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SUNDERLAND DOMESTIC HOMICIDE REVIEW

INTO THE DEATH OF Mrs X

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1. REVIEW PROCESS

This executive summary outlines the Domestic Homicide Review process, and subsequent learning, undertaken by the Safer Sunderland Partnership in reviewing the death of Mrs X. This was the second statutory domestic homicide review carried out in Sunderland.

In April 2014 Northumbria Police notified the Safer Sunderland Partnership of the death of Mrs X and her husband Mr X. Initial investigations highlighted that Mr X has possibly administered drugs to his wife and then taken his own life. At an initial case review meeting it was established that the deaths met the criteria for a Domestic Homicide Review under Section 9 of the Domestic Violence Crime and Victims Act.

The purpose of a Domestic Homicide Review as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews is 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.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.

DHRs are not inquiries into how the victim died or who is culpable; in the case of Mrs X this was a matter for the coroner to determine. The conclusion of the Coroner's Inquest was the unlawful killing of Mrs X by asphyxiation, and the

taking of his own life by Mr X. Within the Inquest the Coroner described how Mrs X's health had been in severe decline, and how family and agencies supported the couple throughout this. He referred to evidence of 'mutual despair', and stated that no one could have predicted events.

The review panel consisted of representatives of both statutory and non-statutory agencies. These included those agencies that had had contact with Mrs and Mr X, as well as other agencies acting as 'critical friends' in the review process. Other agencies invited to take part in the review process were those were felt to have specialist knowledge around areas identified as specific to this case; such areas included Mrs X's diagnosis of Parkinson's and Parkinson's related dementia, and the role of Mr X as her main carer.

The specific terms of reference agreed for this review were:

- Subject to family and friends or colleagues wanting to participate in the review, were they (i) aware of Mr X's ability and willingness to take on the caring responsibilities for his wife and (ii) aware of any abusive behaviour from Mr X to Mrs X or vice versa, prior to the homicide
- Was there any domestic abuse or indicators of domestic abuse within Mr X and Mrs X's relationship and was this known to agencies? If so, how was this responded to and were any assessments undertaken?
- Was Mrs X considered an 'adult at risk' in agencies' dealings with her?
- Did Mrs X have capacity and was she capable of making informed decisions about her care in agencies' dealings with her?
- At any point was Mrs X seen alone so that her own wishes and feelings could be expressed about her care?
- Were agency assessments carried out and decisions made about Mrs X done in an informed and professional way? Were appropriate enquiries made, services offered or services provided given what was known or what should have been known at the time?
- Was the extent of Mr X's and his children's caring responsibilities

recognised? Were appropriate enquiries made, services offered or services provided given what was known or what should have been known at the time? Was a carer's needs assessment carried out on Mr X and/or his children and if so, were decisions made in an informed and professional way?

- At any point was Mr X or his children seen alone so that their own wishes and feelings could be expressed about their caring responsibilities?
- Were there any missed opportunities for agency intervention or referrals to support agencies in relation to the family's caring responsibilities? Were agencies sensitive to the needs of the family in their caring responsibilities? Was it reasonable to expect staff, given their level of training and knowledge, to fulfil these expectations?
- Given that Mr X and Mrs X were self-funders, how did this impact on the assessments carried out, enquiries made, services offered or services provided around Mrs X's care and the family's caring responsibilities?
- Were appropriate managers or other agencies and professionals involved at the appropriate points?
- To what degree could the homicide have been accurately predicted and prevented?

The time period to be covered by the review was set from two years before the deaths of Mrs and Mr X. It was also requested that any significant events since Mrs X's Parkinson's disease was first diagnosed be included, where it was felt that this would provide further context for the review.

As part of the review process Individual Management Review (IMR) reports were completed by five agencies where it was identified that significant contact had taken place with Mrs and Mr X within the specified time period. All IMR authors were independent of the case and had had no contact with

Mrs and Mr X, either as a practitioner or through the management of staff involved. IMR reports were received from the following agencies:

- Sunderland Clinical Commissioning Group (CCG)
- South Tyneside NHS Foundation Trust (STNHSFT)
- City Hospitals Sunderland NHS Foundation Trust (CHS)
- Northumberland Tyne and Wear NHS Foundation Trust (NTW)
- Sunderland City Council covering: Occupational Therapy; Social Work (Adult Services); and Reablement at Home.

