SAFER CORNWALL

Kernow Salwa

Cornwall Community Safety Partnership

Adult A

Author: Paul Northcott

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Contents

Contents 2
Preface 3
1.0 Introduction 4
2.0 Summary 5
3.0 Timescales 6
4.0 Confidentiality 7
5.0 Methodology 7
6.0 Involvement of family, friends, neighbours and the wider community 11
7.0 Contributors to the Review 11
8.0 The Review Panel Members 12
9.0 Author of the Overview Report. 13
10.0 Parallel Reviews 14
11.0 Equality and Diversity 14
12.0 Dissemination 15
13.0 Background Information (The Facts) 16
14.0 Chronology 19
14.0 Overview 21
16.0 Analysis 23
17.0 Conclusions 39
18.0 Learning 40
19.0 Recommendation 42
Glossary 45
Bibliography 46

Preface

I would like to begin this report by expressing my sincere sympathies, and that of the Review Panel, to the family of Adult A. The death of Adult A was a tragic and unforeseen incident and it is apparent from the information that has been reviewed that it has had a huge impact on all concerned.

I would like to thank panel members for their time and co-operation in identifying the relevant themes in relation to this review.

1.0 Introduction

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by Safer Cornwall Partnership and examines the interaction by local agencies in relation to Adult A, prior to the point of her death.

1.2 The key purpose for undertaking a DHR is to enable learning from homicides where a person has died as a result of domestic abuse. In order for the learning to be shared as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 In this particular case Safer Cornwall wanted to use this methodology to review the death of Adult A in order to establish if intervention by agencies could have taken place prior to her death and whether she had been a victim of abuse prior to the incident taking place.

1.4 This report will consider the contact and involvement that agencies had with Adult A between the dates of 1st January 2014 and the 19th July 2018. The reason for choosing these dates is that they provide a comprehensive overview of the deterioration of Adult B's mental and physical state with a view to looking at how these issues may have affected his relationship with Adult A.

1.5 In addition to agency involvement this review has also sought to examine the past to identify any relevant background or specific risks to Adult A and whether there were opportunities to provide her with additional support. Consideration was also given to whether there were any barriers to accessing services.

1.6 By taking a holistic approach the review has sought to identify appropriate solutions to make the future safer. This report also summarises the circumstances that led to the review being undertaken in this case.

1.7 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have made every attempt to manage the process with compassion and sensitivity.

2.0 Summary

2.1 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.

2.2 Adult A and Adult B had been previously married and both of them had children in those relationships. The two of them maintained regular contact with their children and on occasions they would visit their parents at their home address.

2.3 Adult A and Adult B had initially contacted each other via an internet site and after their relationship had developed they had decided to live together in Adult A's home.

2.4 Those that knew the couple described the two of them as caring towards one another and there were no reports of any violence or abuse in the relationship.

2.5 There was little interaction by either Adult A or Adult B with statutory or third sector agencies except for Health services.

2.6 Adult B was being treated, and medicated, for epilepsy by his own doctor and a consultant neurologist. In the months leading up to the tragic death of Adult A these episodes of epilepsy had become more frequent and the details of them were being captured in a diary that was being kept by Adult A.

2.7 In July 2018 police were called by neighbours to a street close to the home address of Adult A. At that time neighbours had witnessed Adult A being chased by Adult B down the street. They had then seen Adult B catch up with Adult A and on doing so he knocked her to the ground and had then started to violently assault her. One of their neighbours had tried to intervene but was unable to physically prevent Adult B from continuing the assault. In order to stop the assault this neighbour had to resort to hitting Adult B with a plank of wood.

2.8 Upon the arrival of the Police Adult B was arrested on suspicion of attempted murder and conveyed to a local police station.

2.9 Adult A received medical attention at the scene and was immediately taken to hospital. Adult A subsequently died as a result of the head injuries that she had sustained during the attack by Adult B.

2.10 Whilst in police custody Adult B had a mental health assessment by a qualified professional. Adult B was subsequently deemed to be unfit for detention under

the Mental Health Act 1983 and was taken to a secure unit for assessment and treatment.

2.11 On Monday the 18th November 2018 Adult B was charged with the murder of Adult A and following assessment was conveyed to a second secure mental health facility.

2.12 Following the death of Adult A, Adult B was diagnosed with suffering from Lewy Body Dementia. Health Care professionals have subsequently identified that Adult B was suffering from this condition at the time of the assault on Adult A. This condition was seen as a major contributing factor to his behaviour at the time that the homicide took place.

3.0 Timescales

3.1 The decision to commission a review was taken by the Chair of the Safer Cornwall Partnership on the 13th August 2018. The Home Office had been informed of the decision to undertake a review on the 18th August 2018. The review adhered to the processes detailed in the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

3.2 This review commenced on 14th September 2018. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision made to proceed with the Review. For this reason an initial timetable was drawn up to ensure that agencies complied with this request.

3.3 The review was unable to be completed in the six-month time frame due to ongoing criminal proceedings and the need to speak to family members who declined to take part in the review until after the judicial process had concluded.

3.4 The Independent chair was appointed on 10th September 2018 and the first panel meeting was held on the 13th August 2019. During this meeting, the draft terms of reference were discussed and the panel agreed upon their content.

3.5 The family of Adult A were contacted and invited to actively contribute to the review. Although initial contact was made with one of Adult A's sons they made the choice not to take any further part in the process.

3.6 The panel met formally on three occasions. In this case there was little contact with agencies and consequently the information available to the review panel was limited. The panel was aware of its duties under the statutory guidance and the Chair met with key agencies and individuals to illicit more information and identify the key issues in this case. Much of this information was explored and robustly challenged in individual meetings with specialist representatives from Health.

The panel member with a specialist knowledge of dementia accompanied the Chair to those meetings. This information was then fed back to panel members who had the opportunity to provide regular feedback. Documents including draft reports were circulated electronically to members and discussed virtually.

3.7 The review concluded on 23rd January 2020. The Safer Cornwall Partnership was kept updated regarding the progress of the review throughout the process.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers.

4.2 Before the report is published the Safer Cornwall Partnership will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and the family members. The family will be notified of the publication date.

4.3 The content of the overview report has been anonymised to protect the identity of the victim, the perpetrator, relevant family members and all others involved in this review. The pseudonym/s are as follows;

Family composition and pseudonyms used.

