Herefordshire
Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

into the circumstances

of the death of a woman aged 70 years

on 11th August 2014

Case No HDHR02

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March 2017

LIST OF ABBREVIATIONS

CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
DASH	Domestic Abuse, Stalking and Harassment (Risk Assessment Tool)
DHR	Domestic Homicide Review
DMHOP	Department of Mental Health for Older People
GP	General Practitioner
HCSP	Hereford Community Safety Partnership
HM Coroner	Her Majesty's Coroner
IMR	Individual Management Review
MAPPA	Multi-Agency Public Protection Arrangement
MARAC	Multi-Agency Risk Assessment Conference
MDTM	Multi Discipline Team Meeting
NHS	National Health Service
PCMHT	Primary Care Mental Health Trust
SIO	Senior Investigating Officer (Police)

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HEREFORDSHIRE COMMUNITY SAFETY PARTNERSHIP

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1. Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 70 year old woman on 11th August 2014. The woman's husband, the Perpetrator also died in the same incident. This tragic case was reported to HM Coroner for Herefordshire. On 8th April 2015 Assistant Coroner Mr Roland Wooderson recorded that the Victim had been unlawfully killed by the Perpetrator who then took his own life.

1.2 Purpose of a Domestic Homicide Review

1.2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

1.2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[2], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have*

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

1.2.5 Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and

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

1.3 Process of the Review

1.3.1 West Mercia Police notified Herefordshire Community Safety Partnership (HCSP) of the deaths of the Victim and the Perpetrator on 7th November 2014. HCSP convened a Joint Case Review meeting and decided that the circumstances of the death of the Victim met the definition of a Domestic Homicide Review. A letter was sent to the Home Office to this effect indicating the intention of HCSP to commission a DHR.

1.3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.

1.3.3 Home Office Guidance[3] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

1.4 Timescales

1.4.1 Home Office Guidance requires that DHR's should be completed within 6 months of the date of the decision to proceed with the review. The expectation is the IMR's will be submitted by 8th May 2015.

[3] Home Office Guidance 2013 page 15

1.5 Independent Chair and Author

1.5.1 Home Office Guidance[4] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

1.5.2 The Independent Chair and Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 80 Serious Case Reviews and 13 DHR's chairing those processes and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 DHR Panel

1.6.1 In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Members of the panel and their professional responsibilities were:

Adrian Turton	Learning and Development Officer, HSCB/HSAB/HCSP
Mandy Appleby	Principal Social Worker, Adult Social Care Herefordshire Council
Lynne Renton	Head of Safeguarding – CCG Quality
Cath Holberry	Lead Nurse Adult Safeguarding, Wye Valley NHS Trust
John Trevains	Deputy Director of Nursing – [2]gether, NHS Foundation Trust
Tom Currie	Assistant Chief Officer, National Probation Service
Jan Frances	Chief Executive, West Mercia Women's Aid
DI Helen Kinrade	West Mercia Police
Josephine Cullen	Safeguarding Lead, Adults Wellbeing, Herefordshire Council
Observing:	Adele McGuigan, West Mercia Women's Aid
	Sue Little, CCG

1.6.2 None of the panel members had direct involvement in the case, nor had any line management responsibility for any of those involved.

1.6.3 The business of the panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.6.4 The full panel met on four occasions.

[4] Home Office Guidance 2013 page 11

1.7 Parallel proceedings

1.7.1 The Panel were aware that the following parallel proceedings were being undertaken:

- HM Coroner Inquest
- West Mercia Police investigation

1.7.2 At the commencement of this review there were parallel proceedings held by HM Coroner and West Mercia Police. After a thorough investigation by West Mercia Police, it was decided that there was no further police action required in the circumstances and their investigation was closed. HM Coroner concluded his investigation on 8th April as previously stated

1.8 Time Period

1.8.1 It was decided that the review should focus on the period from 1st January 2011 (the year the Victim was first diagnosed with Alzheimer's disease) to the date of the Victim's death on 11th August 2014.

1.9 Scoping the review

1.9.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with the Victim and Perpetrator prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

1.9.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.

1.9.3 The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Perpetrator where concerns may have been escalated by agencies.

1.10 Individual Management Reviews

1.10.1 The following agencies were requested to prepare chronologies of their involvement with the Victim and her family, carry out individual management reviews and produce reports:

- West Mercia Police
- Health – Including 2gether and Wye Valley NHS Trust and Herefordshire CCGs
- Barchester Latimer Care Home, Worcester
- West Mercia Women's Aid
- Adult Social Care
- Additional Representation from Carers Support and Age Concern

It is considered that more agencies could be added as the review progresses if information suggests.

1.11 Summary

1.11.1 The Victim and Perpetrator were a devoted couple having been married for 37 years. The Perpetrator was a Senior Director in a construction company before his retirement. The Victim was not employed but helped the husband with his business, and the couple lived in a substantial property in rural Herefordshire. The Victim had a daughter (S1) from a previous relationship and the Perpetrator had a son (S2) also from a previous marriage.

1.11.2 The couple were known in the village where they lived as a loving couple who enjoyed a rich social life which involved holidays with their family. The Perpetrator was a registered shot gun licence holder and had been for many years as a large number of people living in that area are. S1 is married and has a teenage daughter who the Victim and Perpetrator doted on and S1 described their lives as perfect until 2011, when the Victim was diagnosed with Alzheimer's disease as well as chronic obstructive pulmonary disease.

1.11.3 From that point the Perpetrator was actively involved in caring for the Victim and even carried out extensive research as to how best to care for someone with these illnesses. The Victim's health and mental health deteriorated to the point that in August 2014 she was persuaded by the family to have a short trial of respite care at a care home in Worcestershire.

1.11.4 The Victim was only there 2 days before the Perpetrator removed her, not being satisfied with the care and took her home.

1.11.5 Sunday 8th August 2014, friends and relatives could not contact either of the couple and the Police were called to their home address and forced entry into a workshop and found both the Victim and the Perpetrator dead from gunshot wounds. Subsequent Police investigation satisfied the Coroner that the Perpetrator had killed his wife and had turned the gun on himself.

1.12 Terms of Reference

1.12.1 The Terms of Reference for this DHR are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

1.12.2 The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?
10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the victim disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the victim, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the victim and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

1.12.3 In addition to the above, some agencies will asked to respond specifically to individual questions once they are identified following the submission of IMR's.

1.13 Individual Needs

1.13.1 Home Office Guidance[5] requires consideration of individual needs and specifically:

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

[5] Home Office Guidance page 25

1.13.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.13.3 The review gave due consideration to all of the Protected Characteristics under the Act. The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.13.4 The perpetrator and the Victim are white European. The Victim was diagnosed with Alzheimer's and Chronic Obstructive Pulmonary Disease. They were both pensioners in their 70's.

1.14 Lessons Learned

1.14.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Adult Safeguarding reviews and appropriate and relevant research.

1.15 Media

1.14.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the Herefordshire Community Safety Board.

1.16 Family Involvement

1.16.1 Home Office Guidance[6] requires that:

"members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances", and:

"Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

1.16.2 The views of the family members and any family friends identified by the family will be taken into consideration. The family members will be invited to participate in the review process. (See section re Views of the Family)

6 Home Office Guidance page 15

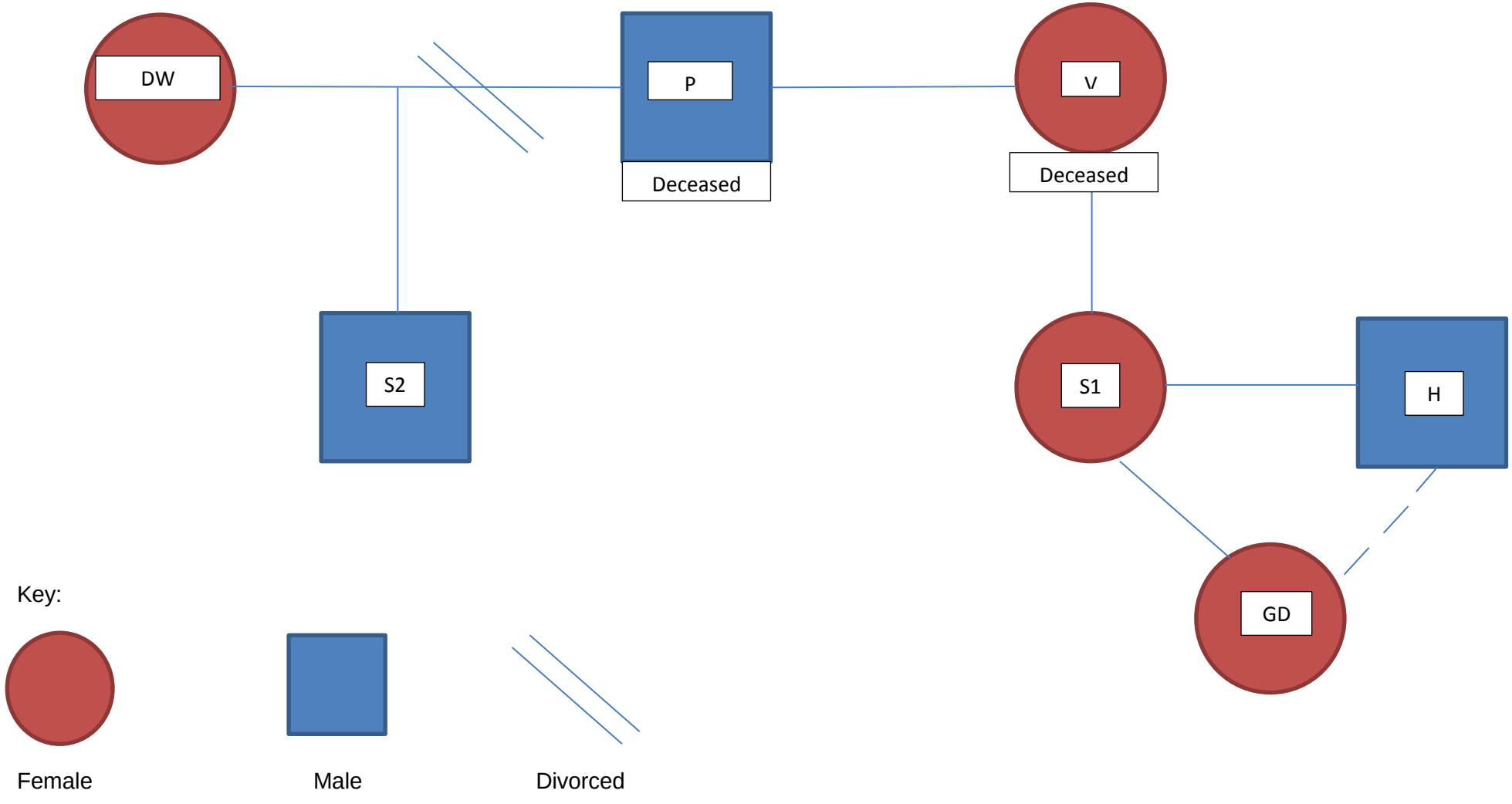
1.16.3 These Terms of reference were considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

