Sunderland Partnership

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

MRS Y/2013

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1. REVIEW PROCESS

This executive summary outlines the Domestic Homicide Review process undertaken by the Safer Sunderland Partnership in reviewing the death of Mrs Y.

At the time of her death Mrs Y was living in the home she shared with her husband, Mr Y, in the Sunderland area. There were no other residents at the address. On 1st May 2013 the bodies of Mrs Y and her husband, both aged 79, were discovered at the home. There was no evidence to suggest any third party involvement and forensic examination of the scene indicated that Mr Y had killed his wife and then himself.

On 3rd May 2013 Northumbria Police notified the Safer Sunderland Partnership of the circumstances of the death of Mrs Y, and that of her husband Mr Y. It was agreed that the case met the criteria for a Domestic Homicide Review under Section 9 of the Domestic Violence Crime and Victims Act. Following a scoping meeting with partnership agencies, the Safer Sunderland Partnership notified the Home Office on 16th May 2013 that a Domestic Homicide Review would be taking place.

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 Y this was a matter for the coroner to determine.

Following the initial scoping meeting on 14/05/13, the Domestic Homicide Review Panel met on 21/05/13 to set the terms of reference for the review and identify which agencies were to undertake Individual Management Reviews (IMRs).

The specific terms of reference agreed for this review were:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfill these expectations?
- Did the agencies have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agencies have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC (Multi Agency Risk Assessment Conference)?
- Did the agencies comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions

appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered. Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign-posted to other agencies?
- Was anything known about the perpetrator, for example, were they being managed under MAPPA (Multi Agency Public Protection Arrangements?
- Had the victim disclosed to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families?
- Was consideration for vulnerability and disability necessary?
- Was there indication of the victim being isolated by the perpetrator and could this have prevented them from contacting services?
- Were there any other issues relating to the case such as drug/alcohol abuse in either the victim or the perpetrator and if so what support was provided?
- If there was a low level of contact with agencies why was this so? Were there any barriers to either the victim of the alleged perpetrator accessing services and seeking support? How accessible were services for the victim and the perpetrator?
- Were senior managers or other agencies and professionals involved at the appropriate points? Are there ways of working

effectively that could be passed on to other organisations or individuals.

- To what degree could the homicide have been accurately predicted and prevented?

The time period covered by the review was from 1st May 2012 to 1st May 2013. Agencies were requested to complete a detailed chronology for this period, as well as providing any relevant historical information outside of this time period that could help to provide further context for the review.

Individual Management Review (IMR) reports were completed by all agencies where it was identified that significant contact had taken place with Mr and Mrs Y within the specified time period. All IMR authors were independent of the case and had no contact with Mr and Mrs Y as either a practitioner or through the management of staff involved. IMR reports were received from the following agencies:

- Sunderland Clinical Commissioning Group
- City Hospitals Sunderland NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Sunderland City Council
- North East Ambulance Service NHS Foundation Trust

Family members and a friend of Mrs Y were informed of the DHR through the Chair and also invited to contribute to the review process. Some declined to be part of the process whilst others agreed to meet with the Chair and Overview Report author and provided information to inform the review.

As Northumberland, Tyne and Wear (NTW) NHS Foundation Trust had significant contact with Mr Y leading up to the homicide, this case was also reviewed concurrently within NTW's Serious Untoward Incident (SUI) Review process. This process is used to formally review Serious Untoward Incidents at a multi-disciplinary panel. As NTW's role was in the provision of services to Mr Y the SUI Review focused specifically upon the care and treatment he received and the decision-making processes in relation to this.

The IMR author for NTW incorporated any relevant information emerging from the Serious Untoward Incident Review into their report for the DHR. Furthermore the recommendations identified by the SUI Panel were included as an addendum within the DHR report.

2 AGENCIES INVOLVEMENT

All agencies completing IMRs as part of this review identified that primary contact had taken place with Mr Y, with Mrs Y having limited contact in her own right.

Mr and Mrs Y were both registered with separate GPs in the local area. During the period covered by the review Mrs Y had 10 GP appointments relating to physical health concerns. Mr Y had a history of depression for which he had consulted his GP since 1987. Between January 2002 and October 2012 there was a break in his contact with his GP, which it was felt may have been in relation to him no longer needing sick notes as he was past retirement age. However, Mr Y's contact with his GP recommenced in October 2012 and at this appointment and urgent referral was made in relation to suspected cancer. Mr Y subsequently attended Sunderland Royal Hospital for further examinations and scans, which revealed a bladder tumour, as well as the incidental finding of an abdominal aortic aneurysm.