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

5.0 Methodology

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 the 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 would 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 of 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 organisation's:

    (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 methods for conducting DHR's are prescribed by the Home Office guidelines[1]. These guidelines state;

'Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'.

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 that intervention could have taken place by agencies.

5.5 Following the decision to undertake the DHR the Safer Cornwall Partnership arranged for all relevant agencies to check their records about any interaction that they had with Adult A.

[1] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016

5.6 Where it was established that there had been contact the Partnership ensured that all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.

5.7 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.

5.8 The Independent Chair obtained additional information from specific individuals where additional clarity was required. Contact was made directly with those agencies outside of the formal panel meetings. This additional information included, recent DHRs, policy and procedures and independent medical advice from suitably qualified professionals.

6.0 Involvement of family, friends, neighbours and the wider community

6.1 Family members of Adult A and Adult B were invited to contribute to the review and they were provided with a leaflet prepared by the Home Office about the DHR process. Contact was made through a letter and email.

6.2 Initial contact was made with a member of Adult A's family via a phone call but after that they chose not to reply to the communications that were sent. Whilst family members are encouraged to take part in the DHR process it is fully understood that many will not want to participate for a variety of personal reasons. The Chair and Review Panel completely respect such decisions.

6.3 In view of the fact that Adult A was not working during the time covered by the terms of reference no work colleagues were seen as part of this review. The views of friends and neighbours were obtained through access to statements taken by the Police.

6.4 Consideration was also given to speaking to Adult B. Contact however was not deemed to be suitable due to the deterioration in his mental health and the impact that this would have had on his current treatment programme.

7.0 Contributors to the Review

7.1 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.

7.2 Specialist domestic abuse advice and scrutiny was provided by the members from First Light[2].

7.3 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.

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

8.0 The Review Panel Members

8.1 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.

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

- Louise Southwell – Safeguarding Lead, Age UK (Cornwall)

8.2 Independence and impartiality are fundamental principles of delivering Domestic Homicide Reviews and the impartiality of the independent chair and panel members are essential in delivering a process and report that is legitimate and credible. 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. This was also confirmed by agencies at the initial panel meeting.

8.3 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report, are the collective responsibility of the Safer Cornwall Partnership.

9.0 Author of the Overview Report.

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

9.2 Paul is a safeguarding consultant specialising in undertaking reviews nationally (critical incidents, investigations, Child Practice Reviews and safeguarding Adult Reviews) and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer in the Devon and Cornwall Police and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

9.3 Paul has not worked in the Devon and Cornwall Police area since 2015 and retired from the service in February 2017. During that time he had no involvement with Safer Cornwall nor the policy and practices of the Devon and Cornwall Police. Paul also had no operational oversight of the resources that were deployed in this case.

9.4 At regular intervals the Safer Cornwall Partnership reviewed Paul's independence. A specific review took place after the submission of the police IMR. No issues were identified.

10.0 Parallel Reviews

10.1 Following the police investigation and the subsequent presentation of all of the evidence at court, HM Coroner's office was sent a Certificate of Conviction in relation to Adult B. In view of the circumstances of this case HM Coroner made the decision not to hold an inquest.

10.2 As a result of initial concerns about the police response to the call by Adult B and subsequent attendance the Force voluntarily referred the matter to the Independent Office for Police Conduct (IOPC). The IOPC on reviewing the information concluded that the Force had acted appropriately.

11.0 Equality and Diversity.

11.1 The review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the Panel as part of the terms of reference and throughout the review process.

11.2 It is acknowledged that Domestic Homicides (DH) are overwhelmingly known to be gendered[3] in that women are significantly more at risk of being killed by a partner or family member than men[4]. There is also growing evidence that risk factors for DH in later life are gender-specific and share some similarities and differences with existing understandings of DH against younger age groups[5].

11.3 In terms of the other protected characteristics that were relevant to this review the Panel also felt that the age of both the Adult A and B was significant and disability in terms of Adult B's epilepsy and dementia as highlighted later in this report.

11.4 Adult A was a white British national and a heterosexual. Adult A was aged eighty one at the time of her death.

11.5 Adult B was also a white British national and a heterosexual. Adult B was aged sixty nine at the time that he assaulted Adult A.

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[3] Ruuskanen and Kauko, 2008.

[4] In the year ending March 2016, there were fifty-seven male and 113 DH victims in England and Wales, representing 14 per cent of all male and 65 per cent of all female homicide victims (ONS, 2018b)

[5] Bow, H (2018)

11.6 As far as the Panel has been able to determine, Adult A did not hold any strong or religious beliefs or have any language or acute learning needs which would have impacted on any services that were offered to her. This is equally true for Adult B.

11.7 There is no evidence that would indicate that Adult A or Adult B were discriminated against by services or individuals with whom they came into contact with.

11.8 No barriers to accessing services in relation to inequality were identified.

12.0 Dissemination

12.1 This version of the overview report is for discussion by the Review Panel. Circulation is restricted to staff directly involved in the review and the managers within the following organisations;

- Safer Cornwall Partnership
- Devon and Cornwall Police
- Cornwall Partnership NHS Foundation Trust
- First Light
- Cornwall Council Adult Social Care
- Royal Cornwall Healthcare Trust
- Cornwall Foundation Trust
- NHS Kernow
- South Western Ambulance Service Trust

12.2 In accordance with Home Office guidance all agencies and the family of Adult A are aware that the final overview report will be published. Although key issues have been shared with specific organisations the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.3 The content of the overview report has been suitably anonymised to protect the identity of the victim, perpetrator, previous partners, relevant family members and friends.

12.4 Prior to any decision being made to publish the report the Safer Cornwall Partnership will attempt to re-engage Adult A's family members to provide them with the opportunity to be involved with the process. The Chair, and review panel members will also be involved. The family of Adult A will be provided with the final version should they wish to review it prior to publication.

13.0 Background Information (The Facts)

13. 1 Adult A lived in Cornwall together with Adult B and at the time of her death Adult A was eighty one years of age.

13. 2 Adult A had been happily married to her previous husband and they had two sons together. Following the death of her husband in 2007 Adult A remained in the family home in Cornwall where she lived for over twenty years.

13. 3 Adult A was described by her sons as a lively, sociable person but that she had become more insular after meeting Adult B. Adult A had a good circle of friends and had outside interests including quilting.

