed to a custody centre. Adult B was given an opportunity to be interviewed but declined to do so. Adult B was subsequently charged with the offence of murder. On appearing at Court Adult B was committed to a secure mental health institution.

6.13 On the 22nd November 2018 Adult B was admitted to a secure psychiatric unit under Section 48/49 of the Mental Health Act. Adult B continues to be treated within that establishment.

6.14 Adult B was described by professionals as presenting with psychotic features of delusional misidentification. Since being detained Adult B has been diagnosed with Lewy's Body dementia. Adult B has since responded positively to this treatment.

## 7.0 Key Issues Arising from the Review.

7.1 Evidence of Domestic Abuse in Adult A and Adult B's relationship

7.2 There is nothing recorded in agency records or information gained from friends and relatives that would suggest that Adult A was exposed to domestic violence or physical abuse at any stage in her life.

7.3 As part of the police investigation consideration was given to whether Adult B had used controlling or coercive behaviour[2] in the context of domestic abuse.

7.4 From the information that has been collated during this review it would appear that Adult B was exerting some emotional control over Adult A to an extent that she had made changes in her life and had become more isolated. It is however difficult to determine whether this was due to his developing dementia as opposed to it being an emotionally abusive relationship. The Panel did however recognise that whilst there was no recorded evidence held by agencies that there was coercive control in the relationship this may have been due to a lack of recognition by Adult A of the impact that Adult B was having on her life or the fact that she hadn't reported it.

7.5 Coercive and controlling behaviour was considered by the police during their investigation and whilst it was acknowledged that there had been changes in Adult A's behaviour since meeting Adult B it was felt by the investigation team that there was no evidence that this was having an impact on the relationship in terms of abuse.

7.6 On checking GP records Adult A was not asked about any abuse in her relationship as part of any routine enquiry. The GP has stated that this would not have been done as there were no presenting risk factors or obvious vulnerability. On reviewing practice it was felt that the use of routine inquiry should be encouraged**. (Recommendation 1).**

7.7 Anecdotal evidence from panel members has indicated that the levels of domestic abuse amongst the elderly and those suffering from mental illnesses associated to old age in Cornwall is increasing. At present it is difficult to quantify the extent of this abuse as much of it goes unreported or is hidden due to the way in which it is categorised. Further work is required to understand the extent and impact of this abuse within this sector of the population **(Recommendation 2)**.

7.8 <u>Adult B's Mental Health</u>

7.9 Adult B was being treated by Health services in relation to his epileptic episodes which he had suffered over a seven-year period. These episodes were frequent and their severity and impact on Adult B would vary on a daily basis.

7.10 Adult B didn't have a previous history of psychosis until the incident in July 2018. The symptoms that he displayed at the time of his arrest and subsequently on his admission to hospital showed that he had become paranoid. Adult B had started to believe that Adult A and '*others*' wanted to steal his money and that she had changed. He had also started to hear voices and believed that people were trying to kill him.

7.11 Following his detention Adult B was diagnosed with a condition which is most likely to be Dementia with Lewy Bodies. From the review of medical records and from interviews

[2] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office

with Health professionals it is clear that Adult B's case, and the fact that he had Lewy Body Dementia, was not previously known.

7.12 Adult B's sudden deterioration in mental health and his subsequent actions could not have been reasonably foreseen. His actions on the day that the attack took place have been described by Health professionals as extremely rare amongst those suffering from Dementia with Lewy Bodies.

7.13 Operational Practice, Policy and Procedure

7.14 There has been nothing found in this review process that has identified a deficiency in staff knowledge and/or understanding of domestic abuse.

7.15 The review has identified that there is a clear need for agencies to recognise the impact of domestic abuse in relation to older people and those suffering from age related conditions such as dementia. This should include the identification of risks and the preventative action required by agencies across all sectors to ensure that potential victims receive the care and support that they need.

7.16 Due to the current demographics in Cornwall it is likely that the numbers of victims of domestic abuse amongst the elderly will increase in the years to come. All agencies therefore need to review current policy and practice to ensure that it addresses the issues associated with domestic abuse amongst the elderly and those suffering from age related conditions **(Recommendation 3).**

7.17 The panel, however, accept that whilst agencies have seen an apparent rise in domestic abuse suffered by people caring for someone with dementia, such occurrences are still rare. Any planned interventions by agencies or changes to services must minimise any unintended consequences such as increasing the stigma of dementia in Cornwall.

7.18 In terms of improving safeguarding practice it is recognised that all agencies need to be able to effectively identify and support individuals who have dementia and mental health issues. Agencies should therefore review current processes to make sure dementia/cognitive problems are routinely enquired about when dealing with the elderly **(Recommendation 4).** There needs to be close inter-agency working in all such cases.

