SHEFFIELD COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

Robert

Note: Robert is a pseudonym used for the purposes of this Report.

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1. INTRODUCTION

1.1 Preface

1.1.1 Context of this Domestic Homicide Review

This report of a domestic homicide review (DHR) examines agency responses and support given to Robert[1], a resident of Sheffield prior to the point of his death in autumn 2018.

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.

By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

On a date in autumn 2018, the alleged perpetrator (referred to in this report by the pseudonym Joan) called 999, very distraught, and said she had stabbed her husband, he was alive and an ambulance was sent. When police arrived at their home address in the Sheffield area, Robert had three stab wounds (two in his back and one in his chest, which was the fatal wound) and was pronounced dead at the scene.

Joan was in shock and was taken to an Emergency Department for assessment. Later, Joan was interviewed by Police and she admitted she had stabbed her husband.

The victim was aged 85 at the time of the homicide and the alleged perpetrator was 83. Both are white British.

The review will consider agencies' contact/ involvement with Robert and Joan from 13/09/2017 to 13/09/2018, covering 12 months prior to the homicide. Only the GP practice had contact with the couple prior to the homicide.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The Panel and all those involved in this Review would like to acknowledge how distressing these events have been for the family and to send our sincere condolences. We would also like to thank all those

[1] Robert is a pseudonym used to refer to the victim of this homicide.

who have contributed in any way to the review process for their time, patience, commitment and cooperation.

1.1.2 Legal context

The Domestic Violence, Crime and Victims Act 2004[2] states that:

"domestic homicide review" means 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.

The purpose of a DHR is to:

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

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

c) *apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;*

d) *prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;*

e) *contribute to a better understanding of the nature of domestic violence and abuse; and*

f) *highlight good practice*

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[2] See Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.1.3 Timescales

This review began on 17th October 2018 and was concluded on 18th November 2019.

The Review timescale was extended in order that every effort could be made to involve family members, should they wish to be involved, once the court case was concluded, whilst at the same time recognising and respecting their ongoing distress.

1.1.4 Confidentiality and consent

The detailed findings of this review are confidential and only available to participating officers/ professionals and their line managers. For this reason, the names of victim and alleged perpetrator have been anonymised. The Overview Report will be published after sharing it with the family.

Consent was sought from the couple's two adult children and from one grandchild for their involvement in the Review and they were invited to contribute. Written consent was also sought from Joan and she consented to make documentation available to the Review but declined to be personally involved.

1.2 Terms of reference

Please note: The whole of this Section below (1.2.1-1.2.11) is taken from the Terms of Reference for the DHR.

1.2.1 Reasons for the Review

On a date in autumn 2018, South Yorkshire Police responded to a 999 call at 09:44hrs from a woman stating that she had stabbed her husband. Police officers attended the relevant address; where a man (Robert) was pronounced dead at the scene. The caller (Joan) was arrested and a murder investigation commenced. Joan was remanded in Prison. The trial was scheduled to start in spring 2019 following completion of a psychiatric report. A post mortem examination found that Robert died as a result of three stab wounds.

1.2.2 Subjects

Name	Gender	Age	Address
Robert	Male	85	Sheffield
Joan	Female	83	Sheffield, (same address)

1.2.3 Specific Terms of Reference for Consideration by the Robert Domestic Homicide Review

The Domestic Homicide Review will be conducted according to best practice, with effective analysis of the information related to the case and conclusions drawn from that analysis.

The purpose of the Domestic Homicide Review is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

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

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

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

- Contribute to a better understanding of the nature of domestic violence and abuse; and

- Highlight any good practice.

In addition, the following areas will be addressed in the Internal Management Reviews and the Overview Report:

- The victim had little or no known contact with agencies. Were there any missed opportunities to identify domestic abuse?

- Were there any barriers to the victim accessing services e.g. was this because the couple were older people?

- The couple were infrequent attenders at their GP practice. Date last seen was 2010. Did something change in 2010?

- Was there evidence of controlling behaviour by the victim or alleged perpetrator prior to the incident?

- Could more be done in the local area to raise awareness of services available to older victims of domestic violence and abuse?

Any obvious failings identified:

- No failings identified from agencies in Sheffield at the initial panel meeting.

Similarities with other Domestic Homicides in Sheffield or elsewhere

- Other reviews that have had the issue of family, or partners acting as carers:
    - Adult D victim caring for adult son (perpetrator)
    - Adult F victim being cared for by adult daughter (perpetrator)

  The subjects of this review did not appear to have carers' responsibilities, but Joan drove her husband everywhere.

- In addition, all previous victims in Sheffield were killed in their own home, with the exception of one case and the victims were not all in contact with specialist domestic abuse support services.

- Nationally, key themes are similar such as; 1) 70% of relationships to the suspect are partners and 2) 49% of people have been killed with a sharp instrument

Equality & Diversity:

The perpetrator was deaf in one ear.

Age

The victim was male

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

1.2.4 Timescales

Both Robert and Joan were seen infrequently by their GP. Robert was last seen in 2010. Therefore, it was agreed that the GP would undertake a retrospective check to see if anything relevant or significant happened before 2010. All other agencies to focus on the last 12 months - start date agreed as 13/09/2017 - end date 13/09/2018

1.2.5 Appointment of Chair/Author

The panel agreed to appoint Older Mind Matters Ltd (lead - Dr Susan Mary Benbow) as independent chair/ author due to experience of work with older people.

At this stage it was thought there was no other assistance or expert help required

1.2.6 Agencies required to contribute

- Department for Work & Pensions -records due to receipt of state pension - only a short statement required.
- Sheffield Clinical Commissioning Group – for the General Practice – full IMR
- Sheffield Teaching Hospitals Foundation Trust
- South Yorkshire Police - only contact was on the day of the incident - only a short statement required.

1.2.7 Panel

Suitable representatives for these agencies will make up the panel for this DHR, along with standing members.

Consideration will be given to voluntary sector involvement.

DHR Team

The team will consist of the Chair, the DHR Co-ordinator, other DACT members as required including Business Support. Email contact mailto:dact@sheffield.gcsx.gov.uk

1.2.8 Individual Management Reviews and chronologies

Use of consistent templates.
Workers should be referred to by (simplified) job titles, not names.
The family agreed pseudonyms to be used in the final report.[3]
Password to be used as necessary for any agencies without secure email.

1.2.9 Family members, friends, colleagues and employers

It is very important to hear the voices of family and friends if this is possible and they are willing to participate.

Immediate family - two adult children and grandchildren. Both adult children and older grandchild to be asked via the Family Liaison Office to be involved in the review if they so wish, after the trial or when police allow.

Interviews with family will be conducted by the chair & DHR co-ordinator, via the Police Family Liaison Officer. It was agreed to ask them about other friends who might be willing to be involved.

1.2.10 Parallel investigations

Criminal investigation proceedings - the Senior Investigating Officer (SIO) is involved in the process of this review.

1.2.11 Publicity/media issues

The Communications lead is Sheffield City Council Press Office. All agencies should refer any enquiries to them. Contact press@sheffield.gov.uk.

[3] This paragraph has been amended. The family agreed to the use of the pseudonyms Robert and Joan in this Report.

1.3 Methodology

1.3.1 Initiating the DHR

South Yorkshire Police informed the Drug and Alcohol/Domestic Abuse Coordination Team (DACT) in Sheffield City Council on the 14th September 2018 of Robert's death and that it may meet the criteria for a Domestic Homicide Review. In accordance with local guidance (based on the statutory guidance), thirty eight agencies were requested to check their records for contact with the victim and his family. A briefing was then prepared for the Consideration Panel outlining the facts that were known at that point.

The Consideration Panel consisted of:

Executive Director, People Portfolio, Sheffield City Council
Head of Barnsley and Sheffield LDU, Her Majesty's Prison and Probation Service
Sheffield District Commander, South Yorkshire Police, co-Chair of the Community Safety Partnership
Chief Nurse, Sheffield Clinical Commissioning Group

The panel members agreed to the recommendation in the briefing that a DHR should be completed on 18th October 2018.

Expressions of interest were sought for an Independent Chair/Author. An initial Panel meeting was held on 30 November to start to develop terms of reference and the Panel agreed to appoint Older Mind Matters Ltd with Dr Susan M Benbow as lead Independent Chair/ Author. She began the role in January 2019.

The date for return of Individual Management Reviews (IMRs) was agreed as the end of January 2019, for review at a Panel meeting in February.

1.3.2 Involvement of family, friends, and other relevant community members

It was agreed to ask both adult children and the oldest grandchild via the Family Liaison Officer if they wished to be involved in the review, after the trial or when police allowed and to provide them with the relevant Home Office DHR leaflet. Family members were sent letters with a link to the Home Office website and a copy of the Domestic Homicide Review Information Leaflet for Family Members[4]. They were offered a range of different ways to be involved (including meeting with the Review Panel) and were given contact details for Victim Support and Advocacy after Fatal Domestic Abuse.

