Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Barbara
in December 2019

Report Author: Christine Graham
October 2021

Preface

Gwynedd and Anglesey Community Safety Partnership and the Domestic Homicide Review Panel wish at the outset to express their deepest sympathy to Barbara's family and friends. This review has been undertaken in order that lessons can be learned. We wish to place on record our thanks to the family for their engagement and challenge with the review; it has helped us form a deeper understanding of those involved and the issues they faced.

The review has been carried out in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances that ultimately culminated in this homicide, in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by Gwynedd and Anglesey Community Safety Partnership on receiving notification of the death of Barbara in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case, **including a chronology** to assist the reader in understanding how events unfolded that led to Barbara's death.

Section 3 will provide **detailed analysis of the information** of agency involvement.

Section 4 will analyse the **issues** identified by this review

Section 5 will summarise the **approach in Wales** to tackling domestic abuse.

Section 6 will summarise the **lessons identified** during the review.

Section 7 will bring together the **recommendations** that arise.

Section 8 will draw together the **conclusions** of the Review Panel.

Appendix One details the continuing professional development of the Chair and Report Author.

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box. Examples of good practice are highlighted in italics.

Contents

Section One – Introduction

1.1 Summary of Circumstances leading to the Review

1.1.1 Barbara and her husband, George, were a couple in their 70s who had been married for 53 years. They had moved from the English Midlands to the North Wales coast in 2018, to be near their daughter. In fact, they moved to a bungalow next door to their daughter and son-in-law in a small cul-de-sac of bungalows. On day of Barbara's death in 2019, Barbara and George went for lunch at their daughter's house. After lunch, they returned home, and George went for a walk with his daughter and her husband: returning home at about 3pm.

1.1.2 Later that evening, at about 8pm, George returned to his daughter's home. His daughter asked: 'What's happened then', to which he replied 'come'. As she was walking towards her parent's home, the defendant told her: 'The moment we left here she started'. She asked what he meant, and he replied that she called him names and 'had a go'.

1.1.3 He was asked what happened next, to which he replied: 'She came at me with a knife again', and when asked what he did, he replied: 'I stabbed her'. Together they went back to her parent's property where Barbara was slumped in the middle of the settee. They attempted CPR but she was deceased. The emergency services were called, and George was arrested for Barbara's murder.

1.1.4 The post-mortem found that there were no significant defensive injuries and that a stab wound to her right upper neck was the fatal wound. The blade had penetrated to a depth of around 16 centimetres and was at a downward angle of 45 degrees.

1.1.5 George was charged with his wife's murder. However, at a subsequent trial, was found not guilty of murder, but guilty of manslaughter. He was sentenced to 3 years 2 months' imprisonment. Evidence was produced during the trial that he was subjected to years of controlling and, at times, violent behaviour from Barbara.

1.2 Reasons for conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, 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) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the perpetrator, Barbara's husband, has been found guilty of the manslaughter of Barbara. Therefore, the criteria have been met.

1.3 Terms of Reference

1.3.1 **Introduction**

1.3.2 This Domestic Homicide Review (DHR) is commissioned by the Gwynedd and Anglesey Community Safety Partnership in response to the death of Barbara, which occurred late in December 2019.

1.3.3 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3.4 The Chair of the Partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

1.3.5 **Purpose of the Review**

1.3.6 The purpose of the review is to:

1.3.7 Establish the facts that led to the homicide and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard Barbara.

1.3.8 Identify what those lessons are, how they will be acted upon, and what is expected to change as a result.

1.3.9 Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

1.3.10 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse, and to recommend any changes as a result of the review process.

1.3.11 Contribute to a better understanding of the nature of domestic violence and abuse.

1.3.12 **The Review Process**

1.3.13 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

1.3.14 This review will be cognisant of, and consult with, the criminal investigation and subsequent criminal justice processes. It will be similarly cognisant of, and consult with, the process of inquest held by HM Coroner.

1.3.15 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident, in order that there is appropriate sharing of learning.

1.3.16 Domestic Homicide Reviews are not inquiries into how the victim died, or who is culpable: that is a matter for coroners and criminal courts.

1.3.17 **Scope of the Review**

1.3.18 This review will:

1.3.19 Draw up a chronology of the involvement of all agencies involved in the life Barbara and the suspected perpetrator, George, to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

1.3.20 Produce IMRs for a time period commencing the date of Barbara's death two years prior to the death, and anything prior to that date that is pertinent. This timeframe was selected as it covers the time leading up to the couple's move to Wales.

1.3.21 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

1.3.22 Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events.

1.3.23 Consider particularly, the ages of those involved and whether this was a factor in the homicide, and whether age affected the provision of service to either party.

1.3.24 Consider the couple's move to another geographical area of the country and whether this affected their relationship, considering in particular the potential for isolation, change of established lifestyle, and any other relevant factors.

1.3.25 Consider whether there is evidence to show a trail of abuse and, if so, what could be done differently to better protect others in the future.

1.3.26 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken, and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

1.3.27 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

1.3.28 **Family Involvement**

1.3.29 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members, and to identify other people they think relevant to the review process.

1.3.30 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

1.3.31 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews, thereby avoiding duplication of effort and minimising their levels of anxiety and stress.

1.3.32 **Legal advice and costs**

1.3.33 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

1.3.34 Should the Independent Chair, Chair of the CSP, or the Review Panel require legal advice, then Gwynedd and Anglesey Community Safety Partnership will be the first point of contact.

1.3.35 **Media and communication**

1.3.36 The management of all media and communication matters will be through the Review Panel.

1.3 Methodology and Timescales for the Review

1.3.1 The Gwynedd and Anglesey Community Safety Partnership was advised of the death by North Wales Police on 27th December 2019. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.3.2 On 31st December 2019, a discussion was held between the Community Safety Partnership Chair, Community Safety Partnership Lead Officer in Gwynedd Council, the Senior Investigating Officer and Detective Chief Inspector. From this discussion, it was agreed that the criteria were met and that a Domestic Homicide Review would be held. The Home Office was advised of this decision the same day.

1.3.3 An Independent Chair and Report Author were appointed at the beginning of February 2020. The family were notified by the Gwynedd and Anglesey Community Safety Partnership that the review was to take place on 28th February.

1.3.4 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act: namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.3.5 The first Review Panel meeting was planned for 25th March 2020. Due to the coronavirus lockdown, it was agreed that a report would be circulated to the panel that established the review. The report set out that, following a discussion between the SIO and the Chair, it had been agreed that the review would proceed in limited scope until the criminal justice process was completed.

1.3.6 The report alerted the panel to the fact that the review would need to include agencies from the Midlands: where Barbara and her husband had lived before moving to the area. The Terms of Reference were shared, subject to the family being consulted.

1.3.7 A chronology was compiled bringing together the information that was known by each agency. The panel met on Microsoft Teams on 30th July 2020, when the following agencies were present:

- Betsi Cadwaladr University Health Board
- Cannock Chase District Council
- Gorwel Specialist Services
- Gwynedd Council
- Hywel Dda University Health Board
- National Probation Service
- North Wales Fire Service
- North Wales Police
- Staffordshire and Stoke Clinical Commissioning Group
- Staffordshire County Council

1.3.8 Individual Management Reports were requested from:

- BCUHB on behalf of GP
- BUCHB on behalf of Mental Health Community Team
- Hywel Dda University Health Board on behalf of the local hospital
- Staffordshire and Stoke Clinical Commissioning Group – on behalf of GPs
- Gwynedd Council – Adult Social Care

1.3.9 It was not possible to complete the review within six months as it was not able to proceed in full scope until the criminal process was completed. Also, Covid-19 further impacted on the progress of the review.

1.3.10 The Review Panel met five times and the review was concluded in October 2021.

1.4 Confidentiality

1.4.1 The content and findings of this Domestic Homicide Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the DHR has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, and their family and friends, Barbara will be used as a pseudonym to identify the deceased hereafter and throughout this report. The person responsible for her death will be referred to as George. Their daughter will be known as Caroline. The pseudonyms were chosen by the report author at the daughter's request.

1.5 Dissemination

1.5.1 The final version of this Overview Report will initially be distributed to:

- Barbara's family
- Statutory partners of Gwynedd and Anglesey Community Safety Partnership
- Organisations represented on the Review Panel

1.6 Contributors to the Review

1.6.1 Those contributing to the DHR do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.6.2 All panel meetings included specific reference to the statutory guidance as the overriding source of guidance for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review, and the statutory guidance.

1.6.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.6.4 The following agencies contributed to the review:

- Betsi Cadwaladr University Health Board
- Cannock Chase District Council
- Gorwel Specialist Services
- Gwynedd Council
- Hywel Dda University Health Board
- National Probation Service
- North Wales Fire Service
- North Wales Police
- Staffordshire and Stoke Clinical Commissioning Group
- Staffordshire County Council

1.6.5 All panel members and IMR authors were independent of any direct involvement with Barbara or George.

1.6.6 Barbara's family contributed to the review.

1.6.7 George was contacted via the offender management unit at the prison and invited to contribute to the review. The Chair and Report Author were able to have a telephone conversation with the perpetrator from prison.

1.7 Engagement of Family

1.7.1 Family and friends are integral to any Domestic Homicide Review and the Independent Chair and Report Author wrote to Barbara and George's daughter at the beginning of March and the letter was given to her by the Family Liaison Officer. This letter provided her with details about the review and a leaflet about AAFDA[1]. She indicated her wish to be involved in the

[1] Advocacy After Fatal Domestic Abuse

review and plans were made to meet with her. However, due to the coronavirus lockdown, these plans were postponed until later in the year.

1.7.2 In September, the Chair and Report Author were able to meet with Barbara and George's daughter and son-in-law: in line with the Government guidelines at that time. Barbara's daughter was invited to meet the panel but did not feel the need to do so. She was very happy with the scope of the review as set out in the Terms of Reference.

1.7.3 Barbara's daughter was provided with a copy of the draft report to consider at her own pace.

1.7.4 Barbara's sister was written to by the Chair and Report Author explaining the review and providing her with details of the AAFDA. She then spoke to the Chair and Report Author on the telephone.

1.8 Review Panel

1.8.1 The members of the Review Panel were:

Gary Goose	Independent Chair	
Christine Graham	Independent Report Author	
Chris Walker	Head of Adult Safeguarding	BCUHB
Kerry Wright	Partnerships, Community Safety & CCTV Manager	Cannock Chase District Council
Oliver Greatbach	Community Safety and Vulnerability Officer	Cannock Chase District Council
Gwyneth Williams	Manager	Gorwel Specialist Domestic Abuse Service
Catherine Eirlys Roberts	Senior Operational Officer: Community Safety Partnership, Gwynedd and Anglesey	Gwynedd Council
Mannon Emyr Trappe	Senior Manager: Adult Safeguarding, Quality Assurance and Mental Health	Gwynedd Council – Adult Social Care
Mandy Nichols-Davies	Head of Safeguarding	Hywel Dda University Health Board
Rachel Munkley	Lead VAWDASV and Safeguarding Practitioner	Hywel Dda University Health Board
Angharad Forshaw	Senior Probation Officer	National Probation Service
Gwyn Jones	Community Safety Manager for Gwynedd and Anglesey	North Wales Fire Service
Sara Evans	Detective Inspector	North Wales Police
Lisa Bates	Designated Nurse for Adult Safeguarding	Staffordshire and Stoke CCG
John Maddox	DHR Coordinator	Staffordshire County Council

1.9 Domestic Homicide Review Chair and Overview Report Author

1.9.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.9.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.9.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous Domestic Homicide Reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and, reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the Independent Office for Police Conduct (IOPC), NHS England and Adult Care Reviews.

1.9.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[2]

1.9.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in Appendix Two.

1.10 Parallel Reviews

1.10.1 There were no parallel reviews as the coroner felt there was no need to reopen the inquest following the criminal process.

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.11 Equality and Diversity

1.11.1 Throughout this review process, the Review Panel has considered the issues of equality. In particular, the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.11.2 **Women victims of domestic abuse**

1.11.3 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[3] Women are more likely than men to be killed by partners/ex-partners. ONS data[4] shows that for the period April 2008 to March 2019, 925 women were killed by a partner or ex-partner, compared with 152 men.

1.11.4 The Femicide Census 10-year report[5] found that the largest number of femicides (888, 62%) were carried out by men who were currently or had been previously been in an intimate relationship with the victim.

1.11.5 **Male victims of domestic abuse**

1.11.6 Whilst George was responsible for the death of Barbara, there is clear evidence of the abuse that she perpetrated against him over many years.

1.11.7 One in three victims of domestic abuse will be male, and one in six to seven men will experience domestic abuse in their lifetime[6]. Men are also less likely to report abuse than women. They are nearly three times less likely (49% as opposed to 19%) than women to tell anyone, and only one in six men will tell the police[7].

1.11.8 **Age**

1.11.9 In this case, the both the victim of the homicide and the victim of the domestic abuse were 74 years old and had been married for more than 50 years. The Crime Survey for England and Wales, conducted by the Office of National Statistics, does not collect data on those over 74 years of age. Therefore, whilst we know that domestic abuse against older people occurs, we do not have a true picture of its prevalence in older people.

