Domestic Homicide Review into the murder of Mary in September 2018

Under s9 of the Domestic Violence Crime and Victims Act 2004

Independent Chair: Deborah Klée

Independent report author: Deborah Klée

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Preface

Norfolk County Community Safety Partnership wishes at the outset to express their deepest sympathy to the family, particularly to their children and siblings. This review has been undertaken in order that lessons can be learned from this situation and we appreciate the support and challenge of the family with this process.

The Independent Chair and Report Author would like to thank the staff from statutory and voluntary sector agencies who assisted in compiling this report.

To protect the identity of the victim, the perpetrator, and family members, the following pseudonyms have been used throughout this Review:

The victim: Mary, aged 76 years at the time of her murder.
The perpetrator: Henry, aged 81 years at the time of the murder.

These pseudonyms were chosen by the family members.

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PART ONE – BACKGROUND

1.0 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Mary, a resident of Norfolk, prior to her murder in September 2018.

1.2 In addition to agency involvement the review has also examined the past to identify any relevant background or history of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 To ensure anonymity pseudonyms have been used for the people concerned. These names were chosen by the family.

Name	**Age at the time of the domestic homicide**	**Relationship**
Mary	76	Victim
Henry	81	Perpetrator

1.4 Both Mary and Henry are of White British ethnicity.

2.0 Circumstances leading to the review

2.1 Mary and Henry lived together in their own sheltered housing bungalow in a rural Norfolk village. Henry had become increasingly disabled over the past few years as a result of osteoarthritis and chronic obstructive pulmonary disease and was dependent upon his wife Mary for care and support. They were not known to adult social care and did not receive any care and support services, apart from that provided by their social housing provider. Henry had memory problems and was being investigated for Lewy[1] Body Dementia.

2.2 In September 2018 Henry stabbed Mary repeatedly at their home and killed her. An ambulance was called by neighbours who witnessed the attack as Mary tried to leave the bungalow. Mary was pronounced dead at the scene. She was lying face down in her doorway.

[1] Lewy Body Dementia is a type of dementia that shares symptoms with both Parkinson's Disease and Alzheimer's Disease. Symptoms include: fluctuating attention and alertness, visual and/or auditory hallucinations, delusions, mobility problems and sleep disturbance.

2.3 Henry was charged with murder and remanded in custody in a secure mental health facility.

2.4 The review considers agencies contact and involvement with Mary and Henry from July 2014, when Henry raised concerns with his GP regarding his memory loss, to September 2018 when Mary was murdered.

2.5 The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. For these lessons to be learned as widely and as thoroughly as possible, professionals need to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risks of similar tragedies happening in the future.

Norfolk County Community Safety Partnership (NCCSP)

2.6 The decision to undertake a domestic homicide review followed the NCCSP Domestic Homicide Protocol (January 2019) and Home Office Statutory Guidance. A decision was made that the death fitted the criteria for a Domestic Homicide Review at a Gold Partnership meeting on the 15th October 2018. The Home Office was notified on the 16th October 2018. The Coroner was also informed on the 16th October 2018. The family were informed of the decision to hold a DHR via the police family liaison officer in January 2019.

Norfolk Safeguarding Adult Board

2.7 The Norfolk Safeguarding Adults Board (NSAB) considered whether the death of Mary met the criteria for a Safeguarding Adult Review (SAR) and recommended that it did not, this was agreed by the Chair of the NSAB. However, the NSAB was represented on the DHR Panel and will implement learning from this review.

Timescales

2.8 The review commenced in February 2019 and concluded in September 2019

2.9 The process was pended whilst awaiting Henry's trial which took place during December 2019. Henry was assessed by a psychiatrist as medically unfit to stand trial. However, he was required to consider entering a plea and arrangements were made for Henry to address the Court via Skype from the mental health secure unit where he was detained. This took some time to organise. This process was concluded in December 2019 with Henry deemed unfit to plea.

Confidentiality

2.10 The findings of this review remained confidential during the review process. Information was available only to participating officers/professionals and their line managers until the report was approved for publication by the Home Office Quality Assurance Group.

2.11 Information discussed within the DHR Panel meetings is strictly confidential and Panel members were made aware that information must not be disclosed to third parties without the agreement of Panel members. At the beginning of each meeting, Panel members were requested to sign a confidentiality clause.

3.0 The Review Process

3.1 The purpose of a Domestic Homicide Review (DHR) 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 expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

3.2 A DHR should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator, or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse earlier and either signpost victims to suitable support or design safe interventions.

3.3 The DHR Panel would like to express their sincere condolences to the family and friends of Mary and Henry. We would like to thank all of the Panel members and their respective agencies who participated in this review process for their contribution to the formulation of this report. Particular thanks go to the friends and family of Mary and Henry, for helping us to understand who they were and how they lived their lives together. In doing so, they have supported the learning and development by agencies working with other adults at risk in Norfolk.

4.0 Terms of reference

4.1 The terms of reference for this DHR were agreed by the Panel as set out below.

4.2 The review will:

4.2.1 Consider the life of the perpetrator, to seek to determine the relevance of any earlier incidents or events that could provide insight and contribute to a better understanding of the nature of domestic violence and abuse.

4.2.2 Draw up a chronology of events from July 2014, when Henry first raised concerns to his GP about his memory loss, to end September 2018. All agencies involved in the life of the perpetrator will contribute to an integrated chronology, to determine where further information is necessary. Where this is the case, Individual Management Reviews (IMRs) will be requested from relevant agencies.

4.2.3 IMRs will cover the same time period as the chronology – July 2014 to September 2018. However, the IMR writer should use their discretion to include any relevant information outside of this time period. IMRs should analyse learning and report it under the following headings:

- **Professional curiosity** – how can we encourage and support appropriate curiosity with families, and between professionals?
- **Information sharing and forum / fora for discussion** – how can we ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?
- **Collaborative working, decision making and planning** – how can we improve timely and collaborative planning and get strong and shared decisions?
- **Leadership: ownership, accountability and management grip** – how do we ensure effective leadership and champion better safeguarding, locating clear accountability?

4.2.4 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.2.5 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.2.6 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding where domestic abuse is a feature.

4.2.7 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judicial issues,

- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

4.2.8 This Domestic Homicide Review will be carried out alongside a Serious Incident (SI) review that is being conducted by the local Clinical Commissioning Group (CCG). The two processes will be co-ordinated to avoid any duplication, including interviews with the family and friends.

Family involvement

4.2.9 The review will involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

4.2.10 The DHR Panel will agree a communication strategy that keeps the family informed, if they so wish, throughout the process. The Panel will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

4.2.11 The Panel will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

5.0 Methodology

5.1 This review has followed the statutory guidance for the conduct of a DHR (Home Office 2016). The following agencies were contacted to check their involvement with Mary and Henry:

- Norfolk Police
- East of England Ambulance Service
- Social housing provider for the couple
- Norfolk County Council Adult Social Care services
- Norfolk Safeguarding Adult Board
- GP Medical Practice for the couple
- Leeway Domestic Violence & Abuse Services
- Local authority in which the couple resided
- Norfolk & Suffolk Relate
- Norfolk Sexual Assault Referral Centre
- Sue Lambert Trust
- Norfolk and Waveney Clinical Commissioning Group
- Norfolk and Norwich University Hospitals NHS Trust
- Norfolk and Suffolk NHS Foundation Trust.

5.2 Six of these agencies provided chronological accounts of their contact with Mary and Henry. Norfolk County Council Adult Social Care Services and Norfolk Adult Safeguarding had no record of contact with either Mary or Henry and therefore

they were not asked to provide a chronology. Leeway Community Services and Norfolk and Waveney CCG had no direct involvement and likewise, were not asked to provide a chronology.

5.3 The DHR covered in detail the period from July 2014, when Henry first raised concerns with his GP regarding his loss of memory, to September 2018, when Mary was murdered. However, agencies were invited to provide additional historical context where appropriate.

5.4 The chronologies were brought together to provide an integrated chronology of events.

5.5 The integrated chronology was reviewed by the DHR Panel and it was agreed that Independent Management Reviews (IMRs) would be requested from the following agencies:

- Norfolk Police
- The couple's social housing provider
- The couple's Medical Practice
- Norfolk and Norwich University Hospitals NHS Trust
- Norfolk and Suffolk NHS Foundation Trust.

5.6 The family liaison officer requested a meeting on behalf of the report writer, with Mary and Henry's son and daughter. The NHS Serious Incident (S.I.) report writer agreed to join the DHR report writer for this meeting, as meeting with the family is also part of the S.I. process. The meeting took place on 4th March 2019. The son and daughter were offered advocacy and support services, namely Advocacy After Fatal Domestic Abuse (AAFDA), and Victim Support Homicide Service (VSHS), by the family liaison officer but declined.

5.7 Mary and Henry's daughter provided contact details of other family members and friends who were willing to talk to the DHR report writer about her parents and the lives they lived prior to the fatal stabbing.

5.8 The DHR report writer interviewed:

- Mary and Henry's two adult children
- Mary's sister
- Henry's youngest brother
- Henry's friend of twenty-five years.

5.9 It was decided that it would not be appropriate to interview Henry, as he was being detained in a secure mental health unit and was not in a sound state of mind to contribute to the review, and further distress could be caused.

5.10 Family and friends were asked how they would prefer to contribute to the review; telephone conversation, email or a meeting with the report writer. They all requested face to face meetings. They were asked where they would prefer to meet and whether they would like somebody to accompany them. The family

liaison officer offered to join the meeting with the couple's son and daughter, but this was declined. All of the interviews, with the exception of Henry's friend, took place in the interviewees' homes. Henry's friend was interviewed in Norwich City Hall. Mary's sister asked for her husband to be present, Henry's brother asked for his wife to be present and Henry's friend was accompanied by his partner. All of the family and friends' requests were honoured including the involvement of spouses/partners, who made a valuable contribution to the review by sharing their own insights.

5.11 The draft report was shared with Mary and Henry's son and daughter on 19th December 2019 in a face to face meeting with the report writer and family liaison officer.

5.12 The DHR Panel met on four occasions:

5.12.1 Meeting one - 15th February 2019. To review the integrated chronology, agree the terms of reference and agree which organisations would be required to provide an IMR.

5.12.2 Meeting two - 8th May 2019. To consider the pen picture provided following interviews with family and friends. Hear presentations of the IMRs and discuss findings. Identify any further information required. Draw out lessons learned.