1.17 Individuals involved in the Review Process

1.17.1 The following genogram identifies the family members in this case, as represented by the following key:

Victim	Female, aged 70, wife of Perpetrator
Perpetrator	Male, aged 71, husband of Victim
S1	Female, daughter of Victim
S2	Male, son of Perpetrator and former partner
GD	Granddaughter of Victim and Perpetrator - Daughter of S1,
FF	Family friend of Victim and Perpetrator
H	S1's husband
DW	Divorced wife of Perpetrator

Genogram



2. Summary of Key Events

2.1 The Victim in this Domestic Homicide Review was 70 years of age and her husband was 71 at the time of their deaths. The couple had been married for 37 years. There were no children from that relationship. However both the Victim and Perpetrator each had a child from previous relationships. The Victim had S1 who is married with a teenage daughter, GD (grand-daughter of the Victim and Perpetrator) and the Perpetrator had a son S2, an adult now, who was adopted by his Mother's new husband some years ago. The Perpetrator had little if any contact with his son. Both the Victim and the Perpetrator were white British, English was their first language and apart from their respective health problems there were no other issues of note in respect of culture.

2.2 The couple were found by Police and S1 in the workshop at the home address at about 10.20am on 11th August 2014. Both had died of shot gun wounds. The Perpetrator was a licensed shot gun holder. The Victim had been diagnosed with dementia some time previously and had significant health care in the months preceding her death, during which time her dementia had worsened.

2.3 The couple lived in a large cottage in a small Herefordshire Village and they were described as being a very close loving couple and well respected in the Village. In recent years, planning permission had been sought from a travelling family to establish caravans and mobile homes in a field at the rear of the deceased couple's property. This caused some concern in the Village and the Perpetrator led a small group of villagers in their objection to the planning application. The Perpetrator would lobby the Council and his wife would support him in the group's endeavours.

2.4 Following the report of the couple's death, there was much press interest in speculating that the pressure of the planning application and the devaluing of the couple's house due to the application had in some way caused the Perpetrator to act in the manner in which he did, but this is refuted by S1 who, to the contrary states that the objection to the planning application was a positive distraction for the Perpetrator away from the health problems of his wife. There is no foundation to the assumption that the planning permission issue had anything to do with the deaths.

2.5 Her Majesty's Coroner for Herefordshire opened inquests into both deaths and on 8th April 2015, the Assistant Coroner recorded that the Victim had been unlawfully killed by the Perpetrator and he had then taken his own life.

2.6 The couple had lived at the home address for 9 years. Prior to that, they had lived in a nearby village for some 30 years. Having been in the cottage for only 3 years, the Victim became ill and eventually was diagnosed with early onset dementia that gradually became worse and more debilitating. It is also known that the Perpetrator was a very proud man who wanted to care for his wife to the best of his ability.

2.7 Prior to the date of the scope of this review, the only contact the couple had with the Police was for the mandatory inspection every 5 years, of the Perpetrator's shot gun certificate for his Norica .410 single shot, shot gun. Police records show that he had been a shot gun licence holder since 2000 without any cause for concern. He was described as a competent shot gun holder and there were no issues identified by the Police as they made those inspections.

2.8 However, in November 2010, the Victim attended at her GP's surgery and spoke about the stresses in her life at that time. She was suffering from guilt as she thought she had not given her late mother enough attention and reported difficulties with her sister over finances. S1 had also been troubled by her former husband being released from prison and he was threatening the Victim by leaving a can of petrol with matches by the Victim's back doorstep. Apparently the Police were involved. The Victim had been referred to the primary mental health team for counselling.

2.9 On 6th January 2011, the Victim was seen by the Practice Nurse at the GP's surgery regarding her Chronic Obstructive Pulmonary Disease (COPD)[7]. She had a history of lifelong asthma resulting in breathlessness. In 2008 she was diagnosed with emphysema with significant and permanent damage to her lungs resulting from her previously poorly controlled asthma. The GP IMR indicates that the Victim had a good relationship with her GP practice and she was a regular attender. She was also known to use the Primecare Out of Hours Service. The Perpetrator was also registered as a patient at the same surgery.

2.10 In April 2011, there was another regular shot gun inspection carried out by West Mercia Police. All was found to be in order.

2.11 In June 2011, the GP wrote to the Victim suggesting that she should join the expert patient's programme to support her to manage her long term medical conditions.

2.12 On 31st October 2011, the Victim attended at her GP's surgery complaining of a low mood and questioning if she was 'going to be like this for ever'. She was described as being emotionally sensitive and anxious and being negative about her own personality. The GP spent a long time with her discussing positive and negatives of her life and the Victim agreed to be referred to 2gether's Let's Talk Service.

2.13 On 28th November 2011, the Victim again saw her GP, complaining of being low in mood and being worried about such things as crossing the road causing her sleepless nights. A referral was made to Improving Access to Psychological Therapies (Let's Talk) Services was made.

2.14 By 13th February 2012, the Victim reported to her GP that she felt somewhat better and although her COPD monitoring showed a slight deterioration, she was able to undertake all of the activities she wished.

2.15 On 16th July 2012, the Perpetrator attended at the GP's surgery expressing concerns about his wife's memory which was deteriorating. He reported that she was often concerned about what other people may be thinking about her especially at social events. S1 would later describe how her mother had to withdraw from a one-time busy social life as her dementia worsened.

2.16 On 6th August 2012, the Victim saw her GP. She was tearful and depressed and worried about things. She found friendships difficult and she was self-critical. She agreed to medication and a mental health referral.

2.17 On 30th August 2012, the GP sent another letter to the Victim about her joining the expert patient's programme to assist her long term condition.

2.18 On 6th September 2012, the Victim again attended at the GP's surgery for a COPD review. She explained that she was still stressed over the threats from her ex-son-in-law

[7] COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and other chronic obstructive airways diseases the main cause of which is smoking.

and she was feeling rebuffed by her friends at the Bridge Club. She was reassured and it was stressed that she was soon to see the mental health team and her GP.

2.19 She was seen by her GP and the Primary Care Mental Health Team on 13th September 2012. It is noted that she was appropriately attired and expressed no thoughts of self-harm. Some issues with her memory were identified but this may have been affected by her low mood. It was also noted that she was having good support from her husband and her daughter.

2.20 On 12th October 2012, the Victim reported to her GP that she was still in a low mood and distressed about the family issues outlined above. She was having negative thoughts. She was given medication and reassured and advised about stress management, assertiveness and developing coping strategies.

2.21 On 26th October 2012, the Victim reported that she was suffering from giddiness and had fallen a couple of times recently. The GP reduced the amount of medication she was to take. She completed a questionnaire used to monitor her depression from which she showed that she had moderate depression, which had not changed much in recent months. On the same day the Victim was seen for an initial assessment by the Primary Care Mental Health Team (PCMHT) following a referral from the GP. She was found to be low in mood, distressed but with no self-harm ideations.

2.22 On 5th November 2012, the Victim reported that her giddiness had been resolved but she took a memory test that indicated her memory had deteriorated over the last two years and she had now a considerable loss of memory. She reported that she felt weepy and depressed again on 21st November 2012.