In the period that followed, up until the time of the homicide, Mr Y had significant ongoing contact with City Hospitals Sunderland NHS Foundation Trust (City Hospitals) as well as ongoing contact with his GP. He also attended a course of radiotherapy at the Northern Centre for Cancer Care. Such contact was in relation to both the treatment of diagnosed cancer and an aneurysm.

On 06/03/13 Mr Y's daughter in law found Mr Y in his car during what appeared to be a suicide attempt. As a result of this, he was seen by both his GP and at the Accident and Emergency Department, where a referral was made to the Northumberland, Tyne and Wear (NTW) NHS Foundation Trust's Mental Health Crisis Team. Following assessment he was discharged home with daily visits to take place by the Initial response Team and the Older People's Mental Health Team. Such daily visits continued until 21st March 2013 when it was agreed that these could be reduced to twice weekly.

During the above period Mrs Y was present at a number of the visits made by NTW staff to Mr Y. She also had some limited contact with the Sunderland City Council during the time period of this review for the purpose of a needs assessment relating to mobility.

The North East Ambulance Service NHS Foundation Trust and Northumbria Police were involved with Mr and Mrs Y solely as emergency responders on the day of the homicide.

3 LESSONS LEARNED AND CONCLUSIONS

In undertaking this review, one of the key concerns identified by the Panel was that Mrs Y remained virtually 'invisible'. Despite her presence during much of her husband's contact with NTW and the references made throughout this regarding 'difficulties' within the relationship, little is know regarding Mrs Y's experiences, views or wishes throughout the period of the review. She remained peripheral to the work being undertaken with her husband and was often only referred to by agencies in relation to Mr Y's thoughts towards her or their relationship.

The IMRs completed by agencies identified some gaps within individual agencies' practices, policies and procedures and these were clearly addressed within single agency recommendations. However a broader emerging theme from the review was that at no stage was Mrs Y considered as a potential victim of abuse or violence and as a result remained outside of all subsequent assessments and decision making. This is despite the fact that a number of potential indicators of domestic abuse and associated risk were present during agency involvement. These included:

- *Mr Y's thoughts of hurting or killing Mrs Y, reported by both Mr Y and Mrs Y to professionals.*
- *The history of the relationship in which it was identified by both Mr Y and other family members that he had not spoken to Mrs Y for a number of years.*
- *Mr Y's suicide attempt, given that in cases of domestic violence threatened or attempted suicide is seen as an indicative factor of heightened risk to others.*[1]
- *Mrs Y's disclosures two days prior to the homicide that Mr Y had accused her of having affairs and of spending his money.*

Failure to view any of these factors as indicators of risk in relation to domestic

[1] Menzies, Webster and Sepejak, 1985; Regan, Kelly, Morris and Dibb, 2007

abuse or violence meant that the assessments, practice, policies and procedures that agencies were able to identify would be used in relation to domestic abuse and violence were never considered. In considering this failure to recognise risk indicators, or to otherwise identify Mrs Y as at risk from Mr Y in relation to his mental health, the Panel felt there were a number of areas of that required highlighting and commenting upon to understand why this was the case. These key lessons learned are summarised below.

Focus on Mr Y's mental health presentation and failure to identify direct risk to Mrs Y within this, or to recognise potential domestic violence indicators.

In regard to Mr Y's contact with NTW it was clearly outlined within their IMR that any thoughts expressed by him, or concerns raised by Mrs Y in relation to his thoughts towards her, were seen as a presentation of his mental health. As such all risk assessments and management plans that followed were based upon this. In relation to these assessments Mr Y was at no point assessed as presenting a high risk to others, namely Mrs Y, and as such no action was taken to directly manage this.

Within the above focus on Mr Y's mental health presentation it was also identified that a lack of previously disclosed history of domestic abuse may have contributed to staff not considering this as a possible factor, despite a number of presenting indicators. Much discussion took place within the Panel as to whether such indicators were sufficient alone to have prompted consideration of risks relating to potential domestic abuse and violence, and there were divided opinions around this. It was felt that from the perspective of a domestic violence practitioner such indicators would likely be apparent in relation to potential risk; however it was also recognised that in their focus upon mental health, staff within NTW may have been less aware of such indicators. It was also believed that this might in part have been impacted upon by the ages of Mr and Mrs Y, as Panel members felt that staff across all agencies were less likely to consider older people as potential perpetrators or victims of domestic violence.

