Safer Stronger North Somerset

Executive Summary of the Domestic Homicide Review relating to the death of Anne in January 2023

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Contents

1 The Review Process

1.1 This summary outlines the process undertaken by the Safer Stronger North Somerset Partnership domestic homicide review panel in reviewing the homicide of Anne who was a resident in their area.

1.2 The names for the subjects of this review were agreed with the family. Anne's daughter clearly stated that her mother would like to be known by her name in the DHR, and therefore this is not anonymised. Bill is a pseudonym to help protect his identity.

Anne was aged 91 and Bill aged 90 at the time of the fatal incident. Anne was White Irish and Bill, White British. Ms X who was Anne's daughter and Anne's Grandson.

1.3 Anne had been found by Police in her home, along with her husband Bill with bags around their heads. Anne had already sadly died, but Bill was still alive. No official cause of death was provided to the review. Criminal proceedings were completed in December 2023, and Bill was convicted of manslaughter having entered a plea of diminished responsibility, and sentenced to 2 years in prison, suspended for 2 years.

1.4 10 of the agencies contacted confirmed contact with Anne and/or Bill and were asked to secure their files.

2 Contributors to the review

2.1 The following organisations and services contributed to the review with their nature of involvement stated below:

Agency	**Reason for Involvement in DHR**
North Somerset Council Community Safety	Commissioner of DHR
University Hospital Bristol and Weston NHS Trust	IMR
Next Link	Expert advisor (Domestic abuse)
NHS Integrated Care Board	IMR

North Somerset Council Adult Social Care	IMR
Curo	IMR
Avon and Wiltshire Mental Health Partnership NHS Trust	IMR
North Somerset Citizens Advice	IMR
SW Ambulance Service NHSFT	IMR
Alzheimer's Society	Expert advisor (Dementia and Alzheimer's)
Avon and Somerset Police	IMR
SW Ambulance NHS Trust	IMR

2.2 All IMR authors were independent of any direct involvement with the victim or perpetrator, with the exception of the original IMR from the NHS ICB, which was authored by the GP.

2.3 Additionally, the DHR chairs made contact with the current provider of the Independent Mental Capacity Advocacy Service (IMCA) to understand if they have a domestic abuse policy and their organizational approach to the issue. This highlighted that they do not have a standalone domestic abuse policy, instead separate safeguarding adults and children policies. These do need updating to reflect the current statutory definition of domestic abuse. It is important to note that this is a different provider to that who delivered the IMCA service when Anne was in receipt of the service.

3 The Review Panel Members

Who	**Agency**	**Role**
Howard Pothecary	North Somerset Council	Community Safety Manager
Hannah Gray	North Somerset Council	DA/VAWG lead

Leena Analyse	UHBW	Safeguarding Adults Operational Lead Nurse
Carol Sawkins	UHBW	Safeguarding Lead Nurse
Sian Scholes	Next Link	Senior Service Manager
Vanessa Colman Lucy Austin	NHS Integrated Care Board (BNNSG) NHS Integrated Care Board (BNNSG)	Designated Nurse for Safeguarding Adults Deputy Designated Nurse for All Age Safeguarding
James Wright	North Somerset Council Adult Social Care	Safeguarding Adults Team Manager
Jack Bailey	Curo	Head of Operations, Curo Choice
Dani Rowan Katherine Ford	Avon and Wiltshire Mental Health Partnership NHS Trust Avon and Wiltshire Mental Health Partnership NHS Trust	Domestic Abuse Lead (until January 2024) (from January 2024)
Fiona Cope	North Somerset Citizens Advice	Chief Executive Officer
Lorna Robertson Alex Keramidas	Alzheimers Society Alzheimers Society	Regional Manager Head of Safeguarding
Su Parker Dave Marchant	Avon and Somerset Police Avon and Somerset Police	Detective Inspector (until 30.11.2023 when retired) Detective Inspector (panel member from 1.12.2023)

Roseanna McCammick	SW Ambulance NHS Trust	Safeguarding Named Professional

3.1 All review panel members were independent of direct involvement with the victim and perpetrator.

3.2 The review panel met five times between May 2023 and June 2024.

4 Author of the Overview Report

4.1 Suzanne Harris and Lucy Macready are directors at the independent consultancy Community Safety Consultancy LLP and have completed the Home Office Domestic Homicide Review training and accredited DHR chair training with Advocacy After Fatal Domestic Abuse (AAFDA). They are both also members of the AAFDA DHR Network.

4.2 Both Suzanne and Lucy have worked for over 15 years at Somerset Council (formerly Somerset County Council), as strategic community safety and domestic abuse leads, and around 10 years of this has been within the Public Health department and they both have public health qualifications.

