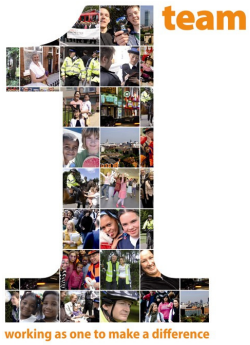

Manchester Community
Safety Partnership

Domestic Homicide Review
Female W

Date of death: 12th of November 2013

Period covered by the Review: 1st of February 2004
to the 12th of November 2013

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Appendices

1 Background to the Case

The victim in this case is referred to as Female W. Female W was 85 years of age when her son, Male W, murdered her. Following the murder of Female W, it is believed that Male W committed suicide by hanging. Both Female W and Male W were found deceased at their home address on 12th November 2013.

1.1 Circumstances of the death of Female W and Male W

At 12.34 hours on Tuesday 12th November 2013, Greater Manchester Police were called to Address 1 by a neighbour who had been concerned as they had been unable to contact Female W. The neighbour had keys to the property and let themselves in. The neighbour found Male W on the landing, hanging from an extension lead, secured in the loft of the property. Upon finding Male W the neighbour called the police.

When police officers arrived they gained access to Address 1 with keys given to them by the next door neighbour. They found Male W hanging as described by the neighbour. Police then moved into the front bedroom of the property where they found Female W, deceased, lying in her bed with a number of stab wounds.

North West Ambulance Service was called to Address 1 where paramedics confirmed that both Female W and Male W were deceased. Both bodies were removed from Address 1 and the property was secured as a scene of crime.

The circumstances described in the report by Greater Manchester Police are consistent with this case being a murder followed by a suicide. A Home Office Post-Mortem was completed.

It is believed by police that Male W murdered Female W before taking his own life. The cause of Male W's death has been confirmed by the Police and the subsequent Inquest to be consistent with a suicide.

There was no sign of disturbance to the property, insecurity of the property or of anything else to suggest any third party involvement.

It is noted in the Domestic Homicide Notification report from Greater Manchester Police to the Manchester Community Safety Partnership that a possible motive for the murder and suicide may have been the deterioration in the health of Male W. This is emphasised by the note left by Male W at the scene. The note states:

> "*I wanted to die can't cope with life any more – I'm going to have another breakdown. Mum would not have survived without me. She would have felt it was her fault so I have sent her to heaven. We lived together all our lives so we should die together…"*

1.2 Background to Female W and Male W

Female W

Female W had three children, two sons and a daughter. One son passed away in 2012. This death was reported as having had a significant effect on both Female W and Male W.

Female W had a long employment history with her final job being at a local hospital from where she retired.

As Female W aged, her health deteriorated and, as a result of this, Male W took special leave from his job to care for her on a full time basis, but did not give up his job.

Female W became dependent on Male W and eventually stopped going out on her own. Male W was Female W's sole carer, although Female W did have contact with her next door neighbour.

Ultimately, Female W was highly dependent upon Male W for her daily care and social interaction. She had clearly been a loving and supportive parent to Male W throughout his life, and had put his needs first when he suffered a severe mental illness in 2003/2004. There is no indication that, other than during this episode, Male W had thoughts of harming himself or his mother. Nor is there any evidence of emotional/psychological, financial or physical abuse being perpetrated upon Female W by Male W.

Male W

Male W had always lived with this Mother, apart from a brief period whilst studying at university. Male W had remained single throughout his life, and was not in a relationship at the time of his death. Male W does not have any children. He had a work based friendship group with whom he socialised outside of work. Male W worked as a civil servant for most of his working life.

Male W was off work for 5 months at the end of 2003 and beginning of 2004 due to a severe mental illness. Male W asked for adjustments to his work in relation to a 'permanent long term condition of anxiety and depression'. These adjustments were put in place by Male W's employer.

Male W had been employed as a civil servant for many years. He was reported as being a capable employee; his last end of year summary is scored as 'consistently good'. His manager described him as extremely hard working, with his knowledge, training delivery and productivity being invaluable to the team

Following the decline in his mother's health over a number of years, Male W applied for Carers leave which he took from 25th November 2012. The reason Male W gave for requiring carers leave was the decline of health of his mother, and the fact she has been badly affected by the death of his elder

brother. This leave was reviewed six months later and was extended until 25th November 2013.

Male W does not appear to have discussed the pressures of caring for his aging mother with any professional or confidante. There was no record of him ever receiving a Carer's Assessment. He experienced significant deterioration in his own physical health in the months prior to taking his mother's life and his own, which may have exacerbated these pressures.

The panel have been unable to speak with Female W's daughter who did not wish to participate in this review (see 1.10 below). There are no other family members or significant others with whom the DHR panel could have asked for contributions to the review.

There is no evidence that either Female W or Male W were in any financial difficulty prior to the fatal incidents and there is no indication or evidence of any financial abuse on the part of Male W. Male W was not in receipt of any carer's allowances in relation to Female W.

The Greater Manchester Police had no previous contact with Female W and Male W and there are no reported incidents at Address 1, prior to the fatal incidents that led to this Domestic Homicide Review

1.3 Diversity issues

Female W had a medical history including, among other diagnoses, temporal arteritis (inflammation and damage to the blood vessels that supply blood to the head), non-cardiac chest pains, chronic stable angina, Type 2 Diabetes Mellitus, osteoarthritis, glaucoma, low mood and anxiety, hypertension and agitated depression with panic attacks. In the period under review, Female W had thirty-seven (37) attendances at clinics in the University Hospital of South Manchester and two emergency admissions.

In this respect, taking account of Female W's age and medical condition, she would satisfy the Social Care and Health Care criteria for the definition to be described as a 'vulnerable adult'.

1.4 Police Notification to the Manchester CSP and submission to the Home Office

An officer from the Serious Case Review Team of the Public Protection Department, Greater Manchester Police Service issued the Domestic Homicide Notification to the Community Safety Partnership who liaised with the Home Office to confirm that the case satisfied the criteria to undertake a Domestic Homicide Review. The Home Office were informed on the 19th of December 2013 that a Domestic Homicide Review would commence.

1.5 Time Period under Review

The time period under review was agreed by the DHR Panel to be from the 1st of February 2004 to the 12th of November 2013. The rationale for this time period is that it corresponded to the onset of a severe mental health illness experienced by Male W, in which he had thoughts of harming himself and his mother.

Authors of Individual Management Reviews, Short Reports, and other submissions were invited to exercise their discretion when submitting information out-with these dates and to do so if they considered the information would be relevant to the context of the case.

1.6 Criminal investigation and proceedings

There were no criminal proceedings associated with the case. The Chair of the DHR Panel informed the local Coroner of the Review procedure and its expected time-frame for completion.

1.7 Serious Incident Requiring Review – Manchester Mental Health and Social Care Trust

In December 2013, the Manchester Mental Health and Social Care Trust convened a Panel, Chaired by the Head of Patient Safety, to undertake a 'Serious Incident Requiring Review'. The subject of this internal review was Female W.

The Review was undertaken in accordance with the Trust's Incident Policy and it applied the principles of 'Root Cause Analysis'. The aim of the Review was to understand the context and the processes that led to the serious incidents in the case and to learn lessons from it so that practice, processes and/or policies can be changed or reviewed to improve services.

The Serious Incident Review Panel noted that the case of Female W would be the subject of a Domestic Homicide Review (DHR) and, consequently, the deliberations and findings of the Review were shared with the DHR Panel and are referred to where relevant in this overview report. The DHR panel received a full copy of the SIR and its findings.

1.8 Inquest

On the 8th of April 2014, the Coroner returned a verdict that Female W was unlawfully killed and that Male W took his own life.

1.9 Sources of Information

The Manchester Community Safety Partnership DHR Panel sought information concerning the Female W and Male W of this from a number of organisations. The Panel identified the following services and agencies:

- Greater Manchester Police Service
- Manchester Mental Health and Social Care Trust – IMR and SIR reports
- South Manchester Clinical Commissioning Group (for General Practitioner Services)
- Age Concern Manchester (for their considerable experience and learning in the area of support for vulnerable older people)
- Employer of Male W
- North West Ambulance Service
- University Hospital South Manchester

1.10 Family Involvement

The panel sought to involve family and any significant others in the review. The panel ascertained that Female W had one surviving child, a daughter.

The Chair of the DHR Panel contacted the daughter of Female W in order to invite her to participate, in whatever form she chose, with the DHR process. Contact was made via a Victim Support Homicide worker who was providing support to Female W's daughter following the tragic deaths of her family members.

Female W's daughter had participated in the Serious Incident Review conducted by the Mental Health and Social Care Trust. She decided that she did not wish to participate in the Domestic Homicide Review. The invitation to participate remained open until the submission of the final report, however, Female W's daughter did not wish to engage and the panel respected her views.

