**South Gloucestershire Safer & Stronger Communities Strategic Partnership**

# DOMESTIC VIOLENCE HOMICIDE REVIEW

# OVERVIEW REPORT

## Into the death of Molly (pseudonym) on 18th June 2014

**David Warren QPM, LLB, BA, Dip. NEBSS**
**Independent Domestic Homicide Review Chair and Report Author**

**Report Completed: 7th April 2015**

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## 1. Preface

1.1. Domestic Homicide Reviews (DHRs) came into force on the13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom she was related or with whom she was or had been in an intimate personal relationship or a member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2. Throughout the report the term “domestic abuse” is used in preference to “domestic violence” as this term has been adopted by South Gloucestershire Safer and Stronger Communities Strategic Partnership.

1.3. The purpose of a DHR is to:

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

- 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 identify what needs to change in order to reduce the risk of such tragedies happening in the future; to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4. This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Molly (pseudonym) in South Gloucestershire, on 18th June 2014 and was initiated by the Chair of the South Gloucestershire Safer and Stronger Community Strategic Partnership in compliance with legislation. The Review process follows the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews (as amended 2013).

1.5.The Independent Chair and the DHR Panel members offer their deepest sympathy to Molly’s and Edward’s family and all who have been affected by Molly’s death and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

1.6. The Chair of the Review thanks all of the members of the Review Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1.7. The Chair is joined by the Review Panel in thanking XX for the efficient administration of the DHR.

## 2. Domestic Homicide Review Panel

David Warren QPM, Independent Chair

Avon and Somerset Constabulary

Avon and Wiltshire Mental Health Partnership NHS Trust

National Probation Service

Department for Environment and Community Services South Gloucestershire Council

North Bristol NHS Trust

South Gloucestershire Clinical Commissioning Group

Department for Children, Adults and Health, South Gloucestershire Council

University Hospitals Bristol NHS Foundation Trust

**Administrator**

South Gloucestershire Safer and Stronger Communities

**Senior Investing Officer**

Detective Inspector

## 3. Introduction

3.1. This Overview Report of the Domestic Homicide Review examines agencies' responses and support given to the victim, Molly, an adult resident of South Gloucestershire, prior to the point of her death on the 18th June 2014 and their previous contacts with the perpetrator Edward (pseudonym)

3.2. Molly who was 87 years of age, lived in a residential care home in Yate; a town in South Gloucestershire situated 11 miles northeast of Bristol. The Yate urban area has a population of approximately 35000. It developed from a village into a sizeable town from the 1960s onwards, as an overspill and commuter town for the city of Bristol. It now has three secondary schools, a large shopping centre and thriving light industry.

3.3. Incident Summary:

3.3.1. On 18th June 2014, just before 1pm, the Police received a call from the manager of a Yate care home informing them that Molly, one of the residents, had been found on the floor of her bathroom apparently deceased. Edward, her step-grandson, had been seen in the room when Molly had been brought her lunch. A short time later Molly's assistance bell was activated. When a member of staff responded she found the ensuite bathroom door shut and when she asked, through the closed door, what Molly needed a male voice responded that everything was OK. The staff member alerted a nurse who sent her back to speak to Molly. Edward was seen running from the room and the care worker found Molly on the bathroom floor not breathing. Edward was later arrested.

3.3.2. Edward gave an account to the police in which he admitted killing Molly as a so-called 'mercy' killing because he thought she had Alzheimer's and epilepsy and he "did not want her to wander around like a zombie". He tried to kill her by smothering her with a pillow for a period of about 5 minutes but she was still alive, fighting for her life. He then dragged her into the bathroom and smothered her again using the pillow and pushed his knee into her throat to ensure she was dead.

3.3.3. Edward was charged with Molly's murder and remanded in custody. While in prison awaiting trial he attempted to kill a fellow inmate who is consequently now in a persistent vegetative state (PVS). Psychiatric reports agreed that at the time of Molly's death and the attempted murder of his fellow inmate he was suffering from a mental disorder, namely paranoid schizophrenia, which substantially impaired and reduced his mental responsibility for his actions.

3.3.4. The Judge at his trial made a hospital order under s.37 of the Mental Health Act 1983 (MHA), with a section 41 MHA restriction order. The judge acknowledged that this might mean he will never be released and it will ensure that he is never released when he remains a danger to the public.

3.4. The key purpose for undertaking this Domestic Homicide Review (DHR) is to enable lessons to be learned from Molly's death. In order for these lessons to be learned, as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.5. The Review considers all contacts/involvement agencies had with Molly or Edward during the period from 1st January 2013 and the death of Molly on 18th June 2014, as well as all events, prior to 1st January 2013, which may be relevant to domestic abuse,

violence or Edward's mental health.

3.6. The DHR panel consists of senior officers, from the statutory and non-statutory agencies, listed in section 2 of this report, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel or any of the Independent Management Report (IMR) Authors have had any contact with Molly or Edward prior to the homicide.

3.7. Expert advice regarding domestic abuse service delivery in South Gloucestershire has been provided to the Panel by South Gloucestershire Council and Survive which provides a range of domestic abuse services across South Gloucestershire. Expert advice relating to mental illness has been provided by the Clinical Commissioning group.

3.8. The Chair of the Panel possesses the qualifications and experience required of an accredited independent DHR Chair, as set out in section 5.10 of the Home Office Multi-Agency Statutory Guidance. He is not associated with any of the agencies involved in the Review nor has he had any dealings with either Molly or Edward and he is totally independent.

3.9. The agencies participating in this Domestic homicide Review are:

Avon and Somerset Constabulary

Avon and Wiltshire Mental Health Partnership NHS Trust

Edward's School

Care Quality Commission

Care Home Owner

Home Choice South Gloucestershire Council

Merlin Housing

National Probation Service,

Next Link

North Bristol NHS Trust

Off The Record

South Gloucestershire Clinical Commissioning Group

South Gloucestershire Council Children and Young Peoples Service

South Gloucestershire Council Department for Environment and Community Services Department

South Gloucestershire MARAC

South Western Ambulance Service NHS Foundation Trust

Survive

University Hospitals Bristol NHS Foundation Trust

Victim Support

3.10. During the preparation of this report the DHR Chair has consulted with Molly's nephew (her next of kin), and with Edward's mother. Notes of the subsequent conversations are set out in Appendix D of this report.

3.11. On completing this report the DHR Chair informed Molly's nephew and Edward's mother of the outcomes of the Review. Edward's mother declined the invitation to read the Overview Report or to attend the final meeting on 7th April 2015. Molly's nephew read the Report and attended the final DHR Panel meeting. He thanked the Panel for the Review and said he agreed with the findings. In particular he was pleased with the recommendation that nursing homes should ensure that their staff are trained to promptly answer assistance buzzers and to check with the individual resident what their needs are rather than accepting the words of visitors. He also endorsed the need for more public awareness about the early signs of schizophrenia.

3.12. Edward's mother who accepted the findings of the review, informed the Chair of the Review that her concerns are outside the remit of the DHR as they are about what happened to her son after he was arrested and remanded in prison as she believes he should have been detained in a secure hospital rather than a prison.

## 4. Parallel Reviews

4.1 The Coroner's Inquest has been opened, but in view of there being a criminal trial relating to Molly's death it was adjourned.

4.2. There were criminal proceedings when Edward was tried for Molly's murder, he pleaded guilty to manslaughter and at his trial the Judge made a hospital order under s.37 of the Mental Health Act (MHA) with an s.41 MHA restriction order.

4.3. Consideration was given to holding a Mental Health Homicide Review, however it was decided that the circumstances of this case did not meet the NHS England Guidance on implementing such an Independent Review as Edward had not been under the care of any mental health service during the six months prior to the homicide.

4.4. The South Gloucestershire Safeguarding Adults Board met and concluded that the threshold for holding a Serious Review had not been met, "as no reasonable measures could have been implemented by the Care Home to prevent Molly's death. The alleged perpetrator appeared to have been focused in his actions and desired outcome. There was "no suggestion of long term abuse or neglect by the step-grandson".

4.5. The Care Quality Commission is conducting an ongoing inspection of the care home where Molly had been a resident, following concerns having been raised by professionals and residents' relatives.