2.23 However, on 30th November 2012, the Victim reported to her GP that she felt more positive and her mood had improved. Some of the issues that had been causing her stress were now improving and she thought that the medication was helping. She was discharged from the Primary Care Mental Health Team back to her GP with advice that she could contact Let's Talk Services in the future if she required.

2.24 On 10th December 2012, the Victim was again referred by the GP to [2]gether memory clinic as she had been seen by the practice counsellor who thought she may have a pre-morbid personality trait, (which may exist before an illness) and that her mood disorder may not have been necessarily a presentation of her memory loss or vice-versa.

2.25 By January 2013, the Victim's memory had deteriorated again. She was now struggling to orientate herself in place and time. She was questioning repeatedly, having difficulty in recalling faces and getting lost in unfamiliar places.

2.26 On 2nd February 2013, the Victim was seen by a Consultant Psychiatrist and it was noted that she appeared to be doing well on the medication she had been prescribed. The Perpetrator was offered a carer's assessment and a referral was made for Carer's Assessment and he was registered with Herefordshire's Carers Support group. On 11th February 2013, the Victim was prescribed antibiotics for a chest infection.

2.27 Her condition, especially her mood, had deteriorated yet again by 27th March 2013. However during March and April 2013, the Victim showed some improvement in her condition, but by June she had a respiratory tract infection and by August 2013, she was unwell again, worrying and not sleeping. She described herself as being lonely. It is recorded that the Perpetrator was also unwell. During August 2013, the GP spoke to the couple and suggested that they register with the local Alzheimer's Support Group as by now the Victim had been diagnosed with Alzheimer's.

2.28 On 25th June 2013, The Victim was seen for her 6 month follow up appointment with the Memory Clinic. .This had been brought forward as a result of concerns from the Perpetrator. The Perpetrator was offered a Social Services Carer's Assessment and referred to a Carers Assessor and albeit registered with Carers Assessment there is no record of any formal carer's assessment being completed. There is no record in the notes of [2]gether which was determined to be unsatisfactory during a Trust's internal review.

2.29 In September 2013, the Victim complained of a cough that she had had for 6 months. She wasn't too concerned about it but her husband was. They were both reassured by the GP that the Victim would not decline quickly and she was offered medication to help with her cough but she declined it.

2.30 On 17th October 2013, there is an entry in the [2]gether IMR to the effect that attempts were made to contact the Perpetrator by telephone after he had written asking for advice. It is not documented if that contact was made or followed up. A note in the IMR identified that despite asking for help and assistance, the Perpetrator often declined the offers of help.

2.31 In October 2013, the Perpetrator attended at his GP's surgery complaining of headaches and anxiety.

2.32 On 3rd December 2013, the Perpetrator contacted the Admiral Nursing service seeking support, stating that he was caring for his wife with Dementia and that he was struggling to meet her changing needs. Three days later, on 6th December 2013, the Perpetrator was seen by Admiral Nurse and a risk screen and assessment of need was completed. The Victim has no physical problems identified impacting on current level of risk. There was no evidence of abuse or the Victim's needs not being met. There was no risk of self-harm or harm to others identified. No major life trauma was identified. It was noted that the couple are considering moving to a retirement village. It was also noted that the daughter is very supportive and the couple had some close friends. The Perpetrator had no physical or mental health problems identified, and there was no evidence of self-harm or risk of harm to others identified. No major life trauma was identified as a problem for the carer. It was reported that the Perpetrator was not sleeping well due to his wife's snoring and a suggestion of earplugs was made by the Admiral Nurse. Wills and LPAs were in place. It was identified that there were unmet needs around the need for knowledge and understanding of Dementia and also adjustment to loss. Both of these needs were assessed as being able to be met by the Admiral Nurse.

2.33 The Admiral Nursing Service considered that this was a timely response in meeting the needs of the Perpetrator in offering support

2.34 On the 6th December 2013, the Admiral Nurse wrote to the GP to stating that the Perpetrator had been seen by the admiral nursing service and that he was struggling to adjust to his wife's changing needs and was seeking further information about Dementia and how to manage his wife.

2.35 On 9th December 2013, the Victim attended the Memory Clinic where she was found to be disorientated, more forgetful, low in mood and feeling isolated within their village. She was not going out. The following day the Perpetrator telephoned the GP's surgery stating that the Victim was low, tearful and becoming aggressive, being the result of the side effects of the medication. The GP IMR author helpfully comments at this stage that the Victim's respiratory function was worsening. She was having repeated and poorly responsive chest infections. A lowering of the oxygen in her blood was also worsening

her cognitive function. The steroids used to treat her chest infection occasionally made her hallucinate.

2.36 On 12th December 2013, the Perpetrator sent an email to the Admiral Nurse thanking her for her time and support. He indicated that he had a memory clinic appointment the previous Monday and that he thought that his wife was 'off form' during her test due to the effects of her steroids that she was on for her Asthma. He commented that they have made her considerably more disorientated and angry towards people and that he hoped it would quickly pass. He also said that he appeared OK and asked that the Victim be more expressive as to how she felt and not put on a brave face. He signed off wishing the Admiral Nurse a Happy Christmas and New Year.

2.37 However, it isn't clear in the records if the email was responded to or if information was shared with anyone else in the care team about the apparent impact that steroid medication was having on the Victim's mood and behaviour.

2.38 On 13th December 2013 the Victim was referred to the Wellcheck Service of the local Age UK.

2.39 On 16th December 2013, the Perpetrator telephoned to speak to the Consultant Psychiatrist because he felt that the Consultant had not been aware of his wife's low mood at a previous appointment. He was advised that the current dose of medication was appropriate and a follow-up appointment would be made for 2 months, although it appears that the appointment remained at 17th March 2014 instead of February as planned.

2.40 On 17th December 2013, Wellcheck Service referred her for Council Tax reduction and attendance allowance.

2.41 On 10th January 2014, the Perpetrator contacted the Memory Clinic concerned that his wife was again in a low mood and he was requesting support. He spoke to the duty clinician and was offered a carer's break and he was advised that this would be discussed in the next Multi-disciplinary Team Meeting (MDT). The minutes of the MDT meetings showed that the lead clinician had not been present at their meeting on 14th January 2014, and therefore, the patient had not been discussed. The patient, however, was discussed at the next MDT on 21st January 2014, but there were no actions recorded and there was no record of whether the husband was phoned back. This has been noted as not satisfactory by the Trusts internal review and is being addressed as part of the internal reviews remedial actions. It will also be part of action post this report.

2.42 On 22nd January 2013, the Perpetrator attended a pre-planned appointment with the Admiral Nurse. He discussed his wife's reduced interest in housework and reluctance to manager her personal care. He reported that she was taking an anti-depressant. The Admiral Nurse explored ways of initiating tasks that the Victim may be able to continue. The Perpetrator explained that he had booked a week's stay at a retirement village with a view to purchasing a house within the complex. He stated that he was hopeful that this would provide his wife with the stimulation and friendships that she could benefit from. The Admiral Nurse explored how the Victim might adjust to a new environment and that the difficulty she may have in making new friendships. The Perpetrator was due to attend the three planned sessions of Psycho education that were due to start the following week. There was a plan to review future intervention following completion of the course.

2.43 During February and March the Perpetrator attended the Psycho education group as planned.

2.44 By 6th February 2014, the Perpetrator reported that his wife was much improved.

2.45 On 21st February 2014, a MDTM took place where the Victim was discussed but there were no actions minuted and no record if the Perpetrator was present. Again an Internal review has recorded that this was not satisfactory but this will be addressed as part of the action plan from the internal review.

2.46 The Perpetrator telephoned 2gether again on 26th February 2014 concerned for his wife's confused state. He was advised that this was probably nothing to do with her medication and that he should contact her GP regarding a potential chest infection.

2.47 On 27th February 2014, the Perpetrator telephoned the GP's surgery stating that the couple had been away on holiday for a few days but on 26th February, a large portion of the Victim's memory disappeared to such an extent that she now could not recall having a daughter or anyone else in the village. The Admiral Nurse wondered if the Victim had been affected by a stroke. The Victim was seen at the surgery where she was referred to a chest physician. Her oxygen saturation levels were low and she was found to have a mild to moderate restriction and a very severe obstruction.

2.48 The GP IMR Author helpfully states that the Victim's breathing difficulties were by this time affecting her 7 days per week, resulting in her struggling to have a shower or get dressed in the morning and she had had to give up her walking club as she could not keep up with her peers. Her daily living activities were being restricted and company with friends was limited.

2.49 During March 2014, the Victim contracted another chest infection that required antibiotics. She was admitted to hospital and was seen by the Wye Valley respiratory service. The Perpetrator informed the staff at 2gether that he was seeking a move to a care village but there was a waiting list. The Victim said that she felt isolated in the village where they lived, but the Perpetrator said that she did see people but she couldn't remember doing so. The 2gther IMR Author points out that this would have been an opportunity to offer the Perpetrator a further carer's assessment.

2.50 On 20th March 2014, the Admiral Nurse had a telephone consultation with the Perpetrator as his wife was unwell. The Victim had attended the memory clinic in Hereford and that there was no change in her level of cognition. The Perpetrator stated that he was more concerned about his wife's physical health and that she had been referred to a chest consultant by the GP. Both had spent the week at the retirement village and the Perpetrator was keen to move her there and had started the process. He was attending open days on a regular basis to keep in contact. He would make further contact with the Admiral Nurse as required. It appears that the Perpetrator was continuing to focus on the move to the retirement village. The Admiral Nurse continued to make herself available for support at any time should the Perpetrator require it.

