DOMESTIC HOMICIDE REVIEW REPORT INTO THE DEATH OF MRS. LOWE

REPORT PRODUCED BY GRAHAM BARTLETT

Table of Contents

SECTION ONE – INTRODUCTION AND BACKGROUND

1.1 Introduction

1.1.1 This report of a domestic homicide review examines agency responses and support given to Mrs. Lowe, a resident of the Isle of Wight, prior to her being found dead, along with her husband Mr. Lowe, on 20th June 2016. The review will consider agencies contact/ involvement with Mrs. and Mr. Lowe from 1st April 2011 to the 20th June 2016.

1.1.2 The circumstances of the deaths are that police were called to Mrs. and Mr. Lowe's address just after 7am on Monday 20th June 2016. A neighbour had found a note on the front door of the house instructing that the police be called.

1.1.3 Officers attended and found the house insecure albeit both the front and rear doors were intact and there were no signs of a break in or disturbance.

1.1.4 Upon entry, officers found the body of Mr. Lowe hanging by the neck by a rope that was tied to the upper landing bannister. A stepladder beneath him was in a position that indicated it could have been kicked over. A note was found on the stairs by the officers indicating Mr. Lowe had killed his wife, Mrs. Lowe, due to her mental illness and his difficulty in caring for her.

1.1.5 Officers then found Mrs. Lowe dead on the sofa in the lounge, lying on her back covered in a blanket. She appeared to have injuries to the back of her head.

1.1.6 Enquiries with neighbours revealed that Mr. Lowe had last been seen the previous afternoon while Mrs. Lowe was last seen alive late afternoon three days before the deaths.

1.1.7 On the day after the deaths were discovered a Home Office Pathologist conducted post mortem examinations on Mrs. and Mr. Lowe. The cause of death for Mrs. Lowe was established as neck compression. The cause of death for Mr. Lowe was established as ligature suspension.

1.1.8 Inquests into the deaths concluded that Mrs. Lowe was unlawfully killed and Mr. Lowe took his own life.

1.1.9 The Domestic Homicide Review Panel and the Isle Of Wight Community Safety Partnership offer their sincere condolences to Mrs. and Mr. Lowe's family and friends on their sad and tragic loss.

1.2 Reasons for Conduction a Domestic Homicide Review

1.2.1 The cross governmental definition of domestic abuse is:

> *any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:*
>
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

1.2.2 Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The Act states that:

a DHR should be '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. '

1.2.3 The purpose of a 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 policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.3 Process Of The Review

1.3.1 This review was commissioned at a meeting of the Isle of Wight Community Safety Partnership on the 23rd June 2016 in line with the Multi Agency Guidance for the Conduct of Domestic Homicide Reviews 2013[1]. The chair and author was appointed shortly afterwards and the review started immediately. It should be pointed out that in December 2016 HM Government published revised Multi Agency Guidance but in light of this review being commissioned some six months beforehand, this review complies with the 2013 Guidance. Consideration was given by the Isle of White Safeguarding Adults Board (SAB) as to whether to undertake a Safeguarding Adults Review (SAR). It was agreed that the SAB would be represented on the DHR panel to ensure that the necessary consideration was given

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

to Mrs and Mr Lowe's care and support needs and whether Section 42 of the Care Act 2014 applied to them and to avoid parallel processes.

1.3.2 Mr Graham Bartlett was appointed to chair and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd and Independent Chair of Brighton and Hove Local Safeguarding Children Board. He also Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards. He has completed the Home Office on line training for independent chairs of Domestic Homicide Reviews and has the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing a number of Domestic Homicide Reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for the city of Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight.

1.3.3 A Domestic Homicide Review panel was established which set the terms of reference for the review and whose report this is. The Panel comprised:

Graham Bartlett	Independent Chair and Reviewer
Amanda Gregory	Isle of Wight Council (IOWC) – Regulatory and Community Safety Services Manager
Helen Turner	IOWC - Community Safety Operations Manager
Sarah Johnston	IOW NHS Trust
Claire Foreman	IOWC – Interim Director Adult Social Care
Jane Janvrin	IOW Community Rehabilitation Company
Val Bell	IOWC Housing
Su Tomkins	IOW NHS Trust
Mark O'Sullivan	IOW Age UK
Maggie Bennett	Independent Homes Association
Mandy Tyson	IOW Clinical Commissioning Group
Bruce Marr	Independent DA Advisor
Ruth Attfield	Hampshire Constabulary

1.4 Terms of Reference

1.4.1 The specific terms of reference set for this review to consider were:

- Whilst Mrs. Lowe had no known contact with any specialist domestic abuse agencies or services, the review will consider whether there was any history of domestic abuse involving Mrs. Lowe and/or Mr. Lowe and

therefore whether there were any warning signs.

- How opportunities to 'routinely enquire' as to any domestic abuse, sexual violence or carer stress[2] experienced by the victim or perpetrator were or were not identified and used by professionals and what was the outcome.

- Whether professionals took opportunities to consider the health and wellbeing of Mrs. and Mr. Lowe as a couple as well as individuals, including any dependencies they had on one another and their capacity to manage those.

- Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced by the victim or committed by the alleged perpetrator (towards Mrs. Lowe or any other partner) to other agencies and whether those opportunities were taken.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mrs. Lowe, the alleged perpetrator or the dependent children that were missed or could have been improved.

- Whether there were any barriers or disincentives experienced or perceived by Mrs. Lowe or her family/ friends/colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide and what they did or did not do as a consequence.

- Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.
- Whether Mrs. Lowe had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on her likelihood of seeking support in the months before she died.

- Whether the homicide could have been accurately predicted and prevented.

In addition:

- The review will give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

[2] the emotional and physical strain of **caregiving**. It can take many forms. For instance, you may feel: Frustrated and angry taking care of someone with dementia who often wanders away or becomes easily upset.

- The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services on the Isle of Wight.

1.4.2 The period set for the review to consider was 1st April 2011 and 20TH June 2016.

1.5 Agency Involvement

1.5.1 Following the decision to commission this Domestic Homicide Review, Isle of Wight Council wrote to the following agencies requesting they return Summaries of Involvement to help the panel understand which agencies had relevant involvement with Mrs. Lowe and/ or Mr. Lowe within the time period of this review:

- Isle of Wight Community Rehabilitation Company
- Department of Work and Pensions
- Hampshire Constabulary
- Island Recovery Integrated Services. (IRIS)
- Island Refuge
- Isle of Wight Adult Social Care
- Isle of Wight Age UK
- Isle of Wight Citizens Advice Bureau
- Isle of Wight Clinical Commissioning Group (CCG)
- Isle of Wight Community Watch
- Isle of Wight Council Children's Services
- Isle of Wight Council Community Safety
- Isle of Wight Council Housing
- Isle of Wight Fire and Rescue Service
- Isle of Wight Mental Health NHS Trust
- Isle of Wight NHS Trust
- National Probation Service
- Spectrum Housing

1.5.2 Having considered these Summaries of Involvement, it was decided that the following agencies would be asked to submit Individual Management Reviews:

- Isle of Wight CCG - Primary Care
- Isle of Wight NHS Trust
- Isle of Wight Fire and Rescue Service
- Isle of Wight Age UK

1.5.3 The authors of the IMRs are, as far as possible, independent in accordance with the guidance.

1.5.4 The objective of the IMRs, which form the basis of this DHR, is to give as accurate an account as possible of what originally transpired in an agency's response, to evaluate it fairly and, if necessary, to identify any improvements for future practice. IMRs also propose specific solutions, which are likely to provide a more effective response to a similar situation in the future. The IMRs have assessed any changes that may have taken place in service provision during the timescale of the review and considered if further changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse

1.5.5 This report is based upon those IMRs, a review of the statements taken by the police, interviews with Mrs. and Mr. Lowe's son and daughter and considerations of the DHR Panel.

1.5.6 An integrated chronology has been prepared which shows agency involvement and significant events during the time period considered by this review. This is contained in Appendix A.

1.5.7 The report's conclusions and recommendations are the collective views of the Panel, which has the responsibility, through its constituent agencies, for implementing the recommendations.

1.6 Dissemination

1.6.1 Whilst key issues have been shared with organisations the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were seen by the membership of the Review Panel, and the IMR authors.

1.6.2 The IMRs will not be published but the redacted overview DHR report and Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

1.6.3 The content of the Overview Report and Executive Summary is 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. All names contained are pseudonyms.

1.6.4 Mrs. and Mr. Lowe's family have been shown a draft copy of this report and will be provided a final copy the day before publication.

1.7 Involvement of Family

1.7.1 Hampshire Constabulary have, through their Family Liaison Officers, facilitated contact with the family members of Mrs. and Mr. Lowe. The chair has met with their son and daughter.

1.7.2 The chair is incredibly grateful that, in such trying circumstances, the family have been so forthcoming in participating in this review. They recognised that their active involvement was important for them to fully understand and contribute to the emerging findings and to provide a valuable personal perspective that professionals are unable to.

