Domestic Homicide Review
Bridget/2017
Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

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Bridget White

Purpose

The key purpose of a Domestic Homicide Review (DHR) is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) 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;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

Scope

This DHR examines the contact and involvement that organisations had with Bridget White between 1st January 2010 and 27th April 2017.

In order to meet its purpose, this DHR also examines the contact and involvement that organisations had with her husband Michael White.

Terms of Reference

The terms of reference for the DHR are set out in *Appendix A* to this report.

Timescales

This review began on 10th October 2017 following the decision made by the Core Group panel members that the case met the criteria for conducting a DHR. The review was commissioned by the Chair of the Kent Community Safety Partnership on 10th October 2017.

Police Officers responded as the result of a call from a neighbour to the home of Michael and Bridget White in April 2017. Upon attending they found Bridget deceased in her bed.

Michael was beside her with injuries to his abdomen/chest. Later that day Michael told hospital staff and Police that he had killed Bridget at her request, and that he had intended to kill himself. Michael was arrested on suspicion of Bridget's murder. Michael was interviewed and bailed to allow the Crown Prosecution Service (CPS) to make a decision as to whether charges against him should follow. Due to the possibility of a trial and following a discussion with the Senior Investigating Officer (SIO), it was agreed that this review would be suspended pending the decision by the CPS and the outcome of any trial. In February 2018 a decision was made by the CPS to summons Michael to Magistrates Court to be charged with Murder and for the case to be heard at Crown Court. At the end of March 2018 Michael took his own life before any court proceedings had taken place. Due to the impact that these events had upon the family and friends of Michael and Bridget, it was decided that a further period of time be given before recommencing the review.

On the 7th July 2018 the review was resumed.

Terms of Reference

1. Methodology

1.1 This Overview Report is an anthology of information gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Bridget White and/or Michael White between 1st January 2010 and Bridget's death. The timescale includes a record of a suicide attempt by Michael White and the involvement of services in supporting and assisting in treatment for both him and Bridget White. However, they had been married for 55 years and as such, further scrutiny or revision was kept in mind if further information came to light.

1.2 The report also addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) as prescribed within the public sector Equalities Act duties and considered if they were relevant to any aspect of this review. The review considers whether access to services or the delivery of services were impacted upon by such issues, and if any adverse inference could be drawn from the negligence of services towards persons to whom the characteristics were relevant.

1.3 A letter was sent to senior managers in each of the agencies or bodies identified within the scope of the review, requesting the commissioning of IMRs. The aim of the IMR is to:

a. Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (i.e. culture, leadership, supervision, training etc.) to see whether the homicide indicates that practice needs to be changed or improved to support the highest standards of work by professionals.

b. Identify how and when those changes or improvements will be brought about.

c. Identify good practice within agencies.

d. Provide an independent assessment by ensuring the individual responsible for the IMR has not had involvement with anyone who is subject of the review. The IMR is signed off by a senior manager of that organisation before being submitted to the DHR review panel.

1.4 Each of the following organisations completed an IMR or a short information report (if an IMR was not required) for this DHR:

- Kent Police
- Kent and Medway NHS and Social Care Partnership Trust
- NHS Clinical Commissioning Group
- Private Healthcare Provider
- Hospice (short report)

1.5 In each of the different agencies IMRs, interaction with both Bridget and Michael was recorded. In the main this related to the management of Bridget's cancer and her treatment plan, and Michael's treatment for his Mental Health and emotional wellbeing. Kent Adult Social Care and Health services were invited to contribute to the review and were represented within the panel but had no involvement or interaction with either Bridget or Michael. As a result, an IMR was not required from them.

1.6 Both Bridget and Michael chose to use private medical care to manage their medical issues. For all of her cancer care and associated treatment Bridget attended a private healthcare provider hospital close to where she lived. Michael also accessed the same hospital for psychiatric treatment and was under the same consultant during the period specified within the review. Therefore, the private healthcare provider was contacted and invited to join the review panel and contribute to the review.

2. The Review Process

2.1 Contributors to the Review

2.1.1 The review panel consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Bridget White and/or Michael White. The IMR authors and DHR Review Panel members have not had any direct involvement with Bridget White and/or Michael White and have not been the immediate line manager of any staff involved with them. This included a senior member of the Kent Community Safety Team. In addition, a senior member of a Domestic Abuse Charity was invited to sit on the board.

2.1.2 The members of the panel were:

Susan Harper	Kent Police
Cecelia Wigley	Kent & Medway NHS & Social Care Partnership Trust
Daniel Lee	Kent & Medway NHS & Social Care Partnership

	Trust
Tracey Creaton	NHS Clinical Commissioning Group
Claire Axon–Peters	NHS Clinical Commissioning Group
Andrew Rabey	Independent Chair
Priscilla Tsang	Kent County Council, Community Safety
Susi Thompson	Private Healthcare Provider
Mark Hutcheon	Domestic Abuse Services & Support
Henu Cummins	Domestic Abuse Services & Support
Janet Guntrip	Kent County Council, Adult Social Care & Health
Catherine Collins	Kent County Council, Adult Social Care & Health

2.1.3 The Independent Chair of the review panel is a retired senior Police Officer since 2014. He has experience and knowledge of domestic abuse issues and legislation, along with a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in serious crime investigation, reviews, multi-agency panel working groups and the chairing of strategic and multi-agency meetings. He is also a trustee of two charities, one being a domestic abuse charity. The Independent Chair has no connection with the Community Safety Partnership other than being commissioned to undertake Domestic Homicide Reviews.

