Confidential

Domestic Homicide Review

Carlisle and Eden Community Safety Partnership

Executive Summary

Prudence M Beever

Chair

In respect of the death of a woman

DHR Case Reference: DHR/2015

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1. Introduction

This report of the Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Mrs A M, date of birth 22 June 1934, aged 80 years, by her husband Mr B M on 2 September 2014.

The Panel oversaw the gathering of information which provided the identification of key points of the case. An Independent Chair with a professional background in Domestic Abuse and public sector regulation was appointed to steer the review. The Chair has knowledge of community safety issues, partnerships and domestic abuse. She has never been employed by any of the agencies concerned with this review, and has no personal connection to any of the people involved in the case. Representatives on the panel were appointed as follows:

- Safeguarding Adults Service Manager, Health and Care Services, Cumbria County Council
- Detective Inspector for North Cumbria Constabulary
- Development Officer for Mentally Disordered Offenders (Cumbria), Cumbria Partnership NHS Foundation Trust
- Head of Lancashire and Cumbria Crown Court Prosecutions Unit, CPS (extended leave prior to completion of the review)
- Communities Director Eden District Council
- GP Safeguarding Lead for Adults in Cumbria, NHS Commissioning Group
- NHS England, Quality and Safety Manager, Cumbria, Northumberland, Tyne and Wear Area Team. Later replaced by:
- Senior Quality and Safety Manager, Cumbria Partnership NHS Foundation Trust.

The review report draws information from the support agencies for Mr and Mrs M before Mrs M's death.

Plain English has been used where possible in the production of this report.

2. Purpose of a Domestic Homicide Review

The Domestic Violence, Crime and Victims Act 2004 establishes at section 9 a statutory basis for a Domestic Homicide Review, which was implemented with due guidance on 13 April 2011. Under this section, a Domestic Homicide Review (DHR):

"means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

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

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

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

- establish what lessons are to be learnt from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard the victim.
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- apply these lessons to service responses, including changes to the policies and procedures as appropriate.
- prevent domestic homicide and improve service responses for all victims and their children through improved intra- and inter-agency working.

3. The Circumstances of the Homicide

Mr and Mrs M were retirees in their 80s. They were both academics and had come to live in an isolated rural spot with only two neighbours, a couple living within the vicinity, who, over time, became their friends and a source of support.

On the morning of 2 September 2014, the police received a call from Mr M at 6.16am stating that he thought his wife was dead. He informed the call handler that he was ill, he could not talk and was going to sleep. Officers were immediately deployed and arrived at his home address in Cumbria. Mr M told them that his wife was dead upstairs in the house. He informed the officers that he had tried to kill himself in his car by placing the exhaust pipe inside his vehicle.

Officers found the car with a pipe in the vehicle and a strong smell of fumes within the garage. His wife was located upstairs with a plastic bag and pillow over her head which was weighted down. She was confirmed deceased by paramedics at 6.50am.

Mr M was arrested and was taken to be medically examined at Cumberland Infirmary**.** He was later formally charged with the murder of his wife by Cumbria Police. He was remanded in custody with the support of a psychiatric report, until given bail on appeal on 13 October 2014. There were address and reporting conditions imposed at the Crown Court. He was found dead by the River Eden on 11 December 2014.

The death of Mr M is the subject of a separate internal review by Cumbria Partnership Foundation Trust. Evidence from this review has been shared with them to avoid duplication of documentation and interviews of key witnesses.

4. Terms of Reference

Terms of reference were to:

- Establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk of harm to his wife, the victim, and whether any action could have been taken to prevent the homicide. To establish whether the domestic homicide was predictable or preventable.
- Identify how effective agencies were in identifying the victim's vulnerability to domestic abuse/ homicide and whether the risks were identified and appropriately managed.
- Identify how effective agencies were in identifying the risks that the perpetrator posed to the victim (or himself), and how such risks were managed.
- Establish how agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working, practice, policies or procedures to improve the identification of people who may be subject to the risk of abuse and homicide within Cumbria and beyond.

5. Time Period

The review covered the time period from approximately February 2012 until 2 September 2014, when Mr M called the police after killing his wife. The review also considered relevant information from individuals and agencies from their contact with the perpetrator after that time period, in order to gain insight into the state of his mind/thinking processes before he was eventually found dead.

6. Key Lines of Enquiry

- **History of events and relationships**

What was known about the perpetrator's relationship with his wife? What was the sequence of events leading up to the date of the homicide?

