South Lakeland Community Safety Partnership

Domestic Homicide Review in relation to Mary

Date of homicide January 2020

Independent Chair and Author: Stuart Douglass

Report completed February 2022

I would like to thank Susan and Naomi who have contributed significantly to the work of this review.

Throughout they have both articulated a strong motivation for the review to act as a driver for learning and improvement, to ensure that when professionals are approached by family, friends or community members expressing concerns, that those are heard and acted upon.

I would also like to thank the Cumbria representatives on the DHR panel for their active engagement in panel and willingness to engage in discussion with the chair both within and outside of formal panel meetings.

Stuart Douglass

Independent Chair

2. Introduction

2.1 This report of a domestic homicide review (DHR) examines agency responses and support given to Mary, a resident of Cumbria prior to her death in January 2020.

2.2 Mary was unlawfully killed by her husband Robert, who then committed suicide at the scene.

2.3 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.

2.4 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.

2.5 The 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.

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

2.7 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.

3. Timescales

3.1 The consideration of a DHR did not take place until 15 months after the death of Mary. Following questions raised with the GP practice by Mary's sister in August 2020 in relation to aspects regarding healthcare of Mary, and a number of escalated responses, the letter finally comes to the attention of the Named Nurse Safeguarding Adults at University Hospitals of Morecambe Bay Trust who refers the case to Cumbria Constabulary in April 2021. The circumstances were immediately reviewed and formally referred for consideration for a DHR to South Cumbria Community Safety Partnership.

3.2 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. The scoping meeting considered the written and verbal summaries of agencies, and a recording of the meeting was made available to the chair upon appointment.

3.3 The Community Safety Partnership notified the Home Office of their intention to undertake a Domestic Homicide Review on 13th May 2021.

3.4 The Domestic Homicide Review (DHR) was commissioned with due regard to the Domestic Violence, Crime and Victims Act 2004 and relevant criteria to this case are highlighted in bold. The Act states:

In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

a person to whom he was related or with whom he was or had been in an intimate personal relationship, *or*

a member of the same household as himself,
held with a view to identifying the lessons to be learnt from the death.

3.5 The chair/author was appointed on 22nd June 2021 and initial review panel meeting commenced work on the DHR on 20thJuly 2021. The review concluded in February 2022.

3.6 The circumstances in respect of the delay in referral to the Community Safety Partnership, following the death of Mary in January 2020, are addressed in the body of the report.

3.7 The review took longer than the 6 months expected in the guidance. This was due to the continuing impact of the COVID-19 pandemic on the NHS and the chair's request for additional information as enquiries evolved[1].

4. Confidentiality

4.1 The findings of each review are confidential until agreement to publish has been given by the Home Office Quality Assurance Panel.

4.2 Pseudonyms have been agreed with the family and are used throughout the report to protect the identity of the individual(s) involved.

4.3 The victim was White British and aged 80 years at the time of the fatal incident.

4.4 The perpetrator was White British and aged 77 years at the time of the fatal incident.

5. Terms of Reference and Methodology

5.1 The Domestic Homicide Review followed the methodology outlined in the Home Office statutory guidance. Sources of information included:

- Individual Management Reviews – completed by Cumbria Constabulary, Morecambe Bay Clinical Commissioning Group and University Hospitals of Morecambe Bay NHS Trust
- interviews of staff

[1] The Chair requests via the Clinical Commissioning Group for GP information were compounded by the former provider organisation no longer responsible for delivering services and cooperation of the practice was often delayed or possibly combined with them being unfamiliar with the DHR process. it would have been helpful to have them engaged with the panel. This is reflected in recommendation 10.

- a combined chronology
- accounts of family and three friends of Mary
- account of a friend of Robert
- documents and information submitted by Mary's sister including information from Mary's personal diaries
- documents and statements provided to HM Coroner, Cumbria
- contributions from panel members with specialist knowledge in respect of adult safeguarding and older person's domestic abuse
- enquiries to the Civil Aviation Authority
- relevant literature review

5.2 The terms of reference were as follows;

Key lines of enquiry:

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.

5.3 Terms of Reference were agreed following the initial Panel meeting on 20th July 2021

6. Involvement of Family and Friends

6.1 The chair contacted Mary's sister, Susan, who lives in the south of England, initially by telephone followed by letter of introduction and background to reviews, together with the Home Office domestic homicide leaflet.

6.2 Susan was aware a DHR had been commissioned following correspondence she had previously from the NHS complaints service in relation to questions she had raised in respect to her sister's health care.

6.3 The chair invited Susan to consider advocacy support from Action After Fatal Domestic Abuse in both the letter and in subsequent telephone conversations. Susan declined the offer, however, the chair indicated that it was an option for her to access at any time throughout the review and he would assist her in making contact if required.

6.4 Draft terms of reference were shared with Susan for comment and the chair followed this up with a telephone meeting (Susan's preferred means of communication) to discuss them. Susan indicated that the terms of reference covered the areas she wished to be addressed by the review. The chair remained in regular contact with Susan throughout the review period by telephone and e mail. The DHR lead for Cumbria assisted Susan to install TEAMS on her computer and ran several familiarisation sessions with Susan prior to her meeting panel using this format.

6.5 The draft overview report was shared with Susan in January 2022 and she was given the opportunity to comment, suggest amendments and discuss the report in detail with the chair.

6.6 The chair was informed that Robert had an estranged sister with whom he had not had a relationship with since the 1980s and no details as to her contact were available.

6.7 Three close friends of Mary were approached, and all had online or telephone conversations with the chair.

6.8 One friend had known Mary all her life, meeting Mary at school, whilst another had known her for almost 20 years as part of a horse syndicate. The third friend, Naomi, who lived in the same area as the couple, had started work assisting with domestic cleaning in 2015 but became a very close friend of Mary and had the most significant amount of face-to-face contact with Mary and Robert for the period under review.

6.9 A former work colleague of Robert, who had known the couple and been a close friend of Robert since the 1970s, was contacted, and again he spoke at length with the chair.

6.10 The accounts of family and friends which covered lengthy periods of knowing Mary are important and offered the review an insight into the lives of a relatively private couple.

6.11 All participants were offered the opportunity to review how their contributions appear in this report.

6.12 Susan and Naomi had provided statements to Cumbria Police for the Coroner's investigation which were taken soon after the tragic incident. Susan and Naomi discussed the statements and related issues at length with the chair.

6.13 This review was commissioned after the inquest proceedings were completed due to consideration for a DHR not being undertaken at the time of deaths. This gave the review a base to work from not always available in DHRs where an inquest may typically follow the review process.

6.14 Both Susan and Naomi met the panel on 4th November 2021 and had an opportunity to talk directly to panel about Mary and Robert, ask review panel members questions, and in turn to invite the review panel to ask them questions. This meeting was considered valuable by both Susan, Naomi, and the review panel.

7. 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

7.1 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.

8. Review Panel Members

8.1 Members of the Panel were as follows;

Cumbria Constabulary	Detective Inspector Scott Elgey, Independent IMR writer, Cumbria Constabulary DC Sarah Edgar, DHR SPOC, Cumbria Constabulary
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.

8.2 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. In addition the chair met online with a number of panel members individually.

9. Author of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[2] sets out the requirements for review chairs and authors. In this review the chair and author roles were combined.

9.2 Stuart Douglass was appointed as the Domestic Homicide Review chair and author. Stuart is an independent practitioner with 30 years' experience in safer communities and safeguarding policy at local (northeast England) and national level, with experience of Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adult Reviews.

9.3 Stuart has not been employed by any agency in Cumbria, though in 2019, facilitated a Safer Cumbria Partnership development day on behalf of the Local Government Association and Office of the Police and Crime Commissioner.

10. Parallel Reviews

10.1 HM Coroner for Cumbria held an inquest in respect of Mary and Robert in March 2021.

10.2 The coroner's officer provided the review chair with all key documentation considered at the inquest and an audio recording of the proceedings.

10.3 There were no other parallel reviews.

11. Equality and Diversity

11.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010.

11.2 The review panel identified sex, age, and disability as protected characteristics relevant to this review.

11.3 It was confirmed by Mary's sister that neither Mary nor Robert were religious. There were no other protected characteristics relevant to the review.

11.4 The Crime Survey for England and Wales estimate that 1.6 million women aged 16 to 74 years experienced domestic abuse in the year ending March 2020. Of domestic homicide victims

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

(killed by ex/partner or a family member) for the year ending March 2017 to the year ending March 2019 77% were female and 96% of suspects were male. [3]

11.5 In respect of age, Mary was 80 years old. Whilst domestic abuse experienced by older people has many characteristics in common with abuse experienced by younger victims, we need to be mindful to not to consider older people as a homogenous group and to not assume simplistic societal stereotypes.

11.6 The report, Safe Later Lives: older people and domestic abuse, published in 2016 by Safe Lives in conjunction with Age Concern, found systematic invisibility of older victims of domestic abuse in services, long term abuse and dependency issues with a quarter of victims living with abuse over 20 years and many victims relying on the abuser to be the carer as their health deteriorates.

11.7 The research also indicated the dynamic of generational attitudes whereby matters in the home were considered private and not to be discussed. This is further compounded by victims not recognising abusive behaviours and having a lower awareness of services available to support. This is an important point and not only attitudes, but law and policy have undergone significant change across the lifetimes of older people. For example, rape within marriage was not considered an offence until the early 1990's[4].

11.8 An alternative view is offered by Benbow et al who reviewed DHRs in older people and they conclude that age itself is not a significant factor in domestic homicide, apart from in the way that stereotypes and assumptions about age influence the health and social care assessments made and interventions offered[5].

11.9 Until changes in the Domestic Abuse Act 2021 the British Crime Survey did not consider data in respect of domestic abuse in the over 65s which has compounded the lack of awareness of abuse in older relationships.

11.10 Mary's health deteriorated significantly in 2019, limiting her mobility within her home. Declining health of victims of abuse and increasing reliance on care from an abusive partner is recognised as a critical escalation factor in levels of abusive behaviour.

---

[3] Office for National Statistics (ONS). Domestic abuse victim characteristics, England and Wales: year ending March 2020

[4] The Law Commission (LAW COM 205) Criminal law rape within a marriage - published 14th January 1992
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228746/0167.pdf

[5] Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age SUSAN MARY BENBOW*†, SARMISHTHA BHATTACHARYYA*‡ and PAUL KINGSTON*Ageing & Society 39,2019 1097-1121

12. Dissemination

12.1 Recipients who will receive copies of the review report:

- Mary's sister
- South Lakeland Community Safety Partnership Board
- Safer Cumbria Board
- Cumbria Safeguarding Adults Board
- Office of the Police and Crime Commissioner
- Cumbria Domestic Abuse Partnership
- Care Quality Commission
- HM Coroner Cumbria

13. Background Information (The Facts)

13.1 Mary and Robert met in the 1960s, were married in 1966, and had lived together for almost 55 years both within and outside of the UK.

13.2 Mary lived with her husband Robert in the Lake District area of Cumbria in a detached home within walking distance of a small town with a significant tourism and visitor economy. The property was described as having a large garden and several neighbouring properties were holiday homes.

13.3 The couple had no children and no other person living with them.

13.4 The area is described as affluent and Public Health England rates the level of deprivation within the area as nine on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. (source Care Quality Commission)

13.5 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.

13.6 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.

13.7 Following the Inquest hearing, the Coroner, in describing in what circumstances the deceased came by her death, recorded the following in Section 3 of the Record of Inquest:

"[redacted] died at her residence (name, address and date redacted) in January 2020. She had been in poor health for several months and evidence suggests that her husband was struggling with, and becoming increasingly frustrated by, her care needs. It is most likely he

gave or induced her to take an excessive dose of her prescribed morphine which rendered her unconscious. He has accelerated her death by suffocation and neck pressure".

13.8 The conclusion of the coroner in relation to Mary was recorded as Unlawful Killing.

13.9 The conclusion of the coroner in relation to Robert was recorded as Suicide.

14. Background prior to the timescales under review.

14.1 This section intentionally gives a long overview of the lives of Mary and Robert. We should be mindful that older people have had extensive life experience and working lives which influence their thinking and activities in older age and to not fall into stereotypical views of age.

14.2 Mary was born and brought up in the northeast of England with her younger sister Susan. Her parents were described as affluent with her father holding a high-ranking post in public service. From childhood Mary loved horses and this continued to feature throughout her whole life as a rider of horses, and when her health prevented this in later life, as a part owner in a horse racing syndicate.