13. 4 Adult B was one of four siblings and prior to his retirement had worked in the Navy, as a salesman, owned his own company and latterly prior to his diagnosis of epilepsy was a taxi driver. Adult B had been married on two previous occasions and he has three sons.

13. 5 Adult A met Adult B on a computer dating site and their relationship developed to the extent that Adult B moved in with her during the winter of 2017. The two of them lived at the house until the tragic incident in July 2018.

13. 6 Adult B had suffered from epilepsy and had a seven year history of seizures. He was being treated for his condition by his GP and had been seen by a neurologist and a specialist epileptic nurse. Adult B had been taking medication in an attempt to control his symptoms.

13. 7 At 0950hrs on a date in July 2018 Adult C was contacted by Adult B on the telephone. Adult C stated that his father appeared to be fine initially but as the conversation progressed Adult B had started to act strangely. Adult C stated that his father spoke to him as if he was a cold caller and then hung up the telephone. Adult C called his father back and his father repeated what he had previously said before hanging up again.

13. 8 At 1009hrs that same day Adult C sent Adult B a text message asking him to clarify what he was talking about. Adult C received no reply. At 1319hrs Adult B telephoned Adult C. During this conversation Adult B was still described by his son as acting strangely and he became increasingly concerned when his

father repeatedly requested that he should call the Police. Adult B stated, **"**call the police armed" before spelling out the word 'armed' and then giving his home address**.** Once the call had ended Adult C called the police (13.21hrs). Adult C and his wife then made their way from their home address to Adult A's house.

13. 9 At 1325hrs that same day, police received a call from Adult B. During that call Adult B requested both the police and ambulance service. He then terminated the call as he did not believe that he was speaking to the police.

13. 10 At approximately 14.00hrs that day, a neighbour heard screaming and on looking out of his window. The neighbour saw Adult A running down the street and at that time she was being chased by Adult B. Adult B then caught up with Adult A and pushed her to the ground.

13. 11 The neighbour left his home address and on approaching Adult B he saw that he was 'stamping' on Adult A's head. The neighbour tried to intervene but was assaulted by Adult B. Unable to prevent the attack from continuing the neighbour went back to his house and took hold of a piece of wood. On returning to the scene of the assault the neighbour struck Adult B with the piece of wood and this caused him to stop his assault on Adult A.

13. 12 Those at the scene describe Adult B as shaking as though he had Parkinson's disease and that he was babbling words almost incoherently. One neighbour heard Adult B say' *he was going to kill her'* and '*she wanted me to kill her'.* Adult B appeared to be very confused at this time.

13. 13 Police had been called by another of Adult A's neighbours who had informed them that there was a male in the street who was seen to be kicking a female in the head. On arriving at the scene police officers saw Adult A lying on a grass verge. Adult A 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.

13. 14 Following treatment at the hospital it was identified that Adult A had suffered a serious bleed on the brain. Adult A was transferred to a specialist hospital where she underwent surgery after which she was transferred to an intensive care unit. Adult A never regained consciousness .

13. 15 At 1600hrs on Friday 3rd August 2018, life support systems where withdrawn and at 0140hrs on the morning of Saturday 4th August 2018 Adult A was

pronounced dead. A forensic post mortem was conducted and the preliminary findings identified the following injuries;

- Bilateral facial fractures.
- Fracture to the right side projection on the 2nd spine bone in the upper neck.
- Bleeding on the brain.

13. 16 Adult B had also been medically assessed at the scene by paramedics. At that time Adult B suggested that he may have a "*brain condition*". Following the examination the paramedics concluded that Adult B did not need medical attention.

13. 17 Adult B was subsequently arrested by the police. On being led to the police car Adult B was constantly saying '*I love you*". The police officers that dealt with him described Adult B as being distant, agitated, confused and '*very up and down'*. One officer described how he was talking incomprehensively and that he would constantly sit or stand and on occasions he would have his head in his hands while crying out**.** Adult B was also heard to say, "*this will make them stand up and listen that I need medical help*" and then moments later he would ask after Adult A. Adult B was unable to comprehend why he had blood on his shoes.

13. 18 The police officers who attended the scene stated that Adult B did not appear to be under the influence of drink or any other substance.

13. 19 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 under Section 3 of the Mental Health Act 1988. Adult B was then taken to a secure unit for assessment and treatment.

13. 20 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.

13. 21 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.

14.0 Chronology

14.1 The chronology date set for this review was from the 1st January 2014 to the 19th July 2018 as these dates provide a sufficient time span that captures Adult B's deterioration in mental health and the impact of this on his relationship with Adult A. Only issues of relevance have been included in the chronology below.

Date	Circumstances
30/06/14	Adult B was seen in hospital by neuropsychology where he complained of everyday memory loss. He stated that he couldn't remember his wedding day and had very profound short term memory problems. In a letter from a psychologist to a neurosurgeon, the psychologist commented that Adult B's presentation of memory problems was quite unusual and not something that would specifically be associated with epilepsy. This individual stated that usually problems were for short term recall of verbal information in particular, and related to seizure activity, postictal problems and medication issues.
05/09/14	Adult B was seen at his GP surgery with his partner. The notes detail that he had had three further witnessed seizures, and a further witnessed chronic seizure (grand mal).
18/05/15	Medical notes detailed that Adult B had another seizure that was witnessed by his partner. The notes state that he had been banging his feet on the floor and had damaged his toe nails.
17/01/17	Adult B was seen by his GP. The notes detail that he was a 'bit fed up of meds'. Mention was made of him being in a new relationship with a lady from a town in Cornwall which was good for his mental wellbeing. It detailed that he was spending significant periods of time with her there.
April 17	Ambulance received a call that Adult B had suffered a 'mild seizure' in a street in Plymouth. Records state that he had drank four units of alcohol and had made a full recovery. Adult A was with Adult B at the time. No further issues were identified.
20/07/17	Adult B was seen at hospital by an Epilepsy Specialist Nurse. The notes state that on 02/07/17 he was on holiday with his partner when he had a seizure and was kicking out in his sleep. Adult B was later found wandering around outside the hotel in a very confused state. The notes further detailed that in 2013 he was diagnosed with severe anxiety. The Nurse noted that she thought that some of Adult B's problems were psychological and were being compounded by the diagnosis of epilepsy, but not necessarily epilepsy itself.