7.19 Agencies also need to be mindful that elderly people may need additional help to raise concerns and safeguarding issues. Victims of all types of abuse no matter what their age should have the ability to readily access services **(Recommendation 5).**

7.20 The Clinical Lead NHS and current Chair of Cornwall Dementia Partnership Board has confirmed that improving dementia care is a priority, within Health, for the County. The partnership board is driving a body of improvement work in relation to dementia care.

7.21 The hospital that was treating Adult B's epilepsy have a morbidity and mortality meeting which takes place every two months. All deaths are reviewed by a consultant at the hospital and if it is identified that there is learning from a case then this will be discussed at the meeting. **(Recommendation 6)**.

7.22 Information Sharing and Communication

7.23 Safer Cornwall has recently reviewed their DASV[3] Strategy (Published - 1ST November 2019). Whilst the strategy considers the development of services in relation to hard to reach groups such as the elderly consideration must also be given to those specifically suffering from cognitive mental health issues, such as dementia, and its impact on those that care for them. This should include appropriate risk assessments and awareness raising **(Recommendation 7).**

7.24 Information received from the NHS Kernow Dementia Programme Lead in Cornwall has shown that there are numerous support services available to those suffering from dementia and their carers. Work is currently taking place to promote early diagnosis and the use of existing care pathways to treat those with dementia. Any future Health strategy must have due regard to the impact of domestic abuse within those relationships where a partner has dementia. Such a strategy should also ensure that it is linked with the action proposed in Safer Cornwall's DASV Strategy **(Recommendation 8)**.

7.25 In this case Adult A would have been unaware of the potential risks associated with Adult B's developing dementia. There is little information available for carers about the risks that they could face **(Recommendation 9)**.

7.26 It is evident that whilst there has been a great deal of work completed there is a continuing need to develop a co-ordinated approach across all sectors in respect of developing comprehensive domestic abuse services that meet the needs of victims and perpetrators whose lives are affected by mental health problems.

7.27 Training

7.28 Representatives of the agencies involved in this review have confirmed that training and awareness continues to be delivered to all staff in order to promote greater knowledge and understanding of domestic abuse processes and / or services in Cornwall.

7.29 The review has however identified that the impact of abuse on the elderly and those suffering from dementia related illnesses in terms of domestic abuse is not fully appreciated or understood by operational staff. **(Recommendation 10)**.

## 8.0 Conclusions.

8.1 Adult A was a loving and caring mother and partner who unselfishly devoted herself to caring for Adult B. Adult A would appear to have willingly supported Adult B in order to identify the causes and treatment of his epilepsy and to further strengthen their relationship.

[3] Domestic abuse and Sexual Violence Strategy (2019)

8.2 There were no reported incidents of abuse or violence between Adult A and Adult B. On review it would appear that Adult A had not considered herself to be at risk and there is no recorded evidence of an escalation to that risk in the days leading up to her death.

8.3 Although the Police stated that they didn't identify specific information that would indicate that Adult A was a victim in terms of coercive control her family members believed that she was being unduly influenced by Adult B and that this adversely impacted on her lifestyle. The information provided by Adult A's family does indicate that Adult B was controlling and that Adult A suffered emotionally due to the demands that Adult B's condition placed upon her. The Panel acknowledged that Adult A may not have recognised that Adult B was controlling or if she had she may not have reported his behaviour.

8.4 From the information gathered during the review it would appear that Adult B's illness and its associated symptoms had a huge impact on their daily lives and were likely to have contributed his behaviour. Despite this impact Adult A would always be there to support and care for Adult B.

8.5 Adult B had a history of epilepsy and was being treated by Health professionals, none of whom were aware that he was suffering from Dementia with Lewy Bodies. According to Health professionals who have informed this review, his condition had not been diagnosed earlier due to the complexity of the symptoms that he was displaying.

8.6 Even had Adult B's condition been identified then this would not have influenced professional assessment in terms of the risk that Adult B presented to Adult A. It cannot be stated with any certainty that any change in his medication (had there been an earlier diagnosis) could have prevented his actions on the day that he had assaulted Adult A. His reaction on the day that Adult A was murdered was extreme and rarely exhibited by those with the condition.

8.7 No one could therefore have foreseen the events that occurred on the 19th July 2018.

8.8 The review has identified that agency interaction with Adult A and Adult B was appropriate and proportionate in the circumstances.

8.9 Agencies working in Cornwall have started to recognise the impact of dementia and its associated risks in terms of domestic abuse. In line with National trends, Cornwall has an increasingly ageing population. The number of older people that are likely to become victims of domestic abuse are therefore also likely to increase. Evidence gathered throughout this review indicates that there is a need for a greater understanding of the issues of elder abuse and a more coordinated delivery of services across all sectors in the County.