14.3 Mary left school and embarked on a career in teaching, leaving home to train and then to take teaching roles abroad. Whilst teaching in Malta, she began a relationship with Robert who was posted there with the Royal Air Force.

14.4 Robert has been described as born in Yorkshire and little is known of his early childhood. Upon leaving school he joined the RAF and became a navigator.

14.5 The couple married in 1966.

14.6 Upon Robert leaving the RAF and returning to the UK, Mary continued to teach whilst Robert trained as a commercial pilot. Following this he progressed to work for large UK based airlines.

14.7 The couple lived in various locations due to Robert's work, including the northeast of England, southwest Scotland and eventually the southeast of England.

14.8 The couple both had an interest in animals and lived in rural locations in properties with land to facilitate this.

14.9 Robert retired in 1993 and purchased a bungalow with large garden in the Lake District area of Cumbria. Both Susan and friend's accounts indicate that Mary was not consulted on the purchase and did not see the property until they moved. It was reported that Mary did not wish to relocate from the southeast, however at Robert's insistence and him agreeing she could take her horse and stable it nearby, Mary retired a year earlier than planned from her teaching career and they moved to Cumbria.

14.10 Robert retained a pilot's licence throughout retirement, frequently renting small aircraft at a local airfield, and the Civil Aviation Authority confirmed with the review chair that he still had a valid licence in place at time of death.

14.11 Robert was physically active throughout his retirement being a regular swimmer at a local hotel, and often described as "out all day", cycling and hiking across the Lake District. Robert was well known locally, though the couple had no local friends, other than Naomi, who became close to the couple and Mary, in particular, from 2015.

15. Friend contributions

15.1 Friend 1, from the horse syndicate described Mary as a close friend and they socialised at horse training and racing events with the four women who formed the syndicate. Robert would bring Mary to many of these events which could be some hours' drive from their home.

15.2 They spoke regularly on the phone and maintained weekly contact after Mary's health deteriorated in 2019.

15.3 Friend 1 referred to Robert as, "intelligent, always asking questions" and never displaying any negative behaviour at their meetings. She indicated that Robert was definitely "controlling" but that Mary would "laugh about it", and frequently say, "it's just Robert" and "you don't want to know, it's Robert".

15.4 The couple were described as "very private". Friend 1 indicated that Mary would have liked more help, but Robert insisted on doing everything.

15.5 Friend 1 said Mary often spoke warmly about her teaching career which she had loved, and she was described as highly knowledgeable about horses.

15.6 Friend 1 related that after Mary had been in hospital on one occasion that she had suggested she should go into a short stay nursing home to "get a head start", but Mary indicated she could not, "because Robert wanted to do everything."

15.7 Friend 1 indicated, (as did others) that when Robert was away or out Mary was much more relaxed on the telephone and would indicate she could do what she liked.

15.8 She telephoned Mary possibly the day before her death and Mary had indicated she was feeling terrible and said she would have to go, ending the call.

15.9 Friend 2 had attended school with Mary and had kept in touch with Mary all her life and they had shared painting holidays together in Europe on several occasions until Mary's health deteriorated.

15.10 Friend 2 described that Mary retired a year early after Robert had bought a house in Cumbria which she had not seen (described as "typical of Robert"). The couple always lived near

Robert's work base airports in rural locations, keeping sheep and other animals. Mary gave up riding after an accident in 2011 and that is when she joined the women's horse racing syndicate.

15.11 Friend 2 indicated that she had observed that Robert had exhibited behaviours that she has since considered limited Mary's independence such as "making visitors uncomfortable".

15.12 She related that this began very early in the marriage, and recounted the couple being posted abroad when Robert was in the RAF and when another close school friend arranged to visit Mary with her partner, Robert reportedly left the home for a few days saying he did not want to see them.

15.13 Friend 2 described that the couple had holidayed together when younger but as they got older in more recent years had holidayed separately or with friends. She had two painting and drawing holidays in Europe with Mary. She described Mary as "open and happy" on these holidays, easily making friends with the other class members. She did however state Mary had to ring Robert every evening at his insistence.

15.14 Friend 2 said Mary attended a painting group in the town where she lived, however, when it closed, and the nearest group was in another town, she gave up.

15.15 Friend 2 described that Robert had access to airline travel due to his career as a pilot and on one occasion Mary indicated she was relaxed as Robert had travelled to New Zealand for a holiday. A few days later she rang Mary again who was disappointed that Robert had arrived in New Zealand and as it was apparently a national holiday with many places closed, had decided to stay one or two nights, and return home. She described this as "typical of Robert's behaviour".

15.16 Friend 2 indicated that Mary had greater independence when she and Robert both worked.

15.17 When Mary was ill, she indicated that Mary told her she was missing appointments at hospital because Robert wouldn't take her, saying to Mary that they couldn't do anything for her.

15.18 Friend 2 recalled that when Mary "wasn't well", she had mentioned the organisation "Dignitas"[6] which Robert had joined, but she said Mary indicated that it was a "stupid idea".

15.19 Friend 2 had not witnessed abusive behaviour and indicated that she thought Mary wouldn't accept it. She spoke to Mary once or twice a week on the phone and last spoke a few weeks before the homicide.

15.20 Robert's friend had met him in 1974, when they both began flying commercial passenger aircraft out of the northeast of England. He and his wife became friends of Mary and Robert,

[6] Dignitas is a Swiss non-profit members' society providing assisted/accompanied suicide to those members of the organization who suffer from terminal illness and/or severe physical and/or mental illnesses, supported by qualified Swiss doctors independent of the organization. source Wikipedia

often socialising together. He described Robert as "highly intelligent" and "very funny" but somewhat dominating in social settings.

15.21 He indicated that Robert had "hated" his father and had said he used to beat him as a child. He described Robert as devoted to his mother, later buying her a flat in Cumbria so that he could be near her as she got older.

15.22 Both couples moved to Scotland when airline employers changed and remained friends as a couple until the early 1980s when the friend and his wife had children and later both moved to different UK locations for work.

15.23 Though contact was then less frequent, the couples meeting perhaps once a year, Robert and Mary attended their children's weddings.

15.24 At work Robert was described as having a dislike of authority and "liked to do his own thing".

15.25 He said Robert had mentioned Exit[7] and Dignitas on occasion saying he would get pills and book a hotel if he needed to end his life.

15.26 The friend described that following retirement and from around 2000 they went skiing twice per year at a friend's apartment, and whilst Mary attended a few times she stopped going, being less interested in skiing than Robert.

15.27 The friend last holidayed with Robert in 2018 and described that in hindsight he realised that Robert "had changed" in that he wouldn't go out to socialise or eat out in the evening, which was always a feature in earlier trips.

15.28 The friend mentioned that Robert and Mary loved dogs, however, Robert would only feed them every second or third day, arguing that this was how they would feed in the wild. Susan also commented on this saying that the dogs would get hungry and escape, often feeding from bins at the rear of local hotels. This was described by Susan as a source of conflict between Robert and Mary.

15.29 On his later visits with his wife to see Robert and Mary, he observed Robert acting strangely, turning the router off when not using the computer, lights not working in parts of the house, and Robert using a torch.

15.30 On one occasion during one of their later visits to Cumbria he recounted that his wife wanted to go for a walk with Mary saying she should not be encouraged to stay on the sofa bed, and he described they couldn't find Mary's shoes as Robert had "apparently hidden them".

15.31 The friend described the couple's relationship as appearing "cold" on occasion, and Robert very much a "loner", never joining clubs or hiking in groups except with him. Despite this he

[7] Exit International is an international non-profit organisation advocating legalisation of voluntary euthanasia and assisted suicide. It was previously known as the Voluntary Euthanasia Research Foundation. Source Wikipedia.

indicated that Robert would readily engage and talk in a friendly manner to tourists and strangers they met when out, even on occasion taking some flying.

15.32 He did not feel he had ever witnessed any abusive behaviour though described in hindsight that Robert occasionally put Mary down or made her uncomfortable in the company of others.

16. Chronology – January 2015 – January 2020

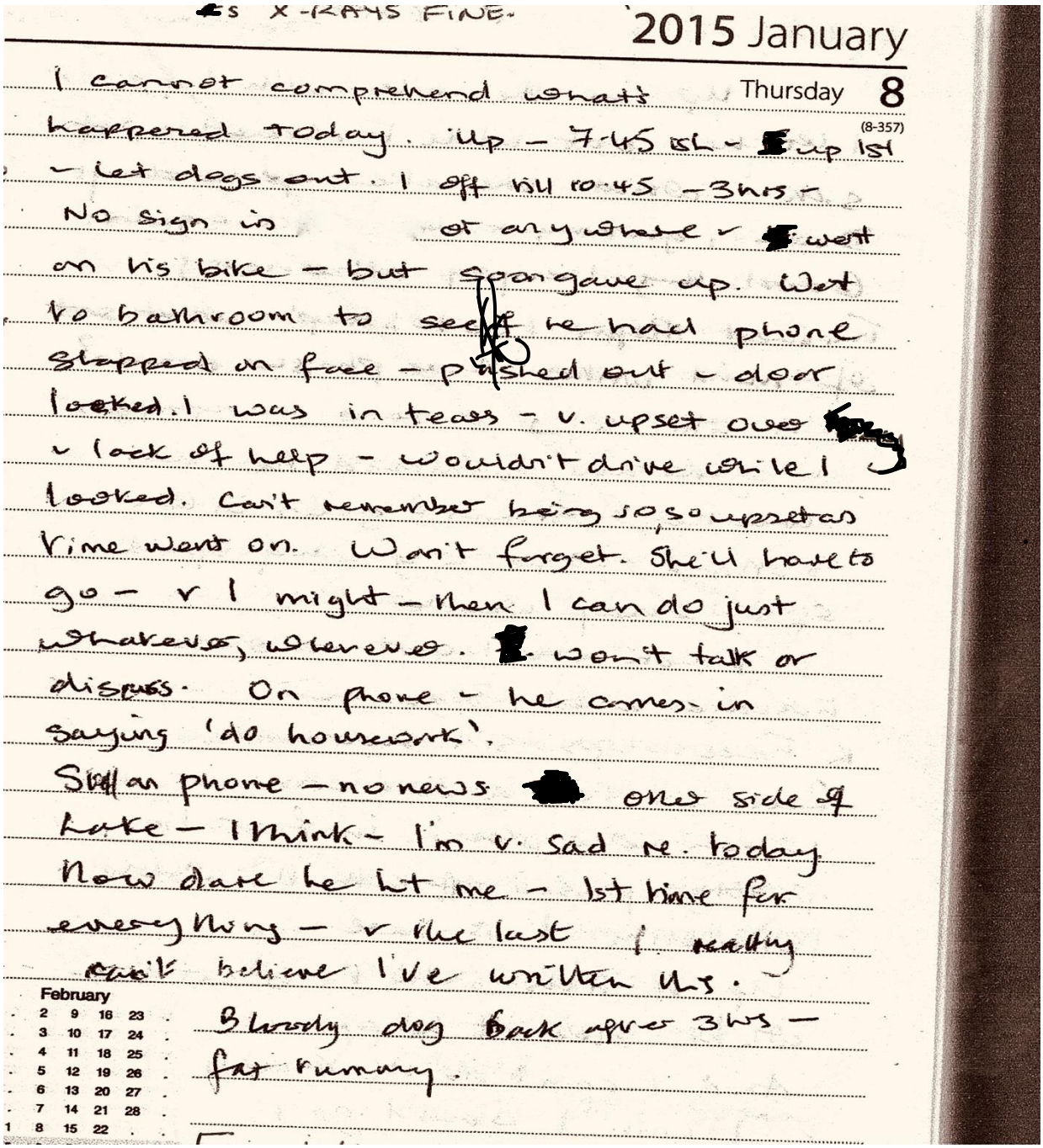
16.1 The DHR scoping had identified that Mary had either no, or only limited, contact with agencies. Mary was never referred or known to Adult Social Care.

16.2 Robert had held a shotgun licence since the 1960's. Cumbria Constabulary firearm licensing department had routine contact with Robert in relation to licence renewals every 5 years. The licence was renewed in 2006, 2011 and 2016.

16.3 The exception to this limited picture of agency contact were NHS services, often centred around the local GP practice.

16.4 In addition, hospital, outpatient, and community-based services had contact with Mary. This reflected Mary's heart condition identified in 2015 and as her health deteriorated rapidly during 2019, contact with and engagement of health services increased in frequency.

16.5 In 2015 Mary records in her personal diary the first time that Robert has been physically violent with her.[8]



s X-RAYS FINE.