2.51 On 3rd. April 2014, the Admiral Nurse had a telephone call with the Perpetrator. It is not entirely clear who made the call. The Victim had an emergency admission to hospital because of breathing difficulties. Her levels of distress were high so this was a short admission and the GP was managing her care. The Perpetrator had stated that he was still hopeful to be able to move to the retirement village but there were complications with this. The Admiral Nurse explored with him, how he can meet his own needs during this time. He asserted that he feels that regular contact with his daughter and knowing he can access the Admiral Nurse at any time was sufficient at present. Contact was arranged again for two weeks. The contact with the Admiral Nurse remains a key source of support for the Perpetrator and there was no exploration recorded of what the issue with the retirement village plans were.

2.52 On 7th April 2014, the Perpetrator explained to the GP that he had taken his wife to hospital as there was no improvement but had to wait for 3 hours to be seen during which time the Victim's anxiety increased and they left the hospital without being seen.

2.53 Two weeks later the Perpetrator took the Victim to hospital where he stated that he was concerned that his wife's breathlessness was now causing her problems walking around the house and garden. He was upset at her deterioration. He was told that there was little more to offer except steroids or admission. He pleaded for her not to be admitted.

2.54 During the latter part of April 2014, the Victim's breathing became worse and she was also more confused. On 23rd April 2014, on the advice of the GP, the Perpetrator called an ambulance due to his wife's breathing problems and she was admitted into hospital, where she was moved to a side ward to allow the Perpetrator to be with her so reducing her anxiety.

2.55 On 29th April 2014, the Perpetrator reported to the GP that he was dissatisfied about the time it took for the respiratory nurse to deal with his wife and the discharge procedure was too long. He was to write a letter of complaint to the Trust. The Victim was discharged from hospital that day, before the necessary paperwork had been completed. In a letter of thanks to the Ward Staff, the perpetrator explained that he removed his wife before the discharge documents were in place to prevent her becoming more agitated. The GP spoke about Managing Future hospital admissions.

2.56 The GP IMR Author points to research by the Alzheimer's Society of 2009, which indicates that the longer people are in hospital the worse effect on the symptoms of dementia indicating that evidence based practice would therefore support the GP's wishes in this case to avoid hospital admissions for the Victim if at all possible.

2.57 On the same day, 29th April 2014, the Perpetrator wrote two letters. One to the hospital detailing his concerns about the lack of understanding regarding the impact steroids have on dementia and the delay in the referral to the respiratory team The other to the nursing staff at the hospital expressing his thanks for the manner in which they had looked after his wife. He explained that he had removed her in order to save her more anxiety whilst waiting for discharge papers.

2.58 On 30th April 2014, the GP spoke to the Respiratory Nurse and discussed the fact that there were concerns that the Perpetrator and the Victim would overuse home steroids, oxygen and antibiotics. A hospice was considered for support but it was appreciated that this may cause the Perpetrator to become more anxious and this would then rub off on the Victim exacerbating her situation.

2.59 On 1st May 2014, Hereford Carers Support made telephone contact with the Perpetrator to offer any support they could. The Perpetrator mentioned that his wife had COPD as well as Alzheimer's and her condition was worse. He thanked the caller for all of the assistance Carers Support had given to them.

2.60 On 2nd May 2014, the Perpetrator contacted the Consultant Psychiatrist stating that he had made a complaint about the recent admission of the Victim into hospital and wanted the views of the Consultant.

2.61 On 6th May 2014, the GP made another referral to the Respiratory Nurse for the Victim. It was noted that both the Victim and the Perpetrator were aware of the frailty of the Victim due to the severe damage to her lungs but the Perpetrator remained anxious. It was arranged for the 'in house care support worker' to make contact with the Perpetrator

to offer to support his through his anxiety. On 8th May 2014, an application for a Blue Badge (free car parking) was made with the assistance of the Wellcheck Service.

2.62 On 6th May 2014, the Admiral Nurse received a telephone call from the Perpetrator stating that his wife had been readmitted to hospital as her breathing had continued to deteriorate but that the experience had not been positive and Mr K discharged his wife early because of her level of distress and being in a busy and unfamiliar environment. He stated that her current needs were being managed by her GP. The Admiral Nurse sent the Perpetrator a copy of an audit report about the needs of people with dementia being met in acute hospitals and encouraged him to forward his experience to them. Again, he confirmed that he felt that being able to access the Admiral Nurse was sufficient support at present.

2.63 On 12th May 2014, the Perpetrator contacted the GP's surgery advising that the Victim was now back on antibiotics and that he would be making an appointment for his wife to see the GP in the near future. This, the IMR Author states, demonstrated the positive relationship the Perpetrator had with the surgery.

2.64 On 16th May 2014, the Wellcheck Service of Age UK received a request from the Perpetrator for an application form for a high rate attendance allowance as the Perpetrator needed help with the Victim throughout the night.

2.65 On 23rd May 2014, the Admiral Nurse made telephone contact with the Perpetrator. He reported that the situation at home remained poor and that the Victim's physical condition continued to need medical intervention by way of steroids and antibiotics. The Perpetrator reported that he recognised that he was starting to struggle. It is recorded that he stated he was unable to continue talking as his wife required assistance. The Admiral Nurse recorded that the Perpetrator was aware that he could make contact with her at any time.

2.66 This is the first time that the Perpetrator indicted that he may have been struggling, and indeed on this occasion the call was cut short so that he could attend to his wife. There is no documented evidence that this information was shared with anyone else in the care team.

2.67 On 30th May 2014, the Perpetrator and Victim attended the surgery to discuss the use of antibiotics and steroids. They were given reassurance. Three days later the Perpetrator attended at the hospital worried about his wife taking antibiotics and steroids. He reported this to his GP who had a long discussion with the couple regarding having antibiotics and steroids at home to be used in acute exacerbation as part of their self-management strategy. These are called 'Rescue Drugs'.

2.68 On 4th June 2014, a Case Management and Supervision discussed the possibility of carers to support the couple and also the possibility of the Palliative Care Team becoming involved, but it was appreciated that this would upset the Perpetrator. The question of Adult Social Care involvement was raised. A referral was made to the Admiral Nurse Service. A Plan was also commenced to deal with admission avoidance and anticipatory care. This, according to the IMR author is in accordance with NICE guidance. It is not clear from the notes who was going to discuss the Admiral Nurse Service with the couple or whether Adult Social Care was in fact contacted.

2.69 On 10th June 0214, a telephone call was received from the Perpetrator stating that his wife had been prescribed antibiotics and steroids by respiratory consultant. He recognised that he was requiring some help with personal care for the Victim. The

Admiral Nurse talked through what questions he may have wanted to ask when contacting the agency. It was recorded that he had a list of agencies for the area.

2.70 This showed evidence that the Perpetrator was beginning to recognise the need for help. The Admiral Nurse understood that he had the ability to be able to identify an agency to support him but guided him as to how he might choose the right one based on the questions he might consider asking. This was in keeping with the ethos of the Admiral Nursing Service to support carers to access the help and support they needed as and when they required it.

2.71 On 1st July 2014, a telephone call was received from the Perpetrator, expressing his distress that as his wife's physical health has improved but her behaviour has become more difficult. The Admiral Nurse explored with him his wife's feelings of worthlessness and frustration and looked at strategies to try and support her but that he was finding it very challenging. Again the Admiral Nurse has recorded that he was aware that he could contact her at any time.

2.72 On 3rd July 2014, the Perpetrator phoned asking to speak to the Consultant Psychiatrist stating that his wife was deteriorating. She was agitated, confused, disorientated, verbally aggressive and showing challenging behaviour and she was unpleasant to live with. Memory Services phoned him back to assess the situation. He said that this was not his wife, but someone else in her body. She was having breathing problems but this was improving. He also mentioned that the Travellers had moved into the neighbouring field. The Victim was advised by the dementia nurse to stop taking the antidepressant Citalopram, which in some cases can be 'activating', and to start Mirtazapine which had a more sedative effect. The process would take 4 weeks to gradually reduce and stop Citalopram before starting to take the Mirtazapine and it was documented that this would be monitored by the GP. Due to the increased need a referral was made for an input from the Trusts Department for Mental Health of Older People (DMHOP) East Team.

2.73 On 7th July 2014, the Perpetrator again contacted the GP's surgery stating that the weekend had been particularly difficult. A change of medication was recommended that calmed the Victim. The Perpetrator reported that his wife has slept well after taking the changed medication. The IMR Author points out that there may be a dilemma on occasions between sedating the patient with medication against being supportive of the carers being able to deal with challenging behaviour of the patient at home.

2.74 The following day, 8th July 2014, S1 called the GP, reporting that her Father was not coping with the Victim. She was told that relying on drugs was not the best way to manage her Mother and for her to speak to her Father and discuss what they considered to be the most appropriate way forward. In the meantime the GP was to discuss her Mother with her psychiatrist.