The panel gave consideration as to whether the neighbour of Female W and Male W should be invited to participate in the review. On the basis of information received following the discovery of Male W's body, that the neighbour had been severely traumatised and in need of support, it was decided that it was not in the best interests of the neighbour to invite them to participate.

1.11 Chronology

All agencies involved in the review were asked to submit a detailed chronology of their contacts with the victim and the pepetrator in this review. The chronology forms a part of the agency's submission to the panel.

1.12 Submission of the Final Report

Because of the date of death and the agreement to commence the review on the 19th of December 2013 the panel were unable to organise a first meeting until January 2014 due to public holidays.

An extension to the deadline for submission of the report was requested to enable the panel to gather further important information from agencies

involved in the review to ensure that all lines of enquiry were fully explored, this included further information regarding Male W's mental health diagnosis in the context of risk to Female W.

The final overview report was submitted to the Community Safety Partnership in September 2014 and discussed at a Community Safety Partnership meeting in November 2014 when it was approved for submission to the Home Office Quality Assurance Panel.

2. Conduct of the Review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.

The Manchester Community Safety Partnership (CSP) has commissioned this Domestic Homicide Review. The Review has been completed in accordance with the regulations set out by the Act, referred to above, and with the revised guidance issued by the Home Office to support the implementation of the Act.

The Review Panel wishes to acknowledge the sad and tragic circumstances surrounding this case and to offer its sympathy to the family and friends.

The Chair of the Panel wishes to express her personal appreciation to the colleagues who have contributed to the completion of this review – particularly so for their time, co-operation and patience.

2.1 Terms of Reference

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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 policies and procedures as appropriate; and

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

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this report.

2.2 The DHR Panel

Following the notification of the death of Female W on the 12th of November 2013, the Greater Manchester Police Service issued a Domestic Homicide Notification to the Manchester Community Safety Partnership (SCP) on the 29th of November 2013. Subsequently, the CSP held a Domestic Homicide Screening meeting on the 19th of December 2013 and the Domestic Abuse Co-ordinator for Manchester City Council liaised with the Home Office to confirm that the homicide satisfied the criteria to establish a Domestic Homicide Review (DHR) Panel.

A DHR Review Panel was established by the Manchester CSP and met on six (6) occasions to oversee the process. The Panel received reports from agencies and dealt with all associated matters such as family engagement, media management and liaison with the Coroner's Office.

The Community Safety Partnership appointed an Independent Chair, Maureen Noble, to oversee and direct the Review, in accordance with the Home Office Guidance. The Chair is an Independent Consultant who has substantial experience in safeguarding and public protection having worked at Executive level for a large metropolitan borough in the field of community safety. The chair has commissioned and developed domestic abuse services and served as a member of the NICE programme development group for domestic abuse and intimate partner violence. The chair has extensive experience of conducting serious case reviews and other investigative processes.

An experienced independent author was appointed to write the overview report. The author is an independent practitioner who was previously employed as a public health manager in the NHS. The author has worked on other domestic homicide and adult safeguarding reviews.

Both the Chair and Author are completely independent and had no previous knowledge or involvement with either the victim or perpetrator.

Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings.

In addition the panel invited an independent organisation with specialist knowledge in relation to the care of elderly people, elder abuse and the needs of vulnerable elderly people was invited to serve on the panel and to provide specific advice as required.

Designation	**Agency**
Chair of the Panel	Independent Consultant with experience of both Chairing and Authoring a range of Serious Case Reviews and Domestic Homicide Reviews
Senior Officer, Public Protection Department	Greater Manchester Police Service
Domestic Abuse Co-ordinator	Manchester City Council
Senior Policy Officer, with lead responsibility for Domestic Abuse, Crime and Disorder	Manchester City Council
Designated Nurse for Safeguarding Adults	Manchester Clinical Commissioning Groups
Head of Adult Safeguarding and Governance	Manchester City Council
Associate Director of Governance	Manchester Mental Health and Social Care Trust
Chief Executive	Age UK, Manchester
In attendance	
Report Author	Independent Practitioner with experience of writing Domestic Homicide and Serious Case review.
Business Support	Manchester City Council

There were no conflicts of interest recorded during the Review. Authors of Management Reviews and Short Reports were not directly connected to the victim or perpetrator and did not sit on the Review Panel.

The panel received an expert opinion from a psychiatrist working in the Mental Health and Social Care trust in relation to Male W's severe mental health illness and its relationship to thoughts of self harm and harming others.

The Chair visited the GP practice of both Female W and Male W to discuss their participation in the DHR and to clarify their role. This resulted in good engagement from the GP practice via an independent GP author.

A training session was also held for GP independent to assist them in writing IMRs.

2.3 Key Lines of Enquiry

Taking account of the vulnerable nature of Female W, the 'carer' status of Male W and the Serious Incident Review conducted by the Manchester Mental Health and Social Care Trust, the DHR Panel agreed sixteen key lines of enquiry. These are set out with summary responses at section 3.1 of this report.

2.4 The Home Office Definition of Domestic Violence

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, 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
>
> "Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
>
> "Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

A member of the same household is defined in Section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as:

a. A person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;

b. Where a victim lived in different households at different time, "the same household as the victim" refers to the household in which the victim was living at the time of the act that caused the victim's death.

2.5 Agencies Submitting Individual Management Reviews (IMRs), Short Reports and/or supporting information

The Manchester Domestic Homicide Review Panel invited the following agencies to submit information to the review Panel:

Agency	Type of report	Reason for request	Completed and submitted by:
Greater Manchester Police Service	DHR Short Report	Greater Manchester Police Service attended the incidents at Address 1 and completed an investigation into the incidents	A Police Sergeant who is responsible for Safeguarding Vulnerable Persons in the Public Protection Division. The Author had no professional involvement in the case prior to completing the Short Report.
Manchester Mental Health and Social Care NHS Trust	A copy of the internal "Serious Incident Requiring Review" report with supplementary information	The Trust had contact with Female W and Male W prior to the incidents occurring	The Head of Patient Safety. The Author had no professional involvement with the victim or perpetrator.
Age Concern		To determine if contact	An examination of

Manchester		had been made with Age Concern. To provide specialist advice on the care of older people and the provision of services to support older people.	the records by Age Concern confirmed that there had been no contact with the victim or perpetrator.
University Hospital South Manchester NHS Foundation Trust	Individual Management Review Report	The NHS Foundation Trust had contact with Female W and Male W prior to the incidents occurring	The Lead Specialist Nurse for Safeguarding Vulnerable Adults. The Author had no professional involvement with the case prior to submitting the Individual Management Review Report.
General Practice	Individual Management Review	One General Practice provided primary health care services to both of the victim or perpetrator.	A General Medical Practitioner, who was not associated with the Practice, completed the IMR. The Author had no professional involvement with the case prior to submitting the Review. This ensures that there is no bias in the reporting of information on behalf of the Practice concerned.
North West Ambulance Service NHS Trust	DHR Short Report	The Trust had contact with Female W prior to the incidents occurring and attended the scene of the incidents at Address 1	The Safeguarding Practice Manager. The Author had no professional involvement with the case prior to the submission of the chronology. The Short Report

			was quality assured by the Head of Clinical Safety for the North West Ambulance Service .
Employer of Male W	DHR Short Report	The Employer of Male W employed Male W prior to the incidents occurring.	A submission by letter was completed by the Contact Centre Manager and is employed by the same employer as Male W.

There were no other processes operating in parallel to or associated with this Domestic Homicide Review. The Manchester Mental Health and Social Care Trust had previously conducted an internal Serious Incident Review. The report of this Review was shared with the DHR Panel and is referred to within this report.

2.6. The sources of information

When constructing their respective Individual Management Review Reports, Short Reports and submissions, the agencies involved analysed information and data from their own specific and systematic sources. The sources of data and information are summarised below:

Agency:	**The sources of information and method employed**
Greater Manchester Police Service (GMP)	The Police National Computer holds information about a subject's previous convictions and arrests; the nature of all recordable offences and information about Court disposals.
Age Concern Manchester	Record of contacts with Age Concern.
University Hospital South Manchester NHS Foundation Trust (UHSM)	Appropriate Hospital Medical Records; the 'CASCADE' Emergency Department Electronic Records; the Lorenzo IT System

	and Community Nurse Records. The Author also interviewed the Consultant Physician (who was the last recorded medical practitioner at UHSM to have assessed Male W on1st November 2013) and also interviewed the Community Nurse who attended Female W at the home address
General Practice (GP)	GP paper records and the electronic EMIS records for both Female W and Male W. The electronic medical records contain scanned letters from outside agencies and these letters were included in the case record review.
North West Ambulance Service NHS Trust (NWAS)	Emergency Operations Centre (EOC) record of emergency calls; Sequence of Events (SOE) is an electronic record of events generated by the EOC; Patient Report Form
Manchester Mental Health and Social Care Trust (MMHSCT)	Medical notes held by the Trust concerning Female W and Male W; the Amigos Care Record for Female W.
Employer of Male W	Employment records help by the Employer of Male W concerning Male W.