- **Information and assessments**

How was information about Mr and Mrs M received and addressed by the agencies? What assessments were completed and what was the outcome of these? Were there trigger points or missed opportunities for sharing information that would or could have made a difference? What were the thresholds for decision making?

- **Risk assessments**

What risk assessments were completed to a) assess the risks to the victim and b) to assess the risks posed by the perpetrator? Did the perpetrator have a history of violence and, if so, how was this managed? What were the outcomes of any risk assessments? Were these completed on a single agency basis or jointly with other agencies? What actions were taken?

- **Contact with and support from agencies**

What contact did each agency have with the victim and the perpetrator? What support did each receive and from whom? What processes were followed and what were the key decision points and why? Was there any additional action that could have been taken and would it have made a difference?

- **Adult safeguarding**

Were there any safeguarding issues in respect of the victim and, if so, were these appropriately managed?

Awareness of domestic abuse indicators

To what extent are staff and agencies aware of the indicators of risk in these circumstances? Were these appropriately identified and what action was taken? Does the agency have policies and procedures in place for dealing with concerns about the possibility of the existence of elderly abuse/homicide/suicides?

Independent Management Reviews were received from:

- Cumbria County Council Adult Social Care
- Cumbria CCG – Brampton Medical Practice
- JK House Care Home
- Cumbria Partnership Foundation Trust, (NHS)
- Cumbria Constabulary
- Alzheimer's Society

In addition, friends and family members were also interviewed and provided invaluable insight into the personalities and background of the couple.

7. Main Issues

It is not possible to know definitively what motivated Mr M to kill his wife, and whether her death could have been prevented. No formal or informal assessment of Mr M's state of mental health was ever undertaken. Knowing what is known about Mr M's personality, it would have been difficult to engage him in conversation about his mental health.

The couple's reluctance to accept help and advice was an issue that his GP felt could not be changed.

An analysis was made in considering whether there were any elements of domestic abuse, and the conclusion was that, although there were elements of controlling behaviour, there was nothing in his history to suggest that any of the agencies involved had any concerns about domestic abuse.

The GP's practice did have evidence that Mr M was under strain and may have been depressed. There was some evidence that he was drinking more than he should.

He was very worried about his wife being left on her own now that he was unwell himself. He was, however, a private man and lived “on his own terms”.

In Summary:

- There was no history of domestic violence in the relationship. Mr M appeared to care a great deal for his wife, but he was clearly not coping.
- Mr M as carer for his wife was under considerable strain and was worried about his own health and what would happen to his wife if he could not care for her.
- It has become apparent within this review process that the three main agencies involved in the support of Mr and Mrs M did not engage in an effective multi-agency process to ensure that regular and focused information sharing took place.
- Engagement between the Adult Services social worker and Mr M was predicated in the main on the way in which the department works with self-funders. Mrs M was considered to be a self-funder early on in the social work relationship, along with Mr M stating that he was prepared to make care arrangements himself. This review highlights a weakness in the way the department engages with self-funders. The terms of engagement heavily influenced decision-making at many of the key events. Whilst the department and the SW acted in accordance with legislation and known practice on the role and responsibility for self-funding customers, the social work engagement placed an overreliance on support being about service options and availability of such services from care providers. The different ranges of therapeutic SW intervention or emotional support were not offered to Mr M. The social worker looked to meet this responsibility by referring to other agencies, for example ECA or Alzheimer’s Society.
- Practitioners needed to look wider than service-specific interventions to the type of therapeutic social work support a person may need, irrespective of the person’s financial circumstances.
- In this case, it seems that the social worker looked to try and support Mr and Mrs M at least as much as Mr M was willing to allow. Mr M appeared to the SW that he was capable of arranging services and willingly pursued this responsibility. The social worker looked to refer to various other agencies to seek wider support for both Mr and Mrs M, but on many occasions Mr M did not pursue this support.
- Mr M was isolating himself from support networks and seemingly ‘going it alone’ to make all of the arrangements for his wife. There seems to have been an overreliance placed upon Mr M and his ability to make decisions in his wife’s best interests.
- Neither Mr nor Mrs M liked visiting the GPs practice, and rarely did so until Mrs M's memory began to fail in March 2012. She had never been keen on medication, and when she became ill she declined medication either for her dementia or for her underactive thyroid.