The Panel concluded that in light of the focus on Mr Y's presenting mental health problems, potential indicators of domestic violence were not recognised as such by NTW staff. It was noted however that as staff had not had specific training in relation to domestic abuse they could not be reasonably expected to have such knowledge. This failure in complex cases to identify the domestic violence, due to focus on addressing other needs, is also one of the key themes emerging from a number of homicide reviews nationally and outlined in the Home Offices 2013 publication 'Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned'.

A further element in the failure to identify potential domestic violence indicators were the missed opportunities by GPs and staff from NTW and CHS to undertake further exploration regarding Mr Y's home circumstances and his disclosed difficulties in his relationship.

Failure to involve Mrs Y in the risk assessment process and missed opportunities in gaining her views and perspective.

Further missed opportunities identified in relation to assessment processes were that Mrs Y's views were not ascertained in relation to Mr Y's mental health, thoughts that he was expressing towards her, or her general relationship with Mr Y. This was primarily in relation to her contact with NTW, due to them having been the primary agency involved during the timescales of this review. Such lack of exploration resulted in risk assessments being undertaken that lacked Mrs Y's perspective, despite there having been significant opportunities to gain this through her presence at home visits. Although Mrs Y was not identified as a primary carer for Mr Y; she was nevertheless included in the care plan, resident within the same home, and someone against whom direct thoughts to harm or kill were being expressed. Despite this the potential risks were never explored with her outside of her presence during discussions with Mr Y.

The Panel felt this to be a critical lesson learned, as there were identifiable

missed opportunities to ascertain the views of Mrs Y. Failure to do so resulted in her remaining 'invisible' within the process and this potentially impacted upon a number of subsequent assessments and decisions that were taken. The lack of involvement with Mrs Y can been seen in relation to both the lack of identification of her as a potential victim of domestic violence, which has already been discussed, but also in terms of assessments relating to Mr Y's mental health.

The impact of Mrs Y's age in relation to the failure to consider her as a potential victim.

Discussion among the Panel around the impact of Mrs Y's age was prompted by a number of areas identified within the IMRs. These included the fact that selective enquiry did not take place within the GP setting; the failure to identify and follow up on potential indicators of domestic abuse by NTW staff; and the lack of further enquiry by Sunderland City Council staff and the GP in relation to Mrs Y's reported falls.

While only the GP directly disclosed that age might have been a factor in the decision not to undertake any further enquiry, Panel members identified that lack of specific training around domestic violence and older people could result in a failure to view older people as either potential victims or perpetrators among staff across all agencies. Much of the research undertaken in relation to older people and domestic abuse has identified that not only do older people face increased barriers in reporting but there is a lack of awareness and training amongst professionals, as well as 'ageist' stereotyping.[2] It was strongly expressed by the Panel that this was an area that needed to be brought to attention as a result of this review. It was further felt that in addition to the need to increase awareness among professionals it was further necessary to ensure that the public in general are aware of such issues, including where they can go to raise any concerns they may have.

2 Hightower, J. (2002) Violence and Abuse in the Lives of Older Women: Is it Elder Abuse or Violence Against Women? Does It Make Any Difference?; Blood, I (2004) Older women and domestic violence (London: Help the Aged); Pritchard, Jacqui (2000) The needs of older women: Services for victims of elder abuse and other abuse (Bristol: The Policy Press); Mullender, Audrey (1996) Rethinking domestic violence: The social work and probation response (London: Routledge)

This was highlighted within this review in relation through concerns and information held by family members that had not previously been shared with agencies working with Mr and Mrs Y.

Lack of training and awareness among staff.

It was identified within the review that lack of training amongst NTW staff in relation to domestic violence and abuse may have impacted upon lack of recognition in relation to potential domestic violence indicators. However, the Panel also felt that while this was highlighted in relation to NTW, as they were the agency that had the highest level of contact, it could be seen as a potential issue across all agencies within Sunderland. This was evidenced by the fact that while domestic abuse training is available it is offered in varying formats, often as part of other pieces of training such as Safeguarding Adults or Children, and is not always mandatory for staff. Furthermore it was felt that the varied nature of the training available across agencies meant specific issues that are arising from this review would not necessarily be addressed within it. These issues include the need to consider domestic violence in relation to recognition of risk indicators (including the Multi Agency Risk Assessment Conference (MARAC) Risk Indicator Checklist), awareness of agencies' policies and procedures, complex presenting needs, and domestic violence as an issue for older people.

