South Lakeland Community Safety Partnership

Domestic Homicide Review in relation to Mary

Date of homicide January 2020

Executive Summary

Independent Chair and Author: Stuart Douglass

Report completed February 2022

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the South Lakeland Community Safety Partnership[1] Domestic Homicide Review (DHR) Panel in reviewing the homicide of Mary, a resident of Cumbria.

1.2 In January 2020 a close friend of Mary's was unable to contact her and visited her home where she discovered Robert deceased and called the emergency services. Robert was found deceased, with an apparent self-inflicted shotgun wound. Mary was found deceased in her bedroom.

1.3 Initially the Police investigation considered a joint suicide, however, the post-mortem indicated that Mary had died of a combination of a morphine overdose, suffocation, and neck pressure. Robert had died from a single shotgun wound and a suicide note was found near his body. The couple had no children and no other person living with them. The conclusion of the coroner in relation to Mary was recorded as Unlawful Killing. The conclusion of the coroner in relation to Robert was recorded as Suicide.

1.4 This review has been anonymised in accordance with the statutory guidance[2]. The specific date of the homicide has been removed. Only the chair and review panel members are named.

1.5 To protect the identity of the victim and the perpetrator and key contributors to the review, the following pseudonyms have been used:

Pseudonym	Relationship to subject	Ethnicity	Age at time of fatal incident
Mary	Victim	white british	80 years
Robert	Husband/Perpetrator	White british	77 years
Susan	Mary's sister		
Naomi	Close friend of Mary		

1.6 The consideration of a DHR did not take place in the immediate period following the death of Mary. Following questions raised by Mary's sister in 2020 in relation to aspects regarding healthcare of Mary, the Named Nurse Safeguarding Adults at University Hospitals of Morecambe Bay Trust referred the case to Cumbria Constabulary in late April 2021. The circumstances were immediately reviewed and formally referred for consideration for a DHR to South Cumbria Community Safety Partnership[3] on 28th April 2021 some 15 months after the death of Mary.

1.7 The referral was formally scoped in line with Home Office statutory guidance on 11th May 2021 with range of key agencies and organisations who may have had previous contact with the victim.

[1] Community Safety Partnerships were established as statutory partnerships under sec 5-7 of the Crime and Disorder Act 1998 and include representatives from the police, local authorities, fire and rescue, health and probation services (the responsible authorities). The partnerships are responsible for ensuring the commission of Domestic Homicide Reviews.

[2] Statutory guidance for the conduct of Domestic Homicide Reviews, published December 2016, Home Office.

1.8 The Community Safety Partnership notified the Home Office of their intention to undertake a Domestic Homicide Review on 13th May 2021. Agencies with contact were asked to secure files.

1.9 The review was submitted to the South Lakeland Community Safety Partnership in February 2022 and approved for submission to the Home Office. The Home Office gave approval to publish in ????

2. CONTRIBUTORS TO THE REVIEW

Cumbria Constabulary	Individual Management Review /Panel
Cumbria County Council	specialist adult safeguarding advice/Panel
HM Coroner Cumbria	Coroner's investigation reports and documentation
Lancashire and South Cumbria Care Foundation Trust	information
Morecambe Bay Clinical Commissioning Group	Individual Management Review/Panel
North Cumbria Integrated Care NHS Foundation Trust	Panel and information
North West Ambulance Service	Information report
South Lakeland District Council	Panel
University Hospitals of Morecambe Bay NHS Foundation Trust	Individual Management Review/Panel
Victim Support	Specialist advice domestic abuse and victims/Panel
Probation Service	Panel

2.1 Individual Management Review authors had no management responsibility for any staff who had contact with either Mary or Robert nor had any contact with them.