2015 January

Thursday 8

(8-357)

I cannot comprehend what's happened today. Up – 7.45 ish – [redacted] up 1st – let dogs out. I off 'till 10.45 – 3hrs – No sign in at anywhere – [redacted] went on his bike – but Spon gave up. Went to bathroom to see if he had phone stopped on face – pushed out – door locked. I was in tears – v. upset over [redacted] – lack of help – wouldn't drive while I looked. Can't remember being so, so upset as time went on. Won't forget. She'll have to go – & I might – then I can do just whatever, wherever. [redacted] won't talk or discuss. On phone – he comes in saying 'do housework'.

Still on phone – no news [redacted] other side of lake – I think – I'm v. sad re. today. How dare he hit me – 1st time for everything – & the last. I really can't believe I've written this.

Bloody dog back after 3hrs – fat runaway.

February

	2	9	16	23
	3	10	17	24
	4	11	18	25
	5	12	19	26
	6	13	20	27
	7	14	21	28
1	8	15	22	

[8] The diary refers to Robert becoming physically violent when Mary is concerned that their dog has run away.
The diary was discovered after the death of Mary by her sister Susan who agreed for the entry to be included in the report. The Home Office Quality Assurance Panel who reviewed this report requested that it was confirmed that Susan wished the page to remain in the report. Susan confirmed this with the review Chair.

16.6 April 2015. Naomi answers an advert from Mary and Robert for domestic help and commences work weekly at the bungalow.

16.7 Early 2016. Mary discloses to Naomi that she has had a row with Robert and would like to leave him. A week later Mary indicates that "things were better" and Robert has apologised.

16.8 Between January 2015 and December 2016 Mary visits or contacts the GP on 17 occasions for treatment and monitoring of issues related to blood pressure which had been causing her to faint and affect her confidence.

16.9 In July 2016 Robert has his renewal of Shotgun Certificate by Cumbria Constabulary.

16.10 Mary continues to be supported by the GP in 2017 with 12 attendances/telephone consultations recorded. Following further fainting episodes Mary is treated at hospital to have a pacemaker fitted in May 2017.

16.11 Medical records indicate following this there was some improvement as recovery progressed however Mary expressed that there were limitations on her ability to exercise and undertake activity.

16.12 In 2018 Mary continues to have health check-ups in relation to the pacemaker and her blood pressure and flu vaccine visiting the GP on 6 occasions with no concerns recorded.

16.13 May 2018. Records of a GP practice monitoring visit indicate, "patient well. Has a healthy diet, remains active doing housework and general activities around the home".

16.14 Between 2015 and 2019 Robert attends the GP 8 times for routine health appointments such as flu jabs and tests to support his pilot licence renewals.

16.15 In 2019 between April and June, Robert visited the practice on 12 occasions mainly relating to diagnosis and regular dressing of a leg ulcer and other routine healthcare appointments.

16.16 February to July 2019. There is a recorded picture of 12 records for Mary at the GP for routine monitoring with no concerns reported until the 23rd of July when notes indicate that Mary, "feeling unwell for a week, short of breath. Sleeping well but not eating. Fells [sic] out of puff and nauseas". Notes document that an ECG was carried out and an x-ray arranged, and "worsening advice" given with documentation indicating husband and wife happy with the plan.

16.17 31st July 2019. Robert calls at the GP surgery to seek further advice as Mary is experiencing abdominal pain. A home visit was arranged which resulted in Mary being admitted to hospital.

16.18 2nd August 2019. Mary is discharged home to the care of her GP and having had an episode of delirium at the time of hospitalisation, a referral to Cardiology and Memory Clinic is suggested in the discharge letter.

16.19 7th August 2019. Mary's "shortness of breath" is reviewed by the paramedic attached to the practice and consequently she is brought in to see a GP the following day.

16.20 8th August 2019. Mary is seen by the GP with Robert to discuss this, and referrals are made (12th August). Robert is noted as saying her memory is worsening. Mary indicates shortness of breath when lying down and is described in records as, "pale, chatty, smiling".

16.21 10th August 2019. Cumbria Health on Call who provide out of hours care are called to Mary (it is not clear from records who called assistance though Naomi confirmed that Robert called her at home, and she attended the house and made the call) and she is admitted to hospital with shortness of breath. The GP submission to the coroner in relation to this incident records that "Mary was keen to be admitted and Robert was reluctant".

16.22 12th August 2019. Mary is discharged home.

16.23 August 2019. Around this time Susan is contacted through a friend of Mary's to inform her that Mary is unwell.

16.24 14th August 2019. Susan travels to Cumbria and stays with Robert and Mary for 4 days. During her visit Susan notices that there is very little to eat in the house and buys food.

16.25 15th August 2019. GP notes indicate that Mary's sister Susan contacts the surgery to request a home visit as Mary is feeling unwell. Notes state that Susan indicated that "patient has not been taking diuretics[9] on a regular basis – daily pill box has been arranged by sister to correct this". GP notes further indicate "No visible shortness of breath, eating and drinking. Patient appears well reassured". [10]

16.26 27th August 2019. The GP reviews Mary in relation to constipation and records indicate "Treatment commenced".

16.27 September 2019. Mary discloses to Naomi that Robert had left her on her own for 16 hours to go flying a few days before. Around this time Naomi notes very little food is in the house and begins visiting more frequently and bringing meals to the house.

16.28 4th September 2019. Mary is visited by a mental health nurse who carries out a cognitive assessment as suggested in 16.18. The report is received by the GP on 20th September 2019 as detailed in point 16.37

16.29 5th September 2019. A telephone call from the GP is made to Mary at her request (stating she was anxious as she had not submitted her blood pressure readings). Notes state she was, "Reassured reading in surgery fine".

[9] prescribed medication used to treat conditions such as heart failure that have fluid retention

[10] Upon reviewing the draft report Susan felt that this record by the GP did not accurately reflect the level of concern she had raised regarding Mary's breathing difficulties and not eating and drinking

16.30 9th September 2019. Mary (Robert in attendance) is recorded as attending the GP for a "Heart failure review". The GP record indicates Mary having trouble sleeping and is short of breath and lethargic. Has taken medication (furosemide), but Robert is recorded as saying he "cannot find medication".

16.31 10th September 2019. GP refers Mary to the Community Heart Failure Team.

16.32 11th September 2019. GP notes state, "very fatigued, cannot lie down so sleep poor", "patients thinks due to see cardiology next week"[11].

16.33 16th September – Community Heart Failure team visit Mary and record that Mary is Frailty scale 6[12], "Poor exercise tolerance", "tired all the time", is married lives in house with husband who supports her with no nearby family. Follow up appointments made.

16.34 16th September 2019. GP records letter from Heart Failure nurse assessment where Mary reviewed at home and reports poor exercise tolerance, short of breath on exertion and increased fatigue.

16.35 16th September 2019. Outpatient appointment with Ophthalmology Clinic recorded as cancelled by patient.

16.36 17th September 2019. GP records indicate that bloods taken from Mary.

16.37 20th September 2019. GP receives the letter from the Community Mental Health Team review and records, "mild cognitive disorder diagnosis relayed to patient at home". "No unmet needs identified".

16.38 24th September 2019. Heart failure review reports improvement on medication change and to review again in 2 weeks.

16.39 September 2019. Naomi observes Robert appearing "low" and he discloses to her it is a return of his "ME"[13] he had 12 years previously. Robert says he has stopped filling in his diary and rain gauge recording. Naomi is surprised at this as Robert has been fastidious in relation to his rain gauge.

16.40 2nd October 2019. Cardiology appointment at hospital recorded as "cancelled by patient".

16.41 8th October 2019. Naomi finds Robert crying in the kitchen. On her way home she attends the GP surgery and raises concerns she has about Robert. This is recorded by the receptionist as follows and is reproduced here:

[11] It was not clear if this was a telephone consultation, visit or appointment
[12] People need help with all outside activities and with keeping house. Inside they may need help with bathing and might need minimal assistance (cuing, standby) with dressing.
[13] Chronic fatigue syndrome – records indicated Robert reported symptoms of this in 2011 but did not continue investigation/treatment.

"This gentleman is the husband of Mary [redacted] who has an appointment to come back and see you on Monday morning.

A good friend of theirs didn't want to be named but wanted us to be aware that she is very concerned about Robert, he is very worried about Mary and thinks that she is going to die imminently due to her diagnosis of heart failure.

He is very tearful, not sleeping, they have no food in the house because she isn't well enough to shop and doesn't feel like eating. The friend wondered if when you next Mary and her husband you could enquire about how he is feeling as he won't make an appointment for himself".

The GP has an appointment with Mary the following week so invites Robert for a joint appointment.

16.42 14th October 2019. The GP sees Robert and Mary at the surgery. Robert is recorded in GP notes as "carer for wife", "reports doing ok, gets out for an hour or two to swim. Declined any support, cooks etc, has a cleaner".

16.43 14th October 2019. Community Heart Failure Team call Mary and record following in notes:

"Telephone call to patient. Spoke to Mary. Suggests her breathing has improved on regular diuretics. Reports sleeping badly and is very fatigues so she has declined to attend clinics and has requested home visits. She has started Vit D[14] as advised. Blood test shows significant deficiency. Reports a very poor QoL[15] due to her symptom burden. Plan. [redacted]. Booked to see her 25th October."

16.44 On 14th October GP records review of low Potassium. Notes state, "fluctuating energy levels are variable and mood up and down".

16.45 22nd October – hospital outpatient Ophthalmology clinic for Mary recorded as cancelled by patient

16.46 28th October 2019. Home visit from Community Heart Failure Team to review medication.

16.47 28th October 2019. Letter from Heart Failure Nurse received by GP and recorded as short of breath on exertion with poor exercise tolerance". Plan recorded to start oramorph.[16]

16.48 28th October 2019. Naomi visits Mary who discloses that she and Robert had a "massive row" at the weekend, and "Robert had told her that he wanted them to end it all. He had said to her that he wanted her to go with him to [redacted] but she had refused to go with him. He left the house on Saturday morning, 26 October and went looking for a bridge to jump off near

[14] Vitamin D
[15] Quality of Life
[16] is an opioid and is used to provide symptom relief of breathlessness in end stage heart failure. NICE CKS guidance

the [redacted] Hotel in [redacted]. Robert had returned about 20.00hrs that night but Mary had been really worried and had searched the house for a suicide note. She was relieved when he had come back but they had another row and he said he couldn't do it as it was too high".

16.49 29th October. Naomi went to the Drs to tell [redacted]. "She was shocked and I said Im happy to speak to the doctor. I didn't hear anything from the GP but each time I went to their house I was worried in case the doctors had been and told Robert it was me who had been in touch with them".[17]

16.50 A few days later Naomi recounts she was contacted by the surgery to ask if they could disclose her name in relation to the concerns disclosed. Naomi declines asking to remain anonymous.[18]

16.51 31st October 2019 – Community Heart Failure team – phone call with Mary recorded in notes. Robert and "carer"[19] recorded as present

"Mary was unable to speak in full sentences due to dyspnoea (difficulty in breathing). Mary reports reduced shortness of breath at night and better sleep since starting Oramorph. Reminded them of the side effect of constipation. Discussed risks/benefits of oramorph ie addition/dependence. Advised that severity of symptoms indicate its use is warranted. Plan: Advised continued use of PRN[20] oramorph as required for breathlessness, particularly PND[21]. Follow up telephone call next week to review the situation."

16.52 5th November 2019. Naomi attends the surgery and speaks to the receptionist and records note the following:

" I spoke with the cleaner for Mr and Mrs [redacted], she doesn't want them to know she has spoken to us about them as she thinks they will feel she has broken their trust and might not regain this. I did mention that you may need to speak to her and she was happy with this. Her name is Naomi [redacted] - Tele no [redacted], she was in the [redacted] [redacted] for a number of years so aware of the problems we are facing with confidentiality and safeguarding. Mr [redacted] has previously suffered from ME and as you correctly recognised he hasn't had to do household duties in the past so this is new for him and finds it difficult he has also lost his independence which she thinks is a problem as he is normally very active and out and about. Naomi thinks he is depressed as she found him crying".

16.53 6th November – phone call from Community Heart Failure Team

Medical notes as follows;

[17] Source – Naomi's statement to Cumbria Police as part of the Inquest enquiries

[18] Source – Naomi's interview with the Review Chair

[19] We understand that this was Naomi who was a friend rather than carer who was present at the house that day.