2.1.4 The Hospice that supported Bridget during her cancer treatment was visited by the Independent Chair, and information was provided by the Care Director regarding their engagement and the support they provided.

2.1.5 In May 2019 the Independent Chair met with representatives of the company that provided the Out of Hours Doctor Service. This followed the presentation of new information surrounding the call made by Bridget to them. This allowed the recording of the call to be listened to and provided a clear understanding of the discussion between the out of hours Doctor and Bridget. This led to an alteration to the recommendation and analysis.

2.2 Review Meetings

2.2.1 The review panel initially met on 15th November 2017 to discuss the terms of reference, which were then agreed by correspondence. The review panel then met on 21st February 2018 to consider the IMRs, and again on the 17th September 2018 when the draft Overview Report was considered, and amendments agreed.

2.3 Family and Friends Involvement

2.3.1 The review panel considered which family members, friends, and members of the community should be consulted and involved in the review process. The panel was made aware of the following family members and friends. All names of family and friends have been anonymised.

Name	Relationship with Bridget White
Michael White	Husband
Steven White	Son
Michelle Smith	Daughter
Sarah Simpson	Friend
Jackie Moore	Friend
Karen Middleton	Friend

2.3.2 The Independent Chair of the review was keen to involve the views of close family and friends of Bridget and Michael and wrote to them inviting participation in the review process. As a result, Steven White, their son and three close friends came forward and were interviewed and provided insightful background information about their lives and treatment.

2.3.3 The Independent Chair wrote to family members on 3rd January 2018 introducing himself, explaining the DHR process, and provided them with a Home Office DHR information leaflet. The letters were delivered by the Family Liaison Officers. On 1st July 2018 the Independent Chair again wrote to family and friends. He offered to meet with them to discuss the DHR process and listen to any views and concerns they had. The letters were sent by recorded delivery.

2.3.4 The Independent Chair met with three friends of Bridget and Michael; Sarah Simpson and Jackie Moore together on 2nd August 2018, and Karen Middleton later the same day. They were able to provide background information about Bridget and Michael's life relevant to the terms of reference and this information has been included within the report. The chair had a telephone meeting with Steven White on 23rd August 2018. He was able to give information and opinion on the care and treatment of both his parents and, where applicable to the terms of reference, this has been included within the report.

2.3.5 The Chair of the panel again wrote to family members and friends on 9th

January 2019. Where requested, he left them each with a copy of the report. At later dates the chair again met with them individually to discuss their views of the report. Where additional information was provided and relevant to the terms of reference, the information was added to the report. The Independent Chair and panel members were extremely grateful to the family and friends for their contributions to this report. It was acknowledged how difficult this was for all who offered help in learning lessons from Bridget's death and the panel wished to put on record their condolences to the family and friends affected by these tragic events.

2.3.6 Following completion of the draft Overview Report, the Independent Chair wrote again to family members, offering them a further opportunity to meet and discuss the content, conclusions and recommendations of the report.

3. The Death of Bridget White

3.1 Events surrounding the Death of Bridget White

3.1.1 The Criminal Investigation timeline informs us that Police attended the home of Bridget and Michael White as a result of a call from their neighbour. Michelle Smith also contacted the neighbour following repeated unsuccessful attempts to contact her parents. The neighbour, who had become concerned that she had not been able to contact Bridget or Michael on the phone, had gone to the house, let herself in and found a note. The note said not to go upstairs but to call the Police. Attending Police Officers found Bridget deceased in her bed and Michael beside her with injuries. It became apparent that Michael's injuries were self-inflicted, and the initial belief was that Bridget had died as a result of her long-term cancer illness. Michael was taken to hospital where he later told a hospital psychiatrist that he had suffocated his wife. Michael later explained in interview with the Police that Bridget had attempted to take her own life but had been unable to do it. She became distressed and Michael stated that following multiple requests from Bridget he had carried out the action to help her and bring about her death. Michael made various attempts to take his own life but was unable and went on to stab himself in the chest. Police Officers also found notes at the house setting out their joint intention to take their own lives.

3.2 Events surrounding the death of Michael White

3.2.1 Whilst this was not part of the review it is felt important to state that following Bridget's death, Michael became very depressed and underwent treatment to help him manage his grief associated with the circumstances and the loss of Bridget. It was apparent when speaking to the friends of Bridget and Michael, as well as the staff who treated Bridget, that they were a devoted couple and loved each other very much. The Police investigation into the circumstances

surrounding Bridget's death had determined that Michael should attend court. In March 2018, Michael took his own life.