2.75 Later that day the Perpetrator contacted the Memory Service and spoke to the duty clinician. He was struggling with his wife's behaviour which he thought had got worse since a change in medication. He was advised to contact his GP to which he said that he had already done so and had been told to contact the Consultant Psychiatrist. This was discussed with the team and a home visit arranged to take place. The [2]gether IMR Author considers that a home visit could have been offered earlier at this point given the escalating number of calls being received from the Perpetrator.

2.76 On 11th July 2014, a CPN visited the couple at home and saw the couple separately, which is considered to be good practice. The Perpetrator described how day to day life was becoming more challenging. The Victim stated that her husband would lose his temper with her and grabs her arms, which frightens her. The Perpetrator stated that his

wife was confusing him with her previous husband. He said that he wanted more support but didn't want to be separated for short periods of time. There was no referral to safeguarding as a result of this disclosure by the Victim, but during the course of this review the nurse has been spoken to and she says that she did not see any signs of abuse, bruising or other physical signs. She had accepted what the Perpetrator had said and did not feel safeguarding to be an issue. However the IMR points out that the judgement behind this decision was not recorded in the electronic health care record, which has been identified as a learning point for [2]gether,

2.77 On 15th July 2014, the Perpetrator attended at the GP's surgery stating that his wife did not want to live. Apparently she was 'lovely' in the mornings but deteriorated during the day. He had considered BUPA care for her but could not afford it. The GP spoke about the Victim going into care and the Perpetrator stated that he wished to care for her and wanted her resuscitated in the event of acute illness. S1 was looking for respite care in Worcestershire due to the changes in medication.

2.78 On 24th July 2014, CPNs visited the couple at their home. The Perpetrator was seen alone and he stated that the Victim was hallucinating and not recognising him on occasions. This was put down to the medication. He was offered respite, day care and a carer's break to which he agreed, but repeatedly remarked about how he would cope with this rather than how his wife would cope. The CPN did not consider that hospital admission was necessary at this time.

2.79 However, on 28th July 2014, the Perpetrator contacted [2]gether saying that he did not want a carer's break at the present time and that his granddaughter was coming to visit in 2 weeks during the summer holidays. He stated that the Victim would not go out with people she didn't know.

2.80 The following day the Perpetrator contacted the GP asking if the medication would be causing his wife to hallucinate. He described how she would wake fine in the morning but then becomes agitated seeing intruders in the house during the day time. The GP thought it unlikely that the medication was causing such symptoms and suggested a variation in when to take the medication.

2.81 On 1st August 2014, the Perpetrator contacted the hospital to discuss the side effects of the drugs his wife was taking. The CPN was not available and he said that he was content to wait until the nurse was next at work. He was told however, that the respiratory Team had diagnosed Aspergillus, a fungal infection in his wife's lungs, which required steroids. The IMR Author considers that another professional could have called the Perpetrator back sooner and this has been noted as unsatisfactory as far as the internal review was concerned.

2.82 On 4th August 2014, the Perpetrator contacted the Dementia Service asking for confirmation that the medication had changed. He was advised of the Plan and that he should contact the CPN on 5th August as planned. On the same day he contacted the GPs surgery to inform them that his wife had been diagnosed with the fungal infection and that she need steroids for 6 months.

2.83 On 5th August 2014, the Perpetrator spoke to the CPN and he said that the Victim's hallucinations had reduced since she had stopped taking the Citalopram. He also said that his wife was going into respite care in a care home in Worcester imminently for up to a month and he would consider respite and day care on her return. The IMR Author notes that there is no documented record of the arrangements or any documented offer for the home to contact the team for support or information if required.

2.84 On the same day the Admiral Nurse sent an email to the Perpetrator stating that she had tried to ring him and requested that he make contact. She acknowledged that the situation at home had been becoming increasingly difficult hence her contact.

2.85 This led to a telephone call from the Perpetrator stating that he was hopeful that his wife would be going into respite for a couple of weeks the next day and that he would make contact to arrange a meeting at the clinic.

2.86 On 6th August 2014, the Perpetrator contacted the Memory Service stating he was finding his wife's behaviour difficult to manage and she was having distressing visual hallucinations. He was asked why he was now reporting that the hallucinations were worse when only the day before he had told the CPN that they had reduced. He stated that because of his level of tiredness he misunderstood what the CPN was asking the day before but they were definitely getting worse.

2.87 On the same day the Community Dementia Nurse (CDN) contacted the Locum Consultant who advised an anti- psychotic medication and asked the CDN Memory Service to gather more information on the physical state of the Victim. It is not clear if that advice was acted upon and the IMR Author indicates that there was an error in communication between the teams. The Community Dementia Nurse Memory Services took the call from the Perpetrator and spoke with the locum consultant. He states that he contacted the DMHOP Community Nurse who was involved in her care to implement this advice or consider it further. The DMHOP nurse received this call but states that it was believed that the CDN was actioning the medication advice. The result of this miscommunication was that neither professional took further action on arranging the medication and /or informing the GP, or contacting the Perpetrator or the residential home.

2.88 Having researched several care homes in the Worcestershire area, the Perpetrator and his daughter S1, made arrangements for the Victim to be accommodated in a care home in Worcester. It took a deal of persuasion to get the Victim to the home, which was for a trial period of about one month. On Thursday 7th August 2014, the Perpetrator took his wife to the care home. There had been an initial home visit by a member of staff from the care home that resulted in the Victim being assessed as in need of care for mild dementia. This decision, according to the manager of the care home, was somewhat influenced by the Perpetrator minimising the degree of illness the Victim was suffering from and the member of staff from the care home recalls how the Perpetrator dominated the conversation and repeatedly mentioned the issue of the travellers in the adjoining field.

2.89 Once the Victim had been taken to the care home, according to the manager, it was obvious that her condition was more severe than initially assessed and there had to be a swift change of plans to accommodate her according to her needs. In an interview with the Overview Author, the manager described how the Perpetrator would ring the home during the night to make sure that his wife was properly cared for. She indicated that he would be concerned that the home were not giving her sufficient medication and he was not easy with the explanation that they were giving her exactly what had been prescribed. The manager and staff formed the opinion that the Perpetrator would administer more than the prescribed amount to ease his wife's suffering whilst in their home environment.

2.90 On 7th August 2014, the Perpetrator was seen at the clinic for a face to face contact with the Admiral Nurse. He stated that he had taken his wife to respite the day before and was her stay booked for two weeks. He stated that she was reluctant to stay. The

Perpetrator stated that he was feeling the frustration that the memory clinic had been unable to reduce the behavioural symptoms of dementia. The Admiral Nurse explored the use of medication and also looked at psycho social interventions. He stated that he had a little more understanding of the situation. The Admiral Nurse started to explore what the future might look like. The daughter was reported to be keen for her mother to remain in respite for at least a month to give her father a break. The Admiral Nurse went on to explore that if the Victim did settle this may have become a longer term option. The Perpetrator became upset to think that this could be the point that they had reached. The Admiral Nurse planned to contact him again in the week beginning 20th August. As things transpired, 7th August was to be the last contact by the Admiral Nurse Service.

2.91 During Friday 8th August 2014, the second day at the home, the Perpetrator arrived at the home very early in the morning and during the day constantly returned home to collect items that he had forgotten and would return to the home with whatever it was.

2.92 On Saturday 9th August 2014, the Perpetrator rang the home, again, very early in the morning to be told that the Victim had had a restless night. He attended at the care home very quickly after the telephone call and asked if his wife had been given her nebuliser. A nebuliser was produced but it was not that of the Victims. The Perpetrator demanded her own and when it was produced the tablets that he had inserted on the day of her admission were still in the nebuliser unused, indicating that she had not been given a nebuliser or at best not her own one. The Perpetrator demanded to speak to the manager and whilst this conversation was being held in his wife's room, another patient entered her room, uninvited, shouted at the manager and struck the manager with her handbag. The manager removed this lady to her own room to calm her down and on her return to the Victim's room, found that the Perpetrator had removed his wife from the care home and had taken her back to their own house.

2.93 The following day the care home received an email from the Perpetrator indicating the reason for removing his wife from the home.

2.94 On Sunday 11th August 2014, the couple were due to have a guest for lunch, but the Perpetrator left a text message for the guest making an excuse for her not to come to the family home that day. The guest did not receive the message and turned up at 11.30am. She could not raise the couple so she left. The couple's daughter tried to contact her parents but did not get a reply from the telephone.

2.95 On Monday 11th August 2014, S1 made further attempts to contact her parents but without success. She attended the address with her husband and found the family car in the garage, but could not trace her parents. She called the Police. On arrival officers searched the house and the workshop, which finding the door locked, officers forced their way in to find the bodies of the Victim and the Perpetrator within. Both had suffered shot gun injuries.

2.96 A full Police investigation was commenced and forensic examination of the scene indicated that the Perpetrator had used his lawfully owned shot gun on his wife and then re-loaded his gun and turned the weapon on himself. There was no note found. Forensic examination of the deceased indicated that there was no alcohol or drugs present in the Perpetrator's blood at the time of his death and only the expect amount of prescribed medication in the Victim's blood at the time of her death.

