Safer Stronger North Somerset

Overview Report of the Domestic Homicide Review relating to the death of Anne in January 2023

Report Completed June 2024

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Family Tribute

Anne (she always said she was “Anne with an E”) was a kind and generous lady, who lived a vibrant life. Born into a Catholic family in Ireland, she moved to London as a young woman, and this is where she met her first husband. Anne enjoyed arts and crafts, including decoupage. Anne was sociable and good at making friends. Professionally Anne also enjoyed a successful teaching career and following that, went on to own and manage several businesses with her second husband.

She is fondly remembered too, for writing short stories in the style of Mills and Boon that was popular at that time. She was creative, much like the rest of her family.

For Anne, ’domestic violence’ or ’domestic abuse’ did not exist. What did exist for her was a difficult marital relationship, but for her this was normal, and she had the stability of a roof over her head.

It is important to the family that readers acknowledge Anne, not as a victim, but as a caring and strong headed woman who’s life mattered. It mattered to the community, to her family and her memory lives on in the hearts of those who will always love her, and she now rests in peace with her parents in Ireland.

Anne (picture kindly provided by Ms X, Anne’s daughter)

Glossary

Access Your Care	Domiciliary care agency (held North Somerset Council contract from 2021)
Alliance Living Care	Domiciliary care agency (held North Somerset Council contract until 2021)
Best Interest Meeting	Multi-disciplinary meeting arranged for a specific decision around a patient's care/treatment, when a person is deemed to lack the mental capacity to make that decision themselves.
BNSSG	Bristol, North Somerset, South Gloucestershire (NHS Integrated Care Board for North Somerset area)
CANS	Citizens Advice North Somerset
Care Act 2014	Legislation relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect
CIT	Complex intervention and treatment team (Avon and Wiltshire Partnership service)
CVA	Cerebral vascular accident – also referred to as a stroke, is an interruption in the flow of blood to cells in the brain
ICB	NHS Integrated Care Board
IMCA	Independent Mental Capacity Advocate
Memantine	Dementia medication
SWASTNHSFT	Southwestern Ambulance Service NHS Foundation Trust
TIA	transient ischemic attack, or TIA, is a temporary blockage of blood flow to the brain
Triangle of Care Meeting	A Triangle of Care is a partnership between professionals, the person being cared for and their carers.

1. Introduction

1.1 The review panel express their sincere condolences to the family and all those affected by the tragic loss of Anne. The family have requested that a pseudonym is not used in this report.

1.2 This report of a domestic homicide review examines agency responses and support given to Anne, a resident of North Somerset, prior to the point of her death in January 2023.

1.3 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.4 This statutory review was commissioned following the manslaughter of Anne. The perpetrator was her husband, Bill. This verdict was decided by Bristol Crown Court in December 2023.

1.5 The review will consider contact and involvement agencies had with Anne and Bill from January 2015 to the date of Anne's death in January 2023. This timescale was chosen because during the multi-agency scoping of information and events it became clear that agency involvement following Anne's diagnosis of dementia in 2015 appeared to increase.

1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order 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 in order to reduce the risk of such tragedies happening in the future.

2 Timescales

2.1 The DHR was commissioned by North Somerset Council on behalf of the Safer Stronger North Somerset Partnership in April 2023. The first panel meeting took place in May 2023; with further panel meetings taking place in September 2023, October 2023 and February and April 2024. The report was completed in June 2024

2.2 The report took longer to complete than the 6 months set out in the statutory guidance, due to the criminal justice proceedings not concluding until December 2023 which delayed the ability for the review chairs to speak formally to the family.

2.3 Additionally, in late April 2024, the North Somerset Safeguarding Adults Board approached the Safer Stronger North Somerset Partnership to request the DHR became a joint Safeguarding Adults Review. This led to protracted discussions that delayed the conclusion of the DHR (see 10.3 below).

3 Confidentiality

3.1 The findings of this DHR are confidential until approved for publication by the Home Office Quality Assurance Panel. During the review information was available only to participating officers/ professionals and their line managers.

3.2 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's daughter was clear that she wanted to use the name "Ms. X" for the purpose of this review.

3.3 Anne was aged 91 years and Bill was aged 90 years at the time of the fatal incident. Bill was White British and Anne was White Irish.

4 Terms of Reference

4.1 The terms of reference were agreed by the review panel at their inaugural meeting in May 2023. The time period as set out in 1.5 aligns with Anne's dementia diagnosis at which point, agencies were readily involved with the couple, and Bill's caring responsibilities began to increase.

4.2 The following key lines of enquiry 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.

4.3 Key Lines of Enquiry (KLOE)

- 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 includes how agencies consider and respond to the 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 extent by which using a private carer reduced or impacted on the engagement of other agencies.

5 Methodology

5.1 The Safer Stronger North Somerset Partnership (SSNSP) received a notification of a death to consider as a domestic homicide review (DHR) on 9th February 2023. To help the SSNSP Chair decide on whether to commission a DHR, information was collated from 10 local voluntary and statutory agencies, including police, a housing provider, Adult Social Care and Citizens Advice. North Somerset's DHR Local Advisory Panel met on the 27th of February 2023, to consider the information known and recommended to the SSNSP Chair that a DHR be commissioned. The SSNSP Chair agreed with this recommendation to proceed and wrote to the Home Office on the 14th of March 2023.

5.2 Anne's daughter was informed that a DHR was to take place on 28th April 2023 by the police Family Liaison Officer. It is believed that this was carried out as part of a telephone conversation.

5.3 The agencies who were required to complete IMRs were identified at the first panel meeting, and were those known to have had contact with Anne and Bill. All agencies were asked to highlight within their IMRs positive practice, any learning, recommendations and actions.

5.4 To assist with IMR authors, the independent chairs delivered a workshop in July 2023 to help them provide good quality IMRs. All IMRs were quality assured, and any recommendations and learning agreed by senior members of staff within each organisation.

5.5 When this DHR was commissioned, the ICB implemented a change in its system where GPs were asked to complete IMRs. This DHR was the first time this new process was used. The IMR produced by the General Practice did not meet with standards

required for the review, so the review chairs and the ICB panel representatives worked to obtain a better level of information. A further revised report and chronology was provided, authored by the ICB, and whilst much improved, led to delays.

Since this time, the ICB has given the review chairs assurances of a further improved process in place whereby, the Named GPs for safeguarding take responsibility for writing the IMRs and the ICB supports the Practice's to complete chronologies. Due to ongoing challenges in accessing records held by individual practices, 2 Named Practitioners for Primary Care who can assist with the smooth running of information requests and building relationships with the Practices across the BNSSG NHS ICB are also now in post. Furthermore, external consultants were commissioned to deliver bespoke IMR writing to the ICB safeguarding team, including named GPs.

5.6 In addition to the IMRs provided by agencies, the chairs were also provided with invaluable insights into Anne's personal life and her relationship with Bill by Anne's daughter, Ms. X.

6 Involvement of family, friends, colleagues, neighbours and wider community

6.1 The Independent Chairs met with Anne's daughter, Ms. X, twice during the review. Ms. X lives outside of the UK, so meetings were conducted via online zoom meetings. This fact also meant that she was not eligible for the National Homicide Support service, however, she did have the ongoing support from the police Family Liaison Service, of whom she stated had been exceptionally supportive and helpful. Soon after the review commenced, the chairs shared the purpose and scope of the review. Regular contact was provided to Ms. X during the course of the review via email. A copy of the draft review report was shared with Anne's Daughter for comment.

6.2 The Victim Support National Homicide Support Service who was supporting Anne's Grandson, contacted the Independent Chairs to express that he may be interested in contributing to the review. Attempts were then made to meet with Anne's Grandson, and whilst some messages were exchanged, he felt that he was unable to contribute.

6.3 Despite attempts by the DHR chairs to identify other possible contributors to the review, none were identified.

6.4 The review panel considered contacting Bill to participate in the review. However, it was established that Bill was in a care home and considered vulnerable and at risk of harm to himself. Therefore, the panel deemed Bill vulnerable and agreed not to make contact.

7 Contributors to the review

7.1 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)
BNSSG 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

7.2 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.

7.3 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 did not have a standalone domestic abuse policy, but 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.

8 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	Alzheimer's Society	Regional Manager

Alex Keramidas	Alzheimer's Society	Head of Safeguarding
Su Parker	Avon and Somerset Police	Detective Inspector (until 30.11.2023 when retired)
Dave Marchant	Avon and Somerset Police	Detective Inspector (panel member from 1.12.2023)
Roseanna McCammick	SW Ambulance NHS Trust	Safeguarding Named Professional

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

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

9 Authors of the Overview Report

9.1 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.

9.2 Both Suzanne and Lucy have worked for over 15 years at Somerset Council, as strategic community safety and domestic abuse leads, with approximately 10 years of this time being within the Public Health team. They both hold public health qualifications.

9.3 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 at Somerset Council for over 13 years.

9.4 Lucy has MSc qualifications in Social Research Methods (University of Surry) and Public Health (UWE) 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.

9.5 Neither Suzanne nor Lucy have worked in North Somerset, or for any of the agencies. They have had no personal or professional involvement with those involved or their families.

10 Parallel Reviews

10.1 At the time of concluding this report, the inquest had not taken place and so the verdict is not known.

10.2 Prior to the North Somerset Community Safety Partnership commissioning a domestic homicide review, in Spring 2023 they liaised with the North Somerset Safeguarding Adults Board (NSSAB) regarding whether a Safeguarding Adult Review would be commissioned. The NSSAB confirmed that following a review of the case, a Safeguarding Adult Review would not be commissioned either singly or jointly with the DHR. Instead, it was agreed that the DHR would have terms of reference which included Safeguarding themes and panel membership including Adult Social Care.