3 (Women's Aid Domestic abuse is a gendered crime, n.d.)
4 Homicide in England and Wales, year ending March 2019, Office for National Statistics, February 2021
5 UK Femicides 2009-2018, Femicide Census,
6 Mark Brooks, Male victims of domestic and partner abuse 45 key facts, Mankind Initiative, March 2019
7 Ibid

1.11.10 That said, we do know that 98,000 older men, aged 60-74 years, were victims of domestic abuse in England and Wales in the past year[8].

1.11.11 Age UK, in a recent report[9], made the point that domestic abuse does not go away with age, and its damaging impact does not lessen. Age UK claimed that, for older people, domestic abuse is a hidden issue, with hidden victims. They make the point that, as people grow older, they may become less able to stop the harmful behaviours, and access support. Importantly, older people may not recognise that they are experiencing domestic abuse.

1.11.12 SafeLives[10] found that people over the age of 61 took twice as long to seek help when experiencing domestic abuse and they found it harder because they are dependent on the abuser(s) financially and/or dependent due to health issues that are more prevalent in later life.

1.11.13 The inability of many professionals to recognise older people as victims/survivors of domestic abuse, not only influences the monitoring of prevalence data and the subsequent service delivery (Wydall and Zerk, 2015), but can also have life-threatening consequences for the victim (Sharp-Jeffs and Kelly, 2016)[11].

[8] No Age Limit: the blind spot of older victims and survivors in the Domestic Abuse Bill, Age UK, September 2020
[9] No Age Limit: the blind spot of older victims and survivors in the Domestic Abuse Bill, Age UK, September 2020
[10] The Domestic Abuse Report 2019: The Annual Audit, Women's Aid, 2019 cited in Age UK report
[11] Sarah Wydall, Rebecca Zerk, (2017) "Domestic abuse and older people: factors influencing help-seeking", The Journal of Adult Protection, Vol. 19 Issue: 5, pp.247-260,

Section Two – The Facts

2.1 Introduction

2.1.1 Barbara was 74 years old at the time of her death. She had been married to George, who was 75 years old, for 53 years. In 2018, the couple moved from the West Midlands to the village in North Wales to be near to their daughter and her extended family.

2.1.2 The chronology that follows, includes not only the information provided by the agencies that had contact with Barbara and George, but also the information provided by their daughter, as this helps to provide a rounder picture of their lives.

2.2 Detailed Chronology

2.2.1 **2015**

2.2.2 Barbara had a urinary tract[12] infection that led to concerns about her cognitive function.

2.2.3 **2016**

2.2.4 In 2016, Barbara had a further urinary tract infection. Her daughter rang 101 and reported that her mother experienced confusion at the time. A doctor called her back and prescribed antibiotics. This was the catalyst for her to speak to her father, George, about her mother's memory and how this had been declining even before she had the infection.

2.2.5 In March, Barbara and George organised their Wills and Lasting Power of Attorney (LPA): understanding that the LPA would remain in the background and would only come into force when it was needed. At this point, George was reluctant to travel anywhere due to his mobility issues, and he was showing signs of minor memory problems.

2.2.6 Around this time, Barbara had a hysterectomy which resolved the infections and appeared to improve her cognitive function somewhat.

2.2.7 **2017**

2.2.8 In June, it was recorded in Barbara's GP record that a cognition test was undertaken by the GP, as Barbara's daughter expressed concern about her mother's memory[13]. She completed the GPCOG[14] and scored full marks, indicating there was no clinical impairment.

2.2.9 **2018**

2.2.10 Barbara's daughter believes that her mother began to show early signs of dementia in the spring of 2018. Her husband was in the process of being assessed (diagnosed in June 2018) and she could see marked similarities between them.

[12] Whilst ordinarily the specific medical condition would not be named. In this case it is felt to be relevant as a urinary tract infcection can produce confusion and delirium
[13] Barbara's daughter does not recollect this appointment and this being undertaken
[14] General Practitioner Assessment of Cognition

2.2.11 Barbara and George decided to move to North Wales. Their daughter, at their request, dealt with the sale and purchase. At the time, Barbara was able to deal with day-to-day activities such as changing addresses but became confused with more complex tasks, which led to her becoming stressed and irritable.

2.2.12 There were two occasions when Barbara visited her GP with a flare-up of migraines causing insomnia. She presented in a tearful state and reported feeling exhausted.

2.2.13 George had his annual diabetic review in March. He reported that his intake of alcohol was 14 units per week.

2.2.14 In May, Barbara saw her GP as she could not sleep. She was very tearful and in constant pain. She was getting more frequent migraines. She was prescribed a low dose of sleeping tablets for seven days. An MRI scan was booked: the results showed no abnormalities. Barbara explained this to her daughter. She said there was no brain shrinkage and that the scan was normal for an older person. Barbara's daughter was concerned about the results and asked her mother to obtain a copy of the MRI report.

The GP records are clear about the result of this scan. However, Barbara's daughter did not agree with this medical opinion.

2.2.15 She then saw the GP with Barbara. Barbara's daughter expressed concerns about her mother's memory, confusion and driving ability, but was assured by the GP that this was a normal sign of ageing. She asked for her mother to be referred to the mental health/memory assessment team. Having carried out a three of the initial five step assessment memory tests with Barbara which she did not pass. The GP agreed to making a referral, but Barbara asked for this to be undertaken once she moved to North Wales. Barbara agreed with the GP that she would discontinue driving after she moved. Once they moved to North Wales, Barbara refused to be referred.

2.2.16 In July, George had a flare-up of trigeminal neuralgia: a brain scan was completed, which was normal.

2.2.17 Barbara had her annual diabetic review in July. During this consultation, a depression score was completed and there was no evidence of depression.

2.2.18 In August 2018, Barbara and George moved to North Wales. Their daughter said that when they moved, it became clear that her mother could no longer deal with all their financial affairs[15], and arrange matters in relation to the bungalow. She would often take the phone round to her daughter and ask her to speak to the person who was on the phone.

2.2.19 Barbara and George registered at a GP surgery in North Wales soon after they arrived. Their daughter registered the LPA with the surgery and although she never spoke to the GP about her father's health, they gradually began to call George's daughter more and more, rather than George. This was only to the extent of arranging appointments, as the date or time would be forgotten.

[15] Barbara's daughter arranged the utilities and set up direct debits. Barbara was able to deal with day to day finances as she only used cash, never cards

2.2.20 George visited the GP surgery in North Wales for the first time in October for a general examination. His alcohol consumption was recorded as 6 units per week.

2.2.21 The same day, Barbara had her first appointment at the GP surgery in North Wales and during a general examination, she said that her alcohol consumption was two units per week.

2.2.22 In December, George was asked to visit the GP surgery to discuss his blood results. He reported having stomach problems which resulted in him not being able to travel if he had not starved for 24 hours. It was agreed that he would have a medication review and his blood tests would be repeated in three weeks' time.

2.2.23 **2019**

2.2.24 George had a general diabetes review at the GP surgery on 7th January. On the same day, Barbara had a consultation with the practice nurse at the GP surgery. She said that she consumed four units of alcohol a week. There was a comment about depression, but she declined to see the doctor about it. She was referred to dietetics.

2.2.25 When George saw the Advance Nurse Practitioner a couple of days later at the GP surgery, there was a discussion about his blood tests: it showed that he was low in sodium. He said that as he starves himself for 24 hours before travelling, this might be affecting the result, however, the last test had been taken at short notice, so he had not done this. It was noted that they should consider the district nurse taking his bloods in future.

2.2.26 On 10th January, Barbara had a new patient examination with the GP. She had lost two stone in weight since she had moved to the area, but was deemed not clinically depressed.

2.2.27 George had a medication review with the pharmacist on 22nd January. It was recorded that George was confused about his medication, as his wife looked after it. He gave permission for the GP to contact Barbara on the telephone and she was given advice about his medication. He was offered medication in blister packs, but this was declined.

2.2.28 On 14th February, the GP received a letter from the dietetics, as Barbara had declined an appointment with the dietician.

2.2.29 George had a diabetic review at the GP surgery on 5th June. It was noted that he required an ECG. When this was completed by the GP, it was noted that the management of his blood pressure at home should continue. He said he was drinking 6 units of alcohol a week.

2.2.30 On 5th June, Barbara had a diabetic review at the GP surgery. During the general examination, she said she drank no alcohol.

2.2.31 In June, the Ambulance Service were called to the address following a fall by George[16]. On 10th July, George had his blood pressure checked.

2.2.32 On 9th August, Barbara's daughter had a Carer's Assessment for her husband. She also asked about referring her mother to the memory clinic as, although her mother would talk to her

[16] There is limited information available about this call out. The Ambulance Service records have it as a 'fall' with no record of any concerns or information about prior abuse or relationship difficulties. The couples daughter recalls telling the crew about these but there is no record of it. Given the lack of information available this is not revisited later in the report.

about how bad she felt she was getting and how depressed she was, she would not agree to her starting the process. She was advised that the request for the referral must come from Barbara.

2.2.33 On 30th September, George was woken (he and his wife slept in separate rooms) in his bed to Barbara prodding him with a knife, which left rips in his T shirt and marks on his body. Barbara's daughter described this as sufficient to wound him. Barbara later told her daughter that she had been looking for his heart, but he had no heart. When she made the stabbing gesture, George got the knife from her by grabbing it, cutting his hand in the process, and smacking her arm on to the metal sides of the bed to make her release it. He went to his daughter's house. George refused to go to hospital or involve the police as he wanted to protect his wife and said that, if the police were involved, he would deny everything. By this time, George was sufficiently scared of what Barbara would do that he set a booby trap involving a vacuum cleaner attached to a piece of string which would clatter if she tried to go into his room in the night. George's daughter had offered to fit a bolt to the door, but he refused to let her do it and set up the booby trap instead.

2.2.34 Barbara left the house with the dog. Her daughter found her at the seafront where she was extremely intoxicated and said she wanted to end it all. Caroline took her mother home, but she left again. As Caroline was in the process of calling the police, Barbara returned home once again. She and her daughter talked and eventually Barbara grabbed George and ordered him to go home, saying she wanted nothing more to do with her daughter. Barbara did not speak to her daughter for four days and made no further mention of suicidal thoughts.

2.2.35 At about 8.30 am on 8th October, George went to his daughter's house to say he could not wake Barbara up. The paramedics were called and when they arrived, Barbara's daughter discussed the possibility of her mother having taken an overdose, although she had no evidence to support this. She also suggested that she believed, anecdotally, that her mother was showing signs of dementia. She was taken by ambulance to the general hospital where initially it was thought she had suffered a stroke. As Barbara and George slept in separate rooms, it was not known when she had collapsed. It was noted that there was a query over Barbara's cognitive impairment and that her daughter had Power of Attorney (POA).

2.2.36 Later that day, when another clinician reviewed Barbara, he spoke to her daughter who informed him that there had been 'recent troubles at home'[17]. She said that her mother was not adjusting well to the new area and had wanted to move back to the Midlands. She said that the previous Monday, her mother had said that she wanted to end it all.

2.2.37 Caroline's recollection is that, at that point, she was told that if her mother recovered, she would have a mental health assessment and care package put in place prior to her discharge.

2.2.38 George's daughter took him to visit Barbara on Thursday afternoon, 9thOctober, and at this point they believed that more than likely she was going to die. During the journey, George told his daughter how the injury to Barbara's wrist had occurred, and she told a member of staff, but she cannot remember who. There is no record of this in the medical notes and the clinicians have no recollection of it. About this time, whilst at home, George had told his daughter about the petrol can and her plan to burn down the bungalow, and her worsening

[17] It is not clear if this was her exact words, or how it was recorded by the doctor. The doctor has since left the hospital so this could not be checked

mental state. She had not known about this until now. During the day, Barbara told the nurses that she had wanted to end her life and that she still felt the same. The consultant asked her how she was feeling. As she had liver failure, he was considering a liver transplant. However, wanting to live is one of the criteria for referral for transplant.

2.2.39 Between 8th and 14th October, Barbara's clinical condition was very poor and her prognosis was uncertain. She clinically deteriorated on 11th October, and on 12th October, she had a seizure: which was thought to be secondary to her liver failure.

2.2.40 On 12th October, Barbara's daughter had just got into the car to return to the hospital when she received a call saying her mother had had a fit and was in the last stages of dying. When she arrived at the hospital, the person assessing her for a liver transplant was also present. They spoke at length about her general health. She was advised that due to her age, suicide attempt, drinking and possible dementia, they would not consider a liver transplant. This had previously been mentioned to her, but she cannot remember by whom and when.

2.2.41 Barbara's daughter recollects that, late that evening, she went to stay in a local hotel and returned to the hospital on 13th. She was advised again that her mother was not going to make it. She was moved to a private room, and then onto the Acute Stroke Unit. On arrival, she was asked to complete an 'Information Release'.

2.2.42 A review of records has established that this was an Adult Inpatient Assessment Record. This is an assessment that records the patient's home circumstances and the current support. The IMR author has confirmed that the form was completed as would have been expected. The extensive questions were about her medical history, circumstances, and how she would cope on release. She challenged why she was being asked to do this form when her mother was not likely to survive. She was told it was standard practice, so she continued. However, she noted that she could see that not everything she said was being written on the form but, as she felt there was little point, she did not challenge her.