2.97 As stated at the beginning of this Overview report, HM Assistant Coroner for Herefordshire accepted the findings of the Police investigation and recorded that the Victim had been unlawfully killed by the Perpetrator, who had then turned the gun on himself to take his own life.

Views of the Family

2.98 On 10th June 2015m the Overview Author visited S1 and her family in Worcester. S1 works as a manager for a support organisation for the elderly. She is married and she has a teenage daughter from a previous relationship. It is clear that the teenage daughter was idolised by her grandparents. They had a special relationship with their granddaughter.

2.99 S1 described how the relationship between the Perpetrator and his own son had broken down over a family dispute and contact between the Perpetrator and his son was very rare. His son is aware of the death of his Father.

2.100 She described how her parents lived in a small village for 30 years and moved to the cottage were they died 9 years ago. Both were very popular with the other village residents. Her Mother was part of a walking group, which she had to give up as she became ill. Her Father would go shooting with friends. Her Mother was diagnosed with her illness only three years after moving into the cottage. It was her Father's plan to sell the cottage and move into assisted accommodation once her Mother became ill, but the planning application by the travellers for caravans in the neighbouring field to their property reduced the value of the cottage which made the idea of buying assisted accommodation unaffordable.

2.101 Regarding the planning application, S1 said that the press were wrong to link that with the deaths of her parents. Her Father led a small group of residents in their objections to the planning application. Her Father was from a surveying background and aware of these issues. When her Mother became too ill, her Father handed the lead of the group to another resident. S1 saw the involvement of her Father in that group as a positive distraction for him away from her Mother's illness. The irony of the planning application, which was granted by the Council, is that caravans have been installed not in the adjoining field but in the next but one field, and S1 informed the Overview Author that the owners of the land have taken great care in sympathetically screening the caravans from view and there is no line of sight to the caravans from her parents property.

2.102 She was aware of the fact that her parents were comfortable with the concept of death and would openly talk about it, even to the point of involving all of the family in their discussions. She was also aware that her Mother had expressed a wish for her life to end.

2.103 With regard to her Mother's illness, she said that she helped her Father as much as she could. Working for a support organisation for the elderly she was aware of the care home in Worcester and even though her Father had done extensive research into care homes and the treatment of dementia in particular, they chose the care home in Worcester for her Mother. She stated that the CQC 'scoring' for the home was good but she is now of the opinion that although the home purported to be a specialist home for dementia patients she didn't think it was able to cope with her Mother's behaviour. She thought that Hereford Hospital was better equipped to take people with the degree of dementia that her mother was suffering from.

2.104 S1 stated that her Mother's GP thought that she should have been admitted to hospital due to her repeated chest infections, but her Mother refused to be apart from her Father, even though it was clear that her Father needed periods of respite.

2.105 Having made those comments, S1 had nothing but praise for all of the medical professionals that dealt with both her Mother and her Father. She is of the opinion that none of them could have done more to care for her Mother and due consideration was given to her Father's need as well.

2.106 Regarding the deaths of her parents, S1 was not surprised that both had died, but was shocked at the manner in which they died, especially being present when they were found and having to break the news to the granddaughter. She is of the opinion that the manner in which her Father took his and her Mother's life was the only sure way that neither of them could be resuscitated.

2.107 The Overview Author had extensive contact with the family in this review and visited them on several occasions. Before the report was submitted to the CSP Board, the Author saw the family members and went through the report with them in great detail ensuring that all of the facts were correct and the family were in agreement with the recommendations and findings. The family also agreed with the use of the terms Perpetrator and Victim throughout the report and executive summary.

3. **Analysis**.

3.1 This review involves a perfectly respectable, devoted couple of good character, in the decline of their years; both of them had planned the end of their lives in a peaceful and tranquil location.

3.2 They had the support of their daughter, son-in-law and their granddaughter who misses her grandparents so much. Nothing is known to their detriment.

3.3 Everything was going according to their long term plans when illness struck the Victim. COPD and the onset of dementia altered their lives significantly. They readjusted their plans and looked for assisted accommodation, when planning application in the adjoining field to their property led to the value of their cottage to fall, making a such move unaffordable.

3.4 The Victim's health deteriorated and health professionals indicated that the Victim and to some extent the Perpetrator, constantly hoped that medication would be the cure of her illness once and for all. Alas, such medication was not possible and it was inevitable that there was no cure for her.

3.5 The Perpetrator was a strong willed man, who, despite his own health problems, was determined to look after his wife in the best possible way he could. Significant Offers of assistance were made by various agencies, mainly health, but often they would be declined with grateful thanks by the Perpetrator, who insisted that the couple remain together.

3.6 The Perpetrator was a licenced shot gun holder, registered with the Police and regular mandatory inspections were conducted regarding the licence renewal and also inspections regarding the safekeeping of the weapon. There is nothing to suggest that the Perpetrator's ownership of the shot gun was anything than totally lawful and responsible. He was granted a licence to shoot, as many people living in rural areas are, and he satisfied the criteria for his possession of the gun.

3.7 It is a matter of record that in October 2013, the Perpetrator saw his GP complaining of headaches and anxiety related to trying to cope his wife's illness and her deteriorating health. There is nothing to suggest that the GP was aware of his patient's possession of a shot gun and even if the GP did know, there is nothing to mandate the GP from informing the Police of any reported illness by a firearm holder.

3.8 The Police IMR however indicated that as from 4th July 2011, letters are sent automatically to the shot gun and firearms applicant's Doctors when a certificate is issued. This provides the GP with an opportunity to inform the Police should they deem it necessary or appropriate should such a patient present with an illness that in the GP's view, would affect his/her capability to hold such a licence or pose a risk to anyone due to the illness. However there is no mandate for the GP to make such a referral, it is left to the discretion of the GP.

3.9 In 2001 the Police decided that this letter would not be back dated, but would be utilised when certificate were due for renewal. The Perpetrator's certificate was not due for renewal until February 2015, so no notification letter would have been sent to his GP until then. Even so, one has to look at the context of the visit to the GP in 2013. Would stress and anxiety due to the illness of his wife, have led to the GP making a referral to the Police? Would those symptoms have reached the threshold for referral in terms of the Perpetrator being a risk to someone including himself? The answer is probably 'No'.

3.10 However, it is not beyond doubt that licensed firearm holders do become ill and present with conditions that may put people at risk if their continued possession of the firearm is allowed. A similar situation arose in Durham (Safe Durham Partnership) DHR re Adults A-F (February 2013) and the following recommendation was made in that review report:

> *'Recommendation 6:*
>
> *a) The Police firearms licencing departments explore the feasibility of carrying out checks both internally and externally with other agencies in particular primary health care i.e. GP's, to help them make decisions in relation to the granting of either a shotgun or firearm's licences. In order to help them to do this and risk assess appropriately, consideration should be given to establishing a system so that consent is sought for the disclosure of information from every person in that household from primary care services. This will enable information to be shared relevant to domestic abuse, substance miss-use, physical harm and mental health issues.*
>
> *b) Once a firearm or shotgun certificate has been awarded, the police firearms licencing department should notify the individual's GP so that they are proactive in their information sharing if they have concerns about the certificate holder and their appropriateness to continue to hold these certificates.*
>
> *c) During the course of those discussions the police representative should also seek permission for a 'flag' to be placed upon the individuals medical record which identifies that if granted a licence it is clearly visible to those accessing the record.*

3.11 As a result of the Durham recommendation the relevant ACPO committee is seeking support from HM Government on this matter. It has to be considered that in 2015, West Mercia Police had over 10,000 firearm and shot gun certificates to renew, of which 2,000 were in Hereford alone.

3.12 West Mercia Police were asked to comment on the Durham recommendation and replied:

3.13 All Police Force Firearms Licensing Units operate according to Firearms Licensing Law and the Home Office Guidance[8] provided around the law.

3.14 Legislation determines the form of Firearms applications. Therefore any change to consider others in the household as part of the application process and obtain their consent re disclosure of medical information, would require an amendment to the Firearms (Amendment) Rules 2013 and the Firearms (Amendment) (No. 2) Rules 2013.

3.15 Internal checks are already conducted regarding the applicant which includes any known intelligence or convictions. The applicant also has to provide consent to medical records and the GP is notified of the licence being granted and asked to provide any information of concern. The GP's response however is not mandated at present within legislation, and there is a reliance on individual practices to be proactive.

3.16 If a GP responds that there are mental health issues, or the applicant themselves have stated they have these issues, then other agencies would be contacted.

3.17 There are currently two national reviews of Firearms Licensing taking place which may be of interest to Herefordshire Community Safety Partnership, should they wish to communicate the findings of the DHR for their consideration:

3.18 There is a national project on behalf of Chief Constable of Hampshire Constabulary, the police national lead for firearms licensing. This project is already considering issues of flags on medical records, mandated referral by GP's and access to the records of other agencies.

3.19 A review of Firearms Licensing Law is being undertaken by the Law Commission who are accepting submissions from interested parties until 21st September 2015 when consultation closes[9].