4.3 Suzanne is a qualified manager and member of the Chartered Management Institute and has worked in management roles in social housing around the UK and at the Somerset local authority. Suzanne has been the subject matter expert for domestic abuse and sexual violence and violence against women and girls within Somerset County Council (now Somerset Council) for over 13 years.

4.4 Lucy has MSc qualifications in Social Research Methods and Public Health and is also a qualified manager with postgraduate qualifications in Management studies and leadership. Lucy has worked in the community safety sector for nearly 20 years. Lucy has been the community safety strategic subject matter expert in Somerset Council for 15 years.

4.5 Neither Suzanne or Lucy have worked for any of the agencies involved with this review. Nor have they worked in the North Somerset area, and have had no personal or professional involvement with those involved or their families.

5 Terms of Reference for The Review

5.1 The terms of reference were agreed by the review panel at their inaugural meeting in May 2023. The time period of January 2015 to January 2023 was

chosen due to Anne's dementia diagnosis being in 2015, and so multi agency involvement was known to have changed during 2015.

5.2 The following key lines of enquiry (KLE) for the terms of reference were agreed by the review panel. These were considered relevant due to the information known specific to Anne at the time of the first panel meeting. A full copy of the terms of reference can be found at Appendix A.

- KLE 1. Identify and examine patterns of domestic abuse in all its forms, including any coercive and controlling behaviours experienced by Anne.
- KLE 2. Review the extent to which agencies/professionals worked together when responding to the needs and circumstances of the subjects of this review and the effectiveness of these responses.
- KLE 3. Determine whether decisions and actions in this case comply with legislation and national guidance and how these may have changed since the period in question; ensuring that learning is considered in the "here and now". This will specifically consider the implications of the Mental Capacity Act.
- KLE 4. Examine to what extent Anne's medical diagnosis was both a risk factor to the abuse she experienced but also a potential barrier to seeking help and whether this was identified by agencies in their responses.
- KLE 5. Consider Anne's sex, and age as factors throughout the review.
- KLE 6. Consider how Bill's age and caring role impacted on agencies identifying potential risk factors both to him and by him. Also include the impact of Bill's own vulnerabilities (risk of suicide, cancer diagnosis, alcohol use)
- KLE 7. Examine how agencies respond to cases where there are carer role considerations, the tools used to support decision making and support pathways. This to include how agencies consider and respond to risk and presence of domestic abuse.
- KLE 8. Examine the impact of Covid 19 on an individual's ability to access information and support and agency's ability to provide services.
- KLE 9. Explore the extend by which using a private carer reduced or impacted on the engagement of other agencies.

6 Summary Chronology

6.1 Anne and Bill had been married for circa 60 years, with Anne having a daughter Ms X from her first marriage which had ended in divorce in around the 1950's.

6.2 In 2015, Anne was diagnosed with moderate stage vascular dementia with possible Alzheimers. During the remainder of 2015, a series of assessments took place, with a care plan devised and reviewed by Avon and Wiltshire Partnership with Bill being the primary carer.

6.3 During 2016, it is recorded that Anne had a series of occupational therapy and physiotherapy assessments and reviews to help with her mobility. Anne also had medication reviews, with the Avon and Wiltshire Partnership Memory Service and GP in liaison regarding prescribing this.

6.4 In 2017, Bill informs Avon and Wiltshire Partnership professionals on several occasions that he feels Anne's health is deteriorating, and reports that Anne was verbally irritable with him. Anne had a fall in September 2017 which required hospital admission due to an arm fracture. As part of the hospital discharge plan, Anne's care package was reviewed, and level of domiciliary care increased.

6.5 In February 2018, the first of a series of safeguarding concerns were raised, due to Anne alleging that Bill was being abusive towards her, including physical violence. Adult Social Care completed a safeguarding enquiry in February which had 'an inconclusive outcome'. Following University Hospitals Bristol and Weston, receiving further safeguarding concerns from both Anne and Ms X, a safeguarding enquiry and a 'best interest' meeting were held in both the beginning and latter parts of March. Both proved the allegations as unsubstantiated due to it being believed that Anne was recalling her first husband who is believed to have been domestically abusive. Bill was present at these meetings, and advised that Anne's first husband was violent towards her. An Independent Mental Capacity Advocate was appointed to support Anne for one of these disclosures.

6.6 Anne's health and mobility deteriorated with her having several falls in May and in September.

6.7 In August 2018, Anne moved temporarily into a care home (until beginning of December) due to Bill having ill-health and needing to receive treatment.