Selective versus routine enquiry

The question of selective versus routine enquiry arose as a result of two previously identified areas. Firstly, that some staff failed to recognise potential indicators of abuse and that this led not only to the failure to explore these further but also the opportunity for them to be shared with other agencies who may have been able to undertake further exploration. Secondly, that Mrs Y's presentation to her GP would not have led to the undertaking of routine enquiry given the absence of presenting indicators.

Mrs Y's appointments with her own GP presented as the one consistent

contact she had outside of agencies that were there to provide services for her husband. It was highlighted by the IMR author for Sunderland Clinical Commissioning Group in relation to Mrs Y's contact that 'As there had been no prior concerns or disclosures regarding domestic violence in this case the key lesson to safeguard victims will be to ensure that domestic violence is routinely covered as part of the assessment and review processes. Doing so will provide patients who may be experiencing domestic violence an opportunity to share concerns or make a disclosure which would not otherwise have been shared'.

The Panel were in agreement that such practice would be useful in ensuring that all opportunities for disclosure were maximised and felt that the difficulties in the case of Mrs Y, in having not been seen as a potential victim for domestic violence, highlighted this.

Limited information sharing within and across agencies.

It was recognised within the IMRs that there was limited sharing of information between staff involved in the treatment of Mr Y's mental health and those responsible for his physical care needs. Furthermore, not all staff working within primary care settings had access to medical records that would have alerted them to concerns relating to Mr Y's mental health. This limited access to information decreased opportunities for further informed assessment and greater consideration of the interplay between Mr Y's mental and physical health concerns, thus resulting in work taking place in silos with little interaction between agencies. The specific difficulties and gaps highlighted within the review regarding the sharing of information within and between different health agencies were addressed through the individual IMR recommendations of each of the relevant agencies.

In addition to the above, there was little information sharing across agencies seen in this case. In considering this it was identified by the panel that the primary issue was the lack of recognition or assessment of potential harm or abuse, as has been discussed previously. Had any risk been identified it was

felt that NTW's domestic abuse policy, Sunderland's multi-agency MARAC procedure, Sunderland's Safeguarding Adults multi-agency policy and procedures, and the Safer Sunderland Partnership Information Sharing Protocol and guidance, would have been sufficient to prompt and allow for the sharing of relevant information across agencies in this case. As a result no specific recommendations were identified in relation to multi agency information sharing practice. However, it was recognised that ensuring awareness of these amongst staff is a critical area for inclusion within the training specification recommended as part of the review.

Lack of exploration regarding Mrs Y's reported falls.

A further area identified by the Panel was one not highlighted within IMRs, namely the failure of the GP and an Independent Living Officer from Sunderland City Council to explore with Mrs Y the cause of her reported falls. Mrs Y reported having fallen three times within the past year to her GP, one of which she stated occurred when she tripped on the stairs. She then told the Independent Living Officer that she had fallen outside resulting in injuries to her leg and ankle, although it is not clear if this in addition to the falls reported to the GP. The Panel felt that further explanation regarding such falls should have been pursued, and also queried whether once more the failure to do so linked to Mrs Y's age. It was acknowledged that such falls may have been age related, and there was no evidence to specifically suggest otherwise, however a failure to clarify and pursue this with older patients could lead to missed indicators in cases of abuse.

Enabling the wider community to support family and friends

Throughout this review a key issue that emerged within Panel discussions was the valuable information supplied by family and friends that helped to gain a clearer picture of the relationship between Mr and Mrs Y. Within such information it was apparent that elements existed within the relationship that had come to be regarded as a 'normal', and generally accepted by those who knew them, but that in retrospect were identified as concerning.

The Panel felt that it was important to acknowledge the difficulties family and friends of those experiencing, or at risk of, abuse may have in recognising concerns and knowing how best to support relatives and friends. Within this it was recognised that in order to enable the wider community to offer support it would be necessary to increase people's confidence in recognising signs, as well as ensuring that they would know where to go to report or discuss concerns and access support services.

Dissemination of Lessons Learned and Implementing Actions

A final area of discussion by the panel centered on the need to ensure that lessons learned from this review were widely disseminated and considered. This was felt particularly important in light of some of the specific learning from the review in relation to older people and domestic violence.

To what degree could the homicide have been accurately predicted and prevented?