[20] as and when required

[21] Paroxysmal nocturnal dyspnoea (PND) is a sensation of shortness of breath that awakens the patient, often after 1 or 2 hours of sleep

"Spoke with Mr and Mrs [redacted] Both agree the Oramorph has helped greatly. Using it at lunchtime and bedtime at present. Has led to improved sleep and reduced episodes of PND[22], Explained she is on a low dose at present and that if she develops tolerance and PND starts to reoccur more frequently we can review the dose and increase it as necessary in increments until it is under control again. They are using macrogol for her constipation".

A visit is arranged for 2 weeks hence to review heart rate and medication and if adequate then discharge from team.

16.54 6th November 2019. Medical notes indicate Mary did not attend cardiology appointment at Hospital and a new appointment to be made.

16.55 18th November 2019. Community Heart Failure Team record:

"Consent to information sharing with family. Verbal consent obtained. Patient accompanied by husband Robert. Assessment undertaken. Social – Married lives with husband on a single floor. Husband happy to manage care requirements at present. Mary was worrying yesterday about what they will do if she becomes more ill. I have advised on contacting GP out of hours if required, or calling 111 if unsure. I have reminded them that if her care requirements escalate the care co-ordinators can help with this. She is not worried about dying as such, as feels that this would almost be a relief, but does not want to suffer. Appears tired but is a good colour and well kept. Clinical RAG red Vulnerability RAG amber. Action plan 1 Increase bisoprolol to 7.5 mg OD. Ask GP to clarify as they have previously expressed this over 20 years go. They are now aware a valid form would be needed in the home. Home visit in 2-3 weeks – discharge if HR adequately controlled. No known follow-up appointments with cardiologist at present. We have discussed heart failure and their prognosis. We have discussed resuscitation – patient for resuscitation/patient not for CPR but wanting actively treating until cardiac arrest/patient on end-of-life care pathway. Preferred place of care/death: home."

16.56 19th November 2019. Mary discloses to Naomi that Robert had been, "in vile mood", at having to clean her up.

16.57 November 2019. Naomi introduces idea of respite in a care home with Mary.

16.58 21st November 2019. Robert is highly aggressive and angry at Naomi for visiting with croissants and a newspaper for Mary.

16.59 26th November 2019. The GP sends Robert a letter dated 26th November offering him the opportunity to come in to talk with him.

16.60 28th November 2019. GP notes indicate Robert attends surgery and speaks to an administration worker thanking the Dr and stating, "he was fine, and the situation was doing well".

16.61 November 2019. Naomi arrives at the house and through the window sees Robert shouting at Mary. He stops when he sees Naomi.

16.62 November 2019. Mary discloses to Naomi a further incident of Robert angry at having to "clean her up".

16.63 2nd December – visit by Community Heart Failure Team recorded in notes as follows:

"Home visit. Consent to information sharing with family. Patient not accompanied at encounter. Mary requested review – feeling unsettled about how her care needs would be met if they increased further. Medication checked. Married lives in bungalow with few internal steps. Husband managing care needs at present. Mary remains concerned about how her care needs would be met if she deteriorates. She reports her husband feels he is managing well at present, and that they needn't yet consider whether a carer is required. I have reassured her of their options should they progress to needing help. Action plan – note left to advise husband to call practice to schedule home visit regarding DNAR[23]. Advised husband to collect Bisoprolol[24] tablets in order to commence increased dose. Review in 2-3 weeks. Discharge if HR[25] adequately controlled."

16.64 3rd December 2019. Naomi visits GP surgery to collect a form. The receptionist asks how Robert and Mary are. Naomi describes the shouting incident and when asked if Mary is frightened of Robert she says "Definitely".[26]

16.65 6th December 2019. The surgery records a DNACPR[27] for Mary noting Mary has been spoken to on the telephone and husband in person.

16.66 December 2019. Mary discloses to Naomi that she has punched Robert's arm because he was being so nasty about her continence health. She also indicates that Robert has told her to not telephone Naomi anymore.

16.67 December 2019. Naomi arrives at the house as Robert and Mary are arguing.

16.68 December 2019. Naomi recounts Robert indicates a willingness to get help with respite care for Mary locally.

---

[23] Do not attempt resuscitation

[24] Medicine to treat high blood pressure

[25] Heart rate

[26] Source – Naomi's statement to Cumbria Police as part of Inquest enquiries

[27] do not attempt cardiopulmonary resuscitation

16.69 December 2019. Mary discloses to Naomi that Robert had taken his guns out the previous evening to shoot himself but returned. Mary says, “don’t worry he’ll never do it”.

16.70 17th December 2019. Naomi observes bruising and swelling on Mary’s hand. Mary discloses to Naomi that Robert had hurt her wrist because she put a torch on to go the toilet in the night. Robert indicates it was an accident. Naomi challenges Robert about his behaviour highlighting that if he intended to hurt her wrist then it could be construed as an assault.

16.71 19th December 2019. Naomi arrives at the house and Mary says Robert won’t take her to the Doctors. Mary declines Naomi’s offer to take her or call the GP, saying, “Robert won’t like it”.

16.72 30th December 2019. Phone call from Community Heart Failure Team to Mary. Records state

“She was very breathless on reaching the phone. She is concerned about whether she now needs care.”

16.73 30th December 2019. Community Heart Failure Team. Record as follows:

“Home visit – patient accompanied by husband. Heart failure information given to patient. Spoke at length about Mary’s concerns regarding her care. She does not want to go into a care home, but wondered if it was necessary. I have assured her that at present I feel she is stable and her husband is coping very well. He is more than happy to continue at present, but knows that they can ask for a carer if they want to pay someone to help with Mary’s personal hygiene etc. They also know they could trial respite if needed. Plan – reassured. Discharge to GP for further input if required.”

16.74 31st December 2019. Naomi and Susan discuss Mary. Susan indicates she will visit on 13th January.

16.75 2nd January 2020. The GP receives a letter from the Heart Failure Nurse, recorded in notes as follows:

“Seen with husband at home. Mobile around home and garden. Reduced Oramorph as patient no longer feels benefit. ‘Managing well at home between themselves at present. Will request care support if feels necessary. Discharged back to care of GP.”

16.76 2nd January 2020. Naomi takes cake for Robert and Mary. Robert states heart nurse visited and said to him, “Mary doesn’t need to go into a care home yet, because she has a loving husband who is looking after her very well”.

16.77 7th January – Mary discloses to Naomi that she has been constipated but declines Naomi’s offers of help to contact the GP, saying, “Robert would stop you visiting if we did anything behind his back”.

16.78 14th Jan – Mary discloses to Naomi she had been at the toilet all night trying to resolve her constipation and had found that distressing and was still upset. Robert recounts he had

found her and had to try to assist which he felt was undignified. Susan arrives later and gives Mary a laxative. Naomi recounts she notices Mary has lost a lot of weight.

16.79 15th January 2020. Naomi and Susan meet at Susan's hotel to discuss concerns about Mary's care and Robert's mood. They decide to tell the surgery.

16.80 15th January 2020 1030am. Naomi and Susan speak to the receptionist in a side room and raise concerns about Robert not giving Mary her laxatives and morphine and Robert physically trying to resolve this.

GP notes state:

"[redacted] (friend / cleaner) and [redacted] (sister) attended the surgery to raise concerns about Mary's deterioration.

She is very frail now and can only get to the toilet using 2 sticks and unlikely to be able to come to the surgery.

She has also been constipated for 9 days and in pain, no contact has been made by her or her husband to request any medication to help with this, her sister has bought some Dulcolax[28], she will be returning home to Croydon tomorrow.

Mary isn't eating and is under 10 stone now (She is a tall lady) and Robert her husband has also lost 2 stone in weight, they say there is hardly food in the house to eat.

Naomi had suggested that maybe she could go into [redacted] for respite care to give Robert a rest and to help with her low mood and hopefully make her more comfortable.

under the care of the heart failure nurse who last saw her on the 31st Dec

Both Naomi and Susan feel that her husband is controlling."

16.81 The action is further recorded in the relevant Individual Management Review under communication within agency as follows;

"Admin to Para 1[29] - I added to list for Monday and asked that he speaks with admin to update him on her condition and the problems around her health.

Also discussed with ? GP1."

16.82 15th January 2020. Naomi recounts Susan still being at the house and Mary saying to her that she wanted to go into a care home. Naomi leaves and Susan is going to walk Mary around the garden.

This is Naomi's last contact with Mary.

16.83 16th January. Susan returns home.

[28] laxative

[29] Surgery paramedic

16.84 17th January 2020. The GP surgery is subject to a scheduled on-site Care Quality Commission Inspection.

16.85 18th January 2019. Susan speaks with Mary by telephone. Mary says she has had a good day and had walked around the garden a couple of times. She also describes that Robert has still not been shopping. This is the last time Susan spoke to Mary.

16.86 20th January 2020. Naomi rings Mary between 1130am and 12 noon and there is no answer. Naomi drives to the house arriving at 1pm. The house is unlocked and unlit. Naomi finds Robert deceased and calls the Police. Police enter the property and find Mary deceased in bed.

16.87 20th January 2020. The paramedic from the GP surgery arrives at the property for the scheduled appointment to see Mary and finds the Police at the property.

17. Overview of information known

17.1 Mary and Robert had been married for over 50 years and both had respective careers as teacher and commercial pilot.

17.2 Upon retirement they relocated to the Lake District, and both maintained lifelong held interests throughout their time living there.

17.3 Agency involvement with Mary and Robert was mainly centred on health service involvement with Mary.

17.4 Mary had heart problems with GP and specialist service support from 2015 onwards. In 2014 Mary had cancer on her arm and after treatment found some household tasks difficult hence the couple employing domestic assistance.

17.5 The couple were both well known to the surgery. Robert was usually present at Mary's consultations.

17.6 The surgery knew Naomi who lived locally and were aware that Mary's sister lived in the south of England.

17.7 Health agencies reported that they had not directly observed or recorded safeguarding or domestic abuse concerns from their contacts with Mary and Robert.

17.8 Welfare and safeguarding concerns were raised with the GP practice by Naomi and Naomi and Susan on five separate occasions between October 2019 and January 2020.

17.9 Whilst a response to each concern was made, no consideration of a safeguarding referral or Care Act compliant assessment of care and support needs was initiated.

17.10 Police had limited routine contact with Robert every 5 years when his firearms licence was due for renewal, and this was last carried out in 2016.

17.11 Robert had stated to a range of family and friends for many years that he would choose to end his own life and had been a member of organisations that promoted information in relation to that. Naomi raises a suicidal ideation incident with the GP practice in October 2019.

17.12 Accounts given after Mary's death indicate that Robert's behaviour over many years was coercive and controlling. There are accounts of him acting in a physically violent manner towards Mary in 2015 and 2019.

17.13 We do not know how frequent the physical abuse was from its first recorded entry in Mary's diary in 2015, however, the later examples she disclosed to Naomi in December 2019, and Naomi witnessing Robert aggressively shouting at Mary, indicate that this had become a feature of Robert's behaviours.

17.14 Robert's behaviours indicate coercive control and abuse. Naomi recounted Mary disclosing that Robert would turn off the water in the property and only allow her to bathe once per week. The bathwater was kept in a large container for a week and used to flush the toilet. Mary related that he only stopped doing this when the drains began to smell strongly. Mary only disclosed this to Naomi after Robert had stopped doing this.

17.15 Mary's declining health and mobility, Roberts coercive and controlling behaviour, combined with Robert's strength and physical size made Mary increasingly vulnerable to Robert's neglectful and abusive behaviours.

17.16 Abuse of Mary as a vulnerable adult or domestic abuse was not known to or witnessed by health professionals however several concerns were raised that could have elicited further professional curiosity by professionals.

17.17 The couple were not in any financial hardship. Robert was described as reluctant to spend money on household maintenance. Robert reportedly dealt with all finances and paid Mary's contribution to the horse racing syndicate of around £300 per month.

17.18 Whilst this financial position would have been likely to put the couple in the position of being "self-funders" in relation to social care, it was not identified that any financial care costs could not have been met or were considered as a barrier to support. Care assessment of Mary and carers assessments of Robert are not dependent upon the financial status of individuals.

17.19 Mary considered a short stay at a local care facility in 2019 at the suggestion of her friend Naomi. Encouraged by Naomi and Susan, and despite initial strong resistance from Robert, it looked as if he would agree to this, however, he continued to insist he could care for Mary. Robert would often forcefully state to Naomi and Mary that he would not allow carers at home for Mary.

17.20 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 "upsetting" Robert.

17.21 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.

17.22 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.