4. Background Information

4.1 Bridget White

4.1.1 Bridget and Michael had been married for 55 years. They had met when Bridget was 17 and Michael 27 years old. They had two grown up children Steven White and Michelle Smith. Bridget was described by her friends as a lovely lady, thoughtful, kind and loving. She was devoted to her husband Michael, her dogs and garden. Her friend, Sarah Simpson, described how Bridget enjoyed a very traditional marriage with Michael. He was responsible for providing for them both and making the decisions that affected them as a couple and she attended to the home and domestic arrangements. Bridget and Michael were very private people. Bridget did not like using public services and when she became ill, would insist on using private health care. Bridget was always immaculately dressed and well presented. Hospital staff at the private healthcare provider hospital said, *"Throughout her treatment for cancer she always arrived at the hospital looking fabulous."*

4.1.2 Bridget had supported Michael through periods of mental ill health which culminated in a suicide attempt in 2010, followed by a long and complex recovery period of 7 years. Bridget and Michael often holidayed together during this period, although this did reduce when Bridget became unwell. It is reported that this had a marked and positive impact on his wellbeing, lightening his anxiety and strengthening their relationship.

4.1.3 Bridget was normally fit and well and suffered only the expected age-related conditions. However, she did have a long-standing history of constipation and was diagnosed with Diverticulitis in 2012. Bridget had terminal cancer at the time of her death which was diagnosed in November 2015. By April 2017 Bridget's cancer had escalated to the point where she received palliative care from Hospice Nurses in her home until her death.

4.2 Michael White

4.2.1 Michael was described as a man of above average intelligence; he had a successful business and worked hard. He was described by his friend Karen Middleton as a great organiser, he had been the chair of the school Parent Teacher Association and organised many events. He was fun to be around and was described as a real 'go getter'. Michael was also a very private person, devoted to Bridget, and each depended on the other. His friends

Sarah Simpson and Jackie Moore said that he was a strong character who was friendly, charming and always very loving towards them. Hospital staff from the private healthcare provider described him as well dressed, charming and noted that he was always very loving towards Bridget. It was clear that Michael was frightened at the prospect of losing Bridget, and worried that he would not be able to cope alone.

5. Chronology

5.1 Introduction

5.1.1 This section considers, in detail, the contact and involvement that Bridget and Michael had with agencies during the period covered by the terms of reference. The facts are based on; IMRs submitted by organisations and interviews with family members, friends and other organisations that Bridget and Michael came into contact with.

5.1.2 In March 2010 Michael took an overdose of Amitriptyline which he was prescribed to treat his depression. Michael reported to his GP that his wife had taken an overdose and had been admitted to hospital. It was later discovered that Michael had taken the overdose.

5.2.3 Michael was admitted informally to an NHS Healthcare Acute Trust Hospital for psychiatric assessment. Following this Michael sought ongoing treatment within the private health care sector. Michael had previously been prescribed Zopiclone to aid sleep but immediately prior to the overdose there had been a change in his medication and he had been prescribed Amitriptyline by his GP instead. Michael stated that he had taken the Amitriptyline for one week before feeling suicidal. A listed side effect of Amitriptyline when first using the drug is an increase in suicidal thoughts. Further details on Amitriptyline can be found within the Glossary at the end of this report.

5.2.4 Michael gave the reasons for the overdose as a three-year history of night sweats, insomnia and headaches. These conditions had been investigated but no known cause was discovered despite extensive investigations.

5.2.5 At the end of March 2010 Michael was discharged from hospital and decided to seek psychiatric treatment for depression privately from a consultant at the private healthcare provider hospital. Michael's treatment spanned seven years with the consultant suggesting remission of depression only weeks before Bridget's death.

5.2.6 During the course of Michael's treatment it was identified by his psychiatrist that his relationship with Bridget was at times fragile. Michael was described as an intelligent man but was rigid and judgemental with a strong premorbid

personality. It was identified by Bridget at the beginning of his treatment that Michael had experienced an emotionally unreliable childhood due to his mother's mental illness. His treatment focussed upon his long-term mood disorder and incorporated psychotherapy, cognitive behaviour therapy and medication.

5.2.7 Michael raised a concern with his psychiatrist that he thought he had bi-polar disorder, and although this was initially dismissed by his psychiatrist, he did commence treatment for bi-polar disorder in 2014.

5.2.8 Notes from Michael's psychiatrist shows that Bridget was very supportive of Michael. They were encouraged to enjoy holidays together and the positive impact this had on his wellbeing was noted.

5.2.9 In 2012 Bridget commenced investigations into her long-standing constipation due to increased discomfort. She attended private healthcare provider hospital and was diagnosed as having Diverticulitis. An abdominal and pelvic CT scan was undertaken but did not identify any other abnormal features.

5.2.10 In January 2014 Bridget was experiencing pain again. This was considered to be a flare up of the Diverticulitis. The pain did not settle so a virtual colonoscopy and blood tests were carried out. This did not identify any other cause for the discomfort and Bridget was discharged.

5.2.11 In March 2015 Bridget was invited for routine bowel screening but she did not respond. In September 2015 Bridget attended her GP with a four week history of abdominal pain and of feeling unwell. The GP ordered a broad screening of her blood including CRP (a marker for inflammation) and Ca 125 (a protein marker for ovarian cancer). The results were abnormal, and a pelvic ultra sound was arranged at her local hospital. At this time Bridget reported that she was feeling better and that the laxatives prescribed had worked well.

5.2.12 In October 2015 Bridget had a pelvic ultra sound. This proved inconclusive, so a CT scan was arranged which identified that Bridget had multiple nodules in the bowel. She was seen the next day by her consultant at the private healthcare provider hospital and the decision was made to commence chemotherapy.

5.2.13 In November 2015, after further tests, Bridget and Michael were told that she had widespread cancer which could not be cured. They were both very distressed. It is noted that Bridget's mother had died of cancer. Michael's psychiatrist described him as 'grief stricken' and additional psychological support was arranged. A referral to a local Hospice was also agreed and information was provided to assist in self-help and the assurance of GP support given.

5.2.14 In November 2015 a nurse from the local Hospice met with Bridget and Michael. They discussed the availability of emotional support, symptom support and counselling. Bridget was very upset, and it was agreed that regular contact with the nurse would be maintained. At this meeting it was identified that Michael would be Bridget's carer.

5.2.15 In December 2015 Bridget commenced a regime of chemotherapy. During this treatment Bridget suffered many side effects including sickness, skin rashes, eye and urinary infections and a small pulmonary embolus. By June 2016 the side effects of the chemotherapy had worsened significantly. This necessitated a suspension of the treatment and a further CT scan to be carried out.

5.2.16 In November 2016 the tumour marker for Bridget had increased, tests followed that confirmed a relapse and additional therapy was commenced.

5.2.17 In December 2016 Bridget was admitted to hospital as she had a bowel obstruction.

5.2.18 In December 2016 Michael was not coping well as Bridget's condition worsened. His Psychiatrist stated that he was now preparing Michael mentally for Bridget's inevitable death.

5.2.19 In January 2017 Michael was presenting with the signs of increased stress but was described as using learnt coping mechanisms taught to him by his Psychiatrist to help himself manage. One to one support was offered but Michael declined.

5.2.20 In January 2017 Bridget was admitted to hospital for bowel obstruction. This was settled with medication and diet. While in hospital Bridget started a second cycle of chemotherapy. Upon discharge her pain was reduced and she was eating semi-solid foods.

5.2.21 In January 2017 a nurse from the Hospice visited Bridget at home. She described Bridget as anxious as she feared a reoccurrence of the bowel obstruction that caused her discomfort and pain. A discussion about pain management in anticipation of the worsening of her condition and the increase in pain she would experience was had, and an anticipatory medications prescription was raised with her GP.

5.2.22 In March 2017 Bridget continued treatment within the Oncology Department at the private healthcare provider hospital. She suffered with a virus which caused a loss of appetite and lethargy. This condition improved and she reported feeling much better.

5.2.23 In April 2017 the out-of-hours service was contacted via 111 and a GP

undertook initial telephone triage as Bridget was vomiting bile. She was constipated, with her bowels not being opened for 24 hours. IC24 (the company providing out of hours GP services) was contacted via safeguarding representative after the initial reports had been written and provided access to a copy of the patient record made on that date, to a transcript of the call and at a face to face meeting to a recording of the call. This revealed that the out-of-hours Doctor undertook a review of her condition through a question and answer process at the end of which Bridget agreed that she would continue to monitor her condition having only recently taken an anti-sickness drug. She agreed that if her condition worsened, she would call back and the GP would attend her home address to undertake a face to face assessment and administer injectable medication.

5.2.24 The following day, Bridget attended the private healthcare provider hospital tearful and stated that she was worried about having a bowel obstruction. She was seen by her consultant and was described as worried and unhappy. She was given additional medication and told to contact the unit in the next couple of days if her condition did not improve. When she left the unit, she was reported to be happier in her presentation.

5.2.25 Two days later, the private healthcare provider, as part of their follow up pathway, contacted Bridget to see how she was. Bridget described herself as feeling weak but no worse than when she had attended the hospital.

5.2.26 The following day, Police attended the home address of Bridget and Michael. They found Bridget dead in her bed and Michael beside her with injuries to his chest/abdomen.. Police Officers initially believed both were dead, but a noise and movement from Michael alerted them that Michael was alive.

5.2.27 On examining the scene two notes were found:

“It’s what we both wanted, I couldn’t live without Bridget. The love of my life. It was hard” and,
“It’s what we both wanted. I couldn’t live without Bridget. The love of my life. Please forgive us”

5.2.28 Blood staining and other knives were also located within the home. These were considered to be connected with Michael’s attempts to take his own life.

5.2.29 An examination of Bridget was conducted by attending officers and a Crime Scene Investigator (CSI, a person trained and skilled in the forensic examination of crime scenes). Bridget was found to have some bruising on her stomach. In line with police protocols the duty Inspector attended the scene. This information was provided to the Inspector, but his review of the circumstances was that the cause of death was not suspicious. His rationale

was recorded as; "*The situation appeared to me to be that Bridget White had died of cancer and Michael White overcome with grief had attempted to take his own life (as supported by the blood in the bath, the notes, and his injury to his chest)".* A Detective Inspector also attended the scene, reviewed the circumstances, and supported the Inspectors decision.