In addition to the above agencies, it was identified that Mrs and Mr X had contact with both **Parkinson's UK** and **MIND,** and thus the contribution of these organisations was sought to inform the review process and is referenced within this report.

Mrs and Mr X's three children, two daughters and one son, were contacted by the Chair of the review to inform them of the process and invite them to contribute. As a result both Mrs and Mr X daughter participated in the review process. The couple's son confirmed he was happy for his sister's to represent the views of the family. The Panel also identified that it would have been useful to meet with friends of Mr and Mrs X identified within the review process, however despite attempts, the contact details of such friend could not be obtained. Further relevant information from both family and friends was however taken from the police report supplied to the Coroner.

2 AGENCIES INVOLVEMENT

As has been outlined previously, five agencies were identified as having had sufficient contact with Mrs or Mr X to warrant the completion of a chronology and Individual Management review (IMR).

Mrs and Mr X had been attending the same **GP practice** since 1986, and were well known to the GPs, nursing staff, Community Matrons, and practice administration staff. They were active members of the Patient Participation Group, as well as being regular attenders at the practice for their own healthcare needs. Mrs X was diagnosed with Parkinson's disease in 2000 and following this regularly attended both her GP practice and **City Hospitals Sunderland (CHS),** including the outpatient clinic with Consultant Neurologists and the Specialist Parkinson's Nurses, where her medications were reviewed and adjusted. Throughout this period her symptoms steadily worsened, including a significant deterioration in the last two years of her life. In September 2013 she was also diagnosed with Parkinson's related dementia.

As regards Mr X's contact with GP services, he was considered to be in good physical health, apart from high blood pressure. He did however have historic issues with anxiety and insomnia and in the 1980s there is repeated reference within his GP records to trouble sleeping, as well as records of repeated prescriptions issued for benzodiazepines (which can be used to treat both anxiety and insomnia). In May 2011 the GP practice altered Mr X's anti-depressant medication for the last time to the prescription of two types of sedating anti-depressants, which he was maintained on until his death. During the period of the review he continued to attend six monthly blood pressure reviews, however his anti-depression medication was not reviewed at these appointments.

Mrs and Mr X were also involved with **South Tyneside NHS Foundation Trust's (STNHSFT)** Community Matron Service, initiated by a request from Mrs X's GP in 2008. The Community Matron Service had regular contact with Mrs and Mr X, either at their home or by telephone, from 2008 until the death of the couple. The Community Matrons are experienced senior nurses who work closely with clients who suffer from serious long term conditions or a complex range of conditions. They plan, organise, and deliver care directly to the client at home, acting as a single point of contact for care support and advice.

In relation to **Northumberland, Tyne and Wear NHS Trust (NTW),** Mr X was referred to their Older People's Mental Health team in November 2008. He was seen on two occasions for assessment, but following this had no ongoing contact. Mrs X's also had contact with NTW, which involved three appointments between July and December 2013. This contact related to her diagnosis with Parkinson's related dementia.

As has already been mentioned Mrs X had ongoing contact with **City Hospitals Sunderland (CHS)** as an outpatient following her diagnosis with Parkinson's. However during the review period she also had a period of in-patient treatment in March 2014, shortly before her death.

Prior to this inpatient treatment Mrs X also had some limited contact with **Sunderland City Council** in the form of a range of equipment provisions from 2007 to 2014. However following her discharge from hospital in March 2014, she had daily support provided at home from the Reablement at Home team and Community Rehabilitation Service. The package in place was intended to provide an interim service while an ongoing long term care package was assessed and put in place.

3 LESSONS LEARNED AND CONCLUSIONS

The IMRs of all agencies involved in the case of Mrs and Mr X present a picture of a devoted and loving couple. Even with the benefit of hindsight, nothing has emerged in the review of the couple's contact with agencies that indicates the presence of any abuse or violence. Mr X presented as a man attempting to care for his wife at home as her illness progressed and her symptoms worsened.

The above picture is strongly reinforced by Mrs and Mr X's daughters who spoke of their mother's deteriorating health and their father's care for her throughout this.

What did emerge within the review was a picture of Mrs and Mr X's contact with agencies where Mr X was the more prominent partner, who often spoke in the interest of his wife. Mrs X's voice was at times noticeably absent, or secondary to her husband's, around her own care needs. During their participation in the review process Mrs and Mr X's daughters confirmed that prior to the advanced stages of her illness their mother was independent with her own thoughts and actions and that she would express her own views.

In addition, Mr X emerged as a man who himself had long term issues in relation to anxiety and depression, that were unsurprisingly impacted upon by the deteriorating health of his wife. While some agencies viewed him as adequately coping with the stresses of being a carer, others were aware of the impact of this upon him, and varying levels of support were offered, which Mr X was often seen to decline. At no stage however did agencies feel that Mr X's own difficulties impacted upon the level of care he was able to provide for Mrs X.

While no significant failures have emerged as a result of this review, a number of areas for improvement in practice have been identified that may have assisted in supporting Mr X in his role as carer, provided greater opportunity for the voice of Mrs X to be heard, and also provided increased monitoring and opportunities for disclosure if there had been hidden domestic violence or abuse. These lessons learned are summarised below.

Limited occasions in which Mrs X was seen alone in order for enquires to be undertaken with her regarding her care needs or any other concerns.

It was identified throughout the review that Mrs X was rarely seen alone by agencies providing services to her. This appears to have occurred solely when she was receiving personal care during her admission to hospital, and following her discharge home in March 2014. Within all other contact, agencies identified that there had been no concerns that made it 'necessary'

for Mrs X to be seen alone; with the exception of NTW who did offer her this opportunity, although this occurred in the presence of Mr X.

This lack of contact with Mrs X alone, reduced opportunities in which she would have been able to disclose any abuse had it existed, or indeed to comment upon any concerns she may have had in relation to her husband's ability to care for her. While it was highlighted that Mr X declined additional support, there were limited occasions when Mrs X's opinion in relation to this appears to have been solicited.

Just as the lack of any presenting concerns resulted in it being felt unnecessary to see Mrs X alone, this can also be seen as a factor in relation to no direct questions being asked around domestic abuse. Most agencies work with an approach of selective enquiry where questions about domestic abuse are posed either with perceived high risk groups, or when there are concerns or indicators that are picked up by staff. While no evidence has emerged from this review to indicate that there was a history of abuse, it does nevertheless highlight that in cases where abuse may be hidden, the lack of routine enquiry potentially results in missed opportunities for disclosure.

Lack of a formal assessment of Mrs X's mental capacity.

It was identified that no formal Mental Capacity Act (MCA) assessment took place in relation to Mrs X, despite it having been identified that this should of taken place in relation to her contact with her GP practice. Furthermore, while Sunderland City Council and NTW did record that consideration of this had taken place and no formal assessment was considered necessary, other agencies such as the GP practice and CHS were only able to address this in hindsight, as no direct consideration of this was present in records. This is of particular importance given the evidence to indicate that Mr X did at times appear to speak on behalf of his wife and, as outlined above, limited attempts were made to speak to her alone.

As a result of this learning both the CCG and CHS included recommendations

within their IMRs to address this.

The need to fully explore the caring role of family members, and to ensure sufficient steps have been taken to offer appropriate support.

One of the key issues identified within this review was the role of Mr X as a main carer for Mrs X. The impact of this cannot fail to be seen as significant, given the tragic outcome of Mrs X's death shortly after her discharge from hospital, and Mr X's report the day before her death that he felt the time had come for long term care for Mrs X to be considered.

It was acknowledged that all agencies recognised to some degree the caring role being undertaken by Mr X in relation to his wife. However it was also highlighted that the extent to which he was seen to be coping with this varied between agencies. A number of agencies, including CHS, STNHSFT, NTW and Sunderland City Council offered carer's assessments, additional support or, in the case of Sunderland Council, explored other services available; however Mr X was seen to decline these on most occasions. What was also identified however is that it was not always clear to what extent these options were fully explored with Mr X, in terms of his perception of the impact they would have on his caring role and whether he fully understood the support available. Furthermore, Mr X's assertions that he was receiving support from other sources appears to have been accepted with little follow up to verify this, or to explore if other services may compliment this. In addition, there were a number of opportunities in Mr X's reviews with his GP, where further exploration could have been undertaken regarding his own emotional well-being and the impact on this of his role as a carer.

Despite the above, it should be noted that the review did not identify any significant indicators missed by staff to suggest that the stress caused by his caring role was in any way impacting on his ability to care for his wife, or thus placing her at risk. However the link to safeguarding issues and carer stress should be acknowledged, and staff need to be cognisant of this when working with carers, as supporting them appropriately may assist in managing and

reducing such risks.

It was also highlighted that the role of Mrs X's children in relation to her care was relatively unknown to services and as a result no further support or assessment of this was offered.

All agencies identified within their IMRs ways in which their services to carers could be improved.

Information sharing and a coordinated response.

Mrs and Mr X had high levels of contact with a range of agencies within the last two years of their lives. Within this, differing levels of insight and information were possessed, particularly around the extent to which Mr X was acting as a carer and the difficulties he had in dealing with this.

In relation to Mrs X's health care, there was evidence of good liaison between the GP and CHS around her attendance at appointments with the Consultant Neurologist and the Parkinson's Nurse. However both the CCG and STNHSFT identified an issue around information sharing between the GP and the Community Matron Service. The GP stated in interview that the Community Matron visited the couple regularly and this is alluded to in letters from outpatient appointments. However there is no formal recording of these visits in general practice records, which could have provided a valuable source of information. Community Matrons are not part of the 'staff' in the General Practice and are employed separately. Because of this they have no direct access to General Practice records, and do not input into the same system of clinical notes. This point was also raised by STNHSFT who highlighted the limited information sharing between the GP practice and the Community Matron Service. In order to address this Sunderland CCG and STNHSFT identified improvements that could be made to existing systems.

It also appears that, outside of Mrs X physical health needs, there was little coordinated approach in addressing the emotional wellbeing of both her and

Mr X in dealing with her illness and its progression. While letters between agencies such as STNHSFT, CHS and the GP highlighted concerns about how the couple were coping, or that they were 'struggling', no action appears to be have been taken in response to the sharing of such information. This links back to the lesson learned around responding to carers' needs, and the need for individual agencies to ensure support is explored to address any concerns identified. In addition however it highlights the lack of any coordinated response to such concerns. Sunderland CCG highlighted that the practice held Multi-Disciplinary Team meetings for patients that were deemed to be at high-risk or 'of concern'. While Mrs X was not deemed to meet the threshold for this, the correspondence received was indicative that the couple were having difficulties in coping. Given the risk linked to carer stress, this raises the question of whether this should perhaps have prompted consideration for discussion at the MDT meetings.

It was also highlighted that staff tended to rely on the self-report of Mr X that he was receiving support from other sources, without this being followed up.

Mrs X's last admission to hospital and subsequent discharge home.

During their participation in this review, the daughters of Mrs and Mr X highlighted that they had concerns regarding a number of aspects of Mrs X's hospital admission including the administration of her medication. The impact of their concerns can also be seen in relation to their decision to take Mrs X home from hospital as they believed they could provide a better level of care than that which she was receiving. Furthermore such concerns, and the accompanying decisions, need to be considered in the context of an already stressful situation in which Mr X and his family were trying to care for Mrs X.

Within the IMR of CHS it was identified that there were a number of issues arising in relation to Mrs X's discharge home from hospital. The IMR author therefore concluded that poor discharge planning was evident. They also highlighted the difficulties around the differences of patients being classed as 'Medically Fit' for discharge, although they may not be 'Therapy Fit'. In order

to address these issues CHS made specific recommendations within their IMR.

4 TO WHAT DEGREE COULD THE HOMICIDE HAVE BEEN ACCURATELY PREDICTED AND/OR PREVENTED?

None of the agencies that undertook IMRs felt that the tragic death of Mrs X could have been predicted or prevented. Even with the benefit of hindsight there have been no indicators of domestic violence or abuse revealed, or any risks relating to Mr X's behaviour that could have predicted the actions he took. While there is one incident within the hospital when he is reported to have become 'aggressive' and 'angry' towards staff, it was recognised that this was most likely a reaction to concern regarding the care his wife was receiving, and as such indicative of his level of stress as a carer.

While it has been recognised throughout the review that the extent of Mr X's stress in his role of carer was not always fully acknowledged or acted upon, there were no significant behavioural indicators that can be seen to predictive of Mr X's ultimate actions leading to the death of his wife and himself.

As regards prevention, it has been identified within this review process that there are a number of lessons that can be learned. These include the need to increase opportunities for victims to be spoken to alone and for their voices to be heard; for practitioners to fully understand capacity and to make assessments appropriately; for the needs of carers to be fully assessed and explored and for appropriate signposting to take place; for the impact of carer stress in terms of risk to be recognised; and for a more coordinated approach to the management of such cases. In addition specific issues related to Mrs X's stay in hospital and subsequent discharge have been identified. Had the above occurred it may have created greater opportunities to address Mrs and Mr X's situation, offer increased support, and should there have been hidden abuse or violence, for this to have been disclosed or identified. However while these are areas for improvement there have been no occasions identified when it can be said that a different course of action would have definitively prevented the tragic death of Mrs X.

RECOMMENDATIONS

Summary of the General Recommendations arising from this Review

A number of general recommendations from this review were identified in relation to the lessons learned and these are summarised below.

Recommendation 1: All statutory health and social care agencies to ensure that service users are offered the opportunity to be spoken to alone, in order to seek their views independent from carers and family members, and that this is incorporated into relevant policy and procedures. Agencies should also consider whether this should include routine enquiry around domestic abuse. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 2: Safer Sunderland Partnership to produce a briefing document outlining the key learning points from this review, including background information on people taking their own life, and links to unlawful killing or homicide, within the older population. All partnership agencies to provide feedback, within one month of the briefing document being produced and circulated, as to how the briefing document has been disseminated among staff.

Recommendation 3: All health and social care agencies to ensure that relevant staff are suitably trained regarding the Mental Capacity Act, including processes for when and how to undertake formal Mental Capacity Act assessments; the recording of any decisions in relation to capacity; and the need to ensure that where a person has capacity their view regarding their treatment and engagement are directly sought.

Recommendation 4: Safer Sunderland Partnership to encourage partners to promote awareness among staff of the role of the Sunderland Carers' Centre, Age UK Sunderland and other care and support agencies.

Recommendation 5: All statutory health and social care agencies to ensure that a carers' assessments is always offered to any one identified as having a caring role. Where declined, further exploration should take place as to any additional support that is being provided and by whom, and information provided as to alternative support that is available. All steps undertaken should be documented. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 6: Sunderland CCG to explore with GP practices the criteria for discussion of cases at MDT meetings and consider if this needs to be amended to fully recognise potential indicators of carer stress and the risks linked to these.

Recommendation 7: All statutory health and social care agencies to ensure that staff are aware of the need to liaise, where possible and with consent, with agencies who are identified by service users and their carers, as providing additional support, especially in cases where this is identified as a way by which concerns are being managed. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 8: Sunderland Safeguarding Adults Board to highlight the benefits of closer liaison with both statutory and third sector organisations and share these, and the key findings of this review, with third sector organisation.

Recommendation 9: The Safer Sunderland Partnership to ensure that the minimum standard training specification developed for all agencies (in response to a previous DHR) incorporates the lessons learned from this

review.

Single Agency Recommendations

In addition to the general recommendations arising from this review agencies identified a number of single agency recommendations within their IMRs to address specific points raised or to improve general practice.