5.12.3 Meeting three - 19th July 2019. To review a first draft of the report and agree next steps.

5.12.4 Meeting four – 2nd September 2019 to agree the action plan and the final draft of the report.

Individual Management Reviews

5.13 The purpose of the Individual Management Review (IMR) is to:

- Enable and encourage agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and
- Identify examples of good practice within agencies.

5.14 The Overview Report Writer provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office 2016). The IMR writers were not directly involved with Mary or Henry, neither were they line manager for any member of staff involved in the case. IMR reports were quality assured by a senior accountable manager countersigning the report.

5.15 IMR writers were thanked and debriefed after presenting their IMRs to the DHR Panel. Senior managers from the organisations concerned met with the IMR writer following completion of the report for a further debriefing.

5.16 These IMRs were discussed with the authors at a DHR Panel meeting. Copies

of IMRs had been circulated to all the Panel members prior to these meetings for analysis and Panel members were able to cross-reference significant events and highlight any missing information for further investigation.

6.0 Contributors to the review

DHR Panel members

6.1 Panel members did not have direct contact with Mary or Henry, with the exception of Dr. Wallace, the couple's GP of many years. The Panel felt that the GP's contribution to the panel discussion was invaluable and it was agreed that Gary Woodward from the CCG would co-write the IMR from the Medical Practice to ensure independence.

Name	Position/organisation
Tabatha Breame	Domestic Abuse Change Co-ordinator, Children's Services, Norfolk County Council
Saranna Burgess	Head of Patient Safety and Safeguarding, Norfolk and Suffolk Foundation NHS Trust
Angela Freeman	Project Support Officer, Public Health, Norfolk County Council
Kim Goodby	Norfolk and Norwich University Hospitals NHS Trust
Service manager	Quality and Patient Safety Lead, for the couple's Clinical Commissiong Group (CCG)
Meadhbh Hall	Adult Safeguarding Nurse, Norfolk and Waveney CCGs
Service manager	Head of service, local registered provider of social housing
Margaret Hill	Community Services Manager, Leeway Domestic Violence & Abuse Services
Deborah Klée	DHR Panel Independent Chair and Overview Report Writer
Walter Lloyd-Smith	Manager, Norfolk Safeguarding Adults Board
Stuart Morton	Head of Integrated Care, Adult Social Care Services, Norfolk County Council.
Amanda Murr	Senior Policy and Research Officer, Office of the Police and Crime Commissioner for Norfolk
Service manager	Head of Early Help for the couple's Local Authority area
Dr. Kelly Semper	Advanced Public Health Officer, Norfolk County Council
Jon Shalom	NCCSP Manager, Public Health, Norfolk County Council
Karen Taylor	Admin Support Adult Safeguarding Team, Norfolk and Waveney CCGs
GP	Medical Practice for the couple
Gary Woodward	Adult Safeguarding Lead Nurse, Norfolk and Waveney CCGs
Detective Inspector Alix Wright	Norfolk Police MASH

DHR Panel Chair and Author

6.2 Deborah Klée was appointed as Independent Chair and Overview Report Writer by NCCSP. Deborah has not worked for any of the organisations involved in this review.

6.3 Deborah has chaired a number of Safeguarding Adult boards. As an independent consultant Deborah has experience of writing both DHR and Safeguarding Adult Review (SAR) overview reports. Deborah previously worked in senior positions at the Audit Commission and Healthcare Commission. Prior to this she worked for 20 years in the NHS as an occupational therapist and executive manager. www.deborahklee.org.uk

Deborah has extensive experience in the field of older people and elder abuse. She was the author of *Living well in later life: a review of progress against the national service framework for older people,* 2015, Healthcare Commission. She was Head of Strategy for Older People, Healthcare Commission; Interim Head of Policy, Help the Aged; Editor Working with Older People, Emerald Publishing. She has peer reviewed several papers on elder abuse for the Journal of Adult Protection.

Parallel reviews

6.4 Notification was sent to the Coroner on 16th October 2018. A trial took place for Henry in December 2019 where he was given a Section 37 Hospital Order.

6.5 A Serious Incident process commenced prior to the DHR being commissioned. As a result of this, the serious incident process paused and a dovetailed approach with the DHR was taken to avoid any duplication of effort.

Equality and diversity

6.6 All of the 9 protected characteristics of the 2010 Equality Act were considered by the writer and DHR Panel. The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

6.7 Age – Both Mary and Henry were in their later years at the time of the fatal stabbing. Mary's age and her upbringing in a very rural part of the County, could have had an influence on how she regarded her marriage and her role as a wife and mother. This is addressed in the report.

6.8 Disability – Henry left work due to physical disability when he was in his forties. He experienced severe back pain all of his adult life, following a fall from a ladder. At the time of the incident he also had osteoarthritis, chronic obstructive pulmonary disease and dementia.

PART TWO – THE FACTS

7.0 Case Summary

7.1 At the time of her murder Mary was 76 years of age. She was living in a rural Norfolk village with her husband Henry aged 81 years in a sheltered housing bungalow provided by a Registered Provider of social housing. Mary and Henry had been married for fifty years and had a son and daughter, both of whom live in the locality.

7.2 Henry had become increasingly dependent upon Mary in recent years due to physical disability: a long history of severe back pain, osteoarthritis and chronic obstructive pulmonary disease, and in the four years prior to Mary's death, memory problems, anxiety and depression.

7.3 They were an independent couple and had managed without any care and support services, having declined any offers of help.

7.4 The couple were well known to their GP as they had both been patients with the same surgery for the past fifty years. When memory problems were first raised by Henry in 2014 the GP investigated and referred to the hospital's Memory Clinic. Mild cognitive impairment and anxiety were diagnosed at this time. This was treated with medication. In 2018 Henry's memory loss had increased and he was experiencing vivid dreams and hallucinations. As Henry was also presenting with Parkinsonian symptoms a referral was made to the Memory Clinic for investigations. At the time of the fatal stabbing the diagnostic process had not concluded, although Lewy Body Dementia was considered the likely diagnosis.

7.5 The day before the fatal stabbing the police received a call from Mary's neighbour. Henry had turned up at her address and was saying that he was frightened of being robbed. He had a large sum of money on him and told the neighbour that he had dementia, requesting her to ring the police on his behalf. A police officer arrived on the scene where Mary had joined Henry. The money was locked up for safe keeping in the neighbour's gun cabinet and Henry and Mary were walked home by the officer. Henry had calmed down.

7.6 The following day, Henry stabbed Mary repeatedly in the head and neck with two long kitchen knives. A couple, who were neighbours, witnessed this, as Mary was trying to leave the house during the attack. They phoned for an ambulance.

7.7 Henry continued to stab Mary, when the police arrived and tried to stab himself in the chest. The police shot Henry with an Attenuating Energy Projectile (AEP) to the stomach. This was the least lethal option to protect Henry, the police and bystanders.

7.8 Mary was lying in the doorway with no signs of life and severe wounds to her head and neck. She was pronounced dead at the scene.

7.9 Henry was arrested for murder. He is currently being detained in a mental health secure unit. His trial was held in December and Henry did not attend or give evidence in any way. The matter was heard in his absence.

8.0 Pen pictures

8.1 The following pen pictures of Mary, Henry and their life together are based on interviews with:

- Their son and daughter
- Mary's sister
- Henry's younger brother
- Henry's friend of twenty-five years.

8.2 These reflect the perception and recollections of family and friends.

Pen Picture Mary

8.3 Mary grew up in a village North of Norwich. She was the youngest of five, with three brothers and a sister. The eldest brother was ten when Mary was born. Mary was called Bearba, by the family and the village, meaning baby in the Norfolk dialect. Her sister describes Mary affectionately as *'always awkward.'* When her sister, three years Mary's senior said, *'I'm the eldest,' Mary would reply, 'I'm the tallest.'*

8.4 Although Mary passed her driving test as a young woman, she preferred to ride her Vespa scooter and didn't drive a car until Henry had to give up driving. She worked as a secretary or what she called a 'ready reckoner' for a building firm. Mary enjoyed coach holidays with her girlfriends from work, before she married Henry. She had one particularly close friend, Phyllis who she knew from both school and work. Phyllis and Mary only met once after Mary married Henry. Henry and Phyllis did not hit it off and so Mary never saw her friend again. Sadly, Phyllis died of cancer the year before Mary was killed.

8.5 Mary is described as *'very sedate', 'precise and fussy in her dress and mannerism.'* Everyone who was interviewed described Mary as fiercely independent. When her sister's family visited Mary and Henry's family, Mary would not sit down to eat with them. Instead, she would wait on them, looking after everyone.

8.6 Although she had a few boyfriends before marrying Henry, Mary decided to approach the Marriage Bureau when she was twenty-five. Mary was the last of her set of girlfriends from work to get married. She would meet Henry in Norwich and a year later, after several dates, they got married. Both Mary and her sister were given a sum of money by their father so that they would always be independent. He advised them to keep the money safe in case they ever needed to leave home.

8.7 Following her marriage, Mary did not have a particular close friend. She gave up work when the children were born, a daughter and then a son. Mary's family all lived close to where Mary grew up and so it was not easy to visit them when the children were small. Mary missed her mother and sister, but when the children were old enough, she took them to her mother's house once a week on the bus and met up with her sister.

8.8 Mary's daughter said, *'It was one of the sadnesses of my mum's life that she never found a true friend. She used to mention it to me a lot. So, there is no person apart from us that she was very close to. But she wasn't generally sad. She had been depressed herself for several years whilst things were tough financially for my parents while my dad was ill but soldiered on. Life didn't turn out for either of them as they had expected, but they eventually won through and made an enviable life for themselves.'*

8.9 Life was hard for Henry and Mary around the time that Henry had to give up work. They were worried about their income whilst they waited to see if Henry would get an Invalidity pension. Mary started work as a cleaner in a local village.

8.10 When the children left home, Mary took up new hobbies including: embroidery - which she enjoyed doing in the evenings, painting – both watercolours and oils and ceramics. It was Henry who encouraged Mary to find new interests when the children left home as he had experienced a similar loss of role when he left work and knew that it was important to keep busy.

8.11 Mary didn't start driving until she was in her sixties. When she had to take over responsibility for driving, she took a few lessons and became a confident driver. Mary joined some of the community groups including the W.I. and went on some organised day outings on her own and on one occasion on a day trip to Windsor Castle. Although Henry could not travel very much, he was happy for Mary to go on holidays with her grown-up children. She enjoyed a holiday in Germany with her son a few years ago and Croatia with her daughter in 2008. Mary even spent a day at a theme park with her son and went on a few challenging rides.