6.8 During 2019, the domiciliary care provider report concerns regarding Anne's care and Bill's health. These were resolved with occupational therapy input and provision of advice to Bill regarding bed transfer and mobility within the home. A triangle of care meeting was carried out in best interest with Bill present in December, with the outcome not recorded.

6.9 In 2020, there is an increase in the concerns by domiciliary care providers about how Bill is supporting Anne, in particular that he is not taking the advice of professionals. Although it is deemed by carers that he is 'not being malicious', Bill is reported 'to treat Anne like a child', and was also not using good manual handling procedures. Subsequently Adult Social Care organised for a hoist to reduce the need for Bill to handle Anne.

6.10 In 2021, there were continuing concerns by health and social care professionals about Bill's care for Anne, in that whilst they deemed him to be 'caring' and was trying to make Anne comfortable, his approach raised safeguarding concerns. This was due to Bill strapping Anne to a chair and trying to make her walk when

she shouldn't. Additional care was also organised by Adult Social Care to help manage the situation.

6.11 During 2022, Anne's health deteriorated, with Bill making seven 999 calls for Ambulance Service assistance due to Anne either being unrousable or choking, (these were June = 1, July = 4, September = 1 and November = 1).

Subsequently the Southwest Ambulance Service make multiple safeguarding referrals and requests for GP involvement, who responded each time. It's noted by the GP in June 2022 that Bill has to restrain Anne in her chair with a belt to prevent her from slipping.

6.12 Although a formal assessment is not believed to have taken place, Anne's care package was reviewed by Adult Social Care at the end of July with Bill noting he was happy with the self-funded care package. This did result in Adult Social Care making a referral to Curo's Community Connect service, who subsequently made a referral to the local Fire and Rescue Service for a home safety check, and also Occupational Therapy.

6.13 In 2023, the GP records making a home visit to Bill and Anne, where it is suggested that Anne is entering a terminal phase of life. The GP had a light-hearted and engaging conversation with Bill, with no concerns noted.

7 Key Issues Arising from The Review

7.1 Both Anne and Bill were well known to a range of services. These being mostly health and social care, with between June 2015 and January 2023 prior to Anne's death, there were 257 entries from agencies participating in this review of contact that they had had with either or both Anne or her husband Bill.

7.2 Anne's daughter Ms X provided value insights into Anne's life as part of this review. Ms X advised that she witnessed behaviours and incidents between Anne and Bill that at the time 'were normal' and so tolerated but in hindsight were clear exhibits of coercive control and economic abuse.

7.3 It is clear from this review, that all the disclosures and witnessed concerns were medicalised. Additionally, Bill's role as Anne's primary carer meant he was often involved in all meetings relating to any safeguarding concerns raised.

7.4 The DHR panel agreed that if Anne was younger, was not in a long term marriage, and did not have Alzheimer's, disclosures of domestic abuse may have been received, assessed and processed differently.

7.5 Domestic abuse can impact across someone's life course. Regardless of when Anne experienced domestic abuse, she disclosed it and was never assessed regarding its impacts on her and did not enable access to specialist support. She

may have been experiencing long lasting trauma. Her age, disability and marriage became factors in professionals not taking action.

7.6 Bill was well-known to health and care agencies, given not only his own health ailments, but majorly as the main carer to Anne. It's clear SWASTNHSFT noted his frailty, and they attempted to engage with the GP via referrals. Although the carer reported to Adult Social are their concerns over his frailty, it's unclear through the analysis that any other agency truly noted the cumulative impact of his own health needs, and any related risks this had for him or Anne.

7.7 Indeed a few weeks prior to the homicide, the GP made a home visit to Anne and Bill and noted how well Bill presented. It was at this meeting, that the GP and Bill discussed Anne reaching a 'terminal phase of life'.

8 Conclusions

8.1 In conclusion, this tragic case demonstrated the importance of considering domestic abuse in all its forms across the system of health, social care, voluntary and specialist services. Anne came to the attention of local services due to her long-term health condition, and was from that point, considered to have needs based on this condition, but not necessarily based on her various vulnerabilities and experience of domestic abuse, whether this was indeed current, or historic.

8.2 Agencies understanding the dynamics and complexities of domestic abuse and how it manifests in older people, taking a trauma informed, intersectional approach, and having tenacity in supporting family carers across all agencies, may have led to a different outcome.

9 Lessons Learnt

9.1 Professionals not considering the presentation of need through a domestic abuse lens

9.1.1 Although Anne discloses domestic abuse, there were no formal assessments (e.g. DASH) undertaken. In addition, any care/safeguarding assessments did not take an intersectional approach, clearly understanding the multiplicity of needs for Anne.