6. Overview

6.1 Bridget and Michael had lived in their home for 50 years and were very established within the community, they had a close network of friends who provided regular contact and support. During this review the opportunity to meet with three of these individuals was provided, and this combined with the telephone conversation with their son, Steven White, gave detailed and rich information about who they were and how they lived their lives. Sarah Simpson was a close neighbour and friend and visited Bridget frequently; she had known Bridget for 27 years. Jackie Moore had known both Bridget and Michael for 23 years. Jackie worked as a cleaner for them going into the house three times a week but described her relationship with Bridget as a close friendship. Both women met the Independent Chair together, at their request, and they described their friendship with Bridget as sisterly. They stated that they all shared their thoughts and views together and each supported the other. They described Bridget as a very happy person, and that she loved her home and garden. They also said that she clearly loved Michael and their life together. They observed that Bridget had taken the news of her cancer very badly and was clearly devastated at the time. However, she was also a very private person and she did not let her cancer and her treatment dominate their conversations. They observed that Bridget did not eat much and as a result grew very weak over time. Sarah was concerned at times that Bridget was living with pain and was not using medication available to her, saying that she was fine and did not want pain relief. They described Bridget as a person who liked to be pampered and chose in the main not to use the National Health Services, always preferring to use private health care. Both Sarah and Jackie knew Michael well and described him as a friendly and charming man who was always loving towards them. It was clear to them that Michael was frightened of the prospect of being alone and that he worried about this. Sarah shared that on the day Bridget died Michael had said to her "*Thank you for everything you do for us"* and gave her a hug.

6.2 Karen Middleton was the third long term friend of both Bridget and Michael that contributed to this review, and she had known them for over 40 years. She was able to give a good overview of their married life together and their own personalities. Echoing what Sarah and Jackie said, she described Bridget as a loving and kind person and described them as a devoted couple who loved each other very much. She described how Bridget was always glamorous, and took great pride in her appearance, which she maintained even throughout her cancer treatment. She said of Michael that whilst clearly affected, she felt he was coping with Bridget's illness.

She said that they had a traditional marriage and Bridget liked Michael to be the decision maker and it was her view that she never considered him as controlling. She said he liked his ways, and that Bridget loved him for it.

6.3 Steven White described his parents as an independent and private couple, and as a result he personally found it difficult to discuss the choices they were making or have a clear understanding of the treatment they were having. He acknowledged that agencies would also have found this difficult, but he was surprised that none of the agencies involved had sat with them and discussed a course of action to manage his mother's end of life and his father's ability to cope alone. He also raised the issue that no referral to Adult Social Care had been made, as he felt an assessment by a local authority Social Worker may have been helpful. Steven wanted to acknowledge that the private healthcare provider had provided very good care and support to his parents, however, he did feel at the latter stages of his mother's life, treatment was prolonged. He felt that this should have been replaced or supplemented with support and help for his parents to cope with his mother's inevitable death. It was his view that if a more formal process had been in place to facilitate an open and honest discussion about end of life choices; this may have prevented the circumstances that led to his mother's death. Age UK completed an *End of Life Review* report in 2013[1] dealing with aspects of end of Life care. It highlights that discussions around dying and planning for death are uncommon, and the challenges that informal carers, such as family and friends, may face.

6.4 Steven also wanted to raise the point that he felt there was a general lack of legal understanding within our society as to what people can or cannot do to assist loved ones in taking their own life, and felt that public information should be available to help people in making such decisions. Steven also wanted to express his gratitude to the police officers who initially attended his parents' home the day his mother died, one of whom accompanied his father to a London hospital and was very kind. He also wanted to acknowledge the support and kindness shown to his mother throughout her treatment, and for the support shown to them both during a very difficult period in their lives.

7. Analysis

7.1 There is no evidence or information available to the review panel from agency contacts, family or friends that would indicate that Bridget was a victim of domestic abuse at the hands of Michael prior to the events that led to her death. Similarly, there is no evidence or information to suggest that Michael had been a domestic abuse perpetrator prior to the actions which caused Bridget's death. Coercion and Control were considered as being aspects of concern within their relationship and extensive questioning around this area of Domestic Abuse with both long term

[1] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_oct13_age_uk_end_of_life_evidence_review.pdf

friends and family identified that there was no evidence to support this view. The only query about the relationship came from Michael's Psychiatrist who felt Michael should devote more time to Bridget so that they would enjoy a "rich retirement lifestyle". Their friends described them as having a close and loving relationship, which had spanned 55 years. Staff supporting them throughout the cancer treatment witnessed them as a caring and devoted couple. The circumstances outlined in this report relate to Bridget's illness, the pain and distress she was enduring, Michael's distress in witnessing this and his concerns about being on his own. These are considered to be the significant and pivotal factors that led Michael to take the actions he did, which ultimately brought about Bridget's death.

7.2 The review of the chronology identifies that the GPs supporting Bridget and Michael were very pro-active in the care that they provided to them. The evidence indicates a holistic care approach that was patient led and the practice acted as a liaison between the various services used by both Bridget and Michael. There were incidents where Bridget had declined the advice of doctors and the doctors had clearly respected her decisions, even when they felt this was not in her best interest.

7.3 The review looked carefully at the Care Act 2014, in particular the opportunity to carry out a needs assessment for Bridget, as well as a needs assessment for them as carers of each other. Bridget was regularly assessed by surgeons and GPs both within the private and public health sector and was also supported by palliative care nurses from the local Hospice. The review agreed that there were numerous missed opportunities for discussing a referral to the local authority for an assessment. While it may be fair to conclude, based upon the evidence and knowledge we have of Bridget and Michael, that they would have declined this. It is essential that carer's needs are identified and explored and this should be an integral part of practice. In this situation both Bridget and Michael were carers of each other, and as such had very individual needs. If they had been in agreement with a referral they may have benefited from an independent assessment.

7.4 The review identified that a significant factor was the assessment made by the out-of-hours GP in April 2017. It is evidenced that the GP was aware that Bridget had been receiving chemotherapy for a year and was presenting with symptoms that may have been suggestive of obstruction. As a result of the triage, an agreement with Bridget was made that he would not list her for a home visit at that point as the new medication had not yet fully had a chance to take effect, but that if her condition worsened she was to phone again via the 111 service and a face to face assessment would then be required. This plan of treatment was reasonable considering the short history of the symptoms provided to the clinician and the fact that the medication had been taken for less than 24 hours. The clinical presenting picture at that time was not a typical picture of an obstruction but safety netting took place to ensure a face to face review if the symptoms persisted. The triage GP

decided that a home visit was not necessary at that time and provisional diagnosis was that the vomiting was likely to be secondary to the chemotherapy. Advice was given to call back if the vomiting did not settle. If further information had been offered or sought by targeted questioning or if Bridget's medical history of constipation and bowel obstruction had been visible to the clinician as special notes using ShareMycare, he may have attended the home and gained a more holistic overview of the circumstances and come to a different decision. Bridget could have been admitted to hospital earlier and her symptoms alleviated more quickly and things may not have escalated as they did. It is evidenced that when she attended the private healthcare provider hospital the next day she was distressed, tearful and in pain. It is fair to conclude that this would have had a significant impact upon Michael's emotional wellbeing, distress and sense of coping.

7.5 The review identified that the care and support of both Bridget and Michael by hospital staff at the private healthcare provider was responsive, sensitive, and caring. The staff were described as going above and beyond their duties and responsibilities.

7.6 The review identified that Kent Police has a policy which outlines the process of investigation when a death occurs. It defines the different pathways to follow if the death is classified as sudden (of natural causes), or suspicious (where the cause is uncertain). It is the initial findings of the attending officers, or the information provided by a member of the public that determines how the death is classified and the process that follows. A suspicious death requires the attendance of a Detective Inspector, trained in the Investigation of serial crime and serious crime, and ensures that a full and rigorous investigation is completed regarding the cause of death. In the circumstances of Bridget's death there were a number of factors that were identified but overlooked and led the Inspectors to classify her death incorrectly. The CSI identified that there was bruising to the body, but other evidence in relation to; her illness, blood stained knives, the two notes left within the house and the report from the neighbour appears to have had more influence over this decision. These factors were however significant enough to have questions raised about how Bridget's death occurred. A recent Home Office study looked at decision making at the initial scene of unexpected deaths: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/484298/Report_into_the_2012_FSR_FP_Audit_Publication_copy_pdf.pdf

It was identified that cognitive bias has led attending Police Officers to sometimes overlook certain evidence, and in those situations failed to recognise some triggers that would otherwise raise concerns. The report states;

"One factor which appears from the data available to be a significant issue is the lack or poor inspection of the body at the scene of death by the first attending officers. There is some evidence that even though there were visible marks indicating

possible violence in many cases decisions were made not to treat the death as suspicious. In five cases there appears to be no inspection of the body at all. There may also be a tendency to treat deaths of elderly people as less suspicious for understandable reasons. One senior Police Officer stated that in their experience what tends to happen at the scene is that first attending officer makes up their mind as to whether the death is suspicious or not, sometimes believing the first account they are given. A cognitive bias (Forensic Science regulator, 2014; Kahneman, 2011) is then potentially adopted by the investigator with regard to any new evidence which comes forward and also when briefing senior officers and the coroner"

This interesting study does clearly resonate with this case and whilst initially, attending officers were focused upon the medical help for Michael, it is possible that a misdirected cognitive bias led to them overlooking evidence that was at odds with a natural death. Whilst the overall outcome in this case was not significantly affected, due to the disclosure made by Michael at the hospital, it raises a practice issue that needs to be addressed.

7.7 Bridget and Michael's son, Steven, was concerned at the lack of information available to the public in relation to assisting suicide. The National Health Service (NHS) via their public facing website provides information about euthanasia and assisted suicide (https://www.nhs.uk/conditions/euthanasia-and-assisted-suicide/). The information clearly defines euthanasia and assisted suicide; it outlines the law in the UK, and the different classification types of voluntary and non-voluntary euthanasia. This is a complex area (fraught with ethical and legal issues) for professionals to discuss with families, as assisting suicide is illegal in the UK. However, there is a useful and informative website provided by the NHS available to the public.

8. Conclusions

8.1 There is no evidence or information available to the review panel from agency contacts, family or friends, that Bridget was a victim of Domestic Abuse before the actions that led to her death, neither was Michael a perpetrator of abuse against her. In this instance, the sole episode of abuse appears to be the final one.