10.3 However, at the point of the DHR overview report draft being written, the North Somerset Safeguarding Adults Review (SAR) Committee Subgroup, due to personnel changes, revised their decision and contacted the commissioners and Chairs of this review to suggest that it become a joint Safeguarding Adult Review/Domestic Homicide Review. After some discussion, it was felt that changing the methodology and terms of reference at such a late stage would have a negative impact on the process, the report and on family members involved. It was also felt that the existing KLOE were suitable for drawing out pertinent learning from an adult safeguarding perspective.

10.4 No other reviews took place.

11 Equality and Diversity

11.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[i], as well as to wider matters of vulnerability for both the victim and perpetrator.

11.2 Anne was a 91-year-old, White Irish woman who had a disability of diagnosed Alzheimer's and was married to Bill, a 90-year-old White British man.

11.3 The panel agreed that age, marriage, disability and religion were particularly relevant to this review. It was evident that these 4 protected characteristics did impact on service

delivery because whilst both Anne and Bill did access universal services, these were specifically focused on Anne's disability[ii] and Bill's ill health.

11.4 Religion

11.4.1 Anne grew up in Ireland as a Catholic. Her religious faith was so strong that when Anne was younger, having been educated in a convent, it is understood that she seriously considered devoting her life as a nun, and was a novice nun for a time. Her daughter commented that Anne, due to her Catholicism, felt conscious of the repercussions of being a divorcee following her first marriage and was very keen that her second marriage did not fail.

11.4.2 Additionally, it is reported by Adult Social Care that Bill also engaged the support of volunteers from their church, and this was perceived positively by him. However, the Adult Social Care IMR thought it likely these visits stopped during peak covid-19 lockdown periods.

11.4.3 It's unclear from the information provided to the DHR whether agencies were aware of Anne's religious faith and the possible significance of this in her decision making, or if agencies understood Bill's religious beliefs and any impacts that this had on him.

11.5 Marriage and Civil Partnership

11.5.1 Anne and Bill had been married for approximately 60 years. When considering the information provided to the review, the chairs would suggest that the fact that Anne had been married to Bill for so long, enabled assumptions to be made about the relationship and also served as justification for Anne's care to fall to Bill.

11.5.2 Disclosures and allegations of domestic abuse perpetrated by Bill were made by Anne and her daughter, Ms. X, but agencies decided that the allegations related to Anne's first husband, with no evidence of this aside from Bill's rationale and the social worker's opinion. This later became 'fact' in case files.

11.5.3 Whether Anne experienced discriminatory treatment as a result of her marriage is explored further in the analysis section (16).

11.6 Age

11.6.1 Despite the majority of evidence and academic research about domestic abuse being based on younger people, the body of research regarding domestic abuse and older people has been building in recent decades (Bows 2018). This gradual change is

reflective of an associated shift in the perception that domestic abuse can impact on people of all ages.

11.6.2 The age of Bill and Anne is significant. Their age did not increase the risk of domestic homicide as an independent risk factor, but it did impact on the way that the couple were understood, assessed and supported by agencies. This will be discussed further in section 16. Age was also significant in attributing to poor physical health for both Bill and Anne.

11.7 Sex

11.7.1 Sex requires special consideration as ONS data in 2020[iii] found that females accounted for 76% of domestic homicides with Domestic Homicide as the most common cause of violent death amongst women (Ruuskanen and Kaurko 2008[iv]). This characteristic is relevant for this case as the victim of homicide was female and the perpetrator of the homicide was male.

11.7.2 In addition, in their study of 31 Domestic Homicides involving over 65s, Benbow et al (2018) found that 25 of these victims were female[v], meaning that women are significantly more at risk of being killed by someone they are personally connected to.

11.7.3 During the course of this DHR Anne's sex does not appear to have been a limiting factor to how agencies responded to her.

11.8 Disability

11.8.1 Disability is a relevant protected characteristic, as Anne was diagnosed with dementia in 2015. Dementia is a disability according to domestic law and international convention. (Alzheimers.org.uk (2023)[vi].

11.8.2 Public Health England research (2015) has found that "disabled people experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people." [vii]

11.8.3 Additionally, Bill was required to take on an increased caring role for Anne as her disability progressed in severity. Whilst Bill was offered carers assessments and enabled to access some support, Anne's disability had a significant impact on their relationship and changed the dynamic further. This was compounded when Bill was diagnosed with cancer.

11.8.4 It's not clear that agencies fully comprehended the potential risks for both Anne and Bill as a result of their deteriorating health. The analysis section (16) considers this further.

11.9 Intersectionality

11.9.1 It is clear that these four characteristics (Sex, age, disability and marriage) cannot be considered in isolation and therefore, the review took an intersectional framework approach to help understand the lived experience of both Anne and Bill. This means to consider each characteristic of an individual as inextricably linked.

11.9.2 Intersectionality, founded in the 1980s by black feminist writers talked about the various forms of oppression faced by black women. It gave an insight into the way that vulnerabilities layer over one another and interweave to build or reduce levels of power and risk. The statutory guidance[viii] borne from the Domestic Abuse Act (2021) for the first time, acknowledged the importance of understanding and assessing the additional struggles met by women due to intersectionality.

11.9.3 In considering intersectionality amongst female victims of domestic abuse, critically, Kelly and Westmarland (2014) [ix] considered that a key inequality in women is that they suffer domestic abuse as a continuum across the life course, with domestic homicide occurring at the end of this in some cases.

12 Dissemination

12.1 The overview report, once approved by Home Office Quality Assurance, will be disseminated to:

- The victim's family
- Agencies directly affected by this review
- Safer Stronger North Somerset Partnership
- North Somerset Local Domestic Abuse Partnership Board
- North Somerset Safeguarding Adults Board
- Avon and Somerset Police Crime Commissioner
- Domestic Abuse Commissioner for England and Wales

13 Background Information (The Facts)

13.1 Anne lived in an urban area within the North Somerset area of England. She died within her home that she shared with her husband of circa 60 years[1]. Anne had a domiciliary carer, and on a day in January 2023 this carer was unable to access the property as no-one was answering the door.

13.2 The carer then telephoned the Police, who upon arrival, forced entry to the property. The Police found both Anne and her husband, Bill, inside the property with bags over their heads and tied around their necks. Sadly, Anne had already died, however, Bill was still alive. Bill was taken to hospital accompanied by Police and subsequently arrested for murder.

13.3 Anne's cause of death has not been officially recorded, and no inquest had taken place at the time of writing this report.

13.4 Bill and Anne lived alone in their flat. They also owned the flat upstairs, which was privately rented. It is understood that the upper flat was previously rented to Anne's daughter, Ms. X until 2018.

13.5 Following criminal proceedings in December 2023, Bill entered a plea of diminished responsibility and was convicted of manslaughter and sentenced to 2 years in prison, suspended for 2 years.

14 Chronology

14.1 This was Anne's second marriage as it is understood her first marriage ended in divorce in the 1950's/1960's. Anne had been a teacher of primary age children for many years, until she left the profession to run several businesses with Bill, who had by then retired from the Merchant Navy.

14.1.1 Anne is understood to have been sociable, whereas Bill was not as outgoing and did not encourage visitors to their home. The couple appeared to have been fairly healthy with no evidence of serious health conditions until their later years.

2015

14.2 During **June and July 2015**, a referral was accepted and assessed by Avon and Wiltshire Mental Health Partnership NHS Trust North Somerset Memory Service (AWP NSMS) for Anne. The assessments noted that there had been a "decline over the previous 6 months in Anne's cognition and mental state". The notes state that there was "moderate stage vascular dementia with possible Alzheimer's and paranoid delusional beliefs that were causing distress... that may well be recalling her previous abusive marriage" was also recorded. Additionally, records showed that Anne referred to "two Bill's"; a good and a bad version, which caused her confusion. *(AWP IMR)*

14.3 Between **August** and **December 2015**, AWP NSMS had 7 contacts with Bill, with the purpose of reviewing the care plan. In August 2015, a care assessment was requested

[1] Authors were unable to establish the precise length of the marriage

with the AWP Mental Health Team (AWP MHT). Additionally, Bill said he'd contact the Alzheimer's Society to enable Anne to complete some activities outside the home. *(AWP IMR)*

14.4 In December, Bill ceased the START reablement service for Anne on her behalf. *(Adult Social Care IMR)*

2016

14.5 **On January 21st,** AWP NSMS recorded that Bill had contacted them to report that Anne was in hospital following a fall. No other information was available regarding this. *AWP IMR)*

14.6 On **3rd March**, AWP NSMS wrote to Anne's GP to state she was to start an antidepressant (Sertraline), and she was to be referred to a couple of specialist services (complex intervention and treatment team (CIT) and the local older person's specialist service), and that they would review in 2 month's time. Also on this date, AWP NSMS wrote to the older person's specialist medic for additional advice regarding Anne's mobility. *(AWP IMR)*

14.7 Between **15th March** and **8th September 2016** there was a referral accepted by the CIT and a subsequent 3 assessment visits, 2 occupational therapy reviews and 3 physiotherapy home visits made (*AWP IMR).*

14.8 On **19th September** the GP records stated that AWP NSMS were involved in the care, and note that the GP was taking over prescribing the recommended treatment from AWP NSMS with input from Bill. *(BNSSG NHS ICB IMR)*

14.9 In **November (1st, 7th and 11th)** Anne's care plan and medication was reviewed, and GP was informed of outcome in writing. (*AWP IMR).*

2017

14.10 On **17th March 2017** the doctor from the memory clinic service visited Bill and Anne's home. Bill informed the doctor that Anne was verbally irritable with him, and that she had a series of health issues, including urinary tract infections and osteoarthritis. The doctor recommended further follow up blood tests at the annual review in September 2017, together with prescription of antibiotics to help with her repeated urinary tract infections. The diagnosis was that Anne had probable vascular dementia in the mild to moderate stage. (*AWP IMR).*

14.11 Bill contacted the AWP memory service on **25th April 2017** to ask when the doctor would be visiting again, as he felt Anne's health had deteriorated since the March 17th visit. He was informed that the doctor had recommended there would be no further review until the September annual review. (*AWP IMR).*

14.12 On **17th May,** the AWP CIT medic agreed to a 6-week review. (*AWP IMR).*

14.13 There followed on **28th July**, a home visit by the CIT medic, reviewing the care plan and medication. The medication was agreed to remain the same, and Bill stated he received good carers support. Anne was encouraged to participate in brain stimulating tasks, and it was noted she enjoyed nature and educational television programmes and gardening. The medic agreed to seek physiotherapy advice for Anne's mobility and that there should be a 6-week review. AWP records stated that the

GP was sent a copy of a summary of this visit and outcome on 8th August. (*AWP IMR).*

14.14 On **1st September**, Anne was admitted to her local hospital due to a fall where she sustained a fractured arm. Anne's daughter telephoned the hospital and stated she did not have the best relationship with Anne nor Bill. *(UHBW IMR)*

Whilst this is a statement from the chronology, through this investigation of events, Anne's daughter has stated that this is factually incorrect.