- Nothing unusual was noted in the couple's relationship. There were no signs that Mrs M was unhappy or unsettled. Mr M was always caring and behaved appropriately. The Consultant Psychiatrist had not noted Mr M appearing depressed.
- Once the surgery was aware that Adult Social Care were involved with the family, their expectation was that the social worker was the most appropriate person to advise on the most appropriate care for Mrs M.
- The Care Home chosen by Mr M for his wife was unsuitable for her due to her wandering from home on a number of occasions, and their inability to keep her safe from doing so themselves. There was insufficient communication between services and the pre-admission assessment undertaken was wholly inadequate. However, Mr M appears to have underplayed the safety issue of 'wandering' in his pre-admission discussions with the Care Home manager.

8. Risk Factors Affecting the Couple

Was it, or could it have been known or suspected**,** that Mr M posed a serious risk of harm to his wife? The answer is probably not. There was no evidence that domestic violence was a feature in the couple's relationship. There is every indication that Mr M loved his wife and was very caring and attentive towards her. However, he could, at times, be irritable and short-tempered with professionals who were trying to help.

There were a number of risk factors identified by the Panel affecting this couple:

1. They lived in isolation in a rural area, and away from support networks of family and friends.
2. Mrs M was suffering from a diagnosis of Alzheimer's disease.
3. The carer was ill and in pain, with the prospect that this would not be alleviated by an operation if appropriate care for his wife could not be found.
4. Notwithstanding his strengths, it is clear that Mr M was experiencing high anxiety about what would become of his wife should he become hospitalised or die first.
5. Mr M demonstrated 'self-sufficiency', and at times he was difficult to engage and oppositional in accepting help and support. He was not welcoming of follow-up by professionals.
6. Mrs M was reluctant to take prescribed medication.
7. Mr M's depression was not picked up adequately by mental health services and the GP.
8. Mrs M had a propensity to wander, and she was active and agile – this was likely to be a source of extra strain on her husband.

9. Examination of Why and How Events Occurred

There were clearly a number of inadequacies in managing the risks identified above as set out in the IMRs produced by the Agencies. In an ideal world and with the benefit of hindsight, these would not have occurred.

To highlight a number of these:

- ASC did not appear to have arrangements for covering part time staff caseloads adequately;
- There was a lack of proactive social work and appropriate support from line management.
- There was a lack of thorough risk assessments by agencies of either Mr M or Mrs M.
- There was an overreliance on communication with Mr M, and little or no direct contact with Mrs M.
- There was a high level of correspondence into the busy GP surgery – this contributed to not all relevant and important correspondence, and documentation of conversations and phone calls, being treated with sufficient care and attention.
- Inadequate assessments were undertaken by the staff at JK House.
- Although details of out of hours contacts were given to Mr M in the case of an emergency, for unknown reasons he did not utilise this service, and possible reasons need to be explored and addressed by ASC.
- There was no recognition that Mr M was struggling to the extent that he was and that he was desperate for help.
- There was no contingency plan in place or even discussed should the residential placement fail.
- The Panel is not satisfied that there was sufficient inter-agency communication and information sharing. What communication there was appears to have been cursory and reactive rather than proactive.
- A great deal of reliance was placed upon the fact that the Ms were self-funders. The interaction between ASC, the GP and JK House was inadequate, particularly in relation to the suitability of the care home to meet Mrs M's individual needs.
- There was insufficient intra-practice cross-referencing of relevant information on the GP records of Mr and Mrs M.
- There was no agreed strategy for Managers of JK House to follow in a situation which may have required an emergency discharge of a resident.

It is the Panel's view that it is impossible to predict whether the homicide could have been prevented if none of the inadequacies highlighted (and largely recognised by the participating agencies), existed. Mr M stated clearly in his

suicide note that he and his wife had an agreement that they would not allow themselves to go into care suffering from dementia.

Whilst recognising that it is difficult to draw a line between respecting the elderly couple's autonomy and breaking confidences by information sharing, nonetheless offering sufficient and appropriate care to vulnerable adults is crucial to minimise the risk of a similar scenario occurring in the future.

10. Lessons to be Learnt

The Panel accepts that some lessons have already been learnt by the agencies by taking part in this very vigorous exercise. Additional suggestions of improvements have been highlighted in the above comments on the IMRs made by the Panel.

It is also suggested by the Panel that it would be helpful if permission from carers and clients/patients is sought at an early stage in order to share information between agencies involved with vulnerable adults and to make them aware that information will be shared.