18. Analysis

18.1 This section will consider the terms of reference which are in bold italics;

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

18.2 Domestic abuse was not known to or identified by agencies and therefore procedures were not initiated.

18.3 In the days before the homicide Mary's sister and friend raised concerns in relation to home and health conditions and mentioned that Robert was "controlling" which is evident in the GP records. The action to explore the concerns was to schedule a visit by the GP practice paramedic to see Mary 5 days later which was the day the homicide was discovered.

18.4 If the term "controlling" had been explored, it may have led to further disclosure and initiation of safeguarding or domestic abuse procedures. The medical practitioner does not recall being aware of the notes regarding this feature prior to the planned visit on 20th January 2020.

18.5 The long-term friends and Mary's sister Susan reported they had not witnessed or had only minimal awareness of the extent of Roberts abusive behaviour. On reflection following the death of Mary they recognised that they had witnessed, across decades, Roberts controlling and coercive behaviour.

18.6 We should note that coercive and controlling behaviour[30] was not recognised as a criminal offence in England and Wales until creation of a specific offence in the 2015.[31]

[30] Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

[31] Section 76, Serious Crime Act 2015

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)*

18.7 Mary was an Adult with Care and Support needs.

The Care Act 2014 provides the legislative base for safeguarding adults and marked a shift in focus from characteristics of adults experiencing harm to abuse of adults linked to circumstances.

18.8 Safeguarding duties apply to an adult who:

Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
Is experiencing, or is at risk of, abuse or neglect; and;
As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

18.9 The Local Authority has a legal duty to undertake enquiries where concerns have been raised of potential abuse or neglect of an Adult with Care and Support needs. However, recognising and reporting of abuse and neglect extends to all partnership organisations working with adults with care and support needs, and they have a duty to ensure that the welfare of all adults is ensured. As part of this they need to understand when to implement their safeguarding adults reporting procedures and they receive training from their own agency and the Cumbria Safeguarding Adults Board.

18.10 Had the accounts of the prevention of access to medical assistance, withholding access to prescribed and purchased drugs, not providing food, control over decision making for example access to bathing been known earlier or considered when Mary and Susan raised some of these concerns, then thresholds of concern leading to an initial safeguarding enquiry would have been considered against the following abuse types. i.e., physical abuse, domestic violence or abuse, psychological abuse and neglect and acts of omission of an Adult with Care and Support needs.[32].

18.11 Mary was receiving care and support from the NHS and whilst domestic abuse, coercive control and neglect were not apparent to those services on their home visits or surgery appointments, there were concerns raised by Naomi and/or Susan on four separate occasions between October 2019 and January 2020. It is the view of the author that responses to some of these were limited and did not adequately explore or respond to those concerns or refer to Adult Social Care.

[32] Care and Support Statutory Guidance (Care Act 2014)

18.12 Robert was resistant to support. In children's safeguarding practice this has been long recognised[33] and is often described by the term "disguised compliance". The same feature can apply in adult circumstances we consider that "highly resistant" sits on a continuum with at one end a certain degree of reluctance to accept help (even if they know they need it), and at the other end a small number who are skilled at manipulating and misleading professionals. Accounts indicate that Robert insisted on delivering care, was cooperative and attentive when professionals met Mary but in private, he was highly resistant to external assistance, particularly as evidenced in accounts from Naomi and Susan, "there's no effing carers getting in this house". This could be an indicator of him wanting to retain his coercive control and that, on occasion, this had prevented Mary from accessing or being considered for a wider care needs assessment.

18.13 At draft report stage, the panel representative from Victim Support who manages specialist domestic abuse services in Cumbria undertook a detailed desktop exercise to risk assess Mary based on the known and unknown (prior to homicide) information.

18.14 This assessment, used the older person Domestic Abuse, Stalking and Honour based Violence Risk identification model (DASH)[34] combined with Professor Jane Monckton Smith's intimate partner homicide timeline[35] (see reference for a link to a summary of the research and a short video where Professor Monkton Smith explains the eight stages).

18.15 In summary the assessment indicated that if Mary had disclosed the full range of potential abuse indicators abuse to a specialist domestic abuse professional then she would have been able to access specialist domestic abuse services.

18.16 Risk indicators identified post homicide were reaching stage 4 of the homicide timeline at the points that a safeguarding referral could have been considered. These included:

- trigger separation (imagined, threatened or real) – Mary was considering going into care
- Life change – Mary's illness and abusers increasing care responsibilities
- Dependency/entrapment – Mary had limited ability to leave
- Mental health issues present – Robert's depression and suicidal ideation
- Animal or pet abuse – apparent earlier in dog feeding pattern

18.17 The homicide timeline can remain in some stages for a long time and move through others quickly and in Mary's case the move through the later stages to homicide at stage 8 occurred in a matter of days. Much of this information was not known to agencies and family or friends at the time. It does, however, reinforce the importance of professional curiosity and raising

[33] Resistant Parents and Child Protection: Knowledge Base, Pointers for Practice and Implications for Policy. John Wiley. Child Abuse Review vol 22. 5-19 (2013)

[34] DASH - The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Multi-Agency Risk Assessment Conference in order to manage their risk.

[35] https: //www.glos.ac.uk/content/the-homicide-timeline/

an initial safeguarding referral, which may in turn have given Mary an opportunity to disclose, and potentially refer to further inquiry by a domestic abuse specialist.

Did agency interventions adequately take account of the caring responsibilities of Robert?

18.18 Mary's declining health made her significantly more at risk to Robert's neglect, abuse, and coercive control. In his "caring" role he has significantly increasing levels of control as Mary's ability to retain some independence and resist that control diminishes.

18.19 There is evidence of several missed opportunities to explore formal caring assessments. The GP surgery had opportunities to do this in 2019 given the level of contact with Mary and Robert.

18.20 The couple on occasion presented as not wanting this, however, records indicate that the care conversations are dominated by Robert who would be present at interactions with professionals.

18.21 Mary's "voice" and her expressed wishes are rarely recorded. Mary clearly indicates that she is concerned about her care needs during the visit by the Community Heart Failure Team on December 3rd, 2019, and in both the phone call and then final face to face consultation with the Team on 30th December 2019, just 2 weeks before her homicide.

18.22 There were no records of any formal discussion of both Care Act and carers assessments being offered by NHS providers through a referral to Adult Social Care (who are responsible for those assessments). There were numerous opportunities to do so particularly following the hospitalisation of Mary, for example, the two occasions in July and August 2019, and the GP, Heart Failure Review, in September 2019.

18.23 The single assessment undertaken at the home by the mental health practitioner from Lancashire and South Cumbria Care Foundation Trust on September 4th 2019 records in the carers assessment section to be "completed next time". Following further exploration of this with the practitioner, and upon reviewing the rest of that detailed assessment, it was accepted that Robert was coping at that point and therefore a carers assessment may not have been required on that occasion. Notwithstanding, the record should however have given a more detailed rationale.

18.24 Naomi raises concerns at the surgery in relation to Robert's ability to cope on 2 occasions and they are recorded for action. The first in October 2019 is responded to by Robert being added to an appointment with the GP and Mary the following week. On this occasion records indicate discussion of how things are going at home but are not explicit in recording any offer or encouragement in relation to formal carers assessment. The second occasion in November (which also follows additional concerns of suicidal ideation) the GP writes to Robert inviting him in to discuss how things are going and he declines by telephone message to reception. This was a missed opportunity for the GP to have made the referral to Adult Social Care to allow for assessment of Mary's care and support.

18.25 In Cumbria, an earlier DHR published in 2016, reviewed a homicide/suicide of older couple, "Mr and Mrs M".

18.26 Mrs M had dementia and significant care needs as a result. The breakdown of an unsuitable residential care placement (chosen by Mr M) led to Mr M murdering his wife and attempting suicide at the scene. Whilst on bail for murder the perpetrator committed suicide.

18.27 A key recommendation of the review was to;

"Put in place procedures and monitoring arrangements to ensure that a carer's assessment is always offered (and encouraged) where a significant other is in a caring role; if it is refused,

this should be recorded and a note provided and placed. Further assessments offered subsequently when appropriate."

18.28 In March 2020 the Adult Safeguarding Board for Cumbria published a Safeguarding Adult Review in relation to "Robyn", who died in December 2018. Robyn was an older woman with significant needs, and was cared for by her son, who was described as highly resistant to offers of support. The review made the following recommendation:

"That Cumbria Safeguarding Adults Board raise the awareness of agencies of the need to offer a further carer's assessment to a family carer when the demands upon them change or, as in this case, continue for an extended period."

18.29 Whilst the review in relation to Robyn was published in March 2020, some 2 months after the death of Mary, the learning and recommendation from the 2016 DHR, was not embedded in relation to carers assessments with "Robyn" and her family, nor subsequently with Robert and Mary.

18.30 Following publication of the Safeguarding Adult Review in relation to Robyn, a range of improvement actions were undertaken by the Adult Safeguarding Board and partner organisations, to raise awareness of carers assessments with frontline staff. This included widely circulated written and face to face briefing.

18.31 That this is the 3rd review with a similar recommendation should highlight that there needs to be further focus on assurance that learning and improvement in relation to carers assessments is undertaken. This review therefore makes the following recommendation:

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.

Were any agencies aware of the suicidal ideation of Robert?

18.32 Medical records provided to the CCG for their Individual Management Review did not evidence awareness of Roberts suicidal ideation, however, in accounts to the police part of the Inquest investigation and in interview with the Chair Naomi described that she had reported concerns in relation to this to the GP in late October 2019. She described that the surgery rang her to ask if they could disclose her name as the referrer by the GP to the family which she declined wishing to remain anonymous. Naomi visits the surgery a few days later with further concerns in relation to Robert's ability to cope and offers to speak directly to the GP if required.

18.33 The surgery response is to write to Robert on 26th November inviting him in to talk to the GP which Robert declines. This is concerning and a significant missed opportunity to initiate a safeguarding referral or further investigation.

18.34 It is not clear that the surgery were aware that Robert held a firearms licence as the letter from firearms licencing in 2016 to the GP was not evidenced in the GP records. A letter sent by Police at renewal in 2011 may have been apparent but unlikely to have been clearly visible in records. This issue is covered further in paragraph 18.113.

18.35 This review makes a recommendation as follows;

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.

18.36 Family and some friends had been aware over a period of many years of Robert indicating that he was a member of organisations that promote voluntary euthanasia, and occasionally it would seem he was "joking" when leaving the house to go out by saying he was going to kill himself.

18.37 After the deaths, Susan reported that she had discovered on the back of the office door Robert had written dates of death of people he knew. Also written directly on the door were the words "sodium cyanide".

18.38 Robert would frequently leave the house when Naomi arrived to see Mary, and comment, that he was going off to "throw himself of Beachy Head"[36]. The frequency of this type of comment became normalised and Mary would reportedly comment that "he will never do it" to Naomi.

[36] Beachy Head are high cliffs in Sussex, an area where the couple previously resided. It is recognised as a notable suicide location.

18.39 Several accounts from Susan and a friend, also indicated that whilst Mary may have gone along with Robert's long held interest in voluntary euthanasia, she was less inclined towards this as she got older, referring on one occasion to it being a "stupid idea". There is evidence that Mary was "frightened" of Robert so it is reasonable to assume that she would go along with Roberts wishes to avoid conflict with him.

18.40 In September 2019 during a detailed memory assessment, the mental health practitioner probed end of life feelings, and whilst Mary indicated that she had fleeting wishes to die in the past she had no desire to do so.

18.41 Mary spoke with her sister the day before her death, and Susan recounted that they discussed things that Susan was sending to Mary to assist her. Susan indicated that the conversation was normal, and that Mary gave no indication of wanting to end her life.

Were services responsive and accessible to Mary?

18.42 Issues relating to medical care indicate extensive involvement with Mary by range of NHS providers including by the GP practice, hospital admissions, outpatient, and specialist services.

18.43 There is evidence that there were appropriate medical referrals and interventions to support her condition by the GP practice, hospital admissions, outpatient, and specialist services.

18.44 There are examples of good practice and timely intervention, for example, the events leading to Mary's hospital admission in late July 2019 where she is assessed and taken to hospital the same day following Robert raising concerns with the GP practice.

18.45 It is also important to consider that Mary herself did not disclose any neglect or abuse to any professional, the home circumstances presented well, and Robert appeared attentive and supportive though professionals readily took these factors on face value and did not evidence further enquiry.[37]

18.46 During the course of this review the former provider of Primary care medical services at the surgery spoke to the locum GP who was involved in the care of Robert and Mary and

[37] The Home Office Quality Assurance Panel upon reviewing this report had suggested that it may have been useful to consider what is known as "routine enquiry". This is an approach by health professionals to enquire regarding potential domestic abuse with all patient contacts as opposed to what is known as "selective enquiry" which is to only ask those questions where there may be indicators of concern.