14.15 On **7th September**, a hospital discharge assessment was requested, and this was repeated on **4th October**, when it was recorded that care would be provided as part of reablement, and then longer-term package, with 3 times a week shower assistance. *(UHBW IMR).*

14.16 On **30th October,** the GP recorded an orthopedic review of Anne with a note regarding the role of Bill. (*BNSSG NHS ICB IMR)*

14.17 **21st December,** the AWP CIT medic phoned Bill who stated that Anne was feeling down, so needed a review in the new year. The medic noted a review was planned for February, and Bill stated this was acceptable. (*AWP IMR).*

2018

14.18 On **9th February** a Triangle of Care dementia review was carried out by AWP, with Bill present. (*AWP IMR).* Later, on **21st February a safeguarding enquiry took place following concerns** raised by Alliance Living Care after Anne disclosed that Bill was beating her". A safeguarding review took place which had an "inconclusive outcome". *Adult Social Care IMR)*

14.19 On **3rd March,** Anne was admitted to the University Hospitals NHS Foundation Trust Bristol and Weston (UHBW) Bristol Royal Infirmary Hospital following a fall and delirium and repatriated to her local hospital at Weston General Hospital. Staff at Bristol Hospital made a safeguarding disclosure to North Somerset Council Adult Social Care, following Ms. X reporting to staff that Bill was verbally and physically abusive towards her mother Anne. (*UHBW IMR)*

14.20 A telephone referral was made to the UHBW Weston General Hospital safeguarding lead, but informed that Bristol Hospital had already made a safeguarding referral to Adult Social Care. It is recorded that the lead tried to discuss it with Anne but was unable to understand anything she was trying to say. The safeguarding enquiry took place immediately, and found the allegations "unsubstantiated" as believed that Anne was referring back to her first husband. *(UHBW IMR)*

14.21 On **14th March** the social worker advised that they would like Anne to be placed in a reablement bed due to the safeguarding concerns. It is noted that Bill was unhappy with this and wanted Anne home with an appropriate care package in place. *(UHBW IMR)*

14.22 A few days later on **19th March** a conversation was recorded by the physiotherapist working with Anne, where she disclosed her husband "liked to drink", shouted at her violently when he drinks; pointed to her chest and said that her husband hit her there

and disclosed she was scared. She went on to say that the violence had been going on for years, but she didn't want to leave her husband. She said that her family knew about the drinking, and she'd like to move into residential care. *(UHBW IMR)*

14.23 The following day, **20th March**, the physiotherapist telephoned the social worker outlining these concerns, which were shared with the safeguarding lead. This lead sought the advice of a domestic abuse worker (the panel were unable to determine any more details of this role). A 'best interest' meeting was scheduled for 26th March, with Bill invited to attend. (*AWP IMR)*

14.24 On **22nd March** the Weston Hospital received confirmation from AWP MS that Anne was in receipt of their services, and she lacked capacity, and that an Independent Mental Capacity Advocate (IMCA) was in place due to the allegations against her husband. *(UHBW IMR)*

The same day the WGH requested a hospital discharge assessment, with the outcome being that her care is increased.

14.25 On **26th March** the multi-disciplinary best interest meeting took place, with Bill in attendance, where it was explained that Anne's allegations of drinking and domestic abuse were in reference to Anne's first marriage. The IMR records noted that Anne was pleased to see" Bill and "held his hand throughout". However, Anne was "unable to meaningfully contribute" to the meeting. The outcome was that the social worker stated that she'd known Bill and Anne for some time, and knows these previous unproven allegations, and so the outcome was that the case was closed to WGH safeguarding team, and the plan was that Anne be discharged home on **3rd April.** *UHBW IMR)*

14.26 On **25th May** Bill requests a medication review as Anne has had several falls.

14.27 On **31st May** a Triangle of Care review took place with Bill and a revised treatment plan put in place. On the same day the GP records show that 'unusually' the memory clinic retains Anne on their caseload due to the need for support to Bill as carer. (*AWP IMR)*

14.28 On **24th August** Adult Social Care records that the social worker completed an assessment for increased care for Anne as Bill was having an operation. Bill states that Anne is becoming 'hard work' and is aggressive. The next day Anne is moved to respite care. *(Adult Social Care IMR)*

14.29 On **1st September** the GP records that Anne has had a fall (in the care home) resulting in a hip fracture. *(BNSSG IMR)*

14.30 Between **14th November** and **19th December**, Bill is recorded as having recurring medical interventions for cancer. *(BNSSG IMR)*

14.31 On **4th December** Bill contacted AWP advising he has now returned home from hospital and would like Anne's medication review to be brought forward, as felt she had deteriorated following being in respite. AWP agreed to send an appointment out for new year. (*AWP IMR)*

2019

14.32 On **28th April, Anne** was admitted to Weston General Hospital following a fall and then discharged the next day. *(UHBW IMR)*

14.33 Between **28th June** and **October** Alliance Living Care (ALC) and WGH note concerns relating to Anne's care and Bill being unwell. However, these were resolved with occupational therapy input and provision of advice to Bill regarding bed transfer and mobility within the home. *(Adult Social Care IMR)*

14.34 A Triangle of Care meeting was held on **19th December** (with Bill present)**,** the outcome was not recorded. *(AWP IMR)*

2020

14.35 On 28th January, ALC report multiple concerns regarding Bill's care of Anne, and raised a safeguarding concern. The carers also recorded difficulties with caring for Anne as Bill was hindering their efforts and putting Anne at risk of injury. It's recorded that there was a discussion that there was not much Occupational Therapists (OT) could do as the issues were already addressed during previous assessment and recommendations were not being followed, however, OT would raise a safeguarding concern based on the new information provided. *(Adult Social Care IMR)*

14.36 Subsequent to the above entry, the OT raised safeguarding concerns on **6th and 12th February**. Following an enquiry including a home visit they were deemed partially substantiated. (*Adult Social Care IMR)*

14.37 On **21st March**, Anne was taken to WGH for assessment due to her having a head injury following a fall. (*SWAST NHSFT IMR)*

14.38 On **23rd March** an emergency call made to Southwest Ambulance Service by Bill due to Anne having a loss of consciousness. Anne was admitted to WGH and discharged on **27th March**. (*SWAST NHSFT and BNSSG IMRs)*

14.39 On **15th May** a safeguarding report is made by ALC that Bill was seen 'smacking Anne's rear' in an effort to obtain a urine sample. The safeguarding enquiry concluded that Anne was not at risk, and Bill was providing a good level of care, but advised him to treat Anne with increased dignity and consider his actions before he acts. (*Adult Social Care IMR)*

14.40 On **11th June** ALC reported that Bill was interfering with the care being provided, and smacked the carer's hand away. The carers said they didn't feel Bill was being malicious but was "treating Anne like a child". (*Adult Social Care IMR)*

14.41 **On 20th July**, ALC reported that Bill continued not to use good manual handling procedures despite being advised of how to help Anne. (*Adult Social Care IMR)*

14.42 On **5th August** the occupational therapist asked for a review of Anne's care. The social worker stated the level of care was right, but Bill's approach was the issue and suggested and they had to prevent him getting involved. A safeguarding enquiry took place that day which found that additional equipment was required (e.g. hoist) to reduce the need for Bill to overly handle Anne. (*Adult Social Care IMR)*

14.43 On **8th October**, ALC made safeguarding alert regarding Bill's care of Anne, and his refusal to listen to their professional advice. Adult Social Care concluded Bill's

approach was unsafe and he'd agree to the occupational therapist professional advice from now on. (*Adult Social Care IMR)*

14.44 On **23rd October,** the GP calls the ambulance service due to Anne having abnormal blood results and deteriorating kidney function. She was taken to WGH for further care. It was noted she was dependent on care for her daily needs. (*UHBW IMR)*

2021

14.45 In **January** another safeguarding enquiry took place, as a result of Bill not taking action as previously agreed, (e.g. making Anne walk when she shouldn't have been) so care was needing to be doubled up. It's noted that Bill is extremely caring and trying to ensure Anne is comfortable. (*Adult Social Care IMR)*

14.46 On **1st February** the occupational therapist responded to a safeguarding concern raised by the ALC carer, due to Bill making Anne Walk when she shouldn't. A joint visit took place with Occupational Therapist and Social Worker and manual handling advice given to Bill. (*Adult Social Care IMR)*

14.47 On **18th April,** the ALC carer attended Anne and found her strapped to her chair. A safeguarding enquiry took place on **20th April**, which concluded that Bill "had no malice" but "was just trying to manage" as he said that he was 'trying to keep her safe'. The outcome of this enquiry being that the carer should stay longer in the afternoon for an extra 30 minutes whilst he was cooking. (*Adult Social Care IMR)*