3. THE REVIEW PANEL MEMBERS

3.1 Members of the Panel were as follows:

Cumbria Constabulary	Detective Inspector Scott Elgey/DC Sarah Edgar
Cumbria County Council	Sarah Joyce, Service Manager/ Safeguarding Adult Social Care
Independent Chair/Author	Stuart Douglass
Eden District Council	Clare Stratford – DHR coordinator for Cumbria
Morecambe Bay Clinical Commissioning Group	Emma O' Kane, Deputy Designated Nurse Safeguarding Adults, Morecambe Bay CCG
North West Ambulance Service	Sharon McQueen, Safeguarding Practitioner, North West Ambulance Services.
South Lakeland District Council	David Sykes, Director of Strategy, Innovation and Resources, South Lakeland District Council
University Hospitals of Morecambe Bay NHS Foundation Trust	Liz Thompson, Deputy Head of Safeguarding, University Hospital of Morecambe Bay NHS Foundation Trust
Victim Support	Sarah Place, Operations Manager, Victim Support

Probation Service	Emma Sutton Riley, Senior Probation Officer South Cumbria, Probation Service.

3.2 The panel met on 5 occasions. Panel members had no line management responsibility for any staff who may have contact with Mary and Robert and the chair was satisfied that the panel members were independent.

3.3 The Review Panel would like to express its sympathy to the family and friends of Mary for their loss.

3.4 The Review Panel would additionally like to thank those who contributed to the DHR process for their participation particularly the family and friends of Mary, who gave important insight into hearing Mary's voice.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 Stuart Douglass was appointed as chair and author. Stuart is an independent practitioner with over 30 years' experience in safer communities and safeguarding policy and has not worked for any agency or organisation contributing to this review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 Terms of Reference were agreed following the initial Panel meeting on 20th July 2021 and were as follows;

The review should address both the 'generic issues' set out in the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues:

Were local domestic abuse procedures followed by agencies who had contact with Mary?

Were local adult safeguarding procedures followed by agencies who had contact with Mary?

To consider if at any stage of the period under review whether Mary was an adult with care and support needs. (*Care Act 2014 definition which would also bring in any consideration of both; 1. an assessment of her care and support needs and 2. concerns of abuse and neglect - safeguarding concerns)*
Did agency interventions adequately take account of the caring responsibilities of Robert?

Were services responsive and accessible to Mary?

Were services responsive and accessible to Robert?

Were any agencies aware of the suicidal ideation of Robert?

Was information shared in a timely manner and to all appropriate partners during the period covered by this review?

Does training and practice in agencies adequately understand domestic abuse, coercive control and risk in older people?

To consider if there were any barriers to the identification and reporting of coercive control, domestic or other forms of abuse in relation to Mary?

Are there areas that agencies can identify where national or local improvements could be made to the existing legal and policy framework?

Specific issues for individual agencies
All agencies should address the key lines of enquiry above but in addition to this, there are some specific issues that should be addressed by the following agencies/partnerships;
Cumbria Constabulary
To consider the issue of the missed referral to the DHR process.
To ensure the Individual Management Review reflects firearms licensing policy in relation to older persons in general and specifically in relation to Robert.
South Cumbria Community Safety Partnership and Cumbria Adult Safeguarding Board
To provide briefing to the review reflecting any relevant learning from previous Domestic Homicide Reviews/Safeguarding Adult Reviews in Cumbria and progress to date in relation to any relevant lessons.

5.2 The review considers agency contact and involvement with Mary and her husband, Robert. Individual Management Reviews detail the period 12 months prior to the deaths and chronologies of agency contact covered the period from January 2015 until January 2020.

5.3 The rationale for the period chosen was that Mary's health began to deteriorate significantly throughout 2019. The longer chronology period was felt to be important to provide a wider context to the review. Key events and family and friend accounts which covered much longer periods were also considered.

6. SUMMARY CHRONOLOGY

6.1 Mary and Robert met and married in the 1960s and had lived together for almost 55 years both within and outside of the UK.