2.2.43 When she returned to hospital on 14th, Barbara had started to recover: at mid-afternoon, she went home. Barbara stated that she wanted to go home from hospital and the next day, 15th October, she was noted to be medically stable and was to be seen by the Crisis Team.

2.2.44 When Barbara's daughter returned on 15th, she saw a fourth consultant who discussed with her Barbara's improvement. He discussed her discharge from hospital and indicated that they were considering transferring her to the community hospital for a mental health assessment, due to their concerns.

2.2.45 Barbara was moved to a heart ward and staff were talking about her discharge. When her daughter asked about the form ('Information Release') that she had completed on 12th, as she was aware that only sketchy details had been recorded on it and was not a full reflection of the circumstances, they knew nothing about it. At this point, her daughter began to be concerned that she was being 'fobbed off' and that Barbara was going to be discharged entirely into her care. At this stage, Barbara's daughter felt that her mother was refusing to eat and was collapsing regularly. However, the medical records note that, when she was no longer 'nil by mouth', she was taking food and fluids well and independently.

2.2.46 On 18th October, her daughter was in email correspondence with her husband's Community Psychiatric Nurse (CPN) about an appointment. She took the opportunity to ask her advice about what she should do to ensure that her mother got the help she needed – a referral to

social services and to the memory clinic were suggested. The CPN gave her the number for social services duty desk and explained that Barbara should be seen by the Crisis Team who would refer her to the appropriate Community Mental Health Team on discharge.

2.2.47 At 3.30 pm on 21st October, Barbara's daughter telephoned the ward and said that she was concerned about her mother's discharge, as she felt her mother, 'would not be safe at home' due to George not being able to look after himself and her own husband having dementia. The nurse talked to Barbara about why she had been brought into hospital. She said that she got lonely and overwhelmed but that she would make plans to visit her sister at these times. She agreed that she needed help but said that she would organise it herself. There was no evidence that she did not have capacity to make that decision and she agreed to be reviewed by the Crisis Team.

2.2.48 The next day, 22nd October, the nurse discussed her discharge with Barbara and her daughter, by telephone. It was noted that they would both like support and the nurse was given the contact details for Adult Social Care by Barbara's daughter.

2.2.49 Later, that same day, Barbara's daughter shared further concerns that she had with the nurse, not in the presence of her mother. She said that her father had told her that he had woken to find his wife 'with a knife at this heart' and she was intoxicated. She said that he had three knife cuts to his hands where he had tried to stop her. The nurse noted that she was told that this had happened three weeks earlier. Barbara's daughter also said that, five weeks previously, her father told her that Barbara had been looking for a petrol can in order to burn down the house. When she heard this, Barbara's daughter hid the petrol can. She expressed concern about her mother's increased alcohol intake. The nurse noted that she shared this information with medical staff and the Crisis Team.

2.2.50 On the morning of 22nd, Barbara's daughter was told that she could go and collect Barbara. She again raised her concerns about the lack of assessment. At about mid-day, she was told that Barbara was being discharged and that she should take her to the Crisis Team office for her assessment. Her daughter explained that she would have to take her husband, who had Alzheimer's, with her and so she was told the assessment would be done in hospital. The nurse on the ward contacted the Crisis Team and explained that it was not possible for Barbara to go to them: they agreed to visit Barbara on the ward.

2.2.51 Later that day, the Crisis Team saw Barbara and recorded that she realised that she had nearly died. It was noted that her mood was improved, and she stated that things needed to change at home, and she was adamant that this was going to happen. She said that her husband had become very lazy over the past 20 years, and he had treated her like a 'doormat'. She said that this would not happen again. During this consultation, she denied any suicidal intent or any issues with alcohol. Her use of alcohol was discussed. She said she would buy a bottle of wine on a Monday and that this would last all week. She said that her husband drank 3 bottles a week. Her memory retention was noted as slow, but intact. When she was asked about the concerns that her daughter had raised, she said that she had an argument with her husband and had held a knife to his chest, but she had no intention to stab him. He had, she said, grabbed the knife off her. She denied any knowledge of trying to start a fire at the bungalow. It was recorded that she was fit to go home, and she was referred to the Mental Health Treatment Community Team 1 (MHCT1) for follow-up.

2.2.52 Barbara was deemed fit to be discharged following the assessment by the Crisis Team. Before she went to collect Barbara, her daughter received a call from the Crisis Team. She

gave the nurse full disclosure about her mum's health, the incident with the knife, the petrol can and George having to set physical alarms so he knew when she was out of bed due to his fear, his lack of sleep and inability to cope, and her personal circumstances. She also stated that she could not provide a safe environment for Barbara and George. She was then called by the Crisis Team, and they spoke for about 20 minutes about why the Crisis Team thought Barbara was safe to be discharged home, and why there were no mental health concerns. She said: "in my 30 years' experience of dealing with domestic incidents, one or other of them is going to end up dead, whether deliberate, accidental or in self-defence". The daughter reports that he said: "this is how people of that generation live. It is normal. They may not be happy with their lives, but they stay". When she realised this was a battle she was not going to win, she asked about support. She recalls that she was told: "well that will have to come from the council, not us, not our remit, I'll submit a form, it will take a while to come through".

2.2.53 On 22nd October, the GP received a discharge letter from the hospital in relation to Barbara's overdose. It was noted that this was a first attempt at suicide using co-codamol. The GP was asked, in the letter, to follow up regarding a mental health review. The information about the use of the knife on George was recorded by MCHT1, but not shared with GP.

2.2.54 On 23rd October, the GP uploaded the referral to the MHCHT1 to Barbara's record. The same day, Barbara's daughter was contacted by the MCHT1. She briefed them on Barbara's problems and an appointment was made for 12.00 pm on 24th October. It was agreed that her daughter would sit in at the first visit, but she did not sit in on any further visits, as she did not wish to affect the interactions.

2.2.55 The MCHT1 carried out an initial assessment with Barbara on 23rd October and she remained under their care until 27th November. In her police statement, the psychiatric nurse said that Barbara was dressed appropriately, and the bungalow was clean and tidy. She said that Barbara appeared relaxed throughout the meeting. She described her mood as 4 out of 10 on that day but just prior to her overdose, it had been 3 out of 10. She said her sleeping had improved slightly since she came out of hospital, but she was still not eating much. She said that the overdose was impulsive, however, a certain amount of planning went into it and she said she thought she had got the timings right so that she would not be discovered. She said that she took the overdose because she felt resentful towards her husband and her quality of life.

2.2.56 It was agreed that the MCHT1 would visit on alternate days for ongoing assessment and to monitor Barbara's mood and mental health risk.

2.2.57 The MCHT1 visited Barbara at home on 26th and 28th October, and full MSE was completed.

2.2.58 George was offered a Carer's Assessment by the MCHT1 on 28th October, but he declined this.

2.2.59 On 29th October, the GP receptionist had a telephone conversation with the district nurses about a visit to Barbara for bloods and cholesterol observations.

2.2.60 On 30th October, the GP received information that Barbara's liver function test was abnormal, and made a note that she was to be contacted.

2.2.61 When she was visited by the MCHT1 on 30th October, Barbara acknowledged that she needed help with the depression, so that she could then start to do things that she knew would improve her life.

2.2.62 Barbara was visited at home by the MCHT1 on 2nd and 5th November.

2.2.63 The MCHT1 referred Barbara to the Mental Health Community Team 3 (MHCT3) for secondary care on 7th November.

2.2.64 Barbara's daughter recalls that she had an appointment on 7th November at the community hospital with the psychiatrist. A member of the team met them. Barbara did not want her daughter to go into the appointment and, as she thought she might open up more alone, she agreed not go in. Barbara was clearly unhappy when she came out of the consultation and was about to leave when the psychiatrist came into the waiting room and asked to speak to her daughter. He wanted to understand how things were from her perspective, as he did not get much from Barbara. He said that she had said there were marital problems, but had minimised the previous incidents. He had, however, read the notes so knew that there was more to the situation than Barbara disclosed. She told him about how her dad had set up an alarm with the vacuum cleaner and a piece of string to alert him when Barbara got up in the night. She said that George did not sleep and was genuinely fearful for his life. She again expressed her concerns, explained the conversation she had with the Crisis Team, and again said that she thought that one of them would end up dead.

2.2.65 He explained the medication that had been prescribed for Barbara and how he thought it would help. He said that once he had got her stable, he would look at addressing the possible dementia. She explained that she was struggling to go and administer the medication three times a day, so was planning to leave her with blister packs. The doctor was concerned about this and she agreed to limit the amount of medication her mother would have access to, and to look after George's medication also.

2.2.66 On 7th November, the GP practice received a letter from the local hospital in relation to Barbara. It noted that she was experiencing severe depression.

2.2.67 When Barbara met with the psychiatric nurse from the MCHT1 on 9th November, she said that she had been asked to move to North Wales to help her daughter to look after her husband. However, his family had also moved to the village, and so she felt that she was not needed and said that all she did was look after the dogs.

2.2.68 Barbara was visited at home by the MCHT1 on 11th November and full MSE was completed.

2.2.69 On 15th November, the GP received test results that indicated that Barbara's liver function test was abnormal, and it was noted that she needed to be contacted. The MCHT1 delivered medication to Barbara's home.

2.2.70 On 18th November, Barbara cancelled the visit of the MCHT1 as she had a migraine. The psychiatric nurse telephoned her daughter to be certain that this was the case. Her daughter told the nurse that her mother and father had many arguments in the past, so the current situation was not new. She said that her mother tended to see the past through rose-tinted spectacles. It was arranged that she would call on the following day. Barbara's daughter recalls that she explained that Barbara had taken back control of the cooking and cleaning from George. She described Barbara as controlling and manipulative.

2.2.71 However, the next day, the psychiatric nurse was running late so she rang Barbara's daughter to let her know. She was advised that Barbara had been to a fitness class and seemed much better, so it was agreed that the visit that day would not go ahead.

2.2.72 Barbara attended the Mental Health Community Team (MHCT2) outpatient clinic on 26th November, and it was agreed that the case would be closed to the MCHT1.

2.2.73 On 27th November, the GP received discharge letters in relation to Barbara from both the general hospital and the MHCT2 at the Acute Mental Health Unit.

2.2.74 The psychiatric nurse from the MCHT1 visited Barbara on 27th November. She said she had continued to attend the gentle exercise class in the village. She said that she thought she had experienced a couple of TIAs (mini stroke) and the right side of her face was noted to look like it had dropped. When asked if she had seen the GP, she said there was no point as she was already taking aspirin. During this conversation, Barbara said that she was not experiencing any suicidal ideation, but that this was mainly because she was worried it would go wrong and she would be in a worse position than before. The nurse felt that she did not need intensive MCHT1 treatment and so she would be discharged to a care manager. She was told that someone would be in touch.

2.2.75 After the visit, Barbara told her daughter that she had made an appointment to see the GP. Later in the day, the GP examined Barbara and suspected that she had suffered a stroke. She was admitted to the general hospital. She was in hospital for less than 24 hours and was discharged once Bell's Palsy was diagnosed. She was to have an MRI scan as an outpatient and to be seen by the doctor in clinic. Barbara died before she had this follow-up appointment.

2.2.76 During this admission, Barbara disclosed that she had experienced suicidal thoughts in the past, but was having psychological support through the MHCT3. It was noted that she was 'positive and motivated' and said that she was going to do more, such as keep fit classes, walking and bingo. She expressed a wish to return home and be independent. She made no disclosure about domestic abuse.

2.2.77 On 29th November, the GP surgery were advised that she had been discharged and that the CT scan of her brain was normal.

2.2.78 On 3rd December, a healthcare assistant at the GP surgery tried to call Barbara's daughter about her mother's medication. She left a message for her to call back.

2.2.79 The MCHT1 visited this day. Barbara's daughter has told the review that she took her husband for a medical appointment and as they were leaving the appointment, she saw the Homecare worker and stopped to chat to her. She asked if there was any update on the CPN, as her mother was deteriorating. The Homecare worker described Barbara as 'very child like' in her behaviour and 'extremely controlling, not allowing your dad to do anything because he does it wrong'. She also stated that: 'your dad is not allowed to speak and clearly has mental health issues of his own, along with his mobility. We have tried to speak to him on his own, but she would not allow it'.

2.2.80 On 4th December, a social worker from Gwynedd County Council visited George with a view to undertaking a Carer's Assessment. George was home alone, as Barbara was at the

hairdressers. George was not interested in pursuing the assessment. He said it was a 'waste of time' and that there was 'no need'. He said that things were better between him and Barbara. The social worker left him with several leaflets and left after 10 minutes.

2.2.81 On 7th December, Barbara had her MRI scan and was due to see the psychiatrist on 12th but, as the psychiatrist was ill, this was postponed.

2.2.82 Barbara had a general examination at the GP surgery on 11th December. It was noted that she was consuming 2 units of alcohol each week.

2.2.83 On 11th December, George had a diabetic review at the GP surgery. His weight was discussed, and he said he was consuming 6 units of alcohol each week.