14.48 On **1st October** A Triangle of Care 'best interest' meeting took place with Bill present. The outcome of this is unknown. *(AWP IMR)*

14.49 On **19th October,** Anne attended the Emergency Department and admitted to the hospital following a choking episode. *(UHBW IMR)*

14.50 On **6th December** a Triangle of Care 'best interest' meeting took place with Bill present. The outcome of this is unknown. *(AWP IMR)*

2022

14.51 During February there were 5 contacts by Bill to the GP requesting treatment advice for Anne regarding minor ailments and support to get a new hearing aid, as Specsavers stated they need a referral from Anne's GP. Subsequently the GP practice secretary made a referral to Specsavers *(BNSSG ICB IMR)*

14.52 On **2nd March,** Bill calls the doctor as he had still not been able to make any progress with organising a home visit by Specsavers for Anne to get a hearing aid assessment, as Specsavers had said they need a referral stating, 'home visit only'. It was recorded that Bill was becoming upset and also that Anne got distressed and he had to shout at her because she cannot hear, and every day was getting increasingly hard. The GP agreed to progress with the secretaries in the practice. *(BNSSG ICB IMR)*

14.53 On **22nd March**, a district nurse from Sirona Healthcare visited Anne at home to take a blood test in response to a recent test request however, "Bill declined as he did not think it was necessary". *(BNSSG ICB IMR)*

14.54 On **17th May**, a safeguarding concern was reported by Access Your Care following Bill declining support in helping care for Anne. *(Adult Social Care IMR).* Also, on this day the

GP spoke to Bill about Anne's health and care, following concerns from carers that Anne had an infection. (*BNSSG ICB IMR*)

14.55 A safeguarding concern was repeated on **18th May.** It is reported that Bill appears physically frailer and that he has employed a private carer twice a day. He is not accepting Anne's deterioration and insists she can still manage some tasks independently. *(Adult Social Care IMR)*

14.56 On **7th June**, a 999 call for an ambulance was made by Bill due to Anne having breathing difficulties. Bill is recorded as not wanting Anne to attend hospital, and that there was no 'respect form' in place to outline an agreed plan for Anne in the event of a medical emergency. It should be noted that at this point, Anne did not have capacity, so it would have been created with Bill. It was also recorded that the ambulance crew noted Anne was nearing end of life and was in state of unconsciousness. SWASTNHSFT made a referral to the GP for a 'respect form.' The ambulance crew followed Bill's wishes and did not take Anne to hospital. *(SWAST NHSFT IMR)*

14.57 The next day **(8th June**) the GP spoke to the carers and Bill, noting that Anne probably had a brain stem TIA. She was on optimum therapy for this, so no more could be done. The GP explained to the carers and Bill that Anne was at risk of further Transient Ischemic Attack (TIA's) or cerebral vascular accident (CVA). *(BNSSG ICB IMR)*

14.58 **10th June** – GP spoke to Bill, who said that carers were reluctant to move Anne into her chair due to her poor health. The GP also spoke to the care supervisor, who mentioned concern about the chair Anne sits in and that sometimes Bill has to secure Anne to her chair with a belt, to prevent her from slipping. GP asks for an OT assessment. *(BNSSG ICB IMR)*

14.59 During **the first week of July,** a 999 call was made for an ambulance by Bill due to Anne having breathing difficulties. Bill is recorded as not wanting Anne to attend hospital. The ambulance crew noted Anne was nearing end of life and was in state of unconsciousness. SWASTNHSFT noted that the GP had not yet completed the 'respect form' and end of life plan was not in place. The ambulance crew followed Bill's wishes and did not take Anne to hospital as the emergency department would not be suitable for her, as she was in a 'deep sleep'. *(SWAST NHSFT IMR)*

14.60 During the attendance by the ambulance crew, the student paramedic telephoned the practice and spoke to the GP, to state that Anne had been completely unresponsive however, was now responsive to voice and had drunk but was still unwell. It was noted there was no ReSPECT form in place, and the GP arranged to consider a home visit and completion of the ReSPECT form.

14.61 Subsequently the GP spoke to Bill about the ambulance visit the previous day. Bill was clear that he wanted Anne to be resuscitated even if admitted to hospital for her survival and care and therefore refused to sign a ReSPECT form. *(BNSSG ICB IMR)*

14.62 On the **morning of 24th July**, a 999 call was made by Bill for an ambulance due to Anne having breathing difficulties. Bill is recorded as not wanting Anne to attend hospital but does want her resuscitated if required. It was noted that the ReSPECT form was not yet in place to outline her wishes. It was also recorded that the ambulance crew noted Anne was nearing the end of life and was in a state of unconsciousness.

The ambulance crew discussed the futility of Anne's situation and that Bill was not coping with the deterioration in his wife's condition. The ambulance crew also spoke to the out-of-hours GP, who stated their GP should be more supportive. This was due to Bill's physical health, denial of her condition and poor state of the property. Bill is reported as stating he'd like to have more support from the GP in the form of a ReSPECT form and end-of-life care. A safeguarding referral was made to ASC. *(SWAST NHSFT IMR).* The GP notes that the ambulance crew also raised a safeguarding concern around carers not completing CPR as directed by control room staff. (*BNSSG ICB IMR)*

14.63 On the **afternoon of 24th July**, another 999 call was made by Bill due to Anne being unrousable. The crew again discussed Anne's health with Bill. (*SWAST NHSFT IMR)*

14.64 As a response to the two ambulance visits, the next day (25th July), the GP spoke to Bill, who advised he did not want Anne admitted to hospital as she is probably getting TIA and treatment for that was already optimised. (*BNSSG ICB IMR)*

14.65 On **26th July**, in response to a recent SWAST NHSFT report, a member of staff at the GP surgery spoke to Bill who had disclosed concerns about finances. Bill agreed to the social prescribing service and a referral was made. Bill is also reported as realising that CPR would not be the best option for her, but he stated he wanted Anne to be kept comfortable and pain free. The ReSPECT form paperwork was sent out the following day to Bill. *(BNSSG ICB IMR)*

14.66 On **27th July,** a 999 call was made by Bill requesting an ambulance due to Anne choking. The ambulance crew observed her eating and noted that Bill had stopped her Memantine medication. It was noted no respect form was yet in place. *SWAST NHSFT IMR)*

14.67 On **28th July**, ASC completed carers assessment review. No formal assessment completed, noted that Bill is happy with self-funded care package, and Bill said Anne would find respite difficult as didn't like it previously. (*Adult Social Care IMR)*

14.68 On 2nd August the GP made a home visit to Bill and discussed Anne's prognosis. It was agreed there would be no benefit of hospital admission, that CPR would be inappropriate and potentially harmful, and a ReSPECT form was completed. *(BNSSG ICB IMR)*

14.69 On **1st September**, an ambulance was called to the home by Bill, following Anne choking and the crew advised Bill that she should sit upright. A referral was made to the GP for support, including home visit. (*SWAST NHSFT IMR)*

14.70 On **5th September,** the Community Connect Wellbeing Worker visited Bill as a result of the ASC care review on 28th July. They had no concerns but did make a referral for a home safety check by the local Fire and Rescue Service. *(Curo IMR)*

14.71 The Wellbeing Worker confirmed the outcome of this visit with Bill on **20th September,** including that they'd made a referral to Occupational Therapy. *(Curo IMR)*

14.72 On **21st September,** ASC received the Occupational Therapy referral and progressed.

14.73 On **28th September**, Community Connect made a telephone call to Bill to confirm what had happened and Bill confirmed that the occupational therapy referral was in progress.

Community Connect closed the case. *(Curo IMR)* Also on this date, a palliative care meeting was held regarding Anne. *(BNSSG ICB IMR)*

14.74 On **5th November,** an ambulance was called to the home by Bill, following Anne choking and they treated at scene and remained at home. A referral was made to the GP for support, including home visit. *(SWASTNHSFT IMR)*

2023

14.76 Between **1st and 4th January**, Bill made contact once with an out of hours service for medication, and also spoke to a GP regarding Anne's health and medication. *(BNSSG ICB IMR)*

14.77 **On 5th January**, the GP conducted a home visit where the GP records that he had a conversation with Bill who he found "*a total delight - apart from talking fondly about his wife and their 62-year marriage and her current situation; we talked about his career of captaining his cargo vessels around the world. He is as sharp as a pin and is surrounded by all his computers, scanners and printers. An inspiration*." The GP suggests that Anne is entering a terminal phase of life at this time, and it's a struggle to encourage her to eat or drink. *(BNSSG ICB IMR)*

14.78 On 20th January, the GP spoke with Bill who advised it was increasingly difficult to get Anne to eat or drink, and the GP explained that this is due to her dementia but encouraged Bill to "get at least 1000mls of fluids into her every day". *(BNSSG ICB IMR)*

14.79 Later in January the Police forced entry to the property as a result of concern over Bill and Anne's safety. The couple were found with bags over their heads. Anne was sadly found deceased, and Bill was found alive. Bill, according to the Police initial statements, suggested that he had killed Anne and attempted to take his own life, so they would both die at the same time. *(Police IMR)*

15 Summary of Information about Anne from her family

15.1.1 The following summary is based on Ms. X's recollection of her mother and Bill, as individuals, and as a couple.

15.1.2 Her mother had creative interests, and loved crafts, decoupage, and liked making butterflies, she even sold some of her arts and crafts at small fairs, she also enjoyed writing short stories.

15.1.3 Anne had told her that "at least he was not like her first husband who used to physically assault her". But Ms. X suggests that Bill was abusive in every other way. She felt Anne was from a generation where domestic abuse was only acknowledged if it was physically abusive.