## 5. Timescales

5.1. The decision to undertake a Domestic Homicide Review was taken by the Chair of the South Gloucestershire Safer and Stronger Communities Strategic Partnership on 4th September 2014 after receiving Home Office advice on 1st September 2014.

5.2. The Home Office Statutory Guidance advises that where practically possible a Domestic Homicide Review should be completed within 6 months of the decision made to proceed with the Review. In this case, due to the delay in waiting for the conclusion of the criminal proceedings, the review was not concluded until 7th April 2015. The Home Office had been notified on 17th October 2014 that there was this likelihood of a short delay.

## 6. Confidentiality

6.1. The findings of this Review are restricted to only participating officers/professionals, their line managers, the family of the victim and the perpetrator, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

6.2. As recommended within the “Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews” to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

6.3. The name Molly is used for the deceased, who was aged 87 years at the time of her death. It was chosen by her nephew who is her next of kin. The name Edward is being used for the perpetrator, it was chosen by his mother.

6.4. The Executive Summary of this report has been carefully redacted. After this Overview Report has been through the Home Office quality assurance process, a decision on whether to publish it will be made by the South Gloucestershire Safer and Stronger Communities Strategic Partnership. If it is to be published, the report and attachments, including the chronology, will first be fully redacted.

6.5. A redaction may simply replace a name with a pseudonym, or may be the removal of personal and sensitive details about an individual, i.e. medical information. Redactions will not be used to protect the identities of organisations participating in the Review.

6.6. The Review Panel has obtained the deceased’s confidential information, (including police and medical records) after Molly’s nephew signed an authority for the DHR to access all such confidential documents. Edward’s mother signed a similar consent form to enable the Review to access his medical records.

## 7. Dissemination

7.1. Each of the Panel members (see list at beginning of report); the IMR authors, the Chair and members of the South Gloucestershire Safer and Stronger Communities Strategic Partnership have received copies of this report. The Report has also been discussed in full with Molly's nephew and Edward's mother. Molly's nephew and one of her step-daughters read the Overview report on 6th April 2015 and attended the final meeting of the Review on 7th April 2015. Edward's mother, who accepted the findings of the review, declined the invitation to read the Overview Report or to attend the Review Panel's meeting on 7th April 2015. She explained that her concerns are about what happened to her son after he was arrested and remanded in prison as she believes he should have been detained in a secure hospital rather than a prison.

Molly's nephew has asked for a copy of the full report once it has been through the Home Office Quality Assurance process and before it is published. South Gloucestershire Safer and Stronger Communities Strategic Partnership have been made aware of this request.

## 8. The Terms of Reference

8.1. **Purpose:**

8.1.1 The purpose[1] of the Domestic Homicide Review is to:

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

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

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

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

8.1.2. DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

8.1.3. The DHR Independent Chair will ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

8. 2. **Overview and Accountability:**

8. 2.1 The decision for South Gloucestershire to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the South Gloucestershire Safer and Stronger Communities Strategic Partnership on 4th September 2014, after consultation with the Home Office

8. 2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. As there are criminal proceedings pending relating to this homicide, a decision has been made to adjourn the Review until the completion of the trial.

8.2.3. This Domestic Homicide Review, which is held within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

8.3. This Domestic Homicide Review will consider:

8.3.1. Each agency's involvement with the following family members between 1st January 2013 and the death of Molly on the 18th June 2014 at her address in Yate, South Gloucestershire. Agencies will also include specific contacts with either the victim or perpetrator, prior to this period, which might relate to domestic abuse, violence or mental health issues.

[1] Paragraph 7 of the Home Office Revised Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2013

Victim: Molly 87 years of age of Yate, South Gloucestershire

Perpetrator: Edward 33 years of age of Yate, South Gloucestershire

8.3.2. Whether there was any previous history of abusive behaviour towards the deceased, and whether this was known to any agencies.

8.3.3. Whether the alleged perpetrator has any previous history of violence and if so was this known to any agency?

8.3.4. Whether the alleged perpetrator has any previous history of mental health concerns known to any agency.

8.3.5. Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

8.3.6. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

8.3.7. Could improvement in any of the following have led to a different outcome for Molly? Considering:

a) Communication and information sharing between services.

b) Information sharing between services with regard to the safeguarding of children and adults.

c) Communication within services

d) Communication to the general public and non-specialist services about available specialist services

8.3.8. Whether the work undertaken by agencies in this case was consistent with each organisation's:

a) Professional standards

b) Domestic Abuse and safeguarding policies, procedures and protocols

8.3.9. The response of the relevant agencies to any referrals relating to Molly concerning domestic abuse or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

d) The quality of any risk assessments undertaken by each agency in respect of Molly.

8.3.10. The response of the relevant agencies to any referrals relating to Edward concerning his mental health. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

d) The quality of any risk assessments undertaken by each agency in respect of Edward.

8.3.11. Whether organisations thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

8.3.12. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

8.3.13. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

8.3.14. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.

8.3.15. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse and safeguarding processes and/or services.

8.3.16. The review will consider any other information that is found to be relevant.

## 9. Schedule of the Domestic Homicide Review

- On 30th June 2014 the South Gloucestershire Safer and Stronger Community Strategic Partnership were notified by telephone by the police of Molly's death.
- On 4th July 2014 they received written notification.
- On 22nd July 2014 the South Gloucestershire Safer and Stronger Communities Strategic Partnership advisory group considered the circumstances of Molly's death and notified the Home Office that a decision had been made not to conduct a Domestic Homicide Review.
- On 1st September 2014 the Home Office recommended that a Domestic Homicide Review should be conducted.
- On 4th September 2014 this recommendation was accepted.
- 17th October 2014 a first DHR Panel meeting met at Kingwood Civic Centre and a decision was a made to adjourn the DHR until the conclusion of the Criminal proceedings.
- 26th February 2014 Panel meeting with presentation of IMRs at Kingwood Civic Centre.
- On 7th April 2015 The DHR Panel met at Kingwood Civic Centre. Molly's nephew and one of her step-daughters attended this meeting.

## 10. Methodology

10.1. This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) of participating agencies;
- The Senior Investigating Officer;
- The Criminal Trial and associated press articles;
- Members of the victim's and perpetrator's family;
- Discussions during Review Panel meetings.

## 11. Contributors to the Review

11.1. Whilst there is a statutory duty that bodies including, the police, local authority, probation and health bodies must participate in a DHR; in this case, nineteen organisations have voluntarily contributed to the review (listed in Para. 3.9). Eight have completed Individual Management Reviews (IMRs) or reports. The perpetrator's and the victim's family have provided information to the DHR.

11.2. **Individual Management Review Authors:**

Avon and Somerset Constabulary

Avon and Wiltshire Mental Health Partnership NHS Trust

Care Home Owner

North Bristol NHS Trust

South Gloucestershire Council Adults, Children and Health

South Gloucestershire Clinical Commissioning Group

South Western Ambulance Service NHS Foundation Trust

University Hospitals Bristol NHS Foundation Trust

11.3. **Senior Investigating Officer**: who briefed the Review Panel about the circumstances of the case.

**12. The Facts**

12.1. In the 1970s Molly married a widower who had nine children. They had no children together. Molly's husband died in 2013.

12.2. Edward was one of Molly's step-grandchildren. He lived with his mother, younger brother and sister. His father was murdered in 1991 when he was 10 years of age, but because of the circumstances, Edward's mother did not allow Edward or his siblings to attend the funeral.

12.3. As a child Edward was seen by his GP for a number of minor ailments, none of which related to his mental health, however in August 1998 when he was 18 years of age his mother took him to their GP as she was concerned that he was suffering with depression. She explained that he had left school at 16 years of age, he had no confidence and had not left the house for over a month. She said he did not make friends easily and spent day time asleep and night time watching TV or using the computer. His two younger siblings were outgoing.

12.4. At the end of October 1998 Edward was again seen by his GP as he was still feeling low, not going out and had no confidence to go for job interviews, his GP prescribed fluoxetine medication

12.5. By December 1998 there were no signs of improvement and he was referred to a psychiatrist. While waiting for an appointment, in January 1999, Edwards mother took him to the GP as he was tearful, withdrawn and threatening self-harm.

12.6. On the day he saw the psychiatrist Edward's mother contacted the GP as he was increasingly withdrawn and had threatened his brother with a knife. He was prescribed zopiclone.