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[4] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/601398/Leaflet_for_Family_English.pdf

Following the trial family members agreed to be involved and one meeting took place with the Independent Chair/ Author and a second meeting took place with the Strategic Commissioning Manager for Domestic and Sexual Abuse. Family members also commented on a draft of the report.

The Panel wrote and asked Joan if she wanted to be involved, and for her consent for access to records. There were various delays in trying to contact her, due to her being in custody and with contacting her via her solicitor. However, the prison governor agreed to look into receipt and return of the letters.

While the family described Joan and Robert as having had lots of friends, the witnesses contacted by the Police were neighbours who were acquaintances rather than close friends. It appeared that the close friends referred to were historic rather than recent.

1.3.3 Contributors to the Review

- Department for Work & Pensions – asked to examine records due to receipt of state pension - only a short statement required.
- Sheffield Clinical Commissioning Group – for the General Practice
- Sheffield Teaching Hospitals Foundation Trust
- South Yorkshire Police – only contact was on the day of the incident – only a short statement requested.

Initially it was thought that Joan had been seen by liaison psychiatry on the day of the incident but it was subsequently clarified that this was not the case and Sheffield Health and Social Care did not contribute to the review.

1.3.4 Individual Management Reviews (IMRs)

IMRs were provided as detailed in the Table below:

Agency	Abbreviated as	Author	Quality assured by
Sheffield Clinical Commissioning Group	Sheffield CCG	Designated Doctor for Adult Safeguarding	Chief Nurse, CCG
Sheffield Teaching Hospitals NHS Foundation Trust	STHFT	Lead Nurse for Safeguarding and Children and Young People	Chief Nurse, STHFT

Both IMR authors were independent of involvement in the case.

1.3.5 Review Panel Members and Meetings

The Table on page 14 lists Review Panel members including their role and the organisation they represented.

Review Panel members were all independent of involvement in the case.

The Review Panel met on the following dates:

30 November 2018 (prior to appointing the Independent Chair/ Author)

12 February 2019

28 May 2019

22 July 2019

1.3.6 Independent Chair/ Author of the Overview Report

The Chair/ Author of this report is by professional background a psychiatrist and systemic therapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands and undertook consultant roles in Manchester and then Wolverhampton until 2009 when she retired early from her NHS roles and started to develop a portfolio career in independent practice.

She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past.

She has no connections or ties of a personal or professional nature with the family, with the Community Safety Partnership, or with any other agency participating in this review. She has an ongoing interest in reviews involving older adults and has published, with colleagues, an analysis of domestic homicide reviews in England involving adults over 60 years of age in 2018.

1.3.7 Parallel reviews

The Review started in parallel with the criminal justice process. A plea was accepted for Manslaughter by diminished responsibility, and Joan received a Section 37 Hospital order under the Mental Health Act 1983[5] in June 2019.

An inquest was not held as the case was dealt with at the Crown Court and an individual was charged with Manslaughter.

1.3.8 Equality and diversity

Of the protected characteristics age, gender and disability were identified in the terms of reference as potentially relevant. Age is relevant in respect of the ages of both the victim and his wife. Disability is relevant in respect of Joan who is profoundly deaf in one ear and also was found during the criminal justice process to have a dementia condition that had not been diagnosed

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[5] See Mental Health Act 1983 Powers of courts to order hospital admission or guardianship at: https://www.legislation.gov.uk/ukpga/1983/20/section/37

prior to the homicide. In addition, gender is relevant since the victim was a man and the perpetrator a woman. These issues and their significance were considered where appropriate throughout the review process.

1.3.9 Dissemination of the final Report

The final Report and Executive Summary will be disseminated to all involved agencies and also published: a hard copy draft of the report was shared with family members in August 2019.

1.3.10 Review Panel Members

The Table below lists members of the Panel.

There was no representation from the local domestic abuse services on the Panel as when this was discussed the Panel felt that there had not been a history of domestic abuse between the couple. Instead it was agreed at the first Panel meeting to ask Age UK and/or the Carers Centre to send a representative in view of the specific issues related to older age and potentially dementia. When the Panel learned that Joan had a dementia condition, it was suggested in subsequent discussion that it might be helpful to involve Alzheimer's Society. Unfortunately, it was not possible to obtain a representative to join the Panel, so the draft Report was shared and discussed with both Alzheimer's Society and the Carers Centre.

Name	Position	Organisation
Alison Higgins	Strategic Commissioning Manager for Domestic and Sexual Abuse	Sheffield City Council
Amy Lampard	General Practitioner	NHS Sheffield CCG
Andrea Bowell	Detective Inspector	South Yorkshire Police
Andrew Goodison	Disability Employment Advisor	Department for Work and Pensions
Christina Blaydon	Lead Nurse for Safeguarding and Children and Young People	Sheffield Teaching Hospitals NHS Foundation Trust
Liz Mills	Head of Barnsley & Sheffield LDU	National Probation Service
Karen Jessop	Deputy Chief Nurse Safeguarding	NHS Sheffield Teaching Hospital Foundation Trust
Keeley Ward	Commissioning Officer	Sheffield City Council
Kitty Reilly	Named Professional Safeguarding	Sheffield Clinical Commissioning Group
Mandy Philbin	Chief Nurse Safeguarding	Sheffield Clinical Commissioning Group
Sam Martin	Head of Commissioning	Sheffield City Council
Sarah Jackson	Senior Business Support Officer	Sheffield City Council
Simon Palmer	T/Detective Chief Inspector & Senior Investigating Officer	South Yorkshire Police
Simon Richards	Head of Service Quality & Safeguarding	Sheffield City Council
Simon Welch	Manager Sheffield	National Probation Service
Steve Eccleston	Assistant Director of Legal Services	Sheffield City Council
Dr Susan Benbow	Independent Chair	Older Mind Matters Ltd
Stacey Grayson	Case Review & Policy Officer	South Yorkshire Police
Tina Gilbert	Safeguarding Board Manager	Sheffield City Council
Victoria Horsefield	Assistant Director Safeguarding & Quality Assurance	Sheffield City Council

2. THE FACTS

2.1 Summary

On a date in autumn 2018, Joan called 999, very distraught, and said she had stabbed her husband, he was alive, and an ambulance was sent. When police arrived at their home address in the Sheffield area, Robert had three stab wounds (two in his back and one in his chest, which was the fatal wound) and was pronounced dead at the scene.

Joan was in shock and, due to her distressed condition, was taken to an Emergency Department before being taken into custody; she was assessed as medically fit. Joan was subsequently interviewed and she admitted she had stabbed her husband.

Her account was that, on the morning in question, after doing the shopping, she wanted to work in the garden, but Robert wanted to go out, she drove him anytime they went anywhere - he had stopped driving a few years previously as he had lost confidence. She said he went on 'nagging' her when he wanted to do something, until she gave in which she always did. This day she walked into the kitchen and picked up a knife that was lying there and went back to the living room where he was and stabbed him.

When interviewed she recalled two stab wounds and stated that there had been no previous domestic violence. Joan recalled two previous incidents during their marriage, once when they were courting some 60 years ago when he slapped her across the face and 15 years ago when he 'approached her aggressively' and threatened her. She said in interview: "I know it would help if I had a mental illness, but I haven't". Joan stated that she didn't know why she did it. Joan had no injuries and Robert had cuts to his hands, which could have possibly been defence cuts.

The Police talked to the family – two adult children. They were very distraught and said they didn't recall any violence between their parents ever, the incident that occurred 15 years ago was not recalled. The neighbours said they saw them in the garden often, always together, and the couple was well known in their local community. No other friends are known to services.

Neither Robert nor Joan was previously known to police. Neither had caring pressures or was known to need care or support.

Joan was subsequently diagnosed with behavioural variant fronto-temporal dementia[6] and found guilty of manslaughter by reason of diminished

[6] For more information about frontotemporal dementia see https://www.alzheimers.org.uk/about-dementia/types-dementia/frontotemporal-dementia#content-start. The condition affects the front of the brain, which deals with behaviour, problem-solving, planning and emotional control. People affected usually don't have insight into the changes they are experiencing, which are likely to include personality change, loss of inhibitions and loss of judgement.

responsibility at Sheffield Crown Court in March 2019. Joan was later sentenced to a Section 37 Hospital Order under the Mental Health Act 1983 in June 2019 and subsequently transferred to a Mental Health Unit.

2.2 Members of the family and the household

Robert	aged 85 at the time of the homicide	white British
Joan	aged 83 at the time of the homicide	white British

The couple have 2 adult children in the locality who are in regular contact and several grandchildren.

2.3 Background information

The information below includes information from conversations with family members and information drawn from various documents. Joan gave consent to the reviewing of her records but she did not consent to be contacted regarding participating in the review. She was asked a second time by letter in August 2019 but did not reply. A family member informed the Panel that Joan did not want to participate in the review or to be contacted again.

2.3.1 Context

Robert and Joan had been married for 60 years by the time of the events that led to this Domestic Homicide review. They met in a pub when Joan was about 19 or 20 and Robert was 21 or 22. Robert was away from ages 18-21 as he was called up for National Service, and they met after he completed his National Service.

