DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY

Report into the death of Sarah

March 2019

Independent Chair and Author: Mark Wolski

Date of Completion: October 2021

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Abbreviation / Acronym	Full meaning
ACS	Adult Care Services
ANC	Admiral Nurse Care
AS	Alzheimer's Society
CA	Carer's allowance
CinH	Carers in Hertfordshire
CH	Care Home
CSP	Community Safety Partnership
DA	Domestic Abuse
DHR	Domestic Homicide Review
DNACPR	Do not attempt cardiopulmonary resuscitation
EMDASS	Early memory Diagnosis and Support Service
GP	General Practitioner
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HoSF	Hospice of St Francis
HSAB	Hertfordshire Safeguarding Adults Board
IMR	Individual Management Review
MDT	Multi-disciplinary team meeting
POA	Power of Attorney
RAG	Responsible Authorities Group
TIA	Transient Ischemic Attack
WHHNT	West Hertfordshire Hospitals NHS Trust

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Dacorum Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the homicide of Sarah and death of Samuel who took his own life. Both were local residents.

1.2 The following pseudonyms have been in used in this review to protect their identities.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Sarah	Victim	82	White British
Samuel	Husband	82	White British
Ann	Daughter	n/a	White British
David	Son	n/a	White British

1.3 The coronial process concluded on the 9th January 2020, where it was concluded that Sarah's death was unlawful killing and that Samuel's was one of suicide.

1.4 The CSP Responsible Authorities Group (RAG) reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and recommended to the chair of the CSP that a DHR should be undertaken. The chair ratified the decision, and the Home Office was notified on 11th April 2019.

1.5 Agencies that potentially had contact with Sarah and Samuel prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Sarah and Samuel.

2.2 The following agencies who had contact and their contributions are shown below.

Organisation	Documents Received/Reviewed
GP Practice	Chronology
West Hertfordshire Hospital NHS Trust	IMR and chronology
Adult Care Services	IMR and chronology
Carers in Hertfordshire	IMR and chronology
Hertfordshire Partnership University NHS Foundation Trust	IMR and chronology
Hertfordshire Community NHS Trust	IMR and chronology
Hertswise (AgeUK)	Chronology
Crossroads Care Hertfordshire	IMR and chronology
Alzheimer's Society	Chronology
Hospice of St Francis	Chronology and Case Reflection Notes
Ashlyn's Care Home	IMR and chronology

2.3 IMRs and factual reports were completed by authors who were independent of any prior involvement with Sarah and Samuel.

2.4 The authors and panel members assisted the panel further, with several one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	Title	Agency
Sue Warren	Dacorum Borough Safeguarding lead	Dacorum Borough Council
Mark Wolski	Independent Chair and Author	Independent Chair
Dawn Bailey	Named Nurse for Adult Safeguarding	West Hertfordshire Hospitals NHS Trust
Naomi Bignell	Named Nurse Safeguarding Adults	HCT
Katie Dawtry	Development Manager DA	Herts County Council
Diane Delicate	Manager	Care Home
Michael Farrell	Chief Executive	Crossroads Care
Deirdre Haynes	Deputy Head of Services	Adult Care Services, HCC
Kelly Huxstable	Deputy Manager	Care Home
Clare Landy	Specialist Safeguarding Practitioner	Hertfordshire Partnership Foundation Trust
Victoria Lyons	Senior Consultant	Dementia UK
Aimee Martindale	Services Manager	Crossroads Care
Steve O'Keeffe	Detective Chief Inspector	Hertfordshire Constabulary
Graeme Walsingham	Detective Chief Inspector	Hertfordshire Constabulary
Fay Richardson	Director of Care,	Hospice of St Francis
Carole Whittle	Health & Wellbeing Manager,	Carers in Herts
Tracey Cooper	Associate Director Adult	E&N Herts and Herts Valleys Clinical Commissioning Group
Martina Palmer	Senior Operations Manager	Refuge
Claire Stockwell-Lance	Area Manager	Alzheimer's Society
Katherine Johnson	Consultant Social Worker	Herts Partnership NHS Foundation Trust

3.2 The review panel met on six occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 30 years-service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained experience leading the response to domestic abuse, public protection and safeguarding. (See Appendix A for Statement of Independence)

4.2 Mark has no connection with Dacorum, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Dacorum's statutory agencies and non-government organisations worked together in their dealings with Sarah and Samuel.

5.2 The purpose of the review is specific in relation to patterns of domestic abuse and/or coercive control, and will:

- Establish how effective agencies were in identifying Samuel and Sarah's; health and social care needs, care and support needs and in providing support.
- Establish the appropriateness of single and inter-agency responses to both Samuel and Sarah, during the relevant period.
- Establish whether and to what extent the single and inter-agency responses to any concerns about domestic abuse and/or coercive control were effective.
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic abuse is a feature.
- Identify, on the basis of the evidence available to the review, the need and required actions to improve policy and procedures in Hertfordshire, and more widely.
- State clearly, where apparent, when the death(s) were deemed to be preventable and the rationale behind this.

5.3 Case specific lines of enquiry included the following.

5.3.1 **Term 1 - Information**:

How was information about Samuel and Sarah health and social care needs received and addressed by each agency and how was this information shared between agencies?