SECTION TWO – DOMESTIC HOMICIDE REVIEW CONCLUDING REPORT

2.1 Introduction

2.1.1 This report is drawn from information and facts provided by and concerning the following agencies:

- Isle of Wight CCG - Primary Care
- Isle of Wight NHS Trust – Surgery, Women's and Children's Health, Clinical Support, Cancer & Diagnostic Services, Ambulance, Urgent Care and Community Services, Medicine, Mental Health and Learning Disabilities Business Units
- Isle of Wight Fire and Rescue Service
- Isle of Wight Age UK

2.1.2 From a review of Summaries of Involvement submitted at the beginning of this review it was established that Mrs. and Mr. Lowe had relevant contact within the time period under review with those agencies referred to in para 2.1.1. Relevancy was determined by the terms of reference agreed.

2.1.3 The report also considers the input from Mrs. and Mr. Lowe's family and a review of the statements taken by the police.

2.2 Subjects of the Review

Name	Age (at 20/06/2016)	Relationship
Mrs. Lowe	83 yrs.	Victim
Mr. Lowe	77 yrs.	Spouse of Victim and alleged perpetrator

2.3 Outline of Case

2.3.1 Mrs. Lowe was eighty-three years old when she died and had been married to Mr. Lowe for fifty-five years. She had been brought up in Kent and Sussex and, due to her husband's employment as an aircraft engineer in the RAF, the couple travelled extensively including living for periods of time in Singapore and Australia.

2.3.2 They had two grown up children, a son (Mike) and a daughter (Gail) who do not live on the Isle of Wight. While regular visits to their parents were not practical, they kept in telephone contact at least once a week and visited when they could or were needed.

2.3.3 Mrs. and Mr. Lowe, in the main, only had contact with universal services or specialist services connected with their medical conditions. The police have no recorded contact with them and there was no agency that had any record of either of them experiencing or being a perpetrator of domestic violence.

2.3.4 Mrs. Lowe rarely visited her GP but did have a history of ovarian cancer for which she had surgery in 2000. In 2014 she was referred by her GP to the Memory Service with concerns around her memory failing. Both Mr. Lowe and their children reported that she was struggling to remember everyday events and 'mundane things' causing her to employ a strategy of writing lists to help her.

2.3.5 On assessment it was found that her symptoms fluctuated and that her cognitive impairment was mild, not requiring any further intervention or treatment.

2.3.6 It seemed the formal assessment of Mrs Lowe's cognitive functioning differed from the views of her family and friends. They saw evidence of her being significantly

more impaired, especially over the last eighteen months. However, Mrs. Lowe told her Age UK Care Navigator that Mr. Lowe 'worried about her too much,' and the Care Navigator certainly did not feel that she had significant problems.

2.3.7 At the same time, Mr. Lowe was quite sick. He suffered from hypertension for which he was reviewed regularly and prescribed medication. He suffered a number of side effects from his medication and felt taking it ruined his quality of life.

2.3.8 In 2009, he was diagnosed with prostate cancer. He would frequently decline surgical procedures and hormone treatment so he was managed conservatively with medication. He made his views very clear that he did not want anything more than that.

2.3.9 In summer 2014 Mr. Lowe was admitted with urinary retention and later a large tumour, which was obstructing his bowel, was found on his pelvis for which he did eventually have surgery in late 2015.

2.3.10 He was subsequently reviewed on a two monthly basis and, in the spring of 2016, a further scan was ordered as he was by then suffering severe pain in his right arm.

2.3.11 Given his terminal prognosis, Mr. Lowe expressed concern that he would soon be admitted to hospital and he worried about how Mrs. Lowe would cope in his absence. However, both would also decline offers of support or intervention when offered, mirroring him declining medical treatment.

2.3.12 All those who knew him regarded Mr. Lowe as a proud man who wanted to deal with his own problems and support his wife who, as he saw it, had a deteriorating condition leading to dementia.

2.3.13 Mrs. and Mr. Lowe were found dead in their home on the 20th June 2016. The circumstances of their death are as set out in paras 1.1.2 – 1.1.7 ante.

2.4 Domestic Abuse Services in Isle of Wight

2.4.1 There are a range of specialist domestic abuse services for women on the Isle of Wight. These include:

2.4.2 **Island Women's Refuge** provides a 24 hour helpline for women escaping domestic violence and for women in an abusive relationship who want to know what their options are but who are not yet necessarily ready to leave. They also run a refuge with space for six families and an outreach and resettlement service for women living outside the refuge and a childcare project. The outreach programme provides services for those who have left an abusive relationship and are re-building their lives and those who are still within an abusive relationship who need specialist support to remain safe.

2.4.3 **Freedom Programme**. The Freedom programme is a 12 week, two hour a week rolling group work education / empowerment programme for women who have experience of an unequal relationship.

2.4.4 **Age UK Domestic Abuse Support Service.** This offers a confidential and safe support service for those aged fifty and over living with domestic abuse. They provide safe place for clients to discuss their concerns, support should the client decide to leave their partner, advocacy to help clients regain control in their decisions and signposting to other services.

2.5 Analyses of Individual Management Reviews

2.5.1 The aim of this section is to analyse the response of services involved with Mrs. and Mr. Lowe in the time period under review. It will look at the nature of the

engagement reported, the recognition of the root cause of the issues presenting and the quality of the response or service provided.

2.5.2 There is always a risk in providing such analyses that due to the passage of time, the events that have ensued and the level of information now available hindsight bias will become a factor. Clearly this is not helpful especially where it incorrectly presupposes that those providing a service would or should have had access to information that was not or could not have been reasonably available to them at the time. However, by examining the sequence of events from the perspective of all the agencies with whom Mrs. and Mr. Lowe had contact it can be useful to predict what information agencies could have known had information sharing arrangements been different. Where that is the case, comment will be made and any lessons learned identified.

2.5.3 The IMR authors are, where possible, all independent of the matters under review and have all provided as full an account and as detailed analysis as possible, triangulating sources where possible and using their significant knowledge of their respective agency's policies, procedures and practices to draw inferences regarding the service provided and make judgements and recommendations regarding that.

2.5.4 Neither Mrs nor Mr Lowe disclosed to any agency that they were either a victim or perpetrator of domestic abuse relating to each other or any other person.

2.6 Information from Family and Friends

2.6.1 During the course of the police investigation into the deaths, a number of witness statements were taken from family and friends of Mrs. and Mr. Lowe. The panel is very grateful to HM Coroner for the Isle of Wight for allowing the review sight of those statements and to Hampshire Constabulary for facilitating this.

2.6.2 The Chair of the panel met with Mrs. and Mr. Lowe's daughter (Gail) and adult son (Mike). Prior to this meeting the chair had read their witness statements, which were recorded by the police shortly after the deaths.

2.6.3 Gail and Mike spoke very fondly of both their mother and father and asked that their father's life, particularly, should not be defined by his final act.

2.6.4 Mrs. and Mr. Lowe had been married for fifty-five years at the time of their death. Gail was born in 1964 and Mike in 1966. The children were brought up in Kent moving later to Lancashire. Mr. Lowe was in the RAF and later worked as an aircraft engineer and Mrs. Lowe was a legal secretary. When Mr. Lowe retired, around 17 years ago, they moved to the Isle of Wight, as they wanted to return to the south coast and that was one of the more affordable places to live.

2.6.5 Gail and Mike do not live on the Isle of Wight.. Despite the distances, they kept in regular contact with their parents and at least one of them would visit once every three months. They also maintained regular contact with their parents' immediate next-door neighbours who they describe as a wonderful support to Mrs. and Mr. Lowe.

2.6.6 Given Mr. Lowe's military background it was not surprising to hear that he was more comfortable taking charge of the family affairs and being very proud to do so. Gail and Mike were at pains to distinguish between Mr. Lowe being 'in control' of his and Mrs. Lowe's affairs from being 'controlling.' They describe a very loving and caring relationship between the two with absolutely no evidence of any sign or symptom of domestic abuse – in any of its forms – between them.

2.6.7 In 1990 Mr Lowe was involved in a serious road traffic crash which resulted in several leg fractures and him going into cardiac arrest twice and having to be shocked.

2.6.8 Mr. Lowe was used to resolving his own problems and was reluctant to ask for, or even welcome, help from anyone else. This was illustrated by his refusal to undergo hormone treatment and other surgical procedures as he felt them intrusive and unnecessary. He would research matters, such as his health problems, assiduously, speak to many experts and then reach a conclusion that he would then not deviate from. These conclusions did not always reflect the information he had been provided. This was frustrating, particularly for Mike, who as a hospital consultant would try to help his father reach a deeper understanding of the nature of his condition and his treatment options but this advice would often be rebuffed.

2.6.9 Mr. Lowe's cancer diagnosis and the onset of Mrs. Lowe's cognitive difficulties were around the same time. Over the years Mr. Lowe's physical condition deteriorated significantly and family and close friends witnessed a worsening of Mrs. Lowe's mental health.

2.6.10 Shortly after Mr. Lowe was diagnosed with cancer he started to prepare for, what he thought was, his imminent death. He knew Mrs. Lowe was struggling with her memory, albeit mildly at that time. He therefore complied a thirty-page instruction document on how the house worked. This included very specific instructions on just about everything he had taken responsibility for. He also started getting their other affairs in order, including selling about 60% of their possessions.

2.6.11 In fact his prognosis was not so bleak but, for whatever reason, he did not understand this. Once he had convinced himself he was soon to die, nobody could dissuade him from that view, despite their best efforts.

