Herefordshire

Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Into the circumstances

of the death of a man aged 78 years

on 3rd November 2014

Case HDHR 4

Independent Author:

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LIST OF ABBREVIATIONS

A&E - Accident and Emergency Department (Hospital)

ASC - Adult Social Care

CCG - Clinical Commissioning Group

CSP - Community Safety Partnership

DAU - Domestic Abuse Unit (Police)

DHR - Domestic Homicide Review

GP - General Practitioner

HCSP - Herefordshire Community Safety Partnership

HMC - Her Majesty's Coroner

IDVA - Independent Domestic Violence Advisor

MAPPA - Multi Agency Public Protection Arrangement

MARAC - Multi Agency Risk Assessment Conference

PPIG - Public Protection Investigation Unit

SIO - Senior Investigating Officer (Police)

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HEREFORDSHIRE COMMUNITY SAFETY PARTNERSHIP

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1. Introduction

This domestic homicide review examines the circumstances around the death of a 78 year old man who was found injured at his home address on 20th October 2014. He had disclosed to several people that his partner had pushed him to the ground on 2nd October and had injured him. She and the Deceased attended a concert on 7th October 2014 and describes how he appeared well and able to walk. She then left Herefordshire and returned to London as she did quite frequently to attend concerts and see her own circle of friends.

1.2 The Deceased was taken to hospital and his condition deteriorated over the following week and he died from multiple organ failure on 3rd November 2014.

1.3 A forensic post mortem recorded the initial cause of death as being from multiple organ failure and ongoing tests and examination were unable to positively establish a cause or link between the assault and his death.

1.4 Police investigation was commenced. His partner, who is a 70 year old lady, was interviewed and released on Police bail to return to the Police on an agreed date once enquiries had been completed. In August 2014, after considering the case papers, Crown Prosecution Service (CPS) decided that there was insufficient evidence to proceed against his partner for any criminal offences. In view of this decision reference is made throughout this report to the 'partner' rather than the 'alleged perpetrator'.

1.5 As a result of CPS' decision, the DHR panel advised that the Home Office should be notified and this review continue as there are still lessons to be learned from the outcome of the review. The Home Office advised that the review should continue as per Home Office Guidance.

1.6 On 14th December 2015, HM Coroner for Herefordshire returned an 'Open' conclusion to the inquest.

1.7 As a result of a specific request of the partner, reference throughout this report to the parties involved will be 'partner' and 'Deceased' rather than Victim and Perpetrator as outlined in Home Office Guidance.

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

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

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 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 the deceased 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 the deceased

- 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 deceased and their children through improved intra and inter-agency working.

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

1.3 Process of the Review

1.3.1 West Mercia Police notified Herefordshire Community Safety Partnership (HCSP) of the death of the Deceased on 7th November 2014 HCSP convened a DHR Sub-Group meeting and decided that the circumstances of the death of the Deceased 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.

1.3.4. The report was presented to the Herefordshire Community Safety Partnership Board on 16th November 2015.

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.

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.

1.6 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

[3] Home Office Guidance 2013 page 15
[4] Home Office Guidance 2013 page 11

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 (Independent member)
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 4 occasions.

1.7 Parallel proceedings

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

- HM Coroner for Herefordshire opened an inquest and adjourned it to a date to be fixed. The DHR Panel Chair advised HM Coroner that a DHR will be undertaken and the Coroner has been updated on a regular basis. An 'Open' conclusion was recorded at an inquest in November 2015.
- West Mercia Police continue to investigate the death and enquiries are ongoing.
- The review was commenced in advance of criminal proceedings having been concluded and therefore preceded with an awareness of the issues of disclosure that may arise.

1.8 Time Period

1.8.1 It was decided that the review should focus on the period 1st January 2010 to the date of the Deceased's death on 3rd November 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 Deceased and his partner 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 partner 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 Deceased and his family, carry out individual management reviews and produce reports.

- West Mercia Police
- Health – Wye Valley Trust, GP's, Herefordshire CCG and 2gether NHS Trust
- Adult Social Care Herefordshire County Council
- West Mercia's Women's Aid

and a report from:

- Kemble Care

1.11 Summary

1.11.1 This domestic homicide review examines the circumstances around the death of a 78 year old man on 3rd November 2014. The Deceased was taken from his home on 20th October 2014 having been found injured on the floor by a neighbour. He disclosed to the carer, a paramedic, a GP and staff from a local dental surgery that his partner, had pushed him to the floor some days earlier and he had been injured. His partner, a 70 year old lady had left 2 weeks after she had pushed him and returned to her own house in London.