2.7 Additional Information – Age UK Manchester

Age UK Manchester has no best practice policies that address directly the very specific issues considered in this Domestic Homicide Review, however, they provided expert advice and guidance to the panel in relation to the issues surrounding elder abuse, and the pressures placed on carers, particularly sole carers.

In the experience of Age UK Manchester, an unaddressed social or caring issue may be hidden behind medical self referral (as may have been true in this case). Their input has enabled the DHR panel to understand and apply to this review the importance of support for carers and those for whom they care, particularly in relation to wider social interaction and the role that professionals play in providing and assessing carer support needs.

2.8 Report from the General Practitioner

A report of the GP's involvement with Female W was commissioned by NHS England. A record of Male W's GP contacts was also provided. The author of the GP report is a practising GP with specialist knowledge of domestic abuse.

3. Responses to Key Lines of Enquiry and Agency Contacts

Each Key Line of Enquiry (KLOE) is commented upon from material contained within the short reports, statements and the deliberations of the DHR Panel.

The Key Line of Enquiry (KLOE) appears in *italics* followed by a considered view by the Panel.

On behalf of the DHR panel the author had separate contact with each of the agencies out-with the submission of IMRs. Specific elements of reports were subject to further scrutiny and challenge by the panel.

3.1 *What services did your agency offer to the victim in this Review?*

Each agency responded to this KLOE by outlining their contacts. These contacts are set out in detail in Section 4 of this Overview Report.

3.2 *Were these services accessible, appropriate and sympathetic to the presenting needs of the victim?*

Each service provider has operated in accordance with the professional standards operating at the time of each contact during the scope of this Review.

Considering the information provided by the Reviews, reports and other forms of information submitted to the Review Panel, it is clear that each service provider followed the correct and appropriate pathways of service.

3.3 *Did your agency have knowledge of domestic abuse of the victim? If so, how was this knowledge acted upon?*

None of the agencies involved in this Review had any knowledge of domestic abuse and no disclosures of abuse were made prior to the incidents occurring.

The IMR completed for the General Practitioner indicated that Female W's GP asked her about domestic abuse at the time of Male W's serious mental health condition in 2004, when Male W was under the care of the Manchester Mental Health and Social Care Trust. During a consultation with her GP in January 2011 concerning an injury "to the face (eyebrow)", the GP asked further questions about domestic abuse however, Female W made no disclosures of domestic abuse. She reported that she had injured her eye on a cupboard door and this was consistent with the injury.

These points are explored further in the relevant Agency Contacts and Analysis section of this report.

3.4 *What, if any, safety planning was offered to the victim/family members including referral to specialist domestic abuse services?*

No safety planning services were offered to Female W as none were deemed necessary by any of the agencies. The agencies involved in this Review had received no disclosures of domestic abuse from the victim and had no knowledge of domestic abuse

During treatment for a mental illness in 2004 Male W disclosed that he had thoughts of killing his mother. This was judged to be linked to his mental health condition and the information was shared with his GP. As Male W's mental health improved he was discharged to his GP. He was not having thoughts of harming himself or others at the point of his discharge and therefore his discharge was appropriate.

Greater Manchester Police Service did not know either the victim or perpetrator prior to the incident occurring. They had never received any reports of domestic abuse from any agency, nor from the victim, perpetrator on anyone else in relation to domestic abuse.

3.5 *What, if any, services were offered to the perpetrator of domestic violence?*

None of the organisations or agencies involved in this Review reported any awareness, knowledge or suspicion of domestic abuse concerning the perpetrator of the homicide in this case, prior to the incidents occurring.

The Mental Health and Social Care Trust monitored and treated Male W's mental health condition in relation to his suicidal and homicidal thoughts and, when appropriate, discharged him to the care of his GP.

As stated earlier, Female W's GP asked her about domestic abuse at a consultation in 2004. Female W did not disclose any domestic abuse then and did not disclose any abuse when asked about the injury to her eyebrow in 2011.

3.6 *Were the victim's family and friends aware of domestic abuse and were they offered support in responding? Were there any confidentiality issues in relation to the family and friends being aware of domestic abuse?*

Female W's family have not contributed to this review, it is therefore not possible to say whether there was any disclosure of domestic abuse to them.

Additionally, none of the organisations reporting to the Review Panel highlighted any issues concerning confidentiality that may have prevented or affected the disclosure of such information.

3.7 *Was the impact of alcohol, drugs or mental health issues properly assessed or suitably recognised? What action did your agency take in identifying and responding to these issues?*

There was no known drug or alcohol issue pertaining to the victim or perpetrator reported by any of the agencies involved in the Review.

It is recorded by the author of the GP and UHSM IMRs and the MMHSCT Serious Case Review report that Male W had an episode of depression and received treatment for this condition from the Manchester Mental Health and Social Care Trust. MMHSCT gave a full account of the care provided to Male W in their chronology.

UHSM noted that there were frequent references to anxiety in Male W's presentation at clinic appointments. UHSM also noted that there was no additional information regarding Male W's mental health available that may have influenced a referral on to mental health services when Male W attended UHSM for an episode of care from July 2013.

3.8 *Were there any specific diversity issues relating to the victim and/or the perpetrator in this case.*

It is important to point out that Female W, because of her age and her medical condition, was a vulnerable adult.

There was no indication from the agencies involved in the Review (setting aside the management of the existing medical conditions described in the chronology) that, whilst Female W was vulnerable, she was at a particular risk of harm.

The Author of the General Practice IMR noted that religious belief was an important protective factor for Male W. The GP did not go into detail about this but the panel noted this view.

Male W experienced mental health problems that were treated appropriately. Further information is provided throughout this report as relevant.

3.9 *Were issues with respect to safeguarding (children, adults and vulnerable adults) adequately assessed and acted upon?*

There were no safeguarding referrals required prior to the incidents occurring and none arose during the completion of the investigation into the incidents.

3.10 *Were there any issues in relation to capacity or resources in your agency that had an impact on the ability to provide services to the victim and to work effectively with other agencies?*

None of the agencies involved in this Review reported any issues concerning their capacity or resources available to provide services or to manage the investigation of the incidents.

3.11 *Was information sharing within and between agencies appropriate, timely and effective?*

The information sharing between agencies regarding the clinical and physical status of the victim and perpetrator was considered by the Panel to be excellent.

However, the Panel noted that the sharing of information between mental health services, general practice and UHSM could have been improved. This was noted by the agencies and has been noted as a learning point and a single agency recommendation for action to improve the coding of the severity of mental illness in order to facilitate an improvement in information sharing.

3.12 *Were there effective and appropriate arrangements in place for risk assessment and the escalation of concerns?*

For the agencies involved in this Review, taking account of the execution of the policies existing during the scope of this review, there were no presenting triggers to activate an adult risk assessment at any presentation with the services involved in this review.

The DHR panel gave specific consideration to domestic abuse risk factors, including emotional, financial, psychological and physical abuse and concluded that none of these risk factors were present.

3.13 *Did your agency conduct any form of carer assessment with the victim or any of the key individuals in the case?*

There were no formal carer assessments undertaken by any of the agencies involved in this case during the period covered by the Review.

The Independent Author of the GP IMR noted that the roles of Female W and Male W changed over time. In 2004, Female W cared for Male W during his period of serious depression and then, as time passed, Male W became the carer for Female W as her health deteriorated.

UHSM noted in 2007 and 2010 that Female W was independent with washing and dressing, was mobile with a stick and was not in need of home help support, day care, meals on wheels. It was noted by UHSM that at this time Male W was her main carer. It was noted by the Panel that a carer's assessment was not offered to Female W or Male W during any contacts with UHSM or any other statutory service.

3.14 *Do any of your agency's policies/procedures/training require amending or new ones establishing as a result of this case?*

A number of the agencies involved in this Review noted learning points and recommendations concerning their own practice when reflecting upon their contact with Female W and Male W.

These considerations form a number of the elements contained within the 'lessons learnt; and 'recommendations' sections described later in this report and they are described in more detail in the relevant section, below.

3.15 *Was it reasonably possible for your agency to predict and/or prevent the harm that came to the victim?*

All of the agencies involved in this Review reported that, given the presentation of both Female W and Male W at each point of service, it was not possible to predict or prevent the harm that came to the victim or, in this case, to the perpetrator.

3.16 *Is there any other information that you think may be relevant to this Review?*

No additional information has been identified or submitted that could be included in this overview report.

4. Agency Contacts and Analysis

All agencies that had contact with Female W and Male W during the period under review were asked to complete short reports or individual management reports.