## 9.0 Learning

9.1 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 10.0.

Multi Agency Learning

- Learning opportunity 1 (Recommendation 1)

  In this case there was no evidence of routine enquiry being used. It would appear that the use of routine enquiry is not fully embedded into all GP practices.

- Learning opportunity 2 (Recommendation 2 and 7)

  With an increasing elderly population and associated increases in dementia related illnesses it is important that Cornwall and the Isles of Scilly identify its impact on domestic abuse services.

- Learning opportunity 3 (Recommendation 3)

  The true extent of domestic abuse amongst older people has to date not been fully identified within Cornwall. From the information gathered during the review it would appear that knowledge and practice in relation to this type of abuse is variable amongst frontline professionals. Agencies and third sector organisations in Cornwall should ensure that policy and practice reflect the changes needed to address this issue.

- Learning opportunity 4 (Recommendation 4)

  There is a need for all agencies to have the capability, policies and procedures to identify and effectively support individuals who have dementia and mental health issues.

- Learning opportunity 5 (Recommendation 5)

  The review identified that not all services within Cornwall are accessible to the elderly. In order to improve confidence in reporting all types of abuse (including domestic abuse) agencies need to ensure that their reporting mechanisms are easily accessible to the vulnerable.

- Learning opportunity 6 (Recommendation 6)

  There Is an opportunity for the hospital neurology department to review and identify (if appropriate) learning from this case.

- Learning opportunity 7 ( Recommendation 7)

  There is a growing recognition of the impact of dementia on Health services in Cornwall and the Isles of Scilly and the need for early diagnosis and treatment. When designing services and care pathways it is essential that such a strategy recognises the impact of domestic abuse on those victims and perpetrators who may be suffering from dementia. Any such strategy should be complimentary to the DASV Strategy.

- Learning opportunity 8 (Recommendation 8)

The emotional and physical impact of domestic abuse on those caring for people suffering from dementia related illnesses can be considerable. Often, they are unaware of the risks that can develop as a result of such conditions. Consideration needs to be given about how to proportionately highlight such risks in order to ensure that carers protect themselves and are able to identify behaviour. Such knowledge will enable them to seek appropriate help and will mitigate risks.

- Learning opportunity 9 (Recommendation 9)

  There is an opportunity to increase awareness of the risks associated with dementia through improving the information that is available. Any such information would need to be proportionate in its content.

- Learning opportunity 10 (Recommendation 10)

  The review has identified opportunities to improve domestic abuse training for frontline staff by including the impact of abuse on the elderly and associated risks from age related disorders.

## 10.0 Recommendations

10.1 This section sets out the recommendations made by the DHR panel for local action and the recommendations made in each of the IMR reports.

- **Recommendation 1**

  NHS Kernow to review the current effectiveness of Routine Enquiry into Domestic Abuse across all service areas in Cornwall.

- **Recommendation 2**

  Safer Cornwall to commission a review of the impact of dementia and associated conditions on domestic abuse in Cornwall and the Isles of Scilly.

- **Recommendation 3**

  Adult Social Care, Police, NHS Kernow and CFT to review and amend current policy and practice to ensure that they recognise and deal with the impact of domestic abuse amongst the elderly and those suffering from dementia related illnesses.

- **Recommendation 4**

  Adult Social Care, Police, NHS Kernow and CFT must review current processes to make sure dementia/cognitive problems are routinely enquired about when dealing with the elderly and that they have the ability to signpost them to support services.

- **Recommendation 5**

Adult Social Care, Police, NHS Kernow and CFT must review current reporting mechanisms to ensure that they are accessible to all vulnerable groups.

- **Recommendation 6**

  NHS Kernow to refer this case to [the hospital] for discussion at the morbidity and mortality meeting.

- **Recommendation 7**

  Safer Cornwall to review the current DASV Strategy to ensure that the priorities that are delivered includes action to address hard to reach groups such as, the elderly and those suffering from dementia.

- **Recommendation 8**

  NHS Kernow Clinical Commissioning Group to ensure that any Dementia strategy within Health includes action to address domestic abuse.

- **Recommendation 9**

  Safer Cornwall, Adult Social Care, NHS Kernow and CFT should review the current information that they provide to those caring for people with mental health related conditions to ensure that they are aware of any risks with the condition and the action taken to mitigate them.

- **Recommendation 10**

  Safer Cornwall, Adult Social Care, Police, NHS Kernow and CFT should review current domestic abuse training to ensure that it includes the impact of abuse on the elderly and that any reference to mental health highlights the impact of dementia.