1.11.2 Officers from West Mercia Police attempted to speak to the Deceased on several occasions following his admission to hospital on 20th October, but were prevented from doing so on medical advice as the Deceased's medical condition was deteriorating. The alleged assault on the Deceased was recorded by the Police and subsequently the partner was arrested and interviewed under caution. She was interviewed on several occasions and was released on bail while Police made enquiries into the matter.

1.11.3 A forensic post mortem was conducted and an initial cause of death was recorded by the Pathologist as multi organ failure. Forensic examinations and tests were conducted in an attempt to confirm or exclude a cause or link between his injuries and the alleged assault but were unsuccessful.

1.11.4 In August 2015, the Crown Prosecution Service decided that there was insufficient evidence to proceed on any charges against the partner.

1.12 Terms of Reference

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.

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the deceased and his partner, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a deceased or his partner?
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 deceased or his partner (DASH) and were those assessments correctly used in the case of this deceased /Partner?
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 deceased 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 deceased's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the deceased should have been known?
13. Was the deceased informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the partner? For example, were they being managed under MAPPA?
16. Had the deceased 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 deceased, the partner 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 deceased and promote their welfare, or the way it identifies, assesses and manages the risks posed by his partner? 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 deceased and the partner predicted and prevented?

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 deceased, the partner and their families? Was consideration for vulnerability and disability necessary?"

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.

1.14 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

1.15.1 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 Partnership 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 deceased's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the deceased and the partner's networks in the review process.

[5] Home Office Guidance page 25

6 Home Office Guidance page 15

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)

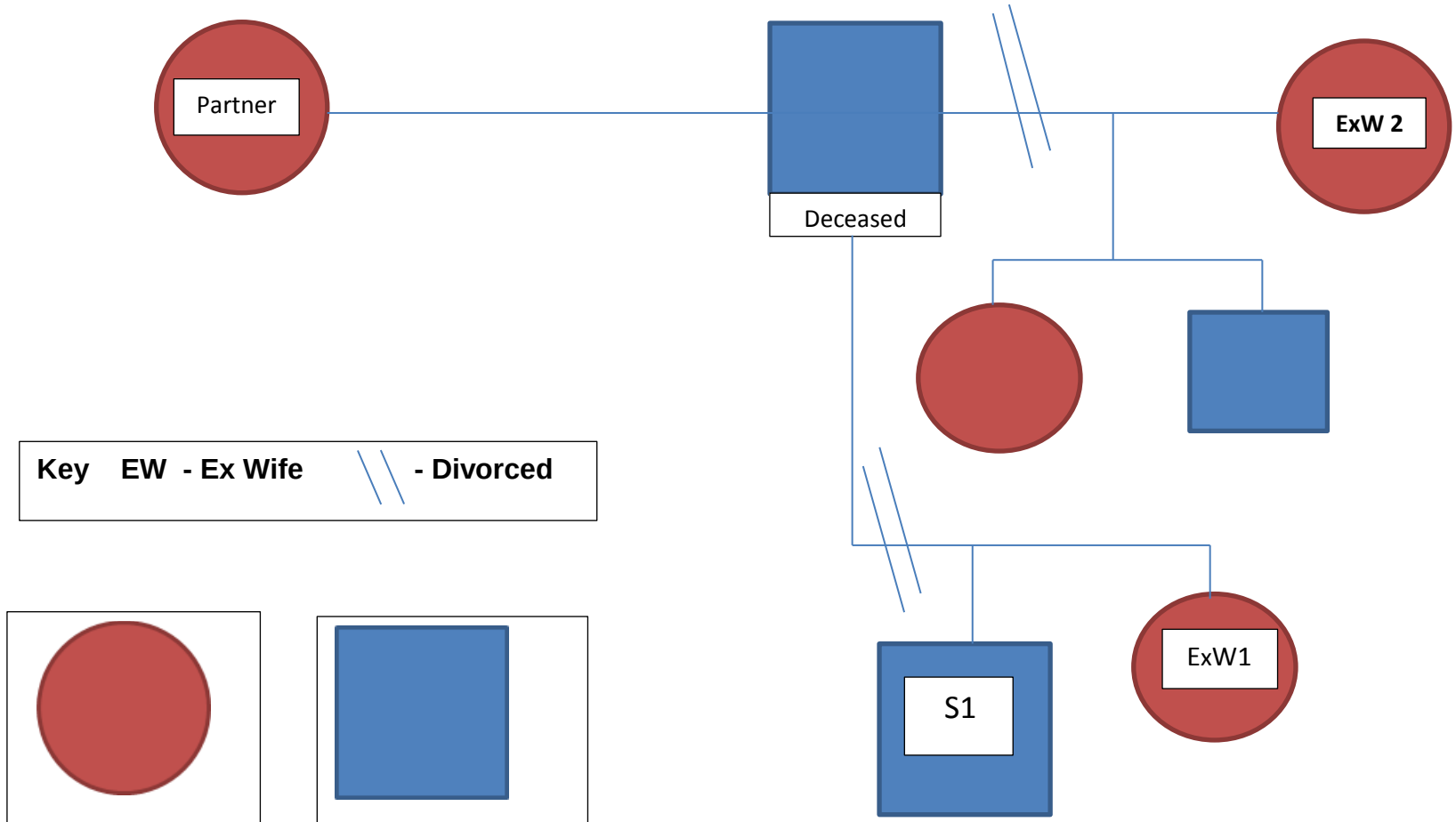
1.16.3 These Terms of reference were considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

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:

Deceased	Male, 78 years old,
Partner	Female, 70 years old, partner of deceased
N1	Neighbour
S1	Male, Son of Deceased by previous marriage
ExW 1	First Ex-wife of Deceased, Mother of S1
ExW2	Second Ex –wife and two children of Deceased

Genogram


Partner
Deceased
ExW 2
S1
ExW1
Key EW - Ex Wife
- Divorced
Female
Male

2. Summary of Key Events

2.1 This Domestic Homicide Review concerns an elderly couple who had been together for nearly 30 years. They were not married and had no children between them. The Deceased had a son from a previous marriage. He re-married and had another two children with whom he has no contact. He has several sisters all of whom live in Kent. The partner has no children.

2.2 The Deceased and partner met whilst they worked for the Civil Service in London. According to the partner the Deceased enjoyed his work and rose to high office within the Civil Service. She described the culture then within the Civil Service which involved long lunchtime sessions of drinking alcohol and then continuing after work. It was here, according to the partner, that the Deceased developed his misuse of alcohol lifestyle.

2.3 The partner has a jointly owned house with the Deceased and her own flat that she rents out in London. She rents the flat but keeps the house for herself. Although some years ago the couple bought a house in Herefordshire between them, she kept her house for the occasions when she needed some space and time away from the Deceased. This was also to satisfy her interests in culture, art and concerts and was usually on a monthly basis.

2.4 Even though she may have been apart from the Deceased during these occasions, she would contact him on a daily basis. She was able to measure how much he had had to drink by his response over the telephone.

2.5 The couple lived in a quiet village, opposite 2 public houses. Domestic disputes between them were common place, often fuelled by alcohol taken in the main by the Deceased. The partner would also drink in moderation. It was not unusual for local residents attending at the public house to walk across the road and calm the situation down between the couple.

2.6 Police attendance at their home address was not uncommon. On 3rd December 2001, Police Officers attended their then home address. There had been another argument and the partner had fallen through a door frame window cutting her wrists as she fell. She admitted being involved in an altercation and said that she had thrown furniture around the house. She had tried to separate the dog and cat during an argument and consequently had broken the window by putting her hands through as she fell. She was detained in hospital for a total of 4 days. Police considered the matter was suitable for filing. This pre-dated the use of the Public Protection Unit booklets that would be submitted today.

2.7 On 10th August 2007, Police Officers were called to a heated verbal argument between the couple. No complaints of assault were made by either and the couple were advised about their future conduct. The matter was referred to the Domestic Abuse Officer. Both of these incidents are outside the scope of this review but help put into context the couple's relationship.

2.8 During 2010, the Deceased had several hospital appointments regarding urology problems and asthma and in October 2010, he was given prostate medication.

2.9 During 2011, the Deceased developed eye problems for which he had hospital treatment.

2.10 On 8th December 2012, Police Officers attended at the home address following a call to the effect that the Deceased was arguing with two female neighbours over one of the neighbour's dog. The Deceased was alleged to have been verbally abusive so the neighbour had slapped him in the face. The Deceased did not wish to make a complaint and the matter was dealt with by a Community Resolution.

2.11 On 15th December 2012, Police Officers were again called the home address following a 999 call from the partner. The Deceased had returned from the Public House in a drunken state and the partner had thrown a glass of water over him. He had then returned to the Public House. On his return, the Officers spoke to both of them and each one was blaming the other for the argument. They were duly advised and the matter was referred to the Domestic Abuse Unit (DAU) which was in existence by this time. A PPIG booklet was submitted and an Independent Domestic Violence Advisor (IDVA) was notified. Officers from the DAU attempted to contact the partner following this incident but she failed to return their calls. The matter was filed with no further action being taken on 20th December 2012.

2.12 The Deceased's medical needs continued into 2013. On 17th May 2013, another domestic incident was reported by the Deceased. Apparently he and his partner had been arguing over the telephone and on her return to the house she had threatened the Deceased with a kitchen knife, that for some reason she had taken into the bedroom. No injury was sustained by either person and the Deceased made no complaint. The partner decided that she did not want to stay in the house overnight but it was too late for her to return to London. The Officer took her to the local Police Station where she stayed in the front office until the morning and then caught the train back to London. She stated that she would be seeking legal advice. The necessary booklet was submitted and the matter was filed. There is a note in the Police IMR that the booklet was not received by the DAU for some reason.

2.13 On 17th September 2013, the Deceased fell backwards down steep stairs in the house, after having drunk a lot of alcohol. The partner was due to go to London the following day but put off her journey for 6 days. She helped the Deceased to the GP who prescribed pain killers for bruising to his back and ribs. It was from this point onwards that the Deceased started to use a walking stick for his balance.

2.14 The partner went to London on 24th September and on 25th September 2013, the Deceased was seen by the Practice Nurse at the GP's surgery with conjunctivitis. He had apparently fallen in the garden the previous evening hitting his head and had been taken to the A&E at the local hospital. He was x-rayed which showed no fractures and he was treated for muscular pain and discharged the same day.

2.14 On 6th November 2013, the Deceased again attended GP practice reporting that he had fallen the previous night and put his hand out to save himself and burned his hand on a cast iron stove. His hand was dressed and he was to attend for a further 8 appointments for dressings to the burn.

2.15 The Deceased reported that he had fallen again In December 2013, this time he had apparently fallen out of bed whilst dreaming. He had fallen backwards but hit his face on a bedside cupboard. Pain relief was prescribed.

2.16 In February 2014, the Deceased was seen at his GP with ectropion, (infected eyelids). It is recorded that the bruising from his last fall was taking some time to heal and that he was sleeping in a chair. He was advised to sleep in a bed.

2.17 In April 2014, the Deceased was found to have Macrocytosis[7] and low Vitamin B12. He was given and injection to counter his low Vitamin B1 and folic acid supplements. It was stated that he may be drinking too much. During July 2014, the Deceased complained to his GP of back problems suggesting that he had twisted his back. He was given pain relief.

2.18 On 20th October 2014, a neighbour of the Deceased called at his house to deliver his paper The partner had returned to her house in London and the Deceased was on his own. When this happened the neighbour was asked to look in on the Deceased on a daily basis. The neighbour found the Deceased on the floor in the lounge. She summoned the assistance of builders from a nearby house and staff from a dental practice opposite. The Deceased reported that he had been pushed over and assaulted some days prior by the partner and injured his back. He had laid on the floor the previous night in an attempt to relieve the pain and found that he could not get up.

2.19 An ambulance was summoned and a local GP also attended. Several people heard the Deceased report that the partner was responsible for the injury.

2.20 The Deceased was taken to the local hospital where he was detained. A Police Officer attended and spoke to the Deceased who repeated the allegation about the partner being responsible. As the Officer was attempting to obtain details of the incident from the Deceased, he became extremely racially abusive towards a member of the nursing staff. He was advised about his language towards this person but continued with his racist ranting. The partner is of the opinion that the Deceased must have been in acute pain or delirious for him to make such comments. The Officer stated that he would see the Deceased once he had been discharged from hospital.

2.21 During this time, the partner was in London but she was informed of the Deceased's admission to hospital and made her way back to Herefordshire and to hospital to see him.

2.22 Enquiries were made by the Police with the Deceased's GP who described him as being not fit or well man but at the same time not being vulnerable. The GP stated that his condition was exacerbated by his alcohol consumption and his prostate cancer and despite several falls there was nothing that caused concern about the Deceased's overall safety.

2.23 The Police Officer recorded this incident as a Common Assault based on the Deceased's verbal account of being pushed over causing an injury to his back some 10 days previously. The Officer recorded the risk assessment as 'low risk' and the necessary forms were passed to the Domestic Abuse Unit. Once here, the forms were re-assessed and indicators of a number of risks were identified and the assessment was upgraded to medium with a need for the Deceased to be seen again for more detail. It is of interest that all questions on the risk assessment form were answered 'No' raising the question 'Was the [deceased] asked the questions or has the Officer just recorded 'No'? It is likely that if he had been asked the questions on the form, some of his answers would have been 'Yes'.

2.24 The Police Officer attended the home address of the Deceased 11 days later to be told that he was still detained in hospital. The Officer went to hospital and was told that the Deceased's condition had deteriorated and because of his fragile health he was not well enough to be seen. The Officer's supervisor instructed that the partner was to be

[7] Macrocytosis is a term used to describe red blood cells that are larger than normal. It typically causes no signs or symptoms and is usually detected incidentally on routine blood tests. Macrocytosis isn't a specific disease, but it may indicate an underlying problem that requires medical evaluation

seen and arrangements were made for her to be seen at the family home later that day.

2.25 The Officer saw the partner at 11.05pm that day and conducted an interview under caution with her. She chose not to be legally represented and gave an account of how the Deceased had made threats towards her and how she had pushed him in self-defence causing him to fall to the floor. She had helped him to his feet, placed him in his arm chair and had given him a watered down whiskey to calm him down. She went to bed in her own bedroom and the Deceased went to his bedroom about 30 minutes later. The interview was concluded at 00.30 hours the following morning (58 minutes later).

2.26 The Officer submitted a crime report for common assault with the comments that it 'was not in the public interest to prosecute in this case and in all likelihood, the suspect has raised a plausible defence which we are going to struggle to disprove.'

2.27 As a result of the initial attendance at the house where the Deceased was found on the floor, both the Ambulance Service and the Dental Nurse made Safeguarding referrals to Adult Social Care. This is to be noted as best practice.

2.28 Adult Social Care expressed the view that it was essential for the Deceased to be seen by the Police prior to him being released from hospital in order that the risk posed by the partner could be properly assessed and before she returned. Following a visit to the Deceased by Adult Social Care, attempts were made to contact the Officer concerned to reiterate that the Deceased wanted to see the Police. They were told that the Officer was on night duty and the matter would be dealt with when he returned from leave in some 4 days. Eventually the Officer responded to an e mail from Adult Social Care to the effect that he thought that there was no safeguarding risk or concerns regarding the Deceased.

2.29 Adult Social Care had discovered from the Police that there had been five incidents reported to the Police in the past and that this current incident had been graded as a Priority 2. This meant that a Police Officer would visit the Deceased the following day before the partner had returned from London. Although discharge dates had not yet been established the situation could have changed and the Deceased discharged at any time before a proper risk assessment had been carried out. Adult Social Care sent a Social Worker to see the Deceased to ascertain if he had any support needs.

2.30 The Deceased's condition deteriorated and he never recovered sufficiently enough to provide a formal account of what happened. He was diagnosed with toxic colitis and was considered too ill for surgical intervention.

2.31 A Forensic Post Mortem was conducted by Home Office Pathologist Dr Hunt who concluded at that stage that this case was very complex but he could not rule out a causal link between the Deceased's injuries and his death. More pathological examinations were conducted resulting in Dr Hunt recording:

> 'The [Deceased's] injuries and the attendant immobility requiring hospitalisation have more than minimally contributed to his subsequent death, in conjunction with his underlying natural disease but I am unable to say exactly how the injuries were caused.'

2.32 The cause of death was recorded as:

> 1a Multi organ failure

1b Pseudomembranous colitis complicating antibiotic treatment for hospital acquired pneumonia in a patient with spinal and rib fractures.

1c Cirrhosis (alcohol), osteoporosis, chronic obstructive pulmonary disease and hypertension.

2.33 Following the death of the Deceased, the partner was arrested on suspicion of manslaughter and interviewed.

2.34 During the subsequent major investigation by the Police enquiries revealed that two other incidents had come to light that formed part of the detective's interview strategy.

2.35 The first of these came from hospital staff whilst caring for the Deceased. It had been declared that the Deceased should have 'Nil by Mouth' and the usual sign placed at the head end of his bed. Staff had informed the partner that, whilst visiting him, he was to have nothing to eat or drink. A nurse reported hearing gurgling noises coming from behind a curtain around the Deceased's bed and when she investigated she Said she found the partner had removed his pillows so he was lying flat and she was pouring liquid into his mouth causing him to choke. She was challenged by the nurse and the partner replied that she thought it was water and she thought the Deceased wanted a drink. This matter was reported to a supervisor on the ward and the partner was informed again about the 'Nil by Mouth' policy.

2.36 During a visit to the partner by the Overview report Author, the partner refuted the claim by the nurse that she had removed the Deceased's pillows. She stated that she was moistening his lips with water and appreciated that he had to have pillows behind him.

2.37 The second incident arose from an interview with a family friend of the couple, who stated to Officers that some time before, the partner had confided in her (the family friend) that she, the partner had been trying to poison the Deceased by mixing his whisky with other substances. Apparently, it was alleged that the Deceased had a quantity of whiskey stored in an outside shed and the partner had researched on the internet how to poison whiskey. She had tried to mix a concoction but each time the whiskey had gone cloudy. She had apparently also tried to mix his whiskey with tablets.

2.38 Again the partner refutes this allegation saying that she had mixed 'paracetamol' tablets with a tiny drop of whiskey for the Deceased's pain relief but he had not taken it and left it overnight, during which time it had turned cloudy so she threw it away.

2.39 During several interviews with the Police the partner denied any intention to harm the Deceased. Crown Prosecution Service decided after a lengthy consideration of the facts, that there was insufficient evidence to prosecute the partner for any criminal offences.

Views of the Family.

2.40 Home Office Guidance requires the views of the family to be recorded and also those of the partner. During the initial stages of this review the Independent Author wrote to the partner informing her of the process of this review and inviting her to contribute should she so wish. She replied that she did want to contribute and wished to do so at an early stage.

2.41 On 24th April 2015, the Author visited the partner at the family home in Herefordshire. The Author explained to her that the visit was to discuss agency intervention and the history of their relationship. It was stressed that the Author would not enter into any

conversation or discussion about anything relating to the evidence in the case. These conditions were strictly adhered to throughout the visit.

2.42 The partner discussed their early life together and the Deceased's drinking habits whilst he worked for the Civil Service. She discussed his medical problems and his developing prostate cancer. She also explained about the Deceased's two previous marriages and children.

2.43 The partner stated how she had tried for some 28 years to get the Deceased to stop drinking but without success. She had even gone to a support charity herself for advice. She said that the Deceased would go to his GP whom she had a lot of time for. He knew that the Deceased drank too heavily but also knew that it would be an impossible task to try and get his to stop drinking. She realised that he had a problem with alcohol when they had been seeing each other for about 18 months. The Deceased asked her on numerous occasions to marry him but she declined on each occasion because of his drinking. She thought that the Deceased's GP could have been more proactive regarding the Deceased's drinking but the Deceased did not receive any advice. She also appreciated that the Deceased simply did not want to give up drinking

2.42 She described how the Deceased's mood changed once he started drinking at lunch time, and how he would become more aggressive, verbally and physically abusive as the day moved on and he drank more. She stated that the Deceased could be really nasty towards her.

2.43 The partner spoke about the Deceased's relationship with his GP in Bromley before he moved to Herefordshire. She said that GP knew he had a drink problem and she had asked for a referral from the Deceased to support agencies but the Deceased would not go.

2.44 The partner admitted that she would also drink but said that her drinking was done out of desperation because of the Deceased's drinking and always in moderation. She also said that when they argued she 'would give as good as she got from him'. She said that she never made a complaint to the police or anyone else about the Deceased's behaviour towards him, because overall she loved him and she could choose to take a break and move back to London for some respite.

2.45 The Primary Care IMR is very helpful in its explanation of a recently developed Domestic Abuse Care Pathway, which has been included on the Herefordshire Safeguarding Children web site. The Care Pathway includes information regarding asking people about Domestic Abuse and it has hyperlinks to the DASH Risk Assessment Tools. However, the Care Pathway has not been agreed by the Herefordshire Safeguarding Adults Board and knowledge of Domestic Abuse and the services available when there are no children involved is less understood than when children are in need. The Primary Care IMR makes its own recommendations aimed at rectifying that issue.

2.46 On 2nd February 2016. The Author saw the partner at her home address and discussed the findings of the review with her. She was content with the report and its findings. She expressed the wish that her partner should be referred to as the Deceased and herself as Partner. The report and executive summary were duly amended.

3. Analysis and recommendations.

3.1 This Domestic Homicide concerns a couple who lived together for many years in a volatile, verbally abusive and sometimes physically abuse relationship. When the situation got too much for one or the other of them, the partner would move back to her house in London, often at least once per month for respite and social reasons.

During the time they were separated however, they would call each other every night before going to bed to make sure the other one was well.

3.2 They were well known in the village where they lived to be the couple that argued and on occasions other residents would come from the public house opposite their house to quell arguments that customers in the public house could hear.

3.3 Police attended on several occasions to calls from either of the couple to help sort out domestic arguments, but there was never any complaint sufficient enough for the Police to arrest or prosecute either one of them. The Police were called to put a temporary end to the arguments. However in each case, Officers did deliver advice notices indicating where the couple could receive information and advice in accordance with policy of that time, but the Police IMR points out other concerns about the action of the officers and processes each time.

3.4 When Police were called on 20th October 2014, the Officer made the decision to take a verbal statement from the Deceased at that stage and to return to take a formal written statement of complaint at a later stage. The Officer also decided that it was not in the public interest to prosecute the partner for this assault.

3.5 It was 11 days before the Officer returned to speak to the Deceased. The Officer was contacted by Adult Social Care, who had received two referrals about the incident, one from the Ambulance Service and one from the Dental Practice opposite the family home from where staff had attended to help the Deceased once he was found on the floor.

3.6 Adult Social Care were concerned that the Deceased would be discharged from the hospital home, into the care of the partner without any investigation being completed or risk assessment into the safety of the Deceased being considered. The Officer's view was that 'there were no risk concerns for the Deceased.

3.7 The Officer did speak to the partner during a short, under caution interview recorded contemporaneously, at the family home at around midnight one evening, during which she stated that she had pushed him over in self-defence. There is no rationale as to why the officer chose to conduct such an interview in that manner, rather than at the Police Station or under arrest conditions.

3.8 The Police IMR helpfully points out:

> 'Police Officers routinely attend domestic abuse incidents and quickly become experienced in dealing with such incidents. They are expected to exercise their powers and arrest offenders and the deceased] bring them before Court if possible'.

3.9 The knife incident in May 2013 should have resulted in the Deceased being seen to see if he wished to go to his solicitor. A referral was made to IDVA but there is no record of that referral to be found at Women's Aid. Additional support may have been considered with the use of Local Policing Teams to try and persuade the Deceased to seek help with his alcohol problem. The 2014 incident was recorded correctly as a medium risk but only when the report reached the Domestic Abuse assessors and their supervisors, although there was no referral to an IDVA.

3.10 There is concern expressed in the Police IMR about the reporting and subsequent paperwork trail for this incident. The report into this matter 'languished' for 7 months with confusion whether the risk assessment was received in the Domestic Abuse Unit. This according to the Police IMR Author was unsatisfactory. The Police IMR makes

relevant recommendations covering all comments about the Police action with each of the attendances to the couple.

3.11 In relation to the actions of Wye Valley NHS Trust staff, the IMR makes comment that record keeping was found to be good, as were the referrals to Adult Safeguarding. There was also evidence of good multi-agency discussions between Wye Valley Adult Safeguarding Team and Adult Social Care.

3.12 Adult Social Care were only engaged with the couple following the Deceased being found on the floor and being admitted to hospital, but there is evidence of planning for the eventuality of the Deceased's discharge. The Police were encouraged to interview the partner to be interviewed before the Deceased was released so that a suitable risk assessment could be completed. In any event this did not happen as the Deceased died in hospital before he was discharged.

4. Conclusions

4.1 The partner and the Deceased lived together in an abusive relationship for years, often fuelled by alcohol consumption on the part of the Deceased. Police were called on numerous occasions to reports of domestic incidents but there was never a formal complaint made against either of the couple. There is little to suggest that consideration was given to a victimless prosecution, i.e. taking the partner to court without a complaint being made by the Deceased, but after examining the evidence of each occasion, it is highly unlikely that a victimless prosecution would have been successful and approved by the Crown Prosecution Service.

4.2 It wasn't until the last incident that the Deceased stated to the police that he wanted to make a formal complaint to the Police but that was never achieved. However, the partner reports that the Deceased stated to several people before he died that he had no intention of making a formal complaint to the police.

4.3 Only the partner will know what was happening behind the closed doors of their home and the true extent of the abuse between them. The fact remains that on 20th October 2014, the Deceased was found injured at his home, alleging that he had been pushed to the ground by his partner some days before. He died on 3rd November 2014. The partner has since been exonerated by Crown Prosecution Service of any blame for the Deceased's death.

4.4 Domestic incidents were common place between them and whilst it may be said that any incident of domestic abuse could lead to tragic consequences, the death of the Deceased in this case could not have been predicted or prevented. There were opportunities in the past for support services to be offered to either of the couple but history indicates that the Deceased in particular was highly unlikely to have accepted support. He was equally unlikely to change his alcohol lifestyle, which it is evident was the root cause for the frequent domestic upheavals.

4.5 It is the Overview Author's and the Panel's view that the matters identified within this review that would attract recommendations have been adequately dealt with by each agency's own IMR recommendations. Thus there are no Overview Report recommendations made.

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 Home Office August 2013

Herefordshire Community Safety Partnership

Domestic Homicide Review Case No. 4

ACTION PLAN

Adult Social Care IMR Recommendations

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Improved contact details	ASC to identify and record NOK and family contact details on front screen of fwi. To include name, address, phone numbers.	Safeguarding operational lead	10 /9/15	Inform team leads at team leads meeting and take to practitioner forum on 10/9/15
Improved communication with self-funders.	To ensure that advice , information and assessments are offered to self-funders	Safeguarding operational lead	31/7/15	This action is now evident in practice and is a requirement of the Care Act 2014.
Reliable recording of information	Ensure that accurate case records are in place which evidences work undertaken and defensible decision making.	Safeguarding operational lead	10/9/15	Direct practitioners to Policy and Procedures document on record keeping. March 2015 Take learning from DHRs to the Practice forums.

Herefordshire Community Safety Partnership

Domestic Homicide Review Case No. 4

ACTION PLAN

West Mercia Police IMR Recommendations

Recommendation	Action Required by Agency	Implementation Lead	Target date for Completion	Summary of Action Taken & Date
Risk assessments conducted by initial attending Police officers must be promptly submitted to ensure appropriate support and referrals to other agencies can be made.	Removal of delays in risk assessment & referral process.	PVP Superintendent Eccleston	June 2015	Action had already been taken to improve this situation prior to the DHR as it was a consistent problem across the Policing area. Paper-based risk assessments no longer exist and DASH is electronically recorded prior to the attending officer going off shift. This assessment is then immediately available for staff to see & is electronically forwarded to the MASH where it is assessed and referred either the same, or next working day.

Recording of risk assessment decisions must be clearly documented on Police systems to explain rationale, especially where risk levels are amended.	Clear documentation of risk assessment and reasoning for re-categorisation	PVP Supt Eccleston – allocated to HAU Supervisor – Worcester - Lisa Ignoscia	Dec 2015	Current working practice within HAU is that decision making re risk is recorded clearly. This is monitored by supervisors & staff involved in decision making in 2013 now work in HAU, & are robust in adherence to this practice. A reminder has been sent by the HAU supervisor reminding all staff of the importance of this.
The actions taken by the attending Constable, with supervisory sign off to be addressed, specifically regarding the submission of a Standard risk assessment in the circumstances outlined, & the filing of the Common Assault investigation despite a significant deterioration in the deceased's condition.	Advice to be given to individual officers relating to their recording and decision making. The need to take account of other information / history when conducting risk assessments is a recurring feature of reviews & subject of wider training / input to staff.	DCI Paul Judge – Local Investigation – Herefordshire.	December 2015	Completed

NHS
Herefordshire
Clinical Commissioning Group

Herefordshire CCG

Domestic Homicide Action Plan

Recommendation	DHR	Action	Lead	Timescales	Evidence
Map of Medicine to include the care pathway for domestic abuse	Case 4	Post HSCB/HSAB/CSP sign off of domestic abuse care pathway upload the pathway onto Map of Medicine	SC	March 2016	Completed
The CCG to include a link to the document managing pain in dementia in their next GP newsletter	Case 4	SB to include link in GP newsletter	SB	November 2015	Completed Info included in pharmacy newsletter to GP practices

The CCG should work with GP practices to develop a universal care plan format which includes information regarding the social aspects of a person's care	Case 4	Review current care plan format, include social element, trial across several practices, review and amend as necessary. Distribute finalised version across GP practices	LR	March 2016	Completed
The surgery should review their processes for documenting alcohol consumption when concerns arise about alcohol use	Case 4	PM to work with GPs to agree processes. Embed process across all disciplines working in surgery	Practice manager	November 2015	Completed
The CCG should utilise the Map of Medicine care pathways approach to support GPs in their work re alcohol abuse and the links between alcohol misuse and domestic abuse	Case 4	Review current Map of Medicine, amend as necessary, agree with substance misuse services and GP practices. Publish agreed Map	SC	January 2016	Completed
The Map of Medicine care pathway for falls should be reviewed to include alcohol misuse	Case 4	Review current Map and amend as necessary	SC	January 2016	Completed