9.1.2 Improving understanding about the continuum of domestic abuse is required. Anne had a history of domestic abuse, but practitioners did not see this as a risk factor. There was no trauma informed approach, in understanding that victims can often go through a cycle of abuse (and in more than one relationship), especially without specific support to help break that cycle. Additionally, understanding and acknowledging that domestic homicide is sadly an outcome for some victims.

9.1.3 The review found that the voice of Anne was through her husband, irrespective of whether Anne was deemed to have capacity. For example, best interest meetings always involved Bill, having the opportunity to justify allegations of domestic abuse. It may be assumed with dementia, there is an inevitability about this, however, more could be done to ensure at an early point, to gather views of the person with dementia, which is regularly reviewed. This is especially important even when there are no reported relationship difficulties.

9.1.4 An early learning point established by the DHR panel was to consider adopting the older people's DASH risk assessment to help better explore the domestic abuse risks faced by older people.

9.2 Taking an intersectional approach to provide a holistic view of need and potential vulnerability.

9.2.1 A main learning point from this review is that there was no single holistic view of the range of vulnerabilities that Anne presented, be that her age, sex, disability and marriage. Considering these characteristics singularly, did not give sufficient importance to understanding the barriers that Anne faced. Nor was there any evidence to suggest any acknowledgement of the potential risk of homicide.

9.3 Professional optimism

9.3.1 The review found an inconsistent standard in case file recording across agencies, with a clear and repeated depiction of Bill as a non-abuser based on opinion and subjectivity. Once written, this can lead to other staff being given an immediate impression of Anne and Bill, that isn't objective. It is noted there isn't a quality standard around this specifically for social care. Supervision, learning and effective training of staff are therefore vital.

9.3.1 Many professionals across multiple health and social care agencies were optimistic about Bill and Anne's situation, and did not appear to objectively identify any potential risks, including that of homicide.

9.4 Awareness of non-physical domestic abuse in the community

9.4.1 This case demonstrated the difficulty in identifying non-physical domestic abuse. Coercive control was later recognised in Anne's story, by her daughter, who witnessed it over the years. Anne herself, did not see herself as a victim of abuse because she was not physically harmed by Bill. At the time of Anne's death, coercive and controlling behaviour was firmly framed in the Domestic Abuse Act 2021 and has been a specific offence since 2015[xxviii]. Therefore, it is not a new phenomenon, and the review panel agreed that more can be done to ensure that communities better understand how to identify this type of abuse.

9.5 Other learning taken from this review

9.5.1 The use of terminology didn't always lead to any escalation of safeguarding concerns, with "beating" being a term recorded in an agency case file. Despite this language, concerns were not reported to the Police and so would suggest there is not a clear understanding of safeguarding practices.

9.5.2 Bill was elderly, was a full-time carer for Anne and also became unwell within the review period, having treatment for cancer. It remains unclear whether there was a specific attempt to engage Bill in a structured conversation about his health and wellbeing or ability to cope with caring for Anne beyond requesting that he undertakes a carers assessment. Learning from DHR Sylvie is relevant also in this case (9.4) which states that carers should be given opportunity to express their feelings and for an agency to be able to assess how the care giver is managing.

9.5.3 As Anne's health conditions deteriorated, the role of Bill as her primary carer should have been reviewed more effectively. The review found that agencies were in regular contact with Bill, but despite safeguarding concerns, a GP home visit in the weeks preceding Anne's death and knowledge of Bill's increasing frailty, his role remained unchanged. It could be argued that the deterioration in Anne's health, increased needs and Bill's decreasing ability to cope, was 'in plain sight'. A holistic and objective approach to understanding trauma, deteriorating health and impact on relationships and caring ability could have perhaps led to an improved intervention.

9.5.4 In examining the chronology, it was felt that carer assessments were not used effectively, nor had the desired impact on Anne and Bill. The DHR panel considered the opportunities that might come with the ability for all agencies that work to safeguard adults, being able to utilise a carer assessment tool as part of an equitable and holistic partnership approach to supporting carers and the cared for.

9.5.5 Whilst this review was not a joint Safeguarding Adult Review/Domestic Homicide Review, the key lines of enquiry did, as expected, draw out potential missed opportunities to safeguard Anne and the panel saw evidence of the 6 principles of Safeguarding Adults (detailed in Care Act 2014 guidance) not being applied appropriately.