03/11/17	Hospital notes state that an Epilepsy Specialist Nurse had been contacted by Adult B. He reported that he had been experiencing daily focal seizures since 25/10/17, which he said started at his partner's family funeral.
08/11/17	Adult B was seen at hospital regarding ongoing health issues and some anxiety problems. Adult B stated he was nervous in company and was having two seizures a day. The notes detailed that his partner Adult A had hobbies, but he didn't have anything to do himself, and that she seemed to find it difficult that he didn't have things to do. The notes state that he found his home town to be boring and that it would be better if he were in an area which offered him more independence and where he was able to get out more. Adult B stated that one of his main concerns was the lack of his libido and sex life, and that this was one of the issues that could cause problems between him and his wife, and which was something he was keen to rectify.
18/11/17	Diary entry by Adult A. Seizure during the night whilst in bed, lasted about one minute with kicks and grasping the duvet
19/11/17	Diary entry by Adult A. Prolonged seizure about 10pm, Adult B stiffened and slid to the floor on his knees and beat the seat of the chair, he laid down on the floor and kicked for a while. When Adult B was quiet Adult A put a cushion under his head and he went to sleep for about thirty mins. When Adult B woke he had no idea of what had occurred.
20/11/17	Diary entry by Adult A. Seizure about noon. Adult B seized up and started to kick but that didn't last long. He was quite out of it for some time afterwards. These two seizures occurred whilst visiting relatives
21/11/17	Diary entry by Adult A . On the journey home at a cafe for a lunch break Adult B had eaten and was chatting when he suddenly dropped his head on the table, when he sat up he had no idea where he was or where we had been.
22/11/17	Diary entry by Adult A. Another episode of disorientation. Adult B had brought breakfast to bed then suddenly asked who had given us the food.
24/01/18	Adult B was seen by an Epilepsy Specialist nurse at Hospital. The notes state that Adult A had sent notes in with him regarding his episodes, but that there didn't seem to be any episodes of convulsive seizures. The nurse noted that some of the episodes didn't look epileptic in nature, and she wondered whether some of this related to underlying anxiety.
15/03/18	GP notes state that Adult B was assessed on 15/03/18 by Outlook[6] and that he presented with symptoms that appeared to be consistent

[6] Psychological therapy service in Cornwall.

	with a depressive episode. The notes further state that he had longstanding depression since his epilepsy returned five years previously.
09/05/18	Diary entry by Adult A. Adult A stated that she was in the sitting room with Adult B who went into a seizure whilst tightly holding the television remote controls which he was trying to twist. Adult A stated that she had tried to take the controller from him and was "fought off" before he relented.
16/05/18	Diary entry by Adult A. Adult A stated that whilst at home with Adult B he had a seizure during which he became "very angry" at Adult A who he stated was trying to get him to take the wrong tablets. Adult A stated this made her angry and so she left him to it.
16/07/18	Diary entry by Adult A. Adult A detailed three seizures which she stated were not remembered by Adult B. He could only recall watching golf. These are the last recorded seizures prior to the murder of Adult A.
19/07/18	Date of incident.
20/07/18	The notes from Adult B's custody records state that he was assessed under the Mental Health Act. The notes state that he believed that Adult A was in a conspiracy against him and that she had been poisoning his food and water. He stated that he had not had any food or drink, not even from the tap for the past two days and had not had his medication. Adult B stated that the neighbours were involved in the conspiracy. The notes state that Adult B did not think he was in a police station, but said it was somewhere that had been made to look like a police station. He was concerned that the police were not who they said they were and were out to get him.

15.0 Overview

15.1 This overview will summarise what information was known to the agencies and professionals involved with Adult A and her family. It will also include any other relevant facts or information about Adult A and Adult B.

15.2 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's previous husband had been described by one of her sons as a good man who treated his mother well. Adult A had

been a school teacher prior to retirement and was respected in her community.

15.3 Following the death of her husband Adult A lived alone for six years. Those that knew her described that 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. One of her friends who had known her for fifteen years stated that ' [Adult A] was a very well liked, respected and was a very friendly and helpful person.' She had lived in her home town for twenty years.

15.4 Adult A met Adult B in 2014 via a computer dating website. Adult B had been married previously and lived in a flat at a location some twenty-five miles away from Adult A's home address. Adult A would often drive up to visit him as he didn't hold a license due to him suffering epileptic fits. 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.

15.5 As a result of her relationship with 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 changed their mother.

15.6 Adult B had been previously married but this had ended in 2005. Adult A remained on good terms with his former wife and she would visit him and Adult A on occasions. He had three sons from his former marriage.

15.7 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 whilst he was serving in the Navy, although he received no treatment at the time and there were no further investigations by Health. In the past seven years his epilepsy had increased and he was subsequently being treated by a range of services within Health.

15.8 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.

15.9 Apart from Health there was very little involvement by agencies with either Adult A or Adult B. Adult A attended the same GP's surgery but apart from routine appointments there was nothing found in records that was of

particular relevance this review. There was also limited information from these encounters that was able to shine a light on Adult A's personality.

15.10 There was no involvement with Adult Social Care as Adult B didn't meet their threshold for intervention and there were no other recorded referrals to other support agencies. There is also no known contact with third sector agencies.

15.11 The Police were aware of Adult B but for minor unrelated issues.

15.12 Following his admission to a mental health facility after his arrest Adult B received treatment for cognitive impairment believed to be related to a dementia type illness and for psychosis. He was described by professionals as presenting with psychotic features of delusional misidentification. Adult B has since responded positively to this treatment.

15.13 Since being detained Adult B has been diagnosed with Lewy's Body dementia. The impact of this condition will be discussed in section 16.0.

16.0 Analysis

16.1 This part of the overview will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

16.2 This analysis considers the previous sections within this report and the content of the chronology of events. The information obtained from Adult A's family has also been used in this analysis.

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

16.3.1 In examining how and why the events in this particular case occurred, the first area for analysis is to determine the extent that Adult A was subjected to abusive and/or coercive or controlling behaviour in her relationship and whether there is any evidence that this led to her death.

16.3.2 Although limited in scale there is a growing body of evidence which has shown that older people are at a high risk of abuse (often labelled elder abuse (EA)), with older women most likely to be abused by spouse/partners[7]. Data

[7] Bows H (2018)

published by the ONS (2018) report that, in the year ending March 2017, there were sixty-four homicides of people aged sixty-five and over. Overall, there were two hundred and twenty-one DHs involving a victim aged sixty and over recorded by the police between 2010 and 2015. This equates to roughly 44 per year, which means that approximately one in four DHs involve an older victim. The review panel therefore sought to identify whether Adult A was the victim of such abuse during her relationship with Adult B.

