DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY OF REPORT INTO THE DEATH OF "ELIZABETH"

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1) DOMESTIC HOMICIDE REVIEW: BACKGROUND AND PROCESS

1.1 Purpose of Domestic Homicide Reviews (DHRs):

The key purpose for undertaking DHRs is to enable specified persons and bodies to learn lessons where the death of a person has or appears to have resulted from violence, abuse or neglect by a person to whom they were related to or to whom they were or had been in an intimate personal relationship with or a member of the same household as themselves. In order for these lessons to be learned as widely and thoroughly as possible, professionals from defined agencies need to be able to understand fully what happened with each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. In particular, the rationale for the review process is to ensure that agencies are responding appropriately, by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents. The review process also looks to identify and highlight areas of good practice.

1.2 Who the report is about

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to "Elizabeth"[1], a resident of Warwickshire prior to her death in 2014. Elizabeth was the wife of "Patrick" and the mother of two children, now living independently as adults. She was in her early fifties when she died. Patrick, who was of a similar age when his wife died, was arrested on suspicion of murder after her death. He was prosecuted and subsequently pleaded guilty to a charge of manslaughter on the grounds of diminished responsibility and received a two-year prison sentence, suspended for two years.

[1] Pseudonyms of Elizabeth and Patrick are used, in place of the actual names of the deceased and husband.

Elizabeth had been diagnosed with Multiple Sclerosis (MS) in her early thirties. In the last seven years of her life, her condition became steadily more serious and she was increasingly dependent on her husband for assistance with personal care needs. In March 2008, her care needs were assessed by adult social care as being *substantial* and by February 2011 this had increased to *critical*, which is the highest level under FACS[2] criteria.

A particular feature of this DHR is that it became evident that there has been no allegation of any prior history of Elizabeth being a victim of abuse, perpetrated by her husband or anybody else. On the contrary, there is strong evidence to indicate that Patrick had been a devoted husband who had cared for his wife to the very best of his ability, over a period of many years, as she became increasingly dependent upon him as her primary carer.

In the last years of her life Elizabeth was a carer assisted wheelchair user, having lost movement in both legs and her left arm. She was an active member of the Multiple Sclerosis Society (MSS) and took part in fund raising activities. She also attended MSS social events and exercise classes organised by MSS volunteer groups. Her husband accompanied her and actively assisted her in taking part in these activities. He was also regarded as an informal but active MSS volunteer.

In carrying out this particular review, the DHR Panel have had respect for family members and their reported ongoing support for Patrick. However, the Panel have been very mindful that Elizabeth is no longer here to tell us her individual experiences, meaning that the DHR has a responsibility to robustly examine all of the key questions, as set out in the terms of reference, which are set out below.

[2] Fair Access to Care Services. See Guidance document: Department of Health in 2002. Updated 2010.

1.3 Family members

Elizabeth lived with her husband Patrick and there was nobody else resident in the household. The couple had 2 adult children, an adult daughter and adult son, each living independently in the Coventry / Warwickshire area. Elizabeth also had a sister and nephew, resident in another part of the UK, who are understood to have been in regular contact with Elizabeth and her husband.

From the limited information available to the Panel, it appears that Elizabeth's children and close family had good relationships with both Elizabeth and Patrick and that they have continued expressing strong support for Patrick, following Elizabeth's death. It is also understood that they were not supportive of the criminal charges against Patrick.

1.4 Family involvement in the DHR

Family members were advised of the DHR and its purpose at the start of the DHR process, but communicated via Patrick's legal representative that they did not wish to contribute. At the time of this initial communication, the criminal process was still ongoing. Following conclusion of the criminal case, the family were given a further opportunity to meet, to go through a final draft of the overview report and to contribute their own views. Elizabeth and Patrick's son and daughter accepted this invitation. Their comments were carefully listened to and are reflected in the final report, findings and recommendations.

1.5 Outline summary of events leading up to Elizabeth's death

In the days preceding her death Elizabeth was experiencing increasingly severe pain, due to a "flare up" of her chronic illness. The family GP was called out and prescribed a 300ml bottle of Oramorph (oral morphine) with 5ml to be taken every 2 hours.