This for Mary would have potentially mitigated against the lack of "professional curiosity" which featured in contacts and her responses would have been recorded.

The Panel did discuss this during the review process however health colleagues concluded that the introduction of this in all health settings would be difficult to achieve. However, in 2022 North Cumbria Integrated Care NHS Foundation Trust have introduced a pilot "routine enquiry" approach whereby patients are asked in all contacts, "how safe do you feel", together with questions on carer relationships and which services are involved with the patient. Staff are trained in the approach with involvement of partner agencies such as Cumbria Constabulary and Victim Support. Early evidence from the pilot has led to direct disclosures, an increase in professional curiosity recording and greater knowledge and confidence in staff to recognise domestic abuse. Cumbria plan to expand the approach to primary care settings.

recorded, “He didn’t feel that that there were missed opportunities, that they had good continuity of care, and that the team were responsive to the couples needs/requests.”

18.47 The surgery was subject to an on-site inspection by the Care Quality Commission in January 2020, during the week before the homicide. The inspection report rates the practice as being “Good” across all domains, having moved from a “Requiring Improvement” rating in 2018.

18.48 The Inspection report found no breaches of regulations, however, recommended that the practice needed a specific policy to manage communications coming into the practice as, “Staff told us how they would remove some items of post without a clinician having had sight of them.”

18.49 We are not aware of any evidence of this impacting in relation to Mary, though it is of note that she missed a considerable number of outpatient appointments which were not recorded as being explored by the GP.

18.50 In 2018 and 2019 Mary was referred as an outpatient to 3 separate services at local hospitals.

18.51 Mary is recorded as not attending or cancelling 8 of these appointments leading to 2 of the 3 services discharging her to the care of the GP following 3 consecutive non-attendances/cancellations.

18.52 The review has evidenced accounts that indicate Robert was actively refusing to take Mary to many of these appointments. This was not known to healthcare service providers.

18.53 Her mobility in 2019 was however known as limited, she no longer drove her car, would be breathless after a few steps and was using sticks to aid her walking.

18.54 Good practice in children’s safeguarding is to consider “did not attend” events as “was not brought” events which can elicit professional curiosity and ensuring this is embedded in adult safeguarding training for NHS should be undertaken.

18.55 It is recommended therefore that:

Recommendation 3

General Practitioners are reminded to regularly review non-attendance at appointments and to consider whether there are barriers to attendance. CCG should consider developing a Did Not Attend/Was Not Brought Policy

Were services responsive and accessible to Robert?

18.56 The review evidenced that health services were responsive to Robert in relation to his medical needs. A surgery practitioner account post homicide indicated that Robert had been offered some advice and assistance, though these were not recorded in medical records.

18.57 Records indicate that the GP met Robert with Mary in October following Naomi's initial concerns to the GP practice, and further wrote to him in November (after Naomi raises further concerns as to his ability to cope and appearing depressed) whereby the GP offers to meet Robert to discuss how he was coping

18.58 The following two terms of reference are considered together:

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

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

18.59 The concerns relayed to the surgery were not shared with the safeguarding leads in the practice. In turn they were not shared with the specialist community heart failure staff who were active in phone calls and visits to Mary during this period. Further, they did not lead to any consideration of escalation to safeguarding referral with Adult Social Care.

18.60 Firstly Naomi, and then Naomi and Susan, raise concerns with the surgery reception team in relation to both Robert and Mary. Whilst information was relayed to the GP and actions were undertaken, there was no further exploration of the issues raised with the referrer/s by medical staff at the surgery. This was a missed opportunity to gauge the responses more effectively. Naomi raises concerns about Robert coping on October 8th 2019. The GP invites Robert to attend Mary's appointment with her the following week. The response did not consider seeing Robert separately and he may have been unwilling to disclose any difficulties to the GP in the presence of Mary.

18.61 Naomi raises further concerns on 29th October in relation to the incident of Robert leaving the house to commit suicide and again on 5th November 2019 in relation to Robert's ability to cope and appearing "depressed" and "crying". The GP subsequently writes to Robert on 27th November, 3 weeks later, inviting him to make an appointment to discuss how things are going. Robert responds immediately leaving the GP a message saying he is "fine", and the matter is closed. There is no rationale as to why the letter was sent some weeks later and whether a timelier response would have been more appropriate.

18.62 Naomi is at the surgery on 3rd December collecting a form and a member of staff asks how the couple are. Naomi describes Robert shouting at her for bringing food for Mary and when asked if Mary is frightened of Robert, she replies "yes". Although this was not a formal report being made by Naomi, it was a missed opportunity for staff to relay further intelligence to the GP or practice safeguarding lead.

18.63 The final recorded concerns in January 2020 highlight potential prescribed drug non-compliance, little or no food in the house, and Mary and Robert losing weight, Mary having been constipated for 9 days, being in "pain" and Robert being "controlling".

18.64 The cumulative impact of the concerns was not evidenced as a consideration. The surgery reflected post deaths that there were no "red flags" for them to escalate safeguarding concerns[38].

18.65 It is not clear if the decision making was based upon each single incident (though on balance of probabilities it appears so) or considered as an emerging picture, and if this had taken place, a referral to the specialist adult safeguarding team at the County Council would potentially have initiated initial safeguarding enquiries which may have engaged services to assist and advise Mary and Robert.

18.66 If this information in the concerns had been shared with other staff in the surgery and the other NHS providers attending the home at the time it may have allowed further insight to be gained during those interactions.

18.67 In a 2016 report commissioned by Standing Together a range of common themes in DHR's were identified. The authors recognised that GP surgeries are in a unique position as they will often have knowledge and contact with both perpetrators and victims of abuse and recommended that there was need for "whole surgery" training involving all medical and non-medical staff[39].

18.68 Mary was seen by four separate GPs in 2019, in addition to the surgery paramedic.

18.69 The concerns by Naomi, and then Naomi and Susan, were raised with non-medical surgery staff.

18.70 Whilst safeguarding and domestic abuse online training was reported to have been completed by all staff there was no evidence of surgery wide training where staff from different roles undertake training together. It is therefore recommended that:

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.

18.71 In the instance of the final concerns being raised by Susan and Naomi to the surgery on 15th January 2020, timeliness of a response to schedule a visit to Mary 5 days later rather than responding the same day or evening using surgery resources or out of hours district nurses is of concern particularly as an 80-year-old patient on morphine has been "constipated" for 9 days and is in "pain".

18.72 The chair invited the GP practice and Clinical Commissioning Group to consider this issue and whether an alternative and more timely response to the appointment 5 days later should

[38] The Home Office Quality Assurance Panel who reviewed this report prior to publication expressed that they were "especially concerned at the approach taken by the surgery and the absence of any 'red flags' about the case".

[39] Domestic Homicide Review (DHR) case Analysis, Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly. June 2016

have been made. The response was limited, highlighting that as the GP was no longer at the practice and therefore could not investigate the GP rationale. They declined on this basis to give a clinical judgement based on similar circumstances.

18.73 The surgery records and witness accounts indicate that it is reported that Mary has been constipated for 9 days and is "in pain", there is little or no food in house and loss of weight of both Mary and Robert. Of additional concern is the reference to Robert being "controlling", which was not identified by the practice as significant of further exploration and should have flagged consideration as an indicator of coercive and abusive behaviour. Briefing prior to the appointment made 5 days later for the paramedic to visit was not documented and the paramedic could not recall this taking place.

18.74 Medical record keeping by the surgery is on occasion sparse and lacking detail which has created some difficulty in understanding when and if Mary was seen alone and whether some contacts were at home or surgery.

18.75 There emerges a general picture (apart from a few notable exceptions) of the voice of Mary not being captured in records. That is not to say those views were not discussed, however if they were then it is not recorded. Records should clearly record the wishes and views of patients. This is more notable given Robert being present at a high proportion of the medical contacts potentially preventing Mary disclosing her concerns. The review makes the following recommendation in relation to this:

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.

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

18.76 Staff across statutory and voluntary agencies in Cumbria receive training in respect of adult safeguarding and abuse and domestic abuse. Specialist training is also undertaken depending on their designation and role. This includes making safeguarding referrals and the panel member from adult safeguarding reviewed the training input given in recording a safeguarding concern. This was discussed with the chair and it was agreed that the advice is robust and easily understood.

18.77 There is evidence that awareness and practice has developed in relation to older people and domestic abuse within Cumbria and has built upon learning from a previous DHR. For example, the Multi Agency Risk Assessment Conferences that safety plan for high-risk victims have used the safe lives domestic abuse risk assessment for older people for some years, and this is good practice. Victim Support who are the provider of the Independent Domestic Adviser Service (IDVAs) have provided high quality awareness training specific to older people to their staff.

18.78 Mary did not disclose domestic abuse to professionals. The home circumstances presented well, and Robert appeared attentive and supportive. Professionals readily took these factors on face value and did not evidence further enquiry or consider the need to speak to Mary alone to ascertain her views, so was never considered or assessed by these support services. The review considers that the Cumbria Domestic Abuse Partnership should consider drawing upon the local good practice from Victim Support and other emerging work such as that of Dewis Choice, an initiative focusing specifically on domestic abuse and older people (Dewis Choice and Aberystwyth University have produced a practitioner guide[40]). It is therefore recommended:

Recommendation 6

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

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?

18.79 Mary was rarely seen alone by professionals which potentially prevented opportunities for her to disclose concerns. When she did raise her concerns about her care going forward for example on three occasions with the Community Heart Team staff in November and December 2020 these are responded to by reassurance that she can get care support when she needs it.

18.80 Mary's age and background may have prevented her reporting (see 11.6 and 11.7. Apart from health care in later life she and Robert had not used public services, and accounts from family and friends indicate that they had been private in many aspects of their lives.

18.81 Family and friend accounts indicate Mary was "frightened" of Robert and "frightened" that he would stop Naomi visiting her if Robert perceived any actions were challenging his authority, such as Naomi offering to take Mary to medical appointments.

18.82 Naomi raised concerns but was aware that if Robert knew she had raised them there would be consequences and she may lose contact with Mary.

18.83 Naomi therefore wished to remain anonymous and that is a key "given" in safeguarding of adults at risk where there should be no barrier to community confidence to report concerns.

18.84 Naomi raising the concerns with the GP was a correct way to report these as evidenced in the advice given on a number of public facing websites in Cumbria such as the Adult Safeguarding Board and Adult Social Care sites for reporting an adult safeguarding concern which states the following:

[40] The Centre for Age, Gender and Social Justice. Transforming The Response To Domestic Abuse in Later Life: Practitioner Guidance, Sarah Wydall, Elize Freeman, Rebecca Zerk

"If you think you or someone you know is being abused, or neglected it is important to tell someone you trust. This could be a friend, a teacher, a social worker, a doctor, a police officer or someone else that you trust. Ask them to help you report it and remember that you understand abuse or neglect is never your fault.

It is important to remember that you must not ignore abuse or neglect. You must report it. If you are not sure what to do you can always seek advice."

18.85 Naomi was the most significant protective factor for Mary. She was worried and aware from her conversations with Mary that raising concerns would potentially lead to Robert removing her from contact with Mary if he was made aware of her reports. The practice member of staff who recorded the concerns was explicit in her notes as to the wish to report anonymously and this is good practice.

18.86 Naomi was known to the practice staff and had made her concerns known to the GP practice on several occasions. On one occasion she specifically expressed a willingness to discuss her concerns further by giving her mobile phone number. That the GP practice chose not to do this was a missed opportunity. Clinical Commissioning Group suggested that this may have been due to respecting patient confidentiality however panel discussion highlighted that follow up enquiry to clarify information with a referrer would not in itself compromise patient confidentiality.

18.87 Current basic awareness safeguarding "level 1" training covers all staff in Cumbria and the Adult Social Care expert on panel evidenced to the chair that there was a strong focus in that training in ensuring as much detail as possible is collected from referrers.

18.88 Naomi's wish to remain anonymous was understandable and the surgery were clear in recording that this was her position which is good practice.

18.89 Naomi, as a member of the public, did not consult the adult safeguarding website in Cumbria though reported to the surgery which was correct and in line with advice that website would have given. Several Adult Safeguarding Boards and adult social care reporting advice available online highlights that referrers can remain anonymous. Anonymous reporting by the public is possible but is not referred to on the Cumbria web-based advice and as a broader improvement action it is recommended:

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.