16.3.3 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. Her first marriage was described by her family as loving and her husband treated her with kindness and respect.

16.3.4 There is no information held on record that would suggest that Adult B had witnessed or was subject to domestic abuse as a child. It would appear that he also grew up in a loving family environment.

16.3.5 Adult B had been married on two previous occasions prior to his relationship to Adult A. There is nothing held within the information that has been made available to this review that would suggest that he was violent or abusive in either of these relationships.

16.3.6 There was also no record in the diary that was kept by Adult A of any specific physical assault or threats of violence when Adult B was having a seizure. This is highlighted as it provides information in relation to his behaviour and attitude when having a seizure but this does not provide an indication that domestic abuse was absent in the relationship. As per the chronology entry dated the 9th May 2018 Adult A did state that she was in the sitting room with Adult B when he had a seizure. On that occasion Adult B was tightly holding the television remote controller which he was trying to twist. Adult A stated that she had tried to take the controller from him and was “fought off” before he relented. There is nothing recorded that provides any detail of how she was ’fought off’ and this would appear to have been an isolated incident.

16.3.7 There is also nothing recorded in any of the entries that would suggest that Adult A was in fear of Adult B during a seizure. The two of them appeared to have had a loving relationship and her family never saw any signs of abuse.

16.3.8 Adult A’s two sons did however state that Adult A had become increasingly insular after meeting Adult B. Within statements held by the police there was intimation that Adult B had an impact on her life in terms of his attitude which

appeared on occasions to alienate friends and family through making them feel socially awkward.

16.3.9 As part of the police investigation consideration was given to whether Adult B had used controlling or coercive behaviour[8] in the context of domestic abuse. Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. The Cross-Government definition of domestic abuse and abuse[9] outlines controlling or coercive behaviour as follows;

'*Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour'.*

16.3.10 The impact of coercive control on an individual's mental and social wellbeing is now considered to be so serious that it became an offence in law in January 2016, under the Serious Crime Act 2015.

16.3.11 The components of coercive control can include behavioural traits such as:

- Deliberate use of alternative moods.
- Excessive jealousy and possessiveness.
- Isolation-preventing partner from seeing family or friends.
- Control of the partner's money.
- Control over what the partner wears, who they see, where they go, what they think.

16.3.12 One of Adult A's sons in his statement to the police had described how he had noticed that Adult B was becoming controlling of his mother. He described this as being a slow process which had occurred over a period of four years and during that time Adult A had become less confident resulting in Adult B becoming more influential.

16.3.13 Adult A had previously been outgoing and social but since meeting Adult B her relationship with others including her sons had changed. This was demonstrated at a family gathering when Adult A would only sit with Adult B and she would not socialise which was totally out of character. As a family

[8] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office
[9] Domestic abuse; Home Office (2016)

they would also normally all get together over the Christmas period, but Adult A had started to make excuses as to why she could not attend and again this was a cause for concern.

16.3.14 Adult A's family also stated that she would always wear bright colours but again since meeting Adult B she had started to wear plain clothes. They also stated that Adult A would hate watching football and soaps on television but would sit with Adult B whilst he watched them.

16.3.15 In July 2018, one of Adult A's sons and his family went to stay with his mother and Adult B. Although Adult A appeared to be happy on one occasion she was asked whether she wanted to go for a walk on the beach. Adult A used to love to do this and therefore it was a surprise when she stated that she needed to ask Adult B and because he did not go she didn't either.

16.3.16 Adult A's family felt that she was on occasions economic with the truth in respect of Adult B and that was shielding him from the family. Adult A would often take Adult B's side and her family felt that he was controlling her emotionally and 'brain washing' her.

16.3.17 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 that there was no evidence that this was having an impact on the relationship in terms of abuse. 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. Research[10] recognises that cases can go unreported for personal (embarrassment, fear of retaliation, economic dependency) and societal (imbalanced power relations for men and women in society, privacy of the family, victim blaming attitudes) reasons.

16.3.18 The difficulty in understanding Adult B's behaviour is that many of the traits that he displayed, such as being apparently possessive, antisocial and curt with people, could be attributable to his developing medical condition.

16.3.19 It is clear that Adult A loved Adult B and wanted to care for him. From the diary entries that were made by Adult A it is evident that she wanted to support him at his time in need and therefore may have willingly sacrificed some of her independence in order to look after Adult B. It is also evident

[10] Gracia (2004); Birdsley et al (2013)

from Health records that due to his depression and anxiety Adult B was in need of constant reassurance and this too would have had an impact on their relationship and how he presented to others.

16.3.20 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.

16.3.21 The only aspect of Adult A and Adult B's relationship that was causing tension (according to Adult B when he was seen by Health professionals[11]) was in relation to the problems that he was suffering regarding erectile dysfunction. There is nothing to suggest that Adult A considered this to be an issue in their relationship or that this was an increasing area of tension between the two of them.

16.3.22 From the entries in her diary there is nothing to suggest that Adult A did not feel in control of her life or that there was any increase in threat on the days leading up to her death. On the day in question there was no evidence of any violence in the house. One of the officers who had attended the scene and subsequently searched the house stated that;

'on checking the rear garden she saw a mobile telephone, computer tablet and an empty teacup on the patio table with no obvious signs of a disturbance'.

The attack on Adult A would therefore appear to have been sudden and unexpected.

16.3.23 Whilst there is an acceptance that in many cases those suffering from domestic abuse may not tell others about their victimisation[12], there has been nothing found in this review that would indicate that there were barriers experienced by Adult A in reporting domestic abuse or concerns to either her family or agencies in Cornwall (if it had existed in the relationship).

16.3.24 Due to the limited contact with family members it could not be ascertained as to whether they knew about domestic abuse or how to report it should they have had concerns in relation to either Adult A or Adult B.

[11] Health records (2017/18)
[12] Farmer E et al (2012)

16.3.25 Again, due to the minimal contact that either Adult A or Adult B had with statutory or non-statutory agencies there was limited opportunity to enquire whether there were concerns about domestic abuse in the relationship. NICE guidelines[13] state that Health and Social Care agencies should;

> *'Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse'.*

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 there is nothing to suggest that this falls outside of NICE guidelines but the use of routine inquiry should be encouraged. (**Recommendation** 1)[14].