6.2 Mary and Robert moved the Lake District area of Cumbria following their retirements from respective careers as teacher and airline pilot. Family and friend's accounts indicate that Mary was not consulted on the purchase and did not see the property until they moved relocating from the south of England.

6.3 Robert led an active retirement, frequently renting small aircraft at a local airfield, swimming, walking, and cycling. Robert would holiday abroad with a former work colleague.

6.4 Mary remained in regular contact with her sister who lived in the south of England and school friends and was a member of a horse racing syndicate following her giving up horse riding due to health reasons.

6.5 The couple had no local friends, other than Naomi, who became close to the couple and Mary in particular, from 2015.

6.6 The review found only 2 agencies had any significant recorded contact with the couple.

6.7 Robert held a shotgun licence therefore had routine contact with Cumbria Constabulary in relation to firearms licence renewal every 5 years (and last in 2016).

6.8 GP and wider NHS hospital and community services had contact with Mary due to heart related health from 2015 and this increased considerably from mid 2019 with 2 emergency hospital admissions.

6.9 Mary was never referred or known to Adult Social Care.

6.10 In 2015 Mary records in her diary the first instance of physical abuse from Robert. This is not reported or known until after her death. In late 2019 she indicates to Naomi that Robert had injured her wrist whilst grabbing a torch from her in bed. Robert states this was an accident. Naomi warns him that it could be construed as assault.

6.11 In August 2019 Mary's sister, Susan, visits from the south of England and notices there is very little food in the house. Mary cannot mobilise beyond a short walk aided with sticks.

6.12 Naomi also picks this up and visits more frequently, bringing meals for Mary.

6.13 Robert refuses advice from Susan and Naomi to seek assistance to care for Mary.

6.14 Mary increasingly cancels or does not attend a number of outpatient visits to health services. She indicates to friends that Robert refuses to take her indicating that he believes it is a "waste of time" as she is "dying anyway". Naomi tries to intervene, but Robert becomes defensive, and Mary is frightened that he will stop Naomi visiting and declines her offers to take her to the GP or hospital appointments.

6.15 From mid 2019 to January 2020 there were many contacts between Mary and the GP service and a specialist heart care team who were based at a local hospital. Consequently, Mary receives frequent medical monitoring, review of medication and is given advice as to what to do if her condition worsens.

6.16 Robert is present at many of these contacts with medical professionals and presents as capable and willing to care for Mary.

6.17 In late December 2019 Mary telephones the heart care team (who are due to visit that day) saying she was concerned as to whether she needed to be moved into care. At the visit that day Robert assures the nurse that he remains able to cope and that they can pay for a carer if needed or trial respite care. As Mary is considered to be in a plan for care the service withdraws at that point and care passes to the GP.

6.18 Between October and November 2019 Naomi raises concerns with GP reception on 4 occasions. Three of these are in relation to Robert and his ability to cope and the impact on his mental health as Naomi has observed him crying. Three of these are recorded in GP records, however one in late October is not and is in relation to Naomi reporting to the surgery that Mary told her that Robert wished to kill himself and had gone out to do so. Naomi raises further issues some days after this and the GP surgery responds to the concerns arranging a joint appointment for Mary and Robert to ask how they are coping and then some weeks later a letter inviting Robert to visit the GP alone.

6.19 Robert responds in the joint appointment by saying everything is fine and that he can cope, and in respect of the letter invite to see the GP alone he declines the offer, and it is not actioned further by the GP.

6.20 During November Naomi is made aware that Robert is angry at having to deal with Mary's personal care and on another occasion witnesses him shouting at Mary when she arrives at the house.

6.21 Robert becomes aggressive in his attitude towards Naomi and her offers to assist and suggestions that Mary goes into a local care home for respite, though eventually agrees this could be explored. Despite this he continues to be vocal in stating there would never be carers in the house.

