SOUTH CAMBRIDGESHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of JW in May 2018

Independent Chair and Author: Ray Galloway

CONTENTS

1 Acknowledgement

1.1. It is very important for us to recognise that this report relates to the life of a person that was valued and loved by his family and friends and that his loss has caused them great sadness. We can only hope that our efforts to learn from JW's death have not added to their trauma and distress.

1.2. To enable the report to be produced the various agencies have gathered, and shared, sensitive and personal information under conditions of strict confidentiality; balancing the need to maintain the privacy of the family and the need for agencies to learn lessons that relate to their practice.

1.3. The support of JW's wife and family is very much appreciated and, also, their forbearance with regard to the time taken to collate all of the necessary information and present it in a way, via this report, that can be easily understood and act as a learning reference for the future.

1.4. It is important to acknowledge, also, that this report will become public, as is required by the Home Office.

2. Confidentiality

2.1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

2.2. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased person will be referred to by first name or initials as appropriate to the narrative.

2.3. At the request of the family, initials will be used for the wife, son, daughter-in-law and a close family friend of JW and his wife, who provide most of the personal background information that is contained within the report:

2.4. BW, JW's wife
2.5. LW, JW's son
2.6. PW, JW's daughter-in-law
2.7. CA, Friend

2.8. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Either secure networks were in place (GSI, PNN) and adopted (CJSM) or papers shared with password protection. A copy of chronologies and IMRs was provided to all panel members for review and discussion.

3. Methodology

3.1. Under s9 Domestic Violence, Crime and Victims Act, 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by South Cambridgeshire District Council.

3.2. In November 2018, Ray Galloway was appointed to act as the Independent Chair of the DVHR Panel, and as the report author. Tony Hester supported throughout, in the role of process manager and Secretary to the Panel.

3.3. This review was commissioned under Home Office Guidance, issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (Appendix 1).

3.4. The following policies and initiatives have also been scrutinized and considered:

3.5. Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016.

3.6. Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016.

3.7. HMIC (Her Majesty's Inspectorate of Constabulary) Reports: 'Everyone's business: Improving the police response to domestic abuse' 2014 and 'The Metropolitan Police Service's approach to tackling domestic abuse' 2014.

3.8. South Cambridgeshire District Council website and related services.

3.9. Such is the extent to which the lives of JW and his wife, were entwined that it would be neither credible, nor appropriate, to undertake this review without full reference to both. The key issues that are highlighted within the review relate significantly to BW, as well as JW, such was the extent to which their lives, and their involvement with the relevant agencies, overlapped.

3.10. It is within this context that regular reference is made in the review to BW and, at times to the records that relate to her, to ensure that relevant and important context is highlighted and understood. The decision to embrace the records and interventions relating to BW was unanimously agreed at the second panel meeting, of 29th April 2019.

4. Contributors To The Review

4.1. Key managers, from each of the agencies with whom JW and his wife interacted, contributed to the panel meetings and review of this case. Where the involvement of the respective agencies was considered to be relevant to the objectives of the review, relevant managers were required to complete Individual Management Reviews, the key elements of which are summarised in this report.

4.2. The agencies in question were as follows; Cambridgeshire Police, Cambridgeshire and Peterborough Adult Social Services, Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire University Hospitals NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust and the South Cambridgeshire Community Safety Partnership.

4.3. Professional opinion and advice was also gathered from the Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership, Cambridge Women's Aid and from Cambridgeshire, Peterborough and Norfolk 'Caring Together' (formerly The Carer's Trust).

4.4. A valuable contribution to the review was also made by Age UK, for which the author is grateful. Consultation was undertaken, by the Chair and Author, with the Cambridgeshire and Peterborough Coroner's office.

5. **The Review Panel Members**

NAME	AGENCY/ROLE
James BAMBRIDGE	Review Officer, Investigation Review Team, Cambridgeshire Police
Helen DUNCAN	Head of Adult Safeguarding/Principal Social Worker, Cambridgeshire County Council and Peterborough City Council
Carol DAVIES	Designated Nurse, Safeguarding Adults, Cambridgeshire and Peterborough CCG
Tracy BROWN	Adult Safeguarding Lead, Cambridge University Hospitals NHS Foundation Trust
Paul COLLIN	Head of Adult Safeguarding, Cambridgeshire and Peterborough NHS Foundation Trust
Amanda WARBURTON	Partnership Officer, Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership.
Chris PARKER	Chair, South Cambridgeshire Crime and Disorder Reduction Partnership
Vivian BECK	Service Manager, Age UK
Miriam MARTIN	CEO, Cambridgeshire, Peterborough and Norfolk 'Caring Together'.
Linda COULTRUP	Named Nurse, Safeguarding Adults, Primary Care, Cambridgeshire and Peterborough CCG.
Kathryn HAWKES	Community Safety, South Cambridgeshire District Council
Angela STEWART	CEO, Cambridge Women's Aid
Ray GALLOWAY	Independent Chair and Author of Report
Tony HESTER	Independent Manager and Panel Secretary

6. Terms of Reference of The Review

6.1. The DHR will seek to understand:

6.2. Whether improvement in any of the following could have led to a different outcome for JW:

6.3. Communication and information sharing between services with regard to the safeguarding of adults.

6.4. Communication and information sharing within services.

6.5. Whether the work undertaken by services in this case is consistent with each organisation's:

6.6. Standards of professional practice and standards of organisational practice.

6.7. Domestic abuse policy, procedures and protocols.

6.8. Safeguarding policies.

6.9. Whether the work undertaken by services in this case is consistent with partnership and/or multi agency:

6.10. Standards of professional practice and standards of organisational practice.

6.11. Domestic abuse policy, procedures and protocols.

7. Equality and Diversity

7.1. Consideration was given to the nine protected characteristics under the Equality Act 2010 in evaluating the various services provided. All concerned are White British and JW is male.