2.2.84 George was seen by the GP on 17th December about an allergic rash: medication was prescribed.

2.2.85 Barbara saw the GP, with her daughter, on 17th December when her prescription was discussed. It was noted that she had an appointment with the psychiatrist, but that this had been cancelled and moved to the New Year.

2.2.86 On 24th December, the Secondary Care Co-ordinator of MHCT3 spoke to Barbara on the telephone and arranged a home visit for 7th January 2020.

2.2.87 On 25th December, Barbara's death occurred.

Section Three – Detailed Analysis of Agency Involvement

The chronology set out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement.

3.1 **CANNOCK CHASE CLINICAL COMMISSIONING GROUP on behalf of the GP in Staffordshire**

3.1.1 **Barbara**

3.1.1.1 Barbara was registered with the GP practice until she moved in August 2018. She had a number of chronic health conditions, including gynaecological problems, gastric problems, musculoskeletal problems, type 2 diabetes, recurrent migraines, essential hypertension, angina, cataracts and a hiatus hernia: all of which she was treated for by the practice. The effect of these conditions on Barbara's everyday life and its potential for effect upon relationships is discussed further at 4.6 within this report.

3.1.1.2 The records evidence that she sought medical advice in a timely manner and expedited specialist consultations through funding private consultant appointments. She attended all her routine screening appointments and vaccinations and was provided with the appropriate guidance and support in relation to healthy eating, drinking, exercise and weight management.

3.1.1.3 Barbara was first recorded as having concerns with her cognitive function in 2015, which was a result of a urinary tract infection. She had a further infection in 2016, with the confusion reported by her daughter. During the annual review of her long-term conditions, her memory was assessed and recorded within the records: there were no clinical concerns identified.

3.1.1.4 **June 2017**

3.1.1.5 The last cognition test was completed during a consultation at which Barbara was accompanied by her daughter, who was concerned about her mother's memory. The GP completed an assessment utilising the General Practitioner Assessment of Cognition (GPCOG), where she scored full marks thus no impairment was highlighted. The GP reassured Barbara and her daughter, and advised them to make another appointment if they had any further concerns. The GP records note that Barbara said, during the consultation, that she thought there was nothing wrong. Whilst it was noted that her daughter did not agree, the details of these concerns were not recorded.

The IMR author notes that the records include pertinent information, but that there is nothing to suggest that this conflict between Barbara and her daughter was explored further.

The review is advised that, in light of this case, the Clinical Commissioning Group has held a reflective practice session with the GP surgery. This session focused on using professional curiosity where there are concerns raised by families including seeking an opportunity to speak to the patient alone. The session also encouraged staff to consider the potential for coercion and control of the patient.

3.1.1.6 In 2018, Barbara was seen on two occasions with a flare-up of her migraines, which were causing insomnia. She presented in a tearful state and said that she felt exhausted. Her physical and mental health were discussed with her. At the appointment on 22nd May 2018,

she had no suicidal thoughts or thoughts of self-harm, and no anger symptoms, but was losing weight and was not sleeping. She was prescribed a low dose of sleeping tablets for seven days. An MRI scan was booked, and a follow-up appointment was also scheduled. She was given advice on how to get urgent attention in the interim if she needed it. The MRI scan did not show any abnormalities.

The GP records are clear about the result of this scan. However, Barbara's daughter does not agree with this medical opinion.

3.1.1.7 **July 2018**

3.1.1.8 Barbara was seen by the practice for her annual diabetic review. She had good control of her diabetes. She was given advice about healthy eating, alcohol consumption, and exercise. Her blood tests were within normal ranges, and she reported drinking 7 units of alcohol per week, which was not a concern. A depression score was completed and indicated no evidence of depression. During the consultation, she said that she was moving to Wales, but there was nothing to suggest that this was a concern.

3.1.2 **George**

3.1.2.1 George had a history of chronic health conditions, including type 2 diabetes, essential hypertension, atrial fibrillation, trigeminal neuralgia, and diverticular disease. The effect of these conditions on George's everyday life is reflected upon further at 4.6 within this report.

3.1.2.2 George sought medical advice in a timely manner and expedited specialist consultations through funding private consultant appointments. He attended all his routine screening appointments and vaccinations, and was provided with the appropriate guidance and support in relation to healthy eating, drinking, exercise and weight management.

3.1.2.3 **March 2018**

3.1.2.4 George had his annual diabetic review, and it was noted that he had good control of his diabetes. He was given advice about alcohol and exercise. He reported that he was drinking 24 units of alcohol each week (which was above the recommended level of 14 units per week), but his blood tests did not indicate that this was impacting on his liver function. A depression score was completed and showed no signs of depression.

The IMR author notes that George had reported, for several years, a higher level of alcohol consumption than is recommended. Whilst lifestyle advice was given, there is no evidence that there was any further exploration or challenge undertaken. The review does note that while the amount disclosed indicated moderate usage on the boundary of being harmful, his blood tests were not indicative of physiological harm.

3.1.2.5 There is no record of any concerns with George's cognitive function throughout his records. Due to a flare-up of trigeminal neuralgia in July 2018, a brain scan was completed that returned as normal: he discussed this at a face-to-face consultation with his GP. At this appointment, he advised the GP that he was moving to Wales: no concerns about this were recorded.

The review is advised that, in light of this case, the Clinical Commissioning Group has held a reflective session with the GP surgery which explored the need for more consideration to be given

in annual reviews, including exploring excessive alcohol use and the links to mental health and domestic abuse, and recording this in the records.

3.2 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) on behalf of the GP in North Wales**

3.2.1 Barbara and George registered at a local GP surgery on 23rd August 2018. During 2019, there were two consultations for Barbara and one for George: all were instigated by them. The other consultations were part of the routine primary care engagement and monitoring. The review also notes the regular monitoring of their diabetes and other conditions. ***This is an example of good practice.***

3.2.2 On the occasions that they were seen, the appropriate care appears to have been given.

The review notes that there was no targeted enquiry with either Barbara or George about domestic abuse. Barbara had disclosed depression, severe weight loss and had attempted suicide. Even after receipt of information about Barbara's suicide attempt, there are no recorded discussions with either Barbara or George about their relationship and/or home environment.

The review notes that there is no record in relation to the SaveLives Pathfinder GP practice briefing having been completed. This briefing highlights the importance of undertaking the Routine Enquiry Domestic Abuse (RE DA), whereby frontline staff ask all service users about their experience of domestic abuse, regardless of whether there are any signs of abuse, or whether abuse is suspected.

Recommendation 1
It is recommended that BCUHB ensures that the relevant legislative information on Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) and the VAWDASV Service User Procedure be shared across all GP practices in North Wales.

Recommendation 2
It is recommended that BCUHB ensures training in relation to domestic abuse is available to all GP practices in North Wales, and seeks assurance from managed GP practices in relation to training compliance.

Recommendation 3
It is recommended that BCUHB reviews MDT documentation to ensure consideration for the wider engagement of services to identify a clear pathway of communication between Mental Health and Learning Disability (MHLD) services and GP practices.

3.3 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) – Mental Health Community Team 1**

3.3.1 The Mental Health Community Team 1 (MHCT1) is made up of psychiatric nurses and Support Treatment and Recovery Workers (STAR). The team provide intensive support for patients and can facilitate early discharge from hospital.

3.3.2 Following her overdose on 7th October 2019, Barbara underwent an initial assessment with the MCHT1 on 23rd October. Part 'A' of The Wales Mental Health Measure was completed

along with Part B, which is known as the Risk Formulation. The initial assessment was undertaken at home with all her family present.

3.3.3 Barbara was under the care of the MCHT1 from 22nd October to 27th November. During this time, there were 11 home visits, five telephone calls and one outpatient clinic appointment. George was offered a Carer's Assessment on 28th October, but he declined the offer. During these visits, the staff monitored the efficacy of her medication, and gave information on relaxation and sleep hygiene. She was given information about other services such as the Samaritans, exercise classes and Mindfulness class. They explored with her the dynamics of the relationship with her daughter. ***Under current legislation, this is determined as good practice.***

3.3.4 A referral to the Community Mental Health Team (MHCT3) for secondary care was made on 7th November. On 24th December, Barbara was telephoned by the Secondary Care Co-ordinator to make an appointment for a visit on 7th January 2020.

3.3.5 During the initial visits, Barbara, with her husband and daughter present, had disclosed an incident whereby she had prodded George with a knife in his chest, although no date or further information about this incident was shared at the time.

Although appropriate care and treatment was given by staff working for BCUHB during their contact with Barbara, there is no evidence to suggest that consideration was given to potential domestic abuse. A Routine Enquiry Domestic Abuse (RE DA) assessment was not carried out. Domestic Abuse Awareness Training has been embedded within mandatory training across BCUHB for approximately ten years. Within the Mental Health and Learning Disability Documentation, RE DA assessments and Domestic Abuse HITS documentation have been embedded into Mental Health Measure 1 and 2 since approximately 2012. Following this, all staff are trained in undertaking routine enquiries using the HITS tool, the SAFELives risk indicator checklist, and referral to Multi Agency Risk Assessment Conferences (MARAC).

3.3.6 Barbara was referred to the MCHT1 by the general hospital. This referral did not highlight that a HITS Matrix had been completed on initial assessment, following the overdose, or indicate if any conversation had taken place about domestic abuse.

The review accepts that there was no evidence to suggest that Barbara was a victim of domestic abuse, but this is based on the assumption that she did not present with any injuries or had made any reports to those involved in her care and support.

Very little was known about Barbara's medical and psychological history, as she had only moved to the area relatively recently. She disclosed social isolation, loss of role and low mood that led her to take an overdose, but no enquiries were made by the MCHT1 in relation to any previous medical or psychological history.

Recommendation 4

It is recommended that that BCUHB ensures regular quarterly audits of the clinical records in relation to key domestic abuse targets.

Recommendation 5

It is recommended that BCUHB update and facilitate Level 3 safeguarding training across MHLD services in relation to domestic abuse legislation and practice.

Recommendation 6

It is recommended BCUHB ensures that the relevant legislative information on VAWDASV and the VAWDASV Service User Procedure be shared across all MHLD services with a particular emphasis on domestic abuse and older people.

Recommendation 7

It is recommended that BCUHB reviews MDT documentation to ensure consideration for the wider engagement of services to identify a clear pathway of communication between MHLD services and GP practices.

3.4 **HYWEL DDA UNIVERSITY HEALTH BOARD on behalf of the general hospital**

3.4.1 Barbara was admitted to general hospital in October 2019, following her overdose. Whilst she was in hospital, the doctor spoke to her daughter; she informed the doctor of 'recent troubles at home'. Unfortunately, it has not been possible to speak to the doctor as part of the review as he has now left the organisation. This disclosure could be widely interpreted, and Barbara was not well enough to be asked herself about this.

The review accepts that there was no evidence at this stage that Barbara was a victim of domestic abuse or that she had tried to harm her husband. The priority at this point was, quite rightly, to manage her poor clinical condition.

3.4.2 When the out-of-hours consultant took over Barbara's care at 9pm, he recorded that Barbara's daughter had informed him that her mother had baseline cognitive impairment and that she was going like her husband (he has Alzheimer's)[18]. She also told him that, a week ago, when intoxicated, her mother had spoken about suicide. There were no disclosures made of abuse or violence towards either Barbara or George.

3.4.3 When he was reviewing her in response to her liver failure, the consultant stated that he did not speak to Barbara about why she wanted to die, but was concerned about her suicidal ideation in the context of her eligibility for a liver transplant. He told the IMR author that he believes that the Crisis Team should see patients, specifically with paracetamol overdose, sooner than at the point that they are medically fit to be discharged, due to the need to consider referral for liver transplant. As stated earlier, one of the criteria for liver transplant is a desire to go on living.

[18] The Report Author has spoken to Barbara's daughter and confirmed that this was incorrectly recorded and that she was referring to her husband not her father

The Crisis Team advised the IMR author that one of the criteria for referral to the Crisis Team is the person being medically fit for discharge. That said, patients can be referred sooner to a psychiatrist for assessment if acute clinicians are concerned about the patient's mental health. In this case, the doctor was very clear that Barbara wanted to end her life and therefore, arguably, should have been referred earlier.

3.4.4 The doctor involved in this episode, does not recall any disclosures of domestic abuse, and none were recorded.

3.4.5 During the time that Barbara was in hospital, her daughter visited regularly. Staff who were interviewed by the IMR author, recall seeing Barbara's son-in-law, but no-one recalls seeing George. It was understood that George did not appear to be present. There is only one mention of him in the records, on 10th October, when there was a discussion with Barbara's daughter, late in the afternoon, and she was informed that her mother was likely to deteriorate: she stated that she wanted to take her father home[19]. Therefore, the IMR author has not been able to elicit any observations about their relationship, his vulnerabilities, or interactions during that time.

3.4.6 The review is advised that the medical records detail regular conversations with Barbara's daughter regarding her mother's medical condition. However, the IMR author notes that it was not until the point of discharge from the hospital and subsequent assessment by the Crisis Team, that she disclosed historical events related to her mother, which included her taking a knife to George and looking for the petrol can to set fire to the bungalow.

The review considers that this is understandable given that, to that point, Barbara's daughter had believed that her mother was not going to survive, and she told the review, therefore, this would not have been uppermost in her mind.