In the early hours of the following morning Elizabeth was taken by ambulance to George Eliot Hospital (GEH), due to the pain she was experiencing. Whilst there she initially refused treatment, but subsequently accepted some pain relief and fluids. On a number of occasions during this admission, she expressed a wish to die. Elizabeth was discharged home, later on the same day.

According to subsequent police statements made by Patrick, following his wife's discharge from hospital he administered her with very high doses of Oramorph. Then, in the early hours of the morning on the following day, he stated that he had held a pillow over his wife's head for approximately 2 hours. At 06.01 on the same day, Patrick contacted Warwickshire Police and told them what he had done. Police and paramedics attended the scene and Elizabeth was confirmed as dead. Patrick was arrested on suspicion of murder. Some months after completion of the Police investigation, the Crown Prosecution Service decided that Patrick should face criminal charges for manslaughter. The Prosecution accepted that when Patrick committed this act he was acting under diminished responsibility.

1.6 DHR Panel members

Job title	Organisation [3]
Richard Corkhill Independent Consultant[4]	Independent Chair / Overview Report Author
Council Member/ CSP Chair	A Warwickshire Council
Communities Manager	A Warwickshire Council
Violence Against Women & Girls Strategy Development Manager	Warwickshire County Council
DHR Officer	Warwickshire County Council
Detective Chief Inspector	Warwickshire Police
Lead Nurse for Safeguarding Children and Vulnerable Adults	Coventry & Warwickshire Partnership NHS Trust
Adult Safeguarding Lead	A Warwickshire CCG

1.7 Individual Management Reviews (IMR)

The following organisations had significant involvement with Elizabeth and Patrick. Each of them prepared an IMR for presentation to the DHR Panel.

- Multiple Sclerosis Society
- GP practice
- University Hospitals Coventry & Warwickshire NHS Trust
- Warwickshire County Council Adult Social Care
- Universal Care Services
- George Eliot Hospital NHS Trust
- Coventry & Warwickshire Partnership NHS Trust
- Warwickshire Police

[3] There was no voluntary sector representation on the Panel. This is now recognised as a process shortfall. A Warwickshire CSP will seek to establish relevant non-statutory Panel membership for all future DHRs.

[4] **Statement of Independence:** Richard Corkhill is a self-employed Consultant with extensive experience in working on DHRs and similar multi-agency reviews. He has never been employed by any of the organisations which were involved with Elizabeth, her husband or any members of their family.

2) SUMMARY OVERVIEW OF FINDINGS AND KEY LEARNING POINTS

The following is a summary of DHR findings and key learning, against each of the questions set out in the Terms of Reference for this DHR:

2.1 Did agencies have any previous knowledge or concerns that Elizabeth could have been a victim of domestic abuse as defined in Home Office Guidance for DHRs[5], perpetrated by her husband or any other household or family member?

None of the agencies which contributed to this DHR appear to have had any previous knowledge or possible reasons to be concerned that Elizabeth was a victim of any form of domestic abuse. On the contrary, there was strong evidence that she had a close and supportive family, with a husband who was highly committed to caring for her to the very best of his ability. This is evidenced, for example, by observations from the GP who had known the family well over many years. It is also evidenced by the couple's contacts with the MS Society, where Patrick was recognised as an exceptionally committed carer who supported his wife to take part in social events and activities.

The first occasion on which there appears to have been any evidence which could have indicated a risk of homicide was at GEH on the day immediately prior to Elizabeth's death, when her husband used the phrase that he "would do it, no messing", indicating a possible intention to take action to end Elizabeth's life.

[5] This definition reads: *"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional"*

2.2 Did healthcare services effectively meet Elizabeth's palliative care needs, including pain management interventions, in line with recognised best practice?

The evidence reviewed by the DHR indicates that the care and treatment provided to Elizabeth by UHCW and her GP was in line with recognised good clinical practice and NICE guidance. There is also evidence of good communication between the specialist clinic and the GP practice. Pain control measures appear to have been effective, at least until the last few days of Elizabeth's life.

During the short period at GEH on the day before she died, she initially refused treatments, including pain control medication. However, following advice from medical staff, she did then accept pain control interventions and she was provided with appropriate medication to take home when she was discharged. On the other hand, Elizabeth's son and daughter report that no effective rehydration therapy was provided, despite them raising concerns with nursing staff.