16.3.26 The GP was confident that in cases where risks are identified then staff at the surgery are confident in their ability to deal with domestic abuse and would make the appropriate referrals. The GP concerned was confident and trained in recognising domestic abuse.

16.3.27 Contact with the neurology department at the hospital where Adult B was treated identified that they do not routinely consider issues relating to domestic abuse when dealing with individuals suffering from epilepsy or dementia. There is also no routine consideration of the risk to partners when such conditions deteriorate unless there are specific risk factors present such as paranoia or violent behaviour. Due to the range of mental health illnesses and the variable nature of the impact that they can have on an individual it was felt that determining specific risks relating to domestic abuse would be almost impossible.

16.3.28 The specialist nurse who had treated Adult B had the most contact that any professional had with Adult B. She was unable to recall any appointments where specific concerns were raised or where she had any concerns about the safety or welfare of either Adult A or Adult B. When asked about what she would do if such a risk arose the nurse was clear that they would refer the matter to Adult Social Care and/or speak to a safeguarding lead for

[13] Domestic Violence and Abuse: Multi Agency Working; Public Health Guideline [PH50]; 2018

[14] Replicates another recommendation agreed as part of (DHR7) in Cornwall which also recommends promoting the use of routine and direct inquiry across all services.

advice and guidance. This specialist nurse had received safeguarding training and was aware of domestic abuse and its effects on victims.

16.4 Adult B's Mental Health

16.4.1 The second area for analysis is to look at the decline of Adult B's mental health and the impact that this had on his relationship with Adult A.

16.4.2 The impact of mental health and its risks in relation to domestic abuse are widely known. Evidence indicates that mental health is a significant risk factor for perpetrating domestic abuse[15] and that it is associated with increased risk of domestic homicide[16].

16.4.3 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. The longest period that Adult B went without a seizure was four weeks. Adult B would sometimes have violent seizures and whilst he was worried that he could injure Adult A due to his size[17] this never occurred. His seizures meant that he was incontinent, lost social confidence, and suffered from anxiety and depression. Adult B was unable to remember any of his seizures or what happened during them.

16.4.4 During their relationship Adult A maintained a diary of his seizures. The diary is entitled "[Adult A's] seizures" since changing from Episenta (used to control epileptic seizures and mania) to Zonegran (used to treat partial seizures in adults with epilepsy).The diary recorded the dates of Adult B's seizures and a short description of what happened on each occasion. In total Adult A documented one hundred and six seizures between the period November 2016 and July 2018. The seizures recorded consisted of;

- four seizures in the last two months of 2016
- fifty-eight seizures during 2017
- forty four seizures in 2018 (these occurred in the seven months up until the last diary entry on the 16th July).

16.4.5 The symptoms displayed by Adult B during the seizures included;

- Irritability
- Agitation

[15] Safelives (2019)
[16] Bridger et al(2017)
[17] Concerns raised to Health professionals.

- Kicking
- Shaking
- Hand movements
- Biting of the tongue
- Gurgling
- Memory loss
- A feeling of Déjà vu.
- Being unaware of his surroundings
- Out of body experiences

16.4.6 Adult B's son stated[18] that he had noticed a decline in his father's behaviour since the onset of his seizures. In his statement to the police he stated that his father 'had got less outward going and was more likely to sit quietly and talk although he would struggle to say what he meant which was frustrating to him'.

16.4.7 Adult B had regular appointments with a Consultant Neurologist and a specialist nurse who were working with his GP to treat his condition. In order to treat his symptoms Adult B had been prescribed anti-epileptic medication[19]. At his last appointment prior to the incident he was prescribed Lacosamide and Zonisamide. These medications assisted in preventing a seizure for a three-week period however after that he had four in one night and one of them was extremely violent. According to the concerns raised by Adult A in her diary none of these medications appeared to effectively control his condition.

16.4.8 In the past Adult B had also received self-guided Cognitive Behavioural Therapy[20] to help with the difficulties that he was experiencing in relation to social anxiety. These sessions which were carried out in 2014 appeared to have a positive impact on his outlook and he was discharged from psychology services.

16.4.9 In November 2017 Adult B had a neuropsychological assessment by a Clinical Psychologist in relation to the ongoing health issues that he was reporting and to address his anxiety. In this assessment Adult B stated that he would often be nervous in company, but he denied that he was suffering from any anxiety. Adult B claimed that one of his major concerns at that time was a lack of libido. The Clinical Psychologist offered advice but felt that there was nothing further

[18] Statement provided to the Police.

[19] Valporate, Carbamazephine, Clobazom, Lamotrigine, Levetiracetam, Zonisamide.

[20] A low intensity therapy which is recommended by NICE guidelines. The CBT approach is an evidence based effective treatment for helping people tackle problems such as anxiety and/or depression.

that they could do for Adult B and therefore he was not offered further appointments. This would appear to have been a proportionate response at the time.

16.4.10 In March 2018 Adult B was seen by a Psychology Wellbeing Practitioner where they identified that the symptoms that he was displaying were consistent with a depressive episode. At that time, he reported that he was feeling low and had stopped his hobbies. Adult B was given suitable advice at the appointment and a follow up appointment was made. Whilst this depressive episode may have made him vulnerable there is no evidence to suggest that he presented a risk to himself or others at that time. Adult B failed to attend a follow up appointment and therefore he was discharged. Again, this was a proportionate response in the circumstances.

16.4.11 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 was paranoid with him accusing staff that they were trying to kill him. He was described as being hypervigilant and showing a complete lack of remorse for the death of Adult A.

16.4.12 Following his detention Adult B reported to Health staff that in the days leading up to the death of Adult A he had started to believe that '*she'* [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. Adult B stated that he couldn't trust anyone and that he believed that his partner was in a conspiracy against him. He thought that she had been trying to poison his food and water. None of this had been reported to any agency or to family members prior to the attack on Adult A.

16.4.13 One of the forensic psychologists who had treated Adult B has stated that even if he had paranoid symptoms prior to the assault on Adult A it is not uncommon for people suffering from them not to tell others. This is due to the level of mistrust that individuals may have or that if they do speak out they will not be believed, or that punitive action will be taken against them. Due to the comprehensive nature of the entries that were made by Adult A in her diary it is likely that had any paranoia been apparent then it would have been recorded.