15.1.4 Ms X recalls Anne wanting to leave Bill many times, which probably started around 30 years ago when Anne was about 60 years old. Anne mistakenly believed that she didn't have enough money or resources to start again.

15.1.5 Anne had been a primary school teacher, and Bill persuaded Anne to give up teaching so she'd run businesses with him. Anne used to make excuses for Bill stating that when he left the merchant navy (as he had been a captain), it impacted negatively upon his behaviour. And that he been used to 'bossing people around'.

15.1.6 Ms X lived in a convent and with an aunt for a few years when Anne left her first husband. When Ms. X returned, she was taken to a weekly boarding school. Ms. X reported that she did not think Bill liked her, he could be mean towards her. When Ms. X did live with them, she was aware of lots of arguments between Anne and Bill. Ms. X recalls that whilst she witnessed no physical violence in the home, there were constant arguments, with her often going to sleep at night listening to shouting, then and waking up to shouting again in the morning.

15.1.7 She recalls her mother saying that Bill was not as bad as her previous husband because he hadn't physically harmed her. Anne was Irish and her mother died when she was aged 9 and Ms. X feels Anne wanted a stable home and Bill provided this for her.

15.1.8 It is recalled that Bill was money focused, and he was in control of all the finances. He felt that he owned everything, and any money was all of his.

15.1.9 Ms X reflected that at the time when growing up as a child in the house, she now realised how disempowered Anne was. This was their 'normal'.

15.1.10 Ms. X feels that when Bill was in control of everything it was all ok, but otherwise there were arguments. Anne was feisty and did try to stand up for herself, but this was only using her words. She never took action.

Ms. X also feels Anne lacked confidence in the idea of living by herself, and also despite any challenges in her relationship with Bill, Anne knew what to expect, so was 'comfortable' in that respect.

15.1.11 Ms. X was aware that many agencies used to visit Anne in her later years, so felt she was well supported, these included the Alzheimer's Society, psychiatrist, befriending, carers and volunteers.

15.1.12 When Ms. X and her son/grandchild visited Anne, Bill wouldn't leave them to spend time in a room alone.

15.1.13 Ms. X said Bill used to act differently when visitors were around. He used to isolate Anne from friends/ family. He didn't like people coming to the house; he felt that they were intruding.

Ms. X considers that he had a personality issue. He wasn't sociable, didn't have friends. Bill made it awkward for Anne to have a social life. Although Anne is believed to have been a sociable person who enjoyed making friends, those friendships didn't last due to Bill.

15.1.14 A social worker telephoned Ms. X out of the blue in 2018, and suggested Ms. X should come to visit Anne. Ms. X explained that Bill had been abusive to her, and she had had to leave due to his aggressive behaviour. She asked the social worker not to tell Bill they had had a conversation. However, the social worker did in fact contact Bill and told him about the conversation.

Bill then phoned Ms. X very angry. The social workers' behaviour created a big rift. Prior to that Ms. X had been trying to maintain a good relationship with Bill so that she could get information about her mother

15.1.15 Ms. X feels that if Anne had seen any advertising regarding domestic abuse, it would more than likely have had to be a TV advert. However, she may not have taken any action depending on messaging, as for Anne domestic abuse wouldn't have existed – however, "difficult relationship" would have been more relevant.

15.2 Summary of Information Known to the Agencies

15.2.1 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. This is summarised below by each agency.

15.2.2 **Adult Social Care**

North Somerset Council Adult Social Services received 40 referrals for Anne and 3 referrals for Bill between January 2015 and January 2023. These referrals were from a variety of sources including, hospital discharge, ambulance service, GP, care providers and Bill himself on 3 occasions.

The referrals for Anne comprised:

- Nine requests for care needs assessment
- Thirteen requests for occupational therapy assessment
- Seventeen safeguarding adults concerns
- One welfare concern

The 17 safeguarding concerns after removing duplicates (Where the same concern is raised from by than one source) included:

- 8 related to concerns around Bill's behaviour toward Anne within the context of his caring role
- 3 related to overt domestic abuse allegations.
- 5 were unrelated to the DHR or inappropriately raised as safeguarding concerns

The three referrals relating to Bill were all requests for carers assessments – two in May 2017 and one in July 2022. There was no evidence to suggest that Bill was considered either as a risk to Anne or to himself.

The three allegations regarding domestic abuse were received closely together in 2018 without further repetition. These were followed by safeguarding procedures, concluding that the statutory criteria were met, and a duty to enquire applied. The enquiry

concluded that it was 'more than likely' referring back to a previously abusive marriage. This is explored further in 16.2.

It was clear that a social worker involved in this case was fairly new and did not have experience of dealing with complex cases, including domestic abuse.

Data recording was an issue, as although abusive behaviours were recognised, they were seen as component parts of abuse, and not as domestic abuse. Therefore, they were not recorded as domestic abuse on case management systems. These points are incorporated into recommendations within section 19.

15.2.3 **Avon and Somerset Police**

Aside from contact on the day of Anne's death, Avon and Somerset Police had records of two contacts in 2019 relating to Bill. Neither of these were domestic abuse related. These were regarding Bill's role as landlord to the tenant of the flat that he owned, one regarding his entering the flat without permission (he left as soon as he realised someone was there) and the second regarding asking the tenant to pay rent in an allegedly abusive manner. In both instances, the Police spoke to Bill and took no further action, which was appropriate.

15.2.4 **Avon and Wiltshire Mental Health Partnership (AWP)**

Between June 2015 and December 2021, AWP had contact with Anne and Bill on 39 occasions; three which contained information that potentially or directly related to domestic abuse concerns. During the majority of contacts, AWP records stated that Bill presented as a caring and supportive husband to Anne and he was well engaged with services in promoting Anne to receive the required care.

As noted in 14.2, Anne described relationship difficulties with Bill, however, these were assessed as her experiencing paranoid delusional beliefs, which were causing distress for both Anne and Bill. It was considered Anne might well have been recalling her previous abusive marriage. A learning point was identified within the AWP IMR that its internal teams didn't communicate effectively, with the memory team not being contacted by the mental health liaison service to be informed of the safeguarding concern in March 2018. Nor was there further information provided following the safeguarding meeting held at Weston General Hospital. However, it's now understood that UHBW now has a dedicated domestic abuse advisor who can accept referrals from either the WGH staff or the mental health liaison service.

15.2.5 **Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)**

A chronology was provided for the period January 2022 to January 2023, comprising of 54 contacts. This does not cover the scope of the review, and so no GP contact prior to this has been analysed. There were highlighted concerns regarding Anne's safety at home, declining health and Bill perhaps showing signs of stress in his role as carer.

It's of note that the vast majority of contacts were with the same two GPs. The support provided by the GP's was largely around ensuring Anne had the appropriate medication and treatment so she could remain at home, which was deemed to be the most suitable option for her care.

The GPs did not identify any concerns requiring any onward safeguarding referrals. In the weeks immediately preceding Anne's death a GP (believed to be a locum) undertook a home visit and commented on him being "*a lovely husband*" and that "*we talked about his career of captaining his cargo vessels around the world. He is as sharp as a pin and is surrounded by all his computers, scanners and printers. An inspiration"*.

There was no reference to any possibility of domestic abuse or relationship difficulties arising from Bill's caring role and Anne's declining health. Nor was there reference to any indication of an increase in Bill's stress levels due to his caring responsibilities.

15.2.6 **Citizens Advice North Somerset (CANS)**

This charity offers a range of free-to-access services, including Social Prescribing. Social Prescribing connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.

CANS had 3 generalist advice enquiries in 2019 and 2020 and two referrals into their Social Prescribing Service from the Medical Centre and GP. The decision was made on both occasions not to visit the client at home, but instead to refer the client to the Alzheimer's Society for a home visit and to Community Connect (Curo) for support with an Attendance Allowance claim.

CANS Advice Services do provide welfare rights advice, form filling and appeals, but does not provide a home visiting service. The Social Prescribing Team work closely with both Community Connect and with the Alzheimer's Society and will make sure clients are referred in a supportive way.

There were no concerns raised regarding domestic abuse within these contacts.

15.2.7 **Care Agencies and Private Carer(s)**

Anne had both North Somerset Council funded domiciliary care and a privately funded care package to support her. The review panel received clarification that 'Alliance Living Care' were the original North Somerset Council funded care provider, but in 2022 this changed to a different supplier 'Access Your Care'. The transfer of contracted provider did not appear to make a difference to the care that Anne received, and this provider continued to raise safeguarding concerns to Adult Social Care if required.

The DHR chairs were unable to establish contact details for the private carer, so any information they may hold has not been included in this review.

15.2.8 **Curo**

Curo are the lead agency delivering Community Connect, a 'social prescribing' support service in North Somerset, offering low to medium support in communities to help people

remain independent in their homes for as long as possible. There were no risk factors relating to domestic abuse made within the referral from the Carers Service, and when triaged within Community Connect the case was deemed as a low support need, for assistance with completing an application for Attendance Allowance for Bill.

Of the 6 engagements, with Bill, 5 were completed over the phone with Bill as the claimant, and where there was no need to speak with Anne. There was one home visit, where Anne was not present. There were no suspicious circumstances identified, and as the referral was made on behalf of Bill there would be no necessity to see any other parties.

15.2.9 **Southwestern Ambulance Service NHS Foundation Trust**

The ambulance service had contact with Anne and Bill on 16 occasions between March 2020 and January 2023. None of these contacts were recorded as being domestic abuse related. Two of these related to the final incident when Anne was deceased.

Two incidents were solely related to Bill and his own health concerns. The remaining contacts varied from Anne having falls and (separately) periods of unconsciousness, these were attributed to Anne's dementia. SWASTNHSFT made referrals to the GP on 5 occasions.

The IMR noted safeguarding referrals for each visit, were not always made when the ambulance service attended more than once on the same day.