A significant area of learning in relation to palliative care relates to the discussion in January 2011, when Elizabeth spoke to her GP of possible plans to end her own life. This discussion about Dignitas led to a situation where ongoing doctor / patient dialogue about Elizabeth's wishes around end of life care was compromised as a result of concern about assisted suicide and the inability of health professionals to discuss this with patients, without the risk of prosecution for aiding what is currently against the law.

Key Learning Point 1

It is not within the DHR terms of reference to comment in detail on the complex legal, ethical and moral debates about end of life care, suicide, or assisted suicide. However, the DHR Panel would suggest that some of the issues arising from the tragic circumstances of this case could help to inform ongoing debate

about what changes (if any) to existing professional guidance, policy and legislation could better serve the needs of other people facing similar circumstances as Elizabeth, her husband and other members of her family. For example, learning from this case could help to inform:

- Professional guidance for GPs and other medical professionals on how they should respond to terminally ill patients if they disclose that they are considering assisted suicide. To include guidance on the professional, ethical and legal dilemmas such disclosures raise, as well as possible safeguarding concerns.

- Ongoing political / social and religious debates on the issue of assisted dying, and measures required to ensure protection of vulnerable people with terminal illnesses.

2.3 Were Patrick's needs as a carer properly assessed and reviewed at appropriate intervals and what services were provided to meet assessed needs?

The evidence from the IMR for Adult Social Care is that his needs as a carer were given due consideration and he was advised of potential services specifically for people with caring roles and responsibilities. He chose not to have contact from the local Carers Support Service, but it is evident that contacts and involvement with the Multiple Sclerosis Society was a valued source of support for both him and his wife.

2.4 Was Elizabeth's potential eligibility for Continuing Health Care (CHC) appropriately assessed, in line with the NHS National Framework for CHC?

Elizabeth was referred for an assessment of CHC eligibility in February 2011, but it was not until January 2012 that a full assessment took place. The assessment determined that Elizabeth was not eligible for CHC funding. The evidence presented to the DHR has not raised any concerns about the outcome of this assessment and there appears to be no causal link between this and the circumstances leading to Elizabeth's death. The reasons for a delay of nearly 12 months between referral and assessment outcome are unclear, but this may be an issue for discussion between Adult Social Care and the Clinical Commissioning Group.

2.5 Was the Mental Capacity Act (MCA) applied appropriately, in line with the MCA Code of Practice and Deprivation of Liberty Safeguards (DoLS)?

It is clear that the Mental Health Liaison Practitioner (CWPT) who saw Elizabeth at GEH advised GEH clinicians that an assessment of Elizabeth's mental capacity (i.e. to agree to or decline treatment) should be carried out. It is also clear that Elizabeth's Consultant at GEH, having consulted further with the CWPT Consultant Psychiatrist and with senior colleagues within his own Trust, made a decision to discharge Elizabeth without an assessment under the MCA having been completed. It is also the case that the mental health team were not informed that Elizabeth had been discharged, or that that this had happened without a mental capacity assessment having been completed.

Whilst acknowledging that discharge was judged to be clinically safe in terms of her physical condition and treatment needs, the DHR Panel does not accept that it was appropriate to discharge Elizabeth without having carried out an MCA assessment, particularly because without such an assessment, none of the opportunities and matters listed at Key Learning Point 2 were given consideration.

Ultimately, the Panel feels that the opportunity to give consideration of such matters would have enabled a more informed approach to be taken with regards to whether Elizabeth was or was not discharged'

It was also clearly inappropriate for this decision to be implemented without full consultation with (or even the knowledge of) CWPT mental health colleagues, who had made a clear recommendation that an MCA assessment should be carried out, prior to any decision to discharge.

Key Learning Point 2:

The benefits of carrying out an MCA assessment prior to discharge would have included:

- An opportunity to more fully explore with Elizabeth the rationale and reasoning behind her stated wish to die.
- A written record of the MCA assessment, which would have set out the factors leading to a judgement that Elizabeth did / did not have capacity to make a decision concerning hospital discharge.
- An opportunity for further discussion with Patrick about his perception of Elizabeth's mental capacity, his role as her carer and his views on what would be in her best interests. This discussion would have been an opportunity to explore the possible intent behind his comment about being willing to *"do it, no messing".*
- If Elizabeth had been assessed as lacking capacity to make a decision on hospital discharge, a best interests decision may have been taken to keep her in hospital, pending consideration of adult safeguarding or other assessment processes.