8.2 Bridget and Michael were a devoted and private couple. They had a close network of friends but chose to manage their difficult health needs independently. It is the conclusion of the review that their deaths were not as a result of any individual or agency failing. Their independent and self-directing nature meant that they chose to use private health care to deal with these issues and unless necessary did not engage in the use of Public Services. They often chose not to engage with the services from the Hospice and their nature meant that they wanted to manage independently. What was clearly strength and resilience as a self-directing couple meant that they did not access support that was available and would have assisted

them at the end of Bridget's life. This includes the use of anticipatory pain relief that was available for her as prescribed by her GP. Ultimately these decisions led to the very tragic circumstances where Michael took Bridget's life and then attempted to take his own.

8.3 The GP practice displayed good practice by acting as a single point of contact and effectively coordinating their private health care with public agency support as required. The GPs provided a clear route for communication between services. They held and shared appropriately essential data on both Bridget and Michael in a format that was easy to access and understand.

8.4 All agencies recognised the impact Michael's caring responsibilities were having on him but did not fully comply with the Care Act 2014.

8.5 Police Officers initial attendance following Bridget's death failed to display an appropriate level of professional curiosity upon being presented with facts. This led to a failure to declare the death as suspicious in line with Kent Police Policy.

8.6 The private healthcare provider care staff demonstrated good practice in their care of Bridget and Michael who received sensitive, responsive and genuinely caring support.

8.7 The actions of the out-of-hours Doctor failed to fully recognise the early signs relating to Bridget's ultimately diagnosed condition based upon initial presenting triage obtained information. Following the initial triage, he and Bridget agreed that a home visit was not required and that she would call back if her condition worsened. If the Doctor had sought further history with regard to Bridget's condition, or had further information made available to him through on screen web based platforms used commonly for palliative care or specialist conditions, then he may have taken a different view and carried out a home visit at this earliest opportunity . This may have led to a different diagnosis and hospital admission.

9. Lessons to be learnt

9.1 This report does not identify any lessons that relate specifically to domestic abuse or the prevention of domestic homicides. This is primarily because there was no evidence that Bridget was a victim of domestic abuse during the period covered by the review, nor was Michael a perpetrator against her prior to the incident that caused her death.

9.2 The Care Act 2014 was amended to include the assessment of carers. This elevated the needs of the carer to be equitable to the needs of the cared for and entitled them to an independent assessment. This report identified that at key times this opportunity was missed. At times Michael expressed that he was struggling to cope with the increasing demands of Bridget's illness and was worried about his

ability to cope. At these times an individual and independent carer's assessment should have been offered.

9.3 The initial attendance of the Police to Bridget's death lacked a level of professional curiosity. Police Officers attending should put aside assumptions, specifically in this case relating to the age of the victim and her illness and consider all of the information available before reaching a final decision. The information provided by the CSI was considered but dismissed without a rational reason being documented.

9.4 The out-of-hours Doctor was unable to fully evaluate the eventual seriousness of Bridget's condition due to a lack of detailed information available or obtained. This information could have been available by a web-based system called ShareMycare. The out of hours provider in this case provides access to a system for CCGs engaging in out of hours services, allowing information to be recorded and shared about patients with specialist conditions and needs. In this case that service was not used, and the provider indicates is rarely used by those agencies that have been provided access to it. In addition, in some areas dependent on local CCG arrangements, a Primary Care Management System (PCMS) and a Medical Interoperability Gateway (MIG) can be available for the visibility of summary of care records, medications, allergies and recent investigations; however it appears this was not visible to the clinician on this case from the notes reviewed. Had this ShareMycare system been used to transfer to the out of hours service, any complex or specialist care information would have been seen and the Doctor would have been more aware of Bridget's ongoing treatment and difficulties she had concerning obstructions to her bowel. Equally, had the Doctor demonstrated greater professional curiosity and asked more in-depth questions about Bridget's condition and treatment he may have gleaned a greater understanding. In either case had better access to information been available or sought, the Doctor may have concluded a more holistic view of her condition was required and therefore undertaken an earlier home visit.

9.5 The panel has outlined 4 recommendations based upon the findings of the IMRs and reports submitted.

10. Recommendations

10.1 The review panel makes the following four recommendations from this DHR:

	Recommendation	Organisation
1	Ensure staff awareness of the impact of being a carer and when the need for a carer's assessment is required. (Kent & Medway Safeguarding Adults Board (KMSAB), GPs and Local Hospice.)	and CCG
2	To ensure staff awareness of the Care Act 2014 and the need for carer's assessments to be provided where appropriate.	Private Healthcare Provider
3	To ensure that awareness training around cognitive bias is provided to all Police Officers who attend sudden or suspicious deaths, highlighting the findings of the report *"a study into decision making at the initial scene of unexpected death".*	Kent Police
4	To examine how specialist patient information can be made available to Out of Hours Services.	CCG

Appendix A

Kent & Medway Domestic Homicide Review

Victim – Bridget White

Terms of Reference

Part 1

1. Background

1.1 Bridget White was suffering from terminal cancer, was in severe pain and very poorly. Officers attended the home of the Whites having been alerted by a concerned neighbour who had gone to the house and found a note stating not to go upstairs but to call 999.

1.2 Attending officers found Bridget deceased in her bed and her husband Michael White beside her with injuries to his abdomen/chest. It was apparent that his injuries were self-inflicted and Bridget's death was initially treated as being due to her illness/natural causes. However, it became apparent that Michael had suffocated his wife through his admission to a hospital psychiatrist.

1.3 Sometime after the incident, due to Michael's admission to hospital, he was interviewed by Police and stated that he and Bridget had discussed suicide. On the evening/early morning in question he stated that Bridget had attempted to take her own life but had been unsuccessful and was distressed. He then suffocated her.

1.4 There were signs of a struggle by Bridget in that she suffered further injuries to her body. Michael stated he tried to take his own life by the same means but had been unsuccessful. Michael has suffered with depression and had attempted suicide some 6 years previously. The Whites had been married for some 55 years and were considered to be a loving, happy couple.

1.5 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on the 10th of October 2017. It confirmed that the criteria for a DHR have been met.

1.6 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

2. The Purpose of the DHR

2.1 The purpose of this review is to:

i. Establish what lessons are to be learned from the death of Bridget White in terms of the way in which professionals and organisations work individually and together to safeguard victims.

ii. Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.

iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

v. Contribute to a better understanding of the nature of domestic violence and abuse; and

vi. Highlight good practice.

3. The Focus of the DHR

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Bridget White.

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 Independent Management Reports (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Bridget White in circumstances relevant to domestic abuse, or

to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not had any direct involvement with Bridget White, Michael White, or any other family members. The reviewer cannot be an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Bridget White, Michael White, Steven White or Michelle Smith from the 1st of January 2010 to the 27th of April 2017. If any information relating to Bridget White being a victim, and Michael White being a perpetrator, of domestic abuse before the 1st of January 2010 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Bridget White and/or Michael White. If the information is not relevant to the circumstances or nature of the homicide, a brief précis will be sufficient (e.g. In 2015, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Bridget White and knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for the NPCC Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Bridget White and Michael White (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Bridget White subject to a Multi Agency Risk Assessment Conference? (MARAC)?

iii. Did the agency comply with information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Bridget White and Michael White (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?

vii. Were senior managers or other agencies and professionals involved at the appropriate points?

viii. Are there ways of working effectively that could be passed on to other organisations or individuals?

ix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Bridget White and promote their welfare, or the way it identified, assessed and managed the risks posed by Michael White? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

x. How accessible were the services to Bridget White (as applicable)?

xi. To what degree could the death of Bridget White have been accurately predicted and prevented?

xii. Why was the cause of death of Bridget White undiscovered until the disclosure of his involvement by Michael White?

xiii. Were the care needs of Bridget White adequately assessed and also the needs of her husband, Michael White, and his needs as a carer to her?

6. Document Control

6.1 The two parts of these Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.

6.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DHR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly, and that version will be used subsequently.

6.3 A record of the version control is included in the appendix to the document.

END OF PART 1

Appendix B

Extract of Kent Police Policy relating to Sudden and Suspicious Deaths.

Sudden Death

A Sudden death is a death where there was no expectation the person was likely to die and no suspicious circumstances surrounding the death, for example natural causes or accident without third party culpability.

Suspicious Death

A Suspicious death is a death which is not a sudden death as defined above, which will require further Police Investigation.

Glossary

Abbreviation/Acronym	Explanation
DHR	Domestic Homicide Review
IMR	Independent Management Review
CSI	Crime Scene Investigator
NHS	National Health Service
KCC	Kent County Council
CCG	Clinical Commissioning Group
GP	General Medical Practitioner (Doctor)
CT Scan	Computerised Tomography scan
Amitriptyline	A prescribed drug used to treat depression
Zopiclone	A prescribed drug to treat insomnia
Bi-polar	A medical disorder that causes periods of depression and periods of elevated mood.
Colonoscopy	An examination of the large bowel and part of the small bowel using a fibre optic camera
CRP	A blood screening marker that indicates Inflammation
Ca 25	A protein marker indicating ovarian cancer
Chemotherapy	A cancer treatment that uses one or more anti-cancer drugs as part of a standardised regime.
Pulmonary Embolism	A blockage of an artery in the lungs by a substance that has moved from elsewhere in the body through the blood stream.
FLO	Family Liaison Officer
CSP	Community Safety Partnership
MARAC	Multi-Agency Risk Assessment Conference
DAVSS	Domestic Abuse Victim Support Services. A community-based charity offering vital and practical support to anyone experiencing Domestic Abuse

DASH	Domestic Abuse Stalking & Harassment Risk Assessment tool
SIO	Senior Investigating Officer (Police)
PCMS	Primary Care Management System
MIG	Medical Interoperability System

The following is an explanation of terms that are used in the main body of the overview.

Amitriptyline

Amitriptyline is a type of drug called a tricyclic antidepressant. Although these are used for anxiety and depression, lower doses are also used to block the long-term pain of some rheumatic conditions. As with many drugs some side effects are associated with it, these include dryness of mouth, low blood pressure upon standing, and in some cases an increased risk in suicide. The increased risk in suicide mainly affects persons less than 25 years of age.

Informal Admission (Mental Health Act MHA 1983)

An informal patient has agreed to come and stay in hospital voluntarily. This means they are not being detained under the Mental Health Act 1983. A voluntary patient is a person who voluntarily remains in a mental health facility for treatment, care or observation, or a person who is admitted under section 7 as a voluntary patient by his or her guardian. Voluntary patients are generally in hospital as they can benefit from inpatient care.