The review agrees with the IMR author that there was an apparent lack of professional curiosity in asking Barbara's daughter what she had done in relation to these incidents, and what she expected in response to her disclosure. Agreeing with Barbara's daughter on the phone that the family would sort out support from social services, was not inappropriate in principle, but once the additional disclosures were made, there was a responsibility by the ward to take decisive action. The panel agreed that action should have been taken and a safeguarding referral should have been made. This is discussed in more detail later in the report.

Recommendation 8

It is recommended that the UHB holds a reflective practice session with staff, exploring professional curiosity where there are concerns raised by individuals about the action taken and expectations.

3.4.7 The nurse on the ward in charge of Barbara's discharge, did hand this information to the Crisis Team to inform their assessment. The Community Psychiatric Nurse (CPN), who

[19] Barbara's daughter has told the review that when her father came to visit, Barbara was delirious and made upsetting accusations towards him and so she had taken him home.

carried out the assessment, did ask Barbara about these incidents. The CPN noted that Barbara did not deny that she held a knife to her husband's chest, but that she had not intended to hurt him and said that she had done it out of frustration. Barbara denied looking for the petrol can to burn down the bungalow and said that this was something that George had made up.

Barbara's daughter stated that she had found her mother looking for the petrol can[20]. This was another opportunity when the nurse could have explored what action she had taken.

3.4.8 The nurse involved in Barbara's discharge, recalls that her daughter had said that she had spoken to her husband's social worker who said that they would arrange help for them. Barbara's daughter has clarified that the social worker had signposted them rather than agreeing to arrange it.

It would have been best practice for the staff to submit a MARF regardless of this, and inform them of the reason for doing so. There appears to have been an over reliance on other professionals, than those to whom the disclosures were made, to act, assess the risks and safeguard the individuals involved.

The review is aware that, since Barbara's death, HDUHB has updated group 2 'Ask and Act' and level 3 adult safeguarding training to include domestic abuse and older people.

3.4.9 The Social Services and Wellbeing (Wales) Act 2014, imposes a legal duty on relevant partners to report to a local authority if it is suspected that an adult is an adult at risk. The legislation and statutory guidance allow for a reasonable cause to suspect a person is an adult at risk and it is necessary for that fact to be established prior to a referral[21]. The guidance is clear that practitioners should seek to be transparent with people they are working with regarding the circumstances where they may need to share information with social services or the police. Barbara may not have consented to a referral, but the principle of maintaining confidentiality or not having consent should not lead to a failure to take action to protect the adult or others from abuse or harm.

Under Section 126 (2) of the Act, the local authority has a duty to make enquiries where reasonable suspicion exists that an adult is 'at risk' of abuse or harm. This, therefore, could have triggered an assessment of risk and care and support needs on discharge from hospital for both Barbara and George.

3.4.10 The CPN advised the IMR author that when the assessment was undertaken, Barbara had capacity to participate in the assessment and while she had mild cognitive decline, it could not be proved at the assessment that the alleged incident with the petrol can had taken place. Furthermore, it was noted that Barbara and her daughter's reporting of Barbara's alcohol intake were different, and he was not able to prove it either way at the assessment.

[20] Barbara's daughter had not seen her with the petrol can but had been told about this by her father. It may be that the nurse may have misunderstood.
[21] Working Together to Safeguard People: Volume 6 - Handling Individual Cases to Protect Adults at Risk, 2018

The review agrees that it was not the role of the CPN to make a judgement about whether he could prove if the incident had occurred. The information should clearly have been shared across the safeguarding arena.

While the review recognises that Barbara's daughter had believed that her mother was not going to survive and, therefore, disclosing incidents between her parents may not have been a priority until she became ready for discharge, when she did disclose, those full disclosures and discussions by Caroline did not take place in Barbara's presence. Also, Barbara's view of some of those incidents were not consistent with her daughter's.

3.4.11 During the assessment, Barbara told the CPN that since George had retired, he did 'nothing', and she was waiting on him hand and foot. She also identified that things needed to change in the relationship. She described being treated as a 'doormat'. The CPN noted that her daughter contradicted this, but not in front of her mother, and said that her mother had chosen to do this all her married life and that she was a control freak. It is not understood why she did not discuss her full concerns in front of her mother[22].

On reflecting on the assessment and decision-making at the time, the CPN reflected that it was not clear that George was an adult at risk of abuse or neglect. When he was specifically asked about Barbara's daughter's comment that she feared that 'they would kill each other in time', he reflected that it was not clear who was the potential aggressor, despite being told that Barbara had taken a knife to her husband.

The assessment concluded that Barbara was not detainable under the Mental Health Act and that she was fit for discharge, with follow-up from the MHCT3. The CPN felt that follow-up by the MHCT3 would enable better insight into the reality of the family relationships and identify if a safeguarding referral was required.

The review notes that there was no apparent consideration given by professionals that domestic abuse may exist within this relationship: with Barbara being either the victim or the perpetrator. This will be considered in more detail later in the report.

Whilst Barbara was negative about her husband, there was no reference by Barbara herself to incidents of assault towards her, or caused by her, or intent to cause harm to her husband. The CPN did target the enquiry in accordance with 'Ask and Act', as set out as part of the National Training Framework based on the information available. Barbara agreed that she had taken a knife to her husband, albeit she said that she did not intend to harm him. George was not present to do targeted enquiry with him, however, there were missed opportunities to submit a multi-agency referral form, via safeguarding procedures, for everyone potentially involved in the incidents disclosed by the daughter.

The review is aware that, since Barbara's death, considerable work has been undertaken to address the issues identified. These include:

[22] Barbara's daughter explains that this was because she had spoken to the CPN twice on the phone when she discussed her concerns.

- **Reviewing existing safeguarding and 'Ask and Act' training within HDUHB to strengthen awareness of domestic abuse and older people, including identification of females as potential perpetrators**
- **Escalating the bullet point above to the NHS Wales VAWDASV Steering Group to share learning across Health Boards and NHS Trusts**
- **Distributing a seven-minute briefing on domestic abuse and older people to raise awareness of domestic abuse and older people, along with the Live Fear Free Helpline**
- **Circulating the Welsh Government VAWDASV Good Practice Guidance for non-specialist Welsh Public Services on Working with Adult Perpetrators and referring to this in safeguarding training to make staff aware of support available to perpetrators**
- **Continuing to promote Dewis Choice training to promote understanding of domestic abuse and older people**
- **Making a recommendation to the Regional VAWDASDV Steering Group that accessibility and tracking of agency uptake of the Dewis Choice training is made available through the national multi-agency system.**

Section Four – Analysis
Understanding Barbara's life

4.1 INFORMATION SHARED BY BARBARA'S FAMILY

4.1.1 Barbara's daughter described her mother's personality as being very 'up and down'. This was extreme, much more than what one would generally describe someone as being 'up and down'. To illustrate this point, she talked about how her parenting would fluctuate widely. When she was 13, during a time when her mood was very 'up', she was happy for her daughter to go out wherever she wanted and return home at 3 am. A few years later, when she was experiencing a 'down' time, she wanted her daughter to be in by 9pm, even though she was, by this time, she had embarked on her career.

4.1.2 In her police statement, Barbara's daughter described her mother having a 'gruff voice', which would suggest that someone was 'going to get it'. She described this voice as an alert that suggested 'you're treading on eggshells now'. 'That's the voice that I've learnt to know since I was a child'.

4.1.3 Barbara was, according to her daughter, a fiercely independent woman.

4.1.4 Looking back, she realises that her mother started to 'close down' before they moved to North Wales, but she did not see it clearly at the time.

4.1.5 Barbara's weight fluctuated throughout her life, depending on how she was feeling. Her daughter has told the review that when things were not going well for her mother, she would stop eating. Before she took the overdose, she had talked about not eating.

4.1.6 According to their daughter, Barbara and George were not great mixers: they did not have a group of friends. Barbara did not see anyone other than her sister, who she would go shopping with once a week and out on trips with occasionally.

4.1.7 During the time that Barbara was being seen by the MCHT1, she described her life prior to moving to North Wales in glowing terms. She said that she had been a sociable and busy lady and that it was this lifestyle that she missed.

The Review Panel considered this view of life in the Midlands, portrayed by Barbara following her overdose, as very different to that described by her husband and daughter. The panel considered the possibility that she had mixed up her lifestyles and was talking about a time when she was much younger, rather than just prior to their move. This could have occurred as a result of depression or dementia.

4.1.8 George told the review that he and Barbara moved to North Wales as they wanted a change, and their daughter had asked them to move nearer to her to support her with caring for her husband. He said that he had not seen the bungalow, but that Barbara had travelled there. When she returned, she had told him that they were moving. George felt that this was a good move for them and that for the first few weeks, Barbara agreed with him. However, she became fed up with not being able to see her sister and having to rely on her daughter to take her shopping, as she had given up driving by this point.

4.1.9 Barbara's sister, in her police statement, said that her sister became unhappy when she moved to North Wales as she felt that she had gone there to help her daughter look after her husband but found that there was a lot that he could do. She said that, at first, her sister had thought she was needed, and she was a person who needed to be needed. She confirmed that her sister was not a person who made close friends.

4.1.10 In her police statement, the psychiatric nurse from the MCHT1 said that, at their initial meeting, Barbara had said that she felt resentful towards her husband and daughter, as she had not expected to move so quickly.

4.2 EVIDENCE OF DOMESTIC ABUSE

4.2.1 The purpose of a DHR is to explore if there is evidence of a trail of domestic abuse leading up to the incident that resulted in Barbara's death. No domestic abuse was reported to any agencies by either Barbara or George. The review has relied upon the judge's sentencing remarks, all of the evidence presented in the two-week trial, and information provided by George and his daughter.

4.2.2 George did not tell his daughter about what his marriage was like until they had moved to North Wales when, one day, he went into her house and cried. He told his daughter about his marriage and called his wife 'evil'. His daughter said that he is a man who was not emotional and did not show emotion, so she was not surprised that he had not talked to her before about what was happening.

4.2.3 There has been no evidence provided to this review to suggest that George was domestically abusive towards his wife, Barbara. The judge said that, having heard evidence, he believed that George was a decent, hardworking responsible man who had never been violent before to anyone.

4.2.4 Their daughter described Barbara and George's relationship as being great at times, with moments of joy. Barbara's sister told the court that Barbara loved George 'to bits', and he loved her as much back. George told the court, and the review, that he still loved Barbara and that he always will. At the same time, the judge said there were difficulties in their marriage that persisted throughout.

4.2.5 Barbara was, said the judge, the dominant personality in the relationship. For all her good qualities, she could be controlling and manipulative. She took control of everything in the home, but criticised George for not helping. She put him down and would have constant digs at him.

4.2.6 A particular source of difficulty in the relationship, the judge said, was alcohol. In the past, they had both drunk too much and this had led to arguments. Barbara would sometimes let George drink what he wanted, but at other times she would give him an allowance. Their daughter's perception was that this was both because she cared about George and did not want him to drink himself to death, but that she also did this to hurt him. The review cannot comment on this. Whist alcohol may be the source of arguments, it was never, the judge said, the source of violence. The court heard evidence that George would sulk and give Barbara the silent treatment.

4.2.7 Barbara would try to hide her own drinking whilst discussing her husband's drinking with her daughter. George was aware that Barbara did this but, according to his daughter, he was

not worried about it. However, his daughter saw it as control. She told the review that her mother would buy whisky, show it to George, and then pour it down the sink. On ~~Christmas Day~~ the day of Barbara's death, after he drunk a bottle of red wine over lunch, Barbara had been trying to get George to drink more. He wanted to drink Vermouth, but she was trying to encourage him to drink whisky. He did not want to drink whisky as he knew that if he had one drink, he would drink the whole bottle. Nonetheless, Barbara had poured a whisky for him.

4.2.8 The judge said that when the couple moved to North Wales in 2018, their relationship deteriorated. Barbara felt that they had moved to a small place with nothing to do, and she described it as living in a coffin with the lid off. She felt isolated and alone. She was intensely jealous of the relationship that her daughter was developing with her stepdaughter, and with George. She told her sister that she had been conned into moving. She blamed George and her daughter and felt bitter towards them. George had been content to move, and that only added to her bitterness.

4.2.9 When the Chair and Report Author spoke to George, he was asked if Barbara's unhappiness at moving to North Wales brought tension to the marriage. George replied that it was not really any worse: there had been tension for 54 years. She would be alright one minute and then blow up into a mood. He explained this was partly due to his wife's gynaecological problems over the years.

4.2.10 George told the Chair and Report Author that on one occasion, early in their marriage, he had walked out of the family home and gone to his mother's. She had asked why he was there, and he told her that he and Barbara had had an argument. His mother advised him that he should deal with Barbara in the same way as he did with her – let it go in one ear and out of the other. He said that he returned home and adopted this approach in the years ahead. He explained that she would carry on at him and he would ignore her, and if it became too much, he would just walk out of the house for a time. He said that this would happen 2-3 times a week and had worsened over the last 2-3 years. When asked, he said that the deterioration had been triggered by alcohol.

4.2.11 The court was told that arguments between Barbara and George seemed to worsen but George's reaction to arguments was not violence. He would, instead, go to his daughter's house and sit in the garden or in the house. Barbara's daughter told the court that she left the doors open for George and on one occasion, he just sat and cried. He told his daughter that she just did not know what it was like in his home. When Barbara's daughter went to speak to her mother, on the night before she died, she found her drunk and her mother told her that she hated everyone and would make George's life hell. Barbara said that she felt that George was a grown man who could sort things out with her, and by him walking away from arguments, it incensed her.

4.2.12 Barbara looked after all the couple's finances, and he would ask her for any money that he needed. For example, if he wanted to buy a sandwich whilst he was out fishing, she would give him £2. There were three bank accounts: a joint account into which went George's pension; Barbara's account into which went her pension; and, George's sole account. This account had only been opened recently so that their daughter could transfer the money from the sale of the house in the Midlands. When Barbara was in hospital, George had drawn £100 from the joint account and so, when she returned from hospital, Barbara cut up his bank card.

4.2.13 The review is very careful in suggesting that this may have been evidence of economic abuse, as Barbara looking after the money began many years ago for a good reason. The reason being that George was the only breadwinner and he began gambling, causing financial problems for the family, so Barbara had taken over the money. Their daughter believes that, prior to her overdose, this arrangement had suited them both.

4.2.14 On 30th September, George was woken (he and his wife slept in separate rooms) in his bed to Barbara prodding him with a knife, which left rips in his T shirt and marks on his body. She made as if she was going to stab him. She later told her daughter that she had been looking for his heart, but he had no heart. When she made the stabbing gesture, George got the knife from her, cutting his hand in the process. He went to his daughter's house. George refused to go to hospital or involve the police as he wanted to protect his wife and said that, if the police were involved, he would deny everything.

4.2.15 George told the Chair and Report Author that although she had threatened violence many times over the years, this time was different. He said that he was frightened.

4.2.16 By this time, George was sufficiently scared of what Barbara would do that he set a booby trap involving a vacuum cleaner attached to a piece of string, which would clatter if she tried to go into his room in the night. George's daughter had offered to fit a bolt to the door, but he refused to let her do it and set up the booby trap instead. Later, George told his daughter that this was because, on a previous occasion, Barbara had been looking for the petrol can for the lawn mower because she was threatening to burn down the house. Barbara denied this. However, the judge said that he was sure that she did as George had no reason to make it up. He said that he had not told anyone about this as he was afraid that they would take her away.

4.2.17 On several occasions, Barbara minimised this incident. She told the psychiatric nurse from the MCHT1 that 'it was something and nothing' and was very dismissive about it.

4.2.18 The psychiatric nurse noted, in her police statement, that whilst she was visiting the home, she noticed that Barbara would have 'little digs at George quite a bit'. She explained that, by this, she meant that she would say things such as: 'he does nothing round the house'. She said that George appeared very placid and laid back, and that he would just sit and take all the comments from Barbara.

4.2.19 Barbara's daughter told the court that, during this time, her mother was getting more difficult and more aggressive. Barbara told George and others that she would make their lives hell. Their daughter told people that something had to be done or one of them would end up dead.

4.2.20 Barbara's daughter has expressed her wish that it is made clear that: 'numerous times it is mentioned that mom did not intend to do dad harm when she stabbed him. She was so intoxicated that she felt able to carry out acts of violence against not only him but me. She was incapable of making a rational thought. On that night she had consumed almost a whole bottle of vermouth and she was only tiny at the time. The knife she used was extremely sharp – as proved in court – it needed minimum pressure to cause a fatal wound, hence when I was stating one would end up dead, I included the wording – by accident'.

4.2.21 Barbara's daughter told the review about an instance in North Wales when she was painting her fence and could hear her parents talking in the garden. She was shocked and upset by

the way in which her mother spoke to her father: there was a nasty edge to the way she spoke. She was certain that her mother was aware of how she was speaking. On another occasion, she heard her mother speaking about her father on the telephone. She was speaking very nastily about her father. When she challenged her about what she heard, her mother refused to speak to her for a week.

4.2.22 Barbara's daughter told the court about a striking incident on the day before Barbara's death, when she saw her mother sitting on the settee in her home and stabbing at it with a small knife. She was also running the blade through her fingers. Her daughter said that she seemed to be unaware of what she was doing. The review has been told by her daughter that this was not a one-off incident for Barbara to sit in the chair with the knife by her side. She did this often and it was intended to harm George.

4.2.23 In the first account of what had happened, George told his daughter that Barbara had been goading him and hurting him in the most hurtful way. The review has been told by both Barbara's daughter and sister that this goading stemmed back to an incident some years previously when George had been called a 'paedo' by a neighbour who was high on drink and drugs. This neighbour later apologised, but George was mortified by this accusation and carried it with him. Barbara would use this as a way of hurting him.

4.2.24 The judge concluded that, given the history of their relationship, this was in all probability, what happened. He said that things may have been exacerbated by Barbara trying to stop George from getting more alcohol, but that this was an added layer of controlling behaviour. The judge said that he was sure that what truly caused him to lose control was the matters that he had told his daughter at the time.

4.2.25 The loss of control had to be seen firstly, the judge said, against the background and culmination of years of Barbara putting him down and her controlling behaviour. Secondly, the judge said it should be seen against the more recent background of verbal and physical aggression, Barbara's threat to harm George or both of them, her physical attack on him with the knife, and her stated intention to make his life hell.

4.2.26 The judge made it clear that, having heard all the evidence, he was sure that what George had endured through his marriage, and most acutely since the move to North Wales, went very far beyond domestic arguments and a difficult relationship, and is properly characterised as domestic abuse.

4.2.27 Only recently has George talked to his daughter about what had happened on the day that Barbara died when they returned from her house. George had gone out for a dog walk with his daughter and her husband, which was unusual for him. When he returned to his bungalow, Barbara was waiting behind the door with the knife. He heard it fall to the floor and so he went round and entered through the back door. His daughter has told the review that, on the day of her death, her mother had said to George that 'by the end of the day he will be going to prison'.

4.2.28 George told the Chair and Report Author that the day of Barbara's death had started normally. Barbara had got up and cooked bacon and eggs for their breakfast. He recalled that she was 'a bit rough talking to me about walking the dog'. He said that they went early to their daughter's house and Barbara was nagging and moaning, continually asking their daughter if there was anything she could do.

4.3 WHAT WERE THE BARRIERS TO GEORGE LEAVING OR TELLING SOMEONE WHAT WAS HAPPENING?

4.3.1 George's daughter has said that, for her father, marriage was for life – it was a case of being 'for better or for worse'. She said that Barbara looked after her father.

4.3.2 When talking about their marriage, the couple's daughter told the review that, at times, both her mother and father would threaten to leave the marriage, but if her father said he was going to leave, Barbara would lock him out of the house.

4.3.3 When they spoke with George, the Chair and Report Author asked him why he had stayed with Barbara, despite the risk of serious harm. He said that he had met her 60 years ago and he had loved her from the first kiss. He loved her for 60 years and he still loves her now. He said: 'I will still love her when I die'. He said that he could not see life without her and she's a good wife, and he never wanted for anything.

4.3.4 When asked if he had ever considered talking to someone about his life, he said that he had not because 99% of the time they had always made up after the arguments. He said that sometimes things would blow over after ½ hour, but on the day of Barbara's death it had been going on all day.

Recommendation 9
It is recommended that the CSP holds a series of awareness-raising campaigns in the local area. These should focus upon male victims of domestic abuse and older victims of domestic abuse. The campaigns should be targeted where they are most likely to reach these groups.

Recommendation 10
It is recommended that the CSP reviews its current publicity arrangements in the local area to ensure that the information that is available on an ongoing basis is providing information about the different aspects of domestic abuse (i.e. it is not just physical abuse), and where support is provided.

Recommendation 11
It is recommended that the CSP ensures that, as part of the publicity they are using locally, there are clear messages for family and friends of those who are experiencing domestic abuse about how they can support their loved ones.

4.4 THE RISK THAT BARBARA POSED TO GEORGE AND THE RESPONSE OF AGENCIES TO THIS

4.4.1 When Barbara was in hospital, at the point of discharge, staff became aware of the incidents that had occurred when George had been at risk from the actions of Barbara, and that the disclosures made by Barbara and her daughter differed. There is no evidence to suggest that any action was taken by staff once this information was known. The panel felt that there should have been, at the very least, a referral to the local authority.

4.4.2 The panel was of the view that a DASH could have been completed and a referral to MARAC should have been considered. The review accepts that staff may have not considered this, or may have found this difficult as George had not been seen at the hospital, other than on one occasion. However, the review believes that this should not have prevented a MARAC referral, which could have been made on professional judgement.

4.4.3 The panel was very concerned that staff did not consider domestic abuse being a feature in these reports, as the couple were older and had been married for more than 50 years. The genuine risk that George was in was not considered. The panel wondered if there was also an element of gender bias. The question was debated about whether they may have been more alert to the risk if the victim had been Barbara, and the perpetrator, George. The panel agreed that both age and gender bias seemed to influence the decisions made.

4.4.4 In its deliberations, the panel also observed a lack of professional curiosity when staff engaged with Barbara's daughter. There was no information given to her about where she could get support and assistance.

4.4.5 The review notes that the ward on which Barbara was being treated had not been in the priority group for training on 'Ask and Act'. This was in accordance with the VAWDASV National Training Framework and so staff may not have been aware of where to signpost Barbara and her daughter for domestic abuse specialist support. However, these resources have been communicated via other means, including the UHB safeguarding intranet page and global email communications. They should have advised her daughter to contact police if she felt her mother and/or father were in danger. Professionals had a responsibility to empower her with information for support, such as the Live Fear Free Helpline.

4.4.6 Discussions at the panel meeting included a view, by some health colleagues, that the challenges faced by practitioners when there are differing accounts by family members and there are no concerns about cognition, should be recognised. These discussions included a debate about 'who should have been believed?' It is not view of the review that it is the role of healthcare staff in these settings to make a judgement about who should and should not be believed. There was information about an incident of clear concern that should have been referred on and was not.

4.5 ALCOHOL IN THE RELATIONSHIP

4.5.1 The level of alcohol misuse, of both Barbara and George, is somewhat of a conundrum for this review.

4.5.2 Barbara and George's daughter told the review that alcohol had always been a problem for both of her parents. In her view, they were both alcoholics. Her mother would say that George was an alcoholic and that she controlled his drinking. When her mother was admitted to hospital on 8th October 2019, she told them that her mother drank two bottles of wine each week (equivalent to 20 units), and was a binge drinker. Barbara told staff that she bought one bottle of wine each week.

4.5.3 George told the Chair and Report Author that he would drink 1 litre of Vermouth a day, when they lived in the Midlands. When they moved to North Wales, they would go to the nearest town to do their shopping and, on one occasion, Barbara had put a couple of bottles for her, and four bottles for him, into the shopping trolley. They had an argument about the weight of the bottles. On another occasion, when Barbara's daughter had taken her shopping in the car, she had bought more than 20 bottles.

4.5.4 George had decided he was not going to drink a bottle a day. He had decided he was going to drink three bottles a week and he would choose the days on which he was going to drink. He explained that they had built up a stock of bottles in the shed. There were, he said, 60 bottles at one time, but they got them down to 30. He related an incident when they had

an argument and he decided he was going to have a drink and set off to the shed. Barbara said that he was not having a drink and started to smash as many as she could. He got a bottle and went to his room to drink it. The next morning, she asked him how many bottles he had and when he said between five and seven, she said that he would have no more as she had thrown them in the river. He did not, however, believe her as they were very heavy. George said that Barbara would only drink a one litre bottle each week.

4.5.5 The table below indicates the level of alcohol consumption declared by both Barbara and George to their GPs:

Date	Units that Barbara disclosed	Units that George disclosed
7th March 2018		24 per week
4th July 2018	7 per week	
5th October 2018	2 per week	6 per week
6th December 2018		6 per week
7th January 2019	4 per week	
5th June 2019	0 per week	6 per week
11th December 2019	2 per week	6 per week

The NICE guidelines are 14 units per week

4.5.6 The review fully acknowledges that many people, when asked by a health professional, will not disclose truthfully the amount of alcohol they consume. However, during this timeframe, there was nothing in the regular blood tests to suggest physiological harm and, therefore, nothing to prompt the GPs to press further on the information they were given. There is no evidence in their blood tests to indicate the level of alcohol consumption that has been disclosed. Hence, the conundrum for the review.

4.5.7 It does appear that the Home Treatment Team (MCHT1) had some indication of the possibility of alcohol misuse when they received the referral on 22nd October 2019 as, during the consultation with Crisis Team, Barbara said she did not have any problems with alcohol. She said she would buy a bottle of wine on a Monday and that this would last all week. She said that her husband drank 3 bottles a week.

4.5.8 On 24th October, after the overdose, she was advised to abstain from alcohol whilst waiting for the results of her liver function tests.

Barbara disclosed limited alcohol use to the MCHT1, but there is no evidence that screening tools were used or that there was any discussion with her that might have led to a referral to a specialist alcohol treatment service for assessment and support.

The link to alcohol use and the risks associated with domestic abuse were potentially missed.

4.5.9 Misuse of alcohol can affect the physical and mental health, and increase the risk of developing problems and conditions in later life. For example, increased risk of accidents,

stroke or heart disease, poor liver functioning, depression, dementia, anxiety, and memory impairment[23].

4.5.10 As people get older, alcohol is broken down more slowly and they become more sensitive to the effects of alcohol. Therefore, if people continue to drink the same amount of alcohol, as they get older, it is likely to affect them more. According to The Royal College of Psychiatrists, one in six older men and one in 15 older women are 'drinking enough to harm themselves'[24].

4.5.11 Diagnosing alcohol misuse in older age can be harder as it can be obscured by non-specific illnesses and conditions such as gastrointestinal problems and insomnia, or misdiagnosed as dementia or depression[25].

4.5.12 The Judge said, in sentencing, that George had never reacted to an argument with violence before, even when intoxicated. The judge said that George may have drunk a lot that day but that was not exceptional for him and could not, in itself, explain what he did.

4.5.13 The review notes that the incident of Barbara stabbing George whilst he was in bed, happened when she was drunk. However, she was sober in the incident when she was searching for the petrol can with which to burn down the bungalow.

4.6 BARBARA'S HEALTH

4.6.1 This review has looked at the medical records of Barbara, her interaction with professionals, and heard the concerns of her daughter, with a view to understanding if her behaviour in the last months of her life could be attributed to undiagnosed dementia.

4.6.2 Barbara's daughter said to the review that she felt that the delay, as she saw it, in carrying out tests for her mother in relation to possible dementia, brought additional pressures for the family. She felt that her mother deceived professionals and lied to them. She felt that there was not enough notice taken of what those caring for Barbara were reporting.

4.6.3 The panel has discussed, at length, this situation and it mirrors the dilemma faced by medical professionals when the patient does not consent to medical intervention or tests.

4.6.4 **Informed consent[26]**

4.6.5 The principle of consent is an important part of medical ethics and international human rights law. The underlying principle is that, for consent to be valid, it must be voluntary and informed, and the consenting person must have the capacity to make the decision.

4.6.6 If an adult has capacity to make a voluntary and informed decision to consent to, or refuse, a particular treatment, their decision must be respected.

[23] Alcohol, drugs and older people, HSC Public Health Agency,
[24] Ibid
[25] Older people and alcohol Factsheet, Institute of Alcohol Studies, May 2013
[26] MCHT1ps://www.nhs.uk/conditions/consent-to-treatment/

4.6.7 **Barbara's capacity to make decisions**

4.6.8 Reading Barbara's GP records, there is no sense that, at any point, she did not have capacity to make her own decisions. Arguably, she *did* understand that she needed to make changes to her life. She agreed with her GP that she would not drive when they moved to North Wales. At this particular appointment, on 26th June, her GP planned to refer Barbara to the memory/mental health assessment team. Whilst Barbara appeared to agree to this, she successfully persuaded the GP that she would sort this out when they moved to North Wales. When the issue was raised by her daughter after they had moved to North Wales, she refused to pursue this. This suggests that she *did* have capacity to manipulate this situation. Why she took this course of action, no-one can know but it is, arguably, possible that she was concerned about what they might find, hence her reluctance to engage with the process.

4.6.9 On 21st October, when Barbara was being prepared for discharge from hospital, her daughter advised the ward that she was very concerned about her mother coming home as she 'would not be safe at home' due to George not being able to look after himself, and she being the carer for her husband, who had Alzheimer's. When a nurse talked to Barbara about why she had been brought into hospital, Barbara acknowledged that she needed help, but said that she would organise this herself.

The review considers that these incidents demonstrate that Barbara was adept at saying what she thought people wanted to hear, and at keeping professionals at arm's length.

4.6.10 **Diagnosis of dementia**

4.6.11 Barbara's reluctance to engage with an assessment by the correct professionals means that her family are left with the unanswered question about whether she was suffering from the early stages of dementia.

4.6.12 The concerns about Barbara's cognitive function were first raised, by her family, in 2015 and again in 2016, when she had a urinary tract infection. On both occasions, this, quite ordinarily, led to concerns about her cognitive function. In 2016, George and his daughter discussed Barbara's memory and the decline that they had observed, even before the urinary tract infection. In March 2016, Barbara had a hysterectomy that resolved the urinary tract infections and, in turn, improved her cognitive function somewhat.

4.6.13 In 2017, Caroline once again raised her concerns, with the GP, about her mother's memory. At this time, the GP completed the GPCOG[27]. As she scored full marks, it was noted that there was no impairment.

4.6.14 In May 2018, Barbara had an MRI scan and reported to her daughter that she had been told that this was normal for someone of her age.

4.6.15 It is important that the review remembers that Barbara's daughter's husband was diagnosed with early onset dementia in June 2018, and that she was strongly of the view that her mother was displaying similar characteristics. Whilst she was able to look after day-to-day activities in the home, she became confused with more complex tasks.

[27] General Practitioner Assessment of Cognition

4.6.16 Barbara's daughter accompanied her mother to the GP at the end of June, as she was concerned about her mother's memory, confusion and driving ability. During this visit, the GP sought to reassure her that there was nothing on the MRI to be worried about and that her concerns were a normal sign of ageing. As Barbara's daughter remained anxious, the GP agreed to refer her mother to the mental health/memory assessment team. As they were about to move, Barbara asked for this to be delayed until she was settled in North Wales. However, as we know, Barbara refused to follow this through.

4.6.17 Following the move at the beginning of August, Barbara's daughter said her mother was unable to manage household matters and would often take the phone to her so that she could speak on her behalf.

The panel acknowledged that this was not her mother's normal behaviour and that she had seen significant changes. The review is in no doubt that had her mother's life not been taken in December 2019, her daughter would have continued to seek a full assessment of her mother. That would, in time, have provided the answer to the question, but we do not have this answer.

4.6.18 **Depression**

4.6.19 Whilst we do not know if Barbara was suffering from dementia, we do know that she had been diagnosed with depression.

4.6.20 In December 2018, Barbara took an overdose but was not hospitalised.

4.6.21 When Barbara saw the practice nurse on 7th January 2019, there was mention of depression; however, she declined to see the doctor to discuss this further. She did see the GP a few days later, on 10th January, for a new patient examination. It was noted that she had lost two stone in weight since moving to North Wales, but was not clinically depressed.

It is not possible from the GP records to ascertain how the GP arrived at the diagnosis that Barbara was not depressed, but the review is surprised that this was not explored further, given that she had spoken of feeling depressed to the practice: twice within a few days.

4.6.22 In August 2019, Barbara's daughter talked to a professional, who was supporting her husband, about how her mother would talk to her about how bad she felt that she was getting and how depressed she was, but she would not agree to a referral to a specialist.

4.6.23 On 5th October, Barbara told her daughter that she 'wanted to end it all'. Three days later, George awoke and could not rouse Barbara. An ambulance was called, and Caroline suggested to them that her mother may have taken an overdose and that she believed that her mother was showing signs of dementia.

4.6.24 Barbara was very clear with nurses that she had wanted to end her life and that she still felt the same. When the Crisis Team saw her on 21st October, she realised that she had nearly died. It was noted that her mood had improved, and she realised that things needed to change at home: she was adamant that it was going to happen. She denied any suicidal ideation or issues with alcohol.

4.6.25 When Barbara met the MCHT1 for the first time, she appeared to have good insight into the social isolation that she was feeling. She said that she and George never did anything enjoyable together, that they no longer had a car, and that she missed the company of her sister. She was struggling to adapt to living in a small, quiet and isolated village. She said she was struggling to integrate into the local community and was feeling isolated.

4.6.26 On 7th November, Barbara's GP practice received a letter from the Acute Mental Health Unit which advised that she was experiencing severe depression.

4.6.27 When Barbara was admitted to hospital with what was diagnosed as Bell's Palsy on 27th November, she was noted to be 'positive and motivated'.

There is no doubt that Barbara had experienced depression over a period of time and was described as severely depressed just a few weeks before her death. Given the long history of abuse within the marriage, the review is not able to comment on the extent to which her depressed state may have contributed to her state of mind on the day that she died.

4.6.28 **Caroline's view of the involvement of family in care planning**

4.6.29 Barbara's daughter recalls that it was during the evening of 8th October when the junior doctor and consultant discussed her mum's medical history more fully with her. The consultant was told that a few days earlier, her mother had said that she wanted to end it all and that she was not adjusting well to the new area.

4.6.30 Barbara's daughter's recollection is that, at that point, she was told that if her mother recovered, she would have a mental health assessment and care package put in place prior to her discharge. Caroline recollects that, in this conversation, they said that she had a possible fracture to her right wrist – at the time, Caroline did not know how it had happened. There is no reference to this within the medical notes, and medical staff cannot recall this.

4.6.31 She took George to visit Barbara on Thursday afternoon, 9th, and it was at this point they said that, more than likely, she was going to die. During the journey, George told his daughter how the possible fractured wrist had occurred: she told a member of staff, but she cannot remember who. No record of this could be found in Barbara's records. About this time, whilst at home, George had told his daughter about the petrol can and her plan to burn down the bungalow, and her worsening mental capacity. She had not known about this until now.

4.6.32 As soon as she had taken George home, Barbara's daughter returned to the hospital. Barbara's sister, her husband and son were also there. She stayed at the hospital until late afternoon on 11th.

4.6.33 On 12th, Barbara's daughter had just got into the car to return to the hospital when she received a call saying her mum had had a fit and was in the last stages of dying. When she arrived at the hospital, the person assessing her for a liver transplant was also present. They spoke at length about her general health. She was advised that due to her age, suicide attempt, drinking, and possible dementia, they would not consider a liver transplant. This had previously been mentioned to her, but she cannot remember by whom and when.

4.6.34 Late on 12th, Barbara's daughter went to stay in a local hotel and returned to the hospital on 13th. She said that she was advised again that her mother was not going to make it. She was

moved to a private room, and then onto the Acute Stroke Unit. On arrival, she was asked to complete an 'information release'. The extensive questions were about her medical history, circumstances, and how she would cope on release. Barbara's daughter challenged why she was being asked to do this form when her mother was not likely to survive. She was told it was standard practice. She continued but noted that she could see that not everything she said was being written on the form but, as she felt there was little point, she did not challenge her.

4.6.35 She stayed in a hotel again that night and when she returned on 14th, Barbara had started to recover: at mid-afternoon, she went home. When she returned on 15th, she saw a fourth consultant who discussed with her Barbara's improvement. He discussed her discharge from the general hospital and indicated that they were considering transferring her to the community hospital for a mental health assessment, due to their concerns.

4.6.36 Over the next week, Barbara's daughter went back and forth to the hospital. Barbara had been moved to a heart ward and they were talking about her discharge. When Barbara's daughter was asked about the form ('Information Release') that she had completed on 12th, they knew nothing about it. At this point, she began to be concerned that she was being 'fobbed off' and that Barbara was going to be discharged entirely into her care. At this stage, Barbara was refusing to eat and was collapsing regularly.

4.6.37 Whilst Barbara was in hospital, George could sleep peacefully: he was very fearful of her coming out of hospital.

4.6.38 In her Victim Impact Statement, which was part of the criminal process, Barbara's daughter referred to them as a family that was in crisis, shouting for help. This review has sought to recognise the family's view balanced against agency records of those who were involved in supporting the family at this time.

Section Five – The Wales Approach to Tackling Domestic Abuse

5.1 **National Strategy on Violence against Women, Domestic Abuse and Sexual Violence**

5.1.1 In July 2018, the Welsh Government published its Cross Government Delivery Framework for 2018-2021[28], which complements the Welsh Government's National Strategy, required by the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. This document sets out how the Welsh Government is delivering the actions set out within the Strategy.

5.1.2 The strategy has six key objectives that Welsh Ministers expect to achieve by November 2021:

Arrangements for the <u>Prevention</u> of violence against women, domestic abuse, and sexual violence

- Increase awareness and challenge attitudes of violence against women, domestic abuse, and sexual violence across the Welsh Population
- Increased awareness in children and young people of the importance of safe, equal, and healthy relationships and that abusive behaviour is always wrong
- Increased focus on holding perpetrators to account and provide opportunities to change their behaviour based around victim safety
- Make early intervention and prevention a priority

Arrangements for the <u>Protection</u> of victims of violence against women, domestic violence, and sexual violence

- Relevant professionals are trained to provide effective, timely and appropriate responses to victims and survivors

<u>Support</u> for people affected by violence against women, domestic abuse, and sexual violence

- Provide victims with equal access to appropriately resources, high quality, needs led, strength based, gender responsive services across Wales

5.1.3 The cross-Government Delivery Framework outlines the specific actions that will be undertaken to deliver the objects. Delivery of the strategy is in line with the five ways of working outlined in the Well-being of Future Generations (Wales) Act 2015 through:

- Involvement
- Prevention
- Integration
- Long Term thinking
- Collaboration

5.1.4 Notable in the actions undertaken by the Welsh Government are:

- Development of the 'This is Me' campaign that aims to tackle gender stereotyping
- Development of the 'Don't be a Bystander' campaign that encourages anyone who has concern for someone to ask, 'are you OK?'

[28] MCHT1ps://senedd.wales/laid%20documents/gen-ld11671/gen-ld11671-e.pdf

- Developed and published the National Training Framework which is statutory guidance
- Developed an e-learning programme to raise awareness, increase knowledge of the indicators and improve learner confidence to offer help through the Live Fear Free helpline
- Funded nationwide training for domestic abuse workers, significantly increasing the number of qualified, specialist professionals across Wales
- Developed a principles-based approach to prevention – 'Ask and Act'

5.1.5 This Framework is reviewed on an annual basis to ensure it reflects accurately the work being undertaken and planned.

5.2 **'Ask and Act'**[29]

5.2.1 'Ask and Act' is a process of targeted enquiry to be practiced across the Public Service to identify violence against women, domestic abuse, and sexual violence. The term targeted enquiry describes the recognition of indicators of violence against women, domestic abuse, and sexual violence as a prompt for a professional to ask their client whether they have been affected by any of these issues.

5.2.2 The aims of 'Ask and Act' are:

- To increase identification of those experiencing violence against women, domestic abuse, and sexual violence
- To offer referrals and interventions for those identified which provide specialist support based on risk and the need of the client
- To begin to create a culture across the Public Service where addressing violence against women, domestic abuse and sexual violence is understood in the correct context, where disclosure is accepted and facilitated, and support is appropriate and consistent
- To improve the response to those who experience violence against women, domestic abuse, and sexual violence with other complex needs such as substance misuse and mental health; and
- To pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm

5.2.3 The Welsh Government emphasises that it is not expected that the same process of 'Ask and Act' will be implemented in each organisation, but that each organisation should consider how best to offer 'Act and Act' within their varying functions and professional roles.

5.2.4 The training element of 'Ask and Act' is delivered through the National Training Framework.

5.2.5 The Cross Government Delivery Framework for 2018-2021 has committed to:

- Roll out 'Ask and Act' nationally
- Continue to monitor the impact of these documents and revise and republish with statutory provisions as necessary

[29] MCHT1ps://gov.wales/identifying-violence-against-women-domestic-abuse-and-sexual-violence-ask-and-act

5.2.6 The North Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023[30] has committed to:

- Roll out Group 2 and 3 'Ask and Act' across North Wales from April 2018
- Routine enquiry within BCUHB and ensure consistency and roll out across all health services
- Mental health services implementing Group 2 of National Training Framework (NTF)

> The review notes that the ward on which Barbara was treated in HDUHB has not been a priority group for training on 'Ask and Act'. The Health Board started the rollout of 'A&A', as set out by the NTF, in years 1 and 2 for priority groups, but all staff in the Health Board are required to do Group 1 VAWDASV training.

The review notes that 'Ask and Act' is now being offered to all staff who require the competency, and good progress is being made with compliance.

5.2.7 The Review Panel expressed concern that there was not sufficient attention given to domestic abuse and older people in 'Ask and Act' training.

Recommendation 12

It is recommended that the Welsh Government reviews the content of 'Ask and Act' training to ensure it sufficiently demonstrates the prevalence and challenges with DA and older people, and older females as perpetrators of abuse.

5.3 **National Training Framework**

5.3.1 The Welsh Government's National Training Framework[31] sets out statutory requirements for training across the Public Service and specialist third sector. It is made up of six groups. All professions within the Public Service will fall into one of these groups and a minimum training requirement is outlined per group.

5.3.2 The groups are:

- E-learning – this is delivered through Learning@Wales, a national e-learning platform
- 'Ask and Act'
- 'Ask and Act' Champions
- Specialist sector – aimed at professionals whose client group is made up only of those affected by violence against women, domestic abuse and sexual violence
- Managers of specialist sector
- Public service leaders

5.3.3 E-learning is for *all* professionals working in the public sector. The training provides:

- Basic awareness of what violence against women, domestic abuse and sexual violence is
- How to recognise domestic abuse and sexual violence
- Help available to victims

[30] MCHT1ps://www.northwalessafeguardingboard.wales/wp-content/uploads/2018/03/North-Wales-VAWDASV-Strategy-2018-23.pdf
[31] MCHT1ps://gov.wales/national-training-framework-violence-against-women-domestic-abuse-and-sexual-violence

5.3.4 The National strategy delivery document says that they will fully implement the National Training Framework ensuring that relevant professionals are trained to provide effective, timely, and appropriate responses to victims and survivors.

5.3.5 The National advisers' assessment of the Welsh Government achievements in 2019 to 20[32], states that: 'The National Training Framework (NTF) up-skills public services to respond more effectively to those experiencing abuse. During the past year there has been significant work to meet the statutory requirements of the NTF for training to raise basic awareness of VAWDASV in the relevant authorities. We are pleased with the drive and commitment to engage workforce in their development, the targets and completion rates continue to provide confidence in professionals responding to the needs of victims and survivors of abuse.'

5.3.6 The North Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023[33], committed to a Training Sub-Group to develop full NTF project and action plan for the next five years: showing how the National Training Framework will be rolled-out, when each local authority will begin their roll-out, and how this will be monitored.

5.3.7 Betsi Cadwaladr University Health Board has developed a training package for GPs, however, they cannot mandate GPs to use it.

5.4 **Live Fear Free Helpline**

5.4.1 The helpline provides help and advice about violence against women, domestic abuse and sexual violence. The helpline is funded by the Welsh Government who have committed to continue to fund this 24-hour confidential support.

5.4.2 The North Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023[34], committed to ensuring adequate resources are available to ensure that the North Wales population has access to the 24-hour helpline.

5.5 **Domestic Homicide Reviews**

5.5.1 The Welsh Government's Single Unified Safeguarding Review (SUSR) project is working to create a safeguarding review process where a multi-agency approach is required, incorporating the following review processes: Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review.

5.5.2 The SUSR final report is then submitted to the Welsh Safeguarding Repository where all safeguarding reviews are collated, curated, and used to inform professional practice. This enables data to be drawn upon and used by practitioners, through an archival platform, which galvanises information and intelligence into usable formats with a focus on learning.

5.5.3 This will ensure all recommendations are collated into a central location to ensure any learning identified is embedded into policy and learning across Wales. It is the first repository of its kind which conducts thematic explorations using social science and computer science perspectives. It will also be proactive by informing panels, at the

[32] MCHT1ps://gov.wales/violence-against-women-domestic-abuse-and-sexual-violence-national-advisers-annual-report-2019-2020-html#section-50329

[33] MCHT1ps://www.northwalessafeguardingboard.wales/wp-content/uploads/2018/03/North-Wales-VAWDASV-Strategy-2018-23.pdf

[34] MCHT1ps://www.northwalessafeguardingboard.wales/wp-content/uploads/2018/03/North-Wales-VAWDASV-Strategy-2018-23.pdf

commencement of a review, of similar incidents and the recommendations made across Wales.

5.6 IRIS Interventions[35]

5.6.1 The IRIS (Identification and Referral to Improve Safety) programme is a training, referral, and advocacy model to support clinicians in the health service to better support their patients affected by domestic abuse, and to increase the awareness of domestic violence and abuse within general practice. IRIS provides specialist domestic abuse training to clinical professionals, alongside administration staff, within local general practices.

5.6.2 The North Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023[36], committed to considering the implementation of a project similar to the IRIS programme, using the model, and applying this to VAWDASV (roll out of IDVA provision within GP surgeries, as well as other primary health provision).

5.6.3 There is currently a pilot of IRIS underway in another area of North Wales (Conwy and Denbighshire), across a cluster of GPs.

[35] MCHT1ps://irisi.org/
[36] MCHT1ps://www.northwalessafeguardingboard.wales/wp-content/uploads/2018/03/North-Wales-VAWDASV-Strategy-2018-23.pdf

Section Six – Lessons Identified

6.1 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) on behalf of the GP in North Wales**

6.1.1 Although physical needs were assessed and met, there is no reference to Barbara or George's psychological wellbeing having been addressed or explored directly.

6.1.2 No verbal engagement between GP Primary Care services and MHLD services to discuss current involvement and interventions.

6.1.3 There is no record of the SaveLives Pathfinder GP practice briefing having been undertaken. This highlights the importance of undertaking the Routine Enquiry Domestic Abuse (RE DA), whereby frontline staff ask all service users about their experience of domestic abuse, regardless of whether there are any signs of abuse. Barbara had disclosed depression and an attempted suicide was made – these are indicators to suggest that domestic abuse could have been discussed.

6.2 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) Home Treatment Team**

6.2.1 There was no consideration of routine enquiry around domestic abuse during the initial assessment, or upon receipt of referral, following her overdose, from the general hospital.

6.2.2 There was no evidence of selective or routine enquiry around domestic abuse that was carried out during the timeline.

6.2.3 There was no previous medical or psychological information known.

6.3 **HYWEL DDA UNIVERSITY HEALTH BOARD on behalf of the general hospital**

6.3.1 That individuals may raise concerns about the action being taken or their expectations, and that there is a need for staff to be more curious about these concerns.

6.3.2 There is no evidence that practitioners recognised Barbara as a potential perpetrator of domestic abuse, and her husband as a potential victim.

6.3.3 There was a lack of professional curiosity in establishing what action had been taken by Barbara's daughter in response to the disclosures, and in establishing what she expected the outcome to be of making those disclosures.

6.3.4 A MARF should have been submitted to the local authority to share information and enable an assessment of risks and provide a support plan as appropriate.

6.4 **GWYNEDD AND ANGLESEY COMMUNITY SAFETY PARTNERSHIP**

6.4.1 There appears to be a lack of understanding in the local community about domestic abuse – what it is, and who might experience abuse.

6.5 **WELSH GOVERNMENT**

6.5.1 The 'Ask and Act' training does not adequately demonstrate the prevalence and challenges with domestic abuse experienced by older people, and abuse perpetrated by women.

Section Seven – Recommendations

7.1 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) in relation to GP service**

7.1.1 That BCUHB ensures that the relevant legislative information on Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) and the VAWDASV Service User Procedure, be shared across all GP practices in North Wales.

7.1.2 That BCUHB ensures training in relation to domestic abuse is available to all GP practices in North Wales, and seeks assurance from managed GP practices in relation to training compliance.

7.1.3 That BCUHB reviews MDT documentation to ensure consideration for the wider engagement of services to identify a clear pathway of communication between Mental Health and Learning Disability (MHLD) services and GP practices.

7.2 **BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) – Home Treatment Team**

7.2.1 That BCUHB ensures regular quarterly audits of the clinical records in relation to key domestic abuse targets.

7.2.2 That BCUHB update and facilitate Level 3 safeguarding training across MHLD services, in relation to domestic abuse legislation and practice.

7.2.3 That BCUHB ensures that the relevant legislative information on VAWDASV and the VAWDASV Service User Procedure, be shared across all MHLD services with a particular emphasis on domestic abuse and older people.

7.2.4 That BCUHB reviews MDT documentation to ensure consideration for the wider engagement of services to identify a clear pathway of communication between MHLD services and GP practices.

7.3 **HYWEL DDA UNIVERSITY HEALTH BOARD on behalf of general hospital**

7.3.1 That the UHB holds a reflective practice session with staff, exploring professional curiosity where there are concerns raised by individuals about the action taken and expectations.

7.4 **GWYNEDD AND ANGLESEY COMMUNITY SAFETY PARTNERSHIP**

7.4.1 That the CSP holds a series of awareness raising campaigns in the local area. These should focus upon male victims of domestic abuse and older victims of domestic abuse. The campaigns should be targeted where they are most likely to reach these groups.

7.4.2 That the CSP reviews its current publicity arrangements in the local area to ensure that the information that is available on an ongoing basis is providing information about the different aspects of domestic abuse (i.e. it is not just physical abuse), and where support is provided.

7.4.3 That the CSP ensures that, as part of the publicity they are using locally, there are clear messages for the family and friends of those who are experiencing domestic abuse about how they can support their loved ones.

7.5 **WELSH GOVERNMENT**

7.5.1 That the Welsh Government reviews the content of 'Ask and Act' training to ensure it sufficiently demonstrates the prevalence and challenges with DA and older people, and older females as perpetrators of abuse.

Section Eight – Conclusions

8.1 This case demonstrates clearly that the indicators of domestic abuse should always be shared and considered fully across agencies.

8.2 Whilst only one report was received, that report related to a serious incident that was not recognised for the underlying seriousness which it betrayed. It is likely that several factors affected that thinking – the age of those involved, their health at the time, and the emotive circumstances in which it was raised. Nonetheless, the real issues in the case were not identified.

8.3 It is also clear that the age of the perpetrator and victim did affect their own thinking; the perpetrator of this homicide did not tell anyone about the abuse he was suffering for years, and he declined support when it was offered after his wife's overdose. His wife also resisted any suggestion that she may be becoming unwell and seemed to resent those who tried to help her. This is perhaps a generational issue that all organisations need to continue to consider when concerns are raised and offers of assistance declined.

Appendix One– Ongoing Professional Development of Chair and Report Author

2.1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews – Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)

2.2 Christine has completed the Homicide Timeline Online Training (Five Modules) led by Professor Jane Monckton-Smith of University of Gloucester.

2.3 Gary and Christine have:

- Attended training on the statutory guidance update (2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)