7.2. Extensive discussion was undertaken at the panel meetings to determine whether any evidence was apparent that would suggest that JW or BW had been the victim of discrimination, or received a lesser quality of service, due to their various health conditions, their frailty and/or their advanced age.

7.3. The relevant legislation that provided the context for the panel was The Care Act 2014, The Disability Act 2016 and The Equality Act 2010.

7.4. Police and partner agency enquiries established that there was a history of domestic abuse between JW and his wife, the most recent known incident having occurred the day before his death. It is within that context that a Domestic Homicide Review was proposed, as detailed below.

7.5. Research indicates that older people are not being represented in domestic abuse services, for a wide variety of societal and attitudinal reasons, with very few cases being considered at Multi Agency Risk assessment Conferences. *(Safe Later Lives. Older People and Domestic Abuse 2016).*

7.6. To place the suicide into some form of national context, in 2018 three quarters of the total of 6507 deaths by suicide registered in the UK were those of men. *(ONS, Suicides in the UK, 2018 registrations).*

7.7. Of those suicides 21 per 100,000 were men aged over 90 years of age, which represented part of an increasing trend, with the suicide rate for males aged 75 years and over being 32% higher than in 2017. *(ONS, Suicides in the UK, 2018 registrations).*

7.8. In 2019 just over 13% of suicides recorded in the UK were men and women over 90 years of age, with suicide rates tending to increase in the oldest age groups for both men and women *(ONS 2019).*

7.9. Whilst a verdict of suicide was recorded at the Coroner's Inquest relating to JW's death, no note or other indication was left and, thus, the reason for his suicide was never definitively established.

7.10. There was no sound basis to conclude that the primary factor that led to JW taking his own life was the fact of his abusive relationship with his wife. Whilst both JW and his wife suffered from ill health and a lack of mobility, neither were registered as disabled. He cared for the needs of his wife.

7.11. Both JW and his wife were very elderly and both suffered from significant physical impairments that caused each of them pain and discomfort and whilst also limiting their mobility. Whilst they both still had mental capacity, they also both had care and support needs.

7.12. The key question for the panel was whether the gender, age, health conditions, limited mobility and the domestic situation of JW and his wife influenced how the various agencies dealt with them and the support that they were offered.

7.13. The detail of what considerations were applied will be addressed in the respective sections that relate to each of the agencies involved, and then brought together in the report conclusions and recommendations.

7.14. It is clear is that the respective perceptions of JW and his wife, with regard to their own personal wellbeing, were detrimentally influenced by their health conditions in that they could both feel down about their quality of life and, in JW's case, about what he perceived as his related inability to care for his wife effectively.

7.15. What was difficult to determine was the extent to which the inability of JW and his wife to manage their physical limitations and their pain had any influence on their behaviour, especially towards each other.

7.16. Such was the limited size of their home, and their respective limited mobility, it was inevitable that any difficulty or frustration that either of them experienced as a result of their inability to venture beyond their domestic setting was likely to manifest itself in tension in their relationship.

7.17. Whilst their son provided evidence to the review that his parents had always had something of a verbally robust relationship, the worsening of the relationship into physical abuse came about only after his father lost the ability to drive and to leave his home.

7.18. It is that which appears to be the catalyst for the abusive behaviour that was to bring JW and his wife to the attention of the police and, in turn, several other public agencies, although they both already had a long history of contact with health services.

7.19. JW and his wife had been married for nearly 70 years and their home, which was a purpose-built annex, was situated in the large rear garden of the property owned by his son and his wife.

7.20. Whilst such an enduring relationship does not prevent the relationship from being abusive, it was clear to the author, upon visiting the family and a long-standing friend and neighbour who visited every day, that there was an absolute commitment to each other and their marriage.

7.21. The physically abusive aspect of their relationship had developed only in the latter years of their marriage as both parties had struggled with their own health and care needs.

7.22. Whilst the author did not specifically discuss the views of BW with regard to their marriage when he visited her in her home, it was clearly evident from their discussion that she enjoyed her long marriage to JW and missed him greatly.

7.23. From the conversations held with the family, and BW herself, it was evident that the abusive incidents of 2018 were not representative of what had otherwise been a mostly happy and harmonious relationship.

7.24. The panel found no evidence that, whilst the proximity of a family support network was a factor in the considerations of agencies such as the Police, the GP and Adult Social Care, it significantly inhibited the appropriate offer of support or respite.