They both worked all their lives. Robert was an architectural technician, who worked for himself towards the later stages of his working life. Joan was an administrative assistant, running the office at a service station: she could add up a column of figures almost as quickly as she could read it.

They both lived in Sheffield all their lives, and bought the house, where they were living at the time of the incident, in 1958. They moved in when they married: at that time the back garden was a building site and they planned, developed and tended the garden between them over the years. Some years later their first child was born, followed almost three years later by their second child. Both children went to local schools and were encouraged in their education. Both later moved on to University educations – the first children in the family to do so. The couple is described as emphasising education and planning, managing money and making the most of a limited income in later life. They functioned as a team and were “fiercely independent”, remaining fit into their 80s. Neighbours have described them as a “lovely couple”.

Over the last couple of years, they were maybe both getting a bit frailer but remained remarkably fit and did not require any help with daily activities. They were independent and believed in looking after themselves and not burdening others. For example, they would tell a member of the family that one of them had been ill for several days (with influenza) only after recovering. They took on jobs that their family felt they were getting too old to do: for example, the two of them laid some new flagstones in the garden in summer 2018. They shrugged things off and just got on with life. Social services were never involved as there was no need – they were managing. The house was spotless, as was the garden. One of their children had experience of Alzheimer's disease and its progression, through his partner's family, but never thought that his mother might have dementia. She was driving right up till the incident: she had driven a lot in relation to her job (sometimes collecting cars for the service station), was proud of her skill and could get in any car and drive it.

Their grandchildren used to visit the couple on their own and family members had no concerns about that. When the grandchildren were younger, Robert and Joan helped to look after them and Joan was driving the grandchildren around until not long before the incident. Joan was particularly close to her first grandchild, who used to go and stay with the couple regularly.

For the family, what happened came completely out of the blue: they were shocked and dumb-founded, and, at first, convinced that a third party must have been involved. When notified of Robert's death, one family member said they told Police that Joan had mild confusion and that family thought she might be in the early stages of a dementia.

Joan didn't want to see her family after the event – they think this was because she was afraid of being judged.

The neighbours told Police that they saw them in the garden often, always together. Family said that they also had a lot of friends from their years of attending jazz clubs and visiting local pubs.

2.3.2 Robert

Robert lost confidence in driving and gave up, maybe 10-15 years ago. He had never been an assured confident driver and, after a change of cars, he stopped driving altogether, but was fine with his wife acting as driver.

In January 2007 a Nurse seeing Robert in primary care noted "family problems" and that they had "almost resolved" in March of the same year. On investigation it is clear that these records did not refer to the couple's relationship.

Robert is described as being "as sharp as a nail" with no cognitive problems and his personality was mild-mannered and calm. The couple functioned as a team and were both active in their retirement. They used to go to local jazz evenings (jazz was primarily an interest of Robert), but their social network

was shrinking as contemporaries died. They would take the bus into town to go shopping and/ or have a pub lunch, or drive out to more rural pubs for lunch. They also enjoyed looking after their garden. Robert's attitude was we're fine, keep your nose out!

2.3.3 Joan

Joan is profoundly deaf in one ear following mastoid problems[7] in childhood and an operation at age 12. She is partially deaf in the other ear. Her illnesses affected her education, as she missed a lot of early years of her education and told family that she learned to read with comics that her mother brought for her. Her father died when she was young, so she went out to work after finishing school although it sounds as though she was a bright scholar. As a result of her deafness, she lip-reads, and sometimes family members are not sure whether she has heard them. She has never shown any signs of being impulsive or quick tempered in the past.

Records confirm that she is deaf in her right ear and hard of hearing in her left ear. She wears a hearing aid in her left ear. She is also reported as having a congenital abnormality of her oral palate. She wears bifocal glasses. She was known to suffer from shoulder pain that may have been related to her gardening activities.

There were few indications of her health changing prior to the incident and no-one was unduly concerned, but family and neighbours had noticed that she was a bit more forgetful over the previous 2 years and not hearing as well as she did in the past, also they think now that her husband was gently reminding her more. Sometimes she would repeat herself, but she had always done this to some extent so it did not seem unusual.

Looking back now, family members remember that she might have made one or two inappropriate comments, but cannot remember exactly what they were. Joan was still doing everything she had always done. She did all the cooking at home, although her husband might make a cup of tea, maybe some toast. She had no assistance with personal care and family members are not aware of any change in her activities of daily living.

Family found out that there had been a car accident where she had reversed into a stationery car in a car park which was empty; the couple waited for the owner of the car to return and exchanged details for insurance. It was a minor crunch to the bumper. The owner then claimed that they had been in the car at the time and had whiplash – the ensuing legal letters caused a lot of distress and family regard the incident itself as unusual and of note.

[7] This refers to an Ear Nose and Throat condition, see https://www.nhs.uk/conditions/mastoiditis/

Her family understand now that a diagnosis of behavioural variant frontotemporal dementia[8] has been made since the event.

2.3.4 Attitude to discipline and violence

Both Robert and Joan were against violence in any form. Neither of them hit their children, although at the time their children were growing up smacking was a fairly common way of disciplining children and most of their school friends were smacked by their parents. Robert and Joan might tell their children off sternly but they never screamed or shouted. They set boundaries and rules and expected compliance. The children were never sent to their rooms but would be told the consequences of unacceptable behaviour, eg if the children behaved badly at the supermarket they wouldn't be included in shopping in the future. In fact, one member of the family remembers Joan telling other adults not to hit their children and getting backchat for it: for example, she would say things like it won't work or it will only make things worse. Joan's own father had been a disciplinarian and physically punished his children. No-one has any evidence whatsoever that there was ever domestic violence of any kind between the couple.

2.3.5 Would an earlier diagnosis have made any difference?

The family wonders why older adults are not screened for developing dementia and whether this reflects ageism in society. We screen for a number of conditions but dementia tends to affect older people, maybe older people are not worth screening or not as important? Would screening give the chance for people to be involved earlier in helping someone living with dementia and their family? Would it give earlier access to treatment and support? Against this, the couple didn't need practical help, so what would have been different if an early diagnosis had been made?

2.3.6 Issues that concern the family

1. How does a GP practice identify and diagnose dementia at an early stage?

Family members commented that GPs are not proactive in assessing elderly people who do not attend the surgery and that this means that serious conditions, that could be picked up early, are missed.

2. Is prison the only option for someone in Joan's situation?

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[8] For more information about frontotemporal dementia see https://www.alzheimers.org.uk/about-dementia/types-dementia/frontotemporal-dementia#content-start.
The condition affects the front of the brain, which deals with behaviour, problem-solving, planning and emotional control. People affected usually don't have insight into the changes they are experiencing, which are likely to include personality change, loss of inhibitions and loss of judgement.

We were told that Joan remembers what happened but can't explain why, and is herself traumatised by the event. She was not given permission to attend her husband's funeral, although she has been pragmatic and said that she expected permission to be refused: she accepted this.

Family members described feeling angry and frustrated by the legal process that was set in motion following the homicide and believe that there needs to be a recognised process for this type of homicide. They observe that the police knew fairly early on that there was no history of domestic abuse, no criminal history and the age of the couple. Given all this, they believe Joan should have been bailed to a hospital facility where she would have been assessed at an early stage, avoiding months of court proceedings. Indeed, family members question whether punishment is appropriate, and comment that remanding Joan in prison can serve no purpose to rehabilitate her, as there is no treatment for bvFTD. They observed that the criminal justice system decision making process seems to decide to prosecute first then find out what/if there is anything wrong with the person, and they feel that logically this should be the other way around. They felt that police, prison and probation staff acted with kindness and compassion but were having to adhere to procedures that were not fit for purpose in these particular circumstances.

The family ask: is prison appropriate for someone of Joan's age and who has dementia? They feel that the prison system is inflexible, although they appreciated that prison staff did their best. For example, Joan had difficulty working out how to control the TV in her room. Her family couldn't understand what the difficulty was and staff didn't seem to understand the problem either. Making a phone call was a major exercise and, as they understood it, involved dialling a long number of maybe 25 digits – a challenge for someone with dementia. The family found it very stressful negotiating the prison system. They feel that her experiences in prison added to their mother's trauma.

Another concern is that the family found it difficult to get any information about Joan's healthcare whilst she was in prison, although they were assured that she was getting appropriate care: they were told that this was for reasons of confidentiality.

Family members commented that they received good support from the Victim Support Homicide Service and from a Family Liaison Officer.

> Note: Joan was transferred to a Mental Health Unit on a Section 37 Hospital Order under the Mental Health Act 1983 in summer 2019.

2.4 Chronology

2.4.1 Narrative

The couple involved in this homicide had been married for 60 years and were living independently at the time of the incident. Only the GP practice had contact with them, and most of their contacts with primary care were unremarkable and for routine reasons or minor physical illnesses (see chronology below for details). The CCG IMR confirmed that Robert rarely saw his GP or any of the practice staff. He had no significant health issues. Similarly, Joan had no significant health issues. In particular, there were no contacts suggesting that either Robert or Joan was subject to domestic abuse, although neither Robert nor Joan was asked about domestic abuse or coercive control.