12.7. The psychiatrist noted no forensic history, no drug use and only occasional alcohol use. He was confident Edward was not a suicide risk and suggested a referral to 'Off the Record'. There is no documentation to indicate that he ever attended "Off the Record". In April 1999 Edward was again seen by the psychiatrist who placed him on antidepressants and referred him to the Orchard Day Therapy Unit.

12.8. In June 1999 Edwards's mother wrote to the consultant psychiatrist describing Edward's behaviour as angry and destructive. He was seen at the Orchard Day Hospital, where it was noted that he was shy, not able to make eye contact, and that had not been out for over a year; he was, therefore, provided with one to one rather than group therapy. He was also referred to a social worker and allocated a community care worker. In September 1999 he was discharged from Orchard Day Hospital.

12.9. In February 2000 Edward was again assessed by a clinical psychologist and offered regular follow up sessions. There were some signs of improvement in his mood and socialisation but due to multiple non attendances he was later discharged.

12.10. In March 2002 Edward was referred by his GP to the Community Mental Health Team because of his ongoing problems with social phobia and anxiety. Edward described a continued volatile relationship with his brother, including physical violence. Once again, as he missed most of his appointments and as there was no evidence of him being likely to self-harm, he was discharged in December 2002.

12.11. In September 2004 Edward's GP noted that he had lost his job, not been out of the

house for 18 months and was isolating himself from his family. He was referred for counselling. A Community Psychiatric Nurse (CPN) visited him at his home. Edward refused to leave his room but agreed to have email contact with the nurse. This was followed up by him being given further visits at home from a psychiatrist and the CPN who provided cognitive behavioural therapy (CBT) for his extreme anxiety.

12.12. In May 2006 Edward was discharged by the clinical psychiatrist; after Edward and his mother agreed that significant changes had been made but that further psychological work would be of little benefit. He continued to be prescribed 20mg citalopram medication.

12.13. In January 2013 Edward was reported missing from home. He had left a letter saying he was going away to find himself as he needed a break. The police graded the risk as medium and took all of the appropriate actions to find Edward. The next day he returned home of his own accord. He was interviewed by the police and said he had been feeling guilty living at home without contributing financially.

12.14. The day after he returned home his GP made an urgent referral to the Avon and Wiltshire Mental Health Partnership NHS Trust Primary Care Liaison Service (PCLS) due to concerns raised by Edward's sister that he was obsessed by the Bible and thought that devils were after him. His sister asked that he was not told the nature of her concerns. An appointment was made with the CPN who had previously worked with him.

12.15. On 17th January 2013 Edward's grandfather (Molly's husband) died after a long illness. Edward felt guilty that he had not been to see him and started to spend a lot of time with Molly. Due to the bereavement the appointment with the CPN was postponed until February 2013.

12.16. Edward's sister took him to his appointment with the CPN. It was noted that he had no obvious signs of mental illness and was advised on primary care counselling and vocational support before being discharged from the PCLS.

12.17. In May 2013 Molly fell and broke a bone in her foot. She was treated and allowed home as she was able to walk with the help of a zimmer frame. A month later she was admitted to hospital suffering from back pains after another fall. The Hospital notes recorded that she had decreased mobility, epilepsy and urinary problems. Her mental state was described as disorientated. As she lived alone arrangements were made for her to move temporarily into a care home.

12.18. Molly was unhappy in the care home as she felt lonely. She wanted to go home but as her step daughters were not able to help she was discharged home with the help of a home support service calling four times a day to assist her.

12.19. Five days later Molly was re-admitted to the care home after a safeguarding adult alert was raised by the ambulance service as a result of three call outs to her within 24 hours as she had been falling at home and not managing. Subsequently, Molly's family found her a new care home. Molly's GP, suspecting she was suffering from dementia, referred her to the memory clinic.

12.20. In January 2014 Molly's GP received a letter from the Memory Clinic diagnosing probable vascular dementia. Molly's GP provided the care home with a care plan and her nephew, who had power of attorney, was informed.

12.21. During May 2014 South Gloucestershire Council received mounting concerns from professionals regarding the number of staff leaving the care home in which Molly resided;

a multi-agency meeting was convened and CQC decided to hold an inspection at the home. The home owners agreed not to take any new residents and a peripatetic home manager was appointed.

12.22. On 7th June 2014, Edward was reported missing by his mother who was worried that the note he left could be construed as a suicide note as he was suffering from depression. He turned up home the next day having been to Cornwall. He told the police he was depressed as he couldn't get a job.

12.23. During the same month, a senior practitioner from South Gloucestershire Council Institutional Safeguarding team saw Molly and her nephew, after family members had raised concerns about poor quality care at the home. Work to address the issues raised was already being taken by the care home owners.

12.24. On 17th June 2014 Edward left home at approximately 5pm, leaving behind a note saying he was going away, would not be coming back and did not want to be found. The family did not report this to the police but at 1.15 am on 18th June 2014 he phoned home saying he was in Chippenham and was returning home, he arrived home at 6am. This was the day he killed Molly.

12.25. Details of the incident are set out in paragraph 3.3 of this report.

12.26. A full chronology of agencies' contacts with Molly and Edward were set out in full for the panel to consider.

## 13. Overview

13.1. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that their reviews have been conducted in line with the Terms of Reference.

13.2 Agencies completing IMRs were asked to provide chronological accounts of their contact with Molly and/or Edward prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference the DHR has focused on agencies contacts from 1st January 2013 to 18th June 2014, but also includes all relevant information prior to that period. The recommendations to address lessons learnt are listed in section 17 of this report and action plans to implement those recommendations are catalogued in Appendix C.

13.3. The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation. In line with the Terms of Reference, each IMR author has detailed in their IMRs how these were considered. Whilst Molly was elderly and suffering from aged related infirmities, there was no evidence that these adversely affected quality of care provided to her by agencies. It is noted however that Edward told the police that he had killed Molly because he did not want her to become a “zombie” because of her dementia and epilepsy.

13.4. The Review Panel has checked that all of the key agencies taking part in this Review have domestic abuse policies and are satisfied that they are fit for purpose and are being implemented correctly by management and staff.

Nineteen agencies/multi-agency partnerships were contacted about this review.

13.5. Eleven agencies responded as having had no relevant contact with either Molly or Edward.

They are:

Edward’s School

Care Quality Commission

Home Choice South Gloucestershire Council

Merlin Housing

National Probation Service,

Next Link

Off The Record

South Gloucestershire Council Department for Environment and Community Services Department

South Gloucestershire MARAC

Survive

Victim Support

13.6. Eight agencies provided IMRs or reports setting out their contacts with either Molly or Edward.

**13.7. Avon and Somerset Constabulary**

13.7.1. In January 2013 Edward's sister reported him as missing from home. He had left a letter stating that he wished to "Go away and find himself". It was recorded "Edward was social phobic who suffered with anxiety and depression. He was not taking any medication. He had been suffering from mental illness from a young age".

His family believed that the reason he had gone missing was that his grandfather was very ill and he was feeling guilty he had not been to see him for some time. There were no indicators that Edward was at risk of self-harm.

A missing person entry was graded as medium risk as it was believed that Edward would return home in a short while. Nevertheless enquiries were made with local hospitals and parks were checked. Edward's photo was added to the police report and the family were seen again. In the early hours of the following morning an Inspector reassessed the situation and confirmed the medium risk rating. Local officers were alerted and Edward's name was placed onto the Police National Computer (PNC).

In accordance with Constabulary policy the missing person's report and concerns were shared with multi-agency partners via the First Contact Team of South Gloucestershire Adult Social Care Team (SGASC). This is a 'one stop shop' where referrals for adults can be signposted to appropriate organisations including Mental Health teams and General Practitioners.

Edward returned home later the following day and told officers where he had gone and explained he had been feeling guilty living at home as he was not contributing financially.

13.7.2. On two occasions, in April and October 2013, police attended at Molly's home to assist in gaining entry after she had suffered falls. The ambulance service attended on the second occasion and no further police action was required.

13.7.3. In June 2013 Edward was again reported missing to the police, after he left a note stating that he was never coming back. Although at that time Edward had only been reported as a missing person on one previous occasion, the family said he had also gone missing a month earlier when he camped out for three days before returning home of his own accord. Edward's mother worried that the note left on this occasion was effectively a suicide note. Edward had not taken a coat and only had £60 on him, this caused the police to treat the episode as serious. A missing person's log was created on the force "Guardian" database system with the risk assessed as high. The matter was circulated on the police national computer (PNC). During the evening Edward telephoned his mother and said that he was in Cornwall. The risk assessment was reduced to medium and Edward returned home the next morning on his own accord.