16.4.14 The telephone call to his son and the police on the day of the assault and the behaviour observed by witnesses at the scene, show the levels of confusion and paranoia that he was experiencing. This included one witness hearing him

say' *he was going to kill her',* and then *'she wanted me to kill her'* and*' I would have killed her'*.

16.4.15 Adult B was described on that day by witnesses as being distant and later reported to health professionals that he was playing '*a game'* with Adult A and that it was as if he were 'i*n a movie'*. Post incident health examination has described him as experiencing visual and auditory hallucinations at that time.

16.4.16 Following his arrest and detention at a mental health facility 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 with Health professionals it is clear that Adult B was a complex case to fully diagnose and the fact that he had Lewy Body Dementia was not known.

16.4.17 According to an independent neurologist and the heath professional that supported this review such a diagnosis is not easy and would normally be undertaken by a psychiatrist who would also require additional supporting evidence such as computerised tomography (CT) scans. In this case Adult B's presenting symptoms would have meant that there was no need to refer him to a psychiatrist. Adult B's loss of memory was attributed at the time to his epilepsy and dementia had not been diagnosed.

16.4.18 There has been nothing identified during this review that would indicate that medical professionals failed to act appropriately in relation to Adult B's treatment. Although his condition had not been diagnosed those professionals informing the review have stated that this would not be uncommon due to the complexity of his presentation. Even if an earlier diagnosis had been made then there is no certainty that any subsequent treatment would have prevented the deterioration in his mental state on the day that the attack took place. Those currently treating Adult B still consider him to be a risk in terms of violence despite the intervention that has been put into place.

16.4.19 Dementia with Lewy Bodies may account for ten to fifteen per cent of all cases of dementia[21]. DLB can be diagnosed wrongly and is often mistaken for Alzheimer's disease. This type of dementia is a progressive disease and as the patient's condition declines risks to the person suffering from the illness and to others can (but not always) increase. This will be discussed further in paragraph 16.5.

16.4.20 Adult B was being seen on a regular basis by a consultant and by an epilepsy specialist nurse. Adult B's GP has stated that he was confident that he was

[21] Alzheimer's Society 2019.

receiving the right level of care and was reliant on the consultant neurologist to inform him of any specific change in diagnosis due to the complexity of Adult B's condition. There was a good level of information sharing shown in medical case notes.

16.4.21 Whilst Adult A and Adult B had concerns that he was not receiving the right medication to control his epilepsy his GP and his consultant neurologist have confirmed that the treatment that they had prescribed was entirely appropriate with their diagnosis at the time. There has been nothing found by the review panel that would contradict this view.

16.4.22 Following the incident consideration was given to whether the medications that Adult B was taking could have made him psychotic. A Neurologist has confirmed that the medication was extremely safe and evidence of it increasing psychosis was extremely rare[22].

16.4.23 From the records made available to the review it is apparent that it has taken a considerable amount of time (many months) for those professionals working within a secure mental health facility to identify the specific type of medication and dosage that has been required to effectively assist in stabilising Adult B's condition. It was only following a full diagnosis that this could be achieved.

16.4.24 From the records and letters sent to his GP by the specialist nurse it is clear that medical professionals were keeping an open mind about Adult B's condition due to his presentation at appointments. As he was exhibiting symptoms such as a tremor, they were considering other underlying causes to his condition[23]. The competency of the specialist epilepsy nurse has been described by the independent expert on the panel as exemplary.

16.4.25 Physical aggression among people with dementia is not unusual [24] / [25]. Homicide committed by older adults has been described as an extreme and infrequent outcome in terms of the level of violence and has a prevalence ranging from 1% to 4%. Risk factors in relation to such violence largely remains 'unknown'[26]. There are very few studies or bodies of evidence in relation to such homicides which makes risk identification particularly difficult.

16.4.26 Adult B had never used non-prescription drugs and would only drink alcohol on social occasions. Whilst it is known that these substances have a considerable impact in terms of increasing the risk of domestic abuse there is

[22] Khaled(2016)
[23] Health record entry by specialist epileptic nurse dated 24/01/18.
[24] Lund(2017)
[25] Putkonen H (2010)
[26] Devantoy et al (2010)

nothing to suggest that they had an impact on Adult B's risk in the months leading up to, and on the day of the assault.

16.4.27 On the information available and the subsequent diagnosis from Health professionals the extent of 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 Lewy Body Dementia.

16.5 Risk Management – Adult B

16.5.1 As previously stated dementia with Lewy Bodies is a progressive disease and the risks associated with it are likely to increase over time particularly if it is accompanied by psychotic symptoms. Research suggests that elderly patients with dementia have significantly higher levels of physical aggression against their partners than patients without dementia. At the time of the assault Adult B had not been diagnosed with dementia.

16.5.2 There was no recorded history of violence or abuse between Adult A and Adult B prior to the assault. The diary entries made by Adult A did not indicate that she felt threatened by him or that she was concerned for her own welfare. On Adult B's presentation alone, it would have been unlikely that any professional would have perceived any form of threat to Adult A or had seen the need to brief her about any risks.

16.5.3 Although it has been identified post incident that Adult B had been suffering from paranoia and confusion in the days leading up to the assault on Adult A these were not reported to professionals or family members. As a result, the level of risk could not have been predicted or additional measures put into place to protect Adult A.

16.5.4 From discussion with Health professionals involved in the review process the conclusion was that even if dementia with Lewy Bodies had been diagnosed no one could have predicted the actions of Adult B on the day in question. There is also no certainty that even if Adult B was prescribed different medication that the incident would have been prevented or the risks minimised.

16.5.5 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 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)**.

16.6 Operational Practice, Policy and Procedure

16.6.1 The DHR process would ordinarily assess the effectiveness of policy and practice in respect of domestic abuse. Whilst there were no specific reported incidents in respect of domestic abuse in this case the review panel still considered whether professionals had a good knowledge of relevant policy and practices, and whether this was reflected in operational practice. This was completed in order to address the terms of reference that were originally set for this review.

16.6.2 The Panel reviewed and confirmed that robust policies were in place with regard to safeguarding and domestic abuse at the time of the incident . These policies which continue to be updated are known to staff and are available to them through internal intranet sites.

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

16.6.4 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. Such action will also assist in identifying those individuals who may potentially become abusive due to their condition. Identifying these individuals will ensure that any risks are effectively managed in terms of themselves and their families. This action is particularly pertinent in view of the demographics of the population in Cornwall which continues to become more elderly[27] (one in four people are aged sixty-five and over) and is expected to grow by eleven percent by 2037[28]. Many of these people live in isolated communities where access to services and support in relation to domestic abuse can be limited.