5.3.2 **Term 2 - Assessments and diagnosis**:

- What was the impact of Sarah's mental health and well-being on Samuel's physical and mental health and well-being?
- Were there any recent changes in Samuel and Sarah physical or mental health and well-being that may have affected Samuel's behaviour?
- Was there any evidence that Sarah's condition had an impact on Samuel's mental health?
- Could the physical or mental health and well-being of Sarah or Samuel have compounded any safeguarding concerns or considerations or masked evidence of domestic abuse and/or coercive control? Did this result in specific or increased risk and missed opportunities for agencies to probe and respond effectively?
- Is there any clear information in relation to domestic abuse and/or coercive control and its impact? Were any carer's/agency assessments completed?
- Were any carer's/agency assessments completed on any family member?
- Was there any indication or sign of any cultural perceptions or beliefs that were relevant? Did these bring with them any implications on the relationship and behaviours?
- Were there any barriers to seeking support? What were they? How can these be overcome?

5.3.3 **Term 3 - Contact and support from agencies**:

- What was the nature and extent of the contact each agency had with Sarah, Samuel and family?
- What support did they receive and from whom, individually and as a family?

- Were there any indicators or history of domestic abuse and/or coercive control? If so, were these indicators fully realised and how were they responded to? Was the immediate and wider impact of domestic abuse on Sarah fully considered by agencies involved?
- Was there any collaboration and coordination between any agencies in working with Sarah and Samuel individually and as a family? What was the nature of this collaboration and coordination, and which agencies were involved with whom and how? Did agencies work effectively in any collaboration and did services work effectively with those working with the family?
- Were there any issues of intersectionality identified and how were they dealt with by agencies? Did the interventions of agencies demonstrate competent strategies and practice of intersectionality in their responses?
- What lessons can be learnt in respect of domestic abuse and/or coercive control, how it can affect adults, children and young people and how agencies should respond to any impact?

5.3 The timeframe for this DHR was agreed as from March 2017 until their death in March 2019. This was agreed proportionate, covering a year before Sarah was formally diagnosed as living with dementia.

6. SUMMARY CHRONOLOGY

6.1 Sarah and Samuel had contact with eleven agencies during the relevant period, all of which related to Sarah's diagnosis of dementia, though some agencies also had contact with Samuel owing to a number of health concerns. There was no known history of domestic abuse.

Family Perspective

6.2 Sarah was one of three children. Her brother had passed away and she had lost contact with her sister many years ago.

6.3 The chair was able to speak to Sarah's son and three friends of Sarah and Samuel. Their daughter passed a letter through the police for the attention of the review panel, drawing attention to their lifetime love story, how inseparable they were, through to demands on Samuel of caring for Sarah as her condition progressed.

6.4 They had been childhood sweethearts, married for over 50 years and had lived in the house in which she had grown up, where they brought up one son and one daughter.

6.5 She was described as a strong character, and both were very independent and did not like anyone doing things for them.

6.6 She had found it difficult to accept the diagnosis and did not like talking about her condition.

6.7 As the illness progressed Samuel took on greater responsibility for managing the home, and the personal care needs of Sarah, being reluctant to accept any help.

6.8 Family and friends describe being concerned about Samuel not coping, though he maintained his independence, often refusing help outside that provided by his children.

GP Practice

6.9 Sarah had significant contact with the GP during the relevant period, with nearly one hundred entries on the chronology. The majority of contacts were related to her failing cognition, her subsequent diagnosis of dementia that included night wandering and falls.

6.10 Samuel lived with a number of health conditions, and it was clear that he found looking after Sarah and her needs difficult. He did at times have 'low mood', but declined medication,

counselling or other support. His reluctance to seek or accept help was accepted by the practice as a matter that would have benefited from improved curiosity. The subject of professional curiosity has subsequently been and continues to be subject of learning bulletins that are highlighted within the practice.

6.11 It was clear that the GP practice has been flexible and responsive, making several house visits. It was also noted that the GP engaged with Sarah's children on a number of occasions.

6.12 Inevitably, when the practice saw either Samuel or Sarah, and in particular when Samuel went to the GP to speak about Sarah, the consultation referenced both patients. On occasion entries relevant to Samuel were made on Sarah's notes and not his. Linked to this, was the need to ensure that other health professionals learning of medical and other concerns, needed to make better use of an internal patient task system that would bring information to the attention of a GP. These matters have been shared and are continuously reminded with all practice staff, with specific instructions regarding information recording about spouses/partners and using patient tasking systems.

6.13 Whilst there was no evidence of domestic abuse, neither was there evidence of screening for domestic abuse. A number of academic studies were subject of discussion including; - the increased odds of domestic abuse for people living with dementia[1]; - women with mental health problems are more likely to be domestically abused[2] and benefits of routine screening.[3] In discussion with the GP, she reflected on the opportunity for all practice staff to ask about domestic abuse for patients living with dementia. The practice has now given instruction and continues to reinforce the need for routine enquiry in dealing with families living with dementia and is currently exploring how this may be audited via its electronic patient recording system.

West Hertfordshire Hospitals NHS Trust (WHHNT)

6.14 In December 2017, Sarah had a fall at home and was taken by ambulance to hospital. In attendance at the hospital were Samuel and their daughter Ann. They described four similar episodes of collapse and how there had been a decline in Sarah's cognition and that the notes recorded Sarah lacked capacity and a decision was recorded Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR). However, there is no record of a capacity assessment or best interest decisions having been undertaken.