The policy of leaving self-funders to determine what is best for the vulnerable adult is clearly not adequate and leaves the care home itself to undertake the assessment. If that assessment either does not take place or is inadequate, as in this case, this can clearly lead to serious difficulties.

There were many issues in the circumstances of the lives of Mr and Mrs M that may have contributed to this tragic homicide, but it is extremely difficult to conclude that it would have been avoided altogether if the improvements had already been implemented to address the shortcomings as identified by the agencies themselves and by this Panel.

The personality of Mr M was a factor in itself. He was at times difficult to engage, and the evidence is that he was a determined, independent and intelligent gentleman, and had clearly put considerable planning into his actions. However, he was not coping as well as he might have suggested, being saddened and overwhelmed by his wife's illness, and he too was vulnerable, in spite of his outward appearance.

Most of the participating agencies which provided IMRs gave insightful analyses of the shortcomings within their agency. Changes clearly need to be made to improve services, and some have been acknowledged and already implemented.

Providing care to a person with dementia can be highly stressful for carers, and has been shown in many cases to be highly predictive of mistreatment and abuse on the part of the carer. There is considerable evidence that carer stress is related to levels of support, and that greater understanding about Alzheimer's and other forms of dementia and ways of working with people with these conditions can reduce carer stress.

Abuse occurring in families can be considered from two perspectives: abuse that is perpetrated deliberately, and abuse that is not. Sometimes the perpetrator is doing his or her best but cannot provide the level of care and support that is needed, sometimes because they don't know what care and

support is available and sometimes because the necessary support is not available. Abuse which is not deliberate can include a wide range of actions, including neglect or the unnecessary restraint of a person with dementia.

Worryingly it is possible that elderly abuse and homicide/suicide cases may become a phenomenon that is likely to become more common as the population ages and more of the population suffers from Alzheimer's or other forms of dementia. It is crucial that all professionals are aware of the risks that exist.

It is the Panel's view that it is imperative that all professionals who are involved or likely to be involved with the affected families have training in understanding the social, psychological and emotional effects of Alzheimer's disease and dementia on both the sufferers and their carers, and that training is kept up-to-date.

11. Recommendations

These recommendations are made with the sole purpose of suggesting improvements in:

(a) Identifying people, and in particular the elderly, who may be subject to the risk of abuse and homicide within Cumbria and beyond.

(b) How agencies could work better together.

(c) Strengthening inter-agency working practices, policies and procedures, and services.

The Panel's SMART recommendations are set out below:

All Agencies

1. All agencies to put in place processes that ensure that significant information concerning a service user, patient/carer is shared with other relevant agencies.

2. All agencies to recognise the need for multi-agency planning meetings to consider potential high risk cases, and develop a coordinated 'one-stop' response to needs of vulnerable adults.

3. Carers should have their own file if assessed as requiring services. This should be retained on the social care file and the health file. If services are declined, the reasons for this should be carefully documented together with the reasons why.

4. Obtain consent early from carers and vulnerable adults in order to share information between key agencies to improve lines of communication.

5. Put in place procedures and monitoring arrangements to ensure that a carer's assessment is always offered (and encouraged) where a significant other is in a caring role; if it is refused, this should be recorded and a note provided and placed Further assessments offered subsequently when appropriate.

Adult Social Care

6. Monitoring arrangements to be put in place to ensure that all health, risk and carer's assessments are regularly reviewed and updated, at least annually.

7. Clear guidelines to be put in place to highlight the need for the vulnerable adult to be seen on their own during their involvement.

8. To consider revisiting and revising their policy of 'no care plan' for those who are self-funded, and to offer an assessment to the service user in order to provide such a plan. Put in place processes to ensure that care plans are monitored.

9. To ensure that a contingency plan is available to identify what support and care arrangements would need to be put in place in the urgent event of the carer being unable to fulfil their caring duties.

10. To consider reinstating regular audits, (at least biennially) of care homes and their procedures and policies by Local Authority Adult Services, and to offer advice/support (see below).

11. ASC and the Police, (PPU) to arrange a multi-agency review of the Vulnerable Adult Process in order to look in particular at more effective gatekeeping of referrals from the police to ASC and to request a multi-agency response, if appropriate

12. The panel recommends that the Cumbria Safeguarding Adults Board:

    (a) reviews the adequacy of training across agencies on how to better understand and meet the needs of the carer of those working with adults with Dementia, particularly those who are difficult to engage.

    b) requests that the learning and development sub-group considers how training can be improved and shared, utilising a combined package of e-learning and face-to-face training sessions the latter of which would enable the participants to meet peers and share ideas and experiences.