An officer spoke with Edward's mother, advising her to seek help for herself regarding the 'difficult home situation'. She was also given the telephone number for the mental health

charity MIND. It is noted that Edward has depression but refused treatment. The officer also spoke with Edward.

13.7.4. In December 2013 as a result of an allegation that money had gone missing from Molly's purse at the residential care home where she was living. Officers attended and carried out enquiries, searching her room and interviewing key staff. The money was not found and there was no evidence against anyone at the home. The case was later closed as an undetected crime *a*nd the South Gloucestershire Adult Social Care Team were informed.

**13.8**. **Avon and Wiltshire Mental Health Partnership NHS Trust.**

13.8.1. Edward was referred to the Community Mental Health Team (CMHT) on three occasions: January 1999, March 2002 and September 2004. In January 2013, he was referred to the Primary Care Liaison Service (PCLS). On these occasions Edward was assessed as struggling with psychological difficulties, rather than experiencing any serious mental illness.

13.8.2. Edward saw three psychologists between 2000 and 2006. The longest involvement being with a clinical psychologist from 2004 to 2006. All of those contacts took place at his home as did subsequent medical reviews.

13.8.3. During Edward's involvement with the Community Mental Health Team (CMHT) from 2002 onwards, his care was managed in accordance with the Care Programme Approach (CPA).

13.8.4. Edward was first referred by his General Practitioner in January 1999. At this time he was experiencing feelings of acute social anxiety and shyness. He was reluctant to engage in talking therapy in a group setting at a local therapeutic day unit, but did benefit from one to one psychological work. Family therapy was also considered as an intervention, following some conflict between Edward and his brother. This was not taken up by either Edward or his brother, and so Edward was discharged from AWP Psychological services in July 2000.

13.8.5. When Edward's GP again referred him in April 2002 he was assessed by a Psychologist who worked with him until December 2002. His social phobia, anxiety and some anger (particularly towards his brother and household objects) were explored, however, there were no particular concerns regarding any risks posed by Edward, either to himself or others. It was noted that Edward appeared depressed at this time but felt unable to engage in psychological work. Due to several missed appointments and a lack of engagement he was discharged back to the care of his GP.

13.8.6. Edward was subsequently referred to mental health services in September 2004. Having lost his job in the intervening period, his mood had again become a concern to his mother. The assessment was attempted at his house in October 2004 but Edward felt unable to be present. The appointment was undertaken with his mother and he was taken on for treatment by the local CMHT.

13.8.7. Following the appointment in October 2004 an initial risk assessment was completed and the risk management plan was updated at each of the subsequent review meetings. Although early concerns involved fighting with his younger brother (and on one occasion brandishing a knife) there was never felt to be any significant risk to others. The

main concerns were Edward's increasingly isolated behaviour, inability to find work and loss of social functioning.

13.8.8. Contact with Edward's family between 1999 and 2007 was primarily with his mother, who was consulted by the mental health clinicians visiting the house. Due to Edward's at times extreme social phobia, which prevented him from leaving the house and attending appointments, he was discharged from psychology in 2000, 2002 and 2007.

13.8.9. Edward's urgent referral to the Primary Care Liaison Service in January 2013 by his GP was driven by concerns raised by his family. Due to a family bereavement and his declining alternative appointments, Edward was seen in February 2013. Every effort was made to engage with him, and without the involvement of his sister it is doubtful he would have attended his assessment at all. Unfortunately, the assessing clinician was prevented from sharing with Edward, the family's specific concerns (at their request). These concerns included Edward copying out large sections of the Bible and reportedly feeling strange physical sensations. However, as Edward again did not present or disclose any symptoms that would warrant further involvement from secondary Mental Health services and he declined follow up assessment, the assessing clinician was obliged to discharge him back to the care of his GP. A risk summary was completed as a standard component of the assessment. The only risk highlighted was that Edward had experienced suicidal thoughts following the then recent death of a film director who had recently committed suicide. Edward denied any current thoughts or plans of harming himself or others. Mental health services had no further contact from Edward.

13.8.10. Avon and Wiltshire Mental Health Partnership had only one contact with Molly when she was assessed, at the request of her GP, by AWP's Memory Service in January 2014. Her care was subsequently transferred back to her GP following this one contact, and there was no further contact between AWP and her GP.

**13.9. Health Care Company (Care home owner)**

13.9.1. Molly was admitted to the Care Home in November 2013 as a self-funded resident. She was known to suffer from some dementia but it was not considered that she needed specialist care provided by the dementia unit at that time. She had regular visits from family members including her nephew (who was her next of kin), her step daughters and step grandson Edward.

13.9.2. During April 2014 she was moved into another room, after she had been found wandering into other resident's rooms. She appeared to settle well in this new room.

13.9.3. Access to the care home was via a keypad lock at the front door. The code was given to regular visitors to enable them to have free access to their relatives. Strangers and infrequent visitors needed to ring the doorbell to be admitted. All visitors were expected to sign in and out so that in the event of an emergency it was clear who was in the building.

13.9.4. On 18th June 2014 staff noted that Edward was visiting Molly. He spoke to staff who took lunch to her in her room. Sometime later Molly's assistance bell rang and a member of staff went to see what she needed. Molly was in her ensuite toilet and when the care worker asked, through the closed door, if she needed something a male voice answered that she was fine. The care assistant left the room but met a nurse in the corridor who asked her to return to the room to provide any necessary assistance to Molly.

On returning to the room the care assistant was pushed aside by Edward, who then left the building in a hurry. Molly was found lying, not breathing, in her bathroom. The care assistant pressed the emergency bell to summon assistance.

**13.10**. **North Bristol NHS Trust**

13.10.1. The Trust had contact with Molly over a number of years, as set out in section 12 of this Report and in the Chronology. The contacts indicate that Molly suffered from epilepsy which was controlled by appropriate medication, nevertheless she often reported that she had balance problems which resulted in a number of falls. This is consistent with the condition combined with developing memory problems. There are a number of Accident and Emergency Department attendances due to these issues.

13.10.2. Molly was never routinely screened for domestic abuse as this was not NHS practice at the time when she attended the Accident and Emergency Department for the falls. As her presentations were consistent with the description of the events told to staff and the mechanics of the injuries also fitted the explanation, selective screening was not considered to be justified.

13.10.3. Molly's medical records indicate growing confusion and deteriorating health, in particular a loss of mobility and incontinence. A Do Not Attempt Resuscitation Order (DNACPR) was in place with the consent of Molly. This is normal practice for a person presenting with this illness profile.

**13.11. South Gloucestershire Clinical Commissioning Group.**

13.11.1. Both Molly and Edward were regular patients with their GP practice and their visits are detailed in Section 12 and appendix E of this report.

13.11.2. From Molly's medical records there is no evidence of interactions between her and Edward, nor of concerns from her, the family, or care staff about domestic abuse.

13.11.3. In Edward's medical records there were frequent mentions of mental health problems. In 1998 his mother expressed concerns about him being agoraphobic. Later that year he presented as "worried and agitated". He was referred appropriately to a clinical psychologist, but did not attend his appointment, a pattern that was repeated throughout 1999. There was regular, good communication between his GP and secondary care.

13.11.4. Edward's medical records also show that in 1999 he threatened his brother with a knife. He was assessed rapidly by a psychologist who did not record a suspicion of psychosis and he was treated for "depression". He continued not to engage with psychiatric input and was eventually discharged with a diagnosis of "social phobia". In 2000 and 2001 he was offered family therapy but repeatedly did not attend the appointments. In 2005 he was seen for Cognitive Behavioural Therapy (CBT) for anxiety, and was assessed again in 2006 and 2007. In 2013 he was assessed urgently by the Primary Care Liaison Service (PCLS) following concerns about him going missing and having obsessive actions. No further intervention was felt to be needed. There is no record of any contact between February 2013 and July 2014 between Edward and any medical related services.