6.22 In January 2020, five days before the homicide/suicide both Susan (who is visiting Mary from the south of England for a few days) and Naomi raise concerns with the GP reception again. These included concerns that Mary had been constipated for 9 days, was in pain, losing weight, there being no food in the house and that Robert was "controlling".

6.23 The surgery responds by arranging a visit of the practice paramedic 5 days later.

6.24 The paramedic arrives for the appointment to find that emergency services are dealing with the discovery of the deaths of Mary and Robert.

7. SUMMARY OF INFORMATION KNOWN

7.1 The couple were both well known to the GP surgery. Robert was usually present at Mary's consultations and Mary was rarely seen alone. Robert always presented to professionals as capable and coping and he would decline support.

7.2 Health agencies provided consistent medical intervention and support to Mary however there were no referrals made to adult social care for a Care Act assessment of Mary's care needs or a carers assessment for Robert.

7.3 Family and friend accounts post homicide indicate that Robert had been a member of 2 organisations that promote euthanasia (possibly for decades). Mary expressed to friends that she did not want to be part of this.

7.4 Naomi and Susan raised concerns with the GP practice on 5 occasions between October 2019 and early January 2020. Only 4 were recorded. Actions were taken but involved initially speaking to the couple together preventing any opportunity for Mary to disclose and writing to Robert inviting him to speak to the GP which he declined. The final concerns were responded to by arranging a routine home visit 5 days later. The visit took place but at this point Mary and Robert had been found deceased.

7.5 Accounts from family and friends and evidence from Mary's personal diary (given after Mary's death) indicate that Robert's behaviour was coercive and controlling throughout the marriage. There are accounts of him acting in a physically violent manner towards Mary in 2015 and 2019.

7.6 Accounts of Robert's behaviours indicated coercive control, abuse, and neglect. Naomi recounted Mary disclosing that Robert would turn off the water in the property and only allow her to bathe once per week, lack of food in the house, Robert refusing to take Mary to medical appointments, and refusing to let care services be explored or engaged.

7.7 Mary's declining health and mobility increased Robert's ability to carry out coercive and controlling behaviour. This combined with Robert's strength and physical size made Mary increasingly vulnerable to Robert's neglectful and abusive behaviours.

7.8 By contrast Robert would appear to health professionals as attentive and supportive of Mary and concerns of abusive behaviour were not witnessed or recorded by health professionals.

7.9 Mary, despite her debilitating physical health, maintained contact with her friends and her interest in horse racing. Mary had capacity and ability to express her wishes and fears, however, was "frightened" of Robert and would avoid any situation that would annoy him.

7.10 The Panel considered that Robert had challenged Naomi's offers of assistance either through displaying an abusive response or by possibly manipulating her by indicating he was struggling to cope. Whatever the motivation, they were potentially signals to keep Naomi at a distance from seeking support.

7.11 Despite this, and the fear that Mary would be isolated if Robert forced her to withdraw from her visits, Naomi would directly challenge Robert, offer support, and report her concerns to the GP practice, an agency with safeguarding responsibilities, who had frequent contact with Mary and Robert.

8. KEY ISSUES ARISING FROM THE REVIEW

8.1 There was oversight following the police investigation in not recognising a referral of the circumstances for consideration for a DHR.

8.2 Mary had been in poor health since 2015 and that declines further from mid 2019, considerably increasing care responsibilities on Robert.

8.2 Concerns regarding Robert and Mary were raised on 5 occasions with the GP practice by the friend of Mary and her sister. Whilst 3 responses to those concerns were made, no consideration of a safeguarding referral or Care Act compliant assessment of care and support needs was initiated. One of the concerns in late October 2019, which indicated that Robert had suicidal ideation, was not recorded by the GP practice. The final concern raised questions regarding domestic abuse with reference to Roberts controlling behaviour.