We enquired further into a contact in the GP records on 18 January 2007 relating to Robert. He was having a blood pressure check and the Nurse recorded: “having family problems…". This was followed by a contact on 6 March /2007, again relating to Robert having a blood pressure check-up, and the Nurse noted “personal problems almost resolved”. Information from the family is that this did not refer to the relationship between Robert and Joan.

Joan had contact with STHFT in 2002, 2005, 2008 and 2009, all contacts relating to orthopaedic problems.

Neither Robert nor Joan had been seen by a GP since 2010.

Adult Social Care and Adult Safeguarding had no knowledge or record of either party.

Benefits records were checked since both Robert and Joan were in receipt of state pension and there is no record that Robert or Joan had been seen by anyone from the Department for Work and Pensions (DWP) in recent years. No issues or problems were known to the DWP.

South Yorkshire Police were involved with the couple only on the date of the death in autumn 2018.

Joan was taken to the Emergency Department at a local General Hospital at 11.09 hours, in Police custody, after allegedly attacking and killing her husband. A post mortem report found that Robert died as a result of a stab wound to the chest.

The Emergency Department card states that Joan was confused and appeared to have no awareness of the situation, but that there was no obvious sign of injury to her and no blood on her. She was assessed by nursing and medical staff with two Police Officers present. Documentation states that she had no signs of any physical or medical issues. She was orientated to time and place. She was crying and upset but able to hold a

conversation, asking to go home, and could not recall why she was in hospital. She was deemed by staff to be appropriately upset. Her score on the Abbreviated Mental Test[9] was 7/10 (she said the day was Wednesday, year was 2017 and could not recall her address). This was not thought to indicate cognitive impairment: the medical impression was that she was exhibiting a grief/ stress response. She said that she could be forgetful at times and joked 'that can happen as you get older'. She also said at times she wandered at night.

There was no evidence of acute physical illness and a CT scan of her head revealed only mild global cerebral atrophy (a mild degree of shrinkage), thought to be in keeping with her age. She was therefore discharged into Police custody.

During Police interviews Joan was asked about the nature of her relationship with Robert. She described the marriage as 'convenient' and commented that Robert had never loved her. None of the family recognise this as an accurate account of their marriage, and comment that they would have known if Joan had felt her marriage was unhappy. They think these statements were linked with the dementia, and that they show how Joan drifts from reality at times. She also reported that she wanted to celebrate their 60th wedding anniversary in August 2018, but Robert did not want to do anything and it went unmarked - this was around a month before the death.

Throughout questioning she repeatedly stated that there had been no previous domestic violence. She recalled two incidents during their marriage: Joan said that Robert had once hit her, this having happened when they were courting 60 years ago. She said that he had threatened her 15 years ago, but had not actually hit her on that occasion. She reportedly said in interview "I know it would help if I had a mental illness, but I haven't". Referring to the stabbing, Joan stated that she didn't know why she did it.

During the criminal justice process psychiatric reports were obtained on Joan and indicated early behavioural variant frontotemporal dementia (bvFTD).

Joan was found guilty of Manslaughter by diminished responsibility in March 2019, and received a Section 37 Hospital order under the Mental Health Act 1983[10] in June 2019.

2.4.2 Timeline

See overleaf for a timeline.

For a fuller collated chronology see Appendix 2.

[9] See a version of the Abbreviated Mental Test on page 19 of https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/alzheimers_society_cognitive_assessment_toolkit.pdf

[10] See Mental Health Act 1983 Powers of courts to order hospital admission or guardianship at: https://www.legislation.gov.uk/ukpga/1983/20/section/37

Timeline

Date	Client	Source of information	Event
1975-2006	Robert and Joan	GP records	Regular contacts for minor physical illnesses and flu vaccination.
Jan 2007	Robert	GP records	At a blood pressure (ABPI) check-up, Nurse recorded “family problems”.
March 2007	Robert	GP records	At a BP check -up, Nurse recorded “personal problems almost resolved”.
2008-2012	Joan	GP records	Regular contacts for orthopaedic problems and other minor illness/ flu vaccine/ screening. Responded to EARLI (Emergency Admission Risk Likelihood Index) questionnaire[11] in 2012.
2010	Robert	GP records	Several contacts for minor illness/ flu vaccine/ screening including response to EARLI questionnaire.
13 Sept 2018	Joan	Police	Joan rang police on 999 at 09.44 to report she had stabbed her husband. Officers attended the address where Robert was pronounced deceased.
13 Sept 2018	Joan	Emergency Department (ED) records	Brought to ED by the Police at 11.09 hrs following her arrest on suspicion of stabbing and killing her husband. No physical injuries or treatment required.

[11] For more details see: https://watermark.silverchair.com/cml069.pdf?token=AQECAHi208BE49Ooan9kkhW_Ercy7Dm3ZL_9Cf3qfKAc485ysgAAAkAwggI8BgkqhkiG9w0BBwagggItMIICKQIBADCCAiIGCSqGSIb3DQEHATAeBglghkgBZQMEAS4wEQQMEGBqFHeQjL-NwDzaAgEQgIIB857ENnO4F3gxiTVQCuUX2rTyIBEsHerQWVri2g8aO2RD6RMDYSYZfuTds_mA1tJElbUK7no1ScHcX-30Y3aMCEwJ5tupNJcE1kGAqO3cqq85S80aWurBCdePpYcYiaD4GPw0hrOUWTOy4G3L3TPfuuy1DVif_wjrljWULiWT0CoBoUJ7VFbTEYqHFFIk9ilp8w27mRUeZd2wte6EVRwoGEWcMpCpUq-RCKZAqV0DNC9kNOU4jgFLRzfa26TiwhdTdVbDEv1vkEkByDuYx6jDttmBQOYDvWzujj-ZExtxEvJZ4mLiPVEA0wyIkPC2xKzp4ucw4SVGm36zlA0axo6oAFdsii0RbtrlFN4BmEyMPK_u4xNt_lWSLWRDNOu_gJiRJGw6l2hoNsdVSksyMdJlNzvi8D4yB6S9Sg08kxmMZyDUqXLfrJS14bnI50KwPf4yBBT6c9j4xWRx3H_hZ1ThL2fY5fDcEDbIKmEAZmcD5daUuYJpNOHEQJN0IcRIJs2OrilRSahishqNg90_PTgsG__rzK4hs7n7Uc3IFH8zR_yBaFgYwzZMP-M9bQOJjBsSLLbL1WF6q7O-NdxBz3nMfjpM5YAxpDhYriVq0tffa7JJHMBKvnjh6MM_fN4RPoJIcuA3f1kZwgZoSZxwP6PUk3kPIXs

3. ANALYSIS

3.1 **Overview summary**

This Review focuses on a couple in their 80s who were in a long-term marriage and were living independently in their own home without input from any agencies and in contact with family members living locally. They had consulted their GP practice regularly till around 2010-2012. They were regarded as relatively fit for their age and, to our knowledge, no one had concerns about them.

Joan rang the Police to report that she had stabbed her husband, and he subsequently died. She was seen in an Emergency Department because the Police were concerned about her shocked distressed condition, but she was found to be medically fit and her level of "confusion" was thought to be understandable in the circumstances.

During the criminal justice process that followed, additional information emerged, psychiatric reports were requested, and Joan was diagnosed with behavioural variant fronto-temporal dementia. She was found guilty of manslaughter by diminished responsibility and received a Hospital order (Section 37) under the Mental Health Act 1983.

The analysis that follows sets out themes identified during the DHR process.

3.2 Themes identified

3.2.1 "Out of the blue"

This homicide appeared to come "out of the blue" and was a complete shock for the family, who at first believed that a third party must have been involved rather than that Joan could have stabbed Robert. They had never been aware of any violence between the couple.

Of particular note:

- No previous incidents of domestic abuse involving either party were known to agencies
- No previous incidents of domestic abuse involving either party were known to family members
- There was no evidence of suspicious injuries incurred by either party
- There is no evidence of coercive control
- The couple was not known to agencies
- They were relatively physically fit for their ages
- They were managing independently in their own home

The evidence is that this homicide could not have been predicted.

During the criminal justice proceedings, it emerged that Joan had been diagnosed with behavioural variant frontotemporal dementia (bvFTD)[12].

3.2.2 Behavioural variant frontotemporal dementia and aggression/ violence

FTD is relatively rare, probably accounting for fewer than 1 in 20 cases of dementia[13]. There are three main types of FTD and behavioural variant FTD is the most common of these. People often think of dementia as being about memory problems, but in this condition the main symptoms often start as changes in the person's personality and behaviour, some of which are relevant here, namely:

- The person might lose their inhibitions and behave in ways that others regard as socially inappropriate or act in an impulsive manner that may be out of character for them
- They may become less appreciative of, or less responsive to, other people's needs
- Their judgement may be affected
- They may have difficulty with planning, organising and making decisions
- They may have no insight into the changes in them and people around them are more likely to notice the changes

The Author has not formally reviewed the literature relating to bvFTD and violence but will briefly summarise below a few papers that illustrate the possible connection between bvFTD and aggression/ violence.