6.15 During the overnight admission, Ann informed staff that her father was providing a lot of help and was nearing the point of carer breakdown, whilst Samuel described Sarah as being relatively independent. This contradictory picture was not explored at the time, though an alert was created in respect of Sarah as needing a social care input. Samuel was not signposted for a carers assessment. The pattern of Samuel and Ann providing contradictory information was again apparent six months later when Sarah was seen by a consultant. Samuel said that he was coping, and Ann said the level of care was having an increased effect on his wellbeing.

6.16 The potential for domestic abuse was not considered at the point of admission, though the panel learned that routine enquiry is required in the maternity setting and that the recent introduction of IDVAs at the hospital had resulted in increased referral rates to advocacy.

Carers in Herts (CinH)

[1] Source: A systematic review of the prevalence and odds of domestic abuse victimization among people with dementia - PubMed (nih.gov) (Accessed January 2021)
[2] Source: Mental health statistics: domestic violence | Mental Health Foundation (Accessed January 2021)
[3] Source: Screening women for intimate partner violence in healthcare settings | Cochrane/ (Accessed October 2020)

6.17 Carers in Hertfordshire is a local charity, and its primary role is to advise and support unpaid carers - people looking after someone who is elderly, disabled, has a physical or mental illness or who misuses drugs or alcohol. There are two elements to the service, the first is a care planning service that is telephone based and the second part being Admiral Nurse Care (ANC) who provide specialist dementia nurses to support families who are in crisis in their caring role. During the relevant period, ANC carried out one home visit, whilst a number of phone calls were made to Samuel and the children.

6.18 The telephone assessments provided insight, describing that Sarah was in denial about her condition and that the family could not talk about it in her presence. This in part explains why he declined free carers breaks and support. The difficulty this caused was apparent at the only visit by ANC where it was described "His caring role caused many difficulties for him as his wife was in denial of her diagnosis and thus refusing any supportive services input".

6.19 During further phone calls, further concern was expressed about Samuel not coping and him becoming depressed and also about his confusion about the number of agencies he was working with. CinH acknowledge that the potential for carer burden and signposting Samuel to carers assessment may have been considered.

6.20 The confusion about agencies was also added to by the fact that CinH had been using three databases, resulting in the telephone care planning service being unaware of ANC care contact. These databases have now been reconciled and will minimise the risk of miscommunication.

6.21 Whilst domestic abuse was not apparent, nor asked about, the panel learned about a care planning tool that is used that explores areas such as 'choice and control' that does contain a specific section on risk. As a result of the review, they have further adapted this tool, to enquire about domestic abuse that will be incorporated into mandatory safeguarding training.

Hertfordshire Partnership University NHS Trust (Early Memory Diagnosis and Support service – EMDASS)

6.22 Sarah was referred to EMDASS in January 2018, following her attendance at the emergency department following a night fall. It was this assessment by EMDASS that resulted in her formal diagnosis of Subcortical Vascular Dementia

6.23 Her assessment was one of the few occasions that she was seen alone by any agency as it was important that the assessment of her cognitive functions is undertaken without any external influence.

6.24 The panel learned that broader assessment is subject to an assessment of need and risk, though did not ask any questions about domestic abuse. Whilst domestic abuse was not apparent, it was agreed to adapt their risk assessment protocols to include domestic abuse, thereby helping to avoid the potential for systemic invisibility within elderly communities.

6.25 The chronology showed there was a delay in receiving post diagnosis support, as Sarah was not deemed a high priority. Unknown to them, was the fact that ACS and her GP had been alerted to how Samuel was struggling. It was acknowledged that EMDASS could not have reasonably been expected to know this. Upon further discourse about the delay, the panel learned that EMDASS work very closely with the Alzheimer's Society (AS) who provide post diagnosis support. At the time, a patient such as Sarah would have been open to both EMDASS and AS and this did result in a lack of clarity in how her case was progressed. A revised pathway now ensures that once 'active work' has been concluded, the case is closed

to EMDASS and passed to the AS. This evolution provides clarity as to what may be expected from EMDASS as post diagnosis support passes to AS who have their own client care system.

6.26 Whilst acknowledging that on initial contact, Sarah had declared she did not want to talk about dementia, her voice seemed to be absent, relying on Samuel having legal power of attorney (POA). However, whilst patients are asked about POA, proof of its existence was not asked for. A practical effect was in her case that he declined cognitive stimulation therapy later in 2018, and yet the extent to which she was made aware of this therapy is unknown as is her involvement in the decision to decline it.

6.27 The ability for Alzheimer's Society to work within the same office space as EMDASS, to share information and access systems and information, to take part in MDT meetings is seen as positive. The evolution and clarity as to roles and closures of cases to EMDASS and handover to AS is seen as a welcome development.

Hertfordshire Community NHS Trust

6.28 The Trust's involvement related to personal care needs. Attendance was made within two weeks and relevant services provided. None of the contacts provided an opportunity to consider the impacts of Sarah's health on Samuel, or whether there was any indication of domestic abuse or to barriers to seeking support.

Adult Care Services

6.29 Sarah first came into contact with ACS following a referral for assistance regarding mobility. It was apparent how difficult Sarah was finding dealing with her diagnosis and as a result most of the communication was with Samuel and their children each of whom had legal power of attorney. Balanced against this, ACS have recognised the need to continually involve clients in decision making, assessing a client's capacity and best interests.