7.25. On occasion, JW's daughter in law would accompany him to visit the GP which proved a tangible example that a support network was in place and was accessible.

7.26. The existence of the support network, including its proximity, is likely to have had some contributory influence on the fact that the care needs of JW or his wife never seem to have been made a priority by any agency, although that assertion must be considered within the context that both JW and his wife consistently declined the offers of help and support given to them.

7.27. The only aspect of the processes, protocols, procedures and risk assessments that were used, with regard to JW and his wife, which were considered to have fallen short of what may be considered to be a reasonable and objective standard, and potentially discriminatory, related to the scoring matrix used within the DASH framework. That issue is addressed within the body of the report and is the subject of Recommendation 1.

8. Background Information and Chronology

8.1. JW and BW, aged 92 years and 90 years old respectively at the time of his death, had been married for nearly 70 years. Despite the longevity of their marriage it had, according to their son, always been something of a verbally robust relationship with arguments and disagreements a regular feature of daily life.

8.2. JW and his wife lived in a purpose-built annex that had been constructed in the back garden of their son's property, which had previously been their own home before they gave it to their son and his wife in 2009. This followed a health scare for BW, in the form of a heart attack.

8.3. The annex is situated within a generous garden, in which JW enjoyed tending to the plants and shrubs and feeding the birds. He also liked to get out and about by going for a walk or a drive. However, as JW grew older his health deteriorated and his personal mobility became restricted, including the fact that, about three or four years ago, he lost his confidence to drive, and he also became unable to walk very far.

8.4. These restrictions on his mobility meant that JW no longer had the opportunity to spend some time alone, beyond his domestic environment, which is something that he both enjoyed and valued.

8.5. Prior to their deterioration in health JW and his wife used to have a very active social life, with lots of friends. He would sing in a local pub, and she would love to dance. In more recent year's BW liked to knit and watch television whilst JW enjoyed sitting quietly and watching the birds in the garden.

8.6. As their age advanced, both JW and his wife suffered from a series of significant health ailments and conditions, that caused them virtually constant pain, and they had both been hospitalised due to ill health.

8.7. Indeed, on several occasions over recent years they had both, but especially BW, made remarks that suggested that they were each finding life to be, at times, intolerable.

8.8. Both were prescribed a whole range of medication, including liquid morphine, which they would either self-administer or JW would give to his wife, as part of his role as her primary carer.

8.9. A consistent theme of the review was the fact that JW wanted to remain in his own home and for his wife to accept care provision, due to his own limitations, but his wife appeared to show little insight with regard to his physical inability to provide her with the care that she needed.

8.10. Although JW and BW's son and daughter-in-law lived immediately adjacent to them, they were both still in full time employment. Therefore, whilst they would call in regularly to check on the well-being of JW and his wife, their work commitments meant that they did not play any significant role in terms of caring for the elderly couple.

8.11. The fact that JW could no longer get out and about certainly led to an increase in tension between him and his wife. There was no longer an opportunity for him to relieve any of the domestic pressure that may have built up between them by going out for a walk or a drive.

8.12. In effect, they were living together, all day every day, in a very small property. BW described it as being 'shut in together' and 'in each other's faces' resulting in a feeling of social isolation.

8.13. The result was an escalation in the gravity of their disputes which, previously, had primarily been verbal in nature. This escalation reached the point where they would sometimes strike each other, often with their walking sticks, and push each other over.

8.14. This behaviour reached the extent where it came to the attention of the local police, their first involvement being in October 2013, when a neighbour reported seeing an argument between the two in which BW was seen striking out at JW with a broom.

8.15. Some 6 months after that incident the police were called to an episode of bad driving, reported by witnesses, which turned out to be JW driving to a hospital, about 10 miles from his home, in which he had formerly worked. This followed an argument with his wife. No formal police action was taken.

8.16. No further matters came to the attention of the police until 2018, when four incidents required their attention within the space of 6 weeks, three of which occurred within a 12-day period at the start of February 2018.

8.17. They all involved allegations of assault, with one incident resulting in JW being taken to a police station, interviewed and a crime formally recorded against him for assaulting his wife. 'Adult At Risk' referrals were submitted in each case by the officers that attended the respective incidents. The latter incident of the four, which occurred in March 2018, involved BW taking an overdose of prescribed medication which, ultimately, resulted in her being hospitalised for several days.

8.18. It was following another dispute, which is believed to have involved BW striking her husband with a walking stick, that, at about 9.00pm on an evening in May 2018, JW came to the door of the conservatory that is situated at the rear of the bungalow occupied by his son and daughter in law. The two properties are linked by a short, paved path.

8.19. JW asked his son if he might sit in the conservatory as he had been arguing with his wife. His son agreed to his father's request, thinking nothing of it as his parents would regularly argue between themselves and had done so for as long as he could remember.

8.20. One thing that his son did notice as being unusual that evening was the fact that his father was carrying a glass of wine with him as he entered the conservatory. JW was not a person that drank a significant amount of alcohol, his only regular consumption being two glasses of wine with his midday meal. However, the son did not ask his father why he was drinking that evening.