9.5.6 Nevertheless, the panel felt that there may be benefits in a further thematic review of family caregivers and identifying risk factors that may lead to domestic homicide from a safeguarding adults perspective, considering this case and potentially other similar cases.

10 Recommendations

10.1 Single Agency IMR recommendations

The following single agency recommendations were made by the agencies in their IMRs. They are described in section 15 following the analysis of contact by each agency, and are also presented collectively in the action plan (Appendix B).

10.1.1 Adult Social Care

Recommendation 1: Adult Social Care to review current training and competency framework for staff, and assure the North Somerset Domestic Abuse Board that DASH and MARAC training with inclusion of how to respond to individuals who lack capacity, is included as mandated training.

Recommendation 2: The Principal Social Worker to ensure that staff are able to accurately record domestic abuse on their internal case management system and report back to the North Somerset Domestic Abuse Board.

Recommendation 3: Adult Social Care commissioners to ensure that all contracted care and support providers (including the IMCA provider) have an update to date Domestic Abuse policy that aligns with the Domestic Abuse Act (2021)

Recommendation 4: Carers assessments should consider what feedback the care giver would wish to be given to the cared for person's social worker.

Recommendation 5 – Update and promote guidance on working with carers who are considered a source of risk.

10.1.2 Avon and Wiltshire Mental Health Partnership NHS Trust

Recommendation 6: AWP North Somerset Mental Health Liaison Service to contact the relevant AWP care-coordinating team for service users when made aware of a safeguarding concern to review its assessment and response to initial concerns of domestic abuse.

Recommendation 7: AWP to ensure that the North Somerset Memory Team receive up to date DA training as part of professional development

10.1.3 Southwest Ambulance Service NHS Foundation Trust

Recommendation 8: Safeguarding education specialist to review training offer. Specifically, how frontline staff identify carer breakdown and ensure referrals and support are put in place to safeguard the patient and carer.

10.1.4 Bristol and North Somerset and South Gloucestershire Integrated Care Board

Recommendation 9: ICB to review training offer to ensure that primary care staff across the ICB area are able to access training that includes safeguarding for adults, carer stress and domestic abuse. when presenting with a NICE indicators of DA

10.2 Multi-Agency Recommendations

10.2.1 The Review Panel has made the following recommendations as part of the DHR.

10.2.2 Safer Stronger North Somerset Community Safety Partnership (SSNSCSP)

Recommendation 10: The SSNSCSP formally approaches the Adult Safeguarding Board to consider carrying out a thematic review around family care giver abuse which should include identifying the risk indicators

Recommendation 11 - The SSNSP/Domestic Abuse Board, should consider the use of the ‘older person’s DASH risk assessment’ or a list of supplementary questions additionally to the standard DASH risk assessment, when local professionals identify possible older victims of domestic abuse.

Recommendation 12 - The Domestic Abuse Board to review current domestic abuse training across all agencies around being Trauma informed and acknowledging the continuum of abuse through the life course and associated patterns in behaviour and vulnerabilities, including lack of mental capacity.

Recommendation 13– The Domestic Abuse Board to work with the Safeguarding Adults Board to ensure the LGA/ADASS guide for safeguarding victims of domestic abuse (referenced in the appendices and in section 16 of this report) is effectively disseminated to relevant staff groups in all agencies involved in this review.

Recommendation 14 – Domestic Abuse Board to provide a learning briefing document for all relevant agencies to improve understanding of the importance of taking an intersectional approach when assessing vulnerable service users.

Recommendation 15– The Domestic Abuse Board to undertake local campaign to raise awareness in the community about how to recognise the signs of coercive control/non-physical domestic abuse, targeting older age groups.

Recommendation 16 - Organisational policies should be reviewed to clearly identify how to respond to situations where there are safeguarding concerns about a carer of a family member. Where a carer is exhibiting signs of increased stress and inability to cope, staff should be clear on the pathways to assessment and support (NSSAB).

Recommendation 17 - The Safeguarding Adults Board to promote the broader use of the carer's assessment tool for those agencies, statutory and non-statutory who may be well placed to offer carer support.

Recommendation 18: North Somerset Safeguarding Adults Board to publish refreshed guidance on how to identify and support carers at risk and promote to all ASC staff and stakeholders.

Recommendation 19: Health and social care professionals to ensure that questions on the person's mental capacity are mandatory on safeguarding forms to ensure they cannot be completed on signed off until a person's views and wishes are sought, or if they are unable to provide them a referral to advocacy is made.

Recommendation 20: The Safeguarding Adults Board requests an assurance report from Adult Social Care on the current case allocations and social worker supervision procedure in North Somerset to assure itself that social workers are supported to take on complex cases.