6.30 In dealing with the family, ACS have been proactive and flexible, such as co-ordinating conference calls to a family member who lived abroad. However, it is also acknowledged that co-ordination and effective communication was at times difficult to manage, suggesting that it may be useful to have a lead family member to deal with in similar circumstances.

6.31 ACS made offers of support to Sarah and Samuel including a free sitting service. Upon realisation that savings precluded free care, they signposted the family to other care agencies and offered support for brokerage that would secure care at local authority rates.

6.32 A point of contention for the family was the continued healthcare assessment and also the 'fast-track' scheme, with the question as to the role of the family in completing the assessment being unclear. Whilst a senior professional took the lead, there was a missed opportunity to refer the family to 'Beacon', a specialist advocacy service that may have helped avoid some of the misunderstanding. All staff have been reminded of this service and it features in local training.

6.33 ACS worked with some of the agencies engaged with the family and it was recognised that the number of agencies did become challenging for Samuel and the family. ACS were invited to a multi-disciplinary meeting across some of the agencies, but were unable to attend, nor was the outcome of the meeting recorded by ACS. Notwithstanding the learning around 'record keeping', it was apparent that this case was complex by virtue of the number of agencies involved, as opposed to the complexity of Sarah's needs. Since the incident new strategic and local guidance has been introduced, that provide the mechanisms to call multi-disciplinary team meetings for cases such as this.

6.34 The review also showed that a 'connected lives assessment' nor any other 'risk assessment' was completed. The panel learned there is now a Connected Lives Board and a Practice Management Board, that oversee monthly audits of assessments that includes necessity and quality. The circumstances and learning of this review will be presented to these boards.

6.35 Whilst domestic abuse was not apparent and we know that risk assessments were not completed, it remains no-one was asked about domestic abuse, nor would it have featured as a prompt to be asked about. The challenges of systemic invisibility of DA in elderly populations was recognised and protocols will now be adapted to include questions on DA.

Hertswise

6.36 Hertswise is a countywide service designed to support people and families living with dementia, low level memory loss or mild cognitive impairment. The service is delivered by a partnership of community and voluntary groups, including Age UK Hertfordshire, Hertfordshire Independent Living Service, Herts Mind Network, and Carers in Hertfordshire.[4]

6.37 Initial contact was made by Sarah's daughter Ann, when she sought advice, before referrals from EMDASS, her GP and Carers in Herts. Ann described Samuel as being stubborn and not welcoming help, and his reticence to accept help was apparent when he explained that Sarah did not want to talk about dementia. An article by International Psychogeriatrics[5], describe a number of barriers to accepting support, as well as enablers that the review panel considered, concluding a need for constant professional curiosity whilst keeping in mind an individual's right to decide what to accept or follow up.

6.38 Hertswise offered practical advice across a range of subjects including Attendance Allowance (AA); - Council Tax reduction (CTR); -Carers Allowance (CA); - Disabled Facility Grant. In so doing, Hertswise have listened to Samuel and the daughter Ann to develop a trusting relationship, offering a breadth of support.

6.39 In order to assess need, the review learned that a needs assessment is used about care and environmental needs. Whilst domestic abuse was not apparent in dealings, neither was it asked about, nor did it feature within the needs assessment.

6.40 Hertswise had limited face to face engagement, visiting on three occasions in the Autumn of 2018. Their service is limited to Monday to Friday. During visits they observed Samuel appeared to be stressed and only went out once for fifteen minutes, being concerned to return home quickly. They learned that ACS and ANC were also involved but were unaware of other agency involvement.

Crossroads

6.41 Crossroads Care Hertfordshire North provides support for unpaid family carers and the people they care for in Hertfordshire.[6] A referral was initially made in August 2018 before a telephone assessment and home visit in November respectively. Further visits were postponed until March at the request of Samuel as his daughter was in the UK from Australia.

6.42 On exploring the delay in making contact, it was apparent that there had been systems issues with prioritisation and paper record keeping that have been resolved to ensure all clients

[4] Source: About us – Hertswise (Accessed December 2020)
[5] Source: Persistent barriers and facilitators to seeking help for a dementia diagnosis: a systematic review of 30 years of the perspectives of carers and people with dementia | International Psychogeriatrics | Cambridge Core (January 2021
[6] Source: Crossroads Care Caring For Life Hertfordshire Home (crossroadshn.org.uk) (Accessed January 2021)

priority is assessed and recorded electronically by an App that are now overseen by client services within Crossroads.

6.43 The review learned that the new App assesses over seventy features, but not including wider concerns of domestic abuse and safeguarding, adding credence as to discussion points about systemic invisibility of domestic abuse.

6.44 Crossroads were unaware of the breadth of agencies involved in this case. They were not invited to a multi-disciplinary team meeting called by HoSF.

Alzheimer's Society

6.45 There were two elements to the work of AS. The first element being their work at HPFT (EMDASS service) starting in February 2018, the second element being the community-based service. At the time of engagement with Sarah and Samuel AS were primarily recording their interactions on the HPFT records system, with limited commentary on the AS system. An internal review has resulted in AS introducing their own client record keeping system to ensure accurate record keeping. This is welcomed considering the challenges in unpicking a chronology from one system that reflects interactions from two organisations.

6.46 The initial assessment by a memory nurse (EMDASS) resulted in the situation being deemed 'low priority' as it was noted Sarah had a supportive husband and family. Further contact wasn't made until June and August when appropriate support and signposting took place. It wasn't until September the case was closed to EMDASS and opened with AS.