16.6.5 As a consequence, it stands to reason that the numbers of victims of domestic abuse amongst the elderly are likely to increase in the years to come. All agencies therefore need to review current policy and practice to ensure that it

[27] McCurdy C (2019)
[28] Cornwall and the Isles of Scilly Safeguarding Adults Report 2018-2019.

addresses the issues associated with domestic abuse amongst the elderly and those suffering from age related conditions **(Recommendation 3).**

16.6.6 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. Those representing older people on the panel have stated that stigma is the main issue that's stops people seeking help. Those suffering from dementia and their carers should have the confidence to seek out support in the early stages of the condition.

16.6.7 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.

16.6.8 Agencies also need to be mindful that elderly people may need additional help to raise concerns and safeguarding issues. As part of the work that is currently being undertaken in the County it came to light that one elderly lady who ran a memory café had tried to report a safeguarding referral by phone and was told to report it on the internet. This individual didn't have the ability to access the internet. Victims of all types of abuse no matter what their age should have the ability to readily access services **(Recommendation 5).**

16.6.9 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. Current work includes improving access to diagnosis, raising awareness, supporting carers, education, and reviewing and developing the current care pathways. Moving forward the chair will task the Board to review how agencies can raise awareness of domestic abuse/risk in line with work streams.

16.6.10 The hospital that was treating Adult B's epilepsy have a morbidity and mortality meeting which takes place every two months. This meeting is attended by all the available consultants. 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. There is also a weekly regional neuroscience meeting attended by consultants from Treliske, Exeter, Torbay and Plymouth and this is an opportunity to present unusual cases. The consultant neurologist

at the hospital will look to discuss this case at these meetings **(Recommendation 6)**.

16.7 Information Sharing and Communication

16.7.1 Due to the limited involvement by agencies it is difficult to truly assess the effectiveness of information sharing and communication between and within the services involved in this case. From the records that were reviewed it was however clear that there was regular correspondence and contact between the specialist nurse, the neurologist, and the GP who were treating Adult B. This should be seen as good practice.

16.7.2 Whilst not a specific aspect in this case the terms of reference also requested that the Panel look at the wider issues relating to domestic abuse communication. This includes communication to the general public and non-specialist services in Cornwall about the role of the services that are available to victims and perpetrators.

16.7.3 Safer Cornwall have and continue to promote the services that are available to victims and perpetrators through literature, events, social media and relevant websites. This continues to be work in progress and is part of the overall domestic abuse strategy for the county.

16.7.4 Safer Cornwall has recently reviewed their DASV[29] 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).**

16.7.5 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)**.

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

16.7.6 In this case Adult A would have been unaware of the potential risks associated with Adult B's developing dementia. The feedback from professionals involved in the review and from open source searching on the internet showed there is little information for carers about the risks that they could face. Whilst there is an acceptance that any such information would need to be proportionate in its content, it could still assist in mitigating any risks to them. Such information should include seeking help and advice when those individuals suffering from dementia start to become violent or develop paranoia symptoms **(Recommendation 9)**.

16.7.7 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.

16.8 Supervision

16.8.1 There were no issues raised or identified during this review in respect of supervision. From those records that were reviewed suitable supervision practices were in place and followed.

16.9 Training

16.9.1 The review panel have confirmed that effective 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.

16.9.2 The circumstances of this review have 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. All agencies should therefore review the 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 **(Recommendation 10)**.

16.9.3 Health agencies in Cornwall including those dealing with mental health adhere to the Intercollegiate document[30] which clearly sets out levels of competency for professionals working in the sector and includes domestic abuse. This training is mandatory. The Clinical Lead NHS has also confirmed that as part of education Health are promoting the use of National Dementia training

[30] Adult Safeguarding: Roles and Competencies for Health Care Staff (2018).

standards framework.

17.0 Conclusions

17.1 Adult A was a loving and caring mother and partner who unselfishly devoted herself to caring for Adult B. This level of devotion came at a cost in respect of her ability to be socially active and for her to enjoy family life to the extent that she used to in the past. 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.

17.2 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 from his behaviour and there is no recorded evidence of an escalation to that risk in the days leading up to her death.

17.3 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.

17.4 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 towards his behaviour. Despite this impact Adult A would always be there to support and care for Adult B.

17.5 Adult B had a history of epilepsy and was being treated for the symptoms that had been identified by Health professionals, none of whom were aware that he was suffering from dementia with Lewy Bodies [31] . 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.

17.6 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

[31] Dementia with Lewy Bodies may account for ten to fifteen per cent of all cases of dementia[31]. DLB can be diagnosed wrongly and is often mistaken for Alzheimer's disease. This type of dementia is a progressive disease and as the patient's condition declines risks to the person suffering from the illness and to others can (but not always) increase.

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.

17.7 No one could therefore have foreseen the events that occurred in July 2018.

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

17.9 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.

17.10 These agencies will continue to work together to address these issues with the current Domestic Abuse Strategy within the County.

18.0 Learning

18.2 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 19.0.

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 it could still help in assisting both the carer and the individual suffering from dementia.

- 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.

19 Recommendation

19.1 This section of the overview report sets out the recommendations made by the DHR panel and includes the recommendations made in each of the IMR reports.

19.2 The DHR panel therefore offers the following overarching recommendations for local action:

- **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.

Glossary

CCG - Clinical Commissioning Group.
CFT - Cornwall Foundation Trust.
CMHT - Community Mental Health Trust.
CSP - Community Safety Partnership.
CT - Computerised tomography
DH - Domestic Homicide.
DHR - Domestic Homicide Review.
EA - Elder Abuse.
ED - Emergency Department.
GP - General Practitioner.
GSC - Government Security Classifications.
ICMHT – Integrated Community Mental Health Teams.
IMR - Independent Management Review.
IOPC - Independent Office for Police Conduct.
MCA - Mental Capacity Act.
MHT - Mental Health Team.
NHSE - National Health Service England.
OOH - Out of Hours.
PCT- Primary Care Trust.
PLS - Psychiatric Liaison Service.
RCHT - Royal Cornwall Hospitals Trust.
RE - Routine enquiry.
SWAST – South West Ambulance Service Trust

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