2.6.12 His anticipation of death disrupted his long-held expectation of how his and Mrs. Lowe's lives would unfold. Given that he was seven years younger than she, he had expected that he would outlive her. The thought that she might have to manage alone never occurred to him until his diagnosis. This, coupled with her declining mental health, concerned him greatly.

2.6.13 Mrs. Lowe was declining over her last seven years. While physically fit, those who knew her well – primarily Gail, Mike and the next-door neighbours – saw her mental health diminishing. For example, she had always been very excited over an impending visit by Gail or Mike and their families. The house would be ready, beds made up, meals prepared and her appearance would be immaculate.

2.6.14 Towards the end, despite being aware of family arriving, she would be surprised to see them when they did. No rooms were ready, her personal hygiene was not what it had been and she struggled to cook. Sometimes, even after they had arrived, she would be shocked when one of them entered a room as she had forgotten they were visiting.

2.6.15 Mrs. Lowe had fallen around four years ago whilst at Gail's house. This was witnessed by various family members and resulted in Mrs. Lowe sustaining a black eye. She had also fallen in early 2015 and Gail encouraged her to see her GP as she was suffering from pain.

2.6.16 In some ways their parallel declines meant, initially, they could cater for each other. Mr. Lowe was physically impaired but could, for example, provide Mrs. Lowe with a shopping list and she would go out shopping. She could not have done this without the list and he could not make it to the shops; the family were aware of Mr. Lowe falling at home once in early 2016 (although the GP notes suggest more frequent falls.)

2.6.17 The family were very complementary over the consultant psychiatrist taking the time to carry out his assessment at their home but were frustrated with the outcome of the diagnosis. Although Mrs. Lowe was assessed to have mild cognitive

impairment, no further advice was provided and no follow up assessment arranged. Only the very basic information from the family was included; only that which was given at the GP appointment which led to the referral and which was repeated by Mr. Lowe to the psychiatrist.

2.6.18 Although Mr. Lowe took charge of affairs at home, Mrs. Lowe was not a passive partner in the marriage. She was able to assert her views and opinions (e.g. when she told a doctor that Mr. Lowe was not sleeping and when she informed a care navigator that Mr. Lowe overly worried about her.)

2.6.19 Mrs. Lowe, for some reason, would be able to present to strangers or casual acquaintances as being quite lucid. Many of the statements given to the police say this but that contrasts starkly with what was known by those who knew her best – Gail, Mike and the next-door neighbours. They all give a very different account of her being unable to remember very simple conversations, events and really struggling to cope. When Mr. Lowe was admitted to hospital to have a colostomy fitted, despite having been told this, Mrs. Lowe appeared at her neighbours' house in a distressed state as she could not find her husband.

2.6.20 During this period of Mr. Lowe's hospitalisation, it had become necessary for friends and family to leave notes all over the house reminding Mrs. Lowe to carry out basic tasks, as well as where her husband was, and telling her not to panic.

2.6.21 As her condition worsened, Gail and Mike tried very hard to persuade their mother to undergo a second psychiatric assessment. She refused and Mr. Lowe supported her rejecting the idea. However, up until her death somehow she was still able to appear to some as being in much better health than she was. The family wonder whether she was actually aware of her condition.

2.6.22 By the early summer of 2016, Mr. Lowe knew that when he next went into hospital it would be very difficult for Mrs. Lowe to look after herself. He suspected that when he did go in again, he would be unlikely to come out. He was suffering intense and constant pain – he would not take morphine – and he was barely mobile.

2.6.23 The family felt that, while Mrs. Lowe slept on the sofa to be near Mr. Lowe, whose bed was by now in the lounge, she did not really recognise the physical pain and distress he was in and if she did see it, she would be seeing it for the first time.

2.6.24 The family had hoped to slowly introduce some outside care through Age UK. To support this, the next-door neighbour, who is a fire fighter, made a referral to Age UK through the Isle of Wight Fire and Rescue Service 'Isle be Safe and Well' scheme. This was one of the rare occasions that they accepted some support. However, as described later, this did not result in any further significant ongoing help being agreed to.

2.6.25 Mrs. Lowe had always made it clear that she did not want to go into a care or nursing home or have carers. She was adamant about this. Mr Lowe, on the other hand realised she would need help and therefore tried to encourage her to accept it but eventually, through his sense of loyalty, he supported her decision.

2.6.26 In the last few months of their lives, Mr. Lowe pleaded with his children not to force things on them and to respect their wishes. Gail and Mike said that they also did not want every conversation to be about care options. They knew their father had capacity and he was expressing his wishes very clearly to them. They also knew he did not have long left and wanted to enjoy his final days, as much as he could, without facing pressure from them or anyone else.

2.6.27 Options seemed to be running out for how Mrs. Lowe would be cared for when Mr. Lowe's inevitable hospital admission occurred. Mike described Mr. Lowe as being severely clinically depressed. It seemed to the family, in hindsight, that once

Mrs. Lowe had said she did not want outside care he had made his mind up of what he was going to do.

2.6.28 It was fortunate that both Mike and Gail had been over to see their parents just before their deaths. Both were encouraged by Mr. Lowe to take their mother for a walk on those visits. Also in hindsight, they felt that this was their father engineering for them some final quality time with their mother. The farewells at the end of the visits were unusually poignant too with Mr. Lowe holding them for just a little longer than usual.

2.6.29 Neighbours described seeing Mrs. Lowe looking physically less healthy over the last few months of her life. One said that Mrs. Lowe struggled to recognise him, despite them knowing each other well. The next-door neighbour said that Mr. Lowe insisted on paying him some money for a new fence they had agreed to jointly fund, despite him not needing payment until after he had bought the materials.

2.6.30 The family knew how fixed both Mr. Lowe and Mrs. Lowe could be in what support or interventions they would entertain. Gail and Mike found this deeply frustrating, especially as they lived so far away so could not be on hand every day. They knew of the medical interventions that Mr. Lowe had declined and of the lack of care options Mrs. Lowe would allow should Mr. Lowe go back to hospital or be unable to care for her.

2.6.31 However, they do question why no professional joined the dots regarding how life was deteriorating for their parents. While the psychiatric diagnosis, nearly two years previously, was one of mild cognitive impairment, their GP was aware that there had been deeper concerns raised by the family. The GP would also have known that Mr. Lowe's condition was deteriorating. The family rightly question why no one enquired who was looking after Mr. Lowe; whether Mrs. Lowe – given her diagnosis – was capable of caring for him or vice versa and why no carer assessments were carried out.

2.6.32 Clearly Mrs. and Mr. Lowe may not have accepted any additional support had those questions been asked and enquired into, but they may have done. The fact is they were not asked and, other that Age UK and the next-door neighbour, no-one considered their worsening situation in the round so no-one else offered any additional support based on their combined needs to enhance their quality of life, health or wellbeing. Any opportunity to accept or decline was denied by this omission.

2.7 Individual Management Review – Primary Care

2.7.1 The individual management review in respect of primary care was carried out by the Named GP for Safeguarding Adults and Children for the Isle Of Wight Clinical Commissioning Group. She has extensive experience but has no personal knowledge of either Mrs. Lowe or Mr. Lowe neither does she have any connection with the general practice surgery at which Mrs. and Mr. Lowe were registered.

2.7.2 Throughout the period under review both Mrs. and Mr. Lowe were registered at the same GP surgery. Although that time period is from 1st April 2011 to 20th June 2016, the IMR author has reviewed medical records from 2000 in respect of Mrs. Lowe and 2001 in respect of Mr. Lowe.

2.7.3 Mrs. Lowe was normally fit and well and not on any regular medication. She had surgery for endometrial cancer in 2000 and her blood pressure was variable and often on the upper end of the normal range.

2.7.4 In autumn 2014 she saw her GP regarding short-term memory loss. Her son and daughter expressed concerns that she was forgetting things such as what she had gone to the shops for and what she had for dinner. On testing she could not

recall words but her numeracy and reasoning were good. She was referred to the memory service where she was assessed by the Older Persons Psychiatric Team and diagnosed with mild cognitive impairment. She was discharged from the clinic with no further follow up.

2.7.5 In late 2014 she was seen twice for hypertension screening assessments where, on the second occasion, her blood pressure was found to be moderately raised. This was repeated in early 2015 when she was normotensive so no medication was required.

2.7.6 Two months later she was seen with abdominal pain after a fall in the street. She was asymptomatic and the clinical examination was entirely normal. Extensive baseline bloods and an ultrasound were organised at this time all of which were subsequently reported as normal.

2.7.7 Other than annual influenza vaccines, the last being in autumn 2015, there were no other occasions during the period under review that Mrs. Lowe was seen by her GP.

2.7.8 There were no details regarding Mrs. Lowe's socio-economic circumstances, her home environment or family relationships recorded in the notes. One entry, prior to the period under review, in the summer of 2008 describes that she attended with a dry cough. It was documented that she was "accompanied by husband (he was quite firm that he attended during the first part of the consultation.)"

2.7.9 Mr. Lowe had known hypertension for which he was reviewed regularly and prescribed medication. He suffered a number of side effects from his medication and expressed his displeasure at the operational aspects of the medical system. In 2008 he felt medication ruined his quality of life and the time taken to collect medication was unacceptable. That year he wrote to the practice complaining of feeling low and tired all the time, humourless and "looking for domestic trouble." He found the regular need to urinate at night unacceptable and not conducive with satisfactory rest.