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

18.90 These are covered in the firearms analysis section.

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.

18.91 DHR referrals are typically made by police to the Community Safety Partnership at the instigation of the lead investigator following a sudden or suspicious death.

18.92 In this case that referral was not considered by the officers involved and the DHR referral was only initiated up much later following complaints regarding medical care issues raised by Mary's sister with the NHS, who then referred the case back to police to review whether a DHR should have been considered.

18.93 Upon reviewing this the police referred the case to the Community Safety Partnership for consideration of a DHR and issued an apology for the oversight to Susan in May 2021.

18.94 The Community Safety Partnership who have 30 days to review referrals then scoped the case, agreed that it met the criteria for a DHR, and informed the Home Office of the decision to undertake a review.

18.95 The Terms of reference required Cumbria Constabulary to consider the issue of the late referral within their individual management review and summarised the cause as being oversight of the newly qualified investigating officer, who was not familiar with the DHR considerations. The supervising officers who would have had oversight of the investigation have subsequently retired and were unable to be spoken to directly as to rationale at the time.

18.96 The deaths were initially considered to be a double suicide and the Senior Investigating Officer had used her discretion to request full Home Office post mortems which identified the homicide of Mary. A standard post mortem would not have identified the homicide therefore this was considered good practice. The Individual Management Review author subsequently has concluded that due to the suspect being deceased, the case being a coronial file build, coupled with the newly qualified investigating officer being unaware of DHR requirements the referral was missed at this stage.

18.97 Cumbria constabulary as a response to this identified that there were several processes that needed to be reviewed immediately to prevent any further missed referral.

18.98 This issue was addressed in detail in the IMR submitted to the review panel and actions are considered as comprehensive and summarised below:

- Comprehensive information regarding DHR considerations have been placed on the Force intranet in July 2021 which act as an aide memoire for any officer investigating sudden or suspicious deaths.
- Home Office DHR guidance has been distributed to all area Detective Inspectors and placed on the intranet.
- DHR inputs on sergeant/Inspector training and training for Senior Investigating Officers and Deputy Senior Investigating Officers
- DHR considerations to be embedded in investigation plans
- Prompt on sudden death forms to consider Domestic Abuse and Controlling and Coercive Behaviour at incidents of suspected suicide.

18.99 In conclusion the review considers that the actions of Cumbria police to learn from the missed consideration for a DHR and to prevent any future reoccurrence are robust and comprehensive and therefore makes no further recommendations in respect of this issue.

18.100 The Named Nurse Safeguarding Adults who referred the case to Cumbria Constabulary for consideration showed good practice and the subsequent timely actions of the Force and Community Safety Partnership to consider the circumstances for review demonstrate a genuine concern for the delay and its potential impact on the family in this case.

18.101 The chair of this review is aware that missed and late DHR referrals are not unique to Cumbria and can be compounded by initial investigations awaiting forensic and other outcomes.

18.102 The Home Office in their feedback in respect of this review had raised that a Safeguarding Adult Review[41] (known as a SAR) or joint SAR/DHR could have been considered. There was no record of this case being referred for consideration of a SAR to the Safeguarding Adults Board. Given the accounts given to the coroners inquests and the conclusions of those (which had been completed prior to the decision to undertake the review), a DHR was agreed as the most appropriate type of review. The partnership now has consideration of alternative reviews such as a SAR embedded in their DHR decision making process.

To ensure the Individual Management Review reflects firearms licensing policy in relation to older persons in general and specifically in relation to Robert [redacted].

18.103 Cumbria Police's contact with Robert was limited to renewal of his firearm licence for two shotguns and although the period of detailed review was the 12 months prior to their deaths, the police Individual Management Review author reviewed in detail the renewals in 2006, 2011 and 2016. The licence would have been due for renewal in 2021.

[41] Safeguarding Adults Reviews (SARs) are a statutory duty under the Care Act for Safeguarding Adults Boards to undertake. A SAR is completed when:

- an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult
- an adult is still alive but has experienced serious neglect or abuse and there is concern that partner agencies could have worked more effectively to protect the adult

18.104 Cumbria is a large rural policing area and in 2021 there were 3246 firearm certificate holders and 8645 shotgun certificate holders.

18.105 To put that in context In England and Wales the areas with the highest number of firearms (held on certificates) per 100,000 people are the rural areas of North Yorkshire (2,887), Dyfed-Powys (2,675) and Cumbria (2,565).

18.106 In England and Wales in 2020/2021 1,141 shotgun certificates were revoked, a 2% increase of 25 from 1,116 in the previous year.[42]

18.107 Firearm and shotgun certificates can be revoked by the chief officer of police for the force concerned if they have reason to believe that the holder:

can no longer be entrusted with firearms in accordance with the Firearms Act 1968, is of unsound mind or is otherwise unfit to be entrusted with a firearm and/or shotgun, can no longer be permitted to have the firearm and/or shotgun or ammunition to which the certificate relates in their possession without danger to the public safety or to the peace, no longer has a good reason for having in their possession, or for purchasing or acquiring, the firearm or ammunition which they are authorised.

18.108 We know from family accounts that Robert and Mary had lived on rural smallholdings for many years and the firearms were used for clay pigeon shooting on his land. Police records indicate that Robert stated he had held a firearms licence since 1967. There were no accounts from contributors to the review of the firearms being used whilst living in Cumbria, where although they had a large garden which may not have been a suitable area for shooting given proximity to neighbours.

18.109 The licence applications ask for the reason for holding firearms and fell under the valid category of “sentimental reasons” which covers holders who wish to hold firearms for purposes other than vermin control or other reasons such as clay pigeon shooting and sporting purposes.

18.110 In 2011 and 2016 the licence renewal included a home visit by a licensing officer and telephone discussion with referees which is not expected in national guidance and is considered good practice by the Force, Firearms Act 1968 (as amended) and Home Office Guide to Firearms Licencing Law 2016. The licensing is based on assessment of suitability of the applicant and does not consider factors such as age of the applicant. Home Office data indicates that the over 65 years of age make up 19% of the population in England and Wales however make up 30% of licence holders.

[42] Home Office statistical bulletin 18/20 ISSN: 1759-7005

18.111 In 2016 the most recent renewal police records indicated that Robert wanted to retain the shotguns for "sentimental reasons", "is in good health, appears fit, has regular health checks for a pilot's licence he holds, security adequate, reference from former flying colleague known for 42 years and domestic violence question ticked "no" ". It was noted on the records that Mary was present during the home visit.

18.112 On granting a licence in 2011 the Force writes to the applicant's GP informing them of the decision and asking for any concerns to be raised within 14 days (national guidance at the time).

18.113 The police and GP surgery could not locate a copy of the letter from the renewal in 2016 so for review purposes it seems that there was either an oversight in either not sending this letter, or it was sent and not received, or it was received and possibly not filed. Discussion with Cumbria Police firearm licensing regarding this has highlighted that the system now ensures that the letter is sent and recorded as such on the national firearms database.

18.114 Whilst some concerns over Robert's ability to cope were flagged with the surgery in 2019 it would have been unlikely that these would have raised immediate concern in relation to the firearm, however in other circumstances, for example if agencies had been aware of his suicidal ideation this would have been relevant.

18.115 The review is aware that the "firearms licence holder" would not necessarily be flagged at the front of medical records though police letters to GPs ask that it is encoded and therefore agreed that this would be important if health conditions of a holder changed and police needed to be informed of this.

18.116 In December 2021, following events in Devon in 2021, the Home Office published updated of firearms licensing statutory guidance. This introduced new guidance in relation to medical checks and records to be held by GP's. It is recommended therefore:

Recommendation 8

That Cumbria Constabulary and relevant GP Clinical Commissioning Groups actively promote to GPs the 2021 Home Office Statutory Firearms Licensing Guidance[43] and what actions to take where there may be concerns due to changes in the health circumstances of firearm licence holders.

18.117 We understand that the revised Home Office Guidance will be more robust in relation to licence renewal and assessment. In is therefore further recommended that:

Recommendation 9

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

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.

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.

18.118 The review considered learning from a previous DHR and a recently published Safeguarding Adult Review which had relevant findings and recommendations. These have been considered separately under the carer role term of reference.

19. Conclusions

19.1 It is difficult to identify abuse in older people where signs are hidden or there is no disclosure. The memory assessment of Mary taken in September 2019 describes Mary and Robert as a "loving couple" with Robert described as "attentive and concerned".

19.2 Naomi described the first year when she worked weekly with the couple in 2015 that they seemed to be the "perfect couple".

19.3 Lifelong friends and family members were aware of Robert's domineering personality, however, did not recognise or consider this as abuse or neglect. That picture was fragmented and much of it private to the couple and not known to agencies, family, and friends until after the deaths.

19.4 No domestic abuse was formally reported which may have triggered agency responses or multi agency safety planning.

19.5 The abuse and neglect were again either hidden and concerns not known to agencies until a relatively short period between October 2019 and January 2020. Responses to concerns were not escalated for multi-agency safeguarding consideration and only elicited actions by the GP practice when there was potentially a role for wider assessment by Adult Social Care.

19.6 Health services were engaged appropriately in the care of Mary in a proactive manner and on occasion initiated a rapid response to her illness such as in the instance of Robert calling the surgery in 2019, leading to a visit the same day and subsequent hospitalisation to stabilise her health, however safeguarding concerns from the friend and subsequently Mary's sister were not acted upon in a robust way in all instances and further professional curiosity was warranted.

19.7 Those concerns should have been shared more widely within the practice and with other NHS services active in the care of Mary. There was no evidence that consultation regarding the concerns was undertaken with safeguarding leads within the practice. There was no

exploration of the concerns made with the referrer. Further to this escalation to adult safeguarding enquiry and advice with Cumbria County Council was not initiated.

19.8 The review concluded that Robert was skilled at control of interactions with agencies and "disguised compliance" was evident when considering Robert potentially withholding medication from Mary, refusing to take her to appointments, not buying food and ignoring her considerations of temporary respite care. Accounts of him frequently telling Mary, "she was going to die", that seeking medical help was "a waste of time" and "there's no effing carers getting in this house" contrasted starkly with the picture Robert presented to professionals who had interactions with Mary.

19.9 The later accounts from Naomi indicate that Robert becomes angry at her advocacy for Mary's need to attend medical appointments and for bringing food to the home. Naomi directly challenges Robert's violent behaviour when she is told about him injuring Mary's wrist, when trying to take the torch from her in the night. Whilst initially angry Robert would then become contrite and saying he couldn't cope. The Panel considered that this was possibly a manipulative tactic by Robert to divert Naomi's concerns and could be considered as an example of his ability to influence those around him and to retain his level of control.

19.10 The caring responsibilities of Robert and care needs of Mary were not adequately considered, and there were several missed opportunities, given the frequency of GP and outpatient interactions with Mary, to explore and record the outcomes of those assessment discussions.

19.11 It is a feature of many types of review in relation to serious harm or avoidable death that the so called "rule of optimism" is a feature. In essence this is the belief that the carer will act and is acting in the best interests of their partner. In this case there were high levels of medical intervention to support Mary which were appropriate and whilst abuse was not suspected, once questions were raised, they should have been robustly explored.

19.12 The voice of Mary was not adequately documented and there was potentially an over reliance on professionals relying on Robert to advocate Mary's interests. Mary speaks on the telephone with the Community Heart Failure Team prior to their visit on 30th December 2019 and raises concerns about her care. These concerns are answered by Robert's insistence that he can cope in the face-to-face contact with the team later that day.

19.13 A picture emerges post deaths of concerns around Robert's mental health that was not observed by family and friends and largely remained "hidden". Mary's diaries indicate that for many years Robert had depressive periods which could last many weeks when he would as she put it "take to his bed". In the chronology period of 5 years Robert is generally recorded as being in good health and nothing remarkable is noted. In 2011 Mary noted in her diary that Robert had been to a GP for "depression" and was prescribed an anti-depressant medication. GP records confirmed this indicating that Robert visited his GP due to feeling tired some days. Robert did not repeat the prescription and treatment ceased.

19.14 The review considers that there could have been motives for not accessing support by Robert. The period in which he was "socialised" would be recognised as potentially carrying

"stigma" in relation to disclosing to professionals any mental wellbeing concerns. In addition, it was considered that his regular pilot licence renewals which required a comprehensive health check via a Civil Aviation Authority Doctor and the firearm certificate renewal could have been affected if he had disclosed depressive tendencies.