Liljegren and colleagues studied the records of over 2000 people seen at a United States Memory and Aging Centre and reported their findings in 2015. They found that:

> *Criminal behaviour is more common in patients with bvFTD and semantic variant of primary progressive aphasia than in those with AD (Alzheimer's Disease International) and is more likely to be an early manifestation of the disorder.* [14]

Grochmal-Bach and colleagues[15] looked at a small group of nursing home residents and compared people with Alzheimer's disease with those with FTD. They found a greater intensity of aggressive behaviours in people with FTD, particularly physical aggression.

A more recent paper published by Liljegren and colleagues in 2018 reports on the clinical findings in 281 people with dementia who had a neuropathological

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[12] For more information see the Alzheimer's Society website, at https://www.alzheimers.org.uk/about-dementia/types-dementia/frontotemporal-dementia-symptoms

[13] See https://www.alzheimersresearchuk.org/about-dementia/types-of-dementia/frontotemporal-dementia/ftdabout/

[14] (Liljegren et al., 2015)

[15] (Grochmal-Bach et al., 2009)

dementia diagnosis made at a brain bank in Sweden. They summarised their findings as follows:

> *The patients with frontotemporal dementia exerted physical aggression earlier in the course of their disease than Alzheimer's disease patients. The most frequent victims of the patients' physical aggression were health staff and other patients. The aggression also affected family members as well as (to the demented patient) unknown people. The frequency of the physical aggression differed among the different diagnostic groups; frontotemporal dementia patients exhibiting a higher physical aggression frequency score than did Alzheimer's disease patients.*[16]

The Author understands that evidence was given in court that Joan had shown some personality and behaviour changes prior to the homicide that are compatible with the diagnosis of behavioural variant fronto-temporal dementia, and that it was suggested that impulsive behaviour and loss of self-control may have been relevant to the homicide.

3.2.3 Would early diagnosis of Joan's condition have made any difference?

The family raised issues about screening and early diagnosis: what difference would an early diagnosis have made to Robert and Joan?

Firstly, it seems likely that any minor changes in Joan's personality and behaviour pre-dating the homicide had not been seen as significant by those in a position to observe them. In particular, as people grow older, sometimes changes are attributed to increasing age with the result that alternative explanations for these changes may not be considered. It is not uncommon for those close to a person (particularly partners) to compensate for changes which can make those changes more difficult for others to spot.

Secondly, it is important to acknowledge that early diagnosis can be particularly difficult in FTD since it often presents with symptoms different from Alzheimer's disease. The public tends to equate dementia to memory problems but this is not always the case. We know that Joan completed an Abbreviated Mental Test[17] (usually referred to as the AMTS – Abbreviated Mental Test Score) when she was seen in the Emergency Department following the homicide. This was not an ideal situation for cognitive testing as she was distressed and in an unfamiliar environment. The Test involves 10 simple questions, and is quick and easy to administer. The usual cut off for considering further investigation is around 7. Given the circumstances, her score at the time was accepted as within the normal range. The diagnosis of bvFTD was only made after more in-depth assessment and investigation including brain scanning and neuro-psychological testing, so it is probable

[16] (Liljegren, Landqvist Waldö, & Englund, 2018)
[17] See a version of the Abbreviated Mental Test on page 19 of https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/alzheimers_society_cognitive_assessment_toolkit.pdf

that, had she been seen in a memory clinic prior to the incident, it may not have been possible to make a diagnosis without in-depth investigation.

Joan had not been seen by her GP for about 7 years before the incident and her GP therefore would not have been in a position to suspect cognitive impairment and to assess and/ or investigate further.

And what if a diagnosis had been made? The couple would have been given information about dementia and the condition that was diagnosed. There is no specific treatment for bvFTD. There is no evidence that the couple needed practical help. Robert may have been seen as her carer (and perhaps offered a carers assessment), but, unless he saw himself as her carer; what would have been different? No evidence has come to light suggesting any aggressive incidents prior to the homicide. Witness reports shared with the Review suggested some minor changes in terms of frustration and perhaps loss of self-control but nothing that would lead to concern about physical violence. The family might have increased their input, monitoring and support, but nothing would have alerted them to the possibility of an incident like the one that occurred. The NHS England document Dementia: Good Care Planning Information for primary care providers and commissioners[18], published in 2017, sets out (pages 10-12) the core elements that a dementia care plan should include, helpfully using the mnemonic DEMENTIA, which gives:

- D = diagnosis review
- E = effective support for carers review
- M = medication review
- E = evaluate risk
- N = new symptoms inquiry
- T = treatments and support
- I = individuality
- A = advance care planning

Thus, evaluating risk is regarded as a core part of dementia care planning. The document connects evaluating risk with safeguarding and suggests a useful question for the carer: does the person you are caring for do or say anything to make you feel uncomfortable? Had an early diagnosis been made care planning would have been initiated. The indications from what we know of this couple is that they would have continued to function independently but early diagnosis and the actions that follow from it would be regarded as good practice in relation to dementia care.

The Author has been involved in an analysis of Domestic Homicide Reviews in England involving people aged 60 and over as victims, perpetrators or both. Six of the homicides we analysed featured dementia: in four homicides a person with dementia was the victim and in two the perpetrator[19]. Similarly,

[18] Available at https://www.england.nhs.uk/wp-content/uploads/2017/11/dementia-good-care-planning-v2.pdf

[19] (Benbow, Bhattacharyya, & Kingston, 2019)

Salari[20] published a study of intimate partner homicide–suicide (444 deaths) in 2007 and reported that 7.5% of victims had a dementia but that dementia was rare amongst perpetrators. She describes as the more common scenario, that victims may suffer from dementia and have a stressed and burdened caregiver who lacks a proper support system.

3.2.4 What would trigger psychiatric assessment of an alleged perpetrator?

The Panel initially assumed that Joan had been seen and assessed by mental health staff in the Emergency Department but it later became clear that she had not, raising the question what would trigger psychiatric assessment of an alleged perpetrator?

Why did the Panel assume this? She was an elderly woman who had allegedly murdered her partner of 60 years out of the blue, so Panel members may have assumed that the situation was sufficiently unusual as to merit psychiatric assessment.

In this case Joan was taken to the Emergency Department and seen there. We understand that what happens, in practical terms, is that, after someone is released from hospital, they will return to custody with any clinical directions necessary. South Yorkshire custody suites have a medical professional based in the custody suite. They are registered nurses and have the ability to call out a Doctor or return the detainee to hospital should they think it is appropriate.

In the Emergency Department Joan was described as “not engaging with the assessment”. The Emergency card noted that she was confused and appeared to have no awareness of the situation. It was also noted that she was “asking to go home and could not recall why she was in hospital”. No evidence of acute medical illness was found and she was thought by staff to be “appropriately upset”. Thus, there were possible indicators of cognitive difficulties at this point but these were not thought by staff to lie outside what might be expected in the circumstances. The Panel was informed that a psychiatric assessment would be triggered by evidence of a psychiatric illness and medical opinion at the time was that she was exhibiting appropriate grief/ stress response to the incident.

We understand that the Police and Criminal Evidence Act 1984 and the associated Codes of Practice cover fitness for detention. The welfare and treatment of detained persons is the responsibility, in law, of the custody Sergeant. They are independent of the investigation, and the welfare of the detained person is their primary concern. The general requirements around the treatment of detained persons is contained within Code C. The legislation and Codes require that a medical history and risk assessment is conducted at the time that the person presents at custody and this will be a continuing exercise throughout their detention.

[20] (Salari, 2007)

The Police informed us that under the Police and Criminal Evidence Act 1984 and the associated Codes of Practice the custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonably practicable if the person:

(a) appears to be suffering from physical illness; or
(b) is injured; or
(c) appears to be suffering from a mental disorder;
(d) appears to need clinical attention.

It is noteworthy that the eventual diagnosis of bvFTD took some months for specialists to make and it is therefore not surprising that the Emergency Department did not pick it up.

3.2.5 Issues relevant to conducting Domestic Homicide Reviews

Several issues relevant to conducting DHRs were identified:

- In asking alleged perpetrators for access to information it may be helpful to ask for access to defence reports.
- When alleged perpetrators have established cognitive problems approaches to them concerning their involvement and access to information need to be cognisant of and compliant with mental capacity legislation.
- The distress to families is considerable, likely to persist beyond the completion of criminal justice proceedings, and likely to affect their involvement in DHR processes despite expressed willingness to be involved.
- There were difficulties in contacting Joan in prison, both with the solicitor and with the prison service, and this has been a feature in other DHRs: it might be helpful for the Home Office to communicate with the Law Society and the Prison Service about best practice in engagement with DHRs.

3.2.6 Similarity to other reviews

A Serious Incident Review was undertaken following a serious assault on an older man by his adult son in 2016. This case is the only other case reviewed in Sheffield where the victim has been an older male. The review found this case highlighted the need for more consideration of the needs of those at risk of perpetrating violence to family members (adult family violence) and those at risk from them. This should also be linked to the need to identify and assess those with caring responsibilities.

When presented with familial abuse agencies need to consider whether family members such as parents may be minimising the risks to themselves given their concern for their adult child and the caring role they have undertaken. The other reviews into the deaths of older people have also been in relation to adult family violence rather than a circumstance where the perpetrator was an intimate partner. A case has also been reviewed where the victim was a

young man but again the perpetrator was a member of the victim's family as opposed to a partner.

3.2.7 Post-script: events after the death

This Review does not cover the period following Robert's death, and the family's concerns about how their mother was treated in the judicial system fall outwith the terms of reference. However, the Panel feel that it is important to acknowledge the family's concerns and propose to write to the agencies concerned (CPS and Prison Service) to pass those concerns on.

3.3 Questions raised in the terms of reference

3.3.1 The victim had little or no known contact with agencies. Were there any missed opportunities to identify domestic abuse?

It has not been possible to identify any missed opportunities to identify possible domestic abuse or any evidence of coercive control. The question of control was raised in relation to the fact that Robert had ceased to drive and Joan drove him everywhere, but to people who knew them this made sense as Joan had been a more confident and more experienced driver earlier in life.

3.3.2 Were there any barriers to the victim accessing services e.g. was this because the couple were older people?

Robert and Joan were independent and did not seek help from their family or from agencies. They were from a generation that traditionally valued autonomy and independence – although in writing this the Author is aware of the risk of stereotyping them. They were regarded as managing on their own, although looking back now family members identify possible signs that Joan was changing and perhaps developing forgetfulness. They did not regard it as significant at the time and it was not, to anyone's knowledge, affecting the couple's activities of daily living, nor did it suggest that services were needed. Although Joan primarily did the cooking at home, the description is that the couple functioned as a team, that Joan did the driving and that both of them were involved in carrying out relatively heavy work in the garden together, rather than fulfilling what might be regarded as "traditional" gender roles for their generation. Evidence suggests that it is more difficult for men who are subject to domestic abuse to seek help for a number of reasons, including that this admission might challenge their masculinity, and that they may lack confidence that others will believe them, since domestic abuse is primarily viewed as a phenomenon involving men being abusive towards women[21]. There is however nothing to suggest that this was the case with this couple. Throughout questioning Joan repeatedly stated that there had been no previous domestic violence, although she recalled two incidents during their marriage: one when she said Robert hit her many years earlier and a second

[21] (Drijber, Reijnders, & Ceelen, 2013)

when she said that he had threatened her. The family had, however, not seen any signs of domestic abuse between the couple at any time.

3.3.3 The couple were infrequent attenders at their GP practice. Date last seen was 2010. Did something change in 2010?

It has not been possible to identify any change that might account for infrequent attendance becoming even more infrequent. The Panel discussed this and raised the issue of professional curiosity in respect of patients stopping regular attendance and its relevance to policies dealing with patients who miss appointments.

3.3.4 Was there evidence of controlling behaviour by the victim or alleged perpetrator prior to the incident?

The Review has not identified any evidence of controlling behaviour by either party.

3.3.5 Could more be done in the local area to raise awareness of services available to older victims of domestic violence and abuse?

Part of raising awareness is raising awareness amongst practitioners that older adults may be victims of abuse and alerting them to pathways and sources of support. A training pack focused on older people and domestic abuse was shared with the Author, who was impressed to see a previous DHR suitably anonymised used in training and a scenario centring on an older male victim of abuse in a complex caring situation.

We understand that Sheffield City Council commissions domestic abuse training that covers all types of people that may be victims and how specific vulnerabilities can make abuse more dangerous or likely – this includes specific training around domestic abuse and older people developed in consultation with older adults services. The commissioned provider offers multi agency sessions available to any worker or volunteer in Sheffield and also offers briefings and bespoke sessions to relevant teams such as Adult Social Care teams or home care providers.

The local domestic abuse service and Sheffield Carers' Centre are making links in order to share knowledge and best practice. The report will be shared with the Alzheimer's Society locally and nationally and an offer will be made to discuss joint working.

3.4 Other issues from the IMRs

The CCG IMR raised some issues where practice might be improved. When the couple did not respond to postal invitations for immunisations (influenza, pneumococcal and shingles) the practice did not contact them by an

alternative method. More recently the practice has changed their policy and now phones patients who don't attend.

The couple was allocated Named Accountable GPs (and sent letters to inform them of this fact) but this was largely a paper exercise and the Named GP did not have any oversight of the people they had been allocated. This raises questions about the role of Named Accountable GPs.

The CCG IMR author noted that it was not clear from the practice records whether Robert or Joan attended appointments accompanied or alone. Whether a person is accompanied or not might, of course, impact on whether they are able to disclose domestic abuse or coercive control, so it is important to know whether someone is seen alone or not. In the Author's experience this issue (i.e. that of recording accompanying people present) has come up in other Reviews.

3.5 Good practice

3.5.1 The only agency involved with this couple was primary care so there was little opportunity to demonstrate good practice.

3.5.2 The Author wishes to note that she was impressed with the content of the training pack focused on older adults and domestic abuse that was shared with her. This is delivered a few times a year by the current commissioned provider IDAS as referenced in 3.3.

3.5.3 Family members told us that individual Police Officers they dealt with were "amazing", including the Family Liaison Officer and the Investigating Officer who did his job with great professionalism, compassion and understanding. This is included here in order to acknowledge their good practice.

4. CONCLUSIONS

4.1 The Review has not identified any opportunities to predict the death of Robert and there were no opportunities to prevent it.

4.2 There was no evidence of domestic abuse, violence or coercive control prior to the homicide.

4.3 The couple at the heart of this DHR was living independently: only the GP practice had contact with them, they were rarely seen, and most of their contacts with primary care were unremarkable and for routine reasons or minor physical illnesses. There were no contacts suggesting that either Robert or Joan was subject to domestic abuse or coercive control (although neither was asked directly).

4.4 No other agency was in contact with either husband or wife.

4.5 After the homicide, Joan was diagnosed with a relatively rare dementia condition but, given the complexities of diagnosis, it is unlikely that this diagnosis could have been made earlier, and, even if the diagnosis had been made earlier, it would have been unlikely to change the course of events.

5. LESSONS TO BE LEARNT

The main lessons learned in this Review are set out below.

5.1 Incidents that come "out of the blue"

Incidents that come out of the blue may arise on a background of subtle or minor changes that have not been seen as significant by those in a position to observe them. In particular, as people grow older, sometimes changes are attributed to increasing age with the result that alternative explanations for these changes may not be considered.

5.2 Older adults not in contact with their GPs

Both Robert and Joan had less contact with their GP practice in later years and it was suggested by the Panel that, when older adults become less engaged, this might trigger the exercise of professional curiosity and further enquiry. Non-response to annual health checks, cancer screening programmes, immunisations and other communications from their GP practice might not result from capacitated decisions: it might be that those concerned lack the capacity to decline the offer. People may also be influenced by those who accompany them to appointments so it is important to record whether people attend alone or accompanied and, if accompanied, by whom they are accompanied. This is particularly important in connection with possible domestic abuse and when capacity might be impaired.

5.3 Behavioural variant fronto-temporal dementia

BvFTD may present with symptoms that are not regarded as typical of what would be expected, e.g. by people who are more closely acquainted with Alzheimer's disease. There is some limited literature suggesting an association between FTD and criminal and/ or aggressive behaviour but this is not strong.

5.4 Early diagnosis

It is unlikely that an early diagnosis of Joan's condition would have prevented what happened.

Robert and Joan were not seen by their GP in the lead up to the incident and it is unlikely that Joan's condition would have been diagnosed, even if she had been seen, unless Robert had been alert to, and appraised the GP of, changes in his wife: it took specialist input, time and further investigations to clarify the diagnosis. Robert's independent character suggests that he would not readily have sought help even if he was aware of changes.

Early diagnosis should, however, be followed by a care planning process and this should include risk assessment, including risk to others alongside the other risks that are more commonly associated with dementia conditions.

5.5 Barriers to accessing services

The main barrier to accessing services was probably that the couple were staunchly independent and did not see a need for outside help – to some extent this may have reflected their generation: they had lived through the second World War. Both Robert and Joan had less contact with their GP practice in later years and it was suggested by the Panel that, when older adults become less engaged, this might trigger the exercise of professional curiosity and further enquiry.

5.6 Barriers to accessing domestic abuse services

The Review found no evidence of domestic abuse prior to the homicide but raised questions about what domestic abuse services are available to older adults and about opportunities to ask about possible domestic abuse and coercive control. From the primary care records, it was not possible to be certain when one partner attended an appointment alone and when they were accompanied. Questions about domestic abuse and/or coercive control were never asked of the couple, but no triggers were identified that should have led to such enquiry.

5.7 Psychiatric assessment of alleged perpetrators

The Panel initially assumed that Joan was seen and assessed by mental health practitioners when she was taken to the Emergency Department but this was not the case. Given that the diagnosis of bvFTD took several months and further investigation for it to be made by a specialist, it is unlikely that assessment in the ED by mental health practitioners would have identified the condition.

5.8 Domestic homicide reviews

The distress to families experiencing a domestic homicide is considerable and agencies involved in Domestic Homicide Reviews need to acknowledge and be sensitive to the conflicting emotions that people are experiencing that may influence how far they are able to be involved in the Review process.

6. RECOMMENDATIONS

6.1 Single agency recommendations

Sheffield CCG

1. *Non-response to annual health checks, cancer screening programmes and immunisations:* Sheffield CCG requests that GP practices review their policies regarding non-response to annual health checks, cancer screening programmes and immunisations. Practices should ensure that capacity to decline the appointment is assessed and that reasonable adjustments are made for those who lack capacity.

The GP practice has a robust system to invite patients for their Annual Review however there was no assessment of Robert and Joan's capacity to understand the impact on their health of declining to attend appointments and no follow up of their repeated non-response to invitations. The Panel was told that, as independent contractors, GP practices set their own policies.

2. *Named Accountable GP:* Sheffield CCG will request guidance on the role of the Named Accountable GP from NHS England and circulate this.

In 2015 GPs were asked to allocate a Named Accountable GP to all patients as part of their core contract. This was described by the British Medical Association as "a role largely of oversight – working with relevant associated health and social care professionals to deliver a multi-disciplinary care package that meets the needs of the patients." The practice informed their patients of the allocated GP but no further efforts were made to gain this oversight of the patient's situation.

3. *Accompanying persons:* Sheffield CCG will encourage clinicians in GP practices to document who each patient attends their appointments with.

It is not clear from the practice records whether or not Robert or Joan attended appointments accompanied or alone. This has an impact on the ease of enquiring about domestic abuse.

6.2 Multiagency recommendations

6.2.1 Dementia and risk: To remind partner agencies that risk assessment is part of the care planning procedure in people living with dementia and this should include risk to others. This is relevant to primary care, carers centres, dementia assessment services/ memory clinics and adult social care.

6.2.2 Processes to support older adults experiencing domestic abuse: Adult Safeguarding Partnership to seek reassurances that local processes are fit for purpose with regards to supporting people over the age of 65 where there may be mental health and domestic abuse concerns.

6.2.3 Raising awareness with older adult groups: The report will be shared with the Alzheimer's Society locally and nationally and an offer will be made to discuss joint working to raise awareness of some of the issues in DA and older adults.

6.2.4 Raising family concerns about treatment of older adults in the judicial system: the Panel feel that it is important to acknowledge the family's concerns and will write to the agencies concerned (CPS and Prison Service) to pass on the family's concerns about how their mother was treated in the judicial system.

6.2.5 Recommendations for future DHRs:

- Alleged perpetrators should be asked for access to defence reports.
- When alleged perpetrators have established or suspected cognitive problems approaches to them concerning their involvement and access to their information need to be cognisant of, and compliant with, mental capacity legislation.

6.2.6 Recommendation for Home Office consideration: it would be helpful for the Home Office to communicate with the Law Society and the Prison Service about best practice in engagement with DHRs.

Appendix 1: Bibliography

ATMS

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Care Planning in Dementia

Dementia: Good Care Planning Information for primary care providers and commissioners (2017). NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/11/dementia-good-care-planning-v2.pdf (accessed 7 August 2019)

Domestic Homicide Reviews

Link to Domestic Homicide Review Information Leaflet for Family Members. Home Office: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/601398/Leaflet_for_Family_English.pdf (accessed 7 August 2019)

The EARLI

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Frontotemporal dementia: What is fronto-temporal dementia. For an accessible account of what FTD is and for further information, see https://www.alzheimersresearchuk.org/about-dementia/types-of-dementia/frontotemporal-dementia/ftdabout/ (accessed 7 August 2019) and

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The Mental Health Act 1983

For information about Section 37 see: https://www.legislation.gov.uk/ukpga/1983/20/section/37 (accessed 7 August 2019)

Appendix 2: Glossary

AMTS	The Abbreviated Mental Test Score: the abbreviated mental test score was designed to rapidly screen elderly people for possible dementia.
BP	Blood pressure
bvFTD	Behavioural variant fronto-temporal dementia – this is a dementia condition that affects the front of the brain, which deals with behaviour, problem-solving, planning and emotional control. People affected usually don't have insight into the changes they are experiencing, which are likely to include personality change, loss of inhibitions and loss of judgement.
CCG	Clinical Commissioning Group - Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible.
CT scan	Computed tomography scan – a CT scan can be used to produce a cross-sectional image of the brain.
DACT	Drug and Alcohol/Domestic Abuse Coordination Team - in Sheffield this team is responsible for two separate areas of work; support for victims of domestic abuse, and support and treatment for drug and alcohol misuse.
DHR	Domestic Homicide Review
DWP	Department for Work and Pensions
EARLI	The Emergency Admission Risk Likelihood Index – this is a six-item questionnaire used to identify patients over 75 who are at high risk of admission to hospital.
ED	Emergency Department
FTD	Fronto-temporal dementia
GP	General practitioner or family doctor
IMR	Independent Management Review
LDU	Local Delivery Unit
Mental Health Act 1983	The Mental Health Act sets out the law relating to "mentally disordered persons".
NHS	National Health Service

Section 37	This is a Hospital Order under the Mental Health Act 1983. It gives the courts powers to order hospital admission or guardianship - see https://www.legislation.gov.uk/ukpga/1983/20/section/37
SIO	Senior Investigating Officer
STHFT	Sheffield Teaching Hospitals Foundation Trust

Appendix 3: Collated chronology

Date from	Client code	Source of information	Event
26/11/1975	Robert	GP records	care started at named Medical Practice
30/12/1975	Joan	GP records	care started at named Medical Practice
31/10/1978	Joan	GP records	minor operative procedure
20/01/1983	Joan	GP records	contact re physical illness
19/07/1993	Joan	GP records	contact re physical illness
1995	Joan	GP records	3 contacts including one recorded as screening
1998	Joan	GP records	3 contacts including flu vaccine and one screening procedure
1999	Joan	GP records	1 contact flu vaccine
2000	Joan	GP records	5 contacts re minor physical problems
2001	Joan	GP records	1 contact flu vaccine
2002	Joan	GP records	7 contacts re physical health
2002	Joan	STHFT	Orthopaedic input re heel pain. Treated with injections.
2003	Joan	GP records	3 contacts including flu vaccine
22/02/2005	Joan	GP records	left knee swollen, tender xray and diclofenac
23/02/2005	Joan	GP records	13 contacts for physical health
2005	Joan	STHFT	Seen in orthopaedic Clinic re shoulder pain.
2005	Robert	GP records	1 contact: flu vaccine declined
2006	Joan	GP records	4 contacts re physical health including refusal of flu vaccine
2006	Robert	GP records	7 contacts re physical health including declining flu vaccine
18/01/2007	Robert	GP records	"BP 174/80 having family problems, divorce"
2007	Joan	GP records	3 contacts for physical health
16/02/2007	Robert	GP records	BP 168/80 never smoked

06/03/2007	Robert	GP records	BP 150/80 feels well, personal problems almost resolved
13/04/2007	Robert	GP records	BP 170/80 still raised has been up/down for last 6 months
2008	Joan	GP records	5 contacts including knee replacement and refusal of flu vaccine
2008	Joan	STHFT	Left Total Knee Replacement
2009	Joan	GP records	5 contacts including knee replacement and invitation for patient health check
2009	Joan	STHFT	Right Total Knee Replacement. Discharged home with husband and son. Son and daughter in law to help out on discharge.
2010	Joan	GP records	8 contacts including Invitation for patient health check - patient questionnaire EARLI score low
2010	Robert	GP records	4 contacts including EARLI score - low
10/02/2011	Robert	GP records	flu imms invite
10/02/2011	Joan	GP records	Invite for pneumococcal vaccine
04/03/2011	Robert	GP records	2 contacts pneumococcal vaccination declined
01/04/2011	Joan	GP records	care notes opened by Sheffield Integrated Care Team - Locality 2
19/09/2011	Joan	GP records	Care ended by Sheffield Integrated Care Team - Locality 2 (district nurses)
04/01/2012	Robert	GP records	1 contact for physical health
19/09/2012	Joan	GP records	Sent EARLI questionnaires
01/10/2012	Joan	GP records	Responses from EARLI questionnaire (Emergency Admission Risk Likelihood Index[22]) (XaX24) 1 - Have you ever had heart problems?: No Have you ever had leg ulcers: No Can you go out of the house without help?: Yes Do you have problems with your memory and get confused?: No Have you been admitted to hospital as an emergency in the last 12 months?: No

[22] For more details see the bibliography or go to: https://www.researchgate.net/publication/6590377_Predicting_the_likelihood_of_emergency_admission_to_hospital_of_older_people_Development_and_validation_of_the_Emergency_Admission_Risk_Likelihood_Index_EARLI

			Overall would you say the state of your health is good?: Yes
22/10/2012	Joan	GP records	Invite to participate in study "Putting Life into Years"
20/06/2013	Joan	GP records	Letter from Optician - referred to Glaucoma clinic
22/07/2014	Robert	GP records	Named GP letter
22/07/2014	Joan	GP records	Letter to patient informing of Named GP
24/02/2015	Joan	GP records	Invite for shingles vaccine
13/09/2017	Robert	Benefits Records	Robert was in receipt of state pension, and hence was known to DWP, since 30.3.1998. There is no record that Robert had been seen by anyone from the DWP in recent months/years. No issues or problems known to DWP.
13/09/2017	Joan	Benefits Records	Joan was in receipt of state pension, and was hence known to DWP since 30.3.98. There are no records to suggest that Joan had been seen by anyone from DWP in recent months/years. No issues or problems were known by DWP.
13/09/2018	Joan	Police	Joan rang police on 999 at 09.44 to report she had stabbed her husband. Officers attended the address where the male was pronounced deceased.
13/09/2018	Joan	Emergency Department Records	Brought to ED by the Police at 11.09hrs following her arrest on suspicion of stabbing and killing her husband. No physical injuries or treatment required.