6.47 Within the revised pathway the same dementia support worker/dementia adviser now holds cases from the point of diagnosis when clients are closed to EMDASS and open to AS. This is recognised as improved practice providing consistent support for the end client.

6.48 Processes have evolved further and now AS use two screening guides. The first is a guide that summarises the level of support available and that may be needed. The second is a 'keeping safe' checklist (risk assessment) which is now used at every contact with a client. This is recognised as positive given the fluctuating nature of risk.

6.49 Whilst we know she was not asked about domestic abuse at the initial assessment by EMDASS, it was apparent the 'keeping safe' checklist used by AS also did not refer to domestic abuse. During discussions between the chair and AS they agreed that given the evidence of systemic invisibility of domestic abuse in elderly populations, there was an opportunity to include prompts regarding abuse within their risk/needs assessment protocols.

Hospice of St Francis

6.50 The HoSF received initial referrals from the GP for respite in July 2018 that resulted in an assessment in August, where it was noted that Samuel was supporting Sarah with daily care tasks. During that assessment, he declined a carers assessment and offers of equipment.

6.51 It was clarified that the HoSF uses a Carers Support Needs Assessment Tool for its initial patient assessment. This covers elements such as mobility and a social assessment. Within the social assessment element, there was a binary question regarding risk, "yes" or "no" with no further prompts. In discussion with the chair, HoSF agreed for domestic abuse to be included to improve the opportunity to identify underlying domestic abuse.

6.52 Over subsequent months, HoSF hosted family meetings and a review meeting where family were present. At the family meeting a request for one night's respite care was declined on the basis of facilities not being able to manage night wandering and demand for bed space for those at 'end of life', a point that Sarah had not reached. This was confirmed separately by

Sarah's GP who explained that dementia unlike other illnesses, is not one where one can know that someone will die within a probable amount of time.

6.53 The HoSF signposted and engaged with Adult Care Services, suggesting avenues for appropriate support. At the review meeting, ANC and a social worker were unable to attend, but the HoSF consultant liaised with the geriatric consultant and GP to arrange appropriate medication. HoSF maintained open lines of communication with the family GP via monthly meetings throughout and the attempts by HoSF to work across agencies is acknowledged as positive, though in crafting a single agency recommendation, they observed the opportunities to improve multi-disciplinary co-ordination more widely for complex cases.

6.54 During the relevant period Sarah's condition deteriorated and the impact on Samuel became more pronounced, with Samuel reportedly not being able to cope, though portraying a different image to professionals. However, he declined offers for carers assessments, which was consistent with how he behaved across multiple agencies. HoSF on conducting their own 'case reflection' identified opportunities for periodic in-depth exploration as to carers feelings such as when there are changes in the cared for patient's condition or other trigger points.

Care Home

6.55 The care home (CH) is a private enterprise with a number of residences across the UK offering long term accommodation, specialising in provision for those living with dementia.

6.56 Sarah's daughter first made contact in October 2018 to enquire about fees and Sarah visited in November to assess requirements. Whilst a room was offered, a number of different factors became apparent. These included, Sarah and the family wanted a particular type of room and, when her daughter was due to return home which was abroad.

6.57 Sarah and Samuel visited the care home periodically and met with friends who lived at the home. During this short period of time, Samuel did occasionally become upset, seeking reassurance about visiting times. This was not considered unusual.

6.58 The care home did not engage with other agencies, there was no overt cause for concern or need to seek further information or alert agencies to any matters arising. This period of contact was considered typical of a family and a client making a transition into a care home.

Police

6.59 Samuel held a shotgun licence. In 2017, he applied for the licence to be renewed. As part of that process his GP observed there was no medical reason of concern, but that that no assessment of behavioural or personality disorders had taken place.

6.60 On exploring the reviewing licences outside the application process, a question was posed, "if the police were to learn that the licence holder (either himself) is suffering from dementia or someone they are caring for is suffering from dementia has access to firearms, would this, could this, should this trigger a review of that licence." The answer was yes. Upon examination of the firearms renewal form, there did not appear to be any opportunity to disclose details about other parties (or partners) who are resident at the address, nor does it highlight any obligation to inform the police of any changes in circumstances for the applicant or people living at the same address.

6.61 Two matters arise as a result, the potential obligation for a GP to alert authorities and for the licence holder to notify the police of changes in circumstances.

6.62 Whilst the GP was aware of Samuels low mood and offered counselling and medication that was turned down, he never expressed suicidal ideation.

6.63 The panel learned the renewal process involves completion of a form that includes, questions in respect of personal health and whether the applicant has received treatment for depression or any other kind of mental health condition. The process makes no reference at all, as to other people that co-habit with the licensee and/or their medical conditions.

6.64 Whilst trying to avoid hindsight bias, it is arguable that an individual such as Samuel, who was law abiding up until the point of the homicide, may have considering declaring a change in home circumstances, had the application process placed an obligation for him to do so, in much the same way that exists for individuals who hold a driving licence. It seems to the panel that this merits further exploration, as does the expansion of the application/renewal process to incorporate details of others living at an address where firearms are stored.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Sarah and Samuel had been married for over 50 years having been together since school. Both had enjoyed successful careers and a lasting impression from friends and consideration of the facts is that of Samuel being a devoted husband and of a couple who were inseparable. It is apparent that Sarah had possessed a particular strength of character, and that Samuel was a very proud and independent man finding it difficult to accept help, save from his children.