3.20 In view of the above enquiries and the limitations to what West Mercia Police are able to directly change, the following recommendation is now proposed as an IMR recommendation to appear in the Police Action Plan:

*West Mercia Police to amend the post grant letter to reinforce that the consent of the certificate holder for the sharing of medical information throughout the life of the certificate has been given***.**

3.21 Whilst dealing with the Police input into these circumstances, when their attendance at the cottage on Monday 11th August 2014 is concerned, officers were despatched and arrived very quickly, clearly understanding the significance of the call for assistance from S1. They acted promptly in searching the house and outbuildings and when the bodies of the couple were found they immediately called for specialist and detective officers to commence a major enquiry. The family were dealt with in a very sympathetic and professional manner at the scene and throughout the investigation. It was clear from an

8 https://www.gov.uk/government/uploads/system/ploads/attachment_Adata/file/417199/Guidance_on_Firearms_Licensing_Law_v13.pdf

9 http://www.lawcom.gov.uk/firearms-making-the-law-more-balanced-and-more-effective/

early stage that this matter would rest with H.M. Coroner, who dealt with the inquest in a prompt and efficient manner.

3.22 Throughout the summary of events section of this report, the Author has mentioned comments made in the [2]gether NHS Foundation Trust IMR, indicating where the author of that report considers areas where health professionals may have done things differently and where there were processes and record keeping requirements were not always adhered to. The author points out, for example, that the escalation of calls for assistance from the Perpetrator should have raised concerns, but did not. There was no obvious care plan for the Victim, and no identification of any crisis plan. There was no risk assessment documented on the RiO system (Health computer system) and therefore no action plan created.

3.23 There is evidence that the Perpetrator constantly contacted various agencies for advice even after being given advice. There was no clear ownership of the advice being given to him and the [2]gether IMR states:

> 'Best practice would have been a clear and consistent signposting of [the Perpetrator] to a single point of contact. Though this IMR recognised this is difficult when patients are transitioning between teams' …… and ….
>
> 'it is not reasonable to expect carers who are potentially under the distress of caring for a loved one to be experts in navigation care systems.'

3.24 Comment is also made regarding the lack of assertiveness on behalf of professionals when dealing with the Perpetrator and considering a carer's assessment. The [2]gether IMR states:

> 'Staff involved have offered the husband opportunities to consider his own needs then dismiss them stating he did not need additional support'.

3.25 Mention was made about a carer's assessment but verification that such an assessment had been completed was not adequately documented. From this the IMR indicates two areas worthy of improvement, Firstly is an older person's service level audit and analysis of recorded carer's assessments, and secondly, education and development work is required, including liaison with other agencies regarding best practice in facilitating carer's support.

3.26 There is nothing to suggest that there was a co-ordinated plan to look at both the mental and physical health of both the Victim and the Perpetrator and there was an absence of a professionals meeting, possibly best triggered by the GP or Mental Health Services which may have resulted in a multi-agency care plan. This issue has been identified as a key point for learning in the [2]gether action plan.

3.27 Those matters are dealt with adequately in 8 key points and 12 actions to be taken, in the [2]gether IMR and there is little to be gained by repeating these as Overview report recommendations. They appear in [2]gether's action plan.

3.28 Both of the couple had extensive dealings with their respective GP's at the same surgery. Throughout the period of this review there was nothing to indicate that there were any concerns whatsoever about the possibility of any form of domestic abuse taking place. They appeared, and the evidence points to the fact that they were, a very loving couple, devoted to each other so the suggestion of any domestic violence did not arise. Both died as a result of one act of violence.

3.29 It is clear however, that the dynamics of person, the Perpetrator, who approaches numerous agencies looking for a cure for his wife. It appeared that he would not accept the inevitability of her condition deteriorating with little chance of long term improvement. His desperation comes through the information in the IMRs.

3.30 Equally, it was difficult for agencies to coordinate their response because of the Perpetrator's actions. There was no professionals meeting which may have helped with the exchange of information between agencies and there was no coordinated care plan. The services acted in isolation of each other but this was exacerbated by the Perpetrator. In addition, he constantly declined all offers of help.

3.31 The DHR panel have carefully considered all aspects of this sad event and are satisfied that there are no recommendations that can be made in this case that are not already contained within each individual IMR.

3.32 The Admiral Nursing Service responded to the Perpetrator's self- referral in a timely manner and continued to offer support as an when he required it. The nature of the service is to provide information and understanding of dementia and support carers to manage all aspects of caring for a family member with dementia. It is not the nature of the service to 'take over' where families and carers are capable of managing. The Perpetrator presented as a very capable man who was a retired company director and the couple had experienced a comfortable lifestyle. It was towards the weeks approaching the incident that it became apparent that the Perpetrator was struggling to manage. At that time however, things were being put into place i.e. carers and then respite, to support him in managing the care of his wife.

3.33 The Admiral Nursing Service report however, illustrates several areas where improvements and learning have been identified:

- Cross Boarder Working

  Other than the initial letter to the GP, there was no recorded information sharing to the rest of the care team, or indeed from anyone in the rest of the care team to the Admiral Nurse. On discussion it is apparent that there is a reliance on the carer to make contact and feedback to other members of the care team about the intervention and support from the Admiral Nurse where they are able and willing. The Root Cause Analysis undertaken after the incident also highlighted cross border working as an issue. An action plan was developed to ensure that all cross border cases were discussed in clinical supervision to ensure that there was a plan in place to gain information from other services.

- Recording Systems

  In the Trust, carers do not have individual records and are not recorded as being in receipt of individual services on the Trust database. Admiral Nurses record their client contact on a National Admiral Nursing Record system, WANDA. These records are therefore not available to other members of the care team. Where patients are within the County, relevant information is added to the patient record about the carer and any issues that are raised. The Trust is about to launch a new electronic record keeping system.

- Information Sharing

Throughout the time that the Perpetrator was known to the service, there was no indication that he was contemplating taking any action to end his or his wife's life. There was no indication that he was struggling to such an extent that the outcome could have been predicted. However, the interventions offered by the Admiral Nursing Service were in isolation of the other members of the care team. Information was not actively shared although it is known that should any other member of the care team had made contact then information would have been shared in line with policy.

3.34 The Community Safety Partnership has also made improvements to systems with regard to the delivery plan for the DVA Delivery Group. This now includes developing and delivering as part of the multiagency DVA training, a new unit covering age, dementia and other vulnerabilities as a possible indicator of DVA. Similarly, the DVA referral pathways and advice for professionals are being revised to reflect DVA and older people, and DVA and vulnerability.

3.35 As part of this Review, two experienced panel members visited the care home where the Victim had been taken by her family in order to assess the suitability of the care home for the needs of the Victim. The panel members were impressed with the care home and its policies and procedures for caring for patients with dementia.

3.36 The Manager of the care home was seen and was candid in her assessment of the manner on which the Victim had been assessed and cared for during her short stay at the home. The manager agreed that she had initiated changes in practice since this incident with the Victim in relation to the delivery of care and if such an incident occurred again, she would seek assistance from Adult Social Care or the patient's GP

3.37 The manager stated that the following areas of policy had been revised:.

- A Mental Capacity Act assessment to be conducted as an integral part of the assessment process to ascertain the prospective resident's understanding of the move to a care facility.
- A BASOLL (Behavioural Assessment Scale of Later Life) questionnaire to be completed at each assessment to improve care planning.
- Should a family member show signs of distress the senior member of staff with the care home should support the family member away from the care giving area to enable interruption free conversations to be held.
- The service should review their training delivery to support staff with care delivery as soon as possible after induction. At a minimum Mental capacity Act DoLS and dementia training should be available for those staff working with the dementia unit as part of their induction processes.
- The home should develop a system to include identification of family carer's needs as we'll as the resident's needs.

4 Conclusions

4.1 The Perpetrator and the Victim were not known to any agency prior to the onset of the Victim's ill health problems. The Perpetrator loved and cared for his wife during her illness and did everything he could for her.

4.2 There is much research into domestic abuse and dementia and how dementia patients are more susceptible to become victims of abuse. (Worcestershire DHR Case 6 2015) However despite the research there is nothing in this case to suggest the findings of such research is relevant.

4.3 It is clear that the Perpetrator was determined to make sure she was comfortable despite his own needs, anxiety and desperate requirement for respite. He reluctantly admitted her into a care home but that did not stop him worrying about her care. He removed her suddenly after an altercation at the home, not involving him or his wife. What followed in the next 24 hours or so, no one will know, but one can imagine the desperation of the situation that the couple must have found themselves in. Neither of them could imagine being without the other and the Victim's health was deteriorating rapidly. She had indicated that she wanted to die so the Perpetrator took the steps to end the life of his wife and then end his own. No one will know if this was planned or a spontaneous action, or in fact, whether the Victim appreciated or agreed with what was to happen.

4.4 The fact remains that the Perpetrator, in a desperate act, took both of their lives. His actions could not have been predicted or prevented and despite attempts of the media to link this with the planning application in the adjacent field, there is nothing to suggest that this effected the Perpetrator's decision.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Revised August 2013 Home Office

Herefordshire

Community Safety Partnership

ACTION PLAN

DOMESTIC HOMICIDE REVIEW CASE HDHR02

INDIVIDUAL MANAGEMENT REVIEW REPORT RECOMMENDATIONS

WEST MERCIA POLICE

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
West Mercia and Warwickshire Police Firearms Licencing Departments to consider the feasibility of implementing the wording of the Recommendation 6 of Durham DHR re Adults A-F (February 2013) and report back to the Hereford Community Safety Partnership within 3 months. (see below for 3 parts of that recommendation)	Firearms Licensing Department consideration but taking into account the obligation to comply with Home Office Guidelines.	Superintendent of Firearms Licensing Unit	1/11/15	The issues of flags on medical records, mandated referral by GP's and access to the records of other agencies, are subject of a national project on behalf of CC Andy Marsh of Hampshire Constabulary, who is the police national lead for firearms licensing. Unknown when report due – further detail below re specifics. For Home Office Guidance from which Police forces operate see: https://www.gov.uk/government/uploads/system/ploads/attachment_data/file/417199/Guidance_on_Firearms_Licensing_Law_v13.pdf The DHR may wish to know that there is currently a review of Firearms Licensing law being undertaken by the Law Commission who are accepting submissions from interested parties. http://www.lawcom.gov.uk/firearms-making-the-law-more-balanced-and-more-effective/
a) The Police firearms licensing departments explore the feasibility of carrying out checks both internally and externally with other agencies in particular primary health care i.e. GP's, to help them				Internal checks are conducted regarding the applicant only, as the national form only stipulates the applicant's details. The internal checks on the applicant include any known intelligence or convictions. Regarding the applicant, consent to medical records is received & the GP is notified of the licence being granted but asked to provide

make decisions in relation to the granting of either a shotgun or firearm's licences. In order to help them to do this and risk assess appropriately, consideration should be given to establishing a system so that consent is sought for the disclosure of information from every person in that household from primary care services. This will enable information to be shared relevant to domestic abuse, substance miss-use, physical harm and mental health issues.				any information of concern. The GP's response is not mandated at present. (this is part of national agenda) If a GP responds that there are mental health issues, or the applicant themselves have stated they have these issues, then other agencies would be contacted. Regarding others in the household providing their consent, the form of application is determined by statute in the Firearms (Amendment) Rules 2013 and the Firearms (Amendment) (No. 2) Rules 2013. Therefore a change in legislation would be required to ensure that every person in a household identified themselves and gave consent for the disclosure of medical information. (also part of national agenda)
b) Once a firearm or shotgun certificate has been awarded, the police firearms licencing department should notify the individual's GP so that they are proactive in their information sharing if they have concerns about the certificate holder and their appropriateness to continue to hold these certificates.				Individual GP's are already notified of the certificate being awarded but their response is not mandated, & relies upon individual practices being proactive. West Mercia Police are open to amending the post grant letter to reinforce that the consent of the certificate holder for the sharing of medical information throughout the life of the certificate has been given.
c) During the course of those discussions the police				The issue of an enduring flag on medical records is also part of the national project & sits outside the remit of individual Police forces.

representative should also seek permission for a 'flag' to be placed upon the individuals medical record which identifies that if granted a licence it is clearly visible to those accessing the record.				

WYE VALLEY NHS TRUST

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Trust to look at ways of ensuring that information leaflets for carers of patients with a diagnosis of dementia is given to all carers, in order that they are aware of how to access help if required.	Wye Valley NHS Trust	Lead Nurse Elective Care	June 2016	**COMPLETED**
Trust to look at developing a carer's self-assessment tool that could be completed by carers of patients with dementia, in order to identify those carers who are finding it difficult to cope.	Wye valley NHS Trust	Lead Nurse Elective Care	June 2016	**COMPLETED**

2gether NHS Foundation Trust Learning Action P

Action Number	Actions	Lead	RAG	Timing	Update	Comments
1	Deliver a learning event to the teams involved in this episode of care delivery. This will provide staff with the learning from this review and give education on the actions.	J Trevains/D Topham	**Completed**	Completed October 2015		This is part a whole Older Person Service Development programme
2	Provide a Trust wide briefing on this case, detailing the observations, learning and recommendations from this individual management report. This will be communicated and Team managers will be directed to discuss in Team meetings.	J Trevains	**Not Completed Awaiting publication of DHR**	On publication of DHR	The IMR will be shared with senior team mangers and clinical director. The DDN is preparing a Trust wide briefing on this for publication when the	

					multi-agency DHR is published	
3	SBARD training will be delivered to the teams involved in this case and will also be made available to other Trust services in Herefordshire.	S Ashton - Clinical Improvement lead	**Completed**	Completed October 2015		This is part a whole Older Person Service Development programme
4	Conduct an audit of carers assessments completion and review dates will be completed for the Herefordshire Memory Assessment Service and Older Person Services.	T Wallin - with support from team management	**Completed**	Completed November 2015		Matt Edwards Audit team provided technical assistance
5	Conduct an audit of completion of care plans, risk assessments and crisis contingency plans for the Herefordshire Memory Assessment Service and Older Person Services.	T Wallin - with support from team management	**Completed**	Completed November 2015		Matt Edwards Audit team provided technical assistance
6	Development work on better liaison and promotion of careers support services linked with wider Trust work in this area. This will include the development and communication of strategies to be used when reasonable support is being refused.	Tanya Stacey - Jodie Thomas & DMHOP Manager	**Completed**	Completed December 2015		

7	Review the interface between the Memory Services, Primary Mental Health Teams and Older Adults Community Mental Health Teams utilising the learning from this review.	D Topham	**Completed**	Completed December 2015		
8	Review the Herefordshire Memory Assessment and Older Person Services sharing of information with clinicians, patients and carers, including the practice of copying or addressing letters to patients. This will also consider the sharing of information regarding medication and care planning.	T Wallin/ J Thomas	**Completed**	Completed October 2015		
9	Provide clear guidance to ensure that patients and carers are offered and consistently reminded of a clear single point of contact at whatever level they are engaged, and that appropriate supporting information is given regarding planned interventions and indications for contacting services before crisis.	T Wallin/ J Thomas	**Completed**	Completed September 2015		
10	Provide clear guidance on the process for ascertaining that a carers assessment has been requested, and undertaken or refused, should be reviewed, including its documentation and reference to actions in RIO.	T Wallin/ J Thomas	**Completed**	Completed December 2016		

11	Provide additional training and guidance for the Herefordshire Memory Assessment Service and Older Persons Services regarding safeguarding information on older persons abuse issues.	A Feher- Trust Safeguarding team	**Completed**	Completed November 2015		
12	Meet with Wye Valley Trust nursing lead to discuss methods for improving communication between services in light of the learning from this IMR.	J Trevains	**Completed**	Completed November 2015		

HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

PRIMARY CARE

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Map of Medicine needs to include the car pathway for domestic abuse	Post HSCB/HSAB/CSP sign off of domestic abuse care pathway upload the pathway onto Map of Medicine	SC	March 2016	Domestic abuse care pathway updated, awaiting final version to include in GP processes **COMPLETED**
The care pathway needs to be reviewed to assess whether it is fit for purpose for all age groups, amended as necessary and published on adult focused web	Post HSCB/HSAB/CSP sign off of domestic abuse care pathway upload the pathway onto Map of Medicine	SC	March 2016	Domestic abuse care pathway updated, awaiting final version to include in GP processes **COMPLETED**

The CCG to include a link to the document managing pain in dementia in their next GP newsletter	SB to include link in GP newsletter	SB	November 2015	November 2015 **COMPLETED**

Admiral Nursing Service

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
All cross boundary Admiral Nursing cases to be discussed at Clinical supervision to ensure that there is a plan to try and gain access to information.	All cross boundary referrals to be discussed in supervision and also discussed at team meetings weekly	Helen Springthorpe, Admiral Nurse Team Leader	December 16th 2015 **COMPLETED**	Admiral Nurses already participate in monthly clinical supervision which is facilitated by an external supervisor and monitored by Dementia UK. All cross boundary cases are discussed and plans to proactively gain and share information are identified. This will be recorded in the carer records on WANDA All staff have already been made aware of this action on December 16th 2015 and this will be highlighted and discussed during weekly team referral meetings
When Care Notes Electronic records are introduced, separate records should be created for carers who are in receipt if direct interventions	All staff to undertake core electronic Care Notes	Sally McKeag, Operational Lead.	January 6th 2016 **COMPLETED**	The Admiral Nurse team have undertaken the core training for Electronic Care Notes during the first week of December 2015 and are currently awaiting access to the system to ensure the recommendation identified is followed through.

from Trust services with links to the patient's records so that other services within the Trust can have access to carer records. Separate interventions for a carer would be visible and in the case of Admiral Nurses, the involvement of the service would be clear to all who view the record.(the Admiral Nurse would still need to maintain their WANDA records)	training and be able to access Care Notes			
Where Admiral Nursing Service are seeing carers, key points of information and concern should be actively shared with other members of the care team e.g. GP and Psychiatrist etc via telephone, email or letter as appropriate	Team to proactively seek and share appropriate information with professionals and agencies involved in the care and support of the family.	Helen Springthorpe, Admiral Nurse Team Leader	December 16th 2015 **COMPLETED**	Admiral Nurses to proactively engage with other professionals and agencies to ensure effective communication through face to face liaison, attendance at multidisciplinary meetings where appropriate, by secure email and telephone. All staff have been made aware of this at the team meeting on December 16th 2015