2.6 What are the views of Patrick and other family members about the quality of care and treatment services provided to Elizabeth as a terminally ill patient and Patrick as a carer?

Until the day prior to her death, Elizabeth's son and daughter felt that the standards of care and treatment to Elizabeth and support for Patrick were of an acceptable quality. They confirmed that Patrick was very reluctant to ask for help in his caring role, as he saw this as his responsibility.

A significant concern they have raised is their observation that GEH failed to provide effective re-hydration treatment on the day immediately prior to Elizabeth's death. They state that they raised their concerns regarding the re-hydration treatment on a number of occasions with nursing staff, but this did not result in any action from those staff. As outlined in section 2.9, they believe that, had Elizabeth been properly hydrated, Elizabeth may have been in an improved physical condition, less distressed and perhaps thus less likely to be asserting her wish to die. This could in turn have reduced the possibility that their father would have acted to end her life in the hours immediately after her discharge.

2.7 In particular, what (if anything) might have been done differently - within existing legal frameworks - which could have prevented Patrick from feeling compelled to end his wife's life?

There was a missed opportunity to have a discussion with Patrick about his intentions, on the day before the homicide:

Key Learning Point 3

On the day before the homicide, when Patrick told clinicians from GEH and CWPT that he would *"do it, no messing*". There was a difference of understanding between those that were privy to this comment as to whether Patrick was making a statement of future intent to end his wife's life. The CWPT clinicians have stated that they perceived this comment to relate to events in the past, not an indication of any current intent. On the other hand, the GEH IMR is clear that GEH clinicians *did* recognise the comment as a possible indication of future intention.

However, there is no record of any follow up discussion with Patrick. Such a discussion with Patrick would undoubtedly have been very difficult and would have required a skilled and sensitive approach. However, it could have resulted in a more accurate assessment of risk. That this did not take place was a **missed opportunity** to explore exactly what he meant and to assess the actual level of potential risk of an assisted suicide or homicide.

It would also have been an opportunity to ensure that Patrick was fully aware of the range of potential palliative care options, including community based treatment and care services and approaches to pain control. Whether or not this would have stopped him from feeling compelled to end his wife's life some hours later is unknown, but it is at least a possibility.

3) RECOMMENDATIONS

3.1 Individual Agency recommendations

The following recommendations are reproduced from the Individual Management Reviews:

MS Society[6]

- Clearer messaging on the volunteer microsite, so that it is easier to find the Safeguarding resources
- Article in our regular 'TeamSpirit' newsletter to volunteers as part of roll-out of new Safeguarding policy and procedure to highlight that all new volunteers should be made aware of these
- Clearer messages to Chairs and support volunteers during their inductions that they must ensure that all volunteers are aware of the Safeguarding policy and guidance and how to report any concerns
- Consideration to be given to producing a very brief A5 flier type document with the key messages about safeguarding and reporting, to be given to all volunteers by branches, including those who don't attend generic induction.
- Consideration of more specific guidance within the Committee Handbook when the resource is reviewed
- Briefings to be used with local staff at Autumn volunteer forums as part of the roll-out of the new Policy and guidance to specifically reference the need to get the message to all volunteers

[6] The Multiple Sclerosis Society has identified a large number of recommendations, based on their learning from this DHR. These recommendations (for internal oversight by MSS's managers) have the full support of the DHR Panel. However, it is important to emphasise that this volume of recommendations does not indicate that different responses by MSS managers, staff or volunteers could have prevented the events leading to Elizabeth's death.

- Briefings to all departmental staff as part of the roll-out of the new Policy and guidance to include the need that staff working with volunteers must ensure that induction to volunteers covers Safeguarding
- The new Welcome Booklet to include a clear paragraph on the need to understand that people with MS may be vulnerable and subject to harm or abuse, and the need to be aware of our guidance and reporting process
- The planned review of our Chair's induction session and participant pack to clearly highlight safeguarding
- The planned review of our generic induction and participant pack to clearly highlight safeguarding
- The planned development of Committee induction training to include safeguarding
- As an interim measure (as the induction training updates won't be complete until well into 2015), the Volunteering Team and the Branch Resources Officer to consider how to promote clearer messaging on the volunteer microsite
- The forthcoming review of all induction training includes a summary, highlighting the national website, information resources, online forum, National Helpline and national grants programs etc.
- That the Volunteering Team and Branch Resources Officer consider a template leaflet that branches can customise and give to attendees at social and exercise groups, or who attend one-off branch information or social activities.