8.3 There was no evidence of the concerns being viewed cumulatively and missed opportunities to clarify with the referrer/s further detail on those concerns. In addition, there was no sharing of the concerns with safeguarding leads at the practice or another NHS service that were visiting Mary at home at that time, which may have elicited further information or disclosure. There were missed opportunities to make a safeguarding referral which may have led to further enquiry by Adult Social Care regarding the situation at the home.

8.4 Robert was able to present to medical professionals as capable and attentive.

8.5 There was evidence that the perpetrator had mental health concerns, and this coupled with increased caring responsibilities and suicidal ideation are increasingly identified in academic research as trigger factors in homicide/suicide cases.

8.6 Mary was rarely seen alone, and her voice was infrequently heard or recorded in medical records. This limited any opportunity to disclose neglect or abusive behaviours.

8.7 Non attendance or cancellation of hospital appointments was not explored.

9. CONCLUSIONS

9.1 The consideration of a DHR was delayed for 15 months however once recognised was actioned. Robust improvement activity in respect of this was undertaken by Cumbria police and the review makes no further recommendations in respect of this.

9.2 The review experienced some difficulties and delays in obtaining information from the GP practice as the providers had changed post homicide. The Covid pandemic further exacerbated this.

9.3 There were missed opportunities for the GP practice to investigate more robustly the concerns raised by Mary's friend and sister, share information regarding those concerns both with staff at the practice and other NHS services engaged with Mary's care, or refer to adult safeguarding.

9.4 There were missed opportunities to refer to adult social care for a care needs and carers assessment.

9.5 Surgery staff had completed safeguarding training, however, that training did not take a whole surgery approach whereby medical and non-medical staff train together.

9.6 The perpetrator was skilled at disguised compliance presenting a false picture to professionals.

9.8 Mary was rarely seen alone by professionals and a "rule of optimism" existed whereby professionals did not question wider circumstances and focussed on medical care.

9.9 Mary's voice was infrequently evident in records.

9.10 The surgery and Cumbria Police did not have a copy of the 2016 letter to the GP indicating that Robert had been granted a firearms licence renewal. Whilst the letter should have been on file it was unlikely to have been marked at the front of records and had the concerns regarding Roberts suicidal ideation been recorded, may have led to a missed an opportunity to refer licence concerns to police.

9.11 The full picture of coercive control and abuse was not known fully to friends and family until after the homicide.

10. LESSONS TO BE LEARNED

10.1 Early agency learning was identified during this review process via individual agency reviews and the learning and recommendations are in the process of being implemented.

10.2 Cumbria Constabulary have completed several improvement actions in relation to identifying suicide related cases as Domestic Homicide Reviews and those actions are robust and complete.

10.3 University Hospitals Morecambe Bay Trust identify one recommendation which relates to the Heart Failure Team that they will introduce distinct safeguarding supervision for all staff working with vulnerable adults. This is to be separate to clinical supervision and to be documented accordingly.

10.4 The Clinical Commissioning Group have equally identified a range of improvements and have undertaken to deliver those prior to completion of the DHR.

10.5 The surgery which undertook a significant proportion of medical care with Mary has taken a position of not identifying or implementing any learning or improvement, nor responding to a complaint from Mary's family until the DHR process is complete and has consistently followed a position that their actions were proportionate and responsive. It is the view of the chair that this is disappointing, could be interpreted as lacking candour, and followed a letter to the practice from the coroner, following the inquest in 2020 which emphasised that the inquest should act as a catalyst for significant learning for the practice.

10.6 In terms of the DHR a range of learning has been identified.

10.7 Coercive control and domestic abuse is hidden in the older population. Practice and training reference older people and abuse. Awareness and practice knowledge however need to be continually updated with a focus on specific training and raising community awareness of abuse and older people.

10.8 There is a danger that when focussing on age related healthcare a "rule of optimism" can disguise needs and concerns of victims.

10.9 Perpetrators can be skilled at "disguised compliance", appearing to be caring and hiding resistant to support.

10.10 The impact of increasing caring responsibilities is underestimated in terms of its impact on mental health of carers and as a driver for perpetrators to escalate their behaviours.

10.11 Formal carer assessments should be encouraged and routinely considered.

10.12 Wherever possible patients should be seen alone, and their voice should be routinely heard and recorded.

10.13 Abusers are skilled at avoiding discovery and can manipulate those who may question their actions and behaviour.

10.14 Previous learning and improvement work in Cumbria in relation to awareness of older people and domestic abuse should be built upon with further work and using this review as part of that learning.

10.15 There was key learning around the handling of safeguarding and welfare concerns raised by members of the public – there were missed opportunities to talk in more detail to referrer. Concerns from family and members of the community should be treated with the level of consideration as concerns that are raised by professionals trained in making concerns known.

10.16 Surgery staff respected Naomi's request to remain anonymous when she raised concerns and panel agreed that this is important to members of the community. If Naomi had consulted Adult Social Care with her concerns her anonymity would also have been assured however it is recommended that this is added to the public available information on adult safeguarding website advice.

10.17 The surgery responded to concerns but missed opportunities to explore these more fully, missed opportunities to share intelligence with other health professionals and referrals to adult safeguarding were not deliberated. Cumulation of concerns should have been considered.

10.18 Home Office Guidance in relation to firearms licensing was substantially revised in December 2021 and it would be beneficial to actively promote to GP's the new arrangements to ensure that any identified health concerns are reported to police licensing. It was also identified that firearm recording on medical records needs to be easily visible to health practitioners. Whilst the firearm in this case was not used to take Mary's life the panel agreed that learning should be applicable to other scenarios which may have different factors.

11. RECOMMENDATIONS FROM THE REVIEW

Recommendation 1

That Cumbria Safeguarding Adult Board seek assurance (within 12 months from publication of this review) to ensure that appropriate partner agencies actively promote carer assessments, and that those actions are fully documented.

Recommendation 2

That Cumbria Clinical Commissioning Groups request GP providers to ensure that all safeguarding concerns (and rationales for actions arising from those) are fully documented.

Recommendation 3

General Practitioners are reminded to regularly review non-attendance at NHS appointments and to consider whether there are barriers to attendance. This should be supported with consideration of introduction of a was not brought/did not attend policy.

Recommendation 4

The Clinical Commissioning Groups in Cumbria support GP practices in Cumbria to initiate and pilot whole surgery training in relation to safeguarding and abuse of older people. The importance of recording and sharing intelligence should feature within that training.

Recommendation 5

NHS records should capture the feelings and wishes of a patient, and in turn it should be clearly recorded who was present, and where possible the patient should on occasion be seen alone.

Recommendation 6

The Safer Cumbria Domestic Abuse Partnership, in conjunction with the Cumbria Safeguarding Adults Board, to agree a countywide approach to promote awareness around issues relating to older people and domestic abuse. This should consider training for professionals and community awareness raising.

Recommendation 7

That the Safeguarding Adult Board highlight on reporting pages that whilst it is beneficial for members of the public who report safeguarding concerns to leave contact details, they can be assured anonymity if they request that.

Recommendation 8

That Cumbria Constabulary and relevant GP Clinical Commissioning Groups actively promote to GPs the 2021 Home Office Statutory Firearms Licensing Guidance[4] and what actions to take where there may be concerns due to changes in the health circumstances of firearm licence holders.

Recommendation 9

That the Community Safety Partnership receive progress report/s on the implementation of the Home Office statutory guidance within 12 months. Reports to be provided by Cumbria Constabulary and relevant GP Clinical Commissioning Groups.

Recommendation 10

That the Chair of the Community Safety Partnership writes to the Home Office to request that any future revision of the statutory Domestic Homicide Review guidance considers further clarity in respect of the role in DHRs of both GPs and any services commissioned to provide those.

[4] Home Office Statutory guidance for chief officers of police on firearms licensing – updated 16 December 2021