8.12 All of her life Mary was very private. At home they kept their doors closed so that the neighbours would not hear their business. Mary left a job because work colleagues were asking too many questions. Mary was open with her sister and brother-in-law and they never felt that there was any reason to be concerned for her welfare.

8.13 There was a period of three years when Mary fell out with her sister. Their mother was unwell after having three amputations below and then above the knee on one leg and then the other leg. Mary worried about her mother but could not visit because of Henry's dependence on her. Her mother would not accept any paid care and so Mary's sister was her caregiver and she resented Mary's lack of involvement. Their mother made Mary's sister her Lasting Power of Attorney for finance and this caused some friction. Henry wasn't happy that Mary was being excluded from the management of her mother's financial affairs. There was a bit of squabbling but then things settled down again.

8.14 Mary went to her mother's funeral without Henry, as Henry would not go to any funerals. Mary did not accept a lift from her brother-in-law as it was supposed that Henry would not have approved. Instead, she caught a bus.

8.15 Mary didn't say very much about her husband's decline. She would laugh and say to her daughter, *'He's taking all of my time,'* or *'He's my priority and the dog.'*

8.16 The children noticed that their mum was finding it tough caring for their dad but said that she never complained. Mary would borrow books from the library and read to Henry. *'Between six to twelve months ago, Mummy started to say that Daddy was taking up all of her time.'*

Pen Picture Henry

8.17 Henry was born in a village in Norfolk. He was one of four children, having an elder brother and two younger siblings: a sister and the youngest, a brother. He had a keen interest in country life and from a young age cultivated an in-depth knowledge of wildlife and the countryside.

8.18 Henry was an intelligent boy and could have gone to the grammar school if he hadn't failed his eleven-plus on purpose, after hearing his dad say that he couldn't afford the grammar school uniform.

8.19 National Service call-ups formally ended in December 1960, so Henry was required to do National Service as a young man. He was posted in Malta where he worked with the armoury department and as an aircraft engineer. It is likely that Henry requested a posting overseas as he had an attitude to life that was to make the most of any opportunities and always say 'Yes'. A lesson that he taught his children. Although Malta was not involved in any conflict at this time, Henry was stationed there when the Cuban Missile Crisis was taking place.

8.20 When Henry was twenty, he fell from a roof and this injury caused him to have back problems for the rest of his life.

8.21 Henry only had one girlfriend, a girl from the neighbouring village, before meeting and marrying Mary. He was more interested in fishing than girls. But when he was thirty, Henry decided that it was time to marry, encouraged by his parents who wanted to see him settled in a home of his own. So, Henry paid fifty pounds to join a marriage bureau, which would have been a lot of money to him in those days. A year later he married Mary.

8.22 In the early days of married life, Henry was working in a cardboard factory. The pay was good and with his earnings and savings, Henry and Mary paid off the mortgage on their cottage in just three years. Good with his hands, Henry turned what was an old cottage into a comfortable home. He even made the stairs in their cottage.

8.23 When he was thirty-two, Henry joined an electrical motor company, where his brother-in-law worked as an overhead crane operator. He worked there for eleven years before he had to leave due to back problems. Trapped nerves over the years had resulted in a lot of sick leave. And so, at the age of forty-three, Henry retired from work on an invalidity pension. At first, the loss of his role as provider and the occupation of employment was hard for Henry, but he adjusted, taking up new interests.

8.24 Henry was a good gardener and enjoyed his garden, although he found it hard physically because of his back. There was always a surplus of vegetables from the vegetable garden which even in recent years Henry would sell to people in the village rather than let them go to waste.

8.25 Henry's main interest was shooting. He had a shooting buddy and would go to the pub with this friend. He also enjoyed fishing and would go sea fishing with his next-door neighbour who owned a boat. An intelligent man, Henry was a founding member of a Wild Bird Association and served on the committee. When Henry could no longer shoot due to physical disability, he was made an honorary member. He was considered *'blunt but wise,'* and could cut through a dispute, being fair-minded and direct.

8.26 Henry attended Parish Council meetings to keep abreast of developments in the village. Both he and Mary participated in community activities, such as the Village Sculpture Trail. One year, Henry made a sundial for the event, which was sold and taken to Ireland. Another year, a local artist bought a seat that Henry had made. Henry was always *'good with youngsters'* and instigated the opening of a youth club in the village. Henry wrote poetry and would pin observations on village life outside his home for passers-by to read.

8.27 Henry was described by his friend as, *'a very gentle person. He loved nature, gardening and making beer and wine.'*

8.28 Although he had many admirable qualities, Henry was not always good in social situations. He valued his privacy and had strongly held views. Sometimes, *'Henry would let his mouth run away with him.'* He had a reputation for saying what he thought, and this could cause friction. Some years ago, Henry fell out with his mother, his sister and older brother. His mother has since died but Henry is still not on speaking terms with his sister and older brother. Henry's younger brother asked Mary why they had fallen out and she said, *'over something stupid.'*

8.29 Over time, Henry's health deteriorated. He suffers from chronic obstructive pulmonary disease (COPD), rheumatism, aortic aneurysm, sciatica and incontinence. In later years, Henry wore a catheter when he went out with Mary and an insole in his shoe. However, it was painful for Henry to walk over rough terrain and eventually he had to give up going to shoots. Instead, Henry went fishing more. Mary would drive him to a fishing spot and collect him later. He enjoyed Sudoku and being read to by Mary. Henry gave up his motorbike six years ago as Mary had a car. Later he gave up his guns, which would have been a big loss to him given his lifetime passion for hunting.

8.30 Henry's children would ask their dad if he was depressed to which he would reply, *'Of course, I'm depressed.'* But, his son says*, 'Dad still got up every morning and made an effort. Every Sunday they would go out for a Pensioners' lunch to give Mum a break.'*

8.31 Henry's children noticed his forgetfulness a couple of years ago, although they were told that the doctor thought it was just normal forgetfulness associated with ageing. A year ago, Henry and Mary went out with their son and daughter and other family members for a meal to celebrate their fiftieth wedding anniversary. Henry panicked because there was too much food on his plate and became tearful and distressed. At his son's wedding a couple of years ago, Henry expressed anxiety about being around strangers.

8.32 Henry's friend of twenty-five years noticed what he recognised as symptoms of dementia three years ago. Henry had to write things down when he had always had a good memory. One day Henry contacted his friend because he had stripped down his gun and didn't know how to put it back together again when it should have been second nature to him. His friend persuaded Henry to go to his GP to tell him about his memory problems but was told by Henry that the GP did a memory test in the surgery and did not refer him on to a Memory Clinic at that time.

8.33 When Henry was eventually diagnosed, it did not come as a surprise to his children. They were concerned that he might have a change of personality and become short-tempered, but he didn't. He was just frustrated that he couldn't do things for himself. On waking, Henry was disorientated and often didn't know where he was or recognise his wife. The daughter suggested that Mary keep their wedding photograph by their bed, so that she could point to it as a reminder, when that happened.

A Pen Picture of Mary and Henry's Life Together.

8.34 Despite meeting through a Marriage Bureau, a secret that they kept from family and friends for some time, Mary and Henry *were 'a good match.' 'They were similar in temperament and their outlook on the world.'* Both were private people, disliking gossip.

8.35 Soon after getting married, they made a joint decision to buy a house together. Mary would bundle £600 into a carrier bag and with it stowed in the pram walk to the building society to make each payment. They lived frugally, although there was always plenty of food from the land. They didn't have a family car but rode a Honda scooter and sidecar together. They called it Wallace and Gromit. Neither of them was interested in luxuries or fashion.

8.36 When Henry had to give up work, they were without any income for two months and did not know if Henry would get an Invalidity pension. This of course caused a lot of anxiety. Despite the pressures of life, Mary and Henry were generally happy. They did not argue in front of the children, although there were a few occasions when Mary could be heard banging the saucepans as she worked in the kitchen.

8.37 The children had a happy childhood. Their father was strict, but he wanted them both to do well at school and they did. Their daughter won a scholarship to Norwich Girls School and their son became a civil engineer. Both excelled, achieving master's degrees. Mary and Henry were proud of their children.

8.38 Mary and Henry got a Spaniel dog when the children left home. Henry doted on this dog and took him hunting. When their first dog died it hit them both hard, although they still had another dog. Sadly, this dog died too, six years ago and they got their current dog, another Spaniel, who is now living with their son. Before the second dog was put down, Henry and Mary took her for a walk. They asked their daughter not to visit, as they needed to be alone at that time.

8.39 When the garden became too much to manage, Mary and Henry moved to sheltered housing. They put away money from the sale of the house to pay the rent. Before making the decision to move to sheltered housing they had already considered and turned down the offer twice. When Mary eventually persuaded Henry and they moved, they were glad that they had. They loved the bungalow and were delighted with the maintenance provided. New windows were fitted not once but twice and solar panels. Recently a new kitchen was fitted. Before moving to the bungalow, they hadn't had a fitted kitchen. It was true that they moved a little before they needed to, but they wanted to do their own decorating. They were also able to move most of their possessions themselves, ferrying them the 1.5 miles from their old house. *'They did it all themselves. If there was anything heavy to move, they got help.'*

8.40 Following the move, Henry and Mary started going to the local community centre. Lots was happening there at the time, not so much now. *'They preferred to do things themselves, as they didn't like other people asking about their business. They were more interested in talking about things like travel and nature (rather than gossip)'*. They were both community minded and got involved in village activities.

8.41 When they sold their cottage, they invested in high risk stocks and lost a lot of money, about thirty thousand pounds. Henry worried about money and kept it in the house.

8.42 Following Henry's diagnosis in 2014, *'they became more private as they didn't want everyone to know.'* Mary didn't want her sister to find out the restrictions on her life compared to her sister's. Henry became more withdrawn, as he was shy communicating with people. Mary put the children off from visiting, because Henry couldn't cope with long visits. He would doze a lot in the chair. When Henry had nightmares, he disturbed Mary's sleep and so they would both nap during the day.

8.43 Mary was offered support as a carer by the GP, but declined. They did get carer's allowance, but they didn't want strangers in the home. If Mary's sister came over, they wouldn't want her to see the incontinence pads.

8.44 Henry's brother explained that they had always been self-sufficient. *'Neighbours are more important in the country. We don't expect anything from anybody. Only friendship. Henry would have hated anyone going into his home to provide care. The daily phone call from [the social housing provider] was alright. (*This was in fact a weekly phone call.) *Henry and Mary were grateful for that. They would have accepted help with aids and adaptations, because there are lots of gadgets and things that can make life easier, but you don't know that unless you're told'.*

8.45 Mary's sister believes that if Mary had accepted professional help then the deterioration in Henry might have been recognised and he might have benefited from some intervention.

8.46 Henry's friend is frustrated that after persuading Henry to go to the GP to discuss his memory problems, it wasn't followed up immediately with referral to a Memory Clinic.

8.47 Mary and Henry's children think that more general information for the general public on dementia would help with early diagnosis.

9.0 Key incidents

9.1 The key episodes that follow are a narrative chronology drawn from the integrated chronology. They are presented in chronological order. Comments in italics are the DHR panel's reflections.

Key episode one – memory problems first raised.

9.2. **30th July 2014** – Henry attended the GP surgery with Mary to raise concerns about his memory. The GP arranged for blood tests to be taken and a memory test, these took place on **5th August 2014.** The blood tests were reported as normal and the memory test score was forty-two out of fifty. As the memory score showed slight memory loss, Henry and Mary agreed to monitor Henry's memory and inform the GP if it got worse.

9.3 **28th August 2014** – Henry went back to the GP with his wife, requesting medication for his memory problems. The GP did not prescribe medication but agreed to refer to the Memory Clinic.

9.4 **4th September 2014 -** Referral received by the Memory Clinic from the GP.

9.5 **19th September 2014** - Henry was seen in the Memory Clinic with Mary. He performed well on the memory test but complained of being low in mood and experiencing anxiety. The assessor felt that his memory problems were due to anxiety and suggested anti-depressants.

9.6 **2nd October 2014** – The GP received a letter from the Memory Clinic following Henry's attendance there on 19th September, suggesting a diagnosis of mild

cognitive impairment and anxiety. A trial of anti-depressant medication was suggested if there was no improvement in symptoms with time. This was offered to Henry by his GP but declined at that time.

Key episode two – Henry has cataract diagnosis and operation

9.7 **6th October 2014** – Henry attended his GP surgery with an acute eye condition. He was directed to an optician, where he was seen and diagnosed with a second cataract.

9.8 **3rd November 2014** – Henry was seen by his GP following the optician's appointment. The cataract had matured but not sufficiently to meet the NHS criteria for surgery. The GP referred Henry to neurology to investigate his double vision.

9.9 **25th November 2014** – The GP received correspondence from Neurology. Henry's diplopia (double vision) was intermittent and occurred mainly when he was tired. The letter confirmed that Henry had been finding it difficult to go upstairs and occasionally tripped on steps. Although the neurology letter did not suggest anything sinister, it did say that an MRI of his brain would be arranged to ensure nothing had been missed.

9.10 **2nd January 2015** – Henry had cataract surgery.

9.11 **30th January 2015** – A letter to the GP from Neurology confirmed that the MRI brain scan was normal with nothing to explain the double vision. *This brain scan would have shown any shrinkage in the brain. The GP has since confirmed that it did not, which indicates that the dementia had not progressed at this time.*

9.12 **General decline in Henry's health and increased dependence on Mary**
The GP chronology details many routine appointments and checks for Henry's general health. Only those entries that might have some significance on the domestic homicide are included here.

9.13 **9th February 2016** – Henry was seen at the GP surgery with knee pain after kneeling to check the tyre pressure. He was advised by the GP that the swelling should reduce and to return if it did not.

9.14 **17th February 2016** – The GP saw Henry at his home address regarding his on-going knee pain. He had been unable to walk for a week due to the pain. He had a walking frame as a result of previous contact with a physiotherapist and could manage single steps using the frame. Bursa of the knee was diagnosed and a course of steroids and analgesia prescribed.

9.15 **19th February 2016** – The GP phoned Henry to enquire about his knee pain. Henry said that it was improving and that he had been up and around the house that day. It was agreed that arrangements would be made for an X-Ray. The X-Ray showed that there wasn't a fracture and changes were made to the analgesia prescription.

9.16 **24th February 2016** – Henry's GP saw him at home. Henry said that since taking Co-codamol for his knee pain that he had not been feeling himself. For example, he didn't know where he was in the mornings. An abbreviated mental test (a mental test for memory) scored eight out of ten.

9.17 **2nd March 2016** – Henry had a fall and as a result had a period of reduced mobility with knee pain. He told his GP that he was having panic attacks and vivid dreams at night about concentration camps. The GP prescribed Diazepam and arranged a follow-up appointment.

9.18 **15th March 2016** – Henry's mobility had improved with sleep and the Diazepam was stopped.

9.19 **12th April 2016** – Henry saw the GP again about his knee which was still stiff. He was continuing to see a physiotherapist.

9.20 **16th May 2016** – Henry slipped and fell on his right arm. He had an infected Olecranon bursitis and was prescribed antibiotics. On **23rd May** 2016 Henry saw the GP again regarding his arm and was prescribed a further course of antibiotics.

9.21 On **14th June** he saw the GP complaining that his knee was still causing problems. The GP discussed surgical options and provided Henry and Mary with information to help them decide if they wanted to pursue this.

9.22 **30th June 2016** – Henry saw the GP as he wondered whether his prescribed medicine was causing him to become disorientated. Shortly after taking a second dose of Finasteride Henry was disorientated in place. This episode was witnessed by Mary and lasted around ten minutes. An examination by the GP ruled out a TIA (Transient Ischaemic Attack). The GP discontinued the Finasteride, although he did not think that this was the cause of Henry's disorientation. Henry came to the same conclusion and phoned the GP later that day to say that it was probably due to him standing up too quickly. The Finasteride was restarted.

9.23 These entries and the other detailed entries of consultations with the GP show a close relationship between the GP and Henry. Henry seems to trust his GP and is able to discuss any concerns openly. The GP follows up visits to the surgery with telephone calls and home visits. All symptoms noted in the chronology are taken seriously and are investigated.

Key episode three – Further decline in memory loss and depression

9.24 **15th January 2018** – Henry attended the GP surgery in a tearful and anxious state. He was concerned that his memory was getting worse and that he was becoming more dependent on his wife. An anti-depressant medication, Escitalopram (5mg), was prescribed.

9.25 **25th January 2018** – Henry was seen by the Practice nurse for a COPD (Chronic Obstructive Pulmonary Disease) review. The nurse noted Henry's

anxiety and his forgetfulness in the context of medication compliance. He had lost his appetite and was eating small meals. The nurse showed Henry some breathing techniques for when he felt panicky.

9.26 **29th January 2018** – Henry saw the GP and reported that he was feeling better in his mood but was having vivid dreams that caused him anxiety. Henry agreed to continue with the medication as the GP felt that it might settle him in time.

9.27 **31st January 2018** – Henry phoned the surgery as he was having more vivid dreams and hallucinations. Escitalopram medication was stopped as the dreams and hallucinations seemed to coincide with the initiation of this medication. Lorazepam was prescribed for Henry's anxiety.

9.28 **13th February 2018** – The GP followed up with Henry and found that the hallucinations and anxiety had lessened. Henry had regained his independence. A follow-up appointment was planned for eight weeks' time.

9.29 **18th April 2018** – Henry attended the GP surgery. His memory was worse and he described Parkinsonian features and hallucinations. A referral was made back to the mental health team to investigate whether Henry had Lewy Body Dementia.

Key episode four – Diagnostic process for Lewy Body Dementia

9.30 **25th April 2018** – The GP repeated the memory test (Test your memory). This time Henry had a reduced score of thirty six out of fifty. A referral was sent to the mental health service on **5th May 2018.**

9.31 **8th May 2018** – The GP referral was received by the mental health service. It was considered a 'routine referral' and so a response within twenty-eight days was expected. The consultant declined the referral at this stage as investigations were first required to rule out Parkinson's disease. A referral was sent, recommending it was prioritised to the acute hospital's (NNUH) neurology or older people's medicine department. An acknowledgement was made of the adverse effects of prescribed anti-depressants as was the possible diagnosis of Lewy Body Dementia.

9.32 **21st May 2018** – A letter was sent to the GP from the consultant psychiatrist explaining that the referral had been declined as Henry should first be seen by neurology or older people's medicine due to Parkinsonian symptoms.

9.33 **3rd July 2018** – Henry was seen in the Movement Disorder Clinic at the acute hospital (NNUH) accompanied by Mary. The summary of his appointment concluded that Henry had evidence of cognitive decline, hallucinations and gait disorder (mild Parkinsonism), REM sleep issues, olfactory disturbance and evidence of arthritis in the left knee. This would suggest that he did have a neurodegenerative disorder and possible Lewy Body Dementia. The NNUH consultant referred Henry to the Memory Clinic.

9.34 Henry was seen by the physiotherapist and occupational therapist on the same day and advice was given to him and Mary on coping with Henry's disability as well as balance exercises. An MRI scan was booked. The consultant suggested a trial on Rivastigmine. There was no routine follow-up appointment made for the Movement Disorder Clinic as this was considered unnecessary. It was reported by the Norfolk and Norwich University Hospital that a letter was sent to the Community Psychiatry Team at Julian Hospital on **27th July 2018** asking them to review Henry with regard to the concerns raised. This letter was not received.

9.35 **11th July 2018** – Mary called the GP expressing concern that Henry had been more sedated and confused since being seen in the Movement Disorder Clinic. The GP made a home visit on the same day. Henry seemed anxious and exhausted from assessments at the hospital but was comfortable reading a newspaper during the visit.

9.36 **7th August** – Mary saw the GP alone for a routine health screening. During the appointment they discussed Mary's concerns. The GP offered Mary support, but she declined to accept any help. The GP actively encouraged her to contact the surgery if she changed her mind and would like some support.

9.37 **23rd August 2018** – The GP received correspondence from the Movement Disorders Clinic with the results of the MRI scan. This showed global atrophy (shrinkage) of the brain and a single micro haemorrhage. No change in management was suggested.

9.38 **17th September 2018** – A referral was faxed to the mental health trust (NSFT) by the acute trust, older people's medicine (NNUH) with a letter attached from the Movement Disorder Clinic dated July 2018. This was the letter previously sent and not received (9.34). A routine referral was made to the Memory Clinic and a worker was allocated. The letter did not indicate any risk factors and so there was no reason to prioritise the referral.

9.39 **18th September 2018** – Henry and Mary visited the GP surgery. They were becoming increasingly distressed by Henry's symptoms of slow movements and speech and night time hallucinations. The GP agreed to chase the mental health team.

9.40 **19th September –** The GP contacted the mental health team to ensure that the referral had been received and questioned the delay. It was explained that a routine referral would typically be assessed within two weeks.

Key episode five – Henry reports stolen cash.

9.41 **September 2018, the day before Mary's murder** – Henry had become confused and wandered over to a neighbour's house. He was concerned about a large amount of cash that he was carrying. The neighbour called the police when Henry arrived on his doorstep, anxious and confused. Mary joined Henry. The police officer attended the scene. The neighbour offered to lock the cash in his gun cabinet until Henry's son could collect it in the morning. The police officer took

the money from Henry and counted it before passing it to the neighbour. The police officer used a bodycam (body camera) to record actions. The police officer spoke to their son on the phone to explain what had happened and when Henry was calm, the police officer walked the couple back to their bungalow. The police officer recorded this incident as an Adult protection incident (API) on Athena, the police information system, and classified it as a Standard risk.

Key episode six – fatal stabbing

9.42 **The following morning** – the ambulance service was called by a neighbour of Mary and Henry as they were witnessing Mary being stabbed repeatedly by Henry. When the ambulance arrived, paramedics found Mary lying prone on the floor in her hallway. There was an obvious catastrophic haemorrhage to the base of her skull and a stab wound off centre on the upper left side near her scapula. It was agreed that she had experienced an irreversible cause of cardiac arrest. Air ambulance and a doctor attended the scene.

9.43 Armed police were quickly on the scene and saw Henry at the front of his bungalow in possession of two knives. He refused to put the knives down and made attempts to stab himself in the chest. AEP (Attenuating Energy Projectile) was discharged by officers. Henry was disarmed and arrested for murder. Paramedics assessed Henry after the deployment of this firearm at close range (rubber bullets) and found no penetration to the skin but visible bruising. Henry was taken to the acute hospital (NNUH), with police present, for treatment as a result of the AEP. Mary was pronounced dead at the scene.

10.0 Overview

10.1 The pen picture shows that close family and friends did not witness, or have any reason to suspect, that Henry abused Mary at any time in the duration of their life together. The organisations that had the most contact with the couple was their social housing provider and their GP.

10.2 The social housing provider shared copies of detailed records with the report writer, including support plans. They also provided an IMR to the DHR Panel. All of the social housing provider's sheltered housing tenants have a minimum of a monthly call and warden call system pull cord checks. Henry and Mary chose to have a weekly call and as the pen picture describes, they appreciated this regular contact with their landlord. The social housing provider had not received any previous reports to the fatal stabbing to suggest unrest or domestic abuse at the couple's address. There had been no previous police presence, and no broken windows or other damage to the property that might have suggested unrest. The couple were described by their social housing provider as 'model tenants.' If they were out or planned to be out when the weekly phone call was expected, Mary would contact the office to let them know.

10.3 The couple had registered with the same general practice all of their married lives and their current GP had known them for the past four years. This GP had regular contact with Mary and Henry including a couple of home visits in the time frame of this review. The GP had no reason to suspect domestic abuse and there was nothing in the couple's medical notes to suggest that there had ever been any cause for concern.

10.4 The pen pictures generated from the author's discussions with family and friends describe elements of the couple's behaviour within their relationship that relate to traditional gender roles not uncommon in older people, but are now understood to be indicative of a level of coercion and control. These include

- Henry not liking her close friend, so Mary saw her only once after her marriage; a family member commented on how sad the lack of a close friend had made Mary
- Mary taking the bus to her mother's funeral, as Henry would not have liked her accepting a lift from her brother-in-law.

10.5 The pen pictures also describe Henry as the dominant one in the couple's relationship, although Mary always maintained an independence with her own interests and hobbies. The couple's insistence on privacy, for example, keeping the doors of their house closed so that they wouldn't be overheard by neighbours, and Mary leaving her job because work colleagues were asking too many personal questions, might suggest that the couple had something to hide. However, Mary and Henry's self-reliance, their unwillingness to let strangers into their home, and a fierce protection of their privacy is not uncommon for older people living in rural areas.

10.6 The Commission for Rural Communities (Manthorpe, Stevens, 2008) emphasised the difference in need between older people who have been born and brought up in small communities, as opposed to those who have moved into rural areas following retirement. Both Mary and Henry were born and raised in small communities. Older people from rural areas interviewed as part of this study (Manthorpe, Stevens, 2008) 'raised issues around confidentiality that they thought concerned many older people living in rural areas.'

10.7 Quotes from different interviews for this study included: '*Small communities tend to know everything.' 'There is a lack of confidentiality in the countryside.' 'The lack of anonymity in rural areas and especially villages means that there will be the potential for loss of privacy.' 'Familiarity breeds contempt; some people gossip, others find this disdainful, and people who are frail do not like neighbours knowing that they cannot cope or have problems.'* These views mirror those described by family and friends of Mary and Henry. It is therefore important to consider this review within that context, understanding the culture of rural life and that of an older generation.

10.8 Although this review has no grounds to suspect that Mary experienced domestic abuse from Henry prior to the fatal stabbing, professional curiosity in examining the lessons learnt prompted the DHR Panel to look more widely at older women living in rural areas and domestic abuse.

10.9 Research shows that domestic abuse is under reported for older people. Benbow *et al* (2018) report that few domestic homicide reviews of older people identified a history of domestic abuse. This may be because older people do not recognise the behaviours of spouse or children as domestic abuse. An older generation tolerate what now might be considered as coercion and control, domestic abuse, violence or rape within a marriage, as historically society has considered this to be a private matter.

10.10 Research shows that domestic homicide almost never occurs out of the blue, there is almost always a history of domestic abuse (Bows 2018). However, older people are unlikely to raise concerns about domestic abuse or ageist stereotypes, and narrow understandings of domestic abuse mean older people are often over-looked (Bows 2018).

10.11 In a study by McGarry *et al* (2011) on domestic abuse and older women, participants spoke of how historically the home was perceived as private and '*what went on there was behind closed doors*.' Study participants also felt a sense of shame or embarrassment and as such kept their experiences 'hidden' from family, friends and neighbours.

10.12 This is further expounded when older women live in a rural community, as described by Few (2005). '*Aging women living with violence may be even more invisible in rural communities where geographic isolation, economic constraints, strong cultural and social pressures, and lack of available services significantly compound the problems that they may confront when seeking support and services to end violence*.'

10.13 An interesting observation is made by Seaver (1996) that '*older women whose husbands are dependent upon them for physical care may be even more reluctant to leave an abusive relationship*.'

10.14 Whilst there is no conclusive evidence to suggest that Mary experienced domestic violence or abuse at any time in her relationship with Henry prior to her murder, it does raise questions as to whether Mary would have felt able to disclose her concerns given her cultural environment. Family and friends describe elements of the couple's behaviour within their relationship that relate to traditional gender roles not uncommon in older people, but are now understood to be indicative of a level of coercion and control. The learning from this review will consider how older women in rural areas might be reached in a way that would be acceptable to them, to reduce the risk of harm by a spouse with dementia or other mental or physical illness.

PART THREE – ANALYSIS

The analysis discusses the key issues arising from the review:

- Support for Mary as Henry's carer.
- Diagnosis of dementia and interventions
- Sharing of information.

It also highlights good practice.

11.0 Support for Mary as Henry's carer.

11.1 Mary's family believe that had she accepted professional help in caring for Henry then the fatal stabbing may have been prevented as professionals would have identified the increasing risk to Mary.

11.2 However, the GP had regular contact with the couple and despite careful monitoring could not have predicted Henry's sudden violent attack upon Mary. The GP saw Mary in the surgery without Henry on 7th August 2018 and encouraged her to accept support in caring for her husband. The GP suggested referral to an Admiral nurse, but Mary declined. Admiral nurses are registered nurses specialising in dementia. They work holistically with families addressing the needs of the person with dementia as well as the needs of the family (carers).

11.3 Mary and Henry had always been self-sufficient as a couple. The pen picture describes how Henry turned what was an old cottage into a comfortable home, even making the stairs in their cottage. The family lived off produce from Henry's hunting and fishing activity, as well as vegetables from a large garden plot and foraging for fruit. When Mary and Henry moved from their cottage into sheltered housing, they transported their furniture and property themselves. This self-reliance was integral to Mary and Henry, it was how they lived their lives together. So, when Henry became increasingly dependent as a result of severe back pain and osteoarthritis, the couple continued to manage the situation without looking for, or accepting, any support or help. Henry's brother explained that people living in small villages do not expect or want support services. Mary's own mother would not accept care and support from statutory services towards the end of her life and so Mary's sister provided her care.

11.4 In addition to being self-sufficient the couple were very private. They did not welcome strangers into their home. Family and friends stress that the couple would not have agreed to have anyone else come into the home to provide care for Henry. Henry had particularly strong views on this and Mary saw caring for Henry as her priority and her main role in life. Her daughter quotes her mother as saying, *'He's taking all of my time,'* and *'He's my priority and the dog.'*

11.5 The social housing provider contacted the couple by telephone once a week. Henry's brother remembers that Henry welcomed and valued this contact. However, the couple did not make any demands or request anything from their

social housing provider in terms of support. The social housing provider agreed support plans with Henry and Mary and updated these annually. The support plans ask whether the tenant requires assistance with: Living safely. Everyday tasks, social and leisure contacts, physical health and mobility, emotional well-being, finance and communication. Neither Henry nor Mary's support plans indicated that they would like any assistance.

11.6 Mary and Henry attended a luncheon club once a week organised by their social housing provider. Henry received Attendance allowance and Mary a Carer's allowance. They did not want any further help.

11.7 This reluctance to accept help may have changed in September 2018 when a police officer was called to an incident regarding Henry's claim that he had been robbed. The police officer recorded on the police system ATHENA, '*Mary is Henry's only carer and appears to be struggling slightly, she states she is finding it harder to cope. Henry seemed quite upset and frustrated about his dementia. I have suggested Mary go back to her doctor and ask for help looking after Henry.'*

11.8 It is possible that Mary might have been open to some help in caring for Henry at this stage and she may have taken the police officer's advice and gone back to her GP, had she not been murdered the following day.

11.9 The services that had contact with the couple offered support to Mary in her role as a carer. The GP practice monitored the situation and kept the lines of communication open through consultations in the surgery, telephone conversations and two home visits on 24th February 2016 and 11th July 2018. It is clear from the GP's records that the couple had an on-going dialogue with their GP regarding Henry's physical and mental health.

11.10 Although Mary and Henry were not open to accepting services and help, they did value and trust the care and support provided by their GP practice and their social housing provider. These were the only two organisations who had regular contact with the couple and could have potentially introduced information and/or services that they might have accepted. However, given the couple's reluctance to accept help or have anyone other than close family in their home, an innovative personalised approach would have been required.

11.11 There was nothing more professionals could have done at that time, however there is some learning on how services might be planned and shaped differently to reach others like Mary and Henry living in small villages.

11.12 In many rural areas Village Agents act as local contact points for older people, providing information and support. Village Agents are local people within villages employed to work part-time as a trusted community member and resource for local people. They signpost and enable access to a range of services (LinkAge Plus 2013). However, different villages will need different approaches and it is important to involve local people in planning what would work best in their community.

11.13 Manthorpe and Stevens (2008) suggest Individual Budgets and personal budgets would give control and independence to the older person in planning support that could make a difference to their quality of life, by addressing what is important to them. *'The more flexible the money is, the more people will be able to cope in rural areas'* (Manthorpe Stevens, 2008). However, people in rural areas would need support to make use of this opportunity.

11.14 In Norfolk, Social Prescribing is being piloted in five localities. Social prescribing was introduced in October 2014 in the NHS *Five Year Forward View.* It enables GPs, nurses and other primary care professionals to refer people to a range of non-clinical services as a preventative approach improving wellbeing. In Norfolk the service consists of staff members known as 'connectors' who work within the Voluntary, Community and Social Enterprise sector or District Councils and receive referrals from primary care. Connectors then work with individuals to understand what matters to them, to identify strengths and existing resources, and facilitate access to services and activities to improve health and well-being. Individuals are encouraged to be self-managing in organising support. This service could potentially provide an ideal opportunity to reach older women living in rural areas who are experiencing domestic abuse, or those who are at risk of domestic abuse in their role as carer.

11.15 The GP offered Mary the support of an Admiral Nurse, although she declined. There are two funded Admiral nurses in the couple's local authority area.

11.16 A recent evaluation (Norfolk and Suffolk Community Care Research Office, 2018) found that the Central Norfolk Admiral Nurse service plays a key role in supporting carers of people with dementia. Carer's quality of life improved, needs when assessed were met and both carers and health professionals valued the support provided by the service. This evaluation has informed the Norfolk and Waveney Sustainability Transformation Partnership review of how dementia services and support across Norfolk and Waveney could be improved.

11.17 NICE Guideline NG97 (June 2018), 1.3 Care coordination (1.3.1) states: *Provide people living with dementia with a single named health or social care professional who is responsible for coordinating their care.* Henry had not had his diagnosis confirmed at the time of Mary's murder. It is possible that the GP, or another member of the primary care team, might have taken on the role of coordinator, following diagnosis. However, the continuity of a trusted professional who can provide ongoing support to the person living with dementia and their family is important. Not all communities in Norfolk will have a consistent GP however the Norfolk and Waveney Sustainability and Transformation Partnership (STP) have prioritised the recruitment and retention of the health workforce across the county.

11.18 Norfolk County Council's Information & Advice services for adults are being reviewed with a focus on creating an integrated and holistic advice and support service for people living with dementia and their carers.

12.0 Diagnosis of dementia and interventions

12.1 The GP, Norfolk and Suffolk NHS Foundation Trust and Norfolk and Norwich University Hospitals Trust worked together, in line with NICE guideline NG97 1.2 (June 2018), in diagnosing Henry's dementia. There were two key episodes in the chronology of events when Henry's memory problems were investigated: Key episode one – memory problems first raised and Key episode four – Diagnostic process for Lewy Body Dementia.

12.2 Each of these episodes is reviewed against NICE guidance.

Table 1 below shows actions against NICE guideline NG97 when Henry's memory problems were first raised.

Table 1 Actions against NICE guideline NG97 when memory problems were first raised.

Date	Org.	Action	NICE Guideline	Comment
30/7/14	GP	Henry raised concerns about his memory. Blood tests and a Test your memory (TYM) test arranged.	1.2.1 At the initial assessment take a history and the impact the symptoms have on their daily life. Talk to someone who knows the person well. Take appropriate blood and urine tests to exclude reversible causes of cognitive decline and use a validated brief structured cognitive instrument such as … (includes TYM).	From the outset, GPs at the Practice talked to Henry and Mary about the impact Henry's symptoms were having on his life. Appropriate investigations were carried out in line with NICE guidance to exclude reversible causes of cognitive decline e.g. urine infection, vitamin B deficiency.
05/08/14	GP	The TYM score showed a slightly reduced memory score. The couple agreed to monitor Henry's memory and contact the GP if symptoms worsened.	1.2.4 Do not rule out dementia solely because the person has a normal score on a cognitive instrument. Take a history from someone who knows the person well and consider referral to a specialist diagnostic service.	Although the results only showed a slight decline in memory, the GP kept the lines of communication open, for an ongoing discussion as the couple monitored symptoms.
28/8/14	GP	Having excluded reversible causes of dementia the GP referred to the Memory Clinic as the first step towards a diagnosis, given the diagnostic uncertainty.	1.2.6 Refer the person to a specialist dementia diagnostic service (such as a memory clinic…) if reversible causes of cognitive decline have been investigated and dementia is still suspected.	The GP made a timely and appropriate referral to the Memory Clinic. Early detection of dementia can have a significant impact on outcome through medication and cognitive stimulation therapy.
19/9/14	NSFT	Henry was seen in the Memory Clinic with Mary. He performed well in the memory test but complained of a low mood and anxiety attributed to his loss of physical independence. The assessor felt his problems were due to his mood and suggested considering anti-depressants (these were not prescribed). A diagnosis of mild cognitive impairment.	1.7.11 For people living with mild to moderate dementia who have mild to moderate depression and/or anxiety, consider psychological treatments. 1.7.12 Do not routinely offer anti-depressants (for these patients) unless they are indicated for a pre-existing severe mental health problem.	Henry had experienced several losses in his life (see below). Anti-depressants were offered to Henry by his GP, but Henry declined at that time. It was agreed to revisit at a later date. Henry may have benefitted from psychological interventions, such as talking therapies, if he had been open to these. However, it is highly unlikely given his reluctance to discuss personal matters.

12.3 When Henry raised concerns regarding his memory with his GP, the GP followed NICE guidance in investigating the cause of Henry's memory problems. The Memory Clinic diagnosed a mild cognitive impairment as a result of anxiety and depression. Henry was depressed as a result of his loss of independence due to physical disability. Although anti-depressants were suggested they were not prescribed by the memory service or the GP at this time. The GP discussed the use of anti-depressants with Henry, but Henry declined, and a note was made by the GP to revisit this intervention with Henry at a later date.

12.4 Henry had experienced several losses;

- His working life and role of provider when he retired in his forties as a result of back pain.
- He gave up his motorbike and sidecar and had to depend on Mary as a driver.
- His guns. Hunting was an important part of his life.
- The cottage that he had renovated.
- His vegetable plot.
- The hobbies and activities that he enjoyed.
- The death of his beloved dogs.

12.5 Talking therapy or other psychological interventions may have helped Henry to adjust to these losses and find a new purpose in life. However, it is unlikely that he would have accepted psychological support any more than he would have welcomed practical help outside of the family.

Table 2 below shows actions against NICE guideline NG97 in the diagnostic process for Lewy Body dementia.

Table 2 Actions against NICE guideline NG97 in the diagnostic process for Lewy Body Dementia.

Date	Org.	Action	NICE Guideline	Comment
18/4/18	GP	Memory worse. Parkinsonian features and hallucinations. An appointment was booked for a memory test (Test Your Memory – TYM).	2.1 At the initial assessment take a history and the impact the symptoms have on their daily life. Talk to someone who knows the person well. …. Use a validated brief structured cognitive instrument such as … (includes TYM).	The GPs at the practice invested time in talking to Henry and Mary to understand what they were experiencing and the impact that this was having on their lives. This enabled the GP to respond quickly when there was a decline in memory.
25/4/18	GP	The memory test this time showed a decline in memory from 42 in 2014 to 36. A referral had already been made to the Memory Clinic and was confirmed.	1.2.6 Refer the person to a specialist dementia diagnostic service (such as a memory clinic…) if reversible causes of cognitive decline have been investigated and dementia is still suspected.	This second referral to the Memory Clinic was four years on from the first. The earlier test enabled the GP to note the degree of decline over four years.
1/5/18	NSFT	A referral was sent by the GP to the specialist dementia diagnostic service. The symptoms described by the GP suggested Lewy Body Dementia. A routine referral appointment was made (28 days).		The presentation of the condition was complex and so the GP referred to a specialist. The Lewy Body Society recommend that referral is made to an experienced specialist for diagnosis, given the complexity of this condition.
8/5/18	NSFT	The referral was declined by the consultant for the specialist dementia diagnostic service, instead requesting a review first by neurology or older people's medicine to check for Parkinson's disease.	1.2.9 Diagnose a dementia subtype (if possible) if initial specialist assessment (including an appropriate neurological examination and cognitive testing) confirms cognitive decline and reversible causes have been ruled out.	Referral first to the acute trust's older people's medicine to rule out Parkinson's disease was appropriate and in keeping with NICE guidance.
3/7/18	NSFT	Seen in Movement Disorder Clinic. Consultant referred back for further assessment for Lewy Body Dementia, having established mild Parkinsonism. Booked to have an		Rivastigmine is a medication for people with mild to moderate Lewy Body Dementia. The referral back to the community psychiatric team was not received initially and so

Date	Org.	Action	NICE Guideline	Comment
		out-patient MRI brain scan and the Consultant suggested a trial on Rivastigmine.		there was a delay in the prescribing of this medication.
23/8/18	GP	A report from the Movement Disorder Clinic showed the results of an MRI scan. Global atrophy (shrinkage) of the brain and a single micro haemorrhage. No change in management was suggested.		
17/9/18	NSFT	Routine referral for Memory Clinic (28 days). An allocation was made to a worker, but no appointment made at this time.		This was in keeping with NSFT policy.

12.6 The diagnostic process took time as the initial referral to the Memory Clinic was declined and a referral made to the Movement Disorder Clinic to assess for Parkinson's disease as the symptoms are similar to Lewy Body Dementia. This is in keeping with NICE guideline 1.2.9 as above. The Lewy Body Society say 'Diagnosis of Lewy Body Dementia can be difficult and requires an experienced specialist e.g. in old age psychiatry or neurology. Accurate diagnosis is essential for successful treatment.' This is precisely what the consultant in the specialist diagnostic service for dementia did on 8th May 2018.

12.7 On both occasions (for this key episode) when the referral was triaged by the specialist diagnostic service for dementia it was considered a routine referral with an expected wait of 28 days. There was nothing to indicate that the referral was more urgent.

12.8 The GP was asked by the DHR Panel what would have changed had Henry had an earlier diagnosis of Lewy Body Dementia. The GP said, *'Specific medication would have been prescribed, as well as a nursing support package (subject to the family's acceptance of diagnosis).'*

12.9 The time period from concerns being raised by the family to the date of a diagnosis was four months. At the time of Mary's death an appointment date had not yet been confirmed. The triaging of these referrals was in keeping with NSFT policy.

Pharmacological management

12.10 The following entries report medication prescribed for Henry's anxiety and later, for Lewy Body Dementia.

15th March 2016 – Henry's mobility had improved with sleep and the Diazepam was stopped, as per NICE guidelines.

12.11 NICE Guidelines recommend that Diazepam is prescribed for short term relief of anxiety and to avoid prolonged use.

30th June 2016 – Henry saw the GP as he wondered whether his prescribed medicine was causing him to become disorientated. Shortly after taking a second dose of Finasteride Henry was disorientated in place. This episode was witnessed by Mary and lasted around ten minutes. An examination by the GP ruled out a TIA (Transient Ischaemic Attack). The GP discontinued the Finasteride, although he did not think that this was the cause of Henry's disorientation. Henry came to the same conclusion and phoned the GP later that day to say that it was probably due to him standing up too quickly. The Finasteride was restarted.

15th January 2018 – Henry attended the GP surgery in a tearful and anxious state. He was concerned that his memory was getting worse and that he was becoming more dependent on his wife. An anti-depressant medication, Escitalopram (5mg) was prescribed.

31st January 2018 – Henry phoned the surgery as he was having more vivid dreams and hallucinations. Escitalopram medication was stopped as the dreams and hallucinations seemed to coincide with the initiation of this medication. Lorazepam was prescribed for Henry's anxiety.

12.12 Escitalopram treats generalised anxiety disorder. Lorazepam is for short term use in insomnia associated with anxiety.

3rd July 2018 Seen in Movement Disorder Clinic. Consultant referred back for further assessment for Lewy Body Dementia, having established mild Parkinsonism. He had been booked to have an out-patient MRI brain and the Consultant suggested a trial on Rivastigmine.

12.13 Rivastigmine should be given to people with mild to moderate dementia with Lewy bodies (NICE guideline). It is unfortunate that Henry did not get the opportunity to benefit from this medication prior to the fatal stabbing, due to the fax sent on 27th July not being received until 17th September.

12.14 The same NICE guideline states that, 'In patients who have dementia with Lewy bodies or Parkinson's disease dementia, antipsychotic drugs can worsen the motor features of the condition, and in some cases cause severe antipsychotic sensitivity reactions.' Henry was not prescribed antipsychotic drugs.

12.15 All medication prescribed was in line with NICE guidance. The GP followed up and reviewed medication as appropriate.

13.0 Sharing of information

13.1 The exchange of information between the GP, Norfolk and Suffolk NHS Foundation Trust (NSFT) and the Norwich and Norfolk University Hospitals NHS Trust (NNUH) was generally good. The chronology describes timely and robust correspondence between clinicians.

13.2 The only exception to this is a discrepancy in relation to a fax sent on the 17th September 2018 to the NSFT from the NNUH on the clinical outcome and referral letter(s) following an appointment with the Movement and Disorder clinic at the acute hospital in July 2018. The chronology says that a letter was sent to the community psychiatric team on 27th July 2018 with this information, but there is no evidence that a fax was received by the mental health trust from the acute hospital any earlier than 17th September 2018.

13.3 The NSFT IMR writer investigated this, as did the NNUH IMR writer. It was concluded through discussion at the May DHR Panel meeting that it could be due to an error in data entry or just an oversight. However, the missing fax resulted in a delay of 7 weeks. Prompt receipt of this referral could have sped up the diagnostic process and led to a timelier intervention. Opportunities for shared diagnostic clinics across the mental health and acute trusts were discussed by the DHR Panel. Also, the need for electronic records rather than fax for sharing information across trusts. This is discussed further in lessons learned.

14.0 Good Practice

14.1 This review identified notable practice. The examples given may be what should be expected of organisations, however they have been noted here to underline the positive benefits, so that good practice is reinforced across the County. They have been grouped under the following headings, in line with Norfolk's thematic learning framework:

- Professional Curiosity
- Information Sharing and Fora for Discussion
- Collaborative Working, Decision Making and Planning
- Ownership, Accountability and Management Grip

Professional curiosity

14.2 The couple's social housing provider systematically check for triggers of domestic abuse, for example, damage to the property.

14.3 Their sheltered housing service make regular calls at a time that suits the person to keep in touch with their changing needs and be of service if required.

14.4 The GP considered the impact of Henry's increasing dependence on Mary and discussed her emotional needs with her.

14.5 The police officer who attended the incident for safe keeping of Henry's money asked Henry and Mary the right questions and raised safeguarding concerns appropriately.

14.6 The Mental Health Trust's initial assessment at the Memory Clinic considered Henry and Mary's needs as a couple.

Information Sharing and Fora for Discussion

14.7 The GP practice held an internal meeting in preparation for this review to discuss the case and identify any learning.

14.8 The flow of information between the GP and hospital consultants was timely and informative, with comprehensive letters explaining medical investigations, outcomes and recommendations.

Collaborative Working, Decision Making and Planning

14.9 The social housing provider carry out comprehensive annual reviews for all of their sheltered housing tenants and agree support plans.

14.10 The social housing provider uses a risk assessment framework when considering whether tenants are at risk of domestic violence, abuse or neglect.

14.11 The Medical Practice engaged fully and meaningfully in the DHR process. They provide a consistent approach to their patient population as a trusted GP.

14.12 The GP, mental health trust and acute hospital trust worked together in line with NICE guidance in diagnosing and managing Henry's dementia.

14.13 The police officer who attended the incident for safe keeping of Henry's money, wore a body camera to record their actions.

14.14 When Henry attended the Movement Disorder Clinic he was seen by an occupational therapist and physiotherapist on the same day. Consideration was given to both Henry and Mary's needs and they were shown balance exercises for Henry together.

Ownership, Accountability and Management Grip

14.15 Safeguarding is high on the social housing provider's agenda. They have champions for domestic abuse and safeguarding adults to support the workforce.

14.16 The social housing provider offers the same level of support to their general housing stock as thirty eight percent of these tenants are over sixty years of age.

14.17 Norfolk housing providers have signed up to the Chartered Society of Housing, *Make a Stand Initiative*, to address domestic abuse in housing authorities.

14.18 The police provide a debriefing to all officers involved in a violent incident such as this one and provide emotional support.

14.19 The Norfolk Safeguarding Adults Board has representation from the housing sector in all of the Board's subgroups.

PART FOUR – CONCLUSIONS

15.0 Conclusion

15.1 There is no conclusive evidence to suggest that Mary experienced domestic violence or abuse at any time in her relationship with Henry prior to her murder. However, family and friends describe elements of the couple's behaviour within their relationship that relate to traditional gender roles not uncommon in older people but are now understood to be indicative of a level of coercion and control. Mary did not have a close friend which increased her isolation.

15.2 Mary and Henry were a self-sufficient couple, wary of strangers and very private. Research tells us that this outlook is not uncommon in rural areas. When Henry became unwell with what was believed to be Lewy Body Dementia, Mary was at risk from changes in his behaviour. This could not have been anticipated by professionals, but with hindsight, Mary might have been better able to manage the situation and protect herself, if she had a coping strategy. Norfolk has many rural communities where older people are caring for loved ones living with dementia. Innovative ways need to be found to reach people who might be in a similar situation to Mary.

15.3 There are opportunities for Norfolk to further develop the Community Connectors approach, social prescribing and information and advice, using best practice to promote engagement with older people living in rural areas who might be resistant to traditional services. Working with organisations that have built a trusting relationship with people, such as housing associations and community and voluntary organisations, as well as using older individuals with lived experience to help train community connectors, could make these services more accessible to this group of people.

15.4 In general, organisations worked well together, sharing information in a timely and robust way. There are many examples of good practice, including the way health professionals met the NICE guidelines in the diagnostic process and treatment of Henry's symptoms. However, a smoother pathway for diagnosing dementia could be achieved, if there was a more integrated approach across the acute and mental health hospital trusts. Integrated physical and mental health clinics and electronic referrals could improve efficiency and outcomes for the patient.

16.0 Lessons learnt

16.1 In addition to the good practice outlined in section 14.0 which should be taken up across the County if not already common practice, the DHR Panel identified areas of learning to improve outcomes for people living with dementia and their carers. These too have been grouped under the Norfolk thematic learning framework.

Professional curiosity

16.2 Norfolk County Council, Norfolk and Waveney CCGs and partners are working together to raise public awareness of dementia. These initiatives will continue with the aim of promoting early diagnosis and appropriate interventions.

- GPs in Norfolk are working to raise the awareness of dementia in their health checks. GPs currently reach approximately 24,000 40-74-year-olds per year with all those aged 60-74 receiving a specific dementia leaflet.
- The Healthy Aging campaign within Public Health includes raising the awareness of dementia.
- Information on dementia is included on the Norfolk County Council website.
- The Alzheimer's Society raises the awareness of dementia through Dementia Friends training and awareness raising events.

16.3 Mary did not, at any time give any indication that she was experiencing domestic abuse or coercion and control. There was no reason for professional staff to delve deeper and it is likely that any probing would have alienated the couple from those services that they trusted. However, this review has highlighted the need to explore how older people living in rural areas can be reached in a way that is acceptable and meaningful for them.

16.4 Norfolk County Council is working in partnership with districts and health providers across Norfolk to improve the accessibility and reach of services to support people more appropriately, including those living in rural areas. This is being achieved through a Social Prescribing approach. Social Prescribing, sometimes referred to as "community referral", is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. This recognises that people's health is determined by a range of social, emotional and practical issues, so Social Prescribing seeks to address people's needs in a more holistic way. In the couple's local authority area, Community Connectors are now working from all GP surgeries as the link workers to deliver social prescribing, working with people to help them access local sources of support.