Key to status	
RED	Action Required
AMBER	Preparation Underway
GREEN	Preparation complete and action ongoing
COMPLETE	Action Completed

	DHR Adult N										
Rec. No.	**Recommendation**	**S.M.A.R.T. Action**	**Milestones / actions taken**	**Lead person**	**Target date**	**Status**	**Status Jan 2020**	**Status May 2020**	**Status August 2020**	**Date completed**	**Evidence of outcome and improvements made**
CCG											
1	*Non-response to annual health checks, cancer screening programmes and immunisations:* Sheffield CCG requests that GP practices review their policies regarding non-response to annual health checks, cancer screening programmes and immunisations. Practices should ensure that capacity to decline the appointment is assessed and that reasonable adjustments are made for those who lack capacity.	To be added to the CCG eBulletins for GPs and Practice nurses, and the safeguarding newsletters	**13.08.2020 waiting on the learing brief to enable her to send out the safeguarding newsletters regarding this action. 2/9/20 learning brief finished and shared**	Amy Lampard	Dec-20	Amber	Green	Green	Green		

2	*Named Accountable GP:* Sheffield CCG will request guidance on the role of the Named Accountable GP from NHS England and circulate this.	AML to contact NHS England regarding this	19.06.2020 - AL has not been able to clarify the role of the accountable GP, AL thinks that the new "ageing well agenda" might impact on this. AL is still working on this.	Amy Lampard	Dec-20	Amber	RED	RED	RED		
3	*Accompanying persons:* Sheffield CCG will encourage clinicians in GP practices to document who each patient attends their appointments with.	To be added to the CCG eBulletins for GPs and Practice nurses, and the safeguarding newsletters	**13.08.2020 waiting on the learning brief to enable her to send out the safeguarding newsletters regarding this action. 2/9/20 learning brief finished and shared**	Amy Lampard	Dec-20	Amber	Green	Green	Green		
Adult Safeguarding											
4	*Processes to support older adults experiencing domestic abuse:* Adult Safeguarding Partnership to seek reassurances that local processes are fit for purpose with regards to supporting people over the age of 65 where there may be mental health and	All key departments / services to be sent a survey to capture their responses to older people and DA / MH and the responses will be discussed as an item on agenda of city wide best practice group	24/06/2020 - Alison to follow up with Safeguarding Partnership. 10/08/2020 - Unfortunately the person who was leading on this has been redeployed since the beginning of the pandemic so we haven't progressed it. I'm not sure when we will have the capacity to pick it back up so unfortunately I can't give a revised timescale. 2/9/20 AH to pick up with head of safeguarding	Tina Gilbert	Jun-20	RED	RED	RED	RED		

	domestic abuse concerns.										
DACT											
5	*Dementia and risk:* To remind partner agencies that risk assessment is part of the care planning procedure in people living with dementia and this should include risk to others. This is relevant to primary care, carers centres, dementia assessment services/ memory clinics and adult social care.	DACT to write to all agencies to remind them of this requirement	Raised at PCG on 20.01.2020. Briefing delivered and working group established. KW to forward SJ report to attach as evidence. Report and summary forwarded via email to SJ on 28/01/2020. 24/06/2020 work on a briefing for the staff workforce is nearly completed. 2/9/2020 briefing completed and to be presented for agreement at the Adults City Wide Best Practice Group 8/9/2020	Alison Higgins	Jan-20	RED	Amber	Green	Green		

6	*Raising awareness with older adult groups:* The report will be shared with the Alzheimer's Society locally and nationally and an offer will be made to discuss joint working to raise awareness of some of the issues in DA and older adults	DACT to share the report with the Alzheimers society	Alison been in touch Alzheimer's Society and is waiting on an identified person in the policy department. @ 24/06/2020 - Alison has shared the document with the national Alzheimer's society, contact made with local branch end August. Waiting for response when key person back from leave.	Alison Higgins	Jan-20	RED	Amber	Amber	Green		
7	*Raising family concerns about treatment of older adults in the judicial system:* the Panel feel that it is important to acknowledge the family's concerns and will write to the agencies concerned (CPS and Prison Service) to pass on the family's concerns about how their mother was treated in the judicial system.	DACT to write to CPS & HMP to raise concerns	Start drafting letter.	Keeley Ward	Feb-20	RED	Amber	Amber	COMPLETE	24/08/2020	Letter to HM Prison Service re. Sheffield [Letter to CPS Robert DHR.pdf

8	*Recommendations for future DHRs: 1)* Alleged perpetrators should be asked for access to defence reports 2) When alleged perpetrators have established or suspected cognitive problems approaches to them concerning their involvement and access to their information need to be cognisant of, and compliant with, mental capacity legislation.	DACT – recommendations to be written into the procedures	Review guidance	Keeley Ward	Mar-20	RED	Amber	Amber	COMPLETE	02/09/2020	Refreshed local guidance has been published here: https://sheffielddact.org.uk/domestic-abuse/resources/domestic-homicide-reviews/
9	*Recommendation for Home Office consideration:* it would be helpful for the Home Office to communicate with the Law Society and the Prison Service about best practice in engagement with DHRs	DACT to write to the Home Office	Need to draft a letter to the Home Office	Alison Higgins	Feb-20	RED	Amber	Amber	COMPLETE	24/08/2020	Letter to Home Office Robert DHR.pc

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30 November 2020

Dear Alison Higgins ,

Thank you for submitting the Domestic Homicide Review (DHR) report (Adult N) for Sheffield CSP to the Home Office. Due to the Covid 19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 23rd September 2020 therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agree the feedback.

The QA Panel felt this is a sensitively written report which has good background information on the victim and perpetrator, that humanises them when there is little agency contact. The wide range of agencies invited to check their records is indicative of the rigour with which the panel approached the review. There's a very clear structure in terms of themes and research and the questions raised in the ToR are clearly answered and is easy to read and understand. There were good condolences at beginning of report and the victim's voice comes through, as does the relationship with the perpetrator. Finally the panel's intention to write to the CPS/prison service is good practice, and commendable, given the family's clear concerns.

The QA Panel felt that following the PQAA process, the report feels up to date and has significantly improved but still requires some revision. Following the completion of these changes, the Home Office is content that the DHR may be published.

Areas of final development include:

- The Panel felt that It would be interesting to have explored gendered roles among older people, particularly in that it stated she did all the cooking with him sometimes making a cup of tea, also that they didn't celebrate their anniversary despite her wanting to, in 3.3.2 in barriers it states they were from a generation that valued

independence, it would be useful to further look at how this can be a barrier. The Panel would have also liked to see how deafness may have presented as a barrier.

- At 4.2 it states no evidence of DA, without acknowledging the 2 disclosures of abuse from the perpetrator.
- There is no independent domestic abuse representation on the panel which is acknowledged on the bottom of page 15 but not explained. Similarly, the report states it was not possible to involve a specialist organisation around age or dementia in the review (but that the two organisations read the final report), but does not explain why this was not possible.
- The conclusion refers to preventability & predictability at 4.1 which is no longer needed.
- The Panel would like to see more focus on what the GP practice should have done, given that 7 years went by without contact – the recommendations in this respect lack direction, words like "encourage", "seek reassurance", don't give confidence that there will be an actual change in practice, with the resultant improvement for patients and their families.
- Was there any attempt to engage with friends of the couple? The family said Joan and Robert had many friends, this might have been an excellent source of further information bearing in mind how little is available here.
- There is useful research discussed in 3.2.3. It would be really helpful if this was referenced as a footnote and then also in the bibliography.
- At 3.5.2 The Chair refers to a useful 'Training Pack', it would be helpful if this was referenced in the review particularly as it is acknowledged as good practice. This would enhance the learning from this review for those reading it.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published along the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel