St. Helens Council

St. Helens Community Safety Partnership.

DOMESTIC HOMICIDE REVIEW

Under Section 9 of Domestic Violence Crime and Victims Act 2004.

OVERVIEW REPORT

In respect of the death of a woman in December 2014.

A report by Michael Murray,

Independent Chair and Author.

August 2015.

Glossary.

5BP	5 Boroughs Partnership (NHS Foundation Trust)
CCG	Clinical Commissioning Group.
CSP	Community Safety Partnership.
DHR	Domestic Homicide Review.
GP	General Practitioner.
IMR	Individual Management Report.
NICE	National Institute for Health & Care Excellence.
SIO	Senior Investigating Officer.
SSRI	Selective serotonin reuptake inhibitor. (Anti-depressant)
TOR	Terms of Reference.

Case References:

Female 1	Victim of homicide, wife of Male 1.
Male 1	Husband of Female 1 and alleged perpetrator.

CONTENTS.

1.0 Chronology of events.

02/12/2014	-	Event occurred.
06/12/2014	-	CSP notified of Domestic Homicide.
18/12/2014	-	CSP Screening meeting, determined need for DHR.
02/01/2015	-	Home Office informed of DHR.
19/01/2015	-	DHR Chair appointed.
16/02/2015	-	1st DHR Panel meeting held.
18/05/2015	-	2nd DHR Panel meeting held.
09/06/2015	-	Chair meets with mental health experts. (St Helens Mind/5 BP)
07/07/2015	-	Panel meeting held with mental health experts. (St Helens Mind/5 BP)
20/07/2015	-	3rd (final) DHR Panel meeting held.

2.0 Introduction.

2.1 The victim in this case is a woman who was aged 79 years old at the time of her death in December 2014. Throughout this report the victim will be referred to as Female 1. The alleged perpetrator in the case was the victim's husband. He was aged 78 years old when he also died on the same day in December 2014. Throughout this report he will be referred to as Male 1.

2.2 The events relating to the deaths of Female 1 and Male 1 unfolded during the morning of 2nd December 2014. The daughter in law of Female 1 attended the home address of Female 1, as pre-arranged, to take her to the doctors where she had an appointment. The daughter in law discovered the body of Female 1 at the address and raised the alarm. Male 1 was missing from the address. A note in the handwriting of Male 1 was found at the home, apologising for his actions. A short time later the body of Male 1 was found by police, in a nearby local dam.

2.3 A Home Office pathologist concluded that Female 1 had died as a result of strangulation and that Male 1 had died as a result of drowning. The police investigation concluded that Male 1 had caused the death of his wife and subsequently took his own life. A report of the investigation has been sent to HM Coroner. Inquests have not yet taken place.

2.4 The St Helens CSP was informed of the death of Female 1 on 6th December 2014. Having reviewed the circumstances of the case the Partnership held a multi-agency screening meeting on 18th December 2014 and agreed that the case met the criteria making it necessary to conduct a Domestic Homicide Review (DHR), in accordance with the Multi-Agency Guidance for the conduct of Domestic Homicide Reviews (01/08/2013). On 2nd January 2015, the Home Office was notified. All partners were requested to collate and secure information held in respect of any engagement or contact with Male 1 and Female 1.

2.5 On 19th January 2015, a Chair was appointed to draw together a multi-agency review panel to conduct the DHR.

3.0 Purpose, Scope and Terms of Reference.

3.1 The purpose of this DHR is as stated in the 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews', as follows:

3.2 *a) 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.*

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

c) To apply these lessons to service responses including changes to policies and procedures as appropriate.

d) To 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.

3.3 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. Also DHRs are not specifically part of any disciplinary inquiry or process.

3.5 It was determined that the DHR would take cognisance of the generic Terms of Reference within the Multi-Agency Guidance for the conduct of Domestic Homicide Reviews (2013), as listed on pages 26 and 27 of that document. The generic Terms of Reference are as follows:

a) *Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?*

b) Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

c) Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

f) When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

g) Was anything known about the perpetrator? For example, were they being managed under MAPPA?

h) Had the victim disclosed to anyone and if so, was the response appropriate?

i) Was this information recorded and shared, where appropriate?

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

k) Were senior managers or other agencies and professionals involved at the appropriate points?

l) Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

m) Are there ways of working effectively that could be passed on to other organisations or individuals?

n) Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

o) How accessible were the services for the victim and perpetrator?

p) To what degree could the homicide have been accurately predicted and prevented?

3.6 Moreover, the Chair and Panel members agreed also to focus on the following specific Terms of Reference, having regard to the information available within this DHR:

a) Reviewing all aspects of medical care/treatment in respect of victim and perpetrator especially in relation to mental welfare.

b) If there was low level of contact with services, why was this so? Were there barriers to either the victim or perpetrator accessing/engaging with services and seeking support? Was their vulnerability a factor in accessing services? How accessible/available were relevant services in the locality of the victim and perpetrator?

c) Could there have been any better recognition of vulnerability, of victim or perpetrator? Could/should this have triggered intervention/support? Were benefits/support applied for? Were there any opportunities to consider any overall Safeguarding issues in relation to the victim and/or perpetrator?

d) Were the formal contacts with agencies appropriately managed and appropriately risk assessed particularly in view of the outcome of this case?

e) Were there any concerns amongst family/friends/neighbours or within the community and if so how could such concerns have been harnessed to intervention and support? How will the review engage and be sensitive to needs of family/friends/neighbours to allow them to contribute to the review. Also consider media strategy as appropriate.

f) Review panel must bear in mind equality and diversity issues at all times. Age, disability, marriage/partnership, race, religion and sexual orientation may all have bearing on the conduct and outcome of the review.

The starting point for the Review should be based on Professional Judgement in relation to the relevant information held by agencies concerned.

4.0 Process.

4.1 Once notified of the events, the St Helens CSP promptly determined that the criteria to instigate a DHR had been met and the Home Office were duly notified. Agencies were requested to retain information relating to the subjects of the review. A Chair to the DHR was appointed. All actions taken were in accordance with the Multi-Agency Guidance for the conduct of Domestic Homicide Reviews (01/08/2013).

4.2 A DHR panel was established to manage the review process, to obtain all relevant information and to consider and review critically IMRs. The panel was chaired by an Independent Chair/Author and panel members were invited from agencies across the partnership. It was a conscious decision that the panel membership should not just be made up from those agencies that had had contact with the subjects of the review, but in addition those with expertise within the relevant issues identified, should be invited to sit on the panel.

4.3 At the first panel meeting a Terms of Reference and Scope of review were considered and agreed by the panel. Initial information indicated that there had only been involvement with either Female 1 or Male 1 by health services (and with police on the date of the event). IMRs were requested of those agencies that did hold information on those individuals subject of the review.

4.4 The IMRs included appropriate chronologies and authors (or their representatives) presented IMRs at panel meetings. Any conflicting information and/or need for clarification of issues presented were resolved by discussion and/or further written communication. The review panel met on four occasions (although one meeting was a sub panel meeting with experts in the field of mental health).

4.5 Timeliness of the Review.

The decision to proceed with the review was taken on 18th December 2014. Therefore, the target date for the completion of the overview report was 18th June 2015. The overview report was in fact concluded at the beginning of August 2015. The Chair and Review Panel did agree an extension to the timescales with the CSP. This was based on two reasons. Firstly, as the main contact with the subjects of the review were health services, it was decided by the local Health Authority to appoint an independent consultant to conduct their internal review. The process to appoint a suitable individual took approximately six weeks, during which time the DHR could not advance. Secondly, it became apparent thereafter that the issue of mental health was more complex and a more long standing issue than was previously reported to the Panel. The Chair decided that it was necessary to seek expert opinion and advice in relation to this issue, to ensure a thoroughness and fairness to the review. The engagement of experts further delayed the process.

5.0 Domestic Homicide Review Panel.

5.1 Independent Chair and Author: Michael Murray.

The Chair and Author of the overview report is a retired police officer who is independent of all agencies and individuals connected to this case. During his police career he was primarily involved in detective duties and performed the role of Senior Investigating Officer on many occasions, specialising in serious crimes committed within families, including a number of Domestic Homicides. During the last years of service he was in charge of a large Family Crime Investigation Unit, specialising in Child Protection, Domestic Abuse, and the protection of Vulnerable Adults. He was

involved in a number of Serious Case Reviews and other Multi Agency reviews. On retirement he received a national award in relation to a lifetime achievement in policing, recognising his contribution to work and expertise within family based crime. After retirement he worked as a manager at Women's Aid, and as a strategic consultant to his Local Authority advising on service delivery to victims of domestic abuse. He has received national and local training in relation to the management of DHRs, and is currently involved in a number of DHRs. Michael Murray is not employed by any of the agencies of the St Helens Community Safety Partnership or the Adult Safeguarding Board.

5.2 Panel Members:

- Community Safety Manager, St Helens CSP.
- Detective Inspector, Merseyside Police, Public Protection Unit.
- Solicitor, St Helens Council, Legal Dept.
- Designated Nurse, Safeguarding Adults, St Helens CCG.
- Manager, Chrysalis Centre for Change.
- Director, Helena Partnerships (Inc. IDVA).
- Manager, Age UK Mid Mersey.
- St Helens Council Domestic Violence Coordinator.

6.0 Individual Management Reviews.

6.1 Based on information received by the review panel, IMRs were requested and duly received from the following agencies who had some involvement with Male 1 and Female 1.

a) Merseyside Police.

b) Primary Care Services, General Practice.

c) 5 Borough Partnership NHS Foundation Trust.

6.2 No Agency Involvement.

A number of agencies across the St Helens Borough reported to the Panel that they had had no involvement with either Female 1 nor Male 1. These included St Helens Council Adult Social Care and Health Services, Victim Support Services, Domestic Violence services, Merseyside Fire Service, St Helens Council Safer Communities Department, Substance Abuse groups (Addaction), Housing Services and Probation services.

6.3 Production of Individual Management Reviews.

Once requested, the IMRs were completed and produced in a timely fashion. Three agencies produced IMRs by reviewing computer and paper records within their organisations and by speaking with staff members to gain a contextual insight of decisions made, including an understanding of both what did happen and what did not happen.

6.4 The panel considered each IMR diligently, scrutinising and quality assuring the IMRs. Much deliberation centred around health provision, particularly that provided to both Female 1 and Male 1 by General Practitioner services. The scrutiny of the IMRs by the panel was robust and challenging. Detailed feedback was given to authors of the IMRs at first submission and as a consequence amended and final IMR documents were subsequently provided to meet the requirements of panel members.

6.5 IMRs were provided as follows:

Agency	Date of initial IMR	Date of Amended and Final IMR
Merseyside Police	3rd May 2015	N/A
Primary Care Services (GPs)	15th May 2015	13th July 2015
5 BP	18th May 2015	1st July 2015

7.0 Background and Relationships.

7.1 Female 1 and Male 1 had been married for 56 years. They had three adult sons, who had all moved on from the family home and lived independent lives. The couple had five grandchildren. The sons did all live in the locality, and were in regular contact with their parents. The couple had lived at their present address for approximately 22 years. The Chair of the review has met with the family on a number of occasions, and they have contributed to the review. (see Section 12.)

7.2 Male 1 worked as a coal miner during his adult life, and retired in the mid-1980s. He is described as a proud and independent individual. He liked to follow his local rugby team and would regularly socialise with his wife at the local church social club.

7.3 Male 1 was described as a regular visitor to his local GP. It was said that he was not afraid to present his views to his GP and believed 'there was a pill for any

ailment'. Male 1 often complained of sore throats and in particular of dryness and an inability to produce saliva, which caused some discomfort, and difficulty eating.

7.4 Male 1 had a long term health issues described by him as 'pains in his head'. The family described this going back over 15 years. The family understood that their father was in the past offered psychiatric help, but this was declined.

7.5 Female 1 is described as a housewife and mother, devoted to bring up her family. She liked to socialise with her husband at the local church social club, playing bingo and dominos. Female 1 was said to be good lively company.

7.6 The family however did notice a change in the personality of their mother in recent years. They did not consider any significance to this and felt that it was just a case of 'growing old'. They did notice some aspects of their mother's behaviour as strange, noticing some obsessive and compulsive features. For example timeliness became an issue. If family were taking their mother to the shops and arrangements had been made to leave at 11am, she refused to leave at 10.59am or at 11.01am; it had to be precisely at 11am. Similarly, if family visited for an hour, Female 1 would time the hour precisely and the visit would then have to end. (After the event in December 2014, the family were surprised to discover up to six clocks in each room of the home.)

7.7 The family were aware that their mother was receiving vitamin injections (B12) and understood her to be taking anti-depressant tablets. She did visit her GP as required, but not as regularly as her husband. Male 1 always accompanied his wife to the doctors, but this was because he always drove her there. The family were aware that Female 1 believed that she suffered side effects from the anti-depressant medication (weight gain, hair loss) and as a consequence stopped taking the medication.

7.8 Overall the couple were described as a loving couple with a strong relationship who over many years had been there for each other. They were

described as an independent couple, who loved to see family, and celebrate family occasions, but did not particularly welcome family interference. The couple understood that if there was a problem they simply had to lift up the phone. They enjoyed their retirement and valued their independence.

7.9 In terms of the purpose of this review the family never saw any evidence of domestic abuse from either party, and do not believe it to have been anything other than a normal loving partnership, prior to the tragic events that unfolded in December 2014.

7.10 In November 2014 Male 1 decided to give up his driving. His insurance renewal was due, but he decided he did not wish to renew. Additionally, he was worried about his eyesight in relation to driving. He was relaxed about giving up driving, and did not consider this to be a major issue. However, the family do know that Female 1 did not share this view, and the decision to give up the car caused her great concern. She worried about shopping, her visits to the social club, and the lack of mobility as having a significant impact on her independence.

8.0 Significant Events and Facts.

8.1 This section of the report will detail and seek to draw together information considered significant by the review panel. The information (and evidence) is drawn primarily from the IMRs (and attendant chronologies), from the police investigation and from involvement with the family of Female 1 and Male 1. (The information and evidence will be analysed in section 9.)

8.2 The panel acknowledge that in terms of agency involvement the main source of information is from health services, and in particular from the visits by the couple to their GPs. It should be noted that the couple were not registered with the same GP practice and therefore did not visit the same GP practice. For clarity is shall be noted that Female 1 attended GP practice 1. Male 1 attended GP practice 2.

8.3 GP Practice 1 (Female 1) is a general medical primary care facility open from 8am to 6.30pm offering a wide range of appointments with access to GPs, Practice Nurses and support staff. The practice is described as compliant with local safeguarding procedures, and staff have undertaken training particularly regarding domestic abuse policies and procedures.

8.4 Female 1 is described as an infrequent visitor to the practice and records were examined from 2002. Most visits were routine in nature. The following extracts from records were considered to have some significance by the panel.

2002 – (Female 1) A diagnosis of anxiety and depression was made. She was also diagnosed with Hypertension. Female 1 received medication for a three year period in relation to the treatment of both these conditions.

2009 – (Female 1) Presented to GP practice 1 together with Male 1, expressed concern over memory loss, agitation, poor sleep and forgetfulness. (Male 1 noted as having to do more in a supporting role). Following routine blood tests pernicious anaemia diagnosed, and a course of B12 injections prescribed to address the vitamin deficiency.

January 2010 – (Female 1) Presented to GP practice 1 together with Male 1, still concerned regarding anxiety, repetitive actions, 'always on the go'. Male 1 described as very patient within with GP practice 1 notes. GP practice 1 made a referral to a specialist psychiatrist (mental health in elderly persons) at 5 BP for assessment of her mental health.

February 2010 – (Female1). A home visit was carried out by 5 BP mental health practitioners when an initial assessment of needs of Female 1 and a risk assessment of needs of Male 1 as a carer for his wife was conducted. Male 1 disclosed his own issues in relation to mental health and medication. Following the assessment day services were offered, which the couple declined. It was concluded

that Male 1 did not require a full and separate carer's assessment as he did not identify any needs. The case was closed to the community team.

October 2010 to December 2011 – (Female 1). 5BP. Female 1 was seen on 5 occasions under the care of 5BP by the same Consultant Psychiatrist. Female 1 was diagnosed with depression and commenced anti-depressant medication (Sertraline 50 mg to be increased to 100mg as required). Male 1 was in company of Female 1 for each consultation.

March 2011 – (Female 1) Presented to GP in company of husband.
Male 1 concerned regarding lack of improvement in wife's condition, depression and compulsive behaviour, unable to cook, spends all time with husband. On advice of Consultant Psychiatrist Sertraline increased to 150mg.

December 2011 – (Female 1) 5BP, couple attended to see Consultant Psychiatrist, reported positive outcomes and Female 1 was discharged back to care of GP practice 1.

June 2012 – (Female 1) Presented to GP practice 1, with husband. Memory loss symptoms. Female 1 had stopped taking the sertraline due to experiencing hair loss, which she attributed to being the side effects of the medication.

2012 – 2014 (Female 1) Periodic visits to GP practice 1 for vitamin B12 injections.

8.5 GP Practice 2 (Male 1) is similarly described as a general medical primary care facility offering a wide range of appointments with access to GPs, Practice Nurses and support staff. The practice is described as compliant with local

safeguarding procedures, and staff have undertaken training particularly regarding domestic abuse policies and procedures.

8.6 Male 1 is described as a regular patient to the practice for the management and review of both his physical and mental health conditions. The practice state that they had a good relationship with Male 1. The following extracts from records were considered to have some significance by the panel.

1990 – (Male 1) Diagnosed with a chronic anxiety depression disorder.

1994 – (Male 1) referred to Consultant Psychiatrist and was admitted, informally, to hospital for 8 days. The diagnosis was recorded as follows:

- No psychiatric diagnosis
- "Masked Depression" – this is often a description of somatic manifestation of depression and can include symptoms of physical pain such as headaches.
- Somatoform Disorder. (This is a psychological disorder whereby physical symptoms are experienced by the patient but these symptoms are inconsistent with and unexplained by any underlying medical or neurological condition.

(It is clear from correspondence in June 1994 that despite this diagnosis Male 1 was very clear that he did not wish to receive any psychiatric treatment and was therefore discharged back to the care of his GP.)

2002 – (Male 1) Presented to GP practice 2 reporting state of anxiety, dry mouth, tinnitus.

2007 – 2008 – (Male 1) Presented to GP practice 2 on number of occasions, records show generalised anxiety disorder. Various dosages of anti-depressant/anxiety drugs commenced and stopped at request of Male 1.

2008 - (Male 1) Following a referral from GP practice 2 consultation by a Consultant Neurologist concerning daily headaches, who recommended topirimate. The dose was increased by GP practice 2 in line with the Consultant neurologist's recommendations.

July 2008 to November 2008 – (Male 1) Prescribed anti-depressant drug dothiepin (brand name dosulepin) in relation to depression and tension headaches. Initially 50mg (at night) increased to 150mg (at night). Patient reported positive outcome.

(It is noted that thereafter that dothiepin (brand name dosulepin) 150mg was a regular repeat prescription up to Male 1s death in December 2014.)

July 2012 – (Male 1) Presented to GP practice 2 with 'low mood'. He described himself as carer for his wife. He was prescribed anti-depressant Sertraline. This appears to have been prescribed only for one month.

8.7 Police Investigation.

Emergency services attended the home address of Female 1 when she was discovered in her bedroom, unresponsive, by her daughter in law. The daughter in law had attended the address to take Female 1 to a pre booked routine visit to the GP.

Paramedics who had attended confirmed that Female 1 was deceased. The daughter in law also contacted her husband, a son of the deceased. He attended and found a note in the kitchen which he confirmed was written in his father's handwriting.

This note read as follows:

"(Female1) was running round the bedroom and I could not stop it's my fault about the B12 I did what I thought best I am soo sorry for everything for us both I did (followed by the names of the three sons)."

The note appeared to be an apology for the death of his wife, and raised immediate concerns for the welfare of Male 1. Later in the day the body of Male 1 was discovered in a local dam. Subsequent post mortems revealed that Female 1 had died as a result of strangulation/suffocation, and Male 1 had died as a result of drowning.

9.0 Analysis of the events and information, and commentary.

9.1 The panel recognise that there is no prior evidence of domestic abuse within the relationship between Male 1 and Female 1. On the contrary there is ample evidence of a long term loving relationship. Family, doctors, professionals and others who came into contact with the couple provide evidence of this and the normality of a couple who had spent a lifetime together, and were so close to each other. The panel recognise the care shown by Male 1 towards his wife, and it is in this context that he regularly accompanied his wife to medical appointments. Doctors and other professionals did not regard this as sinister, and neither do the panel.

9.2 It has to be acknowledged however, that the tragic events that unfolded on 2nd December 2014 were the ultimate act of domestic violence and it is the duty of this panel to examine all aspects of contact with the couple prior to the event to ask the question whether in any way the events could have been predicted and/or prevented.

9.3 IMRs – analysis.

- Police.

  The police had no prior dealings with this couple. In the strictest sense the completion of an IMR was not necessary, but for the sake of completeness

the panel requested an IMR which was duly completed. The report documents the police response to the event. As events unfolded the response by police was immediately led by a senior officer, and all aspects of the police actions and subsequent investigation were appropriate and in accordance set procedures.

Subsequent blood analysis in relation to Female 1 and Male 1 showed the presence of drugs prescribed to them, and in appropriate volumes.

The note left by Male 1 suggests some kind of dispute took place concerning the B12 injections, and he blames himself. He apologises for his actions.

Male 1 appears to have suffered a sudden and catastrophic breakdown, and subsequently takes his own life. The police have concluded that no one else was connected to the deaths, and a report is being forwarded to HM Coroner for Inquests to be conducted into the deaths. No recommendations are made by the author of the police IMR, and the panel concurs with the report.

- Health.

  Two IMRs were completed, one in relation to health services provided by the 2 registered GP's and another from 5 BP. Although two separate IMRs were submitted to the panel, they are inextricably linked and are analysed alongside each other. The reports were considered by the panel at their 2nd Panel Meeting on 2nd May 2015. Neither report made any recommendations at this stage. The panel felt that the IMRs lacked some details in various aspects, and following the meeting the Chair on behalf of the panel wrote to authors requesting more detail and clarification.

  Concerns of the panel centred around the following aspects of the review:

  - The role of Male 1 as a carer for his wife, and agency response to this.
  - The effects of the anti-depressant routinely administered, the considerations of dosages and the consideration of the interaction with other drugs.

- Clarification regarding a perceived lack of detail shown in GP records regarding judgements around benefits and risks of treatment.
- Consideration of any non-drug related therapies.
- Alternative considerations when patients stop taking medication.

In addition the Chair and the panel felt that it was prudent to try to enlist some specialist assistance to the DHR, in relation to what was now being disclosed as long term mental health issues. The Chair met with a local mental health charity who agreed to provide expert assistance to the review. A Consultant Clinical Psychologist and a Consultant Psychiatrist provided an overview to this case. (St Helens Mind and 5 BP).

Amended IMR's were received by the panel for consideration at the final panel meeting on 20th July 2015.

9.4 It was clear to the panel that Male 1, despite his own mental health issues and medical problems had assumed essentially a role as carer for his wife. It is noted that he described himself as such to his own GP (Practice two) during a visit on 19th July 2012. (This is noted in GP records. He attended due to 'low mood' and was prescribed sertraline). The panel feel that given the history of Male 1, this could have been an opportunity to set in motion a process to properly assess the capability of Male 1 as a carer, and an appropriate risk assessment.

9.5 Additionally, although Male 1 was not registered at the same practice as his wife (Practice 2), he was indeed a regular visitor with his wife during consultations and appointments. This is noted within the practice records with reference to 'husbands supporting role' and later what seems an acknowledgement of Female 1s increasing dependency on her husband. The panel again ask if there was opportunity to recognise Male 1 as a carer and to make a referral for assessment/assistance.

9.6 The panel make reference to best practice highlighted within NICE Guidance CG90 (Assessment and Treatment of depression in adults in primary care, published in 2009). The events in para 9.3 and 9.4 may have been more appropriately dealt with under the provision of supporting families and carers.

9.7 The issue of the role of Male 1 as a carer was considered following the referral to the 5BP in relation to his wife's mental health. The IMR makes reference to a home visit 'to complete a full assessment of need including a risk assessment and an assessment of (Male 1s) needs as a carer. (23/02/2010) The couple were offered 'day services' and social support. The couple declined the support as they preferred to 'do things together'. Male 1 also disclosed to the assessors that he was also taking anti-depressants. However, it was decided that he did not require a full separate carer's assessment as he 'did not identify any needs'.

9.8 The panel again feel there was some opportunity to further engage with the couple on the occasion of the home visit and assessment. The panel fully accept the difficulties on hard pressed services, especially when offers of assistance are declined. Indeed, family members have stated how Male 1 was a firm believer in 'the solution being in the form of a pill', and would entirely understand him declining day service support or indeed low intensity psychosocial interventions. However, the panel believe there are some indicators that Male 1 was reluctant to engage with services because some stigma attached to his illness, which is common in that age group. The panel are not convinced there is any recognition of this, or strategies to overcome the stigma. It is significant even as long ago as 1990 that Male 1 made it very clear that he did not wish to receive any form of psychiatric treatment. He was a proud man who the panel suspect saw the suggestion of depressive illness as a weakness. There is further evidence of this stance with his terminology over the years with medical professionals (and indeed family). He always referred to his issue primarily as 'headaches', or 'not coping' (avoiding 'depression') and seems too proud to acknowledge his need for help and support.

9.9 Whilst 5BP determined that Male 1 did not identify (to them) any needs, the panel believe that this occasion may have been an opportunity to trigger a multi-agency response to the situation. Signposting the couple to 3rd sector agencies does not appear to have been considered, and the panel feel that some more encouragement, perhaps with some support with family members, may have enabled the couple to consider accessing some of the practicable support available to the elderly across this borough. Age UK Mid Mersey, who are active in the locality (Lifestyle Activities, Helping Hands, Trust Matters Counselling Service) are surprised that such a joined up approach was not adopted and believe they could have offered this couple some very practical support and would have been happy to have engaged with the couple beyond simple practical support. However, the panel readily acknowledge the complexities and sensitivities of the situation. There are privacy concerns and indeed any suggestion of going against the wishes of the couple could have antagonised the situation. However, the panel feel that on balance, in cases where the carer has disclosed mental health issues, it may have been appropriate to have involved close family members of the couple to give advice concerning accessing 3rd sector support, such as Age UK.

9.10 The panel accept that the mental health issues of Male 1 were long standing and 'non drug' options would not have been appropriate. However, in relation to Female 1 there is no evidence to suggest whether or not this was considered alongside medication. In any event Female 1, in July 2010, was prescribed Sertraline (initially 50mg, subsequently increased to 150mg). Sertraline is an anti-depressant drug of the SSRI group. Female 1 took this drug until mid-2012 (with positive outcomes in both mood and compulsive behaviour). However, she appears to have decided to stop taking the drug due to variation in weight and hair loss, which she attributed as side effects of the anti-depressant medication.

She attended her GP practice 1 on 6th June 2012, accompanied as usual by her husband, with a reoccurrence of symptoms of memory loss and obsessive behaviours. She informed the GP that she had stopped taking the Sertraline. The panel were surprised that there is no documented concern regarding the cessation

of the drugs, or any documented discussion regarding possible alternatives, or advice given.

9.11 It would appear thereafter that Female 1 lived with her depression and there is evidence that her compulsive behaviour got worse during 2014. It is a logical assumption that during this time her behaviours may have become more difficult to manage and live with.

9.12 Male 1 was first prescribed the Dosulepin (this is the brand name of the drug Dothiepin, a tricyclic anti-depressant) in July 2008 and this was on a repeat prescription up until the date of his death. His initial prescription was for 50mg although this increased by the end of 2008 to 150mg, and that dosage appears to have remained constant until his death. The drug appeared to have had a positive outcome for Male 1 in that it stabilised his illness (as evidenced in medical notes).

9.13 All anti-depressant drugs carry some levels of risks in terms of side effects and/or interaction with other medication/substances. Whilst there are some serious but rare side effects attributed to dothiepin, (including suicidal and violent feelings) expert opinion (St Helens Mind) says that such side effects would only present themselves when commencing a course of treatment or when there are significant changes in dosage. Such side effects would not present themselves in cases such as this where an individual had been taking the drug over a considerable period and in a stable manner. Moreover, any such rare side effects would have been precipitated with psychotic symptoms and behaviour; there is no evidence of this in Male 1. There is no history of risk being presented. Any such signs would have developed and have been seen by those in contact with him.

9.14 It should be noted however that for medical reasons the following recommendations are in place in relation to dothiepin:

- when prescribing anti-depressants for older people and age appropriate doses should be prescribed. In the elderly it is recommended that dosage should not exceed 75mg daily.
- It is not recommended that dothiepin is prescribed in conjunction with tramadol
- Dothiepin and SSRI's should not be prescribed concurrently due to the risk of serotonin syndrome. (They appear to have been prescribed together once in 2012.)

The panel accept that the issues in this paragraph had no bearing on the outcome of this matter. However, they feel it appropriate to feed this information back to GP practice 2 as learning points. Note: in line with NICE guidance CG90 (Assessment and Treatment of Depression in Adults in Primary Care, 2009).

9.15 Within this review the panel has been supplied with copies of notes made in relation attendance by both parties to their GPs. The panel overall considered that notes made by both GP practices were lacking in detail. A simple example of this would be the comment on many occasions within the notes, 'Review of Medication', with no further comment. The panel felt this unhelpful without further comment relating to outcome of the medication reviews. Further examples were noted when patients attended, discussions are documented but there is no clear outcomes documented. It is only by reading notes of a subsequent appointment that may then say 'prescription increased…..' that it can be ascertained that the drug was actually administered at the previous visit. Finally, there is no evidence within the notes containing documented discussions concerning the risk versus benefit of taking particular drugs, increasing dosages, or indeed stopping drugs. The panel felt that the GP practices could learn from these points.

9.16 The panel accept that over many years both Female 1 and Male 1 had good access to primary care (GP services). The panel accepts that outcomes for the couple were generally appropriate and the care provided was of a high standard. It is also noted by the panel that in the 12 months prior to their deaths both GP practices had very limited contact with their respective patients.

10.0 Criminal Investigation, and Inquest.

10.1 The Chair of the DHR met with the SIO and the processes have run parallel, sharing information as appropriate. The Chair has also maintained contact with the Coroner's Office. Inquests are yet to be held.

11.0 Good Practice & Equality, Diversity.

11.1 No examples of good practice over and above expected service levels were identified during this review.

11.2 Section 149 of the Equality Act 2010 introduced a public sector duty to consider issues of discrimination and equal opportunity. The panel felt all issues in relation to age and mental health of the individuals were appropriately handled in relation to discrimination and/or equal opportunity.

12.0 Family.

12.1 The family of the couple in this case have had regular meetings with the Chair, and have provided valuable information during the review. A copy of the overview report has been read by family members (three sons) at a meeting with the Chair. The family expressed their agreement with the content of the DHR and the findings. The family specifically felt that their comments and views at previous meetings had been summarised appropriately.

13.0 Conclusions.

13.1 The panel are confident that prior to the events in December 2014 there is no evidence or history of domestic abuse within the relationship. The couple were a loving couple with a supportive family. The couple were however proud of their own independence, liked to be involved in social activities together, and did not feel the need to rely on anyone else despite their advanced years.

13.2 It is clear to the panel that Male 1 suffered long term mental health problems which were generally stabilised with the use of anti-depressant drugs. In later years Female 1 was also diagnosed with depression and there is evidence of an increase in her obsessive and compulsive behaviour.

13.3 It is not unusual for elderly people to feel some degree of stigma in relation to mental illness, and this together with their own pride may have led them to 'play down' their issues, and make it more difficult to ask for or indeed to accept help and support.

13.4 The panel feel that in recent years Male 1 had taken on the role of carer for his wife, and it is likely that this role became more difficult during the last couple of years. Male 1 was not the type of person to seek outside help and considering his own medical issues was likely to have been living under increasing strain.

13.5 The panel feel that the decision to give up the car in November 2014 is significant. It is clear that Female 1 was very concerned about this. At the time she was clearly suffering anxiety, was more obsessive, and was now faced with the fear of increasing isolation.

13.6 It is not possible to accurately state what occurred directly leading to the events on the morning of 2nd December 2014. There had been no warning, or changes in behaviour displayed, even to those closest to the couple who had been in contact with them in the days prior to the event. The panel are of the opinion that

the deaths could not have been predicted in any way, and could not have been prevented.

13.7 The panel conclude that the medical care provided to the couple over many years was generally appropriate and of a high standard. There were no barriers to accessing medical services, the couple readily accessed services as and when they needed to.

13.8 The panel do feel that some learning points have come out of this review in relation to GP notes/records (see para 9.15) and in relation to drug dosages and drug interactions (see para 9.14). The panel asks that these learning points are appropriately fed back to the practices concerned.

13.9 The panel believe that more could have been done to recognise the vulnerability of the couple, in particular the role Male 1 had as carer to his wife. The panel believe that processes need to be reviewed to develop a wider assessment process that could lead to a multi-agency approach to engage with older people who find themselves in these circumstances, to allow better consideration for accessing support, and signposting to such help and support available within 3rd sector services. *A recommendation will be made in relation to this.*

13.10 An independent UK Enquiry into Mental Health and Well-being in Later Life (Age Concern and the Mental Health Foundation, 2006) showed there are five main factors that impact on older people's mental health and well-being: discrimination; participation in meaningful activity; relationships; physical health; and poverty.

Older people feel that being able to make contributions to society (and being recognised for them) is good for their mental well-being. Volunteering was identified as a key way of making contributions and participating in society.

Older people also identify physical activity and maintaining a good diet as the key components of physical health which can have positive impact on their mental well-being.

The Enquiry report concluded local-level action will make the most difference, and recommended that healthy ageing programmes should be established to encourage older people to take advantage of opportunities for meaningful activity, social interaction and physical activity. Specifically, the Enquiry recommended that such active ageing programmes should promote mental as well as physical health and well-being in their design, delivery and evaluation. However other research highlights barriers to taking part, such as people's skills and fears. Volunteering rates fall as people get older and identifies 75 as an age where people's well-being has peaked and generally starts to decline quite rapidly.

The panel believe that the review gives opportunity for agencies to a conduct a publicity campaign across the Borough in relation to mental health in the elderly. This would seek to break down some barriers within this age group around the stigma of mental health, to accept this as an illness and to seek help and support. Issues around isolation and engagement projects and activities, lifestyle and practical support could be included within the campaign.
A recommendation will be made in relation to this.

14.0 Recommendations.

14.1 The panel recommends that relevant agencies consider the development of a protocol where elderly persons identified as carers and where mental health features in the relationship, are signposted as appropriate to primary care, secondary care and 3rd party sectors to ensure access to help and support.

14.2 The panel considers that the case could be recognised as an opportunity to deliver a local publicity campaign to challenge perceptions and heighten awareness around mental health and the elderly. The campaign could target not just the elderly, but families, carers, and those practitioners working closest with the elderly, to educate and breakdown barriers and stigmas associated with mental health, to promote health and wellbeing and to promote services available.

14.3 The panel recommends that the issues regarding drugs dosage and interactions identified by the review (see sections 9.13/14 overview report) are formally reported to GP practice 2 as learning points, and the value of meaningful detailed patient notes, the recording of decisions and rationale be considered as learning points for both GP practices. (see section 9.15 overview report.)

END OF REPORT

Appendix 1

Subjects of this DHR:

Victim (and wife of alleged perpetrator), described as ‘Female 1’:

Alleged perpetrator (and husband of victim), described as ‘Male 1’: