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warwickshire

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

**INDEPENDENT OVERVIEW REPORT
INTO THE DEATH OF
“Mary”**

PREPARED BY RICHARD CORKHILL

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PART ONE

DOMESTIC HOMICIDE REVIEW BACKGROUND AND PROCESS

1.1 Who the report is about:

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to “Mary”¹, a resident of Warwickshire prior to her death in 2014. Mary was the wife of “Peter” and the mother of two children, now living independently as adults. She was in her late 70s when she died from a single stab wound. Peter, who was also in his late 70’s when his wife died, was arrested on suspicion of murder. He subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility and received a suspended prison sentence.

Mary and Peter had been married for 57 years and had been active members of their local community. It is reported that the couple and their children had enjoyed a close and loving family atmosphere. All the available evidence indicates that this had been a very close and loving relationship, with no previous history of domestic violence, or any other form of abuse. They both enjoyed ballroom dancing. Mary had worked in local government and had also been an active carer for her grandchild. Peter was an ex-serviceman and following this had worked in the motor industry. Prior to the onset of Mary’s health problems in 2008, she and Peter had volunteered together, for a local charity.

In the last six years of her life, Mary had a complex medical history. In August 2008 she had elective surgery, as a day patient at George Eliot Hospital (GEH). This relatively minor and routine procedure was completed with no apparent complications and she was discharged on the same day. However, eight days later Mary presented at the GEH Accident and Emergency Department with abdominal pain, a urinary tract infection and other symptoms. Over the following six years, she continued to have serious physical and mental health problems.

There was no medical history of similar problems, prior to the surgical procedure in August 2008. However, the extent (if any) to which there was a causal relationship

¹ Pseudonyms of Mary and Peter are used, in place of the actual names of the deceased and her husband.

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between the surgical procedure and the health problems which followed it, is unknown. There were periods of temporary improvement, but the overall picture was one of a steady deterioration in her physical, mental and emotional wellbeing.

1.2 Events leading up to the homicide incident

The following descriptions of events and of Mary's behaviours are based on information from multiple sources, including Independent Management Reviews (IMRs) provided by health provider services who were involved in the period leading up to the homicide and disclosures by Peter in the course of a psychiatric assessment carried out after the homicide.

In the months preceding the homicide, Mary had become increasingly confused, but there was no confirmed medical diagnosis as to the causes of her confusion. In April 2014, she appears to have had a severe reaction to the death of her brother-in-law (Peter's brother) and presented with acute anxiety and hyper-ventilation, for which an ambulance was called. From April 2014 onwards, Mary's physical, mental and emotional conditions became progressively worse. It appears that Peter was under extreme physical and emotional stress, as a result of his caring responsibilities for Mary. This pressure stemmed from Mary's emotional and physical care needs which she expressed through constantly distressing and demanding behaviours, including:

- Prolonged bouts of wailing, described by Peter as "incessant and horrendous".
- Repeatedly saying "you promised me", which Peter (following the homicide) said he understood to mean that he had promised that he would not let her suffer.
- Needing to be taken to the toilet repeatedly, requiring Peter to stay and comfort her, sometimes for several hours at a time.
- Waking up through the night, resulting in Peter never sleeping for more than two or three hours at a time.
- Refusing to comply with nursing care procedures and interventions which were intended to ease her condition.

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The extreme emotional and physical pressures on Peter were graphically evidenced in the psychiatric reports requested for the purposes of the criminal proceedings against Peter. For example, the psychiatric report for the Crown Prosecution Service describes some quite extraordinary measures taken by Peter, in order to ensure that he would be woken, should his wife need any assistance during the night.

Unfortunately, none of the professionals in contact with Mary and Peter at the time were aware of the extreme levels of stress that Peter described following the homicide incident. In summary, it now appears that he was *'putting on a brave face'* to the outside world, but was in fact finding it increasingly impossible to cope with what he experienced as a desperate situation.

1.3 The homicide incident

In the early hours of the morning, Warwickshire Police were telephoned by Peter, stating that he had killed his wife. Police attended the property, where they found Mary, deceased. She had been stabbed once in the chest. A subsequent post mortem confirmed that the cause of death was a single stab wound to the heart. In police statements, Peter was quite clear that he had intended to end Mary's life, stating that she had dementia and that she had been asking him to kill her.

1.4 Purpose of the Review

The key purpose for undertaking DHRs is to enable lessons to be learned from when the death of a person has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship with or a person who they shared the same household with. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

In carrying out this particular Review, the DHR Panel have been mindful of the unique circumstances of this case and in particular of the fact that there is no evidence of any past history of violence, abuse or neglect. On the contrary, there is

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strong evidence that Peter had been a devoted husband who had acted as Mary's carer over the last six years of her life. However, the Panel have been very mindful that Mary 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.

These terms of reference include a specific requirement for all agencies to carefully review and report on any possible evidence which could have indicated a history of Mary being a victim of domestic violence, abuse or neglect. The DHR has been presented with no such evidence.

1.5 Decision to carry out a DHR

Given the contextual information outlined above, whether or not a DHR should be undertaken was subject to careful consideration by the CSP Chair, with reference to the statutory Home Office guidance and Section 9 of the Domestic Violence, Crime and Victims Act 2004 which states:

“Domestic Homicide Review 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.

Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.”²

Whilst the presenting evidence in this case did not suggest any prior history of violence, abuse or neglect, it was the case that Mary's death resulted from an act of violence by her husband, meaning that there was a legal requirement for a DHR to be carried out.

² Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised 1/8/2013) paragraph 12 Definitions.

Recommendations:

Some recommendations made are not directly related to agency practices towards victims of domestic violence and abuse as per the cross-government definition. This is because the S9 review process enables the Panel to look at agency policies, practices and procedures in relation to factors contributing to the homicide. In this case, the review process has highlighted wider learning, than that directly related to domestic violence and abuse.

1.6 Review timescales

Home Office guidance states that DHRs should, where possible, be completed within six months of the initial decision to carry out the Review. In this case, this has been exceeded by a number of months. The main reason for this was a decision to delay the report until after criminal proceedings had been completed. This allowed the Panel to have access to relevant background information about Mary, Peter and their family circumstances, which could not have been disclosed prior to completion of the criminal case.

1.7 Confidentiality

Pending Home Office approval for publication of the anonymised version of this report, the DHR Panel and the CSP have managed all information about this case as highly confidential. Information sharing has been restricted to members of the DHR Panel, their line managers and senior managers of statutory services which provided Individual Management Reviews.

1.8 Terms of reference

Each of the agencies which had been identified as having significant and relevant involvement with the deceased and her husband carried out an Individual Management Review (IMR) of that Agency's involvement. The terms of reference required that IMRs and this overview report to address the following questions:

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Did agencies have any previous knowledge or concerns that Mary could have been a victim of domestic abuse as defined in Home Office Guidance for DHRs³, perpetrated by her husband or any other household or family member?

Did primary and secondary healthcare services effectively meet Mary's healthcare needs?

Did adult social care services effectively assess and meet Mary's eligible social care needs, in line with recognised best practice?

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

What information (if any) did agencies have about Mary's views and wishes around end of life care?

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

What are the views of Peter and other family members about the quality of care and treatment services provided to the victim and alleged perpetrator?

In particular, what (if anything) might have been done differently - within existing legal frameworks - which could have prevented the homicide from taking place?

The organisations involved provided chronologies and IMRs covering the period from 1/6/2008, until the date of Mary's death in 2014. IMR authors were also asked to consider whether or not any earlier contacts could have had significant relevance to the above questions.

³ 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".

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1.9 DHR Panel membership

Job title	Organisation⁴
Richard Corkhill ⁵ Independent Consultant	Independent Chair / Overview Report Author
CSP Chair	A Warwickshire CSP
Communities Manager	A Warwickshire Council
Violence Against Women & Girls Strategy Development Manager	Warwickshire County Council
Operations Manager, Safeguarding Adults Team	Warwickshire County Council
DHR Officer	Warwickshire County Council
Detective Chief Inspector	Warwickshire Police
Designated Lead for Safeguarding Children and Adults	Coventry & Warwickshire Partnership NHS Trust
Lead Nurse Safeguarding Adults	A Warwickshire CCG

1.10 Individual Management Reviews and Chronologies

Following an initial scoping exercise, it was established that the following organisations had had significant involvement with Mary and Peter during the period specified in the terms of reference:

- General Practitioners (IMR author provided by NHS England)
- Warwickshire County Council Adult Social Care
- Warwickshire Police
- George Eliot Hospital NHS Trust
- Coventry & Warwickshire Partnership NHS Trust
- South Warwickshire NHS Foundation Trust

Each of these organisations provided a chronology of their involvement, together with an IMR addressing the questions as set out in the Terms of Reference.

⁴ 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.

⁵ **Independence statement:** Richard Corkhill (richardcorkhill.org.uk) is a self-employed Consultant, with extensive experience of leading DHRs and similar multi-agency review processes. He has never been employed by any of the agencies which were involved with Mary and her husband.

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Additionally, West Midlands Ambulance Service (WMAS) provided a chronology which recorded some brief contacts, but no IMR was required from this service.

1.11 Contact with Peter and other family members

Peter and his adult children provided extensive background information, for the purposes of psychiatric reports, prepared for the criminal proceedings. The prosecution's report has been made available to the DHR Panel, with permission from the report author. A decision was taken not to subject the family to additional stress by asking questions already answered in this psychiatric report. However, the DHR Chair wrote to Peter's adult children in January 2015. This letter explained the DHR purpose and process and advised that further contact would be made, once criminal proceedings had concluded. This was followed up with another letter in September 2015 (after Peter had been convicted for manslaughter with imposition of a suspended prison sentence) inviting Peter and his two adult children to meet with the DHR Chair and another Panel member, to read through the report and for family members' views to be taken into account. This invitation was politely declined. Given the particular circumstances of this homicide, the DHR Panel is respectful of the family's decision not to contribute directly to this DHR.

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PART 2

CHRONOLOGICAL OVERVIEW OF AGENCY INVOLVEMENT

Introduction

This section of the report is a factual overview⁶ of relevant agency contacts with Mary, Peter and other family members, during the period covered by the terms of reference (1/1/08 to 20/6/14). Most of the relevant contacts were medical appointments. Contacts until May 2014 provide important general contextual background. Those from May 2014 until Mary's death around two months later, are covered in more detail as they had the most direct impacts on the circumstances leading up to the homicide incident.

Jan – July 08

The information reviewed by the DHR panel does not include any relevant or significant contacts or events, prior to August 2008.

Aug 08

Mary had elective day surgery at George Eliot Hospital⁷. This was relatively minor and routine surgery, for a common condition. All pre-operative tests were normal and the surgery was recorded to have been completed successfully, with no complications. Eight days later Mary presented at George Eliot Hospital's (GEH) Accident and Emergency Department with abdominal pain, an infection and other symptoms.

Sept 08 – Oct 08

Mary was seen at GEH for a number of follow up appointments, reporting various symptoms, causing pain and discomfort. Medical investigations were undertaken, but doctors were unable to ascertain the causes of her symptoms. However, by October 08 it was recorded that she was now well, apart from an infection. She was discharged from GEH, back to the care of her GP.

⁶ This overview is not a comprehensive report of every single agency contact, but has been informed by reference to the full combined agency chronologies.

⁷ For reasons of patient confidentiality and out of respect for the deceased and her family, detailed information about Mary's medical conditions, symptoms, and treatments is not included in the published report.

Nov 08 – Jan 09

In January 09, at which time she had been prescribed anti-depressant medication, she was re-referred to GEH by her GP, as she was experiencing a range of painful and distressing symptoms.

At a medical review in March 09, it was documented that Mary described the surgery in 2008 and the symptoms which followed as having been a very traumatic and a 'horrendous experience'. A clinic letter documented the following outcome from the medical review:

“the symptoms described are virtually impossible to explain from a neurological point of view and requested urgent referral to psychiatrist for ‘pathological stress reaction’ to an uneventful surgical procedure”.

April – September 09

Mary was referred to the Psychological Services for Older People Service at Coventry & Warwickshire NHS Partnership Trust (CWPT). Following initial psychological assessment at the beginning of May 2009, she had quite intensive contact with the Psychology Service, including a number of home visits by the Psychologist, and attendance at a weekly 'feelings group'. She attended this group for five of the six scheduled sessions, and was recorded to have found the group helpful. During this period she continued to experience physical discomfort, which at times she found very distressing.

In September 09, Mary was discharged from Psychology Services and referred to Psychiatry. The Psychologist's discharge letter expressed concern that Mary's difficulties may be due to underlying physical health problems rather than mental health problems.

Oct 09 – Dec 11

Throughout this period Mary continued to present with distressing symptoms and problems sleeping. Ongoing medical investigations were unable to identify causes. Most of her medical contacts during this period were with her GP (around 15

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consultations), but GEH also had some involvement including Pain Clinic appointments. In Jan 11 a psychiatric review found her mental health status was stable. In July 11, it was recorded that Mary's daughter thought Mary was suffering from some memory loss. Though some physical symptoms continued, this was reported to have been much improved by Dec 11.

2012

This appears to have been a period of relatively good health for Mary. GP records show that pain control medication was reduced. There were some ongoing concerns raised by Peter with GP, that Mary was experiencing memory loss.

2013

In Jan 13 Mary's Psychiatrist, (who had been carrying out routine reviews of her mental health and liaising with the GP Practice) wrote to her GP, stating that '*all was generally well with generalised anxiety disorder*'. In April 13, Peter advised the GP that Mary was shaking and tearful. In July 13 Mary was discharged from the Psychiatry Service. However, Mary continued to experience some health problems, including 'forgetfulness' reported by Peter. Mary's medication dosage for anxiety disorder was increased. A well person check⁸ was completed in July 13 at the GP Surgery and was recorded as a 'satisfactory consultation'. In Nov 13 Peter attended the GP Surgery (alone) and advised the GP Surgery that Mary's memory was becoming poor.

Jan – April 14

In January 14, Peter informed the family GP that Mary was showing signs of increasing confusion. Adjustments were made to anti-depressant medication, as this was thought to be a possible factor.

In April 14 Mary's brother-in-law (Peter's brother) died. Mary was extremely upset by this and suffered what was subsequently described⁹ as a 'mental breakdown'. On 22 April her family called for an ambulance because she was extremely distressed and they could not calm her down. The ambulance crew found her to be alert and

⁸ This is a standardised general health check.

⁹ This description is from Police records of interviews, following the homicide.

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hyperventilating. Observations were carried out and Mary's blood pressure was initially high, but lowered once she had calmed down. She was not taken to Accident & Emergency services, but the family were advised to dial 999 again if there were any further problems.

On 29th April, Mary was visited by her GP who recorded that she was crying and upset, following her brother-in-law's death. It was also recorded that her physical symptoms and pain had increased. She was prescribed medicines for pain control and to assist with ongoing problems of sleeplessness.

1st - 20th May 14

From early May, Mary experienced increasing problems with physical pain. On 7/05/14 she was taken to GEH's Accident & Emergency (A&E) department, by ambulance.

The GEH chronology entry for 7/05/14 notes:

“Daughter expressed concern about coping at home on 08/05 and that mum's mental health was deteriorating.

Documented ‘anxious’ and ‘agitated’ presentation at times throughout her stay.

Referrals to Mental Health Team, dementia screen, Intermediate Care Team, Pain Team all made during inpatient stay. Dementia screen completed and geriatric depression scale – this is all good practice”.

On examination in A&E, Mary was unable to talk, rocking back and forth. The GEH IMR notes:

The overall assessment/ working diagnoses were ‘confused episode - Dementia’ and ‘acute psychotic episode – due to bereavement’ it was also noted that she needed assessment for physical pain.

She was admitted to GEH on 7/05/14, and remained as an in-patient until discharge on 20/05/14. Throughout this hospital stay, her husband and daughters visited on a

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daily basis. On admission, she was noted to be crying for her husband and required a lot of reassurance from the nursing staff to settle and sleep.

Significant points from GEH records of this in-patient stay include:

- **08/05/14:** One of Mary's daughters expressed concern about how her father and mother were coping at home, the she requested a mental health assessment while her mother was an inpatient.
- **09/05/14:** Mary was very agitated and fidgeting a lot, unable to have a conversation with her so a history was obtained from daughter.
- **9/05/14** A reviewing doctor documented impressions, including possible somatisation (tendency to communicate psychological stress via physical symptoms).
- **9/05/14:** Nursing entries made reference to Mary being agitated, actively resisting nursing procedures and requiring chemical sedation.
- **13/05/14:** An Occupational Therapist (OT) contacted Peter, and he confirmed they had no equipment at home and no package of care.
- **14/05/14:** Mary described feeling anxious and in pain. She also said she could see a relative who had in fact passed way (understood to be her recently deceased brother-in-law).
- **15/05/14¹⁰:** Was reviewed on the ward by a Mental Health Liaison Practitioner (MHLP) from Arden Mental Health Acute Team (AMHAT), but was in too much pain to answer questions.
- **16/05/14:** Was seen again by the MHLP, but she presented as more agitated with constant movement and repetitive speech, described herself as depressed and frightened.
- **16/05/14 (later):** Mary was crying and stating that she wanted to die¹¹.
- **18/05/14:** When her husband visited he took her for a walk and there were no documented episodes of anxiety, agitation or aggression.
- **19/05/14:** Mary appeared calm and stated she had no pain at all when the Ward round took place. Her husband spent most of the day with her in the day room on the Ward

¹⁰ The entries regarding contacts with Psychiatric Service on 15/05/14, 16/05/14 and 19/05/14 are taken from the GEH IMR. CWPT was the provider organisation for these services.

¹¹ This was recorded in GEH nursing notes, but it is not clear from records who Mary made these comments to.

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- **19/05/14:** Mary was reviewed by the Consultant Psychiatrist who concluded that there was worsening anxiety due to bereavement, physical pain, and there was underlying cognitive decline. He recommended weaning off benzodiazepine¹² and to review in memory clinic post-discharge.
- **20/05/14:** Mary was recorded as being asymptomatic¹³ and keen to go home.
- **20/05/14:** The GEH IMR states: '*On reviewing the discharge planning booklet it would appear that the Ward Manager and the OT mentioned the Intermediate Care Team¹⁴ (ICT) to support the discharge. There is no documentation to state whether or not the ICT assessed Mary, or whether this was discussed with her and her husband.*'
- **20/05/14:** Mary was **discharged home**.

21st – 31st May 14

The ICT Team is part of SWFT, who also provide District Nursing Services. According to their chronology and IMR they did not receive any referral for either ICT or District Nursing services to be provided during this period.

1st – 11th June 14

1/06/14: An ambulance was called as Mary was in a very distressed state. Ambulance crew records confirm that she was very distressed, reporting very painful and distressing physical symptoms, which had been present for several days and had become more acute in the last few hours. She was taken to A&E and subsequently admitted onto a Ward. She remained at GEH from 1/06/14 until discharge on 11/06/14. The following are key points from the GEH IMR in relation to this episode of in-patient treatment:

- On admission it was confirmed that Mary had painful symptoms, which had been present for a number of days.

¹² Psychoactive medication, commonly prescribed for people with anxiety related symptoms.

¹³ No symptoms present

¹⁴ ICT (Part of South Warwickshire NHS Foundation Trust) is now called the Community Emergency Response Team (CERT).

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- An Abbreviated Mental Test (AMT) was conducted with Mary on admission and was scored at 1/10 (a score of 6 or less is indicative of cognitive impairment requiring referral to memory services).
- On admission Mary was documented as having a diagnosis of dementia and other co-morbidities including physical health conditions and anxiety.
- A working diagnosis was recorded and treatment provided.
- It was documented by GEH that Mary may have increased care requirements on discharge.
- A nursing care procedure¹⁵ was carried out, but on at least two occasions Mary deliberately reversed this procedure, which was reported as having been very distressing for her and for family members present.
- During the afternoon of the **04/06/14** Peter approached the Ward work station and asked two doctors for help as he felt Mary was experiencing a seizure. She was described as flailing her arms around and shouting. That night Mary was very agitated and up and down to the toilet almost constantly throughout the night.
- A diagnosis was made by her GEH Consultant of Dementia and Behavioural and Psychological Symptoms of Dementia (BPSD). A referral was made for review by AMHAT.
- Mary was reviewed by an AMHAT clinical lead on **5/06/14**. The clinical lead found no evidence of depression or psychosis, but evidence of anxiety, *secondary* to physical cause and pain anticipation.
- Also on **5/06/14**, the GEH Ward Manager recorded in the discharge booklet that Mary lived with her husband and '*no social care required*'.
- For the next three days Mary continued to be very anxious at times.
- By 9/06/14 there were signs of improvement and Peter expressed the view that morphine which had been prescribed for pain control seemed to be helping.
- It was documented in the GEH discharge booklet that an ICT referral had been done and faxed and they were informed of the referral.

¹⁵ As the specific nature of the procedure is not relevant to DHR learning or recommendations, the view of the Independent Chair / Author and DHR Panel was that this information should not be shared in a published report.

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- On 11/06/14 Mary was discharged from GEH.

As with her previous discharge on 20/05/14, the evidence from the SWFT chronology and IMR indicates that no referral from GEH was received, either for ICT support or for District Nursing services.

June 12th - 14th 2014:

12/06/14: West Midlands Ambulance Service received a 999 call from the Virtual Ward¹⁶ at George Eliot Hospital requesting an ambulance for Mary. WMAS records state that the Virtual Ward had attempted to arrange a District Nursing visit, but this had not been possible. (Records do not provide any explanation of why this was not possible) Mary was again experiencing painful and distressing physical symptoms. As she refused to travel in the ambulance, Peter took her to A&E, in his car. WMAS records do not specify any reasons Mary gave for refusing to travel by ambulance.

Mary was re-admitted to GEH. This is documented in the GEH chronology as *'Emergency admission with failed discharge'*.

13/06/14 Mary was discharged from GEH. The GEH chronology notes that the discharge was discussed with Peter:

'Husband required a lot of reassurance about the referrals which had been made, documented his main concern was about her restlessness and frequency of going to toilet. Referrals which had been made; to (Specialist Medical) Team, Pain Team, Memory Clinic, Psychiatry. Documented husband agreed she was medically fit for discharge and the Ward completed referral to Virtual Ward, and District Nurses for a daily visit to check toileting issues'

Again, the SWFT IMR and chronology make no reference to having received a referral for District Nurse visits.

¹⁶ A Virtual Ward is a group of specialists providing support in the community to people with the most complex medical and social needs. Support that would be provided in a Ward environment is provided within the community.

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14/06/14 (Saturday) Peter telephoned the Integrated Single Point of Access¹⁷ (IPSA) at SWFT, reporting that Mary had been discharged the previous day from GEH, and was in pain. SWFT report that:

'A discharge letter had not been sent home with (Mary) and (Peter) reported that the community nurses would be asked to.....' (carry out a specific medical procedure¹⁸ to assist with Mary's symptoms). 'This information however was not present on the referral that was sent to the Community Nursing Team.'

A District Nurse visited on 14/06/14, in response to Peter's call. This was their first contact with Mary. It was decided that the medical procedure should be carried out, but as Mary was in so much distress it was not possible to implement this outside of a hospital setting. Following liaison by District Nurses with the Out of Hours GP service, Mary was transported to A&E, by her daughter.

At A&E, it was confirmed that the medical procedure was required. Peter was present during this procedure and has since (i.e. in the context of his psychiatric assessment following the homicide) recalled this as having been a traumatic experience for both Mary and himself. He remembered that his wife was screaming and wailing and that he had been asked to hold her down, while the procedure was carried out. GEH have confirmed that the procedure was recorded as having been 'traumatic', but further enquiry made by the GEH IMR author (in response to follow up questions by the DHR Panel) did not yield any additional detail of what occurred, or comment specifically on Peter's description of events at A&E on 14/6/14¹⁹. Mary was not admitted to GEH on 14/06/14, but returned home from A&E after the procedure had been completed.

June 15th - 20th 14

Sunday 15/06/14: There was a District Nurse visit, at Peter's request. The procedure carried out the previous day at A&E was reported to be causing Mary

¹⁷ IPSA is a single contact point for referral into all of SWFT's community based health services.

¹⁸ This was the same procedure which had been carried out (and reversed by Mary) during her hospital stay 1-11 June.

¹⁹ GEH advised the DHR that the doctor who assessed Mary had since left employment with the Trust and was unavailable to comment.

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some distress. On examination it was recorded that pain was controlled and Mary had eaten and drank well that day. A prescription was left for medical supplies.

18/06/14: The GP made a referral to the Old Age Psychiatry Service for generalised anxiety disorder. The referral included an observation that *“she has an excellent and supportive family network, However she is still declining mentally, more confined to her bedroom and expressing suicidal ideology²⁰”*.

19/06/14: On the day immediately preceding the homicide, Peter telephoned Warwickshire County Council Adult Social Care (ASC) and spoke to an advisor. This call which lasted about nine minutes was audio recorded, in line with standard practice. The recording has been listened to by the DHR Chair and Panel.

Peter referred to Mary’s recent hospital discharge and stated somebody from Social Services had said they would come to the house, but nobody had visited as yet. (ASC records have been reviewed, but there is no record of any previous contact, with any Local Authority Social Services personnel. On this basis, it has not been possible to ascertain whether or not Peter had in fact been spoken to by anybody from Social Services, or if he had been mistaken.

The call included a standard screening assessment. The advisor offered Peter an assessment for Mary, to see what equipment she may need and Peter replied ‘lovely’. Following this call a referral was made for assessment by the ASC Occupational Therapy service.

All of the Panel members who listened to the audio recording agreed that throughout the call, Peter’s manner, tone of voice and use of language were entirely polite, appropriate and unremarkable. There was no evidence of undue distress or that he may pose any risk of causing harm to Mary, himself or to anybody else.

April14: Homicide incident. This is described at 1.3 above.

²⁰ Expressing suicidal thoughts

PART 3:

COMMENTARY, ANALYSIS AND KEY LEARNING

3.1 Introduction

The DHR Panel has carefully considered some of the wider and historical issues, including the fact that Mary's significant physical, mental and emotional health problems appear to have followed what was recorded as a relatively minor, routine and uneventful surgical procedure in August 2008. It is not within the remit or ability of this DHR to comment on the root causes of Mary's health problems, or on clinical matters such as whether there was any causal relationship between the operation in 2008 and the medical problems which followed. However, it should be acknowledged that agency records indicated, from their contact with Mary and Peter, that they both disclosed that they felt that Mary's health problems from August 2008 onwards were very directly related to that surgical procedure.

The IMRs from GEH and CWPT indicate significant differences of professional opinion, about the extent to which Mary's symptoms were likely to be primarily caused by physical illness, or rooted in psychological or mental health problems. Again, it is not within the remit or ability of the DHR to attempt retrospective 'diagnoses'. However, the DHR has reached a conclusion that the absence of clearly defined and agreed causes will have added significantly to the levels of distress for both Mary and Peter.

Whilst earlier events and medical interventions were highly significant historical factors, the view of the DHR Panel is that the key lessons for the future arise from events and agencies' responses in the last weeks of Mary's life. Specifically, hospital discharge planning appears to have been the most significant aspect of agency involvement from which lessons need to be learned..

The following sections of commentary and analysis are structured in line with the questions which are set out in the Terms of Reference:

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

All of the evidence presented to the DHR (i.e. agency IMRs, chronologies and the forensic psychiatric report on Peter) shows that there had been no previous knowledge or concerns of this nature, and no reason to suggest that any of the agencies could have identified such concerns.

On the contrary, there was very solid evidence from what was documented by agencies that Mary and Peter had a caring and loving relationship. This was confirmed by observations from the family GP and by family background information collated for the psychiatric report for criminal proceedings against Peter. It was also evident from GEH records which showed that, during periods when Mary was an in-patient, Peter spent many hours on the Ward, sitting with Mary, reassuring her and helping to manage her physical discomfort, pain and anxiety. Two days before the homicide, a referral letter from the family GP referred to an “*excellent and supportive family network*”.

3.3 Did primary and secondary healthcare services effectively meet Mary’s healthcare needs?

As already outlined, it is not within the DHR’s terms of reference to review or evaluate clinical diagnoses and treatments provided. However, there appear to have been some major failures of communication between GEH and SWFT, resulting in Mary being discharged from hospital twice in the weeks immediately preceding the homicide, without effective discharge planning having taken place. The following table summarises conflicting information²¹ between the GEH and SWFT IMRs and chronologies, which highlight these communication failures:

²¹ In the light of conflicting information, both agencies were asked by the DHR to re-check their records. Both agencies have confirmed that their records are as summarised in the table.

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GEH	SWFT
<p>Mary's inpatient stay at GEH on 7/5/14 from to 20/5/14: The GEH chronology states that, during this inpatient stay, referrals were made to Mental Health Team, dementia screen & Intermediate Care Team.</p> <p>Mary's discharge from GEH on 20/5/14: <i>"On reviewing the discharge planning booklet it would appear that the Ward Manager and the OT mentioned the Intermediate Care Team (ICT) to support the discharge. There is no documentation to state whether or not the ICT assessed Mary or whether this was discussed with Mary and her husband.</i></p> <p><i>Ward Manager remembers asking Peter about help at home and he appeared very confident in his ability to manage, stating he did not require any help, had a good network of support with his daughters and he would ask for help if needed."</i></p>	<p>SWFT IMR and chronology make no reference to receiving a referral for ICT, or any other SWFT service, on or before Mary's discharge on 20/5/14.</p>
<p>Mary's discharge from GEH on 11/6/14: <i>"Plan was for home that day, with support from the Intermediate Care Team (IMC). Documented in the discharge booklet that IMC referral had been done and faxed and they were informed of the referral."</i></p> <p>The GEH analysis concludes; <i>"Ward Manager also identified the staff nurses who had referred Mary to IMC and District Nurses, both nurses are experienced, competent and are dementia friends. They both engage with the dementia link nurse meetings and after some discussion with Ward Manager there is no doubt these nurses would have made the referrals as per their documentation."</i></p>	<p>SWFT IMR and chronology make no reference to receiving a referral for ICT or District Nurses on or before Mary's discharge on 11/6/14.</p>

GEH's record of the discharge on 20/5/14 does not make it clear that a referral was made to SWFT, only stating that *'it would appear that the Ward Manager and OT mentioned the ICT Service'*. However, a GEH chronology entry does state that such a referral was made, during the course of this in-patient stay (i.e. at some point between 7/5/14 and 20/5/14). GEH appear to have no documentary record of the

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referral itself. They also have no record of such a referral having been discussed with Mary and Peter, or confirmation of receipt by SWFT.

For the subsequent hospital discharge on 11/6/14, there is a similar conflict between the records of GEH and SWFT. The GEH discharge booklet recorded that there had been a referral to ICT and that this was part of the discharge plan. On the other hand, SWFT have no record of receiving a referral. The GEH IMR author expresses confidence that the members of GEH staff involved *'would have made the referrals, as per their documentation'*. The documentation referred to is an entry in the discharge booklet stating a referral had been made. But there appears to be no confirmed record of the referral itself or any other communication between GEH and SWFT in relation to Mary's discharge arrangements. The evidence from both agencies' IMRs indicates a lack of jointly agreed or implemented procedures for making and recording referrals of this nature.

The picture is further confused by the WMAS records from 12/6/14 when they received a 999 call. WMAS records relating to the call state *"that the Virtual Ward (GEH) had attempted to arrange a District Nursing visit, but this had not been possible"*. It is unclear precisely what attempts had been made to arrange a District Nursing visit, when the attempts were made, or why the attempts had been unsuccessful. The only point of clarity is that SWFT can find no record of receiving a referral from GEH.

As Mary was re-admitted to GEH on 12/6/14, the discharge on 11/6/14 was described by GEH as having been a 'failed discharge'. It is significant that, when she was discharged again on 13/6/14, Peter required a lot of reassurance about the referrals made by GEH, with his main concern being about Mary's restlessness and frequency of going to the toilet. Whilst GEH records again confirm that a referral had been made for District Nursing services, SWFT continue to state that they received no such referral from GEH. They state that their first visit to Mary was on 14/6/14, in response to a telephone call from Peter, earlier that day.

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SWFT records do mention that the nurse was handed a 'community nursing letter' when she made the home visit on 14/6/14. As SWFT have not retained a copy of this letter, it is unclear whether or not the letter originated from GEH, but this is the most probable explanation. If GEH gave Peter a letter to be handed to the District Nurse, this is an indication that GEH believed a referral for this service had been made, even though SWFT have no record of such a referral. However, there is still further confusion, as SWFT's original IMR refers to '*the referral that was sent to the Community Nursing Team*' but the SWFT addendum refers to the nurse being handed a community nursing letter by Peter. It is unclear whether the IMR and addendum are alluding to the same letter, but this appears to be the case. This raises further questions about whether or not a referral letter was in fact sent by GEH to SWFT.

On the basis of the evidence made available to the DHR, it is not possible to say with complete certainty whether or not referrals were made by GEH and / or received by SWFT.

On the other hand, it is reasonable to observe that GEH, as the referring agency, should have retained a copy (paper or electronic) of the referral documentation and should also have sought confirmation that the referral had been received by SWFT and was to be actioned, within an agreed time frame. GEH have not presented the DHR with any evidence to show that this occurred. Similarly, SWFT should have retained a copy of the letter which they report was handed to the District Nurse on 14/6/14.

In summary, there were clear failures of communication, referral procedures and record keeping. Consequently, Mary was being discharged from hospital without any effective plan being implemented for care and support at home. On the last of these discharges, one week before Mary's death, Peter had been anxious and had sought re-assurance that relevant referrals had been made. He may have received this re-assurance, but the reality was that a District Nursing Service was only provided in response to him making a referral himself, on the day following discharge. The more

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intensive support which could have been offered by the ICT service was not provided, even though GEH records suggest an ICT referral was made.

Either no referrals were made, or they were made then 'lost', at some point in the processes between the two NHS Trusts. It is not within the remit or resources of the DHR process to further investigate the exact causes of (or responsibilities for) these communication failures. This requires urgent review by GEH and SWFT, to establish exactly what took place and to ensure that the lessons from this are learned. (See recommendation 1).

Key learning point 1

Failures in discharge planning and inter-agency communication resulted in Mary being left without adequate support, and Peter with increased caring responsibilities as a result of this shortfall, in what were extremely distressing circumstances. The DHR has concluded that this was a significant factor in the circumstances leading to the homicide incident.

Whilst Peter's extreme reaction on 20/6/14 could not have been predicted by any of the agencies involved, the fact that he was left to care for his wife without an effective hospital discharge plan is likely to have contributed to the personal distress he was experiencing. Had there been a discharge plan including daily inputs from District Nurses and the Intermediate Care Team, this could have reduced the levels of stress that Peter was experiencing at this extremely difficult time.

Whether this could have prevented the homicide is unknown. However, it is reasonable to observe that, if such services had been in place, this would have provided opportunities for Peter and Mary's levels of distress as carer and cared for, to be better understood and for additional services (for example longer term carer support services) to be discussed with him.

A further area of key learning is that of joint working between the Medical Ward at GEH and Mental Health Services provided by CWPT. It is clear that referrals were

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made to AMHAT and that these were responded to. Even though the predominant view of CWPT mental health professionals was that the primary root causes of Mary's distress were physical in nature, they still provided psychological and ongoing psychiatric review. This is recognised as having been good practice.

However, it is also clear that there was not a mutually agreed or coordinated treatment plan in place. This appears to be mainly due to the differences of professional opinion as to whether Mary's problems were primarily psychological / mental health related, or were primarily physical health problems.

Whilst GEH clinicians placed a strong emphasis on psychological and mental health causes, mental health assessments generally concluded that Mary's anxiety states were secondary to underlying physical conditions. It is recognised that differences of opinion between medical professionals are sometimes unavoidable. However, in this case this seemed to result in an 'impasse', which is reflected in CWPT's IMR:

.. 'There is little evidence to suggest that information between medical and mental health staff was shared in a meaningful way regarding decisions made regarding Mary's care, particularly during the most recent admissions to hospital.....her needs may have been better met if communication between Medical and Mental Health staff was improved and a more holistic approach adopted'.

3.4 Did Adult Social Care Services effectively assess and meet Mary's eligible social care needs, in line with recognised best practice?

ASC did not assess and meet Mary's eligible social care needs, because at no stage did they receive a referral to request such an assessment. That no referral was made could be seen as a criticism of the health care services which were involved and they could possibly also have observed that a carer's assessment would be appropriate. However, it is understood that Peter was very independent by nature and it is doubtful whether he would have agreed to such a referral being made.

As the only direct contact which Peter made with ASC was the phone call on the day preceding the homicide, this has been closely scrutinised by the DHR Panel, who

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have listened to an audio recording of that telephone conversation. The firm conclusion of the Panel was that the contents of this call gave no clue whatsoever of a potential risk of Peter causing harm to Mary. The Panel also concluded that the Warwickshire County Council Customer Service Centre staff member who took this call communicated with Peter in a very courteous and professional manner and ended the call, having clarified Peter's request for an OT assessment. This was then followed up with appropriate recording and the information was logged with the ASC OT team, to be actioned. The DHR Panel's positive conclusions about how this call was handled have been communicated to the relevant ASC Manager and passed on to the staff member concerned.

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

There is no record of Peter having had a carer's assessment, at any stage. As with the previous question, there were no referrals received by ASC to indicate that a carer's assessment was required, so there was no opportunity when this could have been carried out.

There is some evidence to show that doctors at GEH had discussions with Peter about his possible needs as a carer, but that he stated that he did not want any assistance in this area. Again, it appears that he presented as being highly independent and the extent of his needs as a carer were not easily recognisable. However, this further highlights the importance of learning point 1. If there had been a package of post discharge support in place, this would have significantly increased opportunities for recognition of Peter's needs as a carer and to have engaged with Peter, about his needs. It may then have been possible to persuade him to have a carer's assessment, with a view to a longer term package of carer support services.

Key learning point 2

The evidence from this DHR, suggests that Peter was very reluctant to disclose the extent of the distress he had been experiencing, which only became clear after the homicide incident, in the course of his psychiatric

assessment. Peter's ability to present as a person who was managing the situation without undue levels of stress was particularly evident from the audio recording of the phone call to ASC, on the day before the homicide. His request for an Occupational Therapy assessment for Mary gave a clear picture of a routine and non-urgent request, with no indication (in content or in tone) that he was unable to cope with his caring role. Given this background, it would be entirely incorrect (and unfair) to suggest that anybody could have had reasonable cause for concern that such a tragic outcome may follow.

On the other hand, this case can act as a reminder of the extreme stresses that carers may be under, and that many people (and older carers in particular) are highly skilled at presenting as coping quite well, and/or are perhaps uncomfortable seeking outside support or assistance, when in reality they may be in urgent need of help. It is important that all agencies involved in assessing and meeting carers needs should maintain an awareness of this learning point and to continually develop strategies and professional skills for engaging with such 'hard to reach' carers.

3.6 What information (if any) did agencies have about Mary's views and wishes around end of life care?

The DHR has seen no evidence that any agencies held information about Mary's views and wishes in this respect. However, as Mary's health conditions were not diagnosed as life threatening, there would not have been an expectation of medical professionals pro-actively discussing her options for end of life care. On this basis, the DHR has concluded that there is no significant learning in relation to this question.

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

The evidence reviewed by the DHR has raised some questions and concerns in relation to this question. The DHR has concluded that, during her GEH admissions in May and June 2014, there was evidence to suggest Mary may have lacked

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capacity to consent to treatment. However, there is no record to show that the need for an MCA assessment or DoLS was ever considered.

In particular, Peter's report (in the course of the psychiatric assessment after the homicide) of events on 14/6/14, when he states he was asked to hold Mary down whilst a medical procedure was carried out, is a very disturbing account. If she needed to be held down, this may have indicated that she was not consenting to treatment. If this was the case, the opinion of the DHR Panel is that treatment should only have been given if she was assessed as lacking capacity and the treatment was then confirmed as being in her best interests. But it is difficult to envisage that such a decision would have included asking her husband to assist in this manner.

The DHR Panel requested an IMR addendum from GEH, as this A&E attendance was not discussed in the original report. The addendum confirms that the procedure was documented as being 'traumatic', but GEH have been unable to comment on Peter's report that he was asked to hold his wife down, as the doctor who carried out the assessment has since left the employ of GEH. Similarly, the GEH addendum does not comment on whether potential issues of consent and mental capacity were considered by the staff involved with this A&E attendance.

The conclusion reached by the DHR is that the events at A&E as described by Peter raise some important questions for GEH, including:

- Was the procedure carried out with Mary's consent?
- If there was no consent (or indeed implicit or explicit refusal) was there any consideration given to the need for an assessment of Mary's capacity to give / withhold consent for this procedure?
- If she was assessed as lacking consent, was the procedure carried out following a best interests decision, in line with the MCA?

The DHR has not seen evidence of any specific causal relationship between these events at A&E and the homicide, some six days later. However, by Peter's own account, this was an extremely upsetting incident, for his wife and for himself. It is

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reasonable to observe that this would have been an additional stress factor, adding to numerous other sources of emotional and physical distress affecting Peter during that period.

3.8 What are the views of Peter and other family members about the quality of care and treatment services provided to the victim and alleged perpetrator? In particular, what (if anything) might have been done differently - within existing legal frameworks - which could have prevented the homicide from taking place?

As Peter and his daughters have chosen not to directly engage with the DHR, their general opinions about the quality of care and treatment services are not known. However, it is known that Peter and Mary were firmly of the view that Mary's health problems stemmed directly from the surgical procedure in August 2008.

The DHR conclusion about what might have been done differently which could possibly have prevented the homicide, is addressed above. (See learning point 1).

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PART 4:

RECOMMENDATIONS

4.1 DHR Overview recommendations

Overview Recommendation 1

GEH and SWFT should jointly review the issues about discharge planning, referral systems and failures of inter-agency communication, which have been highlighted by this DHR. The Review should aim to:

- Establish the facts of what actually occurred, including whether or not the referrals to SWFT (as stated in GEH's IMR and chronology) were in fact sent by GEH and / or received by SWFT.
- Having established the facts, to identify the root causes of no ICT service (now known as Community Emergency Response Team) being provided and the District Nursing service only commencing as a result of a direct request by Peter, following Mary's last discharge.
- Establish a multi-agency action plan (for implementation by GEH, SWFT and any other relevant parties) to address the root causes. This is likely to include work to ensure that that future hospital discharge plans are clearly recorded and agreed between GEH and partner health and social care providers, for services to be delivered within time frames specified in the discharge plan.

This recommendation should be overseen by the relevant Warwickshire Clinical Commissioning Group, who should report to Warwickshire Safeguarding Adults Board (SAB) on the findings of the GEH/SWFT Review and on implementation of the resulting action plan. Lead involvement by the SAB is indicated, as the issue of discharge planning is recognised as a wider Safeguarding Adults concern, rather than being specific to issues of domestic abuse or homicide, which would have indicated a lead role for the Community Safety Partnership (CSP).

Overview recommendation 2

GEH should further review the questions raised by this DHR (see section 3.6) about Mary's mental capacity to consent to treatment, during her admissions in May and

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June 2014 and the A&E attendance on 14 June. This Review should consider whether or not clinicians worked appropriately and in line with the MCA Code of Conduct and Deprivation of Liberty Safeguards. GEH should advise the CCG of the findings from this Review and any action plan which may follow.

Overview Recommendation 3

Key learning from this case should be shared and utilised within the Warwickshire area and more widely, with a specific reference to the key learning points relating to:

- Hospital discharge planning
- Raising awareness about the needs of older and 'hard to reach' carers who may refuse help and / or go to considerable lengths to conceal the need for carer support services.

Overview Recommendation 4

The CSP Chair should write to the Care Quality Commission (copied to the relevant Warwickshire CCG) drawing their attention to the findings of this DHR, with specific reference Recommendations 1 and 2.

4.2 Individual Agency recommendations:

The following recommendations are reproduced from Agency IMRs:

George Eliot Hospital NHS Trust

MCA training and regular updates for all decision makers.

Coventry & Warwickshire Partnership NHS Trust

To re-iterate within care planning training and via a learning alert across the Trust the importance of effective communication between professionals, services and agencies and the need for the patient and their experience to be at the centre of this where agencies hold differing views as to the source of the ill health .

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South Warwickshire NHS Foundation Trust

As a response to this Review awareness will be highlighted in the Safeguarding Adults training when it is reviewed in April 2015.

General Practitioners, Adult Social Care and Warwickshire Police

No recommendations

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APPENDIX 1: GLOSSARY

A&E	Accident and Emergency
AMHAT	Arden Mental Health Acute Team (part of CWPT)
AMT	Abbreviated Mental Test
ASC	Adult Social Care (Warwickshire County Council)
BPSD	Behavioural and Psychological Symptoms of Dementia (Medical diagnosis)
CERT*	Community Emergency Response Team provided by SWPT (Previously known as Intermediate Care Team / ICT)
CSP	Community Safety Partnership
CWPT	Coventry & Warwickshire NHS Partnership Trust (Providers of mental health services)
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberties Safeguards
GEH	George Eliot Hospital NHS Trust
ICT*	Intermediate Care Team (provided by SWFT, now known as Community Emergency Response Team)
IMC*	Intermediate Care
IMR	Individual Management Review
ISPA	Integrated Single Point of Access (at SWFT)
MCA	Mental Capacity Act
MHLP	Mental Health Liaison Practitioner (within AMHAT)
SWFT	South Warwickshire NHS Foundation Trust (providers of District Nursing services and ICT / CERT)
WMAS	West Midlands Ambulance Service

*CERT, IMC and ICT all refer to the same service provided by SWFT. They were used interchangeably in some IMRs. The correct name for this service (which has undergone name changes in the recent past) is CERT.