Due to the reactive nature of the ambulance service and varied clinicians seeing them it was difficult to ascertain the couple's care and support needs from each individual contact. The IMR noted that ambulance crews should use professional curiosity to identify any care and support needs that are not being met.

16 Analysis

16.1 The DHR panel agreed to the terms of reference and the KLOE for the review, which are analysed within this section.

KLE 1. **Identify and examine patterns of domestic abuse in all its forms, including any coercive and controlling behaviours experienced by Anne**

16.2.1 Allegations of Anne experiencing both physical and non-physical forms of domestic abuse were disclosed or reported, with Bill being the alleged perpetrator. These were raised as safeguarding concerns to Adult Social Care by carers and UHBW.

16.2.2 Disclosures to the OT and physiotherapist in WGH, resulted in attempts to explore the allegations of domestic abuse and seek advice from a domestic abuse expert. However, the social worker advised safeguarding staff at the hospital that domestic abuse was not a concern, and this action did not progress.

16.2.3 Shortly after, it is shown that in a multi-disciplinary meeting in 2018, when the social worker considered that allegations made against Bill, she stated that she had known the couple for a long time and felt that Anne was regressing to memories of a previous husband. It is also noted that despite the meeting being held to consider the alleged domestic abuse, Bill was not only invited to the meeting but was asked to give a rationale to the allegations. This is contrary to best practice standards of safe enquiry around domestic abuse [x].

16.2.4 At the same multi-disciplinary meeting in 2018, Anne was noted by Western General Hospital as "...very pleased to see (Bill) throughout". The DHR panel noted that it is not unusual for domestic abuse victims experiencing controlling behaviour to appear outwardly happy and does not prove that Anne was not experiencing domestic abuse.[xi]

16.2.5 In 2018, Anne was formally deemed to lack capacity to make decisions around her safeguarding arrangements and an IMCA was provided following the domestic abuse allegations. However, the IMCA only appears to have been provided once to support decision making. Given Anne being diagnosed with Alzheimer's, professionals were reliant on Bill providing information to them, and whether overtly or subconsciously, Anne's validity as a true victim was reduced. Age UK report[xii] that older victims of domestic abuse face significant barriers which can be severe when experiencing long term health impacts or disabilities.

16.2.6 DHR authors have reflected that the events played out here is one of the many examples throughout the chronology of "the role of optimism". This is where professionals may not recognise the risk of abuse due to their confidence in the carer, particularly when this is a family member, to care in a safe and effective manner. This concept is a key factor when working with people who experience domestic abuse who also have care and support needs, according to the LGA and ADASS in their 2015 guide to safeguarding adults with domestic abuse.[xiii]

16.2.7 In addition, there was no specialist domestic abuse support available when Anne received support from WGH. The DHR panel, at the time of writing this report have been informed that UHBW now have Independent Domestic Violence Advisor's (IDVA)s in all 3 of their Emergency Departments (WGH, Bristol Royal Infirmary and Bristol Royal Hospital for Children). If the IDVA identifies that they are unable to complete an assessment and suspect that a patient may be lacking mental capacity (i.e. Dementia etc) they contact the UHBW safeguarding team who advise and gain support. Complete a mental capacity assessment if appropriate and make a domestic abuse service referral.

16.2.8 Domiciliary carers witnessed Bill restraining Anne to a chair with a belt. Whilst this could be evidence of coercive and controlling behaviour, as well as physical abuse, professionals involved with the couple at the time considered that this behavior, whilst inappropriate, was considered to contain "no malice'' (14.47 - ASC chronology entry 18th

April 2021) , and was carried out to prevent Anne from personal injury in the home at a time when she had poor mobility. However, the IMRs indicated that this was not a one-off event.

16.2.9 The DHR chairs suggest that this review indicates more work is required to increase understanding by social workers and other professionals to identify domestic abuse in the older populations, especially when there are other health conditions.

16.2.10 The DHR chairs' view is that there were clearly some incidences when agencies were aware of indicators of domestic abuse, but they were only specifically labelled as such on a handful of occasions. Any allegations were either dismissed as related to Anne's first husband or as a result of Bill's good intentions in keeping his wife safe from harm. No Domestic Abuse Risk Indicator Checklist appears to ever have been completed or considered, so no referral was ever made to a specialist domestic abuse service for support. Any support was centered around Anne's or Bill's health needs.

16.2.11 Analysis contained within the Adults Social Care IMR included comments from practitioners which demonstrate that domestic abuse awareness has changed over the years - "*Knowing what I know now, I would immediately try to involve an IDVA. I was newly qualified – my first year and experience in Domestic abuse work was minimal… DASH/MARAC/IDVA/Next link is much more part of our language now.*" Whilst part of the definition of abuse in the Care Act, domestic abuse may not be included sufficiently in the social worker qualification curriculum or induction to explore the indicators and dynamics.

16.2.12 As noted in 11.9.3, domestic abuse can impact someone's life course. Regardless of when Anne experienced domestic abuse, she disclosed it and was never assessed regarding its impact and not enabled to access specialist support. She may have been experiencing long lasting trauma. Her age, disability and marriage became factors in professionals not taking action here.

16.2.13 Anne's daughter disclosed during this review, that she witnessed behaviours and incidents between Anne and Bill that at the time 'were normal' and tolerated but in hindsight, were clear exhibits of coercive control and economic abuse.

16.2.14 Information provided to this DHR by Ms. X suggests Anne felt ashamed of having been divorced prior to her marriage to Bill. This notion of shame from divorce, keeping Catholic women in marriages where gender based violence is occurring, is supported by research undertaken by Simister and Kowalewska (2016)[xiv] who found that Catholic women are more at risk of being in abusive marriages because they are less likely to divorce following the ban on divorce by the catholic church.

16.2.15 In July 2022, SWAST case files state that Bill had independently decided to cease the administration of Anne's medication for her Alzheimer's without GP approval. In addition, despite regular 999 ambulance call outs to Anne due to her ill health, Bill refused to allow Anne to be admitted to hospital. The DHR Panel noted this behaviour, was not considered through the lens of coercive control.

16.2.16 Economic abuse was also a factor, with Ms. X reporting her mother did not feel she had means to access her own money. And this was a factor in preventing her from leaving the relationship.

16.2.17 Ms. X advised the review that behaviours were sometimes subtle but constant. Such as Bill telling Anne where she can put her mug of tea, what chair she was allowed to sit on. Nevertheless, Anne did not see herself as a victim of 'abuse' or 'violence'. Her marriage was stable and a comfort to her, regardless of the behaviours that were normalised in her home.

16.2.18 The 'homicide timeline'[xv] is a research-based framework for tracking the homicide risk in cases of coercive control. As the difficulties within Bill and Anne's relationship were solely identified as being due to caring tensions, the risk of homicide was not identified. If there had been a focus on domestic abuse as being an underlying factor in their relationship, then the risk of homicide may have been identified, as the homicide timeline suggests. It should be noted that there is not a similar timeline and risk of committing homicide for those who are carers (where no domestic abuse exists).

16.3 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.

16.3.1 There is evidence of several agencies having periods of involvement with both Anne and Bill. These were largely due to medical concerns, and Anne's gradual physical decline.

16.3.2 What has been observed throughout the chronology, is that agencies working to support the couple, knew very well of their individual and joint needs, vulnerabilities and limitations and suggested solutions for support. For example, in 2022, the carer reported to adult social care that respite would be useful for both parties in light of their individual physical limitations and Bill's lack of ability to cope with caring duties

16.3.3 Prior to that in 2020, there are examples where professionals in health and social care recognised behaviours in Bill's care that may not have been in Anne's best interests. These were challenged and reviews and actions completed. Whilst this is recognised as good practice, there was missed opportunities to consider these behaviours through a domestic abuse lens.

16.3.4 However, what prevailed was support being offered based on Bill's wishes, meaning that Bill continued to care at home for Anne despite his inability to cope. The DHR panel agreed that there appeared to be a good understanding of safeguarding, with several partner agencies raising appropriate safeguarding concerns in relation to Anne's care. However, this was not through a lens of domestic abuse. In fact, the panel recognised that on the adult social care case management system, although domestic abuse could be recorded as a category of abuse, this was not chosen at the time of recording. – as noted in 15.2.2 above.

16.4 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.

16.4.1 The DHR panel noted that Bill made decisions on behalf of Anne, such as ceasing START reablement service in December 2015, and declining care needs assessments on occasion. The points at which these decisions were made were missed opportunities for professionals to challenge whether they were being made in Anne's best interests. Moreover, in 2015, Anne had not been deemed to lack capacity and should have been able to make decisions for herself. There is no evidence that she was being consulted in relation to these decisions, nor encouraged and supported to make these decisions herself. The Social Care Institute of Excellence has clear guidance[xvi] on the application of the Mental Capacity Act which are not clearly evident in the interactions by professionals with Anne.

16.4.2 In early 2018 Adult Social Care undertook a thorough mental capacity assessment which concluded that Anne lacked mental capacity to make decisions around her safeguarding arrangements and a best interests process followed resulting in the decision to return home from hospital. This included a face-to-face assessment, and an Independent Mental Capacity Advocate supported her through that process, demonstrating good practice.

16.4.3 The IMCA only appears to have been used once to support Anne, and it is not clear whether professionals actively sought to gain Anne's views and wishes in any further safeguarding enquiries. Given Anne was diagnosed with Alzheimer's, professionals were reliant on Bill providing information to them, and whether overtly or subconsciously, Anne's validity as a true victim was reduced. Age UK (2019) report[xvii] that older victims of domestic abuse face significant barriers which can be severe when experiencing long term health impacts or disabilities.

16.4.4 Adult Social Care received multiple safeguarding referrals and completed reviews in a timely manner for each of these. Their IMR suggests that their safeguarding response was in line with both legislation and national guidance. However, through the process of conducting this review, it has been found that this was not always the case with other agencies reflecting on the practice and identifying that the 6 principles of Safeguarding Adults (detailed in Care Act 2014 guidance) were not applied appropriately.

16.4.5 Robbins et al (2016) suggested that there is a disconnect between legislation, policy and practice between approaches for safeguarding adults, specifically in relation to older people, and pathways for identifying and responding to domestic abuse. This challenge results in older people often falling through gaps in provision.

16.4.6 In this case, added complexity was the health pathways but the principles apply, that professionals in this case would have to navigate 3 different systems and apply the most suitable. Whilst it is acknowledged that legislation and policy in these areas have changed since the time of this research, in practice, as this case shows, professionals at times, missed opportunities to safeguard Anne regarding her risk to abuse by not considering her needs in relation to domestic abuse.

16.4.7 A care needs assessment for Anne was not completed because Bill stated that he and his wife were doing well in August 2022. Adult Social Care noted that there was not a sufficient level of concern to warrant challenging whether Bill's decision was in Anne's best interests. The Care Act S.11(1) gives a person the right to refuse an assessment with S.11(2) setting out the exception of unless the adult lacks capacity to refuse or is at risk of or experiencing abuse or neglect.

16.4.8 If this had been challenged, it may have been disproportionate as by this time, Bill had proved able to arrange adequate care independently. This was the last social work/care needs assessment referral received for Anne. Between this and the safeguarding concern raised in September whereby it was alleged that Anne was slipping down and being restrained in the chair seems to be the time when things changed significantly for Anne and Bill and could have been an opportunity to work more closely with multi-agency partners to develop a contingency plan however what is clear it that Bill was not able to accept intensive involvement; once again raising the challenge of working with family carers as alleged perpetrators and the need to balance challenge alongside support.

16.5 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.

16.5.1 Anne had several health issues prior to her death, with Alzheimer's as the primary condition. In analysing agency records, it's clear that the effect of Alzheimer's and any domestic abuse impacts was not always clearly understood.

16.5.2 Case files indicate that Anne did disclose domestic abuse, but this was minimised by professionals who believed it was in reference to a previous marriage. Regardless if the abuse was historic, Anne was recalling and expressing the trauma she had experienced from a domestically abusive relationship. This was dismissed due to Anne 's medical diagnosis, and was a barrier to her receiving specialist support around being a survivor of domestic abuse.

16.5.3 Southwestern Ambulance Service NHS Foundation Trust followed their policies by attending on receipt of 999 calls and making safeguarding referrals as required. The review found that the volume of calls was not sufficient to meet the criteria for any more focused intervention in accordance with their policies.

16.5.4 Research suggests that domestic abuse clearly affects people with dementia.[xviii] However, this may not be overtly specified in agency policies and procedures and how they can respond to people experiencing domestic abuse who have long-term and deteriorating health conditions. The causal link between domestic abuse and long term health conditions such as Alzheimer's is not clearly known.

16.5.5 In 2022, Anne had numerous suspected TIA but Bill refused she be taken into hospital. SWAST NHSFT confirmed that the ambulance team followed all relevant polices in handling these call outs, and did not raise any concern about Bill's decision, so it was clinically justifiable. The GP was then contacted as required who in turn then followed up by speaking to Bill, and agreeing that Anne should not be admitted to hospital.

16.5.6 It is clear from this review that all the disclosures and concerns from practitioners were medicalised. 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.

16.6 KLE 5: Consider Anne's sex, and age as factors throughout the review.

16.6.1 Agency IMRs provided to this review, commented on equality and diversity, however, they did not sufficiently identify how domestic abuse was considered against age, and sex.

16.6.2 Anne's age and the fact she had been married to Bill for over 50 years appears to have minimized the likelihood of domestic abuse, and indeed any harm from it taking place. Agencies did not consider fully the multiplicity of need and impact on their service delivery.

16.6.3 Although as stated in 16.3.4 domestic abuse was not identified as a specific factor. This may have been due to Anne's age. Research by Yechezkel, R and Ayal, L (2013)[xix] states "Social workers tended to define intimate partner abuse against an elderly woman as non-abusive, in contrast to intimate partner abuse against a young woman. The findings show that, in general, social workers preferred to initiate therapeutic intervention rather than legal intervention, particularly in cases of emotional abuse. "

16.6.4 Domestic abuse is a gendered crime and 5.7% of women versus 3.2% of men are estimated to be victims of domestic abuse (ONS 2023)[xx]. Therefore Anne 's sex as a female is directly relevant to the likelihood of her experiencing domestic abuse.

16.6.5 The Vulnerability Knowledge and Practice Programme Domestic Homicide Review Project (2022)[xxi] found that 25% of the domestic homicides between 23 March 2020 and 31 March 2021 were aged 65 years or over. This also found that there were more older victims of domestic homicide during the pandemic than prior.

16.6.6 This is supported by research undertaken by Benbow, Bhattacharyya and Kingston[xxii] 2019). Their analysis of domestic homicides of older people in England concluded that whilst age did not contribute to risk of domestic homicide itself, it did influence health and social care assessment, and interventions offered.

16.6.7 Research from Bourget, Gagne and Whitehurst (2010) considers older homicide offenders and, just as this case sets out, homicide was quickly followed by the offender taking their own life. This research included findings that: *"Several victims had pre-existing medical illnesses, indicating that the offenses may have been committed by individuals who were caregivers to chronically ill spouses"*.

This reflects Bill's situation in that he was caring for Anne who had a progressive long-term health condition. This research, whilst it is acknowledged that this is not a UK study, indicates that the circumstances and case considered for this review are by no means a one–off. Patterns of behaviour and risk factors have been considered over recent decades. Learning from this might be that professionals need to take more account of the nature, history and vulnerabilities of older couples.

16.7 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, alcohol etc.)

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

16.7.2 In March 2018, Anne disclosed that Bill 'liked to drink' and suggested he was being physically violent toward her. The DHR panel were not given information to validate concerns around Bill having any alcohol or other substance use issue. However, research was considered that suggests that 'Caregivers with alcohol problems were 3 times as likely to be violent with elders for whom they were providing care.'[xxiii] This risk was acknowledged; however, the response was not specifically focused on the resulting risk Anne may have faced.

16.7.3 Adult Social Care records stated that Anne may have created her own bruising through 'dementia related behaviours', and/or be as a result of manual handling of her, so "It didn't cause concern". Additionally, it is recorded by the social work team that they never observed Bill shouting or exhibit any negative behaviours, and he always seemed caring. Any physical restraint for Anne was done from the perspective of Bill being caring. It should be borne in mind, nevertheless, that Ms. X stated that Bill always behaved differently when there were visitors to the house and was polite, which is not an uncommon phenomena where coercive and controlling behaviour manifests. His overt behaviour may have contributed to the optimism professionals had in the couple's relationship.

16.7.4 This is supported by research by Thiara (Safe Lives 2016) [redacted] highlights how abusive perpetrators who are also carers often present themselves as 'caring heroes' to outsiders but in fact use this to exert greater control.

16.7.5 Caregiver stress has been identified as a factor that Bill was experiencing. For example his efforts to restrain Anne in her chair were to protect her from falling. The DHR panel agreed that due to Bill being Anne's main carer, this did impact on the ability of agencies to objectively see Bill as a potential risk to Anne as a domestic abuse perpetrator.

16.7.6 Research by Carthy, N and Holt, A (2016) notes that domestic abuse in older women is not always recognised by professionals and may be confused with other forms of abuse. Case files in this DHR have already demonstrated that this is the case (see point 15.2.2). Brandl (2002) and Straka and Montminy (2006) identify problems that can occur when domestic abuse is not adequately investigated. The Caregiver stress theory is one example where abuse can be explained away by mental fatigue or just being too 'heavy handed'.

In these cases, as was seen from case files here, the carer is offered support and advice, but the victim is not. They argue that this leaves the victim more isolated and

vulnerable. In cases such as Anne and Bill's, this research suggests that a thorough investigation is important to ensure behaviours are not symptoms of domestic abuse. Sadly, in this case, it is evident that the enquiries were not thorough enough, and domestic abuse was not considered, which is a learning point for agencies involved.

16.7.7 There is an example in May 2022 whilst Bill is employing private carers to assist with Anne's care, which indicated to professionals that he was able to seek help if he needed to. However, case notes include references to "Bill being frailer" and being noted as not accepting Anne's deterioration. There is no reference to it either being suggested to Bill that he may require any mental health support or assessment or him seeking help for this, at any point in records available to this DHR.

16.8 KLE 7: Examine how agencies respond to cases where there is 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.

16.8.1 As noted in 16.2.10 information provided to this review found that no domestic abuse risk assessment appears to have taken place at any point following the allegations of domestic abuse received. Additionally, Bill's role as Anne's main carer appears to have hidden any possibility of domestic abuse, as his actions were only considered through a 'carer lens' and not as a perpetrator of domestic abuse.

16.8.2 The information received about Bill in the IMRs presented him, not as a perpetrator, but as a loving husband, doing his best to care for his wife. The case files demonstrate Bill's tenacity to access services and assessments for his wife, which support the notion of him not being neglectful towards Anne and wanting to take on the caring role himself despite his own need for support. Due to this, the motivation behind Anne's death was not primarily considered as domestic abuse by all panel members, which was a point of panel debate throughout this review.

The optimism displayed by practitioners involved with Anne and Bill, allowed Bill not only to be involved in all meetings that considered Anne's care and allegations of abuse, it enabled him to be her voice, having control over her care and health outcomes.

"People pity him because he is taking care of you...people are reluctant to criticise this saint ..."

(Safelives (2017) Disabled Survivors Too: Disabled people and domestic abuse[xxiv])

16.8.3 The Adult Social Care IMR reports that whilst carers assessments 'were on offer' and completed twice, their impact was minimal. There was also a gap of 5 years between carers assessments, and Bill had needed 'a lot of encouragement' to complete this.

Carers not taking up available assessments is not unusual. However, it is unclear to the extent agencies were considering both Anne and Bill's declining health within their interactions, and whether a more systematic approach to considering Bill's caring role, and assisting him further could have taken place. Supporting this notion, Bausewein,

Currow and Billson (2016) note that “evidence-based tools and approaches exist and can help but are not a one-off exercise. Carers’ needs may change as the patient’s condition (or location of care) changes, or as carer health or systems change.”[xxv]

16.8.4 Therefore the independent chairs concluded that this may highlight the need to develop practice across agencies to consider using carer assessments as part of a holistic approach. Particularly within all interactions with individuals where there is declining health. Please see 18.5.3 below.

16.8.5 In January 2023, shortly before Anne’s death, the ICB noted that the GP advises Bill on how to care for Anne, who, at this point, cannot eat, nor drink. The panel representative reflected on this entry in the chronology and feels that it demonstrated that Bill was now being told very clearly that Anne was dying and felt that this may have been an opportunity for him to have been offered support in how to care for his dying wife.

16.9 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.

16.9.1 The review considered what, if any, impact the covid-19 pandemic had on the circumstances of Anne and Bill receiving information and support by assessing the case file records between March 2020 to Spring 2021. The review finds that there was no reference to this couple being more isolated or unable to receive or access support due to covid 19.

16.9.2 It is widely accepted that family carers were put under a lot of strain during the pandemic lockdown conditions; access to support services such as day care and some respite was ceased. The Adult Social Care records were not clear as to how this might have affected Anne and Bill. It is also unclear if they ever accessed traditional day care or respite facilities but did benefit greatly from the consistent support of three support worker visitors from the church. It is likely that these visits stopped during peak lockdown periods.

16.9.3 There was in fact limited reference to covid 19 across case files. However, the DHR panel acknowledged that due to covid-19 restrictions there was significant changes to working practices. Some of which extended beyond the lockdown restriction periods.

16.9.4 Nevertheless Adult Social Care noted that home visits continued to be undertaken by Occupational Therapists following a risk assessment in June & August 2020 and April 2021. Safeguarding visits continue to be made, subject to risk assessments. This is considered good practice.

16.9.5 However, it is of note that between April 2021 and October 2021 there is a gap of agency contact, despite safeguarding concerns raised in the January and April of that year. Although England had come out of ‘lockdown’ at that stage, this lack of agency involvement may coincide with the effects of covid-19 pandemic which were felt during that year by many agencies and the wider population (see 16.9.3)

16.10 KLE 9: Explore the extent by which using a private carer reduced or impacted on the engagement of other agencies.

16.10.1 In considering the IMRs and case files, there is no evidence to suggest that using a private carer impacted on the engagement of other agencies, nor did the self-funding arrangement impact on any safeguarding response. The combined chronology demonstrates that a range of agencies were involved with the couple throughout the review period.

It should be noted that the Independent Chairs were not able to make contact with the private care company to establish their views.

17 Conclusions

17.1 Anne's death was devastating for her family. The review panel has been grateful to her daughter Ms. X's contribution to the report, to help provide a sense of Anne as a person as a loved mother.

17.2 This DHR has sought to maintain a strict focus on domestic abuse, given this was a domestic homicide, despite the significant health issues that Anne faced and the subsequent increased caring role that Bill experienced in more recent years.

17.3 The review presents a couple who had intensive involvement from a number of agencies and services between 2015 and 2023. In considering the amount of involvement the couple had with services, agencies worked well; endeavoring to wrap support around the couple. During this time period, professionals were made aware of disclosures of domestic abuse and also raised their own concerns about Anne's welfare and level of care. However, the investigations and processes that were triggered were health and social care focused, meaning that conversations were not considering domestic abuse nor the risk of homicide.

17.4 Anne was a woman who suffered a progressive disease, was in her 90s, married and grew up catholic. These characteristics were not considered holistically when exploring Anne's needs or potential barriers to accessing services. In the face of disclosures of domestic abuse, again, factors like her religious and cultural beliefs, marital status and age, were not considered as risk factors.

17.5 The review panel sought to understand whether agencies could do more to understand domestic abuse in the older population, and specifically where there are health and medical complexities affecting someone. The DHR panel agreed that there could be improvements to understanding the intersectionality faced by domestic abuse victims of any age, specifically relating to those who are older and/or have a disability.

17.6 Research indicates that the issue with age is not that it is a risk factor to becoming a victim of domestic homicide, but being older is an intersectional factor that increases vulnerability. Age can create barriers to accessing services and can increase the chances of falling through gaps in services and the range of pathways designed to keep people safe.

17.7 Further research from Safelives in the analysis section 16.8.2 describes the way that people in carer roles might be perceived by others; including professionals, as positive gatekeepers for services and support. In this case, Bill became the voice of Anne.

17.8 The Care Act does not appear to have been fully and effectively implemented in this case, with the 6 principles of safeguarding adults[xxvi] not being applied by all agencies involved in this review.

17.9 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.

17.10 Understanding amongst professionals about 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.

18 Lessons to be learnt

The conclusion sets out some key themes, under which, the lessons learnt have been organised for this report:

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

18.1.1 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.

18.1.2 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.

18.1.3 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.

18.1.4 An early learning point established by the DHR panel was to consider using supplementary questions as part of the DASH risk assessment to help better recognise

the risks posed to older people. This may be by creating a separate older people's DASH risk assessment similar to the DASH used in Cambridgeshire or agreeing a list of supplementary questions that would cover health-related vulnerabilities such as mobility or cognitive impairment, dependency on caregivers and abuse by family members in caregiving roles.

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

18.2.1 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.

18.3 Professional optimism

18.3.1 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.

Whilst there is the Social Work England professional standard "Be accountable for the quality of my practice and the decisions I make" [OBJ], professional optimism is not specifically stated as an issue to be aware of. Supervision, learning and effective training of staff are therefore vital.

18.3.2 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.

18.4 Awareness of non-physical domestic abuse in the community

18.4.1 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[xxvii]. 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.

18.5 Other learning taken from this review

18.5.1 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.

18.5.2 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 undertake a carers assessment. Learning from DHR Sylvie is relevant also in this case (9.4) which states that carers should be given the opportunity to express their feelings and for an agency to be able to assess how the care giver is managing.

18.5.3 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.

18.5.4 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.

18.5.5 Whilst this review was not a joint Safeguarding Adult Review/Domestic Homicide Review, the key lines of enquiry did, 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.

18.5.6 Nevertheless, the panel felt that there may be benefits in a further thematic review into family caregiver abuse to identify risk factors that may lead to domestic homicide and suicides from a safeguarding adult's perspective, considering this case and potentially other similar cases.

19 Recommendations

19.1 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).

19.1.1 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.

19.1.2 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

19.1.3 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.

19.1.4 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

19.2 Multi-Agency Recommendations

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

19.2.2 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 a 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.

Appendix A

TERMS OF REFERENCE FOR REVIEW PANEL

North Somerset DHR 6

1. Introduction

1.1 The chair of the North Somerset Community Safety Partnership has commissioned this DHR in response to the death of Anne. Following a trial this was concluded to be manslaughter with the person causing harm, being her husband.

1.2 All other responsibility relating to the review commissioners (North Somerset Community Safety Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in January 2023 and whether there are any lessons to be learned from the case about the way in which local

professionals and agencies worked together to safeguard the family

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
    - the actions of all the involved agencies;
    - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
    - analyses and comments on the appropriateness of actions taken;
    - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic abuse related homicides and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period from January 2015 to January 2023, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, neighbours & friends to provide a robust analysis of the events. Taking account of the criminal proceedings in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature. The timescale will be impacted by the criminal justice (CJ) procedures, but where we will carry on in tandem to any CJ processes
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Anne or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
    - In regard to age and disability and any potential impact this had in ensuring the safeguarding of adults during the review.

- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4 Key Lines of Enquiry

- Identify and examine patterns of domestic abuse in all its forms, including any coercive and controlling behaviours experienced by Anne.
- 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.
- 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.
- 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.
- Consider Anne's sex and age as factors throughout the review.

- 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, alcohol etc.)
- Examine how agencies respond to cases where there are carer role considerations, the tools used to support decision making and support pathways. This includes how agencies consider and respond to the risk and presence of domestic abuse.
- Examine the impact of Covid 19 on an individual's ability to access information and support and agency's ability to provide services.
- Explore the extent by which using a private carer reduced or impacted on the engagement of other agencies.

5 Role of the Independent Chair

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSNSP Chair)

6 Domestic Homicide Review Panel

a. Membership of the panel will comprise:

Agency
Independent Chairs and Overview Report Authors
Adult Social Care
Alzheimer's Society
Avon and Somerset Police
AWP

Citizens Advice
Curo
Next Link Domestic Abuse Service
BNSSG NHS ICB
North Somerset Community Safety Partnership
Southwest Ambulance Service NHSFT
University Hospitals Bristol and Weston NHSFT

This was confirmed at the first Review Panel meeting on 16th May 2023

b. Each Review Panel member to have completed the DHR e-learning training available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

7 Liaison with Media

7.1. North Somerset Council as lead agency for domestic abuse for the North Somerset Community Safety Partnership will handle any media interest in this case.

7.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8 Dissemination of the DHR Report

8.1 The report once it has been quality assured by the Home Office, will have a summary shared with the:

- North Somerset Community Safety Partnership Board (the commissioners of this DHR)
- North Somerset Domestic Abuse Partnership Forum
- North Somerset Adult Safeguarding Board
- Domestic Abuse Commissioner for England and Wales
- Avon and Somerset Office for Police Crime Commissioner
- Home Office (for their national DHR repository)

Appendix B – Action Plan

(see separate document)

Appendix C – Bibliography

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