2.7.10 In 2009 he was diagnosed with locally advanced intermediate high-risk prostate cancer. At this time there was no evidence of metastatic disease on MRI and he declined radical surgery, radiotherapy (other than once) and hormone treatment opting only for a Transurethral resection of the prostate (TURP.) He was prescribed medication for symptomatic relief and reviewed at three monthly intervals initially.

2.7.11 Nice Guidance[3] on advising patients with localised and locally advanced prostate cancer recommends that diagnosis and prognosis with treatment options should be discussed with a patient in the specialist secondary care clinic. All care must be patient centred, involving the patient (and family / carers if appropriate) and advice can be proffered but it must be the patient's informed choice. For this to be ensured, a capacity assessment must be undertaken and documented if there is any doubt pertaining to the decision. There seems to be no such doubt and the guidance, in respect of this was followed.

2.7.12 In summer 2012 Mr. Lowe requested six monthly check-ups as his intention was not to have any intervention. However, in late 2012 he wrote to his GP concerned at the rise in his Prostate-specific antigen (PSA) and his leg pain; he also sent his blood pressure readings which he had taken at home the previous day.

2.7.13 Many patients self-monitor and contact their surgeries with various observations. This is especially true of blood pressure as this can be raised unnaturally in a clinical setting ("white coat hypertension"). With the developments in

[3] https://www.nice.org.uk/guidance/cg175/chapter/1-recommendations#localised-and-locally-advanced-prostate-cancer-2

modes of consultations e-consult, video conference and telemedicine, surgeries encourage much more self-management if possible.

2.7.14 The tone of some of the letters may indicate that he may be a patient who needed to see a specific GP for continuity and relationship. His letters suggest he did not want regular monitoring or to attend the surgery unless absolutely necessary. It may have been that a regular planned review at a convenient time, with intermittent sharing of self-monitoring results, would have been more conducive to maintaining the relationship and both being able to have some input into his care.

2.7.15 The GP has met with the IMR author. He said that he encouraged Mr. Lowe to write letters as he found this a useful way to keep him, the GP "up to speed" with his various consultations in secondary care without Mr. Lowe having to come in. The GP would often follow them up with a phone call but this was not always documented in the individual patient record. The IMR author did discuss this with the partners and reiterated that all interactions and communications with patients should be acknowledged and documented in the notes.

Recommendation 1

Primary Care practitioners should be reminded of the importance of recording all patient interactions, of any nature, in the individual patient record so as to provide a full record of care and communication.

2.7.16 In the spring of 2013, he was referred to an orthopaedic surgeon regarding the right leg pain. He underwent radiological investigations and the cause was attributed to metal work from multiple fractures sustained in a significant road traffic crash twenty years previously. At this point the orthopaedic surgeon noted the increasing PSA and alkaline phosphatase and recommended a referral back to Urology as the scans indicated possible pelvic metastasis. Mr. Lowe declined, saying he did not want to see the urologist again.

2.7.17 In summer 2014 Mr. Lowe was admitted with urinary retention and fitted with a urinary catheter. The same month his PSA started to rise significantly indicating progressing disease. He was referred to and saw the urologist who, after counselling, in line with the NICE Guidance on advising patients with localised and locally advances prostate cancer, started Mr. Lowe on hormone therapy and ordered a pelvic and whole body MRI. He was also referred for palliative radiotherapy for his hip pain.

2.7.18 This MRI demonstrated locally advanced as well as metastatic disease. His catheter was successfully removed in the autumn of 2014 but he continued to suffer for urinary symptoms and recurrent infections.

2.7.19 He developed further urinary symptoms and, despite hormone therapy, his PSA continued to rise over the next year. An MRI scan in autumn 2015 detected his prostate tumour was, by now obstructing his bowel. After several attendances at the surgery he had declined admission for surgical intervention. He was initially treated with medication but his symptoms persisted and his condition deteriorated. As a result he was eventually admitted for surgery to fit a colostomy in late 2015.

2.7.20 During that admission he underwent palliative radiotherapy for the extensive pelvic metastasis for pain relief and it was noted he had a number of falls during this time. He was followed up at 2 monthly intervals and attended for review of his PSA and adaptation of his medication for adequate pain relief. He had a further scan ordered in late spring 2016 when he developed significant pain in his right arm.

Analysis of Involvement

2.7.21 While primary care is often the first point of contact for people experiencing domestic abuse (after the police)[4] there is no evidence that Mrs. Lowe told, or even intimated to, her GP that she was suffering or feared domestic abuse. She rarely attended the surgery and, for those matters when she did seek help, none could reasonably be assumed, of themselves, to be symptomatic of domestic violence.

2.7.22 When Mrs. Lowe did seek treatment she was taken seriously and referred to appropriate services for those conditions or for investigation.

2.7.23 Mr. Lowe could best be described as a reluctant patient. He had a number of health issues related to his hypertension and, most significantly, his prostate cancer. He would challenge the management of his conditions (such as the inconvenience of collecting of prescriptions from the surgery or pharmacy) and declined surgical or radiological intervention for his cancer.

2.7.24 In one letter to his GP in autumn 2008 he wrote, "I feel low and tired all the time, humourless and looking for domestic trouble", he complained of being irritable and wrote, "ask my wife". No one enquired further into this unusual description of how he felt nor did anyone consider that it might be indicative of tension at home.

2.7.25 This might have been even more pertinent as, in the previous month he had been insistent that he attend a consultation with Mrs. Lowe when she presented with a dry cough. This was the only time he did this. On neither occasion was any 'routine' or 'targeted' enquiry made as to whether domestic violence or abuse was a factor in their lives.

2.7.26 These two incidents were before the review period but are worthy of comment. They were before Mr. Lowe was diagnosed with cancer and before the concern that Mrs. Lowe was suffering from the early signs of dementia. However, Mr. Lowe was being treated for hypertension and seemed to relate his concern over the time taken to collect prescriptions and their side effects with "looking for domestic trouble" and the proposition that the GP should "ask my wife." This could have been as much a cry for help that Mr. Lowe would ever be likely to give, but it was not heard.

Lessons Learned 1

Some Primary Care practitioners have a poor knowledge base or understanding of the prevalence and risk factors for Domestic Violence and do not routinely enquire whether it is a factor in their patients' lives. This may be a consequence of there currently being no mandatory training regarding domestic violence within primary care on the Isle of Wight.

Recommendation 2

That Isle of Wight Clinical Commissioning Group supported by NHS England, develop mandatory workforce development measures for Primary Care to ensure that the knowledge and understanding of the prevalence and risk factors around domestic abuse are fully understood enabling them to embed the NICE Quality Standards on Domestic Violence and Abuse[5] into practice.

2.7.27 Most practices will review patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. These patients

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215635/dh_125938.pdf
[5] https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-75545301469381

quickly resume consultations in general practice at an increased rate to pre-diagnosis and treatment, therefore primary care has an important role in managing survivorship. This review represents an initial opportunity to address patients' needs for individual assessment, care planning and ongoing support and information requirements.

2.7.28 These reviews will only provide a snap shot in time so should be repeated regularly to ensure developing and changing care and support needs are identified and met. The frequency of these reviews is something that may be negotiated between GP and patient taking into account clinical and lifestyle factors.

2.7.29 Mr. Lowe's diagnosis was coded in late 2009 but there is no evidence of an in-depth formal assessment. Similarly in summer 2010, each entry clearly documents "under care Urology" with a "review every 3 months." Mr. Lowe had by this point declined active surgical and radiological intervention. There is no evidence that this was discussed in primary care or considered as a risk or vulnerability for the couple as his condition deteriorated.

2.7.30 There is no record of a full physical health or wellbeing check being carried out for either Mrs. Lowe or Mr. Lowe in primary care during the review period. This is a chance to consider the patient holistically by also enquiring and discussing their social and environmental circumstances, their diagnosis and prognosis and the impact of that on their health and emotional wellbeing. This may have highlighted risk factors and opportunities for support and intervention.

2.7.31 There is no evidence of any formal assessment of either individual's mental capacity in primary care. This is especially pertinent to Mrs. Lowe who was coded as "senile dementia" and referred to the memory clinic where she was diagnosed with mild cognitive impairment and discharged and to Mr. Lowe when he repeatedly declined treatment and active management.

Lessons Learned 2

Following a new diagnosis of cancer, Primary Care practitioners do not always regularly review patients' physical health, mental health, mental capacity or wellbeing. This misses the opportunity to address any changing needs, care plans, requirements or support especially where the patient's main carer develops their own care and support needs.

Recommendation 3

That Isle of Wight Clinical Commissioning Group, in conjunction with NHS England, remind Primary Care practitioners of the importance of leading the arrangements for regular multi disciplinary reviews of the treatment and care and support needs of patients with new diagnoses of cancer based upon assessments of their holistic health and wellbeing and that of any carers.

2.7.32 There is a GMS contractual requirement to provide a named and accountable GP for over 75s. The contract requires the named accountable GP to take responsibility for the co-ordination of all appropriate services required under the contract and ensure they are delivered to each of their patients where required (based on the clinical judgement of that GP). This has since been extended to all registered patients. Specifically for the over 75's this means that the Named GP will:

- work with relevant associated health and social care professionals to deliver a multi-disciplinary care package that meets the needs of the patient

- ensure that these patients have access to a health check

2.7.33 This should be a full physical assessment and holistic review of the care requirements for each patient. Mrs. Lowe had her blood pressure measured when she attended following a fall but had no routine screening or review in the last 2 years of her life.

2.7.34 Mr. Lowe had a number of 'hypertension' and 'over 75' coded entries added in a cancer care review in autumn 2013 but there is no evidence that any assessment was undertaken for his care needs or those of his wife given his rapidly deteriorating health. This is a missed opportunity especially as both patients were registered at the same practice and had the same named accountable GP.

2.7.35 Each registered patient is required to have his or her medication reviewed at least annually. This involves checking compliance, side effects and potential interactions between different medications if more than one pharmacological agent has been prescribed.

2.7.36 Mr. Lowe had declined a number of medications because of side effects. He was under the care of urology who after counselling, prescribed him a number of tablets and injections. There is no evidence that compliance was checked but equally no evidence that his mental state changed over the period as a consequence of his medication. There is no clear documentation that this was proactively managed in primary care; the records suggest the majority of his management was coordinated by secondary care, including his specialist medication, and he only attended the surgery for monitoring blood tests and in the event of acute symptoms.

2.7.37 Medication review, in general, is the responsibility of Primary Care. On admission as an inpatient, all medicines are checked within 24 hours and anything requiring review would be highlighted. During outpatients consultations, there would be a review of the specific drugs for the condition only.

2.7.38 There was little evidence of multi-agency working led by the GP during the review period. Mrs. Lowe was rarely seen in surgery, the last time in 2015 following a fall in the street. Mr. Lowe had multiple teams involved in his care including community nursing, palliative care, urology and the practice. Secondary care coordinated the care and liaised with the practice who worked very much in a responsive manner even when Mr. Lowe care was palliative.

Lessons Learned 3

In the case of some patients over the age of 75, some named and accountable GPs do not meet their contractual requirements in respect of undertaking full physical assessments and holistic reviews of their care requirements, undertaking medication reviews and co-ordinating multi agency care packages that meets their needs.

Recommendation 4

That NHS England, supported by the Isle of Wight Clinical Commissioning Group, develop robust mechanisms to assure that the contractual requirements regarding the function of named and accountable GPs are adhered to fully so that this cohort of potentially vulnerable people receive co-ordinated and tailored health care which meets their changing needs.

2.7.39 95% of GP surgeries adopt the basic principles of The Gold Standards Framework (GSF)[6] at foundation level. This aims to improve the quality and organisation of care for all people nearing the end of life. This process facilitates the Advance Care Planning discussions thus enabling better coordination and integrated working aligned with the wishes of patients and their families. There is no evidence that this was done for Mr. Lowe. This was a missed opportunity to explore his wishes and any possible concerns and those of his wife.

Recommendation 5

General Practices across the Isle of Wight should adopt the principals of The Gold Standard Framework so that they are able to offer integrated and co-ordinated end of life care which meets the wishes and needs of their patients and their families.

2.7.40 Following Mrs. Lowe's diagnosis of "mild cognitive impairment" there was no discussion with her regarding how to manage the impact of this, how it would effect her role as carer for Mr. Lowe (one consultation mentions her having this role) nor the inconsistency between her family's perception of the gravity of her impairment and that held by the psychiatrist. No information was provided to help Mrs. Lowe should her condition deteriorate and no plan to re-asses her was in place.

Lessons Learned 4

In some cases, mild cognitive impairment in the older population can be seen as a static state rather than the onset of dementia and worsening mental health. The consequence of this is a lack of further review or the provision of information should symptoms deteriorate. Had Mrs. Lowe's health check been in place, this may have been picked up.

Recommendation 6

Linked to Recommendation 4, NHS England supported by CCG should ensure that older patients who have a diagnosis that may indicate a progressive illness, including but not restricted, to dementia have information provided to them should their symptoms worsen and have their condition and care and support needs regularly reviewed.

2.7.41 A recent NHS document, 'An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing'[7], published in May 2016, reminds those delivering health and social care functions of their responsibilities towards carers under the Care Act 2014 and its statutory guidance around Care and Support[8].

2.7.42 It also promotes the adoption of a Memorandum of Understanding around seven principles to identifying, assessing and supporting Carers' health and wellbeing needs. These include; supporting the identification, recognition and registration of Carers in primary care, carers having their support needs assessed and receiving an integrated package of support, carers being empowered to make choices about their caring role and access appropriate services and support for them and the person they look after and carers being supported by information sharing between health, social care, carer support organisations and other partners.

[6] http://www.goldstandardsframework.org.uk/primary-care-training-programme
[7] https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf
[8] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

2.7.43 While this was published just a month before Mrs. and Mr. Lowe died, the principles reflect the Care Act 2014 and it was significant that no carer's assessment was carried out regarding their ability to care for one another and what support each may need.

Lessons Learned 5

The principles of the Care Act 2014 in identifying, assessing and supporting carers' health and wellbeing needs is not fully embedded across the Isle of Wight health and social care system, potentially leaving some without the necessary support and information they require to provide care, especially when they have their own care and support needs.

Recommendation 7

That the Isle of Wight Safeguarding Adults Board works with the Health and Wellbeing Board to adopt the Memorandum of Understanding suggested in 'An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing' in order to demonstrate commitment to the duties of co-operation and promotion of wellbeing, as well as the wider commitment to identifying, recognising, assessing and supporting Carers.

2.7.44 Given that domestic violence, or any other abuse or neglect, was not identified it would not have been expected that, either under the Isle of Wight Safeguarding Adult Policy 2010 or the 2015 version[9] updated as a consequence of the Care Act 2014, Mrs. Lowe or Mr. Lowe's situation would have been raised as a safeguarding alert or concern.

2.7.45 The Isle of Wight Safeguarding Adults Board set up a Vulnerable Adults panel in 2015. Its purpose is to receive referrals from all agencies of adults who have a vulnerability yet do not meet the eligibility criteria to be provided with statutory safeguarding provision. The panel is multi agency consisting of the Local Authority, Fire Service, Police, NHS Trust, Public Health and housing providers. It considers referrals and provides or recommends interventions from partners. Many referrals are made where individuals are not engaging with other services but are perceived to be vulnerable or at risk.

2.7.46 This appears to be a useful forum for helping those who, due to eligibility thresholds, may fall between the gaps of statutory services yet still have need or those not engaging. Had Mr. and Mrs. Lowe been referred to such a panel, a multi agency plan **may** have been developed and there **may** have been suitable interventions to address their needs or encouraged them to engage with services.

Lessons Learned 6

There may be a lack of awareness of the role and function of the Vulnerable Adults Panel on the Isle of Wight. This may mean that those people who fall below the safeguarding threshold, yet still have needs, are not considered in a multi agency environment potentially leaving them vulnerable.

[9] https://www.iwight.com/azservices/documents/2880-4LSAB-Multi-Agency-Safeguarding-Adults-Policy-and-Guidance-May-2015.pdf

Recommendation 8

That agencies on the Isle of Wight ensure that professionals who encounter those people with safeguarding needs that may fall below the eligibility threshold are aware of the Vulnerable Adults Panel, are familiar with its role and function and are trained so as to be confident in identifying relevant cases and making referrals to it.

2.8 Individual Management Review – Isle of Wight NHS Trust

2.8.1 The IMR for the Isle of Wight NHS Trust was co-ordinated by the Adult Safeguarding lead of the Trust drawn from material provided to her by the areas of the Trust that had contact with Mrs. Lowe or Mr. Lowe. She has extensive experience of safeguarding adults but was not directly involved or responsible for the delivery of services to these patients.

2.8.2 The Isle of Wight NHS Trust is the only integrated acute, community, mental health and ambulance health care provider in England. Established in April 2012 following the separation of the provider and commissioner functions within the Isle of Wight PCT, the Trust provides a full range of health services to an isolated offshore population of 140,000.

2.8.3 In-patient services and Emergency Services are based on site at St Mary's Hospital, Newport, with additional community services provided in community locations across the island in 3 localities.

2.8.4 Services are further arranged into 5 Clinical Business Units for governance purposes as follows:-

- Clinical Support, Cancer & Diagnostic Services which includes associated inpatient services and Pharmacy services
- Medicine which includes all associated medical specialities and medical wards
- Ambulance, Urgent Care and Community Services which includes the Emergency department and community nursing services
- Surgery, Women's and Children's Health which includes maternity Services and
- Mental Health and Learning disabilities, which includes inpatient and community mental health services and drug and alcohol services (Island Recovery Integrated Services- IRIS.)

2.8.5 Each of the Clinical Business Units submitted a management review for the purposes of this Domestic Homicide Review

2.8.6 Prior to the period of this review, Mr. Lowe had been diagnosed with prostate cancer (2009) resulting in him being under the care of the **Clinical Support, Cancer & Diagnostic Services.** He had surgery and subsequently was having regular follow up appointments by the urology and oncology teams.

2.8.7 In summer 2011 he was discharged from urology into shared care with his GP, as he was reluctant to have further treatment. Having been referred to orthopaedics by his GP in spring 2013 due to leg pain, he declined an MRI scan but agreed to be seen eight weeks later. Tests revealed that he should be re-referred to urology but he declined.

2.8.8 In summer 2014 he was admitted, by **ambulance**, through A and E for a catheter to be inserted due to urinary difficulties. The ambulance had been called to

Mr. Lowe's home address and it had been the intention to take him to the Beacon Out of Hours surgery but the decision was taken to transport him to A and E for assessment and treatment. This was the only time either Mrs. Lowe or Mr. Lowe was attended to by the ambulance service.

2.8.9 The subsequent procedure being successful and, following a conversation regarding care with his son, Mr. Lowe was discharged home with analgesia. The following month he was referred back to urology due to abnormal blood results. At this appointment Mrs. Lowe was present and raised concerns regarding Mr. Lowe's reduced mobility and increased sleeping. From this point on he was seen regularly within outpatients, by both the urology doctors and specialist nurses, referring him back to urology and oncology in late summer 2014.

2.8.10 His general condition stabilised until autumn 2015 when he was admitted to hospital with a history of his bowels not being opened for 3 weeks. Following all investigations including a scan, he was diagnosed with chronic constipation and discharged shortly after. He was then seen in clinic by the colorectal team and was placed on the waiting list for bowel surgery and admitted for surgery later that month staying in hospital for just over two weeks later.

2.8.11 During this period he travelled to the mainland for radiotherapy treatment. It appeared that he only had one such treatment. On discharge he was provided support at home from palliative care and with a stoma. District nurses were arranged prior to discharge and he was regularly reviewed by oncology.

2.8.12 Between summer 2014 and the beginning of 2016 Mr. Lowe received community nurse visits from the **Community Services** area of the trust. These were connected with catheter care and enema administration. There were no concerns identified either with the medical procedures or with the relationship between Mrs. and Mr. Lowe.

2.8.13 In late 2015 Mr. Lowe asked for telephone contact rather than a visit and this was adopted. The following month the final Community Nurse visit was for a 'Trial without Catheter' to be performed and the catheter was removed with consent. Telephone calls were made later that day to check progress. Mr. Lowe was reported as having successfully passed urine, with no discomfort. All relevant information was given, and in the event of concerns, numbers to contact.

2.8.14 It is quite normal practice for the district nurses to provide telephone support for patients with long-term urinary catheters – especially if following up from a previous intervention. Catheterised patients are encouraged to self-care and the nurses usually only see them every 12 weeks for routine catheter changes. For this reason, it would not be normal for the community nursing team to inform the GP that telephone contact had been requested.

2.8.15 In this case Mr. Lowe was seen by a bank registered nurse who may have assumed others would be visiting weekly for assistance with catheter bag change and support which sometimes happens. This may explain why Mr. Lowe asked for a phone call support instead as he was experienced in his catheter care.

2.8.16 Mr. Lowe was deemed to have the capacity to understand all the information given, with no concerns reported. No further intervention was required from the Community Nursing team.

2.8.17 Team members who recall Mrs. and Mr. Lowe report that there was no concern at all about their interaction and certainly none was ever documented or brought back to the team for discussion, nor were there any concerns raised about either's ability to manage independently

2.8.18 In late 2014, the memory service – part of the **Mental Health and Learning Disability Services** provided by the trust - received a referral from Mrs. Lowe's GP detailing that her "memory was failing, she writes lists, her son and daughter have both commented on this and that Mr. Lowe was sick with prostate cancer." The referral reported that her Mini–Mental State Examination (MMSE)[10] was 23/30 with "the recall of words being completely beyond her." A score of 23/30 indicates 'mild impairment' where 'formal assessment may be helpful to better determine pattern and extent of deficits.' The guide indicates there may be 'significant effect on day to day functioning' and the patient 'may require some supervision, support and assistance.'

2.8.19 Two weeks later, Mrs. Lowe was seen at home by a consultant psychiatrist. She said that she had short-term memory loss. It was noted that Mr. Lowe told of a nine-month history of gradually deteriorating short-term memory, forgetting recent events and "everyday mundane things." She said she had no word-finding difficulties and no hallucinations but there was a definite fluctuation in her symptoms from day to day.

2.8.20 The psychiatrist found that she was 'calm and co-operative with normal speech and euthymic mood and was not psychotic,' and that 'her insight was fair.' She scored 26 out of 30 on the MMSE and 80 out of 100 on the Addenbrookes Cognitive Examination[11] (ACE-R) with a 'significant deficit only in the domain of memory.'

2.8.21 He diagnosed Mrs. Lowe as having mild cognitive impairment and perceived no risks. He informed Mrs. Lowe and, with her consent, Mr. Lowe of this and discharged her. There was no advice provided either to Mrs. or Mr. Lowe nor to the GP other than to re-refer her if her metal state deteriorated. No members of the family were consulted about symptoms and no care plan was considered.

Analysis of Involvement

2.8.22 None of the presentations of either Mrs. Lowe or Mr. Lowe indicated, in themselves, that domestic violence and abuse was a factor in their relationship. However, Mr. Lowe's deteriorating physical health – coupled with him declining certain treatments – and the worries about Mrs. Lowe's cognitive deterioration demonstrated that this was a couple who had developing care needs.

2.8.23 Once it was clear that Mr. Lowe had capacity – and there had never been a suggestion that he did not – his wishes regarding his treatment were respected. Alternatives were offered and, where he accepted them, adopted.

2.8.24 The one interaction Mrs. Lowe had with IOW NHS Trust related to her memory problems. In both the referral and the assessment it was noted that Mr. Lowe was in poor health but the impact of her mild cognitive impairment with his increasing needs was never considered in terms of them being each other's carer. Only information from Mrs. and Mr. Lowe was considered, despite it being clear from the referral that other family members held concerns. There was also no plan for Mrs. Lowe's condition to be monitored nor any advice provided to her should she or her husband consider her symptoms to be in decline.

[10] http://www.dementiatoday.com/wp-content/uploads/2012/06/MiniMentalStateExamination.pdf
[11] http://egret.psychol.cam.ac.uk/medicine/scales/dubious/ACE-R_2005_scoring_guide.pdf

Lessons Learned 7

While memory service assessments are undertaken in a timely way and at the patient's home, they do not take into consideration the needs of carers nor provide guidance as to how to seek help should symptoms deteriorate or care needs are no longer able to be met.

Recommendation 9

Isle of Wight mental health and learning disabilities services should ensure that all assessments take into account the needs of carers and, where appropriate, referrals to carers' support agencies should routinely be offered as well as information regarding available services and pathways should the patient's condition deteriorate or needs change.

2.8.25 On one occasion a health professional contacted a relative to discuss care for Mr. Lowe but, other than that, their care needs were neither considered nor addressed. Particularly when Mr. Lowe started to decline various forms of treatment, how he was able to live with the consequences of those decisions was not a factor addressed and certainly never considered in light of Mrs. Lowes apparent deteriorating mental health.

2.8.26 That said, there was never an indication that Mrs. and Mr. Lowe were **not** coping nor that either was suffering from carer stress but this was never explored. From all of the evidence presented to this review, this was a couple who treasured their independence and would do all they could to cope on their own. They might have denied there were any problems in caring for themselves or one another or may have asserted that they were able to deal with any stress that may be arising. They may have declined services offered to them. However, the fact remains that they and, other than once, their family, were never asked so the trust was blind to any opportunities to help.

2.9 Individual Management Review – Isle of Wight Fire and Rescue Service

2.9.1 Isle of Wight Fire and Rescue Service (IOWFRS) provide the statutory response service to fire and emergency incidents across the Island. Similar to other Fire and Rescue Services across the UK, IOWFRS works closely with a number of council service areas including community wellbeing and social care, children and young people services, economy and environment as well as partner agencies including the police, the NHS and the community and voluntary sector to collectively deliver local initiatives and agreements.

2.9.2 As part of their preventive initiatives, IOWFRS offer local residents free Home Fire Safety Checks. These checks provide advice to residents on general fire safety awareness, smoke alarms and escape routes. The allocation of Home Fire Safety Checks correlate with target groups that, data identifies, are at higher risk from accidental dwelling fires. These groups are lone pensioners, people with long term illness and single parents as well as those in rented accommodation (private and housing association) homes of multiple occupancy, shared houses and some self-contained flats. These checks are called 'Isle be Safe and Well' checks. In the course of these, or any other, interactions with the public IOWFRS have arrangements whereby they can refer people to other services for support. Such referrals are made with consent. One agency to whom IOWFRS will refer is Age UK.

2.9.3 The IOWFRS IMR was completed by a senior manager within the service who was independent of the services provided.

2.9.4 Originally it was thought that IOWFRS undertook a Home Fire Safety Check through their normal allocation and prioritisation process. The reason for this was that Age UK Isle of Wight received an 'Isle be Safe and Well Visit' referral form requesting that they provide Mrs. and Mr. Lowe with further support. The form appeared to have been signed by Mr. Lowe.

2.9.5 However, further investigation revealed that, acting in the capacity as Mrs. and Mr. Lowe's next door neighbour, an off-duty Firefighter from IOWFRS was aware of their support needs. The Firefighter, who is trained in the services available through Age UK, gave Mr. Lowe an 'Isle Be Safe and Well Visit' referral form to enquire about support services available through Age UK. Mr. Lowe completed this form, indicating an interest in receiving support from Age UK in a number of areas. A Care Navigator from Age UK subsequently contacted Mrs. Lowe and arranged a visit to discuss this request for support.

2.9.6 IOWFRS had no further contact with Mrs. and Mr. Lowe during the period under review.

Analysis of Involvement

2.9.7 While IOWFRS did not have any organisational contact with Mrs. and Mr. Lowe, the fact that one of their Firefighters had the sense to use his training and knowledge to use IOWFRS referral pathways to meet their needs is commendable.

2.9.8 The Firefighter concerned was one of those who knew Mrs. and Mr. Lowe well and had seen their decline over the year prior to their deaths. He also knew that they rarely accepted services and that Gail and Mike had wanted them to avail their parents of Age UK support. He used his unique position by applying his personal and professional knowledge to ensure that happened. Even though they did not accept many of the services subsequently offered to them, this was an important step in attempting to meet their care and support needs.

Good Practice Point 1

The Isle of Wight Fire and Rescue service enable their 'Isle be Safe and Well' referrals to be made by trained staff acting in a personal as well as professional capacity in appropriate cases. Other agencies would be well advised to ensure their staff are enabled to act in this way.

2.10 Individual Management Review – Isle of Wight Age UK

2.10.1 Age UK Isle of Wight is a voluntary sector organisation which, supported by a large volunteer force, delivers a number of services to the older population of the Isle of Wight. Its IMR was written by a Team Leader from a different part of the service to that which met Mrs. and Mr. Lowe.

2.10.2 It provides a provide free independent, impartial and confidential information and advice service that enables people to make informed decisions and exercise maximum control over their lives.

2.10.3 Its Good Neighbour Scheme, supported by 550 volunteers, provides help for people with no other support. Among the areas it helps in are befriending and visiting those who feel lonely or isolated, helping with outings or shopping, carrying out small tasks in the home, providing confidential support for those suffering domestic abuse and helping those going through illness or bereavement regain confidence.

2.10.4 Its Health and Wellbeing service includes community memory groups, a care navigator service, a falls prevention service and a hospital discharge support service.

2.10.5 In early 2016 Age UKIW received an 'Isle Be Safe & Well' referral form from Isle of Wight Fire and Rescue Service. In answer to the question 'Any comments or

other areas of support?' it was recorded: "We need general household support, please, and would welcome an assessment of our requirements." It is not known whether Mrs. Lowe or Mr. Lowe made that comment but the form seemed to have been signed by Mr. Lowe.

2.10.6 As a consequence of this referral Age UKIW determined that Mrs. and Mr. Lowe would benefit from their Care Navigator service. A Care Navigator (CN) uses a holistic person centred approach to support and navigate individuals through statutory, voluntary, health and social care services. Based in GP surgeries they provide advice and guidance for people over 50 who may require extra support to remain independent in their own home. Support is offered for a limited period to empower people to self manage and make informed choices.

2.10.7 Given the CN was based in the GP surgery, it would have been expected that the referral would have come from the GP had they been leading a multi disciplinary care package as required by their GMS contract.

2.10.8 During the CN's first visit, it was established that Mr. Lowe had prostate cancer and had some difficulty in moving about and getting dressed. As Mrs. Lowe had no such problems and that neither drove a car she would walk to the shops using a list prepared by Mr. Lowe. They had no financial concerns nor concerns about falling. They spoke of their family and the support they received from their neighbours.

2.10.9 Mrs. Lowe expressed a desire to go out for walks more but was reluctant to leave Mr. Lowe in the house alone for long. He was concerned how Mrs. Lowe would cope if he had to go back into hospital. On how she presented, the CN considered any dementia that Mrs. Lowe had was minimal and she was quite able to follow a line of conversation and provide logical answers. Mrs. Lowe denied that she needed support.

2.10.10 On discussing available support Mrs. and Mr. Lowe declined carers, nursing support, the Age UKIW 'Falls Prevention' service, Alzheimer's Cafe support, Memory Group support, support from Dementia Advisors and respite options. The did accept advice about claiming attendance allowance and an emergency telephone number for 'First Response.'

2.10.11 The CN visited again five days later and spoke to both Mrs. and Mr. Lowe, providing details of local gardeners from a 'Buy with confidence' list. Details of the 'Optio' driving support scheme were provided to Mr. Lowe. The CN then sat with Mrs.& Mr. Lowe and completed a form DS1500 for Attendance Allowance.

2.10.12 In spring 2016 the CN was due to visit again to go for a walk with Mrs. Lowe but as Mrs. Lowe had a cold she called to cancel the visit. It was re-scheduled for the following month.

2.10.13 On that occasion the CN and Mrs. Lowe went for a fairly long walk. During that, Mrs. Lowe made a point of introducing the CN to a friend who was providing her and her husband support. Mrs. Lowe said that her husband worried too much about her. She again declined introductions to walking groups, social groups, dementia advisors, Alzheimer's cafes and Memory Groups. On return to the house, Mr. Lowe reported that he was now receiving Attendance Allowance, had not followed up the gardener information but had filled in a form for Optio but had not yet submitted it. No further CN support was deemed necessary but contact details were left in case future help was needed.

2.10.14 During this last visit the CN formed an overall impression that Mrs. & Mr. Lowe were a couple with health problems but who were managing these issues

together and who did not want any help from outside organisations either statutory or voluntary sector.

2.10.15 No routine enquiry was made regarding whether domestic violence was a factor in Mrs. and Mr. Lowe's lives.

2.10.16 A routine enquiry with clients specifically regarding domestic abuse, sexual violence or carer stress does not form part of the Age UKIW Care Navigation Service client assessment process. However, clients are asked, as part of this process about their ability to deal with worries and anxieties, and whether they feel OK about their ability to cope with things. Should any relevant disclosure be made at any time during a CN encounter a referral would be made to the Age UKIW Older Persons Domestic Abuse Support Project.

Analysis of Involvement

2.10.17 The very fact that Age UKIW received a comprehensive referral from the IOWFRS demonstrates a close and effective working relationship between the two agencies. There were sufficient concerns to prompt Age UKIW to provide a service and they were quick to do so.

Good Practice Point 2

The arrangements between Isle of Wight Fire and Rescue Service and Age UK Isle of Wight to directly support those found to be in need, appear to be simple, timely and effective allowing older residents to access a range and variety of services to enhance their health, wellbeing and quality of life.

2.10.18 The CN in this case is a qualified social worker but an understanding of what a CN is (and is not) is important to make an assessment of the support provided. They aim to provide information and advice including signposting additional support services, advising on benefits and financial issues, housing issues and help in planning additional care and support.

2.10.19 They do not purport to be a crisis intervention team, a replacement for specialist health and social care services, a single point of contact or provide long-term interventions.

2.10.20 Age UKIW had no information at its disposal at any point during their engagement with Mrs. and Mr. Lowe that suggested that domestic abuse was present in their relationship. There were no disclosures or warning signs that may have created that concern.

2.10.21 Age UKIW have considered, during this review, whether their CNs should be asking mandatory questions around domestic abuse/violence. They conclude that they would need balance this requirement against its true value in a CN setting (e.g. most clients are seen as a couple and may say "no" anyway) against escalating any danger for the client who may then go on to being re-victimised as a result of answering the question either way.

2.10.22 This appears to be a wise position providing that if a client does reveal they are a victim of domestic abuse/violence or it is suspected through any signs or symptoms becoming evident, that CNs are aware of the course of action to be taken in such cases.

2.10.23 The CN assessment process looked at Mrs. & Mr. Lowe as individuals but also considered them in the context of their relationship together. The only obvious discrepancy was how Mr. Lowe's assessment and concern for Mrs. Lowe and her 'dementia' was not matched by how she presented to the CN. The CN found that although there was evidence of the early signs of very mild dementia, Mrs. Lowe was

still capable of shopping on her own and going for walks. Mrs. Lowe was also able to demonstrate an ability to follow a line of conversation and give logical answers. Although the CN addressed this with Mr. Lowe in conversation he maintained his view regarding his wife's condition. This would not, and did not, provide any reason to be concerned about Mrs. and Mr. Lowe from the contacts the CN had with them.

2.10.24 Age UKIW offered a number of services to Mrs. and Mr. Lowe and most were declined. Some were offered more than once but, again, they were declined. For those that were, in part, accepted (gardening scheme, driving support and the application for attendance allowance) the CN did as much as she could to help Mrs. and Mr. Lowe access them.

2.10.25 All CNs have received domestic abuse training. Given that the CN saw no signs or symptoms of domestic abuse nor did they receive any disclosure, there was no missed opportunity to refer Mrs. Lowe to any specialist domestic abuse support agency.

Section Three - Conclusions

The content of this section will address the terms of reference in the statutory guidance and will be organised to reflect the case specific terms of reference identified as part of the review.

1. Whilst Mrs. Lowe had no known contact with any specialist domestic abuse agencies or services, the review will consider whether there was any history of domestic abuse involving Mrs. Lowe and/or Mr. Lowe and therefore whether there were any warning signs.

3.1.1 From all of the information gleaned from family, professionals, friends and neighbours there was no suggestion that there was any history of domestic abuse between Mrs. and Mr. Lowe or involving either of them with anyone else.