Below is an overview of the key information considered by the panel in each of these reports. This is presented in alphabetical order and agency information is presented chronologically as follows:

- Employer of Male W
- General Practice
- Greater Manchester Police Service (GMP)
- Manchester Mental Health and Social Care Trust
- North West Ambulance Service NHS Trust
- University Hospital South Manchester NHS Foundation Trust

The analysis section beneath the agency contact contains the panel's observations on adherence to professional standards, good practice, opportunities for interventions and any areas where the panel feel opportunities were missed. This incorporates responses given to the key lines of enquiry by each agency.

When submitting their information, each agency was asked to consider the Key Lines of Enquiry listed in **Section 2.2** above and address them accordingly.

Reports were followed up by conversations and enquiries with the agency in question where further information was required to ensure that comprehensive and satisfactory responses were received to questions from the DHR panel.

4.1 Employer of Male W

It was noted by the DHR Panel that the Employer of Male W does not have a statutory obligation to provide a report to the DHR Panel, as set out in the Home Office guidance. Due to the circumstances of the case and in recognition of the public interest, the Manager of the service where Male W worked submitted a précis of relevant factual information.

Male W was an employee for over 30 years. In the 6 months prior to the incidents occurring, Male W was taking Carers Leave in accordance with the policy of his employer. Unpaid carers leave can be taken by employees of this organisation, subject to qualifying conditions (12 months satisfactory service) for a period of at least 6 months but less than 5 years.

Carers leave is granted for staff to care for dependants; a dependant is defined by the employing organisation as someone who is sustained by a person, i.e. 'they depend on you or live in your household as a member of the family'. After taking carers leave, employees have the right to return to employment in the organisation and this may be to a previous post or to a similar post on the same grade.

During his time away from work, Male W remained in contact with his Team Leader and was contacted 2 days before the incidents occurred in November 2013 to arrange a time to visit the office. The team leader recalls that Male W was keen to attend and was looking forward to the meeting. The meeting did not take place due to the events described at 1.2 above.

With regard to medical assessments by occupational health, the records of Male W's employer show that the last time Male W needed this service was in 'late 2010' – a contact prompted by a change in job role when the centre where Male W worked became a telephony contact centre. Following the referral, it was decided that Male W would assume an administrative role that did not involve taking calls from the public.

4.1.1 Analysis of Contact

Male W's employer acted in accordance with their policies in relation to health and safety, occupational health, carers leave and staff supervision during the period of carers leave.

Following receipt of an overview statement from Male W's employer, the panel made further specific enquiries regarding Male W's health at work, and whether or not he may have discussed or disclosed specific stress factors brought about by caring for Female W.

It was noted that the employer of Male W has a contract with an independent organisation to provide occupational and health support to employees. The service is confidential and is primarily a telephone service for all employees if they wish to use it.

It was reported by the employer of Male W that Male W, as an experienced member of staff, was aware of how to access the service. However, it is not known if Male W contacted the service.

On further enquiry, the Panel noted that contact with the service is not routinely shared with Line Managers, unless the member of staff consents to share the information. The employer of Male W has no records that Male W contacted this service. Their policy makes it clear that the employees use of the service will almost always remain a matter between the provider and the employee.

The service provider does operate a disclosure policy that states that there are some (very rare) circumstances when they are required to share some limited information. The provider states that the situations where confidentiality may need to be broken include the threat of serious harm to self or others and where they have a statutory obligation to disclose information as outlined in Acts of Parliament, such as The Prevention of Terrorism Act 1989 (as amended) or the Proceeds of Crime Act 1986 (as amended). The service provider is also clear that, although not bound by statute, they have a moral responsibility to report suspicions or allegations of abuse of vulnerable people.

The panel concluded that a recommendation is necessary to highlight that disclosure of domestic abuse may constitute 'serious harm' to an individual, and should be included explicitly in disclosure policies such as those referred to above.

The Chair of the panel undertook to write to the Employer regarding domestic abuse policies once the DHR overview report had been approved.

4.2 General Practice

Male W and Female W were patients at the same General Practice and were registered there for the full duration of the DHR period (10 years) and both received a range of primary health care services for a number of health conditions.

A General Medical Practitioner was commissioned by NHS England to complete the IMR on behalf of the Practice.

Female W

Female W received general medical services for a number of health conditions, including diabetes, glaucoma, depression and arthritis. These health related conditions required regular consultation with the GP. During the period of the Review (10 years), Female W had contact with her GP Practice on more than 30 occasions. The significant majority of these contacts can be described as 'routine' and be defined as involving the management of existing medical conditions by her GP and the primary care team in conjunction with Clinical staff from UHSM.

Female W's GP made appropriate referrals for treatment of on-going medical conditions and prescribed and treated Female W in line with clinical guidance.

The Author of the GP IMR noted a record of Female W being asked about her safety in 2004 when Male W was living with his serious depressive illness.

Female W did not make any reference to domestic violence or abuse at that time. However, the question had been asked by the GP and this demonstrates good practice.

The Panel noted a record in the Chronology submitted by the GP Author regarding a consultation with Female W on the 12th of January 2011. During the consultation with Female W, the GP noted an injury to "the face – including an injury to the right eyebrow".

It was noted by the GP author of the GP IMR that it was not recorded on the GP medical summary that Female W had a carer, nor was there any record of Female W being referred for a social care assessment.

The GP asked Female W about this injury and Female W reported that she had caught herself on a kitchen cupboard on the 10th of January 2011. Domestic abuse was not explored at this consultation. However, it was noted by the Panel that the GP investigated the cause of the injury.

From late 2011, Female W developed memory loss, suffered the bereavement of a son (who died in September 2012) and experienced deteriorating cognitive function. On the 25th of October 2011, Female W was referred by her GP to the Memory Clinic provided by the Manchester Mental Health and Social Care Trust with suspected deteriorated cognitive ability.

Female W continued to receive medical treatment from her GP but it was noted in the GP IMR that as Female W's health declined, presentations to her GP decreased.

Male W

Male W received services from his General Practitioner for a number of health conditions including a serious depressive illness, kidney stones and latterly sarcoidosis (the definition of which is provided below).

During the period of the Review, Male W had contact with his General Practice on more than 25 occasions. The majority of these episodes of care were for the routine management of existing medical conditions. These are described below, with particular reference to key events in the medical history of Male W.

In 2004, Male W suffered a serious depressive illness. At this time, Male W was under the care of the Mental Health and Social Care Trust.

On the 28th of January 2004, Male W attended his GP Practice and it was recorded that his mood was becoming low and he had recurrent panic attacks and anxiety and occasional thoughts of self-harm. Male W was diagnosed with depression and panic disorder. On the 2nd of February 2004, Male W attended his GP Practice with his Mother (Female W). It is recorded that Male W had no suicidal thoughts but was depressed and tired and had thoughts of self-harm.

On the 4th of February 2004, Male W attended the Emergency services provided by the Manchester Mental Health and Social Care Trust and subsequently Male W attended his GP Practice where it was reported that Male W was much calmer and was under the care of a CPN. The practice continued to review the mental health of Male W throughout 2004 and 2005.

In December 2005, Male W was diagnosed with ureteric calculus (kidney stones) and commenced treatment for this condition at UHSM.

In February 2006, Male W reported to his GP that his mood was dropping and discussed re-commencing the use of anti-depressant drugs (as referred to in the discharge communication from the Manchester Mental health and Social acre Trust.

On the 14th of March 2007, the GP for Male W recorded that Male W was anxious because of changes at work and a changing job role that may involve him working on the telephone and talking to the public. A consultation with his GP on the 10th of November 2008 consisted of similar concerns regarding stress at work. At a consultation in November 2010, Male W expressed some worry concerning work and that he had met with his occupational health service. At a consultation with his GP in April 2011, the GP recorded that Male W stated that he was “not doing too bad” and that his workplace had given him temporary work until July.

From June the 27th 2013 to July the 22nd 2013, Male W presented with symptoms of an acute illness with weight loss, cough and night sweats. On the 22nd of July 2013, Male W was, in accordance with best practice, fast-tracked for a cancer referral and investigation.

The GP chronology (9th of July 2013) recorded that Male W was reluctant to be admitted to Hospital because of his caring role. Subsequently, Sarcoidosis was diagnosed and he was prescribed a high dose of steroid treatment. Sarcoidosis is a rare condition that causes small patches of red and swollen tissue – called granulomas – to develop in the organs of the body. This can affect the function of the organs that have sarcoidosis. Sarcoidosis is often found in the lungs, causing a shortness of breath and a persistent cough.

It was noted by the author of the GP IMR that, according to the medical summary, Male W had not been referred for a carer’s assessment.

4.2.1. Analysis of Agency Contact

The GP's involvement with Female W was frequent due to the various medical conditions she suffered. Female W had built a relationship with the GP, sufficiently so that the GP was able to ask her about feelings of safety and, in a later consultation in 2011 about domestic abuse. The panel recognises that a relationship with the GP is not a critical factor in disclosing domestic abuse but feels that in this case trust and confidence would have assisted Female W in making any such disclosure.

Female W's treatment and care appears to have been of a high standard, the GP was responsive to Female W's needs and all appropriate referrals and follow ups took place.

As Female W's health deteriorated she made less visits to the practice, which was to be expected. Female W was receiving more 'home care' at this time.

The Author of the General Practice IMR noted that any information concerning the key elements of the depressive illness suffered by Male W in 2004 was not easy to consider from his records. There was nothing noted in Male W's EMIS record that would have alerted the GP or Hospital colleagues during the episode of care provided to Male W from July 2013 that would trigger a referral to mental health services.

The Independent General Practitioner IMR author noted that the severe depressive illness of Male W was coded in the GP record as 'anxiety and depression'. The detail of the severity of the illness was not visible on the GP EMIS record summary and so would not have been obvious to colleagues in UHSM. The issue of coding is a learning point for general practice and has been noted by the Panel as a single agency action.

The Panel noted that the GP electronic record was "legitimised" in the year 2000 when the transfer of paper records onto the electronic system (a process that took some time) commenced. However, when UHSM provided care to Male W in 2004 (for the treatment of ureteric stones), they were aware that Male W was under the care of Psychiatric services at MMHSCT.

The Independent General Practitioner IMR author noted that the GP had managed the care of Male W's presentation of a serious physical condition in accordance with the guidance concerning the diagnosis and treatment of a suspected malignancy. Indeed, the GP for Male W was particularly tenacious in this regard and ensured that Male W was referred for investigations into a possible cancer diagnosis particularly quickly in July 2013.

The GP referring Male W was unaware of his previous mental illness and suicide ideation because these details were held in the "Lloyd George" recording system and had not been transcribed into the Practice computer at the point of transition in the year 2000. The General Practitioner IMR author considered that it was understandable that the GP, whilst managing the process of diagnosing a patient with a potentially life threatening condition and

referring them to the correct speciality, missed that he was a carer for his mother. Consequently, the potential for a link to be identified between the changes in the physical and mental illness of Male W and the potential for a link between his health and his role as a carer was not formally recorded by the Practice.

4.3 Greater Manchester Police (GMP)

Greater Manchester Police Service had no contact with either Female W or Male W prior to the incidents occurring in November 2013. GMP completed and submitted a short report to the review panel.

On the 12th of November 2013, Greater Manchester Police were called to Address 1. The neighbour had been concerned as she had not been able to contact Female W. The neighbour informed Police that she had let herself into the property and found Male W hanging from the landing. The neighbour had then contacted the Police.

Officers from Greater Manchester Police Service entered the address with keys, and discovered Male W – hanging in the upstairs landing from an extension lead secured in the loft. Police then moved into the front bedroom of the property where they found Female W lying in her bed with stab wounds to her chest.

GMP then commenced and completed an investigation into the incidents. This included recording witness accounts, a full forensic examination, house-to-house enquiries in the neighbourhood of Address 1, CCTV enquiries where they were available and telecommunication analysis. The information and evidence gathered was presented to the Coroner to support the Inquest into the deaths.

4.3.1. Analysis of Agency Contact

GMP acted in accordance with policies and procedures in relation to the case. They had no previous contact with either Female W or Male W prior the events of 12th November 2013.

4.4 Manchester Mental Health and Social Care Trust (MMHSCT)

Female W

The contact with Female W commenced on the 25th of October 2011, following a referral by Female W's GP. The GP referral stated that there had been some deterioration in Female W's short term memory. It was also noted in the referral that Female W lived with her son. The GP enclosed a copy of Female W's past medical history. A suitable appointment was then made. The MMHSCT Memory Clinic welcomed Female W into the service on the 19th of December 2011 and an assessment was completed at home and a full history was taken. It was noted that Female W was active and independent with shopping, personal care and finances.

During the consultation, Female W reported that her son, Male W, had a breakdown and reported that during this episode, Male W had wanted to take his own life, Female W's life and the life of the cat. It was noted that the son (Male W) did not harm her. Female W reported that her son was well, back at work and that she felt safe in her home living with Male W.

On the 28th of March 2012, a more detailed memory testing assessment was completed and Female W's Son (Male W) was in attendance with Female W. On the 20th of April 2012 a CT scan was undertaken on Female W and recorded as normal. Subsequently, when all the necessary tests had been completed (in July 2012) a diagnosis of memory inefficiency due to vascular disease was recorded. Female W was already on a full treatment regime for this condition. It was suggested that a review take place in 12 months. It was recorded that, in July 2012, Female W was independent in activities, self care and finances.

On the 19th of August 2013, the review took place and Male W was present at the appointment and was able to provide a good history concerning Female W's memory functions.

According to the chronology constructed by the MMHSCT to support their internal Serious Incident Review, the service planned to re-test the memory of Female W in six months and to repeat the psychometric test in 6 months to 'firm-up' a diagnosis as to whether there was a mix of Alzheimer disease and vascular dementia. There were no concerns noted during this consultation regarding Female W or Male W.

The care provided to Female W by the Manchester Mental health and Social Care Trust was in accordance with pertinent clinical and service guidelines and was considered by the Trust to be of a good standard and Female W's condition was reviewed in a timely way.

A letter outlining the review was sent to Female W's GP.

Male W

Male W received Psychiatric Services from the Health and Social Care Trust from 2004 to 2005.

The first contact MMHSCT had with either subject of this case was in February 2004 when Male W presented at A&E reporting pressure at work and that he felt suicidal – including thoughts of harming his Mother. Male W had visited his GP in the previous week and had been prescribed Mirtazapine and Diazepam. Male W was referred to the Community Mental Health Team for follow up and monitoring of his mental state and a referral was made to a Psychiatrist.

On the 13th of February 2004, a Psychiatrist at MMHSCT assessed Male W. Male W reported feeling depressed for a long time. There had been no

previous contact with the Service. The Psychiatrist recorded that the depressive illness appeared to be precipitated by work related stress, a restricted social life and a "mid-life crisis". On the 27th of February 2004, a Psychiatrist reviewed Male W and the Psychiatrist recorded a significant improvement in his health and that Male W was having thoughts of returning to work.

On the 12th of March 2004, Male W was brought into the MMHSCT A&E Services by his Mother (Female W). It was reported by MMHSCT that Male W had high levels of anxiety and Male W was admitted as an in-patient for 2 days.

On the 17th of March 2004, Male W reported to the Community Psychiatric Nurse (CPN) that he had thoughts of harming his Mother, triggered by the cat being ill. Male W reported that he would kill the cat and then kill his Mother. It was noted that there was no history of violence and Male W has never been violent to his Mother. It was reported that Male W had insight into his condition and wanted to seek help and comply with treatment. A Psychiatrist reviewed Male W and it was planned to review Male W in approximately 14 days with continued support from the Community Psychiatric Nurse (CPN) in the interim.

On the 26th of March 2004, a Psychiatrist reviewed Male W and it was recorded that Male W continued to feel depressed but the Psychiatrist recorded that he had no plans or intent to harm himself. On the 23rd of April 2004, a Psychiatrist reviewed Male W and recorded that depression and thoughts of self-harm were less frequent. Support from the CPN would continue.

Male W was assessed by a Psychiatrist, accompanied by the Community Psychiatric Nurse (CPN), on the 4th of March 2005. Male W reported as being settled and back at work. There was also a discussion regarding a gradual stopping of medication. Male W was the discharged from CPN care.

On the 26th of April 2005 a Psychiatrist reviewed Male W. It was reported that he had been well for 10 months and the Psychiatrist advised a gradual reduction and withdrawal from medication under supervision.

The final appointment with the Psychiatrist took place on the 15th of August 2005. It was reported that Male W had remained well for over 12 months following a single episode of depression and a discharge letter documented the same information and that Male W had stopped Mirtazapine four months ago and the Psychiatrist suggested that Venlafaxine is gradually stopped. The Psychiatrist suggested that if depressive symptoms began to occur, then Venlafaxine should be started and the dose increased and Mirtazapine added if necessary.

The care and treatment services provided to Male W at the time of his mental ill health were in accordance with all relevant clinical and service guidelines

operating at the time and therefore the service was considered by the Trust to be of a good standard.

4.4.1. Analysis of MMHSCT Involvement

The MMHSCT had brief contact with Female W in relation to memory clinic services. Female W received appropriate services from MMHSCT in relation to her presenting conditions.

Male W was first referred to the Trust in 2004 and was subsequently treated for a number of months before discharge to his GP. At that time there was no formally agreed risk assessment tool. However the treating psychiatrist was trained in the assessment of risk and was familiar with the presentation of homicidal thoughts as part of the psychiatric condition. The Trust introduced a formalised risk assessment tool in November 2005 that was updated in 2008 and again in 2012. It is Trust policy that this risk assessment is completed on first/new presentations and that it is updated as appropriate. The risk assessment policy focuses upon both the risk to self and others and specifically risks to other vulnerable people, children and older adults.

The MMHSCT Report and chronology referred to Male W (in 2004) having suicidal ideation and having thoughts of killing his Mother, Female W. The MMHSCT treatment plan addressed the suicide ideation and the thoughts of homicide (when Male W had said that he would kill the cat and then kill his mother). It is noted by MMHSCT that Male W felt very guilty about these thoughts and found it difficult to talk about them. The thoughts appeared to be short lived and there was no history of any violence. He was regularly reviewed by psychiatry alongside regular communication with his GP. Following this episode of treatment, Male W was discharged to the care of his GP. Female W was aware of the thoughts Male W had and did not express concern for her safety during the period of this treatment and not for the ten years following it.

There was some delay (at the point of Male W's diagnosis of serious depressive illness in 2004) in correspondence from the MMHSCT Outpatient Services to the GPs. The Panel was assured that this matter has subsequently been resolved.

It was noted by the Independent Author of the GP IMR that there is an issue concerning access to the mental health information from the GP when Male W was referred to Hospital in July 2013. The GP referral letter did not refer to Male W's episode of serious depression in 2004. This was because the referring GP was not aware of the episode and the reason for this was because the information was stored in the 'Lloyd George' recording system. This was not an oversight by the GP – this was because the details were not transcribed when paper records were transferred onto EMIS during the period of transfer in 2000/2001. However, the past medical history print-out that accompanied this referral, listed prescribed treatments for anxiety and/or depression 27 times as part of repeat prescriptions from the Practice (underlining Male W's compliance with his prescribed treatment).

4.5 North West Ambulance Service (NWAS)

The North West Ambulance NHS Trust had two previous contacts with Female W prior to the incidents addressed by this Review. The Trust transported Female W to the University Hospital in South Manchester as an emergency admission on both occasions. The Trust also attended the scene at Address 1 in November 2013.

On the 5th of October 2012 at 11.02 the North West Ambulance Service (NWAS) Emergency Operations Centre (EOC) received a 999 emergency call from a "Health Care Professional" (The HCP in this case was the General Practitioner [GP]), for an emergency ambulance to attend Address 1 to attend to an eighty-five year old female (Female W) who was suffering a possible stroke. The patient was confirmed as being conscious and breathing. The GP was not with the patient. The GP gave information that the condition presented an immediate threat to the patient's life. A double manned emergency ambulance, (Ambulance 1) was allocated to attend the incident. The incident was matched to the Government Priority Coding as RED2 requiring ambulance response within 8 minutes.

The GP advised that the patient should be taken to Hospital 1 (UHSM) Accident and Emergency Department. The crew performed an initial set of baseline observations on the patient. The crew requested a courtesy call be put through to Hospital 1 giving details of the patient's condition and estimated time of arrival. Female W as then transported to UHSM.

On the 8th of December 2012 at 09.49 AM NWAS EOC received an emergency 999 call requesting an ambulance attend Address 1 for an eighty-five year old female (Female W), who was conscious and breathing but was unsteady on her feet, shaking and feeling sick. The incident was matched to the Government priority coding Green 2, requiring an ambulance response within thirty minutes. A double manned emergency ambulance was allocated, and became mobile to attend the incident. The crew performed an initial set of baseline observations. At 10.37 the Ambulance arrived at UHSM with Female W.

On the 12th of November 2013 at 12:38, NWAS EOC received a 999 emergency call from Police requesting an ambulance to attend Address 1 to attend to a male (Male W). The call was made from a fourth party caller meaning the caller was not with the patient. The call was matched to the Government priority code Red 1, requiring an ambulance response within eight minutes. EOC were informed that the Police were also en-route. A double manned emergency ambulance (Ambulance 3) and a single Paramedic staffed Rapid Response Vehicle (RRV1), were allocated and became mobile to attend the incident location.

At the scene (Address 1) a member of NWAS staff was asked by the Police Service, who were already at the scene, to enter the house and confirm death. The member of staff completed the Patient Report Forms and Diagnosis of Death Forms for both Female W and Male W.

4.5.1 Analysis of NWAS Involvement

The panel judged NWAS involvement to be of an expected standard in this case. Two single agency actions were identified by NWAS as a result of their involvement in this case, including ensuring the recording of ethnicity and ensuring that diagnosis of death forms are collated with the Patient Report Forms.

4.6 University Hospital of South Manchester

The University Hospital of South Manchester (UHSM) is a Foundation NHS Trust, with its headquarters based in Wythenshawe. The Trust provides Hospital and Community Healthcare Services to the population of Greater Manchester. UHSM had significant contact with the Female W and Male W and submitted an Individual Management Review (IMR) Report to the DHR Panel.

Female W

The University Hospital of South Manchester (UHSM) was involved in providing care to the victim, Female W, since 1963 when she attended the chest clinic with shortness of breath and low mood.

The UHSM Individual Management Report details regular referrals to other clinical services in the Hospital. There is a recorded pattern of chest pain, shortness of breath and anxiety from 1975. The last recorded episode of chest pain and anxiety was in 2007. In 1984 it was recorded that Female W had an anxiety of cancer.

At the time of her death, Female W had documented co-morbidities of: stroke, with residual weakness in the right hand; temporal arteritis (inflammation and damage to the blood vessels that supply blood to the head); diabetes Type 2 as a result of prednisolone treatment for temporal arteritis; osteoarthritis with hip pain and reduced mobility; hypertension and agitated depression with panic attacks.

In the period under review Female W had thirty-seven attendances at UHSM clinics and two emergency admissions. District Nurses (a service that is a part of the University Hospital of South Manchester NHS Foundation Trust) attended Female W in January and March 2013 to take a blood pressure reading and to administer a 'flu vaccination at the request of the GP.

The majority of these three attendances were 'routine' assessments of existing underlying medical conditions. Examples of attendance are given below, with emphasis placed upon the emergency admissions.

On the 21st of June 2004, Female W was reviewed by UHSM and reported that she was under a lot of stress. An episode of disorientation and an odd sensation in her face was also recorded. She was seen by her GP and a referral was made to the stroke clinic where investigations were undertaken.

During a follow up assessment in July 2004, Female W was recorded as living in a house with her son and being 'self caring'. On the 14th of October 2004, during a routine appointment, it was recorded that Female W still had high blood pressure and her medication was increased

Between September 2005 and November 2008, Female W attended UHSM on 5 occasions for routine appointments to manage her hip pain, symptoms of angina, dizziness, hypertension and diabetes.

On the 5th of October 2012, Female W attended UHSM at the Emergency Department via ambulance. Female W attended with symptoms of possible cerebral vascular accident and feeling generally unwell since the death of her son on the Sunday prior to admission date. The CT scan of her head was normal.

On the 8th of December 2012, Female W attended the Emergency Department at UHSM via Ambulance. Female W attended with symptoms of lethargy, weakness, light-headedness and low mood. Symptoms started following the death of her son. The GP had prescribed medication for her low mood in the previous week and Female W had started to notice some improvement in her mood. Diagnosis was recorded as a slow pulse and a low blood level of sodium secondary to her blood pressure medication. Female W was discharged at 18:15 on the same day and referred back to the care of her GP with outpatient follow up.

On the 4th of January 2013, the GP for Female W requested attendance to Address 1 to monitor the blood pressure of Female W. The visit lasted approximately 20 minutes and Male W was present. He did not stay in the room throughout the visit so the patient (Female W) had an opportunity to speak to the practitioner in private (however the panel recognises that there may be a number of factors that prevent victims of domestic abuse from making disclosures). No concerns were recorded, there was no observed change in temperament or anxiety to prompt the District Nurse to pursue questioning regarding her care or social circumstances. The District Nurse reported that Female W appeared happy and well cared for, that Female W was clean and dressed in suitable clothing; that the house was clean and well organised. There was no reason for concern regarding her welfare, nor Male W's ability to care for her.

On the 5th of March 2013, the GP for Female W requested attendance at Address 1 to administer a routine influenza vaccination. Everything appeared normal during the visit. Female W was happy and contented. There were no reasons for concern to alert the nurse. No concerns regarding welfare were highlighted and, despite being a brief intervention, the service was recorded by the District Nurse on the GP EMIS system.

The actions and comments recorded in the UHSM chronology indicate that, following the District Nurse visits, there were no indications to raise an alert regarding the level of care provided to Female W by Male W. Female W was reported as content and displaying no outward signs of neglect or anxiety.

There is no other recorded attendance at Address 1 by the District Nursing Service after March 2013.

UHSM Nursing Staff assumed that Female W had capacity in accordance with the Mental Capacity Act 2005 as she was able to understand, retain, weigh up and communicate all information given to her about her conditions and consent to the interventions that took place.

Male W

Male W first attended UHSM on the 3rd of March 2004 at the cardiology outpatient service following a single episode of chest pain lasting six hours. It is noted that at this time he was under the care of psychiatry services for the treatment of severe depression and anxiety.

Between 2005 and 2007 UHSM treated Male W successfully for ureteric stones, this included laser treatment of the stones and a temporary nephrostomy tube inserted to bypass a blockage of urine from the kidney due to the stone. Male W is reported as being confident in the management of this tube and there are no recorded problems regarding self-management.

The most recent episode of care provided to Male W commenced in July 2013 at UHSM. This concerned investigations by the chest clinic into a dry cough and subsequent diagnosis of sarcoidosis.

On the 31st of July 2013, following a referral from his GP, Male W attended the outpatient department with a 6 week history of a dry cough, intermittent fever and weight loss of approximately 1 stone in 1 month; night sweats and fatigue. It was noted that there had been a recent diagnosis of iritis. Male W is recorded as taking propranolol (a beta-blocker) for anxiety and citalopram, an antidepressant. Male W stated he was single and on carer's leave from work as a civil servant to care for his mother. He also stated his brother had recently died of Hodgkin's lymphoma. Male W reported a recent history of ureteric stones. The symptoms and associated conditions described by Male W raised the possibility of sarcoidosis. A plan for investigations into the symptoms included a CT scan of the chest, abdomen and pelvis, 24-hour urine for calcium and an extensive panel of blood tests.

On the 27th of August 2013, Male W attended UHSM for a follow up appointment to discuss the results of his investigations. In summary, this was a presenting clinical picture of sarcoidosis. In view of the family history, further investigations were planned. Male W was given written information on sarcoidosis and an opportunity to ask questions regarding his condition

On the 11th of September 2013, Male W attended UHSM and other investigations were discussed with him to confirm a pathology in keeping with sarcoidosis. An MR scan to exclude neuro-sarcoidosis was arranged. A referral was made to the Interstitial Lung Disease Team for management of his symptoms of sarcoidosis. Oral steroids were not considered at this time as his symptoms were managed.

On the 23rd of October 2013, Male W attended UHSM where all of Male W's investigations and results were reviewed. It was stated that if the MR scan showed involvement with the brain or nerves, treatment would be escalated with referral to a neurologist. It was recorded that Male W was very anxious about his diagnosis and asked many questions; he was reassured about his lung function but stated he was anxious about his MR scan and the implications of the scan.

The Consultant stated that they spent time reaffirming information about the condition and the Consultant was assured that Male W left the clinic reassured that his lung function was normal. Due to the nature of the clinic and frequent need to "break bad news" the consultant had an awareness of Male W's anxiety and took extra time to explain the facts of his condition. There was no additional information regarding Male W's mental health available a this time that may have triggered a referral on to mental health services.

On the 1st November 2013, Male W had a discussion with the Consultant concerning the results of a brain scan that indicated a likely spread of sarcoidosis to the carotid arteries and a resulting risk of potentially life threatening stroke. At this clinic appointment the need to commence a high dose of prednisolone was discussed, but not fully agreed as Male W was unsure of possible side effects. Male W was unsure and anxious about this treatment. Consequently, time was taken during the consultation to provide information regarding treatment and allow Male W to reflect and weigh up his options to commence treatment. The consultant wrote to the GP to summarise the instructions regarding prednisolone treatment and dosage, and informed the GP of a pending review by neurologist

Male W attended the stroke prevention clinic at this November 2013 consultation when concern was raised by Male W regarding his uncertainty about the commencement of steroid treatment for his sarcoidosis. This was the last contact recorded with Male W by UHSM.

A letter was sent to the GP on 4th November 2013 to summarise the consultation. The letter arrived at the Practice on the 12th of November, the date of the incidents and the date of death of Male W.

4.6.1 Analysis of Agency Involvement

With regard to UHSM, at each contact with both Female W and Male W, referral to specialist services was prompt and well documented. Referral between GP and Specialities at UHSM were timely.

The consultation with Female W in October 2004 – as part of the provision of routine care – identified elevated blood pressure. Consequently, Female W's medication was increased. Chronologically, this episode of care corresponded with the episode of serious mental illness experienced by Male W.

There is no reference to a carer assessment or referral for assessment during the episode of care provided to Female W in December 2012. However, reference is made to her son being her main carer and that she was not in need of support from home help, meals on wheels, district nurse or day care.

In compliance with UHSM discharge policy at the time, Female W was assessed as a straightforward and non-complex discharge. This would be an appropriate response given the short length of stay and the low level of support needed for Female W to fulfil the activities of daily living.

In Female W's record there is reference to her living with her son and that her son was her carer.

There is no evidence in the record of Female W of neglect or omissions of care when assessments were undertaken. Referral to the Integrated Assessment Team at the time of Female W's admission was dependent on information obtained at the point of admission and there was not, at this time, any information to trigger a referral to the Assessment Team.

Whilst UHSM recorded in their contact details that no trigger was present at the time of consultations – either as an in-patient or in her own home – the DHR Panel noted that Female W was brought to Hospital twice in an ambulance as an emergency admission. Despite this, no trigger for a full social care or carers assessment was noted.

At the time of Male W's appointment in July 2013, there was no reference to Male W's mental health diagnosis, other than a treated episode of anxiety and depression in 2004/5. Male W was given the opportunity to discuss his social circumstances at this point. Anxiety and depression was taken into account when evaluating his presenting symptoms. There was no carer assessment undertaken at this point.

Communication between clinical teams was maintained in a timely and efficient way and the treatment was least invasive and responsive to Male W's symptoms.

Male W was reported as very anxious at his clinic appointment on 23rd October 2013. It has already been recorded that the Consultant extended the appointment at clinic to ensure that Male W fully understood his lung function status and left the clinic reassured about his diagnosis.

UHSM followed standards and policies in place at the time of each contact with Male W. The Consultant who saw Male W in November 2013 made considerable efforts to re-assure Male W about his condition.

A GP letter, written by the Consultant, was sent to highlight the concern that Male W may not take this medication and explaining that the Consultant would maintain responsibility for this.

UHSM has a policy concerning the Mental Capacity Act and all staff have awareness training via the safeguarding adults mandatory training programme.

5 Lessons learned from the Review

Set out below are the key lessons learned that the Panel has identified from the Individual Management Reviews, Short Reports and other information submitted to assist in the completion of the review.

5.1 University Hospital of South Manchester

Following scrutiny of the case records for both Female W and Male W there is evidence of good practice in recognising an anxiety state in relation to their individual circumstances and clinical status.

It would be beyond the expertise of the attending clinicians and nurses to explore this in further detail without the background information that related to the historical mental health status of both Female W and Male W.

The GP was informed of concerns regarding the anxiety expressed by Male W in correspondence following his attendance at UHSM. In the correspondence, the Consultant at UHSM said that they would maintain responsibility for the patient and he was not discharged to the care of the GP. The learning in this instance relates to a need for more emphasis on concerns raised regarding anxiety at presentation to be communicated back to the GP and vice versa.

Information sharing concerning the involvement with mental health services in the case records or reference to mental health service involvement in the correspondence between the GP and UHSM was considered by the Panel to be inconsistent. This has resulted in a single agency recommendation for action concerning an improvement to the coding of severe mental illness on the GP EMIS record to facilitate an improvement in the sharing of accurate information concerning a patient's mental health status.

There was timely referral and response to referral in each new presentation, whether at the GP surgery or at the Outpatient Clinic at the Hospital (UHSM). All follow up appointments were sent in the timeframe agreed with both Female W and Male W.

With regard to the anxiety experienced by Male W, clinical staff at UHSM did not document if this anxiety was considered a threat to him or others. This highlights, in this specific case, a gap in working with and sharing information with other agencies, particularly the GP and Mental Health Services. Clinical staff may be at a disadvantage when treating patients without critical information relating to background mental health conditions.

There is an implication for screening vulnerable adults for a social care assessment as part of the offer of a more in depth assessment whilst an inpatient.

The Panel could not ascertain if the District Nurses who visited Address 1 had in their possession the background information concerning the history of Male W to inform their view that Female W expressed no signs of anxiety, neglect or vulnerability.

The current UHSM discharge policy would result in a more immediate multi-disciplinary discharge planning process. Where need is identified the Integrated Assessment Team of Physiotherapist and Occupational Therapist would undertake a further in depth assessment.

Since November 2013, a process of four hourly "Board Rounds" has been introduced in UHSM. This involves the multidisciplinary team discussing all new cases as they arrive on the Medical Admissions Unit. This involves a formal therapy handover in the early morning and a joint assessment at 12:30; this provides "safety netting" for short stay patients and enhances the discharge process for those patients identified with reduced mobility or increased social care needs. Further developments of this review process have included Geriatrician and therapy in reach to A&E and the Medical Admissions Unit to "flag" patients who are identified with reduced mobility and complex needs.

5.2 General Practice

In addition to the point concerning the exchange of information between Primary Care and Secondary Care and Mental Health Services, the Practice that provided services to the Female W and Male W reported that there is a need to improve GP involvement in training concerning domestic violence and abuse, particularly domestic violence and abuse of older people.

Additionally, it is recorded that learning from this DHR suggests the need to strengthen the IRIS training package as it affects older, vulnerable adults. Whilst the abuse of older people is referred to in the training package, the Panel saw no reason not to enhance this particular element of the training.

Only 16 of the 100+ Practices in Manchester have access to the IRIS training and it is suggested that all the Practices need to be made aware of the learning points from this Review. It should be noted that the General Practice in this case had received IRIS training and were an early implementer of this training programme.

Coding on the GP clinical system to denote that Female W was cared for and that Male W was a carer has been a learning area that has now been corrected for all current patients.

Additionally, it is reported that dissemination of the feedback from all DHRs should be shared with all Practices in Manchester and to the GP training schemes.

5.3 North West Ambulance Service

The North West Ambulance Service had contact with Female W – in a clinical capacity – prior to the incidents on the 12th of November 2013 and all relevant policies and procedures were adhered to.

With regard to the response to the incidents, the North West Ambulance Service has identified an important learning point concerning the management of their 'Diagnosis of Death Forms'. These forms are completed by clinical staff and should be placed together with the Patient Report Forms.

In this case these forms were not collated correctly and all clinical staff will be reminded in the 'Learning Lessons Bulletin' to ensure that all forms are collated to ensure efficient and effective scanning.

Additionally, all clinical staff will be reminded to ensure that patient ethnicity is recorded for all incidents.

5.4 Greater Manchester Police

Greater Manchester Police had no recorded involvement with either Female W or Male W prior to the incidents occurring. Consequently, it is not possible to identify specific learning points that arise from this case. However, Greater Manchester Police will work with the Community Safety Partnership to ensure that the Multi-Agency Action Plan is achieved in a timely and effective manner.

5.5 Manchester Mental Health and Social Care Trust

The serious incidents review panel convened by the Trust considered the role of Male W as his Mother's main carer and whether or not a carer assessment should have been offered or a referral made for a carer assessment at any point through contact with Trust Services.

The MMHSCT established a Panel to review the incident and concluded that all their appropriate service standards had been met but recommended that, where appropriate, patients must be asked about their care and that a carer assessment must be undertaken, or referred to be undertaken, when this is necessary.

The serious incident review panel concluded that, during contact with their services, if a need had been identified then a referral would have been appropriate. However, the panel convened by the Mental Health and Social Care Trust – after reviewing the notes and interviewing the staff involved in the case – concluded that there appeared to be no identified need for an assessment to be undertaken.

Nevertheless, it is a recommendation by the Trust's serious incident review panel that there should be some routine enquiry regarding carer support and, possibly, a carer assessment and that a record should be kept detailing the responses to the enquiry and, where necessary, the assessment.

The serious incident review conducted by the MMHSCT highlighted the absence of information from the GP to support the Review as a 'point causing concern'.

The Panel noted the comments made by the Authors of the UHSM IMR and the GP IMR that, in retrospect, additional efforts could have been made to, firstly, make associations between the physical and mental health of Male W and the impact this had on his role as a carer for Female W and, secondly, to assess this complex relationship in order to construct a suitable package of support for both Female W and Male W. These assessments would have made available to Male W and Female W a range of support services and advice offered by the voluntary and independent sector offered within the City.

6. Summary

The Domestic Homicide Review Panel, when considering the key elements of this case and the potential to learn from them, considered the issues outlined below to be pertinent.

Female W

- This is a case where two adults, a Mother and her Son, died. There were some pressures that may have triggered the incidents to occur but taking account of the information gathered at the presentation to services and the assessments undertaken by the agencies involved in this Review, the outcome could not be predicted or prevented.
- The victim (Female W) and the perpetrator (Male W) in this case had consistent and relatively long-standing contact with public service agencies, particularly the NHS, prior to the incidents cited in the review
- The Greater Manchester Police Service did not know Female W or Male W prior to the incidents reported in the review.
- The General Practice knew female W and Male W for many years prior to the incidents occurring. The Practice provided a range of primary health care services to both Female W and Male W. There had been a change in the recording systems in the practice from paper to computer and not all of the information concerning the patient was transferred onto the electronic system. The practice had coded the person being cared for (Female W) on the computer system but had not recorded the person who was caring for them (Male W). The practice complied with all the guidance concerning the diagnosis, referral and care of Male W when he presented with a serious physical illness.
- The North West Ambulance Service had contact with Female W prior to the incidents described by this Review – fulfilling their duties to

transfer Female W, by Ambulance, to the University Hospital of South Manchester.

- There was no involvement of Drug and Alcohol or Domestic Violence Services.
- There was involvement of the mental health services with both the Female W and Male W, but particularly with regard to Male W. The panel noted that Female W was often reported by NHS services as having a history of 'low mood and anxiety', particularly at times of stress.
- The MMHSCT conducted a Serious Incident Review following the deaths of Female W and Male W, the findings of which have been incorporated into this report
- There was no involvement of the Domestic Abuse services with either Female W or Male W
- There was no recorded contact with Age Concern Manchester.
- The essential learning in this case is the assumptions that may occur with regard to the provision of care provided by a relative. Female W appeared to be well cared for by her son, Male W, and, considering the information submitted to the Review Panel, this is a safe assumption to make. However, what the Panel cannot ascertain and cannot assume, is the stress this may have placed upon Male W when his caring role in 2013 combined with his receipt of a diagnosis of a serious medical condition.

The DHR process

- The homicide and suicide that occurred in this case does not indicate that significant changes to the way services respond to clients could or should be made.
- The importance of involving all relevant agencies in the process of completing a DHR cannot be over-stressed.
- Producing a clear chronology is key to the DHR process – not just for the agency involved but also for other agencies involved in the process.
- Key Lines of Enquiry are a very important element in the DHR process. A considered response to each KLOE offers the DHR Panel the opportunity to, firstly, ascertain if the agency submitting information to the Panel complied with its own professional service standards and, secondly, whether the agency is in a position of preparedness with regard to issues such as tackling domestic violence and abuse. This cannot be over-stressed.

7. Conclusion

Whilst it is noted by the Panel that, in retrospect and taking account of the bias this hindsight may introduce, opportunities could have been taken to assess Female W more fully as a vulnerable adult.

The DHR Panel concluded that the homicide of Female W and the suicide of Male W were neither predictable nor preventable within the period under review.

8. Recommendations

Building on the learning from the case set out at section 7 above, the panel has made three multi-agency recommendations to the Community Safety Partnership. These are in addition to the single agency recommendations set out in Appendix 2.

Recommendation 1

The CSP should work with the Local Adult Safeguarding Board to strengthen the response to the statutory guidance in relation to providing carers assessments. This should ensure that all agencies comply with statutory guidance in relation to the conduct of carers assessment. Furthermore, a specific question should be included in carers assessments that relates to pressures upon carers that may result in them harming the person for whom they are providing care.

Recommendation 2

The Adult Safeguarding Board should develop a specific policy in relation to elder abuse. This should be encompassed within the local domestic abuse strategy. The Adult Safeguarding Board should consult with agencies who have specific experience and knowledge in addressing the needs of older people such as Age Concern/Age UK and with specialist domestic abuse agencies.

Recommendation 3

The CCG should work closely with the CSP and other relevant commissioning and provider agencies to ensure that GPs have improved access to domestic violence and abuse training, such as the IRIS programme, and that this continues to be rolled out to all GPs in Manchester.

Appendix 1

Glossary

A&E	Accident and Emergency
CCG	Clinical Commissioning Group
CCTV	Closed Circuit Tele-Vision
CPN	Community Psychiatric Nurse
CSP	Community Safety Partnership
CT (Scan)	Computerised Tomography
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
EMIS	Egton Medical Information Systems
EOC	Emergency Operations Centre
FGM	Female Genital Mutilation
GMP	Greater Manchester Police
GP	General Practitioner
HCP	Health Care Professional
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety
IRIS AE	IRIS Advocate Educator
KLOE	Key Line of Enquiry
MCA	Mental Capacity Act
MMHSCT	Manchester Mental Health and Social Care Trust
MRI (scan)	Magnetic Resonance Imaging
NHS	National Health Service
NMC	Nursing and Midwifery Council
NWAS	North West Ambulance Service
PNC	Police National Computer
PRF	Patient Report Form
RRV	Rapid Response Vehicle
SOE	Sequence of Events
UHSM	University Hospital of South Manchester