8.21. JW initially sat himself down in a chair in the conservatory and, about 30 minutes or so later, his son went off to bed as he was up early for work the next day. As LW retired to bed his father was laid on the sofa in the conservatory. His son thought nothing more than his father had made himself comfortable for the night.

8.22. The following morning, LW rose at about 5.30am and, upon checking in the conservatory, he saw his father still laid on the sofa. As he went in to check on him, he noticed that he had vomit around his mouth and, when he shook him, he could not be roused.

8.23. LW immediately called 111, as his previous experience was that this provided the fastest emergency response, and, as his wife spoke to the operator and relayed instructions, he carried out CPR on his father. When the paramedic crew arrived, they took over and it was at this point that they queried with LW as to what his father had taken, in terms of medication.

8.24. As no medication was evident in the conservatory this prompted LW to go to the annex, where he found an empty bottle of liquid morphine and a packet of tablets next to the draining board. These were provided to the paramedics and JW was subsequently transferred to Addenbrookes Hospital.

8.25. Despite the best efforts of the medical staff JW did not recover from his overdose of medication and passed away at 4.01pm later that day. The cause of his death was recorded as multiple organ failure, which was secondary to mixed drug toxicity.

9. Good Practice

9.1. The GP practice was responsive to the many, sometimes ‘emergency’, calls made to them by JW and his wife. Home visits were often requested and made at short notice in response to ‘crisis’ as well as urgent medical need. Efforts were also made to offer some element of consistency in terms of which clinicians responded.

9.2. The GP records indicate that both parties could, on occasion, be rather demanding and non-compliant. Given the frustrations staff may have felt, it is clear that great care and tenacity was applied to try and offer the best service to the patient.

9.3. Alternative options were offered, and suggestions made, as to a wide range of possible solutions to some of the more, apparently intractable, issues, such as the management of pain symptoms.

9.4. The police officers who attended the various domestic disputes did recognise that the issue went beyond physical and verbal confrontation and had its basis in matters of care and support. Proactive and prompt contact was made with those providing care as a means of seeking to improve and resolve the situation.

9.5. In relation to JW, there is sound evidence that the principles of 'Making Safeguarding Personal' were applied and he was consulted, on many occasions, around his wishes with options for managing the risks being explored. He was spoken to when he was alone and in a safe environment (hospital) and his wishes recorded.

9.6. Reponses to safeguarding concerns were actioned in a timely manner. A DASH form was completed on at least two occasions which afforded an opportunity to explore the impact of the Domestic Abuse on him and, with his consent, share it with a relative who was able to confirm that it was an accurate picture of the situation.

9.7. A safety plan was agreed and shared with the GP with a request for a mental health assessment of BW. Concerns were, with the consent of both parties, openly explored with the Social Worker. Information around capacity is well recorded and there is evidence of relevant professionals being consulted.

9.8. The Reablement Team who were supporting the couple stayed involved longer than the physical needs of the couple required, due to the risks they had identified. There is good evidence of the reablement workers raising concerns with the GP and other agencies regarding risks to both parties, for example, with regard to access to morphine.

9.9. The Crisis and Home Treatment Team (CHTT) responded proactively as did the Joint Emergency Team (JET).

9.10. The assessment of the Liaison Psychiatry Team was of good quality.

10. Lessons Learned

10.1. JW and his wife had been registered patients at the GP practice for decades. There was evidence in the records that theirs was a long-standing fractious relationship but 'normal for them'. It is likely that knowledge of the issues in the relationship were known anecdotally by a wide range of the practice staff, but not often recorded, on the assumption that this was already known and well-established fact.

10.2. In retrospect it can reasonably be concluded that, if the incidents of domestic abuse had been recognised as such, and highlighted in the GP records in some way, staff may have been better able to see the circumstances as a connected series of events rather than as isolated incidents, although it is important to highlight the fact that the panel found no evidence that this lack of recognition was influenced in any way by the advanced age of JW and his wife.

10.3. While it is acknowledged that the focus of a GP practice must primarily be on meeting the health needs of its patients, there are circumstances such as these where the management of the responses made could be more co-ordinated.

10.4. When patients are allowed to self-medicate at home control measures should be in place to ensure that over medication does not take place and, should it be suspected, positive steps are taken to prevent harm and/or abuse to the patient(s) and any other relevant third party.

10.5. It is evident that the police investigation at the home address was limited in its scope, with a particular omission being the fact that JW's wife was not spoken to about her husband's death. When the context of a physical confrontation having taken place between the two of them, only the day before, is considered, this is a line of enquiry that it may have been advisable to pursue.

10.6. The fact that JW sought to find sanctuary in his son's conservatory the previous evening suggests that some form of conflict had occurred between he and his wife. The specific detail of that conflict is not known, but it is believed that it involved a strike to the head with a walking stick, which caused an injury to him.

10.7. This, in addition to the recent overdose by his wife, following which JW encouraged those attending to her not to intervene, are relevant contextual incidents that it would have been appropriate to investigate further.

10.8. The fact of the short timescale within which police intervention was required at four separate incidents, three of which involved overt domestic abuse, and one which involved a deliberate overdose, may reasonably have been expected to prompt a professional judgement, by the officers attending and those considering the subsequent referrals, that the sustaining risks were more significant than appear to have been recognised.

10.9. On several occasions comments relating to them experiencing domestic abuse were made by JW about his wife, and vice versa, where the opportunity to ask more appropriate and relevant questions could have been taken.

10.10. The lack of such respectful professional curiosity or challenge may have been due to a variety of reasons; however, a more positive and proactive approach is likely to have secured a more positive outcome.

10.11. All frontline Domestic Abuse and Sexual Violence staff have, since this incident, received training in Suicide Prevention and Male Victims of Domestic Abuse. In addition, a male Independent Domestic Violence Advocate (IDVA) is to be recruited.

10.12. Whilst it is recognised that real clarity can be difficult to achieve the complexities that exist in situations where bi-directional abuse is taking place were not fully recognised or addressed. This was particularly so in terms of identifying the most appropriate steps to take with regard to support and/or sanction.

10.13. It is essential that a sustained and meaningful professional effort is made to understand why a person, who has indicated a willingness to accept support, then retracts that willingness. Only then can any potential inhibitors to a free and informed choice be identified and addressed.

10.14. When having mental capacity to make decisions is established, there is potential for agencies to be too quick to accept that fact, at face value, rather than seeking to develop their understanding of why a decision, however apparently unwise, has been made. It may be that mistaken perceptions can be corrected and potential inhibitors to seeing and accepting support as a positive option can be removed.

10.15. Despite JW and BW having hospital admissions, within a close time frame of one another, and having mentioned the abusive aspects of their relationship during their respective admissions, including detailing the abuse and the restrictions of their home environment, they were still treated as very separate individuals when they were admitted to hospital.

10.16. More consideration could have been given to their shared experience of their home environment and how their individual admissions impacted heavily upon each other.

10.17. Throughout their hospital admissions there were a number of safeguarding referrals made by CUH staff, social workers and police. Yet, despite the fact that their home environment was becoming more unstable, there did not appear to be an escalation in the way those safeguarding concerns were treated.

10.18. There is no evidence of a co-ordinated, multi-agency meeting to explore ways to best support JW, in particular, in his challenging carer role.

10.19. There may have been reluctance for various agencies to support JW and BW more effectively due to the recurring confirmation of their respective mental capacity.

10.20. Mental capacity was not in question for either party, so the responsibilities of the respective agencies sustained. More creative approaches and/or proposals may well have ensured JW felt supported in a way that suited him better.

10.21. Whilst there is clear evidence of multi-agency involvement; Police, Social Care, Ambulance, GP, MASH, Care Agency, Reablement, Mental Health Team, including crisis team, JET team and Discharge Planning, there was a lack of co-ordination of information, which led to a lack of understanding of the extent and nature of the risk.

10.22. A multi-agency meeting, where the risks could be openly discussed, including the reluctance of both parties to engage and accept support, would have been beneficial and improved risk assessment and planning.

10.23. The overarching question that remains is why no single agency was not more tenacious in seeking to understand the underlying reasons for both parties making the consistent decision not to take up the various offers of help. The dovetailing of relevant information between the agencies could have created a more informed and up to date understanding of the relationship, the abusive behaviour, the home environment and the respective care needs of the couple.

10.24. The report entitled, ‘Standing Together’ (Oct 2019) which sought to analyse Domestic Homicide Reviews in London and identify key learning points, highlighted the benefits of a Coordinated Community Response (CCR) to domestic abuse.

10.25. A CCR is based on the principle that ‘no single agency or professional has a complete picture of the life of a domestic abuse survivor but many will have insights that are crucial to their safety.’ Whilst this case involved bi-directional abuse it is clear that a sharing of information, via a multi-disciplinary discussion, is likely to have secured a more effective understanding of what could have been done to stop the abuse and achieve positive progress.

10.26. Between February and May 2018, there was increased activity and lost opportunities to work with both parties. Whilst in hospital, in February 2018, JW was reluctant to go home, unless BW accepted more care. This would have been an appropriate time to coordinate and convene a meeting.

10.27. There is a significant body of recorded evidence of JW's feelings with regard to his relationship with his wife and what he wanted to happen, but the respective views of BW were not consistently captured, only in the time of a crisis. There is evidence that JW was physically abusive to BW and, therefore, obtaining her views around their relationship may have led to a more informed and appropriate response.

10.28. In 2014 it was accepted that BW did not want to engage with Cambridgeshire and Peterborough NHS Foundation Trust staff, on the basis of JW's telephone call. It may well be that she was in agreement with this. However, that decision should have been confirmed directly with BW herself.

10.29. In relation to a carer's assessment for JW, there is documented evidence of the relevant forms being sent out to him, but never completed or returned. There is no evidence that a more proactive and supportive approach was taken and a face-to-face carer's assessment offered.

10.30. Where there is a significant body of evidence recorded by a number of agencies with regard to the impact that supporting the couple was having on the wellbeing of their daughter-in-law, there is no evidence of a carer's assessment being offered to her, to inform and enhance the understanding of her ability and/or willingness to offer support.

10.31. It is sometimes unclear whether individuals have care and support needs. This is particularly so when there is more than one person, in this case a couple, who may both be at risk. This introduces the potential for at least one person's risk or needs to be overlooked, overshadowed by the other or not identified as meeting, Care Act defined, safeguarding thresholds in their own right.

10.32. Under the Care Act 2014 a person meets eligibility for adult safeguarding intervention if they have care and support needs, whether the Local Authority are meeting those needs or not, which make them unable to protect themselves from abuse, and that may include the person who is fulfilling the caring role, not just the person being cared for.

10.33. As part of a S.42 enquiry a home visit was undertaken and both parties spoken to, together. This was a possible missed opportunity to secure a better understanding of the situation as, whilst it may have been productive, neither party had the chance to discuss without the other partner being present.

10.34. BW had said she wanted matters to be discussed together but there is no evidence that JW was consulted. There is a reasonable expectation, in such domestic abuse or complex relationship situations, that people will be provided with the opportunity to be spoken to on their own.

10.35. Greater consideration could have been given to why JW and BW's son and daughter in law were so reluctant to engage in discussions surrounding medical treatment plans or discharge planning.

10.36. Whilst there is no tangible evidence that the advanced age of both JW and his wife, and the fact that they had proximate and accessible family support, was influential in terms of the prioritisation of their case, or otherwise, it is reasonable to assume that such factors were considered.

10.37. The fact that the 'high' threshold was never reached, with regard to MARAC referrals, may have contributed to the lack of referrals to domestic abuse support agencies, despite there being four reported incidents of domestic abuse within a short period of time. Had that threshold been reached, more professional curiosity applied, and a MARAC referral made, it is reasonable to believe that a broader, more focused perspective may have been applied by a range of agencies and a better understanding of the needs of JW and/or his wife established.

10.38. The audit trail of referrals appears to be an area in which improvements can be made. In more than one agency, primarily the Police and Addenbrookes Hospital, the records contained claims that referrals had been made, yet no such referrals could be located or identified.

10.39. Whilst record keeping systems will never be infallible, and are vulnerable to user error, a clear audit trail, that allows for the recovery of key documents, is an achievable objective for all public agencies.

10.40. The importance of taking social stressors into account in care planning and discharge planning decisions should not be underestimated. The relationship between JW & BW was, at times, exceedingly fraught and their relatively small domestic accommodation seems to have exacerbated this.

10.41. There appears to have been problems with discharge planning, with regard to the arranging of medication for BW, on 16th March 2018. This process needs to have clarity in terms of the provision and management of medication.

10.42. The perceived existing involvement of other agencies in a case, and the extent of that involvement, should be confirmed prior to decisions being made, with regard to the appropriateness of a further agency becoming involved, or deciding not to.

10.43. Inter – agency liaison is crucial to determine whether an abusive relationship involves a perpetrator and a victim or whether there is a complexity that results in both parties being both victim and perpetrator. Such knowledge will influence the care, support and intervention options, that are considered to be appropriate.

11. Conclusions

11.1. Any suggestion that JW would take his own life was neither reasonably foreseeable nor predictable. The greater apparent risk related to his wife who had both expressed her intention to take her own life and actually taken two previous overdoses, with one such occasion being only weeks before his death.

11.2. There is no sound basis for concluding that JW took his own life primarily as a result of the abusive relationship that he had with his wife. The issues of his own poor health, his Carer responsibilities and his inability to get out of his home environment, in his car or walking, are also likely to have been contributory factors.

11.3. As was the case with the police investigation and the coroner's inquest, the DHR process did not identify and evidence that suggested a causal link between the abusive relationship, of which JW was a part, and his subsequent suicide.

11.4. More effective and informed management of the abusive relationship, which had developed between JW and his wife, is more likely to have been achieved via a meeting of the various agencies involved.

11.5. Insufficient sustained and co-ordinated multi-agency focus was applied to a situation in which bi-directional abuse was taking place. Had such a focus been applied a better understanding of the relationship and, in turn, the care and support needs of both parties is likely to have been achieved.

11.6. The lack of co-ordinated attention by those agencies that could provide support in cases of domestic abuse is particularly relevant when one considers the fact that a number of incidents of abuse were reported within a short period of time.

11.7. The co-ordination of knowledge, resources, skills and problem-solving proposals is likely to have enhanced the potential to identify and progress opportunities to secure a positive outcome. Relevant information could have been shared and creative solutions identified and acted upon.

11.8. However, any such meeting must be considered within the context that neither party was found to be lacking in mental capacity, and both consistently chose not to embrace offers of support, in whatever form. Therefore, it is unclear as to whether either party would have chosen to embrace any alternative proposals, in any event.

11.9. There is no clear evidence to inform an understanding as to why both parties chose not to sustain any initial willingness to accept support offered to them from a variety of agencies. It is apparent that insufficient professional curiosity was demonstrated to establish why such decisions were consistently made but, without that evidence, informed conclusions cannot be drawn.

11.10. There is no clear evidence that either party was the subject of any form of inequality that could have influenced their respective decisions not to embrace the support that was offered by any of the agencies with whom they interacted.

11.11. Current safeguarding systems are reliant on a person being identified as having care and support needs, whether that be a victim of abuse or a carer. If that assessment of their potential vulnerability is not made, then significant options may not be considered. It is essential that it is identified when a person has care and support needs that render them unable to protect themselves from abuse.

11.12. Current care and support systems do not work effectively when a person is identified as both a victim and a perpetrator of domestic abuse, as in this case. Such cases are not uncommon and assessment systems and policies would benefit from being more flexible.

11.13. The fact of JW 's completed suicide was not due to any specific shortcoming or failure by any individual agency, nor group of agencies. JW appears to have come to the tragic conclusion that his life was intolerable and acted upon that. The various agencies faced the difficult situation in which JW, especially, would express his frustration and, at times, desperation at the demands placed upon him by his wife, and his role as her primary carer.

11.14. Creative and reasonable care and respite options were presented to him, such as when he was approaching discharge from hospital, but he consistently took the decision not to embrace them despite, initially, giving them some consideration.

11.15. There is little doubt that the mobility restriction that was suffered by JW, when he lost the ability to drive and to walk any significant distance, resulted in an increase of the domestic tension between he and his wife.

11.16. It is clear that JW and BW had always had what their son described as a verbally volatile relationship, and that the increasing distress felt by him was evidence of his lessening resilience to her challenging character, coupled with her behaviour becoming more extreme over time.

11.17. Although it is unlikely that professionals could have changed the nature of their relationship, it is clear the JW did not feel satisfied with his home life. There may have been an acceptance by agencies that this was an unchangeable situation as this was 'how they had always been'.

11.18. It is not clear if a conversation was ever had with BW about her behaviour and the impact this was having on her husband. It may have been helpful for professionals to work more creatively and consider a more personal approach, which did not rely on already established pathways. Perhaps more consideration could have been given to recognising JW as a victim of domestic abuse and whether different support options may have been offered.

11.19. It is apparent that, between the agencies, a lot was known about the nature of the relationship between JW and BW. It is clear that the issues that were the catalyst for conflict between them, reached crisis point on a number of occasions and then subsided again, becoming a recurring pattern over the latter years of their relationship and, most specifically, in the period that followed JW losing his ability to drive and venture beyond their home.

11.20. The normalising of domestic abuse in this way, in that it was becoming expected that the couple behaved in this abusive way towards each other, seems to have limited the opportunities for engagement with domestic abuse support services, which could have supported a more positive outcome. However, whilst there is no definitive evidence to this effect, it may also be that the advanced age of both parties inhibited any referral to such agencies, that may, otherwise, have been considered.

11.21. Whilst Cambridge Women's Aid were notified of the abusive relationship, the fact that they did not offer their services to either party cannot reasonably be considered as a missed opportunity to intervene and prevent the suicide. The decision by the agency was fully rationalised and it is also relevant to recognise that the motivation by JW to take his own life was never definitively established, which prevents any conclusions being drawn as to why he chose to do so.

11.22. The decision by Cambridge Women's Aid not to offer their services, following two notifications from the police with regard to the abusive relationship, was not a refusal to provide a service. The decision was explained and rationalised within the context of their policies and their perception that the agencies already involved were the most appropriate and relevant to the prevailing circumstances.

11.23. The DASH scoring system may be considered to be disproportionately weighted towards those with children, to the potential detriment of the elderly. The weighting of the system may benefit from a review to ensure that all relevant risks are proportionately and fairly considered.

11.24. The case highlights significant 'unwise decision making' from both parties. The case also highlights the complexities of working within family relationships where there is a well-established history of conflict in a relationship in which both parties are dependent upon one another. It amplifies the importance of professionals coming together.

11.25. The discharge planning process, in respect of the arranging of medication for BW on 16th March 2018, was not managed efficiently. The following day a Community Psychiatric Nurse from the CRHTT visited and found there was no evidence of a care package for BW being in place.

11.26. On her discharge from CRHTT, on 29th March 2018, BW's mental state was stable and her cognition clearly intact. The decision to discharge her seems reasonable in terms of her mental health. Whether any intervention aimed at improving the quality of their relationship or alleviating their social stressors would have been acceptable or successful is debateable. However, there does not seem to be any record of this being offered or attempted.

12. Recommendations

12.1. Following a pilot in Cambridgeshire, commenced in August 2001, the standard DASH risk indicator checklist has been amended to take into account the risks faced by older victims. It is recommended that the outcomes of that amendment are reviewed and, if they are positive, then consideration be given to it being embraced on a permanent basis by all relevant agencies. The pilot has been extended to July 2022.

12.2. Guidance is required relating to the potential requirement for a Carer's Assessment be undertaken when a person registers with their GP as a Carer. This guidance could be provided via the Home Office 'Safe At Home' project which is considering the issues relating to both paid and family carers who are abusive to the person they care for.

12.3. Greater procedural clarity is required with regard to what can be done in the circumstances in which a victim of domestic abuse, who meets the Adult at Risk threshold, chooses to decline support that is offered to them.

12.4. Greater procedural clarity and training is required, for the police and their partner agencies, with regard to relationships that involve situations of bi-directional abuse. Options that embrace support, education and, if necessary and appropriate, sanction should be included within that training and procedure.

12.5. Cambridge University Hospital (CUH) to review the process used to monitor referrals to ensure that, when the safeguarding team advise staff to make a referral, that advice is followed up, if a referral is not received. *(Completed by 31st January 2020).*

12.6. The GP practice to consider how they could, more effectively, manage and retain oversight of complex cases where safeguarding concerns exist. *(Completed by 31st January 2020).*

12.7. The GP practice should ensure that an effective policy is in place to address any concerns that a person may be self-medicating beyond prescribed dosages. Any such policy should include the detail of how and when such concerns may be shared and addressed with other agencies as a means of ensuring the wellbeing of the patient(s) concerned.

12.8. The GP practice to define the circumstances under which they would cross reference, or link, the records of two or more patients, registered with the same practice, in circumstances where safeguarding concerns relate to all parties. *(Completed by 31st January 2020).*

12.9. GP Practice staff to receive training on the recognition of indicators of domestic abuse, together with the local support agencies and services that are available. The training should also include effective recording and onward referral processes. *(To be completed by 10th September 2020).*

12.10. GP Practice staff to be able to record, and review, Systm One data relating to domestic abuse being experienced by patients. *(Completed by 31st January 2020).*

12.11. Relevant training to be provided to Cambridgeshire Police duty managers, to ensure that, when officers attend apparent suicide incidents, initial enquiries take into account any indication of domestic abuse or violence and, if they do, to refer such cases to the Duty Senior Investigating Officer for further evaluation. *(Completed by 31st March 2020)*

12.12. Cambridgeshire County Council and Peterborough City Council Adult Social Care to review the current Carers Guidance, by 31st January 2020, with specific regard to Section 42 of the Care Act, 2014, and ensure that it is clear as to the point at which risks to Carers would need to be investigated under a Section 42 Safeguarding Enquiry, and the expectations from the multi-agency working within such an enquiry. *(Completed by 12th March 2020)*

12.13. Cambridgeshire County Council and Peterborough City Council Principal Social Worker to hold a Practice Event, by 31st March 2020, to share the learning from this Domestic Homicide Review, embracing the Good Practice identified and the importance of effective multi agency working. *(Completed by 9th March 2020)*

12.14. Cambridgeshire County Council and Peterborough City Council Adult Social Care Services to strengthen the support to carers, as part of mainstream practice, to consolidate the fact that all front-line practitioners have received one off workshop training since this incident. *(To be completed by 31st January 2021).*

12.15. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) staff to seek consent or refusal of services directly from the patient rather than from relatives. *(This guidance is to be included in the Q3 "Learning the Lessons' bulletin of 2019. The Head of Adult Safeguarding and the Head of Learning and Development are to be the lead managers).(Completed January 2020)*

12.16. The Discharge Planning policy of Cambridgeshire and Peterborough NHS Foundation Trust staff is to be reviewed to ensure that it reflects the fact that it considers the effect of social stresses in care planning and in discharge planning. *(The Director of Nursing and Quality will be the lead manager and the review will be undertaken during the next revision of policy). (Not yet completed)*

12.17. During the discharge planning process, absolute clarity should be achieved with regard to the arrangements for the provision and administration of medication. *(This guidance is to be included in the Q3 "Learning the Lessons' bulletin of 2019. The Head of Safeguarding and Chief Pharmacist will be the lead managers). (Completed January 2020)*

13. Independent Chair and Author

13.1. Ray Galloway was appointed by the South Cambridgeshire District Council Crime and Disorder Reduction Partnership as the independent chair of the DVHR panel and he is the author of the review document. He is a former Detective Superintendent in North Yorkshire Police, where he served for seven years, having worked the previous 24 years of his service in Merseyside Police.

13.2. Ray fulfilled the roles of Head of Major Crime, Head of Serious and Organised Crime and Director of Intelligence. He is a highly experienced and fully accredited Senior Investigating Officer, having led numerous investigations relating to offences such as homicide, kidnap and a whole range of other serious crimes.

13.3. He also has extensive experience of safeguarding related issues, including domestic abuse.

13.4. Upon leaving the police service Ray directed the independent investigation into the abusive activities of Jimmy Savile in Leeds. He also co-authored the public report.

13.5. Following on from the publication of that report, Ray directed the NHS Savile Legacy Unit, which oversaw, and quality assured more than 30 independent investigations into Savile at NHS Trusts around the country.

13.6. Ray regularly presents to safeguarding conferences regarding the lessons to be learnt from the Savile investigations.

13.7. In addition to being the Chair and/or Author of other DHRs, and involvement in several Mental Health Homicide Reviews, Ray has also undertaken independent investigations for a number of commercial organisations, for charities and for the Church of England.

13.8. He has no association whatsoever with South Cambridgeshire District Council or with any agency that is relevant to this review.

14. Secretary to The Panel

14.1. The role of Secretary to the DHR Panel was undertaken by an independent person. Tony Hester has over 30 years Metropolitan Police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

14.2. Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

14.3. His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

14.4. Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.