### 13.12. South Gloucestershire Council Adults Children and Health-Institutional Safeguarding Team.

13.12.1. Molly came to the attention of the safeguarding team on several occasions because of concerns about her ability to look after herself in her own home, there was never any indication of domestic abuse or worries regarding her interaction with Edward. The family were found to be supportive to her, despite some differences of opinion which led to individual safeguarding alerts. As she was self-funding whilst residing in the nursing home the Local Authority had no responsibility to review her care needs. Nevertheless, concerns were raised about the care home in May 2014 and there were a series of meetings between the relevant agencies and the providers which are still ongoing. Improvements have been made at the home but the staff group is still not stable and there are ongoing individual safeguarding alerts, none of which are relevant to the circumstances of Molly's death.

### 13.13. South Western Ambulance Service NHS Foundation Trust

13.13.1. In October 2013 concerns were raised by Ambulance staff that Molly had been unsafe at home, they had been called out 3 times in 24 hours after she had suffered falls. The South Gloucestershire Council Safeguarding team were informed and Molly's GP subsequently made a referral to the AWP memory service.

### 13.14. University Hospitals Bristol NHS Foundation Trust

13.14.1. Molly had several appointments for routine ophthalmic health issues at the Bristol Eye Hospital from 2007 to 2010.There was no reason for staff to consider that Molly may have been the victim of domestic abuse and records do not document Molly informing staff of any such incidents.

## 14. Analysis

14.1. The Panel has considered the individual management reports, through the view point of Molly, to ascertain if each of the agencies' contacts were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has deliberated if lessons have been identified and properly actioned.

14.2. The Panel is satisfied that the authors of the IMRs have followed the Review's Terms of Reference and addressed the points within it. They have each been thorough and transparent in completing their reviews and reports. The following is the Review Panel's opinion on the appropriateness of each of the agencies interventions.

### 14.3. Avon and Somerset Constabulary

14.3.1. On each of the occasions the police were in contact with Edward they acted properly in line with their set missing person procedures. They responded immediately and having recognised that Edward was a vulnerable person and made the appropriate assessment of risk. The enquiries that were made were proportionate and included further enquiries with Edward's family. When officers spoke to Edward after he returned home on his own accord there was no reason for them to consider detaining him under Section 136 of the Mental Health Act 1983 *(*removal to a place of safety) which would have prompted a mental health assessment*.*

14.3.2. With regards the incidents relating to Molly, these were calls for assistance to help an elderly person living alone who had fallen. Once it had been established that all was in order and that Molly was being attended to by the ambulance service the police had no role to play.

**14.3.3. The Review Panel is satisfied that police action was consistently appropriate to each situation, in accordance with the appropriate policies and procedures and that there are no lessons for the police to address in this case.**

### 14.4. Avon and Wiltshire Mental Health Partnership NHS Trust.

14.4.1. The IMR author reviewed all available AWP documents that related to Molly and Edward and interviewed staff who treated Edward during his later referrals. Edward was treated for anxieties and social phobia by different clinicians in different sections of the Trust between 1999 and 2013. As he refused to leave his house and often his bedroom, he missed many appointment including refusing to see clinicians who visited him at home. Nothing was identified during his assessments which would have indicated that Edward was suffering from paranoid schizophrenia.

**14.4.2. The Review Panel is satisfied that both Molly and Edward were assessed and treated appropriately on the basis of the evidence provided to the different practitioners. The panel accepts that there were no lessons for AWP to learn from this review.**

### 14.5. Health Care Company (Care home owner)

14.5.1. The Health Care Company which owns the care home in which Molly was living provided a report which included details of how the entry procedure for visitors has been reviewed and changes made to increase entry security, whilst balancing this with the recommendations of the Serious Case Review of the Winterbourne View Care Home case.

In that Review concerns had been raised relating to relatives not being allowed easy access to residents.

14.5.2. The report also highlighted the actions of the member of the care staff who responded to Molly's assistance bell but accepted Edward's response that Molly was ok without seeing her.

**14.5.3. The Review Panel is satisfied that the care home entry system whereby Edward, as a regular visitor, knew the key pad number had no bearing on Molly's homicide. Edward being a relative and regular visitor would have been given access to her even if he had needed to ring a door bell to gain entry. The Panel believes that the care worker who responded to Molly's assistance bell should have insisted on seeing Molly herself rather than accepting Edward's word that she was alright. Nevertheless, the Panel acknowledges that the care worker had not received any specific training on how to respond to a call bell in circumstances where a resident had visitors. The panel commends the good practice of the nurse who sent the care worker back to physically check on Molly. The lessons learnt and recommendation made is considered appropriate.**

**14.6. North Bristol NHS Trust.**

14.6.1. The IMR author found no contacts with Edward but several with Molly over a number of years, none contained any indicators of domestic abuse and Molly never disclosed that she had ever been a victim of domestic abuse. During that period the Trust did not have a Domestic Abuse and Violence policy in place, nevertheless, the IMR author was satisfied that if Molly presented to the North Bristol Trust now that staff would not screen and this would be acceptable practice due to the lack of indicators and Molly not being a member of a high risk group.

**14.6.2. The Review Panel is satisfied that Molly received the appropriate treatment from the North Bristol Trust and that there was no indication that she was ever a victim of domestic abuse. Since 2013 the Trust has had a Domestic Abuse policy in place and appropriate training is routinely provided to all staff. There are no lessons for the Trust to learn from this Review.**

**14.7. South Gloucestershire Clinical Commissioning Group**

14.7.1. The author of the CCG IMR is a GP and the Clinical Lead for Mental Health, Dementia, Learning Difficulties and Adult Safeguarding for the South Gloucestershire Clinical Commissioning group. His report found no evidence of anything which should have raised concerns about domestic abuse or about Edward's behaviour towards Molly.

14.7.2. After Molly's death, Edward was diagnosed as suffering from paranoid schizophrenia. His violent actions were consistent with his delusional beliefs, which also resulted in a serious assault on another prisoner whilst in custody. The IMR considered whether Edward's paranoid schizophrenia could have been diagnosed and treated prior to the homicide. The medical records were carefully searched for evidence of this. From Molly's records there is no evidence of interactions with Edward, nor evidence of concerns from her, the family, or care staff about her step-grandson.

14.7.3. There are frequent mentions of mental health problems in Edward's records.

- In 1998 his mother expressed concerns about him being agoraphobic. Later that

year he presented as “worried and agitated”. He was referred appropriately to the clinical psychologist, but did not attend his appointment, a pattern that repeated throughout 1999. There is evidence of good communication between GP and secondary care.

- In 1999 he threatened his brother with a knife. He was assessed rapidly by a psychologist who did not record a suspicion of psychosis, and he was treated for “depression”. He continued not to engage with psychiatric input and was eventually discharged with a diagnosis of “social phobia”.

- In 2000 and 2001 he was offered family therapy, but repeatedly did not attend appointments.

- In 2005 he was seen for Cognitive Behavioural Therapy (CBT) for anxiety, and was assessed again in 2006 and 2007.

- In 2013 he was assessed urgently by the Primary Care Liaison Service (PCLS) following concerns about him going missing and having obsessive actions. No further intervention was felt necessary.

14.7.4. There is no record of any contact between February 2013 and July 2014 between the perpetrator and medical or related services.

14.7.5. The IMR author assisted the Review Panel by explaining that paranoid schizophrenia is a psychotic illness of unknown cause in which the sufferer will lose touch with reality, will often feel persecuted, and have delusions that occasionally cause them to harm themselves or others because of those delusions. There is no test to confirm the diagnosis other than the patient’s words and actions. Treatment with antipsychotic drugs can help produce remission, though relapses are common. If a patient with schizophrenia is deemed a threat to themselves or others by means of their illness, they can be forcibly detained under the Mental Health Act 1983. A problem with psychoses is that patients often lose insight that they are unwell, so will not seek treatment and may actively resist treatment. This makes it difficult to manage and even when a patient is known to have the condition and under active psychiatric supervision, they can sometimes acquire delusions which can result in tragic outcomes.

14.7.6. In this case, paranoid schizophrenia was not apparently suspected or suggested by any of the many professionals who assessed Edward over the years. Diagnoses of anxiety, depression or social phobia were made, none of which would suggest subsequent psychosis. The IMR author while collating the chronology before the court case did not suspect a diagnosis of schizophrenia. The attack on the brother was the only suggestion of violence, and the obsession with the bible may have, with hindsight, been a clue as religious delusions are a common feature. However, there is no evidence of substandard clinical care or poor communication. On each occasion Edward was referred and assessed promptly. The high DNA rate was consistent with his perceived social phobia. Even if a diagnosis of schizophrenia had been made or suspected, there is no evidence from the records that he would have been detained under the Mental Health Act.

14.7.7. The family had previously expressed concerns which were responded to appropriately, but no concerns are recorded in the year prior to July 2014, nor indeed were there any interactions with medical or related services. The IMR author is of the opinion that there appeared to have been no opportunity to intervene to prevent the tragedy which occurred.

**14.7.8. The Review Panel thanks the IMR author for his thorough review and his explanation about paranoid schizophrenia. The Panel accepts that while Edward was identified as suffering from paranoid schizophrenia, after Molly's death and the second assault that he committed in prison, this was not evident to the different psychologists who assessed him between 1998 and 2013. The Panel is also satisfied that Edward's GP practice dealt with him appropriately and have no lessons to learn or recommendations to make. Nevertheless the Panel is of the opinion that a general lesson and recommendation should be made in relation to awareness of the early signs of schizophrenia.**

### 14.8. South Gloucestershire Council Adults Children and Health - Institutional Safeguarding Team

14.8.1. There are a number of safeguarding concerns relating to the care home in which Molly was living; however there is no evidence to indicate they had any connection with Molly's death. The care home was not aware of any concerns about Edward and so would not have had any reason to restrict his visits to Molly. Since the Serious Case Review into Winterbourne View (also in South Gloucestershire) the care home like other nursing homes throughout the country had a code pad entrance procedure to enable easy access for family and friends visiting residents.

**14.8.2. The Review Panel is aware of the safeguarding issues that are currently being addressed at the care home and is satisfied that they have no bearing on Molly's homicide. The Panel accepts that there are no lessons to be learnt by the Council's Safeguarding Team in this case.**

### 14.9. South Western Ambulance Service NHS Foundation Trust

14.9.1. The ambulance service had no contact with Edward and only routine responses to incidents where Molly had fallen at home prior to moving the care home.

**14.9.2. The Panel is satisfied that the ambulance service contacts were appropriate and notes the good practice of ambulance personnel raising safeguarding concerns by means of a vulnerable adult referral to South Gloucestershire Adult Social Care and through Molly's GP regarding her ability to cope while living on her own.**

### 14.10. University Hospitals Bristol NHS Foundation Trust.

14.10.1. The IMR details routine treatment to Molly's eyes from 2007 to 2010 at the Bristol Eye Hospital. There was no record of any issues relating to domestic abuse being raised or being considered. At that time the North Bristol Hospital Trust did not have in place a suitable domestic abuse policy but the report author is satisfied that there was no reason to consider domestic abuse from Molly's condition and that even if the current policy had been in place it is unlikely that staff would have screened Molly either routinely or selectively as there were no indicators of abuse that staff could have spotted.

**14.10.2. The Review Panel accepts that the Trust's contacts with Molly were always appropriate and that there are no lessons to learn or recommendations to make.**

## 15. Effective Practice / Lessons to be learnt

15.1. The following agencies that had contacts with Molly or Edward have identified effective practice or lessons they have learnt during the Review.

### 15.2. Avon and Somerset Constabulary

15.2.1. In all contacts with Edward and Molly the police acted properly. Actions taken were both timely and proportionate to the events taking place and were in accordance with Policy and Procedural Guidance.

15.2.2. There are no lessons to be learnt.

### 15.3. Avon and Wiltshire Mental Health Partnership NHS Trust

15.3.1. Edward's level of anxiety and social phobia, which prevented him from attending appointments outside of the family home (and on one occasion, refusing to leave his room to speak with attending clinicians) made engagement particularly difficult. This was addressed by clinicians using emails to communicate with him, offering telephone contact and by the clinical psychologist agreeing to work with Edward at home.

15.3.2. There are no lessons to be learnt in this case.

### 15.4. Health Care Company (Owner of care home)

15.4.1. The care home has identified that care staff need to be trained to check personally with a resident when responding to an assistance bell, even when a visitor is present.

### 15.5. North Bristol NHS Trust

15.5.1. The North Bristol Trust has appointed a lead officer to coordinate and lead on domestic abuse. A domestic abuse policy is in place and training for all staff is being delivered. There is an IDVA service available in the Accident and Emergency service. In conjunction with its health partners the Trust is working toward full implementation of the 2014 issued NICE guidelines for Domestic Abuse and Violence.

15.5.2. There were no lessons to be learnt.

### 15.6. South Gloucestershire Council Adult Children and Health Institutional safeguarding Team.

15.6.1. There were no lessons to be learnt.

### 15.7. South Gloucestershire Clinical Commissioning Group

15.7.1. There are no lessons learnt from this case which would have affected the outcome. Until there is an effective early diagnosis for schizophrenia when it presents in an atypical way and effective long term treatments, rare tragedies from this cruel disease will occasionally happen. In most cases there are issues around management of known schizophrenia, but this does not appear to be the case here. There is a recognition that if more information had been available to the GP or mental health services, it is possible they

may have been able to identify early signs of schizophrenia before psychosis overcame Edward.

### 15.8. South Western Ambulance Service NHS Foundation Trust

15.8.1. There were no lessons to be learnt, but the communication by ambulance staff with the GP practice in identifying safeguarding concerns about Molly not being able to cope on her own is an example of good practice.

### 15.9. University Hospitals Bristol NHS Foundation Trust.

15.9.1. There were no lessons to be learnt.

## 16. Conclusions

16.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Molly or Edward in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?

- Will the actions they take improve the safety of domestic abuse victims in South Gloucestershire in the future?

- Was Molly's death predictable?

- Could Molly's death have been prevented?

16.2. The Review Panel is satisfied that the IMR authors have been open, thorough and questioning from the view point of the victim in conducting their reviews. They have worked in line with the Review's Terms of Reference and in fact gone beyond the required periods to consider earlier relevant contacts. The Review Panel is satisfied that in this case the agencies have followed their correct policies and procedures during their contacts with Molly and Edward.

16.3. In this review no evidence has been found of any prior domestic abuse towards Molly. The Review Panel has had the opportunity to read all of the domestic abuse policies of the agencies who had contact with either Molly or Edward and are satisfied that they are fit for purpose. The implementation of these policies will ensure that any future victims will be safer in South Gloucestershire.

16.4. The Panel is satisfied that the recommendations made within the Review will make life safer for the residents of care and nursing homes.

16.5. The Review Panel does not believe that Molly's death was predictable. Molly had never given any indication that she had ever been abused and the agencies she was in contact with did not find any evidence of abuse. Edward had visited her on numerous occasions without any problems being apparent. In interviews with the police, after the homicide, Edward told the officers that he loved his step-grandmother and had smothered her to prevent her ending up like a "zombie" because of her declining dementia.

16.6. The Panel believes that Molly's death could not have been prevented. In reaching their conclusion the Panel particularly considered:

- Edward had been seen by a number of different clinicians between 1999 and 2013 and they had independently diagnosed that he was suffering from anxieties and social phobia. They had no clear information to suggest he might also be suffering from paranoid schizophrenia.

- From the time he was discharged by the Avon and Wiltshire Mental Health Partnership Primary Care Liaison Service in 2013 he had no further contact with any medical service prior to the homicide in June 2014. During this time none of his family had contacted either his GP or the mental health trust with concerns about his mental health.

- On the two occasions Edward was reported to the police as a missing person he returned home on his own and gave rational explanations for leaving home when he spoke to police officers. They had no evidence to suspect that he was a risk to himself or to any other person and therefore would have no reason to consider that he should be sectioned under the Mental Health Act.

- The fact that Edward was able to enter the care home without checking in with staff was not considered relevant as he would have been allowed in to see Molly even if he had needed to ring the doorbell. It is common practice nationally for nursing and care homes to give relatives and regular visitors door codes so that they have easy access to residents.

- The care worker who answered Molly's assistance bell did not see Molly; she was aware that Molly's step-grandson was visiting and when she heard a male voice answering her that Molly was ok she did not enter the bathroom. She did however inform a duty nurse of what had happened. The nurse told her to go back and check with Molly herself. She immediately returned to Molly's room where Edward pushed passed her and hurried from the building. When she went into Molly's bathroom she found Molly on the floor, not breathing. Edward later admitted to the police that he had held a pillow over Molly's face for several minutes and was surprised that she was still breathing, he then dragged her into the bathroom where he kept his knee on her throat whilst smothering her again with the pillow.

16.7. Whilst too broad to be included within this Report as "SMART" recommendations, the Panel strongly supports the view of the South Gloucestershire Clinical Commissioning Group IMR author who stated "this case does demonstrate the need for further research to find the causes and effective treatments for schizophrenia; had a test been available to make the diagnosis at an earlier presentation, some intervention might have been possible. A raised awareness of the early signs of schizophrenia, might have allowed the family or contacts to alert the medical authorities, and work around de-stigmatising mental health, which might have made Edward more willing to seek help before psychosis overcame him". This view is also supported by Molly's next of kin who is a retired senior social worker.

## 17. Recommendations

### 17.1. National

17.1.1. Care and nursing home providers should introduce a procedural policy that when a resident presses their assistance bell the responding member of staff should check their needs with them personally, rather than accepting the word of a visitor. Management teams should ensure that all staff are aware of this policy and that it is included in all staff induction and refresher training.

17.1.2. That the Department of Health be notified about the circumstances of this case so that:

- Consideration can be given to the need for further research to find the causes and effective treatments for schizophrenia; had a test been available to make the diagnosis at an earlier presentation, some intervention might have been possible.

- That there be a public awareness campaign to de-stigmatise mental health and to provide the general public with information which may enable them to identify the early signs of schizophrenia.

### 17.2. Multi Agency/ South Gloucestershire wide.

17.2.1. Care and nursing home providers should introduce a procedural policy that when a resident presses their assistance bell the responding member of staff should check their needs with them personally, rather than accepting the word of a visitor. Management teams should ensure that all staff are aware of this policy and that it is included in all staff induction and refresher training.

### 17.3. Health Care Company (Owner of care home)

17.3.1. The group will introduce a policy that when a resident presses their assistance bell the responding member of staff will check with them personally other than accepting the word of a visitor. This will be included in all staff training.

17.3.2. The home has changed their protocols so that all visitors have to ring the bell and sign the visitor's book, which now includes their relationship with the resident they are visiting. This will be kept under review.

## 18. Postscript

**Action to be taken after presentation of the Overview Report to the South Gloucestershire Safer and Stronger Communities Partnership.**

On receiving the Overview Report and supporting documents, the Partnership should:

- Agree the content of the Overview Report and Executive Summary for publication, ensuring that they are fully anonymised, apart from including the names of the Review Panel and IMR authors.

- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.

- Sign off the Overview Report and supporting documents.

- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@ homeoffice.gsi.gov.uk.

- The document should not be published until clearance has been received from the Home Office Quality Assurance Group.

- On receiving clearance from the Home Office Quality Assurance Group, the Partnership should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.

- Provide an electronic copy of the Overview Report (this must first be carefully redacted) and the Executive Summary on the South Gloucestershire Safer and Stronger Communities Partnership web page.

- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.

- Formally conclude the review when the Action Plan has been implemented and include an audit process.

## Appendix A Glossary of terms

| ADULT SAFEGUARDING | |
|---|---|
| Access Team | The adult care duty team which investigates individual safeguarding alerts |
| AIS client records | The electronic data base that South Gloucestershire Council uses for its Adult social care records. |
| Customer Service Desk | Initial point of contact with Adult social care in South Gloucestershire, the team manage all first contacts with the department whether by phone, email or letter including safeguarding concerns. |
| Institutional safeguarding team: | A small team which co-ordinates multi-agency concerns about institutions such as care homes and domiciliary care providers |
| Mental capacity | This refers to the formal definition of Mental capacity under the Mental Capacity Act 2005. |
| Occupational Therapist | South Gloucestershire employs Occupational therapists to assess people in the community and support them to remain at home through provision of equipment, adaptations and advice |
| Safeguarding Adults Board | Multi agency Board which oversees Adult Safeguarding, from 1st April 2015 these will be on a statutory basis. |
| Safeguarding alerts/alerts | |
| Self-funding | People are funding their own care without financial involvement from the Local Authority. As the placement is managed by the person/their family the Local authority will not have any involvement in reviews etc. |
| **AVON AND SOMERSET CONSTABULARY** | |
| ASSIST | A "data warehouse" search tool used with Avon and Somerset Constabulary that trawls all other Avon and Somerset systems for information on individuals in relation to road traffic collisions, liquor licensing, firearms, calls for service from the public and details of crimes reported to the Police. |
| BLUESTONE | Operation Bluestone was formed in September 2009 to tackle rape and sexual assault in the City of Bristol. This dedicated team secured dedicated resources to provide a comprehensive service to victims and provided an improved capability in identifying unknown suspects and locating further evidence. The team is now incorporated (since October 2014) into **PROTECT** (see below) and is responsible for all victim-based contact, offering each victim-tailored support and advice with the support of partner agents including the Bridge. |
| CAIT | Child abuse investigation teams – Prior to March 2012 this team solely collated and investigated child safeguarding cases. |
| CMU | Prior to the implementation of Guardian in 2007 domestic abuse incidents were recorded on a paper based CMU system which was then managed using electronic tracking software. |
| DAIT | Domestic abuse investigation team- Prior to March 2012 this team solely collated and investigated domestic violence incidents. |
| DASH | Implemented in 2009- Avon and Somerset Constabulary are currently using this national risk assessment model for cases of domestic abuse. This is a common model used by the police and partner agencies. DASH Is an acronym for Domestic Abuse Harassment and Stalking and includes honour based |

| | |
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| | violence and forced marriage. DASH was implemented throughout the Force by a rolling programme over a year between March 2010 and March 2011. Prior to this the risk assessment model was called SPECCS, an acronym for Separation, Pregnancy, Escalation, Child custody, Cultural issues, Stalking and Sexual Assault. It was conducted on a largely paper based system with additional tracking through electronic software. |
| GUARDIAN | This is a crime and intelligence management system and was implemented in 2007. All criminal offences and crime related incidents will be recorded here, including all domestic abuse cases regardless of whether a crime or verbal argument is reported. The system enables information relating to domestic abuse, child abuse and missing persons to be linked to a nominal record. Information which is not reporting a specific incident will be recorded as "intelligence" – this would include information obtained from a third party, via Crime Stoppers or shared by another agency. Risk assessments use the national DASH questionnaire and are collated in one section, remain dynamic and linked to the individuals involved. These are available at all times to all staff and ensure a complete history can be viewed in one place. |
| Information Received | Has been used in order to protect the source of the information. It would be possible to go into more detail in a personal interview with the overview author, in the presence of the police panel member, with an understanding about what can and cannot be disclosed to a wider group or the public. The disclosure of police intelligence has been considered at great length in the criminal courts. It is not solely about the case in hand and the risks to those specific sources but is also about maintaining the confidentiality around police intelligence gathering so that intelligence can be effectively obtained by the police in the future. |
| Intelligence Reports | Information is recorded as intelligence using the national standard for coding material. It ensures standardisation whilst protecting the source of the intelligence, and is a method to identify risks, and evaluate the source of the information, its provenance and the manner in which it is disseminated. Following this standard ensures that information held is for a policing purpose and in accordance with the law. Guardian is the Force system for recording all intelligence. It is assessed and entered on to Guardian by trained staff who check the report for accuracy and will sanitise reports if necessary to protect the source of the information as and when required. Police intelligence comes from a variety of sources. It can be from an "open" source which is available to a member of the public (e.g. material available on the internet); it can be from a closed source where there is no risk in identifying the source (e.g. minutes from a Child Protection Case Conference, or police officers attending at an address); or it can be from a sensitive source. Sensitive sources include information from people who talk to the police with an expectation of confidentiality, obtained by technical means, obtained from covert police activity or information obtained from other law enforcement or security agencies. |
| NSPIS | A record of every person arrested by Avon and Somerset Constabulary. This not only records the fact of their arrest but also records every aspect of their treatment and detention whilst in police custody. This is a legal requirement under the Police and Criminal Evidence Act 1984. |
| PNC (Police National Computer) | Contains information of convictions, remand history and court appearances of identified individuals. |

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| PND (Police National Database) | A national Police computer system which allows officers to establish, in seconds, whether any police force anywhere else in the country holds relevant information on someone they are investigating. Previously, this information would not have been visible outside the force holding the record and was implemented following the Soham enquiry. |
| PROTECT | Following a Force re-organisation in October 2014, the investigations department consists of multi-skilled investigation teams based in each of the three Policing Areas, whose focus is on the most vulnerable victims and the riskiest of offenders. Teams are equipped to carry out proactive and reactive investigations into all types of serious and complex crime. We also have the Investigation Policy, Strategy and Support Team which includes the Source Handling Unit, Covert Authorities Team and a Major Crime Review Team. Investigators on the Investigation Teams are made up of investigators with specialist skills around three investigative areas of Solve, Protect and Convict. Solve investigators have specialist skills around high risk and complex, both reactive (crime in action) and proactive (organised crime), investigations. Solve also includes the Economic Crime Team and Financial Investigators working within the three Policing Areas. Protect investigators have specialist skills in the investigation of incidents vulnerable victims such as Child abuse, Domestic Abuse and Rape. The Bluestone ethos is embedded within the Investigation Team, the SAIT role has been expanded and additional Investigators are being trained to perform the role force wide. Convict investigators have specialist skills in the investigation of offences linked to IMPACT offenders – those individuals who commit the most crime. Investigation teams are available for help and advice 24 hours a day seven days a week. |
| SAIT | Sexual abuse investigation teams - Prior to March 2012 this team solely collated and investigated sexual violence incidents. |
| WEBSTORM | The command and control system used by Avon and Somerset Constabulary to manage calls for service. Whenever a public contact requiring police action is received a 'log' is created at the first point of telephone contact with the Police and attendance is managed by control room staff based in Police Headquarters. If the call results in the police recording details of a criminal offence or a crime related incident the STORM log will be concluded with a Guardian reference number for the incident. |
| **AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP** | |
| AWP | Avon and Wiltshire Mental Health Partnership |
| CMHT | Community Mental Health Team |
| CPA | Care Programme Approach (framework to manage those with complex mental health difficulties) |
| **SOUTH GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP** | |
| CBT | Cognitive Behavioural Therapy |
| CCG | Clinical Commissioning Group |
| DNA | Did Not Attend |
| PCLS | Primary Care Liaison Service |

**Appendix B - Bibliography**

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## Appendix C Action Plan

| Recommendation | Scope of recommendation ie local/ regional/national | Action to take | Lead agency | Key milestones achieved in enacting recommendation | Target date | Date of completion and outcome |
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| **17.1.1**Care and nursing home providers should introduce a procedural policy that when a resident presses their assistance bell the responding member of staff should check their needs with them personally, rather than accepting the word of a visitor. Management teams should ensure that all staff are aware of this policy and that it is included in all staff induction and refresher training. | National and South Gloucestershire wide | Through dissemination of findings to local Contracting and Commissioning teams and through CQC provider bulletin | South Gloucestershire Safeguarding Adults Board and CQC | One off action to inform providers of Care Homes and Nursing Homes through National CQC provider Bulletin | 1st September 2015 | 7th April 2015 |

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| 17.1.2. That the Department of Health be notified about the circumstances of this case so that:<br><br>• Consideration can be given to the need for further research to find the causes and effective treatments for schizophrenia; had a test been available to make the diagnosis at an earlier presentation, some intervention might have been possible.<br><br>• That there be a public awareness campaign to de-stigmatise mental health and to provide the general public with information | National | To provide an update to the Department of Health to update them on the circumstances of the review and national recommendations developed. | South Gloucestershire Clinical Commissioning Group | | 30th June 2015 | |

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| which may enable them to identify the early signs of schizophrenia. | | | | | | |
| 17.3.1. The group will introduce a policy that when a resident presses their assistance bell the responding member of staff will check with them personally other than accepting the word of a visitor. This will be included in all staff training. | In all of the company's care and nursing homes | New Company policy. Communication to all staff. Training organised. | Health Care Company | 1. Policy written and agreed by Managers.<br>2. All current employees notified.<br>3. Induction and refresher training organised and delivered. | 1st June 2015 | 7th April 2015 |
| 17.3.2. The home has changed their protocols so that all visitors have to ring the bell and sign the visitor's book, which now includes their relationship with the resident they are visiting. This will be kept under review. | | | Health Care Company | | | |

## Appendix D. Contact with the family.

On 25th November 2014 the DHR Chair met with Molly's nephew (next of kin). He provided the pseudonym and a written authorisation for the DHR to access Molly's medical records and confidential papers. He also provided the DHR with his written notes regarding Molly. He was provided with details of the support he can obtain from Advocacy After Fatal Domestic Abuse (AAFDA) and provided with their leaflet. He said he was unlikely to take the opportunity as he lives in Ireland has been receiving excellent support from Victims Support Homicide Service and particularly from the Police Liaison officer.

On 8th February 2015 Molly's nephew telephoned the Review Chair concerned that he had heard that Edward was being released from the hospital order. The Chair reassured him that that was unlikely to occur in view of the sentence of the Crown Court. He asked if he could be given a full copy of the Review's Report in due course.

Contact was initially made with Edward's mother, who is also Molly's step daughter, initially through the Homicide Case Worker, Victim Support. She provided the pseudonym "Edward".

On 26th January 2015 the DHR Chair spoke to Edward's mother and after he explained the purpose and process of the Review she agreed to give the DHR written authority to access Edward's medical records.

On 3rd March 2015 the DHR Chair contacted Molly's nephew and Edward's mother and informed them about the Review's findings. He offered to provide a copy of the draft Overview Report for them to read. Edward's mother declined the offer saying her concerns are about what happened after Molly's death and how her son was treated in prison. The Chair explained the remit of the Domestic Homicide Review and told her how she could make a complaint against the prison if she was unhappy with what had happened. (Whilst on remand in the prison, Edward had attacked another prisoner who is now on a life support system). His mother believes he should have been remanded to a secure hospital unit rather that in prison.

Molly's nephew said he would want to read the report and arrangements were made for him and one of Molly's step-daughters to do so on 6th April. Molly's nephew asked the DHR Chair to pass on to the CQC a paper written by him in which he sets out concerns about the care home which were not relevant to Molly's death.

Edward's mother declined an invitation to attend the final DHR meeting on 7th April 2015. The invitation was accepted by Molly's nephew.

## Appendix F – Letter from Home Office Quality Assurance Panel

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2 Marsham Street
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- **T: 020 7035 4848**
- **www.homeoffice.gov.uk**

Philippa Isbell
Anti-Social Behaviour and Community Safety Team Leader
Department for Environment and Community Services
South Gloucestershire Council
PO Box 299, Civic Centre
High Street
Kingswood
BS15 0DR

9th June 2015

Dear Ms Isbell

Thank you for submitting the Domestic Homicide Review overview report for South Gloucestershire to the Home Office Quality Assurance (QA) Panel. The overview report was considered at the Quality Assurance Panel meeting on 19 May 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. This was a very clear and well-structured report which, subject to the feedback detailed below being incorporated, the Panel judges to be adequate.

There were some aspects of the report which the Panel felt could be revised, which you may wish to consider incorporating before you publish the final report:

- Please ensure that the report is fully anonymised before publication; in particular, the name of the care home should be anonymised;
- The report should clarify the independence of the chair of the Domestic Homicide Review;
- You should review whether the mental health history of the perpetrator is adequately captured in the report and whether that history was adequately shared;
- The Panel queried whether there should be recommendations contained in the report that mental health agencies should take account of.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely

**Christian Papaleontiou**
Chair of DHR Panel

The South Gloucestershire DHR Panel and Independent Chair have reviewed the feedback provided by the Home Office and note the following in response:

- The report will be redacted prior to publication and therefore any identifying factors will be removed, including that of the care home.
- The independent chair of the DHR review in to Molly has clearly stated in the body of the report the independence of the role. This has been followed up with the Home Office.
- Avon and Wiltshire Partnership NHS Trust (AWP) were contacted regarding the feedback in relation to mental health input and recommendations and provided the following statement:

'AWP has considered the Home Office QA panel request to review the report with regards to proposing recommendations for Mental Health agencies to take account of.

We have re-examined the relevant medical records and taking into account the documented evidence regarding clinical interventions undertaken and the continual perseverance of clinical staff in trying to engage Edward, AWP remain of the opinion that there are no recommendations for Mental Health Agencies'.