13. To circulate relevant recommendations in this report to all Care Homes in the county together with the DHR summary report.

GP Surgery

14. GP practices to be encouraged to reconsider and improve their dementia care. Records should ensure that they are all cross-referenced between carer and vulnerable adult and markers of significant events highlighted. All significant conversations regarding the wellbeing of a patient to be documented and also cross-referred where relevant.

15. All correspondence received by the practice to be marked as read and all actions taken properly documented.

JK Care Home

16. All practices and procedures of residential care homes to be documented and brought to the attention of all staff and easily accessible to them. They should be kept up-to-date

17. If standard procedures and policies are ‘downloaded’ by the care home, these should be customised and made relevant to the individual care home.

18. Management is advised to invest in sufficient support and training to ensure staff are trained to acceptable standards and to enable them to sustain and improve those standards. Training records to be kept up to date.

19. A full and detailed pre-assessment undertaken for each new resident and records kept during the post-admission assessment to monitor that the residential home is meeting the resident’s needs.

20. Key conversations with relatives, residents and carers to be carefully recorded within the resident’s records.

21. ASC guidelines dated 4.8.2015 (circulated to care homes under coroners recommendation) followed and to form part of the Care Homes procedures.

22. Documented policies and procedures to be put in place in all residential care homes to ensure that no discharge takes place without:

    a) Fully considering the short and longer term care provisions for those residents to be discharged; and

    b) Notifying other agencies of discharge, including GP and ASC, where appropriate.

Cumbria Police

23. The Police Protection Unit and Mental Health services should ensure that there is a good line of communication to ensure the most effective method of protection, and that risks are properly managed.

12. Conclusion

This is a tragic case that, not only affected Mr and Mrs M, but has deeply affected their family members, the wider community and the agencies who worked with them. Mr M had reached a point of crisis at which he made a decision to end the life of his wife and himself. According to Mr M’s suicide note, he and his wife had made an earlier joint decision that neither of them wished to end their lives in a care home, although it is clear he did attempt to place Mrs M in such a home. Indeed, the evidence is that he made a number of calls to a variety of Care Homes when he learned his wife was being returned. Hey could not assist that evening, but he had a choice to call back the next day. He was not prepared to wait. He could also have made a call to the ‘out of hours’ Adult Service team that evening. It will never be known why he made the decision he did.

The care home manager, Mrs XY was faced with a difficult choice in a situation where there were risk issues if Mrs M remained in their care. Further they were unaware that Mr M was in pain and was desperate or that Mrs M was very likely to remove herself from the Care Home. As well as support from Adult Services, it may also be helpful for the Care Sector Alliance to be made aware of these issues, and to consider whether they have the resources to offer more ‘hands on’ support and guidance in difficult or emergency situations facing care home managers.

It is not possible to know whether this awful tragedy could have been avoided altogether, but it has served to highlight the need for improvements as set out above. The death of Mrs M was not predictable, there was no domestic history to suggest that Mrs M was at risk. Mr M was seen as a caring and attentive husband, but it is now very clear that he was not able to cope with his wife's condition whilst suffering from pain and worry about his own health.

Caring agencies and services, working together, need to be even more supportive of those carers, particularly the elderly, for whom the stress and anxiety and exhaustion endured in caring for a loved one suffering with a degenerative condition such as dementia, often compounded by fears for their own health, may become overwhelming.

It has been highlighted by a number of the panel members how important it is to ensure that professionals in all caring agencies are well supported by senior management. And are not made to feel that they are working within a 'blame culture'.

Professionals on the front line and their immediate line managers need to have sufficient thinking 'time and space' to focus their attention upon providing the correct service to the public they serve in a timely manner, with empathy and compassion. It is recognized by the panel that there are real and serious resource issues which have affected the morale within a number of agencies. This can, of itself lead to a culture of stress, anxiety, blame and fear.

Within such a culture, professionals and agencies generally do not work to the best of their abilities to approach their work in a proactive empathetic manner and are less likely to cooperate with each other. It is generally felt that the future funding of health, police, and adult services will need to be mindful of this need, and of the forecast rise in the older population and longevity.

Prudence M Beever

Chair

25 October 2015