7.2 Samuel found his caring responsibilities difficult to manage, whilst also having the burden of his own health problems. There were a number of reports as to how stressed he was and that he was at risk of carer's burden. However, no-one had any concerns that domestic violence and abuse was ever an issue, nor is there any evidence of it ever having been an issue nor did anyone imagine that a homicide might be the outcome.

7.3 Whilst recognising that mental health is a risk indicator for domestic homicide and Samuel had been described as having low mood and was stressed, in the months before the tragedy, engagement with agencies had been comparatively limited, with no references to stress, anxiety or low mood. He never expressed suicidal ideation during the relevant period or before.

7.4 The lack of any relevant history of domestic abuse or forensic history has been a challenge for the panel, and one may argue the homicide as being 'out of the blue'. However, there was a journey to the final act including the deterioration in Sarah's condition and the impact of caring responsibilities on Samuel's state of mind. It is a matter of fact that, on approaching the date of the homicide, they had recently celebrated a golden wedding anniversary, their daughter had returned abroad, their son was due to go abroad for work and a date had been agreed for Sarah to move into a care home. Acknowledging that separation is an established risk factor in domestic homicide, the conflation of all these factors is likely to have had an effect on Samuel's state of mind.

7.5 However, it is not suggested that the tragic events were either predictable or preventable but reminds professionals of the potential for such events to occur.

Homicide-Suicide

7.6 The limited available research into cases of homicide-suicide, suggests a need for further research to help understand such tragic events. Plans for an online repository of all DHRs is welcomed.

Professional Curiosity and Carer Burden

7.7 Managing dementia had been challenging for Samuel, having an effect on his health and well-being. As a proud man, he found difficulty accepting help from agencies, masking the reality of the situation to professionals, portraying an image of someone coping, as opposed to what

his children observed as someone struggling with his caring responsibilities and at risk of carer's burden. This posed a challenge to professionals, the degree to which the contradictory picture was explored and, why he frequently did not accept help, versus an individual's right to decide. The panel examined a number of theories, including Samuel not recognising himself as a carer being a barrier, but also because he was seeking to protect Sarah from the reality of accepting her diagnosis. He was signposted for carers assessments, frequently declining them before one was completed, though the panel learned of missed opportunities to signpost him for these assessments.

7.8 Agencies have acknowledged the missed opportunity to try and explore why help was not accepted and a number of individual agency recommendations have been made in this regard. The panel also acknowledged and commend the work of Hertfordshire Safeguarding Adults Board and the release of a Learning Bulletin on Professional Curiosity in October 2020, and its continued focus on this challenge. The underlying lesson herein is for professionals to be alert to the potential for a client being at risk of carer's burden, encouraging them to recognise themselves as a carer and signpost for carer assessments.

Systemic Invisibility of Domestic Abuse in Elderly Communities &- Routine Enquiry

7.9 Whilst there were no concerns raised from the review that domestic abuse had featured during the relationship, agencies did not ask Sarah about feelings of safety and well-being, nor did domestic abuse feature as part of routine screening or 'induction' to a new service. It seemed to the panel that the absence of such curiosity adds weight to the debate about domestic abuse within elderly communities being systemically invisible.

Multi-Agency Working – Breadth of Offer, Co-ordination

7.10 The panel learned of the breadth of local offer and support available to those living with dementia, some of which was free, but much of which had to be paid for owing to an assessment of savings. However, many agencies were aware of each-others involvement, not having the benefit of the full picture. There were limited attempts to co-ordinate, save for monthly MDT meetings with the GP that were limited in agency representation and an attempt by HoSF to host a professional's meeting where two agencies did not attend.

7.11 The number of agencies and communication became a point of frustration for the family, with comments as to how overwhelmed Samuel felt, suggesting the need for more effective co-ordination.

7.12 During the latter stages of the review, the chair was signposted to recent guidance "Hertfordshire Safeguarding Adults Board Multidisciplinary Guidance for Complex Cases 2020", that is a guide "for practitioners working with adults outlining the importance of adopting a multi-disciplinary approach to practice, particularly when working with people with complex needs or circumstances". In addition, West Hertfordshire also released recent complimentary local guidance on scheduled multi-disciplinary team meetings across the four localities that make up West Hertfordshire. These meetings have core membership, including social care, GP's and geriatricians. All agencies are able to refer in to and take part in these MDTs.

7.13 The panel agreed that the circumstances of this case were complex, not necessarily by virtue of Sarah living with dementia, but by a combination of a number of factors such as the number of agencies working with her; - working and engaging with multiple family members; the contradictory picture portrayed by Samuel versus that portrayed by his family. The panel agreed the HSAB guidance and recently introduced structured approach to MDTs provides a vehicle by which any one of those agencies, statutory or non-statutory could in the future seek to work more effectively together. These developments are recognised as positive.

Risk Marker - Separation

7.14 There were a number of risk markers present during in the months leading up to the homicide, such as risk of carers burden on Samuel. Other factors in the days before the homicide such as, recently celebrating a wedding anniversary and family members either shortly returning to live or work abroad will have had an effect on Samuels emotional state. Whilst not suggesting predictability, the impending separation from Sarah is considered a core component risk factor in this tragedy, that needs to be shared within the overall learning.

Family Support - Communication

7.15 Samuel was far more comfortable with the support of his children, as opposed to that offered by agencies. One of his children lived abroad and came to the UK for extended periods, whilst the other had his own family and business commitments. Communication with the family presented a number of challenges such as the contradictory picture that his children portrayed versus that which Samuel described. Whilst working with the family, all of whom had legal power of attorney is recognised as positive, adult care services acknowledged the risk of miscommunication and at a point in time requested professionals to cease email communication. It was therefore acknowledged that, careful thought is needed as to how best to manage communication that avoids misunderstanding, perhaps by working with a lead family member.

Continuing Healthcare – Independent Advice

7.16 Continuing healthcare became a point of contention to the family, who proud of Sarah's contribution to the local community, seemed unable to benefit from more help to support their parents. The children explored the options of free continued healthcare to provide that support on the basis of Sarah having been close to end of life. However, such is the nature of dementia, Sarah had not been determined as having been close to end of life. The panel did learn of a missed opportunity to signpost the family to independent advocacy who may have been able to help guide them through the system.

Firearms licensing

7.17 The review found the firearms licensing renewal process merited reviewing, as the police advised the panel if they were to learn of any changes in the wellbeing of a licensed holder or family member living with/having access at the same address, this would prompt the police to risk assess their continued possession". However, the firearms renewal form neither asks about other people living at the address or places an obligation on the licence holder to report changes in his wellbeing.

7.18 Furthermore, it is arguable that an individual such as Samuel, who was law abiding up until the point of the homicide, may have considered declaring a change in home circumstances, had the application process placed a strict obligation for him to do so, in much the same way that exists for individuals who hold a driving licence.

Sarah's Voice – Mental Capacity and Best Interests

7.19 It is clear from the accounts of family and a range of professionals that Sarah did not cope well with her diagnosis of dementia. Whilst this also had a profound effect on Samuel, it is possible this had the effect of isolating her as it seemed to the panel that Sarah's voice was absent, with reliance placed upon Samuel and the family to make decisions such as a declining Cognitive Stimulation Therapy, and there being only one occasion during the relevant period that she was spoken to in private. On the one hand this may be understandable as it appeared that Sarah had not wanted to talk about her diagnosis, finding it upsetting and

causing distress, but on the other hand it may be argued this had the effect of disempowering her, taking away her right to self-determination. In recognition agencies have made recommendations in respect of Mental Capacity assessments, best interests' decisions and ensuring that professionals actions are 'person-centred' in accordance with guidelines.

7.20 Nevertheless, the absence of Sarah's voice remains an overarching impression, arguably itself a barrier to her having the opportunity to put across her view and an opportune point with which to conclude the learning from this review.

8. LESSONS LEARNED

The review identified a number of learning points that build upon agency IMRs. These have then been considered against a background of agency and policy developments that mitigate the need for a number of recommendations that may have otherwise arisen.

8.1 The review found limited available research into homicide-suicide cases and welcomes the planned repository of all DHRs to share learning.

8.2 The review showed opportunities for improved professional curiosity to explore carer burden, though acknowledges the work of the Hertfordshire Safeguarding Adults Board and continued focus on professional curiosity.

8.3 The review found that omission of screening for domestic abuse added weight to the debate that domestic abuse within elderly communities is systemically invisible.

8.4 The review identified opportunities for improved co-ordination and communication across agencies working with families living with dementia.

8.5 The review found that there were a number of risk markers present and the conflation of these with imminent separation will have had a significant effect on the perpetrator.

8.6 Recognising that agencies engaged in a positive manner with all immediate family members, it was acknowledged communication requires careful handling to avoid confusion.

8.7 The review found that managing expectation around the constraints of continuing healthcare provision require careful handling.

8.8 The review identified opportunities for a more robust firearms renewal process.

8.9 The review found that Sarah's voice seemed to be absent, with great reliance on Samuel and children, though acknowledges her reticence to talk about her diagnosis.

9. RECOMMENDATIONS

9.1 Local Recommendations

The following single agency recommendations were made by agencies.

West Hertfordshire Hospitals NHS Trust

9.1.1 Medical staff need to complete Mental Capacity Assessments and best interest decisions when making decisions on behalf of others that lack capacity.

9.1.2 Staff to explore the 'think family approach'.

9.1.3 All Trust staff should be aware of services within the Trust and externally to recognise and support patients who may be carers.

9.1.4 The safeguarding team will continue to highlight the need for professional curiosity.

Adult Care Services

9.1.5 ACS should be more proactive in supporting service users and their carers who are self-funding to access services more effectively.

9.1.6 Staff to attend all safeguarding training courses both face to face and on I-Learn as well as ongoing refresher courses.

9.1.7 Improve recording on ACSIS, encourage staff to attend “Good Recording” training course already offered by ACS Learning and Development.

9.1.8 Improve awareness of domestic abuse for staff. ACS Learning and Development are in the process of working in partnership with The Hertfordshire Safeguarding Children Partnership, Hertfordshire Safeguarding Adults Board and the Hertfordshire Domestic Abuse Partnership to assess the levels of training needs within our organisation on key safeguarding priorities to inform future training priorities.

9.1.9 Staff to continue carrying out assessments and care and support planning that are person centred in line with the Care Act.

9.1.10 Ensure staff members attend training in relation to Mental Capacity and Best Interest decisions.

9.1.11 Regular supervision to take place where complex cases can be discussed.

9.1.12 Continue to improve on joint working with partnership agencies both statutory and in the voluntary sector.

Carers in Herts

9.1.13 A more regular yearly safeguarding refresher is being planned in order to incorporate it within our annual overall in-house Training and Development programme.