16.5 This personalised approach is ideal for reaching older people living in rural areas and people who experience domestic violence. Social Isolation/Life Connectors on this programme have already reached people experiencing domestic violence and worked with them, to enable them to achieve the outcomes that they want in a way that is acceptable and meaningful to them.

16.6 The above initiatives are commendable, and it is recommended that they continue to develop. However, when an informal/family carer is caring for a loved one with challenging behaviours they need additional help and support to enable them to manage potentially dangerous situations, as this case highlighted.

16.7 Recommendation:

- Norfolk County Council Adult Social Care and Norfolk and Suffolk Foundation Trust to work with carers and their families to empower them by providing guidance on how to stay safe and keep patients safe, plan for emergency situations, de-escalation techniques and the provision of resources.

Information sharing and fora for discussion

16.8 The exchange of information between agencies was generally good, with one exception, that was the fax sent from the acute hospital to the mental health trust on 27th July which was not received until 17th September. This missing fax resulted in a delay of seven weeks. Prompt receipt of this referral is likely to have sped up the diagnostic process and led to more timely intervention. The diagnostic process in ruling out Parkinson's disease or another neurological condition before further testing for dementia involved referral and reporting systems across two different health trusts.

16.9 Henry surrendered his guns, when his physical disability meant that he was no longer able to use them. Whilst some GPs raise the issue of holding a firearms licence with their patients, when there is a risk that they maybe a danger to themselves or others, this is not done systematically by all GPs.

16.10 Henry and Mary had a good relationship with their trusted GP. Not all communities have access to a consistent GP, but primary and secondary care services are encouraged to refer on to appropriate services for information, support and advice soon after diagnosis, if this is acceptable to the person and their family.

16.11 Recommendations:

- Norwich and Norfolk University Hospitals Trust and Norfolk and Suffolk Foundation Trust to explore how to provide a smoother diagnostic pathway for people with dementia, considering the integration of physical and mental health clinics.
- Norwich and Norfolk University Hospitals Trust and Norfolk and Suffolk Foundation Trust to explore how best to share information instantly in a reliable way, considering the use of electronic referrals and implement an effective system.
- Norfolk and Waveney Clinical Commissioning Groups, alongside the police, to develop and implement a systematic process for GPs to flag patients who are at risk of misusing firearms in a way that presents a danger to themselves and/or others and to take appropriate action in advising that a firearms licence should be terminated.

Collaborative working, decision making and planning

16.12 There were many examples of good practice where organisations worked well together in supporting Mary and Henry within the parameters of what was acceptable to them and in the diagnosis and treatment of Henry's symptoms.

16.13 The social housing provider played an important role in supporting Mary and Henry and did so in a professional way reflecting the organisation's culture of safeguarding and domestic abuse awareness. They also recognised that further dementia care training was required for their staff and are addressing this.

16.14 The housing sector makes an important contribution to safeguarding adults, as highlighted in this DHR. The Norfolk Safeguarding Adults Board is reviewing how this sector can have the most impact on the Board and in safeguarding adult processes.

16.15 Mary and Henry had the continuity of a trusted professional in their GP, however other people living with dementia and their carers may not have this point of contact. Following the positive evaluation of the Admiral nursing service, the Norfolk and Waveney Sustainability Transformation Partnership should consider how this service or another model that provides trusted continuity of support to people living with dementia and their families can be rolled out across Norfolk and Waveney, in line with NICE guidance and the recommendations of the National Dementia strategy (2009).

16.16 Recommendations:

- The social housing provider to provide dementia training for their staff, and District Councils for all Community Connectors.
- The Norfolk Safeguarding Adult Board to improve engagement with the housing sector, and develop an effective model of practice for domestic abuse safeguarding processes
- The Norfolk and Waveney Clinical Commissioning Group to take a lead from the Norfolk and Waveney Sustainability Transformation Partnership in planning continuity of trusted support to people living with dementia and their carers, in line with NICE guidance, for example Admiral nurses.

17.0 Recommendations

17.1 Norfolk County Council and Norfolk and Suffolk Foundation Trust to work with carers and their families to empower them by: providing guidance on how to stay safe and keep patients safe, plan for emergency situations, de-escalation techniques and the provision of resources

17.2 Norwich and Norfolk University Hospitals Trust and Norfolk and Suffolk Foundation Trust to explore how to provide a smoother diagnostic pathway for people with dementia, considering the integration of physical and mental health clinics.

17.3 Norwich and Norfolk University Hospitals Trust and Norfolk and Suffolk Foundation Trust to explore how best to share information instantly in a reliable

way, considering the use of electronic referrals and implement an effective system.

17.4 Norfolk and Waveney Clinical Commissioning Groups, alongside the police, to develop and implement a systematic process for GPs to flag patients who are at risk of misusing firearms in a way that presents a danger to themselves and/or others and to take appropriate action in advising that a firearms licence should be terminated and social landlords informed.

17.5 All housing sector providers to provide dementia training for their frontline staff.

17.6 To ensure all Community Connectors across the Council are trained in dementia.

17.7 The Norfolk Safeguarding Adult Board to improve engagement with the housing sector, and develop an effective model of practice for domestic abuse safeguarding processes

17.8 The Norfolk and Waveney Clinical Commissioning Group to take a lead from the Norfolk and Waveney Sustainability Transformation Partnership in planning continuity of trusted support to people living with dementia and their carers, in line with NICE guidance, for example Admiral nurses.

Recommendations for the Home Office.

17.9 Section two, point 5 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016) states: 'This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act). The Act states:

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

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

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

17.10 This statutory guidance does not take into consideration when the person who has committed the violence is not of sound mind and the victim has not been subjected to domestic abuse. In these circumstances, a domestic homicide review may not contribute to learning on the prevention of domestic abuse and is likely to cause additional distress to a family. Whilst there will always be some learning, these cases could benefit from a lighter touch approach.

17.11 Section eight of the Statutory Guidance (81) states: *All overview reports and executive summaries should be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the*

review for this not to happen. And *The content of the overview report and executive summary must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998.* As explained in this report, it is challenging to anonymise a case in a small rural community, particularly when the story has been shared through the media. It would be impossible for a Domestic Homicide Report to remain anonymous as the story would be known to local people and would attract local interest.

Recommendation:

17.12 The Home Office to consider whether the methodology for a DHR could be modified for a more proportionate review, when the perpetrator is not of sound mind and the victim has not experienced domestic abuse.

17.3 The Home Office considers how to protect the anonymity of the DHR report for small rural communities.

References

Benbow, S. M., Bhattacharyya, S., & Kingston, P. (2018). *Older adults and violence: An analysis of domestic homicide reviews in England involving adults over 60 years of age.* Ageing & Society. doi:10.1017/S0144686X17001386

Bows H. (2018) *Domestic Homicide of Older People (2010-15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK,* British Journal of Social Work (2018) 0, 1-20, Oxford Press

Department of Health and Social Care (2009) *Living Well with Dementia: a national dementia strategy*

Few, A.L. (2005) *The voices of Black and White rural battered women in domestic violence shelters.* Family Relations, 54, pp 488-500

Home Office (2016) *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide reviews,* London

Lewy Body Society https://www.lewybody.org (accessed 7/5/2019)

Link Age Plus, (2013) *Gloucestershire Village Agents,* Department for Work and Pensions. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/186841/gloucs-village-agents.pdf (accessed 15/5/2018)

Manthorpe, J., Stevens, M., (2008), *Tackling Rural Disadvantage: The personalisation of adult social care in rural areas,* Commission for Rural Communities

McGarry, J. and Simpson, C (2011). *Domestic abuse and older women: exploring the opportunities for service development and care delivery.* The Journal of Adult Protection Vol 13 No 6

NHS England (2014) *Five Year Forward View,* London

NICE Guideline NG97 (June 2018) *Dementia: assessment, management and support for people living with dementia and their carers,* NICE https://www.nice.org.uk/guidance/ (accessed 15/5/2018)

Norfolk and Suffolk Primary and Community Care Research Office (2018) Admiral Nurse Service Evaluation. https://nspccro.nihr.ac.uk/evaluation/evaluation-of-the-admiral-nurse-service

Norfolk Community Partnership Safety Partnership (NCCSP) V 5.0 (2019) *Domestic Homicide Review Protocol,* Norfolk County Council.

Seaver, C. (1996) *Muted lives: Older battered women,* Journal of Elder Abuse and Neglect, 2(8), 3-21.

Other reading

Teaster, P., Roberto, K. and Dugar, T. (2006) *Intimate Partner Violence of Rural Aging Women* Journal of Family Relations, 55, 5, 636-648 (December 2006).

National Rural Crime Network, (2019) *Capture and controlled,* an 18-month intensive research project on domestic abuse in rural areas, presented to parliament. July 2019

Glossary

Athena	Project Athena is a framework agreement for police IT systems to enable data sharing between forces
CCG	Clinical Commissioning Group
DHR	Domestic Homicide Review
GP	General Practitioner
IMR	Individual Management Review – this is a review undertaken by an organisation to look at their interaction with the victim or perpetrator and identify good practice or lessons learned
NCCSP	Norfolk County Community Safety Partnership – this is a statutory partnership comprising agencies serving the county and is responsible for community safety within the county
NNUH	Norfolk and Norwich University Hospital
SAR	Safeguarding Adult Review
SI	Serious Incident

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Appendix – Home Office QA Panel Letter

Home Office

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Jon Shalom
Norfolk County Community Safety Partnership (CCSP)
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15 October 2020

Dear Jon Shalom,

Thank you for submitting the Domestic Homicide Review (DHR) report (Mary) for South Norfolk Community Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 22 July therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agree the feedback.

The QA Panel found this to be a well-structured, easy to follow report. The Panel found that the expression of condolences and thanks to family and friends who contributed, together with the detailed pen portraits of the victim and perpetrator, meant that the reader is vividly invited to consider the tragic events within the context of two lives. The report highlights a significant amount of good practice without seeming defensive and without losing a probing stance. There is a good use of research within the report to explain that how living and growing up in a rural area shapes someone's experiences especially when accessing services.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that, on completion of these changes, the DHR may be published. The QA Panel took the chair's views regarding publication into account and would like the review to be published in full. There is key system-wide learning in this review and a clear public interest. Furthermore, the Panel felt that there is little in the report which has not already been published in the media.

We would be grateful if you could provide us with a finalised digital copy of the reports with attachments and the weblink to the site where the report will be published.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records, for future analysis towards highlighting best practice, and to inform public policy.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other

colleagues, for the considerable work that you have put into this review.

Yours sincerely

Mahala Barker
DHR Quality Assurance Secretariat