3.1.2 The only possible sign was Mr. Lowe's mention in a letter, in 2008, to his GP that he was "looking for domestic trouble" and to "ask his wife." Given that no one enquired further about this it is not possible to understand what this comment referred to. This was a missed opportunity. However, from everything else considered by this review, there was no evidence to suggest that it revealed that domestic abuse was, or was at risk of, occurring.

2. How opportunities to 'routinely enquire' as to any domestic abuse, sexual violence or carer stress experienced by the victim or perpetrator were or were not identified and used by professionals and what was the outcome.

3.2.1 There was one opportunity to 'routinely enquire' whether domestic abuse was a factor in the lives of Mrs. Lowe or Mr. Lowe. That was the letter in 2008 (so outside the scope of this review but included nevertheless) in which Mr. Lowe wrote to his GP "I feel low and tired all the time, humourless and looking for domestic trouble," he went on to complain of being irritable and wrote "ask my wife."

3.2.2 This was not followed up or even referred to again. It could have meant different things but the fact that it appeared not to trigger curiosity in anyone is a cause for concern. This was of even greater concern as a month previously Mr. Lowe had insisted being present during a routine consultation with Mrs. Lowe when she presented with a dry cough. Some perpetrators of domestic violence prevent their victims attending medical appointments alone to discourage them from revealing the abuse they are suffering. There was nothing to suggest that was why Mr. Lowe was determined to attend that appointment but, once the surgery received his letter with the "domestic trouble" comment, the two events should have been put together and efforts made to ascertain whether Mrs. Lowe was safe.

3.2.3 It was notable, however, that there seemed to be no other efforts by Mr. Lowe to prevent Mrs. Lowe being alone with professionals, friends or family. In fact he was very happy for her to go to the shops alone and to go for a walk with the Care Navigator. This may indicate that he did not fear she would reveal that she was suffering from violence and abuse and, the evidence considered by this review points to the conclusion that she was not.

3.2.4 There were missed opportunities to consider how Mrs. and Mr. Lowe were managing to care for one another while each was living with deteriorating health. Mrs. Lowe's dementia was undiagnosed as the only assessment of her revealed she had 'mild cognitive impairment.' On the other hand, Mr. Lowe was well known to primary care, urology and oncology and each knew that he was getting sicker.

3.2.5 He was well known for declining various treatments, procedures and services and, given he had capacity, his wishes were respected. However, no one seemed to

ask the question as to how he was being cared for. Nor did anyone re-consider Mrs. Lowe's diagnosis and wonder whether she was able to meet Mr. Lowe's care needs or whether he could meet hers; no carer assessment was carried out in respect of either.

3.2.6 Both Mrs. and Mr. Lowe hid their worsening situation from everyone, except their family and immediate next-door neighbours. They were adamant as to what help they would and would not entertain and even their son and daughter struggled to persuade them to accept even the most basic support.

3.2.7 Therefore no one else recognised that they were struggling. Even if they had it may have been that they would have rejected offers of support. However, it did not occur to anyone to enquire how they were coping, nor to consider their complex care and support needs and how they might be addressed.

3. Whether professionals took opportunities to consider the health and wellbeing of Mrs. and Mr. Lowe as a couple as well as individuals, including any dependencies they had on one another and their capacity to manage those.

3.3.1 While efforts were made to meet Mr. Lowe's physical health needs and, on one occasion, Mrs. Lowe's mental health needs little consideration was given to the dependencies they had on one another.

3.3.2 Had annual health checks been in place for either, had professionals looked at their socioeconomic and domestic circumstances, how their care and support needs were being met and carried out carers assessments, they may have uncovered a couple struggling to look after one another as each of their health deteriorated.

3.3.3 Had greater efforts been made to learn the perspectives of their family, this may have provided those charged with meeting their health and wellbeing needs a richer understanding of how both Mrs. & Mr. Lowe's capacity to care for each other was diminishing.

3.3.4 Between them they were seen by primary care, psychiatric services, urology and oncology in relation only to their conditions and not their wider circumstances. No one joined the dots that their needs were not being met.

3.3.5 An exception to this was Isle of Wight Fire and Rescue Service and Age UK Isle of Wight who recognised that there were deeper needs than those directly caused by Mr. Lowe's cancer. However, to Age UKIW, Mrs. Lowe presented better than she did to her family and neighbours and Mr. Lowe appeared to be managing. Notwithstanding that, the Care Navigator did offer a whole range of services the vast majority of which were declined.

3.3.6 This review is not asserting that it would have been easy to persuade Mrs. & Mr. Lowe to accept additional support to enhance their health and wellbeing, certainly not since Mrs Lowe made it clear she did not want help and her husband reluctantly supported her views They had a history of preferring to meet their own needs and did not welcome help from outsiders. However, with the notable exception described at para 3.3.5 and the efforts of the family to encourage them to accept help, no professional looked at the couple in the round and was curious whether their needs were being met and if not how they could be.

4. Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced by the victim or committed by the alleged perpetrator (towards Mrs. Lowe or any other partner) to other agencies and whether those opportunities were taken.

3.4.1 There were no reports or suspicions of domestic or sexual violence being experienced by Mrs. Lowe nor perpetrated by Mr. Lowe, on her or anyone else, so no opportunities existed and thus none missed.

5. Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mrs. Lowe, the alleged perpetrator or the dependent children that were missed or could have been improved.

3.5.1 Other than the matter referred to in Para 3.1.1 – 3.1.2 and 3.2.1 - 3.2.2, there were no opportunities for agency intervention related to domestic abuse thus none that were missed or could be improved.

6. Whether there were any barriers or disincentives experienced or perceived by Mrs. Lowe or her family/ friends/colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.

3.6.1 There was no evidence, prior to the homicide, of any domestic abuse having been experienced or suspected in this case so family and friends had no opportunity to report it to any agency.

3.6.2 Regarding family and friends' awareness of services, this is discussed in paras 3.8.3 – 3.8.5.

7. Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide and what they did or did not do as a consequence.

3.7.1 No-one was aware of or suspected any abusive behaviour from the alleged perpetrator to the victim so, again, there was no opportunity for them to act as a consequence.

8. Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.

3.8.1 The family and friends of Mrs. and Mr. Lowe had no reason to consider contacting any domestic abuse specialist services as there was no evidence that domestic abuse was a factor in their lives.

3.8.2 There was no reason to consider that Mrs. Lowe would have sought support from any domestic abuse services. Had she been experiencing any violence and abuse, a perfect opportunity to ask about what options were available to her was when she went for a walk with the Care Navigator, without Mr. Lowe. It was clear during that time they spoke freely and the CN repeated several support options she may wish to consider. None of these were specialist domestic abuse services as there was no reason to think they were needed. However, it is reasonable to predict that despite both Mrs. and Mr. Lowe being reluctant to accept services, if ever Mrs. Lowe felt she needed such support that was the moment she might have asked.

3.8.3 When asked, the family – who do not live on the Isle of Wight – did not know which agencies they would have contacted had they been worried that Mrs. Lowe was experiencing domestic abuse. However, they said they would have carried out an internet search to find out.

3.8.4 The provision of domestic abuse services on the Island is chiefly through Island Refuge and Outreach Services. A simple Google search identifies, through the Isle of Wight Council website, the nature of domestic abuse, basic safety measures people can take and available help lines including Island Women's Refuge and

Outreach team, Police Public Protection, National Domestic Abuse Helpline, Broken Rainbow (for LGBT victims) and Men's Advice Line.

9 Whether Mrs. Lowe had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on her likelihood of seeking support in the months before she died.

3.9.1 Mrs. and Mr. Lowe had been married for fifty-five years and there was no evidence of either being in any other relationship at all during that time. There is no evidence of Mrs. Lowe having experienced domestic abuse prior to her relationship with Mr. Lowe or at any other time.

10. Whether the homicide could have been accurately predicted and prevented.

3.10.1 Mr. Lowe was very sick and his wife's mental health was deteriorating. All those who knew them spoke of a loving couple who were determined to support each other and were, perhaps, too proud to accept outside help.

3.10.2 Mr. Lowe was becoming very concerned how Mrs. Lowe would be cared for should he have to go back into hospital. He suspected that if he did, he would be unlikely to come out. Mrs. Lowe had, for a long time, dismissed the option of moving into residential care, and suggestions that any other form of care be considered were rebuffed.

3.10.3 It seemed that the options for caring for Mrs. Lowe were diminishing and this may well have played heavily on Mr. Lowe's mind but at no time did he appear to be considering killing his wife or himself. Family members are now of the view that he did what he did as he loved his wife so much and could not bear the thought of her suffering or being unhappy while he was in hospital or after he died. They never considered he would harm Mrs. Lowe.

3.10.4 While there were missed opportunities to understand and to attempt to meet their changing care and support needs, nothing seen or suspected by anyone who met or saw Mrs. and Mr. Lowe over the period of this review indicated that Mr. Lowe had an intention to kill his wife nor that he had a suicidal ideation. There was no reason for them to have suspected that to be the case

3.10.5 Based on previous attempts to avail Mrs. and Mr. Lowe with supportive services it is unlikely that, even if more had been done to offer them support, they would have accepted it.

3.10.6 Therefore based of everything available to this review, there is no evidence to suggest that this homicide was either predictable or preventable.

END