Hertfordshire Community NHS Trust.

9.1.14 A recommendation would be that all staff to be aware of the importance of carers needs and to offer a carers assessment. This is a current Key Performance Indicator for patients registered in the East and North CCG area and performance against delivery is being closely monitored.

Crossroads

9.1.15 Review of intake processes to improve oversight. Specifically, all enquiries to be managed and monitored by Client Services Team enabling escalation of local blockages in delivery.

9.1.16 Evaluation of software to facilitate pipeline enquiries.

9.1.17 All waiting list entries to carry a risk and urgency rating (following the system used post assessment).

9.1.18 The organisation has set up a new charitable fund and a volunteer service for welfare calls where staffed support is in short supply.

Alzheimer’s Society

9.1.19 Deliver Dementia Practitioner workshop as a priority to ensure that staff understand the initial assessment and support planning process. This training was completed for DSW’s in the Herts team.

9.1.20 A further operations service review arranged in 3 months to assess the impact of moving to computerised record systems (CRS) on support plans, initial assessments and in particular, eligibility and waiting lists. A lot of work has taken place to reduce waiting lists and to prepare staff to the move to CRS, and this would be an opportunity to ensure that the move to recording on CRS reduces these known issues. The review identified good practice in 60% of areas assessed. Remaining areas for improvement were addressed through regular monitoring of service delivery and established quality assurance mechanisms.

9.1.21 The Safeguarding and Quality team review the need for initial contact to be documented in guidance or service specifications in future, as it has done for Dementia Connect and Side by Side services. Initial contact is documented as part of CRS practice. Initial contact is now attempted via three phone calls at different times of day, if unsuccessful this is followed by a letter and if no response to the letter the case is closed after three weeks if they have not responded to the letter.

9.1.22 Ensure the Safeguarding Incident process clearly states who is responsible for ensuring that actions taken as a result of an audit into a Safeguarding Incident is defined. The Safeguarding Incident process has been reviewed and updated by the Safeguarding & Quality team.

9.1.23 Implement regular catch ups between the local management of services and the Safeguarding and Quality team to ensure actions are not missed and are progressed as required. Monthly meetings are held.

9.1.24 Review if the current prioritisation of the waiting list is adequate and consider rolling out the prioritisation tool used to all services. Review completed, prioritisation tools retained, and cases are reviewed using the CRS reporting processes.

Hospice of St Francis (HoSF)

9.1.25 Include in HoSF risk assessment routine question about whether patient and/or carers have a gun licence or a secured gun (in line with the licence requirements) as appropriate e.g., if a person lives on a farm or offers information about a gun on the premises or any other triggers. Also ask whether there is anything that could harm/put people at risk from having a licensed gun stored in the house.

9.1.26 Whilst carers assessment was proactively offered and declined, include a further trigger for the care team to ensure that they have explained why an in-depth exploration of carers feelings and carers needs could be helpful, reiterating this at each review and/or point of change/deterioration.

9.1.27 As part of business planning/service development process to look at activities in the programme of care that are beneficial for people with dementia and whether there are barriers to access and explore other activities that could improve dementia palliative and end of life care and how these might be taken forward.

9.1.28 Review HoSF dementia awareness and as part of planning service development in 2020/21 offer training at varying levels to continue to build competence, using the training tracker and face to face modules.

9.1.29 Review the threshold for requesting a joint home visit (Community Nurse/GP or Hospice Doctor/GP, Community Nurse/Social Worker).

9.1.30 Use the evaluation system before and after training to provide a self-assessment indicator about how staff rate their competence and confidence in care for dementia patient and family in palliative and end of life care if and when appropriate to HoSF services in 'Spring Centre In Patient Unit' and Community, taking action on the results.

9.1.31 To build on relationships with Hertfordshire Partnership Trust and ANC to Hospice to build on established links, inviting them to the Hospice to explore options for specific dementia support as appropriate.

9.1.32 Regular Spring Centre Multi-Disciplinary Team meetings/North West Herts MDT discussion and documentation for complex cases ensuring the Hospice social work team aware of situation.

9.1.33 Published research articles referred to by senior doctor to support case reflection discussion to be circulated.

9.2 Overview Report Recommendations

9.2.1 The Review Panel has made the following recommendations, which are also described in analysis of each agency involvements. These recommendations form the basis of an action plan that will be overseen by the Dacorum CSP.

Recommendation 1: *The Home Office to consider further research into murder/suicide of cases of a similar profile, to develop an understanding and identify actions to mitigate the risk.*

Recommendation 2: *Agencies (ACS, HPFT-EMDASS, Hertswise, Crossroads, Alzheimer's Society and Hospice pf St Francis) to adapt their risk/needs assessment protocols to include a question/prompt on domestic abuse.*

Recommendation 3: *HPFT (EMDASS) to require proof of legal power of attorney for patients.*

Recommendation 4: *ACS in dealing with complex family dynamics, review whether appointing a lead family member is appropriate.*

Recommendation 5: *The Home Office to consider reviewing firearms/shotgun renewal process to incorporate an obligation to report changes to their medical and mental health and that of those who cohabit with the license holder.*

Recommendation 6: *The learning from this review is shared across the partnership, assisting development of practice and reminding professionals to keep the voice of the person living with dementia at the forefront of their minds.*