St. Helens Council

St. Helens Community Safety Partnership.

DOMESTIC HOMICIDE REVIEW

Under Section 9 of Domestic Violence Crime and Victims Act 2004.

EXECUTIVE SUMMARY

In respect of the death of a woman in December 2014.

A report by Michael Murray,

Independent Chair and Author.

August 2015.

1.0 Background to Domestic Homicide Review.

On the morning of 2nd December 2014, following information received, police officers attended at an address where the body of a female had been discovered by a relative. The body was that of a woman aged 79 years, who lived at the address with her 78 years old husband. The woman is the subject of this review and will be referred to as Female 1. At the time of the discovery her husband was missing from the address, as was his car. A note was discovered at the address in the handwriting of the husband, apologising for his actions. A short time later the body of the husband was found by the police in a nearby dam. The husband will be referred to in this report as Male 1.

A Home Office pathologist subsequently concluded that Female 1 had died as a result of strangulation and that Male 1 had died as a result of drowning. A police investigation ensued, and concluded that no other persons were involved in the two deaths. A report has been prepared for HM Coroner, and Inquests have yet to be concluded.

The St Helens Community Safety Partnership was informed of the events on 6th December 2014, and following a review of the circumstances, it was decided that the case met the criteria for undertaking a Domestic Homicide Review (DHR), as required by Section 9 of Domestic Violence Crime and Victims Act 2004. The Home Office was informed on 2nd January 2014.

2.0 The Domestic Homicide Review Process.

The purpose of this DHR is as stated in the 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews', as follows:

a. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b. To 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. To apply these lessons to service responses including changes to policies and procedures as appropriate.

d. To prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter agency working.

DHR's are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. Also DHRs are not specifically part of any disciplinary inquiry or process.

It was determined that the DHR would take cognisance of the generic Terms of Reference within the Multi-Agency Guidance for the conduct of Domestic Homicide Reviews (2013), as listed on pages 26 and 27 of that document.

Moreover, the Chair and Panel members agreed also to focus on the following specific Terms of Reference, having regard to the information available within this DHR:

a. Reviewing all aspects of medical care/treatment in respect of victim and perpetrator especially in relation to mental welfare.

b. If there was low level of contact with services, why was this so? Were there barriers to either the victim or perpetrator accessing/engaging with services and seeking support? Was their vulnerability a factor in accessing services? How accessible/available were relevant services in the locality of the victim and perpetrator?

c. Could there have been any better recognition of vulnerability, of victim or perpetrator? Could/should this have triggered intervention/support? Were benefits/support applied for? Were there any opportunities to consider any overall Safeguarding issues in relation to the victim and/or perpetrator?

d. Were the formal contacts with agencies appropriately managed and appropriately risk assessed particularly in view of the outcome of this case?

e. Were there any concerns amongst family/friends/neighbours or within the community and if so how could such concerns have been harnessed to intervention and support? How will the review engage and be sensitive to needs of family/friends/neighbours to allow them to contribute to the review. Also consider media strategy as appropriate.

f. Review panel must bear in mind equality and diversity issues at all times. Age, disability, marriage/partnership, race, religion and sexual orientation may all have bearing on the conduct and outcome of the review.

A Chair to the DHR was appointed on 19th January 2015. A multi-agency DHR Panel met on a number of occasions, the final panel meeting taking place on 20th July 2015.

Chronology of events.

02/12/2014	-	Event occurred.
06/12/2014	-	CSP notified of Domestic Homicide.
18/12/2014	-	CSP Screening meeting, determined need for DHR.
02/01/2015	-	Home Office informed of DHR.
19/01/2015	-	DHR Chair appointed.
16/02/2015	-	1st DHR Panel meeting held.
18/05/2015	-	2nd DHR Panel meeting held.
09/06/2015	-	Chair meets with mental health experts. (St Helens Mind/5 BP)
07/07/2015	-	Panel meeting held with mental health experts. (St Helens Mind/5 BP)
20/07/2015	-	3rd (final) DHR Panel meeting held.
02/11/2015	-	DHR findings submitted to Home Office.

The DHR Panel requested Individual Management Reviews and these were undertaken by:

- Merseyside Police.
- Primary Care Services, General Practice.
- 5 Borough Partnership NHS Foundation Trust.

3.0 Summary of the case.

Female 1 and Male 1 had been married for 56 years. They have three adult children and a number of grandchildren who lived nearby. The Chair has met with family members on a number of occasions and they have contributed to the review. The family describe their parents as a loving couple, with a 'normal' relationship, who were always there for each

other, and who valued their independence. The family were in regular contact with their parents.

Female 1 was registered with a local GP. (Referred to as GP practice 1.) In 2002 a diagnosis of anxiety and depression was made and medication prescribed. Female 1 appeared to respond positively to the medication. However, in 2009 and 2010 following visits to GP practice 1 concerning anxiety, Female 1 was referred to a specialist psychiatrist for the elderly at 5 Boroughs Partnership. As part of this process in February 2010 the couple were visited at their home by mental health practitioners, to assess the needs of Female 1, and the needs of Male 1 as her carer. Day services were offered to the couple, but this support was declined by them. Female 1 was subsequently seen on 5 occasions by a Consultant Psychiatrist and was diagnosed with depression. She was prescribed an anti-depressant (sertraline) which appeared to have a positive outcome and Female 1 was discharged back to the care of GP practice 1 in December 2011.

Male 1 was also registered with a local GP, but a different one to that of his wife. (The GP of Male 1 is referred to as GP practice 2.) It is known that Male 1 had been diagnosed in 1990 with a chronic anxiety depression disorder, and in 1994 was admitted informally to hospital for 8 days. However, Male 1 made it clear that he did not wish to receive any psychiatric treatment and was discharged back to the care of his GP practice 2. Male 1 was a regular patient at his GP practice, to attend to both his physical and mental health conditions. In July 2008 Male 1 was prescribed an anti-depressant drug dothiepin (brand name dosulepin) in relation to depression and tension headaches. Male 1 was still taking this medication at the time of his death. It is noted in the GP practice 2 notes at a consultation in July 2012 that Male 1 is described as the carer for his wife.

The family describe that their mother's personality had changed in recent years, on occasion her behaviour became strange, and she clearly displayed some obsessive and compulsive features. It is also noted that Female 1 disclosed to her GP practice 1 during a visit in July 2012, that she had stopped taking the anti- depressant medication due to experiencing hair loss, which she believed to be a side effect of the medication.

It is also a fact that Male 1 had decided to give up driving in November 2014 (due to a number of factors, including concerns about his eyesight). Female 1 was particularly concerned regarding this, and was worried that this would have a major impact on their independence and their ability to get out and about for daily activities.

4.0 Key Review Findings.

The review panel acknowledge that there is no prior evidence of domestic abuse within this relationship. On the contrary there is ample evidence of a long term loving relationship. There is no doubt the couple valued their independence, and in recent years Male 1 did his best to look after his wife as their health and wellbeing deteriorated.

The couple were not in contact with any agencies other than health services. The panel acknowledge that over a long period of time medical care provided was appropriate and of a high standard. Male 1 had long term mental health issues, but with medication had remained stable over a long period of time. In recent years Female 1 had also suffered anxiety and depression, and more recently had displayed obsessive traits.

The decision to give up the car in November 2014 could have been a significant issue and stressor within the relationship, with Female 1 fearing that they were becoming more isolated. There had, however, been no warning (even to those closest to the couple) in the days leading to the tragic events of the 2nd December 2014. The events were sudden and catastrophic and, in the view of the panel, could not have been predicted by any agency.

The panel wish to highlight the following issues in relation to this review.

a. Support for carers. (see sections 9.3 – 9.8 overview report)

   It is not clear that the vulnerability of Male 1 was properly recognised by GPs in relation to his role as carer to his wife, a role that appeared to be developing and becoming more demanding. Similarly, when 5BP carried out a more formal assessment of the couple's needs, despite disclosing his mental health issues, there was ready acceptance that he did not require support offered. Notwithstanding issues of confidentiality and fears of antagonising the situation, the panel believe there was opportunity for a more joined up approach to promote the benefits of help and support available to the elderly in these circumstances. The panel believe that there is an opportunity for relevant agencies to consider developing protocols to develop this joined up approach, to include family members in the process, and 3rd Sector agencies (e.g. Age UK), promoting to the elderly the value and benefits of accepting support and help in such circumstances.

b. Challenges to perception of mental health issues in elderly persons.

   The panel accept that there is some degree of stigma particularly in elderly people around mental health issues. Indeed, this can cloud judgement and make it more difficult for the elderly to seek or accept help and support. The panel feel that this tragedy could be an opportune time to deliver a publicity campaign across the Borough to challenge perceptions and heighten

awareness regarding the issue of mental health and the elderly. Such a campaign could target not just the elderly but families, carers, and practitioners to educate, promote health and wellbeing, to advertise services and attempt to break down barriers to accessing such services.

c. Ancillary issues. (See sections 9.13 – 9.14 overview report).

The panel were concerned regarding the dosage and interaction of drugs prescribed in this case. The panel accept that this had no bearing on the outcome, but believe that there are learning points available to the GP practices. Similarly, shortcoming within GP notes were seen, particularly details of decision making processes, for example in considering risks/benefits of drugs, dosages, or consequences of stopping taking drugs. The following were noted of particular concern:

- when prescribing anti-depressants for older people and age appropriate doses should be prescribed. In the elderly it is recommended that dosage of dothiepin should not exceed 75mg daily.
- It is not recommended that dothiepin is prescribed in conjunction with tramadol
- Dothiepin and SSRI's should not be prescribed concurrently due to the risk of serotonin syndrome. (They appear to have been prescribed together once in 2012.)

5.0 Recommendations.

The panel consequently make the following recommendations:

a. The panel recommends that relevant agencies consider the development of a protocol where elderly persons identified as carers and where mental health features in the relationship, are signposted as appropriate to primary care, secondary care and 3rd party sectors to ensure access to help and support.

b. The panel considers that the case could be recognised as an opportunity to deliver a local publicity campaign to challenge perceptions and heighten awareness around mental health and the elderly. The campaign could target not just the elderly, but families, carers, and those practitioners working closest with the elderly, to educate and breakdown barriers and stigmas associated with mental health, to promote health and wellbeing and to promote services available.

c. The panel recommends that the issues regarding drugs dosage and interactions identified by the review (see section 9.14 overview report) are formally reported to GP practice 2 as learning points, and the value of meaningful detailed patient notes, the recording of decisions and rationale be considered as learning points for both GP practices. (See section 9.15 overview report.)

End of Executive Summary