GP Practice:

- The Area Team, through the GP Advisors and named GPs to promote the take up of Advanced Care Planning in the General Practice.

University Hospitals Coventry & Warwickshire NHS Trust

- No recommendations.

Warwickshire County Council Adult Social Care

- No recommendations.

Universal Care Services:

- No recommendations.

George Eliot Hospital NHS Trust

- Using this as a learning study within mental capacity and Domestic Homicide Training for staff.
- Speaking to patient and members of family privately and documenting this.
- Any potential comments from family/carers and harm will be challenged by clinical staff so that intentions can be clarified and risk assessed.
- Prior to discharge all relevant agencies are in agreement prior to the patient leaving.

Coventry & Warwickshire Partnership NHS Trust

- Safeguarding training for all CWPT staff to include a recognition of the need to assess and reassess carers' circumstances, particularly in families of high resilience.
- CWPT staff to document significant statements of risk made by clients or carers and state if this is a current or historical risk and what has been done to try to stop/reduce the risk.

Warwickshire Police

- No recommendations.

3.2 Overview recommendations

Overview recommendation 1

Learning from this DHR should be utilised to contribute to the ongoing national debate about end of life care, assisted suicide and assisted dying. The aim should be to ensure that policy, legislation and professional guidance frameworks effectively promote the safety and wellbeing of people facing similar circumstances as those experienced by Elizabeth, her husband and other family members.

Overview recommendation 2

GEH should review Trust policies and procedures for discharging vulnerable patients and/ or adults with care and support needs, where there are identified concerns about the patient's mental capacity and where there are potential safeguarding concerns. The review should consider revisions of procedure to ensure that decisions to discharge have the full knowledge and support of an appropriate multi-disciplinary team. This team should include any specialist services (for example mental health or learning disabilities) which might be involved in their care and treatment package.

Overview recommendation 3

GEH should review Trust policies and procedures & practice in working with terminally ill patients who may be at risk of suicide, assisted suicide or homicide. This should include consideration of staff training on identifying and responding to such risks. Learning from this DHR should be utilised to assist with awareness raising and training activities.

Overview recommendation 4

GEH should further review family members' observations concerning reported failures to ensure effective hydration therapy, as summarised at 2.9 above. This review should consider whether the clinical practice and recording of rehydration therapy were in line with recognised good practice and national guidance[7]. If they were not, GEH should seek to identify the causes of this (e.g. policy, procedure, staff training and/or individual practice issues) and take actions to address these causes.

3.3 George Eliot Hospital response to report and overview recommendations

The senior management team at GEH were invited to comment on the overview report and recommendations, in advance of final sign off by the CSP. Their written response shows that there are elements of the analysis of GEH's involvement, with which they are not in full agreement.

However, their response also confirms that they are substantially in agreement with the key learning points and that they intend to implement overview recommendations 2 - 4. In addition, they intend to use this case as a learning tool with future discharge awareness and training, MCA, Safeguarding and Best Interests lessons for the Trust.

[7] This may include reference to *Intravenous fluid therapy in adults in hospital*. National Institute for Health & Care Excellence, December 2013.

APPENDIX 1: GLOSSARY

A&E	Accident & Emergency
AMU	Acute Medical Unit (service delivered by GEH)
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CSP	Community Safety Partnership
CWPT	Coventry & Warwickshire Partnership NHS Trust
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FACS	Fair Access to Care Services
GEH	George Eliot Hospital NHS Trust
GP	General Practitioner
IMR	Individual Management Review
MCA	Mental Capacity Act
MHA	Mental Health Act
MHLP	Mental Health Liaison Practitioner
MS	Multiple Sclerosis
MSS	Multiple Sclerosis Society
NICE	National Institute for Health and Care Excellence
OT	Occupational Therapist
UCC	Universal Care Services (Home care provider)
UHCW	University Hospitals Coventry & Warwickshire NHS Trust