19.15 Roberts friend indicated that on their last holiday together Robert was "different" and didn't want to socialise in the restaurants and bars as they had done in previous holidays, insisting on staying in the apartment in the evenings.

19.16 As Mary's health and mobility deteriorates in 2019 the review found that Robert was less able to spend time walking, cycling, and flying.

19.17 Academic research in relation to homicide suicide in older people indicates an area that is possibly understudied and less understood than many other areas of domestic homicide. There are however a body of studies (mainly from Canada and the United States) which indicate that there are significant risk factors and potential predictors. Bourget et al (2010) published a study in Ontario based on coroners' records in relation to homicide suicide and reviewed other similar studies.[44]

19.18 The findings summarise those risks and predictors of homicide suicide in older people are most prevalent where the perpetrator has undiagnosed mental health issues, increasing caring responsibilities for a partner, a history of previous marital conflict or domestic abuse and the perpetrator has suicidal ideation.

19.19 We know that accounts post death indicate that Robert potentially had undiagnosed depression, his care role was increasing, Mary's health was deteriorating rapidly, he was abusive and controlling, and he frequently referred to suicide.

19.20 Whilst the studies are small in terms of sample populations, the impact of increasing older populations in the UK and Cumbria create a potential for older homicide suicide to increase in prevalence and this aspect of this review should feature in future training for professionals.

19.21 The importance of the GP surgery in the context of DHRs should be considered. Whilst the current statutory guidance places responsibility around the DHR contribution as sitting with health trusts and GPs to provide information via the Trust the chair of this review considers that in this review it would have been useful to have the GP surgery directly involved in the work of the panel. On occasion the surgery provider was reluctant to answer questions and

---

[44] Domestic Homicide and Homicide-Suicide: The Older Offender. Dominique Bourget, MD, Pierre Gagne´, MD, and Laurie Whitehurst, PhD. J Am Acad Psychiatry Law 38:305–11, 2010

questioned request for further information. Direct participation may have elicited a greater understanding of the DHR process and assisted in ownership of identifying learning and improvement. Any future revision of the 2016 Home Office Guidance would be helpful to cover more adequately the role of GPs.

19.22 Cumbria Constabulary have considered the circumstances of the missed DHR referral and completed extensive remedial and improvement actions. In addition, they drew attention to the GP letter not being kept on file in 2016. Again, systems have changed, and those letters are now recorded. It is notable that the organisation has demonstrated a high level of candour throughout and demonstrated a willingness to learn and improve in relation to this DHR at the earliest stage. Consequently, there are no additional learning for the Force arising from this review other than to work with Clinical Commissioning Group to remind GPs of current processes whilst awaiting revised Home Office Guidance.

19.23 Safeguarding and welfare concerns should be fully addressed when made by community members and consideration to work with the referrer to elicit further information is vital. Naomi was the only consistent protective factor in relation to Mary in the final months, alerting agencies and Susan who travelled to assist her sister on several occasions. There is importance therefore to raise community awareness of vulnerable adult abuse and neglect and domestic violence.

20. Lessons to be Learnt

20.1 Early learning was identified during this review process by single agency reviews and the learning and recommendations are in the process of being implemented and attached in section 22.

20.2 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.

20.3 Home Office Guidance in relation to firearms licensing has recently been updated and it is important for police and GPs to embed the 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.

20.4 University Hospitals Morecambe Bay Trust identify only 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.

20.5 The Clinical Commissioning Group have equally identified a range of improvements and have undertaken to deliver those prior to completion of the DHR. (See section 22)

20.6 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.

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

20.8 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.

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

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

20.11 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.

20.12 Formal carer assessments should be encouraged and routinely considered.

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

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

20.15 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.

20.16 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.

20.17 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. These issues are covered in a recommendation in relation to future training.

21. Review Recommendations

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[45] 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.

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

22. Single Agency Recommendations (and action plans):

University Hospitals Morecambe Bay:

Recommendation	Action	Person Responsible	Time Scale	Desired Outcome
Heart Failure Team to be aligned to Community Care Safeguarding Supervision Model, recently established within community care group at UHMB	Heart Failure Team to participate in regular safeguarding supervision	UHMB Heart Failure Team Manager supported by Named Nurse Safeguarding Adults	March 2022	Heart Failure Team have access to safeguarding supervision allowing the opportunity for the practitioner to be supported and advised re case management of potential safeguarding concerns including Domestic Abuse.

Morecambe Bay Clinical Commissioning Group

Recommendation	Actions	Person Responsible	Timescale	Desired Outcome
A review of Safeguarding policies, procedures and training.	Review to be undertaken with Safeguarding leads at [redacted] practice to ensure Safeguarding policies are up to date and supported by staff training.	Morecambe Bay CCG Quality and Safeguarding Team	March 2022	Assurance that consideration will be given to potential cases of Domestic Abuse and potential safeguarding concerns will be appropriately escalated.
a] General Practitioners to be reminded of responsibilities under the Care Act, 2014, to request assessment of care and support needs for individuals presenting with indicators of needs arising from physical or mental health impairment or illness, resulting in a significant impact on the individual's well-being. [b] General Practitioners to consider requesting a Carers	Learning from this case to be shared via: GP Protected Learning Time (PLT) sessions. GP Safeguarding Forums	Morecambe Bay CCG Quality and Safeguarding Team	March 2022	Increased General Practice awareness of the need for Care Act compliant assessments of care and support needs, along with carers assessments where appropriate, resulting in increased referrals from Primary Care to Adult Social Care.

Assessment for individuals who are looking after another person with care or support needs.	Primary Care Newsletter			
Ensuring the voice of the adult is heard and the individual is 'visible'.	Learning from DHR to be shared as a learning brief with Primary and Secondary Care colleagues.	Morecambe Bay CCG Quality and Safeguarding Team	March 2022	All recommendations from this IMR to be shared across GP practices within the MBCCG footprint via Safeguarding Learning Forums and Protected Learning Time (PLT)
Risk assessments to be easily accessible in Primary Care	Identify whether risk assessments for Domestic Abuse are embedded into the EMIS system.	Morecambe Bay CCG Quality and Safeguarding Team	March 2022	Primary Care practitioners can easily assess the level of risk an individual may be subject to, and take appropriate action.
Mental capacity to make decisions around care and support to be recorded and reviewed regularly, particularly where a person may be showing signs of cognitive decline and / or, are making care and support decisions on behalf of someone else.	Learning from this DHR to be shared with Primary Care providers via protected learning time, safeguarding forums and the CCG Primary Care newsletter	Morecambe Bay CCG Quality and Safeguarding Team	March 2022	Practitioners will be better able to identify those making potentially unwise decisions and / or requiring discussions to be held in best interests.

Cumbria Constabulary

Action 1: Promote Officer Awareness around Domestic Homicide Reviews. S - To make officers aware of what a Domestic Homicide Review is, our role within that process and how to refer into it. M – It is measurable by seeing how many are identified and referred, via increased knowledge and prompts on investigation plans. A – The increased knowledge and monitoring is achievable. R – The actions are realistic to be achieved across the force. T - This is to be completed as soon as practicable and the changes and implementation to be done before the end of the panel meetings.
Desired outcome from the recommendation *For Officers to be aware of HDRs and to be able to make the relevant referrals.*

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
2020/SOUTH/2 1.1	Information about Domestic Homicide Reviews, the definition, Guidance, leaflets and template letters to be placed on the Force Intranet Domestic Abuse pages.	Local	*D/Super and PPU*	A new DHR tab created in the Domestic Abuse pages. Within this tab is the guidance, template referral letter, previous DHRs, Home office leaflets, AAFDA leaflets, links to AAFDA website, DHR and IMR training powerpoint.	03-08-2021	22/07/2021 – Email to Marketing and Communication to create a DHR page on the Intranet. 03/08/2021 – Documents sent to Marketing and Communication and placed on the intranet. COMPLETED 03-08-2021
2020/SOUTH/2 1.2	Internal Briefing to staff via the "Need to Know" bulletin and Yammer (force messaging service)	Local	*D/Super Crime & PPU*	Briefing placed on "Need to Know" on the 22nd July 2021, also placed on Yammer on this date…… Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force in April 2011. DHRs are coordinated by the Community Safety Partnership (CSP) and any agency can refer a death into them for a DHR. Under section 9(1) of the 2004 Act, a Domestic Homicide Review means a review of the circumstances in which:	July 2021	Need to Know Briefing circulated on the 29th July 2021 across the force. Article placed on Yammer on the 22nd July 2021 – on Crime and Safeguarding page – seen by 236 staff in that group.

				"The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, suicide* or neglect by— (a) a person to whom they were related or with whom they were or had been in an intimate personal relationship, or (b) a member of the same household as themselves, held with a view to identifying the lessons to be learned from the death. (*where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken) Where the definition set out above has been met, then a Domestic Homicide Review should be undertaken. If you deal with a case that meets the above, then you need to discuss the case with your Inspector to see if a referral should be made for a DHR. If a referral is needed, then if the Inspector contacts DC Sarah Edgar with the details of the case and these can be passed to the CSP, via an official notification letter. The purpose of a DHR is to: a) Establish what lessons are to be learned from the domestic		COMPLETED 29-07-2021

				homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims. b) 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. c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate. d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity. e) Contribute to a better understanding of the nature of domestic violence and abuse; and f) Highlight good practice. The rationale for the review includes ensuring that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with an aim to avoid future incidents of domestic homicide and violence. The review will		

				also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.		
2020/SOUTH/2 1.3	Update Area DIs of Statutory Guidance	Local	*D/Super Crime & PPU*	Domestic Homicide Review Statutory Guidance sent to all area Detective Inspectors via email (attached as a link inside a powerpoint they had watched whilst in DHR training on the 11-05-2021) and again to 3 area DI's who were writing IMR's on 5th August 2021 and placed centrally on the DHR tab for other staff's awareness. DHR input given to Detective Sergeants and Detective Inspectors on the new PIP Managers course. 4 individual DHR cases were reviewed, followed by a group discussion to enhance learning around the process and understanding around types of incidents where DHR referral would be appropriate. DHR SPOC for the Constabulary and the Co-Ordinator for the CSP gave a 1 hour face to face input to DS's and DI's on second part of their course. This was given on 12th November 2021.	Nov 2021	Emailed with Statutory guidance link on 11-05-2021 COMPLETED 12/11/2021
2020/SOUTH/2 1.4	At submission and review of a crime, the crime registrar to place an Action on a relevant Investigation Plan,	Local	*D/Super Crime & PPU*	Crime Registrar given the definition of a DHR and asked that when they review all crimes which have been submitted where a death has occurred, via violence, abuse, neglect or	Aug 2021	COMPLETED 04-08-2021

	for a DI to consider if the case is relevant for a DHR referral.			suicide in a domestic scenario, they add an action for the DI to consider a DHR. This will be added to Crime Investigation plans for crimes and unexplained deaths and suicides.		
2020/SOUTH/2 1.5	Review Form 38's (the form submitted to the coroner by the police at a sudden death).		*D/Super Crime & PPU*	A prompt has been added to the Form 38 for attending officers to consider Domestic Abuse and Controlling and Coercive behaviour at incidents of suspected suicide. The HQ Tactical Mental Health and Suicide Postvention Officer, sends notifications of any suicides they are made aware of, to the DHR SPOC, so that they can again be reviewed against the DHR definition.	July 2021	COMPLETED 06-07-2021
2020/SOUTH/2 1.6	Promote CPD training for senior officers around Domestic Homicide Reviews		*D/Super Crime & PPU*	DHR and IMR training held for all Senior Investigating Officers and Deputy Senior Investigating Officers. The Slides for that training put on the police intranet on the DHR page. (Completed April 2021) DHR SPOC for the Constabulary and the Co-Ordinator for the CSP gave a 1-hour face to face input to DS's and DI's on second part of their course. This was given on 12th November 2021.	Nov 2021	COMPLETED 29/04/2021 COMPLETED 12/11/2021
2020/SOUTH/2 1.7	Recommendation 8 from the DHR.		*DCI*	Email to DCI regards recommendation.	08-04-2022	

	That Cumbria Constabulary and Morecambe Bay Clinical Commissioning Group remind GPs of the current firearm licensing arrangements and what actions to take where there may be concerns due to changes in the health circumstances of licence holders.		*Insight and analysis*	Replied on 07-01-2022 and will speak to Firearm Licencing Officer regards this Action. 10-01-201 - DCI and Firearms Licensing Officer taking this forward and raising it locally, regionally and nationally to increase learning to all forces.		