In considering this question the Panel were at times divided in their views. It was noted that none of the individual IMRs concluded that the homicide could have been accurately predicted or prevented. It was also recognised by the panel that as there was no reported history or direct disclosures of domestic violence and as such practitioners based their practice on presenting concerns such as Mr Y's physical or mental health needs.

The Panel were able to agree that based on the presenting information available at the time, the tragic death of Mrs Y would not in itself have been predictable. Risk assessments relating to Mr Y's mental health were based on the fact that he had no known history of violent behaviour, had never previously acted upon expressed thoughts to harm his wife, and was engaging with the Mental Health Team. However the Panel did feel that a number of factors have been identified that could have resulted in greater exploration of potential risks. These include the completion of structured risk

assessments in relation to Mr Y's expressed thoughts to harm his wife; the recognition of potential domestic abuse indicators and further exploration and assessment of these; greater exploration of Mr and Mrs Y's relationship; and the explicit seeking of the views and perspective of Mrs Y. In light of this the Panel felt that, while it cannot be known with certainty how these would have impacted in relation to actions taken, they would have resulted in risk assessments being more robustly informed which may have led to different risk management plans having been implemented. As such the Panel concluded that Mrs Y's death may have been preventable in light of these missed opportunities.

4 RECOMMENDATIONS

In completing their IMRs all the agencies involved in this review identified a number of individual agency recommendations to address specific lessons learned and gaps in procedure or policy for their individual agencies. In addition to these the following general recommendations arose as a result of the review process.

Recommendation 1: NTW to promote the use of the AVA (Against Violence and Abuse) Complicated Matters toolkit and training with all staff. The recommendation of this review is that the toolkit should be mandatory for all frontline staff working within NTW. NTW to feedback to the Safer Sunderland Partnership, within 3 months of the ratification of this report, as to what steps were taken to achieve this recommendation.

Recommendation 2: NTW to review their care plan approach policy and and procedure to ensure that it fully incorporates the Department of Health's 'Best Practice in Managing Risk' (2007) guidance in relation to the individual exploration of any risk with carers, including consideration of how this may apply to resident family members who are not identified as main carers. Feedback in relation to the outcomes from this action to be shared with the Safer Sunderland Partnership within 3 months of the date that the DHR report is accepted by the Partnership.

Recommendation 3: The Safer Sunderland Partnership, in conjunction with the Sunderland Safeguarding Adults Board, to agree a City wide approach to promote awareness around issues relating to older people and domestic abuse, include details of referral routes to domestic violence services and Safeguarding procedures.

Recommendation 4: The Safer Sunderland Partnership to work with partnership agencies to develop a minimum standard training specification for all agencies. The specification should consider the variety of services delivered, the varied roles of staff, as well as the required content and level of

training. The recommendation of the Panel is that the training specification should incorporate the lessons learned from this and other relevant reviews, as well as identifying mandatory domestic violence training for frontline staff as best practice.

Recommendation 5: The Safer Sunderland Partnership to request that all partnership agencies review their current training provision against the minimum standard training specification. The Safer Sunderland Partnership to seek feedback from all partnership agencies, within 3 months of the training specification being circulated, as to whether the minimum standard is met and what actions will be taken to address any gaps identified.

Recommendation 6: The Safer Sunderland Partnership to share the lessons learned from this review with NHS England to request that it be considered in relation to routine enquiry by GPs on a national level.

Recommendation 7: Sunderland CCG and Sunderland City Council to consider whether further guidance is needed for staff around the need to explore with individuals all reported falls, unless explicit reasons for such falls are already known and recorded. Sunderland CCG and City Council to provide feedback to the Safer Sunderland Partnership regarding action that has been taken in relation to this recommendation, any outcomes evidenced and any further steps needed to be taken.

Recommendation 8: Safer Sunderland Partnership to agreed and implement a city wide approach to increase community awareness in relation to both recognising domestic abuse and knowing where to report concerns and access support.

Recommendation 9: Safer Sunderland Partnership to produce a briefing document outlining the key learning points from this review including background information in relation to older people and domestic violence. 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 shared with staff.

Recommendation 10: Sunderland CCG, NTW NHS Foundation Trust, City Hospitals Sunderland and Sunderland City Council to provide detailed feedback to the Safer Sunderland Partnership, within 3 months of this review being accepted by the Partnership, regarding action that has been taken in relation to their single agency recommendations, any outcomes evidenced and any further steps needed to be taken.