# Domestic Homicide Review

## “Sarah” who died in September 2017

**LDHR16 Final Overview Report May 2020**

# Contents

# 1 Introduction

## 1.1

This domestic homicide review [DHR] examines whether agencies knew, or should have known, that Sarah, who lived in Liverpool, was at risk of domestic abuse from her husband Keith and if so, what they did, or could have done, to reduce the risk and protect Sarah.

## 1.2

In late August 2017 Keith walked to his general practitioner's [GP] surgery and said his wife had collapsed in a chair at their home. The surgery alerted North West Ambulance Service [NWAS]. Their paramedics attended and enlisted the help of Merseyside Fire and Rescue Service whose assistance was necessary to prepare Sarah for transfer to the Royal Liverpool Hospital. The hospital contacted Merseyside Police and raised concerns regarding the extremely poor physical state of Sarah and the squalid conditions in the home as reported by the paramedics. Sarah deteriorated over the next four weeks and died in hospital in mid-September 2017 from cancer [undiagnosed], multi organ failure and infected pressure ulcers.[1]

## 1.3

Keith was charged with gross negligence manslaughter and pleaded not guilty. In September 2019 a jury found him guilty of the offence and he was later sentenced to eight years imprisonment.

## 1.4

Sarah had no close relatives. Her second cousins, who she had not seen or spoken to for about two decades, remembered Sarah as a quiet person, who enjoyed spending time with them. She was kind, respectful and thoughtful. Sarah was sociable with a good sense of humour. She was a thoroughly nice person. The

[1] The reason for the delay in establishing a DHR are examined at paragraph 2 of the report.

cousins told the review chair that Sarah's homicide means they would not be able to resume their relationship with her, something they wanted to do.

## 1.5

'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'.[2]

## 1.6

'The key purpose for undertaking domestic homicide reviews 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'.

## 1.7

The DHR panel wish to extend their condolences to Sarah's family on their sad loss.

## 1.8

Sarah is a pseudonym chosen by her cousins which has family meaning for them. Keith chose not to take part in the review and the name is a pseudonym chosen by the DHR chair and agreed by Sarah's cousins. The chair wrote to Keith informing him of the pseudonym; a reply was not received.

[2] Home Office Guidance Domestic Homicide Reviews December 2016.

# 1.9

Appendix A contains open-source pictures of Sarah's home that may be uncomfortable to look at. The Panel canvassed advice on whether to include them. The panel felt the pictures reinforced the narrative description and illustrated the shocking conditions Sarah was forced to live in, the cousins were asked about the photos and consented to their inclusion.

# 2 Timescales

## 2.1

Sarah died in September 2017 and the police began an investigation into her death. In the ordinary course of events Merseyside Police should have referred the circumstances to Citysafe [Liverpool's Community Safety Partnership] to be screened against the criteria for conducting a domestic homicide review [DHR].

## 2.2

Keith was interviewed under caution by the police in October 2017, April 2018, and September 2018 before he was charged. This trio of opportunities to refer the case for DHR screening were also missed. The reason for not referring the case for screening stemmed from a misunderstanding of the DHR qualifying criteria. Merseyside Police did not appreciate that death through neglect was part of the criteria. After charge, an officer in Merseyside Police recognised the need to refer the case for DHR screening. The panel was assured by Merseyside Police that this lapse has now been addressed and therefore a recommendation is unnecessary.

## 2.3

On 22 February 2019 Citysafe DHR standing group determined they needed more information before deciding whether the criteria for a DHR were met. That additional material was presented to a further meeting of the group on 3 April 2019 at which it was unanimously agreed to recommend the commissioning a DHR to Citysafe; its chair concurred.

## 2.4

The first meeting of the review panel took place on 16 June 2019. The two months delay resulted from the non-availability of panel members. The review was concluded after five meetings and accepted by Citysafe on 27 May 2020. Due to the Covid pandemic, there were delays in populating the action plan for this review, hereafter it was submitted to the Home Office for quality assurance on 4 May 2021.

# 3 Confidentiality

## 3.1

Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

## 3.2

The names of any key professionals involved in the review are pseudonyms.

## 3.3

*Table 1 Age and ethnicity of the victim and offender*

| **Name** **Pseudonyms** | **Relationship** | **Age in Years** At time of homicide | **Ethnicity** |
|---|---|---|---|
| Sarah | Victim and wife of Keith | 61 | White British |
| Keith | Offender and husband of Sarah | 65 | White British |

# 4 Terms of Reference

## 4.1

The Panel settled on the following terms of reference by 19 June 2019. They were shared with Sarah's cousins who did not want them amending.

## 4.2

The review covers the period 1 August 1999 to 30 September 2017. The 1999 start date was selected because of the need to build an accurate picture of Sarah's life in the absence of more recent contact with agencies. It was also suspected she was the victim of long-term domestic abuse. The end date extends beyond Sarah's death in hospital and was aimed at gathering information relevant to the terms of reference from staff who treated and looked after her during her four weeks stay.

**The purpose of a DHR is to**:[3]

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-

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

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.

Specific Terms:

- What indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that may have identified Sarah as a victim of domestic abuse, and Keith as the perpetrator; what was the response and were they signposted to appropriate services?
- What knowledge or concerns did your agency have that Sarah and/or Keith may have been adults with care and support needs and what was the response?
- What knowledge did your agency have that Sarah and/or Keith may have been 'hoarders' and what significance did you put on it when responding to the knowledge?
- What monetary support did Sarah and Keith receive and did your agency consider whether she was the subject of financial exploitation?
- What barriers existed that may have prevented Sarah seeking help and support for domestic abuse, including financial abuse?
- What barriers existed that may have prevented Keith from seeking help and support in his role as Sarah's carer?
- How did your agency respond to any welfare concerns raised by Sarah's family, friends, or neighbours?
- How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Sarah and/or Keith?
- Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Sarah and/or Keith, or to work effectively with other agencies?
- What learning has emerged for your agency?

- Are there any examples of outstanding or innovative practice arising from this case?
- Does the learning in this review appear in other domestic homicide reviews commissioned by Citysafe?

# 5 Method

## 5.1

Once Citysafe decided to hold a DHR it appointed David Hunter as the independent chair and author on 12 April 2019. Thereafter a DHR panel was assembled from agencies judged to have an involvement with the family or contribution to make to the review. Care was taken to ensure people with additional independence and domestic abuse expertise were panel members.

## 5.2

The first panel identified that the family structure was unknown. The chair agreed to explore that aspect. The panel discussed the draft terms of reference identified which agencies were required to submit information. Thereafter they set a timetable for delivering the review.

## 5.3

In between the first and second panel meetings it became apparent from agencies returns that the panel would benefit from additional membership. Accordingly, Age Concern Liverpool and Sefton and Citizens Advice joined the panel to lend their expertise. From the third meeting onwards Plus Dane Housing also attended.

## 5.4

The second panel meeting discussed the agency reports and looked at emerging issues. This process identified significant gaps in the panel's knowledge of the victim and the chair undertook to make more enquiries.

## 5.5

Thereafter draft reports were written and discussed at subsequent panel meetings. The report contained information about Sarah obtained from her second cousins and family letters from the 1990s.

## 5.6

Second and third drafts were prepared. The third draft was shared with the family whose views are reflected in the final report.

## 5.7

Citysafe accepted the report on 27 May 2020.

# 6 Involvement of Family, Friends, Work Colleagues, Neighbours and the Wider Community

## 6.1

The DHR guidance urges reviewers to make the family of the victim an integral part of the process; in Sarah's case that was challenging. She was an only child whose parents were dead. Through the help of Merseyside Police, two second cousins were identified and agreed to take part in the review.

## 6.2

The chair and a colleague saw them and gained an understanding of Sarah's childhood and teenage years. After Sarah move to Cornwall to be with Keith, the cousins lost touch, albeit in more recent years they tried to re-establish contact correctly believing Sarah had returned to Merseyside.

## 6.3

The cousins provided the review with 14 letters that were written by either Sarah or Keith to Sarah's mother and the cousins' mother. They date from the early 1990s and contained material pertinent to the review. They enabled the panel to reach back 25 years and hear the voice of Sarah which the panel found enlightening. Any content used from the letters is attributed. The cousins were provided with DHR leaflets from: the Home Office, Advocacy After Fatal Domestic Abuse [AAFDA] and details of Victim Support National Homicide Team. The cousins did not want to address the DHR panel, nor did they want support from an advocacy service.

## 6.4

As will be seen, Sarah lived an isolated life, and the review was unable to find any friends.

## 6.5

Keith declined the DHR panel's invitation to be involved. In 1996 Sarah wrote to a family member saying that Keith had no close relatives. The review did not find any relatives it could approach. The scant details of his life have been drawn from documents seen by the review. The chair approached his legal adviser who said that Keith 'will not discuss the case or his background'.

# 7 Contributors to the review

## 7.1

*Table 2 Agencies who provided information for the review*

| Agency | IMR[4] | Chronology | Report |
|---|---|---|---|
| Department for Work and Pensions | ✓ | ✓ | |
| General Practitioner | ✓ | ✓ | |
| Merseyside Police | ✓ | ✓ | Statements from the criminal investigation |
| North West Ambulance Service | x | X | ✓ |
| Plus Dane Housing | x | X | ✓ Copies of the contact sheets with Sarah and Keith |

[4] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review which includes a chronology.

| Agency | IMR[4] | Chronology | Report |
|---|---|---|---|
| Royal British Legion | x | X | ✓E-mail response to questions from the review panel |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | x | X | ✓ |

# 8 The review panel members

## 8.1

*Table 3 Review panel members. Those marked * provided additional independence to the review chair.*

| Name and Job Title | Organisation |
|---|---|
| Angela Clarke, Domestic Homicide Coordinator and Team Leader | Safer and Stronger Communities Team Liverpool City Council |
| Angela Clarkson*, Deputy Head of Service | Age Concern Liverpool and Sefton |
| Maria Curran, Administrator | Safer and Stronger Communities Team Liverpool City Council |
| Dil Daly*, Chief Executive | Age Concern Liverpool and Sefton |

| Name and Job Title | Organisation |
|---|---|
| Graham Dumbell, Retirement Services Deputy Director | Department for Works and Pension |
| Caroline Grant*, Domestic Abuse Manager | Local Solutions, Independent Domestic Violence Advisor |
| Paula Nolan**,** Chief Executive | Liverpool Domestic Abuse Services |
| Bev Hyland, Detective Chief Inspector | Merseyside Police |
| Kevin Johnson, Group Manager | Merseyside Fire and Rescue Service |
| Jess Livingstone, Administrator | Safer and Stronger Communities Team Liverpool City Council |
| Liz Mekki, Service Manager, Quality Assurance and Safeguarding | Children's Services Liverpool City Council |
| Debbie Nolan*, Projects Manager | Citizens Advice Liverpool |
| Ifeyinwa Pearson, Team Leader | Adult Services Liverpool City Council |
| Helen Smith, Head of Safeguarding | Liverpool Clinical Commissioning Group [CCG] |
| Jacqui Walsh, Carers Allowance Operations Lead | Department for Works and Pension |
| David Hunter, Chair and Author | Independent |
| Nicola Andrews, Group Community Safety Manager | Plus Dane Housing |

## 8.2

The chair of Citysafe was satisfied the panel chair was independent. The panel chair believed there was proper independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. The addition of Age Concern Liverpool and Sefton and Citizen's advice from the second meeting onwards strengthened the independence and expertise.

## 8.3

The panel met five times: Members diligently discussed the material and identified learning and recommendations. Outside of the meetings the chair negotiated with the Royal British Legion for information relevant to the terms of reverence. He sought a view from AAFDA[5] on the use of open-source photographs within the report. The chair contacted Keith's legal adviser who reported that Keith would not contribute to the report.

[5] Advocacy After Fatal Domestic Abuse A centre of excellence for reviews into domestic homicides and for specialist peer support www.aafda.org.uk

# 9 Chair and author of the overview report

## 9.1

Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the chair and author were the same person.

## 9.2

The chair completed forty-one years in public service [the military and a British police service] retiring from full time work in 2007. Whilst in the police service he was responsible for developing domestic abuse policy and implementation of operational responses to it. To support him in this work he attended domestic abuse multi-agency training and seminars. He has undertaken the following types of reviews: Child Serious Case Reviews, Safeguarding Adult Reviews, Multi-Agency Public Protection Arrangements [MAPPA] Serious Case Reviews and Domestic Homicide Reviews.

## 9.3

The Chair has not worked for any agency providing information to this review. He last undertook a DHR in Liverpool in 2017. He completed two child serious case reviews in Liverpool in 2019. Citysafe had confidence in his independence.

## 9.4

The chair has undertaken all the available Home Office training on DHRs as well as attending regional conferences for chairs, authors and other professionals involved with DHRs; and attended regional events where families of domestic homicide victims have spoken.

# 10 Parallel reviews

## 10.1

Her Majesty's Coroner for Liverpool opened and adjourned an inquest into Sarah's death. Following the criminal trial, HM Coroner informed Merseyside Police that the inquest would not be re-opened.

## 10.2

'It is the Coroner's prerogative to resume an inquest following a criminal trial, but where an inquest does resume, its outcome (conclusion or determination) as to the cause of death, must not be inconsistent with the outcome of the criminal proceedings (as outlined in paragraph 8 of Schedule 1 of the Coroners and Justice Act 2009). It is worth noting that the Coroner is under no obligation to hold an inquest solely in the public interest; an inquest will be held by a Coroner if the circumstances of the death fall under those offences listed in paragraph 1(6) of Schedule 1 of the Coroners and Justice Act 2009'.[6]

## 10.3

Merseyside Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

## 10.4

The DWP and Liverpool CCG undertook internal reviews which informed their IMRs. The panel was assured by them that the findings of the internal reviews were consistent with the content of the IMRs.

[6] www.cps.gov.uk/legal-guidance/coroners

## 10.5

The panel was not aware of any other agency undertaking a review.

# 11 Equality and Diversity

## 11.1

Section 4 of the Equality Act 2010 defines protected characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

## 11.2

Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[7]

[7] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

## 11.3

Sarah and Keith are white British, and English was their first language. There was information from Sarah's cousins that she attended a 'special school' during the primary phase of her education. There are no records of which school or what Sarah's needs were. Sarah and Keith were numerate, and literate as evidenced by the family letters and written information provided to Plus Dane Housing. Sarah's handwritten letters were of a very good standard in terms of construction, use of language, spelling and grammar. Keith's were of a good standard. His spelling was generally accurate.

## 11.4

There is nothing in agency records to suggest Sarah did not have capacity.[8] Sarah's poor health meant she had not worked for many years. Keith was not in paid employment and his mental capacity was never queried.

## 11.5

From the information seen by the panel it is apparent that Sarah had a substantial long-term impairment that prevented her from carrying out normal day-to-day activities and therefore she had a disability under the Act. She was largely immobile and suffered with depression. For many months before her admission to hospital [August 2017] she was reliant on Keith to feed, wash and dress her. It is now known that his neglect of Sarah led to her death.

## 11.6

Keith qualified for Carer's Allowance for Sarah and was receiving Pension Credit for them both.

[8] Mental Capacity Act 2005

## 11.7

Pension Credit is an income-related benefit made up of 2 parts - Guarantee Credit and Savings Credit. Guarantee Credit tops up your weekly income if it is below a set figure. Savings Credit is an extra payment for people who saved some money towards their retirement, for example a pension.

## 11.8

Carer's Allowance is a social security benefit paid to an individual who is undertaking caring responsibilities. The Department for Work and Pensions do not undertake any caring assessment and the questions on their claim form are designed to obtain the relevant information to ensure the applicant meets the qualifying criteria. They do not ask for details of the care provided, the capacity and knowledge of the applicant to deliver it, or the disability/health condition of the person being cared for.

## 11.9

To be entitled to Carer's Allowance the conditions that must be met, include. [Other conditions can apply.]

- the carer must be engaged in caring for at least 35 hours each week.
- the person being looked after must be in receipt of a qualifying benefit (relevant rates of Attendance Allowance, Constant Attendance Allowance, Disability Living Allowance, Personal Independence Payment or Armed Forces Independence Payment)
- the carer cannot be working and earning more than the earnings limit, after allowable expenses
- the carer must be over the age of 16

## 11.10

Keith first claimed Carer's Allowance for looking after Sarah in 2000. A decision was made on his claim on 3 November 2000. He was awarded entitlement to Carer's Allowance, but no payments were made because he was receiving another benefit

and payment of both was not permitted. However, entitlement to Carer's Allowance would enable him to get additional amounts on other benefits such as Income Support.

## 11.11

His claim was closed on 29 July 2002 because the disability benefit being paid to Sarah stopped with effect from 5 August 2002.

## 11.12

A further Carer's Allowance claim was made and disallowed because no disability benefit was in payment on 4 November 2003.

## 11.13

A new claim was received in 2007. He was awarded entitlement to Carer's Allowance on 3 May 2007 with effect from 30 July 2007. Again, no payments were made because he was receiving another benefit and payment of both was not permitted.

## 11.14

In 2012, the other benefit being paid to Keith ended. On 29 November 2012 a decision was made that carer's allowance could be paid. Payments averaging about £245 per four weeks were paid until July 2017. They stopped because Keith began receiving his state pension and payment of both was not permitted.

## 11.15

DWP noted that Keith did not apply to be an appointee for Sarah to act on her behalf. Sarah never had a flag on the system to state she did not have the capacity to conduct her own affairs.

## 11.16

Sarah's general practitioner [GP] prescribed her medicine for anxiety and depression. The prescriptions were irregular and there is no way of knowing whether Sarah took them. The prescription irregularity could have been looked at further by her GP.

## 11.17

Post mortem toxicology results showed that both 'mirtazapine', a prescription anti-depressant, was taken at low concentration [occasionally] and paracetamol was used [repeatedly] within the six months preceding Sarah's death. The mirtazapine was detected in a hair sample. There is no entry in the medical records accessed showing these were prescribed to Sarah or Keith, something Keith acknowledged during his police interview under caution. He conceded he gave Sarah paracetamol for pain relief. The source of the mirtazapine remains unknown and would have been discussed with Keith had he taken part in the review.

## 11.18

When Sarah was admitted to hospital on 24 August 2017 the doctor in Accident and Emergency noted she was unable to communicate because she was so ill.

## 11.19

In conclusion Sarah had significant diversity needs which professionals took into account when providing services. Keith did not have such needs.

# 12 Dissemination

## 12.1

The following organisations/people will receive a web link[9] to the final report after any amendment following the Home Office's quality assurance process.

- The Family
- Police and Crime Commissioner
- All Panel members
- Citysafe for its constituent agencies
- Her Majesty's Prison and Probation Service [Fiona Baker Offender Supervisor, Probation Officer, HMP Liverpool]
- Office of the Police and Crime Commissioner for Merseyside
- Age Concern Liverpool and Sefton
- Citizens Advice
- Royal British Legion
- Plus Dane Housing
- Safelives

[9] The family will be provided with a paper copy should they wish.

# 13 Background, Overview and Chronology

## 13.1 Introduction

13.1.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events beginning in 1999. The narrative is told chronologically. It is built on the lives of Sarah and Keith and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies and the cousins and material gathered by the police during the homicide investigation.

## 13.2 Sarah

13.2.1 Sarah's mother and father lived in Liverpool and were working people. Her mother worked in a public house and her father was a building caretaker and later worked in a department store in the city. Sarah was an only child, and her parents had a very protective approach to her. As a young child Sarah attended a school for children with special needs. Later, she attended a mainstream secondary school and went to college to do a secretarial course. The DHR chair has read the hand-written letters by Sarah from the 1990s and can say these are: articulate, grammatically sound, and almost free from spelling errors. Her handwriting is legible.

13.2.2 The protectiveness shown to Sarah by her parents meant she was fairly isolated with few friends. Her cousins described Sarah as a quiet but sociable person with a good sense of humour. As a young woman she enjoyed spending time with her cousins and extended family. Sarah did not have a wide circle of friends but got on well with neighbours.

13.2.3 Following the death of Sarah's father, she continued to live in the family home and spent time looking after her mother who suffered from poor health. Sarah applied for, and was allocated, a council flat on the same street as her mother. Sarah lived independently although she was still very close to and continued to support her mother.

13.2.4 The cousins thought that Sarah met Keith in 1990 through a mutual friend who they think emigrated many years ago. Sarah and Keith corresponded for some time as pen friends until Sarah suddenly abandoned her flat, walked out, took very little with her, and went to live with Keith in Cornwall. One of the cousins recalled visiting Sarah in Cornwall where Sarah had obtained employment in a nursing home.

13.2.5 Once she had moved to Cornwall, Sarah's communication with her mother became irregular. Keith wrote to Sarah's mother with excuses as to why Sarah could not be in touch with her. The cousins thought that this may have been an example of controlling behaviour and part of a plan to isolate her.

13.2.6 Sarah's mother died in 1992. Sarah and Keith attended the funeral but refused to pay for it despite having access to mother's finances. This left the cousins' mother to pay for the funeral which caused a rift in the family. The family letters seen by the chair reflect this. However, some letters contained olive branches from Sarah. Potentially, Keith 'made' the decision not to pay for the funeral; that is not known for a fact. However, it would be consistent with his control of the finances.

13.2.7 The cousins saw the post-trial press photographs of Sarah and Keith's house including one which showed the chair where Sarah spent all her time. The cousins pointed out a crochet blanket in the photograph. The cousins' mother had made them for all the girls in the family and they were touched that she had kept it for so many years. They hoped it provided a little comfort for Sarah and represented a link with happier times.

## 13.3 Keith

13.3.1 The information about Keith came from documents. There was no family member[s] identified.

13.3.2 Keith told one agency that he was born in Berkshire. His family circumstances remain unknown. It was reported in the press during the trial that his barrister said Keith, '… spent his childhood in care and after marrying his wife, they lived an "unusual lifestyle, perhaps melancholy and socially isolated'.

13.3.3 In December 2017, after Sarah's death and before Keith's conviction, the following unsolicited information was received by a non-police agency from a female caller, who identified herself. She told the agency she had known Keith when he lived in the children's home next to her house. She felt like a mum to Keith and said he had a very difficult life and was bullied at school. Once Keith met his wife the woman said her contact with him waned. The police did not contact the woman. The chair's attempts to contact the woman by telephone were unsuccessful. Keith's legal representative contact the woman on behalf of the DHR chair to see if she would contribute to the review. The woman did not want to be involved in the review.

13.3.4 It is known that Keith lived in Cornwall and had various unspecified jobs in security and engineering companies. He was a member of The Territorial Army between December 1975 and December 1977 and again in February 1980 for two days. The Army Personnel Centre Help Desk 0345 600 9663 was unable to help with the DHR enquiries. The Panel decided not to pursue his Army records as they predated, by at least a decade, his relationship with Sarah.

13.3.5 In one of Sarah's letters, she described Keith as having no close relatives. In a letter from Keith to Sarah's mother [1992] he said he lost his mother a few years ago and nursed her to the end. In another letter Sarah talked about the difficulty in Keith securing employment as a chef. A little more about Keith appears in the next sub-section of the report.

## 13.4 Sarah and Keith's Relationship

13.4.1 The circumstances of Sarah and Keith's 1990 meeting are unknown. At the time Sarah was living alone in rented accommodation in Liverpool and Keith had an address in Cornwall.

13.4.2 Sometime [probably early 1992] after they met Sarah and Keith moved to Cornwall to live. It is abundantly clear from the early family letters [1992] that the move from Liverpool met with her mother's disapproval and the correspondence between Sarah and her mother, and Keith and her mother, are full of recriminations and reprimands. While no letters from Mother to Sarah or Keith have been seen, it is apparent, from the contents of Sarah and Keith's letters to Mother, that she was angry and upset that Sarah had moved away from Liverpool.

13.4.3 The following is a summary of selected parts of one undated letter [probably early March 1992] that Sarah wrote to her mother. Sarah referred to being fed up with people trying to get her to return to Liverpool and that she loved Keith and would marry him. Sarah said she would not allow anyone to split them [Sarah and Keith] up even though things were difficult at present. Sarah felt she had to make a life of her own and told her mother that she would bring Keith to see her.

13.4.4 In March 1992 Keith wrote to Sarah's mother to tell her that Sarah was over her unspecified illness; that he loved her and would look after her and that they must sort themselves out. He semi apologised for sending her a harsh letter in answer to one from her by saying, '…shame we got off to a bad start'.

13.4.5 Keith wrote three more letters to Sarah's mother in 1992. The tone was a little more conciliatory, while retaining an edge. He apologised for Sarah's lack of contact stating she was still recovering from illness. He referred to her gall bladder problems. Strikingly the letters reveal their poor pecuniary position. He bemoaned the £3.20 cost of a 20-minute telephone call. While it is not certain, the context of letter suggests this was a telephone call Sarah made to her mother. He thanked her mother for sending money and asked where the money was from the sale of Sarah's possessions she left in Liverpool. In what looks like a query from mother about what Sarah did with the £11 she gave her for the journey from Liverpool to Cornwall, he itemised the expenditure. Sarah repeated this itemisation in a separate letter to her mother. He acknowledged that mother had been in hospital and offered condolences for her brother's death.

13.4.6 In March 1992 he told mother that he and Sarah were getting married around 17 July 1992 and she would be the first on the invitation list.

13.4.7 He sent Sarah's mother a recorded delivery letter in August 1992 and thanked her for her recent letter to Sarah saying he was replying on her behalf. Keith said Sarah was unwell, run down and had continuing gall bladder problems. He blamed the enduring unpleasantness between Sarah and her mother on Sarah's stress. He was worried that if the unpleasantness did not stop Sarah was likely to end up in hospital.

13.4.8 Sarah's letters to her mother are undated but from the context were almost certainly written in 1992. There are references to the 'nasty letter' Mother sent to Keith and several mentions of how tight money was. For example, Sarah apologised for not sending a condolence card on the death of her uncle and said she could not afford the £1. She asked her mother to send £38 for the train fare so she could attend her uncle's funeral. They needed a new cooker and enquired if her mother had money from the sale of Sarah's belongings.

13.4.9 Sarah acknowledged that mother was concerned about Sarah's health and said she was alright and on a diet from the hospital doctor to get down to nine stone; otherwise, she was perfectly healthy. Sarah wrote that she missed female company.

13.4.10 Sarah said she had been job hunting and had tried to get a loan from Department of Health and Social Security for clothes. It was refused as Keith had not been out of work for long enough. Sarah said they were alright for day-to-day finances but would appreciate £50 for clothes. Sarah enquired whether her mother was going to accept the invitation to come to Cornwall for a few days.

13.4.11 In April 1993 Sarah wrote to a family member saying she would not pay for mother's funeral. There were letters to the same family member in 1994, 1996 and December 1997 and there the correspondence stopped. The 1996 letter came from a new address in the same Cornish town and revealed that Sarah and Keith were buying a house as he was working.

13.4.12 There are no direct disclosures of domestic abuse in any of the correspondence. There are however some domestic abuse risk factors present and these are looked at under term of reference 1.

13.4.13 It is now known that in 1994 Sarah told her GP that she was the victim of domestic abuse. In 1996 Sarah sought refuge in a neighbour's house after being assaulted by Keith. He was arrested for a breach of the peace. The outcome is not known other than it did not attract a conviction.

## 13.5 The Years between 1998 and 2003

13.5.1 These could be described as the silent years as practically nothing is known about them; the little that is appears above. However, given that domestic abuse featured before 1998 and after 2003, the panel felt it was reasonable to say it continued during this period.

## 13.6 Move from Cornwall to Merseyside

**GP Information**

13.6.1 It is not known which year Sarah and Keith moved to Merseyside. It is known that they lived at two addresses there, the second of which they owned.

13.6.2 In March 2003 Sarah and Keith register at a Merseyside GP practice. It was noted Sarah had a Body Max Index [BMI] of >48, meaning Sarah was morbidly obese. Her BMI was significantly higher than 95% of the UK population. This increased her risk of morbidity.[10] Keith was noted as being his wife's carer.

13.6.3 Later in 2003 Sarah and Keith visited their GPs on the same day. They reported being anxious and were referred to psychiatry. There is no record that they were given an appointment and any outcome is unknown. Keith also told the GP they were being harassed by neighbours. There is no record of the harassment in any other agencies' records for this time.

13.6.4 Between then and May 2007 Sarah and Keith visit their GPs about six times. In 2004 it was noted that Sarah had mixed compliance with taking her medicine. Two years later Sarah declined her GP's offer to help her lose weight. Set out below is an extract from research published in May 2014 showing a link between weight and violence.[11]

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[10] Overweight and obesity are associated with increased risk of all-cause mortality and the nadir of the curve was observed at BMI 23-24 among never smokers, 22-23 among healthy never smokers, and 20-22 with longer durations of follow-up.
Source: www.bmj.com/content/353/bmj.i2156

[11] www.researchgate.net/publication/258429500_The_Relationship_of_Violence_and_Traumatic_Stress_to_Changes_in_Weight_and_Waist_Circumference_Longitudinal_Analyses_From_the_Study_of_Women's_Health_Across_the_Nation/link/5786847f08aef321de2c6ca2/download

Objective

To investigate the associations of violence and traumatic stress with changes in weight and waist circumference, hypothesizing that violence in midlife would be associated with increases or decreases in weight and waist circumference.

Method

The longitudinal cohort of the Study of Women's Health Across the Nation (SWAN) comprised the study sample, which included an ethnically/racially and socially diverse group of 2870 women between the ages of 42 and 52 years at baseline. Women were followed annually for 10 years, and assessments included weight and waist circumference measures and data on violence, health outcomes and confounders.

Results

At baseline, 8.6% Caucasian, 10.8% African American, 9.2% Chinese and 5.0% Japanese women reported violence and traumatic stress. Reporting violence and traumatic stress during follow-up was significantly associated with weight gain (OR=2.39, 95% CI= 1.28, 4.47), weight loss (OR=3.54, 95% CI=1.73, 7.22), and gain (OR=2.44, 95% CI =1.37, 4.37) or loss (OR=2.66, 95% CI=1.23, 5.77) in waist circumference, adjusting for age, race/ethnicity, education, marital status, and smoking. Conclusion—Violence and traumatic stress against midlife women was associated with gains or losses in weight and waist circumference.

13.6.5 Sarah was last seen by her GP in July 2014 for weight management. Keith was last seen by his GP during a home visit in December 2015. The record states, 'seen at home with acute illness after wife reported refusing to leave the house. Mention of stress secondary to financial issues, and his carer status'. There is nothing recorded about the condition of the home or hoarding issues. The GP IMR acknowledges that there was insufficient professional curiosity at the time of the December 2015 home visit. It is put in these terms, 'Recurrent themes from the review of general practice include professional curiosity and respectful questioning of patients, recognition and support with caring roles, social prescribing to aid the wider determinants of health…'.

13.6.6 The GP had not prescribed medication to Sarah for several years.

## 13.7 Anti-Social Behaviour

13.7.1 Between November 2009 and January 2014, both Sarah and Keith, reported anti-social behaviour [children in street or noisy neighbours] to Merseyside Police and Plus Dane Housing on about 14 occasions. None of the contacts result in referrals to other agencies for the couple. Plus Dane Housing owned the property where the alleged intrusive noise came from and expended significant resources and effort in dealing with the reports.

13.7.2 The records from Plus Dane Housing show that Sarah and Keith reported being depressed, fed up and stressed by the incessant noise. In November 2013 Keith told Plus Dane Housing that his wife slept upstairs.

## 13.8 Indicators of Domestic Abuse

**Before Admittance to Hospital August 2017**

13.8.1 There are some historic GP records from 1994 and 1995 which documented that Sarah was having problems at home with her husband. He was violent, had beaten and threatened her. On several occasions she had injuries to her face caused by Keith punching her.

13.8.2 Keith was arrested in Cornwall for a breach of the peace in 1996 when Sarah sought refuge in a neighbour's house after being assaulted by Keith.

13.8.3 A professional who saw Sarah in the mid-1990s believed her to be a victim of domestic abuse by Keith; this seemed worse when he was drinking. The professional thought that Sarah would say what Keith told her to say. No referrals were made.

**After Admittance to Hospital August 2017**

13.8.4 Sarah was in hospital for almost four weeks before she died. During that time, she made disclosures of domestic abuse to staff:

- Sarah wished to make a donation to the ward. A nurse explained that she need not, as the NHS were looking after her. Sarah stated that she would like to but asked that her husband was not made aware of her wish as she '…has to be careful what I say in front of my husband'.

- Keith told a nurse that he had spoken to the police and had been informed that nothing was going to happen to him as he was deemed to be neglectfully ignorant.

- Sarah told a health care assistant that her husband had been abusing her.

13.8.5 A police officer saw Sarah in hospital. She said Keith would sometimes not bring her a drink when she asked him to. Sarah though she had been immobile for a few months and remained in bed. She stated that her husband did everything and she had not eaten properly for weeks. Sarah said she had not seen a doctor for a long time and did not know why Keith would not call one for her.

**Post Mortem**

13.8.6 The post mortem report stated that there were various bruises on Sarah's body which may have been because of handling at the hospital. However, there were bruises to both eyes, and below the right eye was overlying minor abrasion/surface loss. The pathologist commented that these were concerning in a non-mobile person such as Sarah. The DHR panel asked the hospital whether the 'concerning' injuries noted by the pathologist appeared in Sarah's medical notes. The hospital reviewed Sarah's health records and reported that the pressure area care continuation chart for 30 August 2017 noted dry and necrotic areas to her lips and cheeks. There appeared to be no suspicion about the skin damage to Sarah's face which was very dry. If the hospital had concerns, they would have raised a safeguarding alert as they did when she was admitted.

**Police Interview**

13.8.7 In October 2017 Keith was interviewed under caution. He said Sarah was unable to cope and that was why he looked after her. He stated that he could not remember the last time he washed her or why the house had become the way it was.

**Criminal Trial**

13.8.8 Keith's conviction for manslaughter gross negligence is the clearest evidence of domestic abuse. The conditions he made her live in were appalling; truly shocking and her treatment by Keith degrading and inhumane.

## 13.9 Life Insurance

13.9.1 Sarah took out an over 50s policy with a national insurance company. It commenced on 09 July 2015 and was worth £7,228.00. No illnesses were declared. The isolation of Sarah commenced before the life insurance policy was purchased.

13.9.2 Claim forms were sent to Keith on 13 November 2017. As of 12 March 2018 Keith had not returned the forms and no money has been paid to him. This could be since a death certificate has not been issued as a Coroner's inquest had been opened. Keith requested a death certificate several times, one being two days after the claim form was sent to him.

## 13.10 Banking Arrangements

13.10.1 The carer's allowance was initially paid to Keith through an order book. After that he received it via a Post Office account and then a national bank. The accounts were in his sole name.

13.10.2 Sarah and Keith had a joint bank account into which her Disability Living Allowance was paid.

## 13.11 Adult Social Care

13.11.1 Neither Sarah nor Keith was known to adult social care before Sarah was admitted to hospital in August 2017. Thereafter they received a safeguarding alert from the hospital and dealt with it in accordance with their policies and procedures.

# 14 Analysis using the terms of reference

## 14.1 Term 1

**What indicators of domestic abuse, including controlling and coercive and behaviour, did your agency have that may have identified Sarah as a victim of domestic abuse, and Keith as the perpetrator; what was the response and were they signposted to appropriate services?**

14.1.1 The period under scrutiny is from August 1999 to August 2017. However, the trail of abuse began before then and is included here in order to build a more accurate picture of Sarah's victimisation by Keith.

14.1.2 In 1994 and 1995 Sarah told her GP in Cornwall that she was having problems at home. It is now known that was a euphemism for significant domestic abuse, involving threats of violence, beatings, and punches to the face. There is nothing in the GP record that described the background to the abuse or to say what advice, services or signposting was offered to Sarah.

14.1.3 The above disclosures reflect more than a single incident of abuse, and the fact that Keith was arrested for a breach of the peace in 1996 following unspecified domestic abuse, is evidence of it enduring. The enduring nature of domestic abuse is supported by research. Safelives[12] quote research which says, 'On average victims experience 50 incidents of abuse before getting effective help'. While Sarah did not 'get help' the panel felt her disclosure to the GP was such a plea.

14.1.4 Twenty five years later [2019] such disclosures would be treated far differently. GPs are more aware of their role in identifying, referring, and supporting victims of domestic abuse. The procedures for them doing so in Liverpool are well established and generally work efficiently. Sarah would also be supported in reporting the matter to the police and should they become involved a criminal justice outcome would be pursued. All this would

[12] www.safelives.org.uk

be done against a plan to keep Sarah safe. However, it is also known from other domestic homicide reviews that, disclosures of domestic abuse made to GPs in current times do not always receive the desired response. 'The work undertaken by clinical commission groups' safeguarding leads needs to continue so that victims who share their experiences of abuse with GPs receive the 'best practice' response each and every time[13]'.

14.1.5 While the above accounts are direct evidence of domestic abuse there were other indicators that suggested Sarah was subjected to controlling and coercive behaviour by Keith.

14.1.6 Firstly, in the mid-1990s, a professional involved in a tangential contact with Sarah and Keith suspected she was the victim of domestic abuse by Keith and noted it seemed worse when he was drinking. The panel was clear in not attributing drink as the cause of Keith's violence towards Sarah. Keith was very likely an intrinsically violent person and drink was an ancillary matter. The professional also felt Sarah would say what she was told to say by Keith. This is clear evidence that Keith was suspected of controlling Sarah. Her 'compliance' with his views may have been her way of staying relatively safe.

14.1.7 Secondly, the family letters referred to earlier also contain clues that Keith was controlling. Keith took Sarah to Cornwall which was against her mother's wishes. In doing that Sarah was isolated from her family and friends; it is not known if that was his intention. In a letter to her mother, Sarah referenced 'missing female company'. Research by Citizens Advice[14] has some bearing on isolation. One question asked of victims was: 'Thinking about your most recent personal experience of domestic abuse, did anyone else know about the abuse?' 48% of respondents said they told friends or a family member

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• [13] Details of that best practice response can be found at; http://www.safelives.org.uk/sites/default/files/resources/Pathfinder%20GP%20practice%20briefing.pdf

[14] A link in the chain The role of friends and family in tackling domestic abuse citizens advice August 2015 www.citizensadvice.org.uk/Global/CitizensAdvice/Crime%20and%20Justice%20Publications/Linkinthechain.pdf

about the abuse. This was by far the highest category of people disclosed to. In Sarah's case she had no friends or family in Cornwall and therefore the predominant avenue of disclosure was not open to her.

14.1.8 Keith wrote several letters on Sarah's behalf to her mother saying she was not well enough to write her own. Whether this was a way of further isolating her is not known. This could be another flag for control and is mentioned on Jane Monckton Smith's Homicide Timeline as 'May try to get close to family/friends so they can exert control over them'. [15] Another potential indicator of controlling behaviour is around financial and economic abuse. [See 14.4 and 14.4.8 for additional details.] Sarah told her mother she could not afford the £1 for a condolences card for her uncle. Sarah also asked her mother for money for herself and Keith. That request may have stemmed from what seems to be the perilous state of their finances or it could have been an indicator that Keith was pressuring Sarah for money, or a combination of those reasons.

14.1.9 After Keith's conviction Sarah's cousins wanted her ashes so they could deal with them compassionately. Keith refused to approve their release thereby perpetuating his control over Sarah after her death. This type of obstruction and control, including the disbursement of personal belongings and property, has been seen in other domestic homicide reviews. It caused additional and significant frustration and sadness to an already grieving family.

14.1.10 After the couple returned to Merseyside there were no disclosures of domestic abuse until Sarah was admitted to hospital in August 2017. Before then there were some prevailing conditions which could indicate domestic abuse. Sarah was seen by her GP in 2004 for a review of her anxiety and depression.

14.1.11 The National Institute for Health and Care Excellence [NICE][16] sites depression and anxiety as a potential sign of domestic abuse. However, these

[15] www.dvact.org/post/do-you-know-the-8-step-timeline-in-domestic-abuse-homicides

[16] www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381

were not published in 2004 when Sarah had her condition reviewed by the GP.

14.1.12 A NICE Guidance paper[17] advises: 'The risk of experiencing domestic violence or abuse is increased if someone; is female; has a long-term illness or disability – this almost doubles the risk (Smith et al. 2011). It is known that Sarah was claiming Disability Living Allowance and had long-term depression/anxiety. The GP's response to Sarah's depression will be looked at under term of reference 5.

14.1.13 Sarah had both of these increased risk factors and the panel heard that GPs now better understand the less obvious risk factors pertinent to domestic abuse. GPs current response to domestic abuse has improved and the position is set out in 14.1.4 above. Sarah's weight gain may have been a sign that she was suffering from violence or other traumatic experience.

14.1.14 Sarah and Keith endured several years of anti-social behaviour. While they reported it put a strain on them it should not be seen as a reason or excuse of Keith's offending against Sarah. He was abusing her long before the reports of noise nuisance to the police and housing, and afterwards.

14.1.15 Sarah's disclosures of domestic abuse came after she had been admitted to hospital and was in a place of safety, away from Keith's 24-hour dominance. The doctor who first saw her in Accident and Emergency stated that Sarah was unable to communicate and was covered in her own faeces. She had pressure sores on her heels that were down to the bone; there were maggots in the creases of her skin; she had a fungal infection under her right breast; a hard mass on her left breast and overwhelmingly septic pressure sores on both buttocks. The doctor spoke to Keith who said Sarah had only been in this condition for a few days. The doctor told Keith that Sarah was very ill and was likely to pass away and noted that Keith was clean and tidy, in complete contrast to Sarah. Keith's response was to ask who was going to

[17] www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621

help him with his constipation. The panel felt this demonstrated a selfish and uncaring attitude which reflected his criminally negligent and morally deplorable care of Sarah.

14.1.16 There is no doubt that Keith's conviction for gross negligence manslaughter is the clearest proof of his domestic abuse against her. The jury found beyond reasonable doubt he:

- Owed a duty of care to Sarah
- By a negligent act or omission, he was in breach of the duty which he owed Sarah
- The negligent act or omission was a cause of the death
- The negligence, which was a cause of the death, amounted to gross negligence and was therefore a crime[18]

14.1.17 In summary: There is overwhelming evidence that Sarah was the victim of long-term domestic abuse by Keith. This included physical, emotional, financial, economic, and controlling and coercive behaviour. He isolated her and in the last two years of her life, built other barriers to keep her invisible from agencies, including refusing to seek medical help for her. Her disclosures to her GP and the police in the 1990's did not result in any respite for her. The apparent lack of action reflected the poor support for victims of domestic abuse 25 years ago.

## 14.2 Term 2

**What knowledge or concerns did your agency have that Sarah and or Keith may have been adults with care and support needs and what was the response?**

[18] This the DHR author's paraphrase of the leading gross negligence manslaughter case of R v Adomako [1995] 1 AC 171i.

14.2.1 The Care Act 2014[19] protects adults with care and support needs and is a complex piece of legislation. It defines what care and support means and places a responsibility on a local authority to provide care and support to meet adults' needs, and to meet carers' needs for support. This is done through assessment.

14.2.2 'Care and support is the mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent - including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations'.[20]

14.2.3 The review period started in 1999 which was well before the Care Act 2014. 'Before the Care Act, people had different entitlements for different types of care and support. These were spread across a number of Acts of Parliament, some over 60 years old. The law was confusing and complex'.[21]

14.2.4 The family letters from the mid-1990s do not indicate that Sarah was in need of care and support.

14.2.5 In 2003 a GP coded Keith's record that 'he is wife's carer, and on practice carer register'. It was noted he helped her with her arthritis. Thereafter, there are several references in Sarah and Keith's GP records to show that she was being cared for by him. There was no referral to adult social care as the GP did not consider they needed additional help. The GP last saw Sarah in July 2014 and Keith in December 2015 at home. There is no note of the home conditions or any other concerns that could, or should, have resulted in a care and support referral, or signposting, to the local authority or other family to services.

[19] The Care Act 2014 was implemented on 1 January 2015.
[20] www.hampshirescp.org.uk/wp-content/uploads/2019/01/Care-and-Support-Needs.pdf
[21] www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets

14.2.6 In October 2014 Sarah attended an ophthalmology appointment at a local hospital. There was nothing recorded that suggest she had care and support needs.

14.2.7 The Department for Work and Pensions knew that Sarah was in receipt of a middle rate disability allowance and that Keith was eligible for Carer's Allowance and on occasions received it when permitted by the non-receipt of other allowances. Paragraph 11.8 identified that The Department for Work and Pensions responsibility is to determine, from the application form, whether an applicant for a particular allowance meets the qualifying criteria. The DWP write to the claimant's GP seeking confirmation of the disability and providing the reply verifies the claimant's statement, the DWP would not probe further into an applicant's circumstances. In this case DWP did not see anything in the case that required a referral to any agency.

14.2.8 Disability Living Allowance has been replaced by Personal Independence Payment which provide more opportunities for DWP to have face to face contact with the claimant, albeit this can be spasmodic with lengthy intervals, tailored to disability/illness reasons and customers treatment. DWP staff, including telephony agents, receive training/coaching on safeguarding and are trained to act on any cause for concern. That action includes referral for attendance at the person's home, by a DWP Visiting Officer, the police or ambulance service. This would involve any concerns such as suicide threat, the carer reported as not caring for the required 35 hours a week and reports of domestic abuse. DWP have a standard Keeping Safe training module for all new staff.

14.2.9 Merseyside Police had 13 contacts with either Sarah or Keith over about four years regarding antisocial behaviour. During the first contact in 2009, Keith told them that he, '…was disabled and the carer for his disabled wife'. The log notes they were both middle aged and not in good health, an ambulance was declined. He did not want a patrol to call on him just wanted the incident logged as per advice from Plus Dane Housing, the landlords of the adjoining property.

14.2.10 The police's dealings with Sarah and Keith were restricted to telephone calls and through passing attention by patrols; the police never entered the home so

could not comment on its condition. The police did not see a need to refer the family to the local authority as being in need of care and support.

14.2.11 Since the time of the incidents under review Merseyside Police have implemented further training for officers and staff relating to Vulnerable Persons. This has led to increased awareness of vulnerability and a greater number of referrals to the relevant partner agencies. Were these incidents being reported today, a Vulnerable Persons Referral Form [VPRF1] would be completed followed by a referral to Adult Social Care.

14.2.12 Plus Dane Housing owns and manages 18,000 homes across Cheshire and Merseyside and own the house next door to Sarah and Keith who were owner occupiers. Sarah and Keith made 14 complaints of anti-social behaviour over about four years and like Merseyside Police, Plus Dane Housing knew that Sarah had some support needs, and that Keith was her carer. They received significant support from Plus Dane Housing in trying to deal with the anti-social behaviour and were visited at home when noise monitoring equipment was installed/removed. Plus Dane Housing did not feel that Sarah or Keith needed referring to the local authority. In April 2014, Plus Dane Housing wrote to Keith closing the case, as they felt the investigations they undertook did not reveal a noise nuisance from their neighbours and the slamming of taxi doors was consequential to living in a terraced property. There was no further contact from Sarah or Keith.

14.2.13 The panel discussed whether owner/occupiers are inherently more likely to be isolated than people living in rented accommodation who need landlords to maintain property, and if supplied with gas, the lawful requirement for an annual gas check. As with DWP staff, Plus Dane Housing staff are trained in recognising and responding to adults with care and support needs and to victims of domestic abuse.

14.2.14 All of the above matters, save for the home visit to Keith by his GP, preceded the 1 January 2015 implementation of the Care Act 2014. The panel felt that since then there had been some improvements in the identification of people with care and support needs and policies and processes and were in place to make referrals to the local authority.

14.2.15 After December 2015, Sarah and Keith did not come to the attention of any agency, and therefore there were no referral opportunities.

14.2.16 However, there were signs that Sarah was isolated. She declined the NHS breast cancer screening in 2014; cervical cancer screening in 2015; bowel cancer screening in 2017 and a flu jab in 2017. Keith also declined bowel cancer screening in 2016 and a flu jab in 2017. The GP who reviewed the medical records noted, 'The surgery was diligent in chasing these up and offering alternatives.' However, there was still no uptake of these services. In 2015 Keith failed to attend asthma review at his GPs following which the surgery made contact by telephone and sent a follow-up letter.

14.2.17 The panel noted that in child safeguarding, missed medical appointments and failing to attend for routine inoculations or milestone check-ups, were indicators of neglect and would be followed up. The panel understood that the processes for safeguarding children are different and need to be more robust. The panel further discussed whether the screening letters sent to Sarah ever reached her. They might have been intercepted by Keith as part of his plan to isolate her from external scrutiny. That would be consistent with his controlling nature.

14.2.18 In summary: Sarah was an adult with care and support needs which were not being provided by Keith. The opposite was true in that he deliberately withheld care and support as determined by the jury's finding of guilt to gross negligence manslaughter. While several agencies knew Sarah had care needs and that Keith was her carer, none of them felt the need to refer either of them to the local authority because there was no known reason to do so. Keith's systematic isolation of Sarah was effective and enable his control of her to continue. Later in the report potential solutions to this type of enforced isolation are explored.

## 14.3 Term 3

**What knowledge did your agency have that Sarah and/or Keith may have been 'hoarders' and what significance did you put on it when responding to the knowledge?**

14.3.1 During the criminal trial it was reported that a psychiatrist said Keith suffered from a hoarding disorder.

14.3.2 The NHS[22] describe hoarding disorder as:

A hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner, usually resulting in unmanageable amounts of clutter. The items can be of little or no monetary value.

Hoarding is considered a significant problem if:

- the amount of clutter interferes with everyday living – for example, the person is unable to use their kitchen or bathroom and cannot access rooms
- the clutter is causing significant distress or negatively affecting the quality of life of the person or their family – for example, they become upset if someone tries to clear the clutter and their relationship suffers

Hoarding disorders are challenging to treat because many people who hoard frequently do not see it as a problem or have little awareness of how it's affecting their life, or the lives of others.

Many do realise they have a problem but are reluctant to seek help because they feel extremely ashamed, humiliated, or guilty about it.

It's really important to encourage a person who is hoarding to seek help, as their difficulties discarding objects can not only cause loneliness and mental health problems but also pose a health and safety risk.

If not tackled, it's a problem that will probably never go away.

[22] www.nhs.uk/conditions/hoarding-disorder/

The reasons why someone begins hoarding are not fully understood. It can be a symptom of another condition. For example, someone with mobility problems may be physically unable to clear the huge amounts of clutter they have acquired, and people with learning disabilities or people developing dementia may be unable to categorise and dispose of items.

Mental health problems associated with hoarding include:

- severe depression
- psychotic disorders, such as schizophrenia
- obsessive compulsive disorder

In some cases, hoarding is a condition in itself and often associated with self-neglect. These people are more likely to:

- live alone
- be unmarried
- have had a deprived childhood, with either a lack of material objects or a poor relationship with other members of their family
- have a family history of hoarding
- have grown up in a cluttered home and never learned to prioritise and sort items

14.3.3 The description of the home, supported by photographic evidence, leave no doubt that the conditions Sarah was forced to live in can fairly be termed as squalid. The overwhelming impression is one of filth, dirt, and chaos, which stemmed from the large volumes of rubbish that were discarded throughout the house. It is apparent looking at the photographs that the conditions had been atrocious for some considerable time. The two upstairs rooms occupied by Keith were cleaner and less cluttered than the other rooms in the house.

14.3.4 The emergency services who extricated Sarah from the house had to wear protective equipment to do so. Keith's treatment of his wife in making her live

in such foul surroundings was demeaning, cruel and inhumane and very likely breached her human rights.

14.3.5 The Human Rights Act 1998, Article 3 protects people from:

- torture (mental or physical)
- inhuman or degrading treatment or punishment, and
- deportation or extradition (being sent to another country to face criminal charges) if there is a real risk, they will face torture or inhuman or degrading treatment or punishment in the country concerned.

'As you would expect, public authorities must not inflict this sort of treatment on you. They must also protect you if someone else is treating you in this way. If they know this right is being breached, they must intervene to stop it. The state must also investigate credible allegations of such treatment.'[23]

14.3.6 In Sarah's case the local authority did not know Sarah's human rights were being breached by Keith; had they, intervention would have followed. It is not known how long the house was in the shocking condition that the emergency services found it in. An officer from Plus Dane Housing visited the property in January 2014 as part of its investigation into an alleged noise nuisance. The officer who went recalls that the condition of the house was untidy, cluttered and Keith apologised saying he was undertaking modification work. However, the officer was able to freely move around the house going up and down the stairs to the bathroom and the living room. Sarah was sitting in the chair and said hello, with Keith telling her not to worry he would get what was needed from the kitchen. The officer recalls being able to walk from one side of the living room to the other and that there were posters on the wall advertising beer. He saw nothing that would require a referral to another agency,

- [23] www.equalityhumanrights.com/en/human-rights-act/article-3-freedom-torture-and-inhuman-or-degrading-treatment

although had the property been one of Plus Dane's he may have flagged it up for a follow up visit given the general untidiness and DIY work. The last known agency to visit the home was a GP in December 2015. The record of that visit does not comment on the condition of the house. The GP IMR concedes that the doctor visiting the home should have been more professionally curious.

14.3.7 Liverpool City Council has a Hoarding Protocol[24] as part of its adult safeguarding policies; it was implemented in March 2017. If the hoarding been known about, this protocol would have provided a pathway to tackling it. The conditions were hazardous to fire safety and public health.

14.3.8 The panel thought the condition of the house went far beyond being cluttered. The environment was injurious to health and contributed to Sarah's death through gross negligence.

## 14.4 Monetary support

**What monetary support did Sarah and Keith receive and did your agency consider whether she was the subject of financial exploitation?**

14.4.1 Sarah and Keith qualified for several state benefits and received all they were entitled to. Their self-declared needs meant that no face-to-face assessment was required for them to qualify; it was a paper-based approach.

14.4.2 While it is known that Sarah's benefits were paid into her bank account. Her lack of mobility may have been a practical barrier to her controlling her finances. Keith's controlling nature, physical assaults and dominance of Sarah's life made it very probable she was financially abused by him. Some of Sarah's early experiences of finances with Keith can be gleaned from the family letters and have been referenced earlier in the report. While they show that Sarah and Keith spoke of money being tight, the impression given was that Keith was the one controlling the household income. That of itself is not necessarily financial abuse, but when

[24] https://liverpool.gov.uk/council/strategies-plans-and-policies/adult-services-and-health/safeguarding-adults-procedure/

combined with his abusive and controlling behaviour is a good indicator that it probably was.

14.4.3 Keith's GP noted in December 2015 after a home visit that his stress might be secondary to his financial issues and his role as a carer. This disclosure shows that there were financial pressures in the home. However, there is no record that the GP signposted Keith to support services. The GP IMR author wrote: 'Keith requested support from his GP when one of his benefits was stopped. Since the date of that contact, a successful city-wide programme for GPs to refer to Citizens Advice for 'advice on prescription'[25] has been successfully embedded within primary care and a similar event today would generate a referral. Social prescribing is now mainstream within primary care'.

14.4.4 The panel felt that the 'advice on prescription' may have benefited Keith, and in turn Sarah, had it been available. However, if Keith was struggling to care for Sarah, then she may have had needs that were not being met by him. In this case it would have been prudent for the GP to have made a 'with consent' referral for the family to adult social care to ensure that Sarah was being properly looked after. The referral would also have benefitted Keith. Had Keith not consented to the referral, the GP should have considered making it in order to support Sarah.

14.4.5 In June 2019 NHS England and NHS Improvement published a paper titled. 'Supporting carers in general practice: a framework of quality markers.' Here is an extract.

'This paper offers a series of practical ideas that have been developed in partnership with carers, primary care teams and other key stakeholders. Collectively, these provide a framework for improving how general practice can better identify and support carers of all ages, and set a clear ambition to:

[25]Launched in 2015 by NHS Liverpool CCG in partnership with Citizens Advice Liverpool, the service enables all Liverpool GPs to refer patients for assistance from Citizens Advice advisers on a range of non-medical issues including housing, homelessness, job loss, complex debts, fuel poverty and welfare benefits. https://www.citizensadviceliverpool.org.uk/advice-on-prescription

- improve carers' health and promote positive wellbeing.
- reduce carer crisis and family breakdown.
- reduce unwarranted variations in carer support, and.
- meet demand more appropriately and better manage demand on service.

The framework provides a range of practical actions grouped into themes that have been developed from carers, and their representatives, and focuses on key areas where the support offered to carers by general practice could be improved'.

14.4.6 The GP IMR noted: 'That on the day of her admission to hospital, Keith walked a mile from their house to the surgery to ask for an ambulance as he said he had neither a landline nor mobile phone. That could indicate financial need. At various points there is evidence that Keith and/or Sarah had telephones. For example, they contacted Plus Dane Housing and Merseyside Police by telephone when reporting antisocial behaviour and neighbour nuisance. In 2012 Plus Dane Housing noted the family's land line telephone number. The GP noted they telephoned Keith [2015] when he missed an appointment. At some time after Sarah was admitted to hospital Keith had an internet enabled device. It is not known if he had it at the time of her admission.

14.4.7 The panel felt a compelling piece of evidence that Sarah was subject to financial control was her remark to a nurse that her husband should not know about a financial gift she wanted to make to the hospital ward.

14.4.8 The criminal investigation showed that Keith had a reasonable level of savings and that his expenditure was unremarkable. He was not in debt. Therefore, the panel concluded that Keith chose not to spend money to meet Sarah's needs, but selfishly spent money on looking after himself. Additionally, Sarah was almost certainly the victim of longstanding economic abuse.[26] The evidence includes Keith's

[26] What is economic abuse? Economic abuse is wider in its definition than 'financial abuse', as it can also include restricting access to essential resources such as food, clothing or

use of housing to isolate Sarah; asking her mother for money from the sale of her belongings; his almost indecent haste to claim on Sarah's life insurance and Sarah's concerns should Keith discover she wanted to make a monetary donation to the hospital ward.

14.4.9 In summary, all the evidence points to Sarah being financially abused/exploited by Keith and that her enforced isolation, enforced by Keith, severely limited the opportunities for it to be discovered.

## 14.5 Term 5

**What barriers existed that may have prevented Sarah seeking help and support for domestic abuse, including financial abuse?**

14.5.1 Sarah told her GP in 1994 and 1995 that she was the victim of domestic abuse by Keith; there is no record of what was done with the disclosure. That was early on in the relationship and Sarah must have felt safe in sharing that information.

14.5.2 A family letter written by Sarah spoke of missing female company. It is known from many DHRs that victims will very often tell friends about the abuse they are subjected to. See footnote 12 page 29. Sarah moved to Cornwall and was without any established support network. Her remark can be seen as a sign of isolation. Therefore, isolation was a specific barrier to disclosure. It is not known for a fact whether Keith engineered the move to Cornwall but geographically remoteness is a facet of isolation in domestic abuse.

14.5.3 A view help on isolation by Hope and Safety[27] states:

'Abusers isolate their victims geographically and socially. Geographic isolation includes moving the victim from her friends, family and support system (often

transport, and denying the means to improve a person's economic status (for example, through employment, education or training). www.womensaid.org

- [27] https://hopeandsafety.org/learn-more/warning-signs-of-an-abuser/

hundreds of miles), moving frequently in the same area and/or relocating to a rural area'.

'Social isolation usually begins with wanting the woman to spend time with him and not her family, friends or co-workers. He will then slowly isolate her from any person who is a support to her. He dictates whom she can talk to; he tells her she cannot have contact with her friends or family'.

14.5.4 Sarah lost contact with her family while in Cornwall. When Sarah and Keith returned to Merseyside, they largely kept themselves to themselves and family ties were not re-established. This solitude perpetuated her isolation. During the early part of their time in Cornwall the internet and mobile telephony were emerging technologies with usage restricted to pioneers. When Keith went to his GP in August 2017 seeking help for Sarah, he told his GP that he did not have a landline or mobile telephone. That meant that Sarah was denied this method of communication which will have significantly contributed to her isolation given her immobility. However, as identified earlier in the report Keith had an internet enabled device at some point after Sarah's admission to hospital and may have had it before. He certainly had the financial means to pay for a telephone.

14.5.5 There were no further disclosures until after Sarah was admitted to hospital in August 2017. From those disclosures it is fair to say that her victimisation by Keith had continued in the intervening years. Sarah's poor mental and physical health and decreasing mobility will have been barriers to her disclosing details of her victimisation.

14.5.6 The panel discussed whether Sarah's reliance on Keith for support made it more difficult for her to seek help and thought he probably used this dependency as part of his overall control.

14.5.7 There is additional specific evidence of a barrier in a remark Sarah made to a nurse. The nurse stated that on one occasion when treating Sarah, she disclosed that she wished to make a donation to the ward. The nurse explained that she did not need to as the NHS were looking after her. However, Sarah stated that she would like to and asked that her husband was not made aware of her wish as she '…has to be careful what I say in front of my husband'.

14.5.8 That exchange suggests that Sarah was in some way frightened of how Keith might react to her donation. Therefore, fear was a barrier to Sarah disclosing abuse. The exchange provides evidence of Keith's controlling nature and financial abuse.

14.5.9 As well as the case specific barriers there are some generic reasons why victims remain silent.

14.5.10 A report from the BMA [British Medical Association] Board of Science Domestic Abuse June 2007 (Updated September 2014) says:

'Barriers to measuring prevalence:

It has been suggested that there are four main barriers to assessing the true prevalence of domestic abuse. They are:

Victims feeling unable to disclose what is happening to them because of:

- a fear of causing a family breakdown and/or bringing dishonour to the family
- a sense of ongoing responsibility for the safety of their children or other family members
- fears for their own personal safety should they report their experiences d) feeling ashamed and/or responsible
- a fear of not being believed, or of the experience being 'too trivial' to mention.

The last point is compounded by the hidden nature of the problem. Domestic abuse is a 'private crime', often taking place behind closed doors, away from the sight of others. This contributes to the culture of silence that can surround the issue while adding to the reluctance of victims to report their experiences.

Many people do not regard the abuse they are suffering as a crime. Figures from the 2010/11 Scottish Crime and Justice Survey found that 29 per cent of those who had experienced physical partner abuse in the last 12 months considered what happened on the most recent (or only) occasion to be a crime'.

14.5.11 The panel discussed whether a victim's 'love' for the abuser was a potential reason why victims stayed in abusive relationships. The National Domestic Violence Hotline[28] [USA] report that: 'Love**:** So often, the victim feels love for their abusive partner…abusive people can often be charming, especially at the beginning of a relationship, and the victim may hope that their partner will go back to being that person. They may only want the violence to stop, not for the relationship to end entirely'. In Sarah's case there is no evidence that she stayed because of 'love'. There is evidence that Keith's abuse and dominance of Sarah was persistent and attritional.

14.5.12 In summary Sarah's 1990's disclosures to her GP did not result in any known action. Thereafter she bore many years of abuse without mentioning it until she was taken to hospital in August 2017. Once in that place of safety she made disclosures albeit against a background of still being frightened of Keith. Her anxiety, depression, economic abuse, financial and physical dependency, mobility difficulties, reliance on Keith as her carer and a near lifetime of being controlled and coerced, will all have been barriers to disclosure.

## 14.6 Term 6

**What barriers existed that may have prevented Keith from seeking help and support in his role as Sarah's carer?**

14.6.1 The review did not identify any barriers to Keith seeking help and support for himself. When he registered with a Merseyside GP in 2003 his record was coded to show he was a carer for his wife. The GP IMR author notes, '…there is a difference between having a register of people coded and being proactive in supporting them. Care Quality Commission and NHS England continue to promote the caring of carers as important to GPs'.

14.6.2 It was noted by the GP in 2015 that his stress may be secondary to his role as a carer. There is no record that any support was offered Keith. The panel felt that the 2015 disclosure should have attracted signposting by

[28] https://www.thehotline.org/is-this-abuse/why-do-people-stay-in-abusive-relationships/

the GP to services or a consensual referral to adult social care who could have considered whether a carer's assessment was necessary. If Keith was struggling to care for Sarah, then she needed additional help. Paragraphs 14.4.3 and 14.4.4 refer to GP social prescribing and the need to ensure the person being cared for was properly supported.

14.6.3 It has been proven beyond reasonable doubt that Keith abused Sarah. Whether his more recent abuse had its origins in not being able to care for her, or not wanting to care for her, is not known. It may be that his wish to continue with Sarah's isolation was driving his actions. A carer's assessment would have helped Sarah by determining whether Keith had the willingness, capacity, and knowledge to provide effective care for her.

14.6.4 Keith's engagement with Merseyside Police, Plus Dane Housing and the Department for Work and Pensions illustrated that he was capable of initiating contact to help with problems. He made no attempt to ask adult social care for help.

14.6.5 His family letters and the hand completed forms for Plus Dane Housing, evidence that he was literate and articulate; two important ingredients for effective communication.

14.6.6 All the evidence shows that Keith looked after himself and criminally disregarded Sarah's wellbeing, dignity and ultimately, her life.

## 14.7 Term 7

**How did your agency respond to any welfare concerns raised by Sarah's family, friends, or neighbours?**

14.7.1 No agency received any welfare concerns from Sarah's family, friends, or neighbours. Very sadly, Sarah lived a life of isolation and did not have friends she confided in. She and Keith were in dispute with their neighbours, and she had lost contact with her family. That loss of contact was more than likely to have been fostered by Keith, particularly when they returned to Merseyside. The family knew she was back in Merseyside and their initial enquires to trace her were unsuccessful.

## 14.8 Term 8

**How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Sarah and/or Keith?**

14.8.1 This term was explored at Section 11 of the report.

## 14.9 Term 9

**Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Sarah and/or Keith, or on your agency's ability to work effectively with other agencies?**

14.9.1 No agency identified any specific issues which could be attributed to its capacity to deliver services. There was a general acknowledgement that all public funded agencies had undertaken reviews of how to deliver services after several rounds of budget reductions.

14.9.2 The panel did not identify any shortfalls in services emanating from resourcing issues.

## 14.10 Term 10

**What learning has emerged for your agency?**

14.10.1 See Section 16 for the learning

## 14.11 Term 11

**Are there any examples of outstanding or innovative practice arising from this case?**

14.11.1 The review did not identify any examples of outstanding or innovative practice.

## 14.12 Term 12

**Does the learning in this review appear in other domestic homicide reviews commissioned by Citysafe**?

14.10.2 Two previous DHRs in Liverpool featured the carer relationship. In one the female victim was an informal carer for a previous partner who had a terminal illness. In the other case the female victim had a learning disability and was killed by the person who cared for her. Paragraph 14.1.12 of this report identified that females with a long-term illness or disability are twice as likely to be victims of domestic abuse. This DHR panel made a recommendation on this point. In a Liverpool Safeguarding Adult Review the victim of neglect was an elderly male in a wheelchair who was being cared for by his wife and daughter.

# 15 Conclusions

## 15.1

Sarah was born and brought up in Liverpool and went to a special school for her primary education. Her cousins say that Sarah's mother was probably overprotective of her because of this; that led to a fairly isolated early childhood apart from family contacts. Sarah attended mainstream secondary school and her mother's shielding of Sarah continued. Her cousins described her, at this time, as fairly quiet, albeit she would join in the family fun.

## 15.2

Sarah's need for a 'special school' primary education did not appear to have affected her ability as an adult to write good quality letters and it is not known why she was given a place.

## 15.3

Sarah left the family home to live independently. This was against her mother's wish and caused some tension between them. Sarah, who lived nearby, continued to provide support and care for her mother.

## 15.4

The circumstances of Sarah and Keith meeting are unknown. It is known that mother frowned on the developing relationship and was severely vexed when the couple moved to Cornwall.

## 15.5

From then on Sarah led an even more isolated life and Keith was the dominant person in the relationship. That dominance was enforced through domestic abuse as evidence by her disclosures to her GP and the attendance of the police. They had little money and received small sums from Sarah's mother to fund specific items. Her mother died and Sarah became estranged from her family over funeral costs. This may have been instigated by Keith as part of his financial and economic abuse.

## 15.6

They returned to Merseyside where their insular life continued. Sarah was seemingly devoid of friends and a social life. The couple were involved in a four year long anti-social behaviour dispute with their neighbours and children in the street. It caused them additional pressures and saw Sarah's anxiety levels and mental well-being deteriorate. Keith told his GP that he was struggling with his carer's responsibilities for his wife. The impact of that on Sarah seems not to have been considered.

## 15.7

Their income derived from public funds centred on Sarah's disability and at times Keith's role as her carer. There were no automatic systems that linked people in receipt of disability benefits or carer's allowance to adult social care or other support

services. It was clear to the DHR panel that Sarah had care and support needs as defined by The Care Act 2014.

## 15.8

The last professional to have contact with Sarah was her GP in July 2014. Keith's last contact was also a GP, in December 2015, when he stated his wife refused to leave the house. There is nothing to say the family was offered a referral, or signposted, to adult social care or any other organisation that may have helped them.

## 15.9

In January 2014 Plus Dane Housing visited the house but did not see anything that warranted a referral to any agency. In December 2015 the GP who visited the house did not make a note of its condition. Therefore, the deterioration took place over the next 20 months. Sadly, no agency knew that the conditions in the house were wholly unacceptable to meet Sarah's needs. Keith had a reasonable level of savings that could have been used to improve the home conditions.

## 15.10

The dynamics of their relationship in the last few years of Sarah's life are largely unknown. It is possible to say that the domestic abuse, including controlling and coercive behaviour, continued as evidenced by Sarah's disclosures after her hospitalisation that he abused her, and her evident fear of Keith finding out about her plans to make a donation to the ward.

## 15.11

From July 2014 until Sarah was admitted to hospital in August 2017, she was invisible to anyone but Keith. The panel felt this invisibility was fostered by Keith to keep people from discovering his gross neglect of Sarah that directly led to her death.

## 15.12

The pace of Sarah's decline escalated in the last two years of her life and was a direct result of Keith's abuse. The domestic abuse risk factors present in the relationship were never identified and therefore Keith's tactics in isolating her meant the horrific conditions she was forced to live in remained undiscovered as did her other forms of victimisation.

# 16 Learning Identified

## 16.1 Agency Learning

*Table 4 Agency learning*

| Agency | Learning |
|---|---|
| DWP | No learning |
| Merseyside Police | The review did not identify any learning for Merseyside Police from this case. Officers and staff have since received further training relating to Vulnerable Persons which has resulted in increased awareness of the different types of vulnerability. This is apparent from the increase in the numbers of individuals referred to partner agencies. |
| Royal British Legion | No learning |
| Royal Liverpool and Broadgreen University Hospital NHS Trust | No learning |
| General Practitioner | There are record keeping and referral issues that are historical, and systems and processes have changed since the events |

| | |
|---|---|
| | recorded. Professional curiosity is an issue, especially exploring events from the past and having a respectful uncertainty towards how patients report events.<br><br>With hindsight, self-neglect and neglect are suggested, with both patients withdrawing from health care from 2014/15 onwards. On almost all occasions, failure to attend an offered appointment, or participate in national screening programmes was followed up by the surgery. |

## 16.2 Domestic Homicide Review Panel

**Introduction**

16.2.1 The GP IMR picked up the missed opportunities for GPs to have been more enquiring into the reasons for Keith's presentation. See 16.1 above.

16.2.2 The panel considered several issues that might be seen as learning. The first was the absence of an automatic referral process between DWP and Adult Social Care, or any other agency, for those people claiming disability/carers' benefits. Such automation would mean that Adult Social Care, or other agencies had knowledge of people who were carers and could offer an assessment of their needs or other support. The panel heard that the DWP had 6000/7000 new claimants each week, and 16,000 change of circumstances contacts, thereby making it impractical to have automated referral. DWP would be overwhelmed in trying to identify which was the most appropriate agency to refer to. It was felt that adult social care would be the most likely recipient. They in turn would be saturated and unable to cope with triaging the referrals. The panel felt any recommendation stemming from such learning would be unrealistic and impractical to implement and therefore discounted automatic referral as a solution. However, the panel felt that the point should be explored.

16.2.3 Other suggestions looked at increasing the awareness of professionals' knowledge of domestic abuse in isolated or hard to reach groups and/or bringing a more forensic approach to identifying other victims of domestic abuse in similar circumstances.

16.2.4 The panel thought the key to identifying Sarah, and 'future Sarah's' as victims of domestic abuse was to adopt a more methodical approach. From 2000 onwards Keith's deliberate isolation of Sarah, provided a barrier that denied agencies the usual means and opportunities of recognising domestic abuse.

16.2.5 This led the panel to thinking about a risk identification model whereby a list of risk factors could be drawn up, that could be applied to 'other isolated Sarah's.' This approach would make it more likely that domestic abuse could be identify if it was present in the relationship.

16.2.6 Using the risk factors applicable to this review, the panel offered the following.

- No previous domestic abuse involvement with agencies in the last 10 years
- Having a disability
- Having an aggressive partner
- In receipt of disability [now Personal Independence Payments] and/or carer's allowances
- Being in dispute with neighbours and/or the community
- Carer living in the same home as a person being cared for
- Carer stress
- Isolation
- Missed appointments including medical ones
- Declining NHS screening programmes
- Owner occupier
- Hoarding

16.2.7 The panel debated how to turn that suggestion into a realistic and achievable recommendation. They asked themselves, 'What would have made a difference for Sarah?' The essential element needed was for professionals who came into contact

with Sarah to have known about the risk factors and gathered information on how many applied. It would then be necessary to make a judgement on what should be done with any concerns. This model would only apply to people who were considered fairly isolated and had no history of being a victim of domestic abuse, say, in the last ten years. A potential outcome could be a referral to MARAC.[29] The panel was also conscious that any solution should be compatible with the current MeRIT[30] risk assessment model used in Liverpool.

16.2.8 The Panel recognised that a very significant amount of work needed doing, including the development of the risk-based approach, its processes, policies, training, and evaluation after implementation.

16.2.9 The panel thought the recommendation should framed around identifying previously unknown victims of domestic abuse who are thought to be living fairly isolated lives. The panel did this in the form of a 'challenge' to Citysafe on how to reach this group of potential victims and provide relevant services.

# 17 Recommendations

## 17.1 Agencies Recommendations

17.1.1 General Practitioner

1. To Increase the awareness of self-neglect in primary care.

2. To increase the awareness of support for people who hoard.

## 17.2 The Panel's Recommendations

17.2.1 The DHR panel identified the following recommendation

3. That Citysafe [Liverpool's Community Safety Partnership] explore whether it would be practicable to develop a risk factor approach to

[29] MARAC Multi-Agency Risk Assessment Conference.
[30] Merseyside Risk Indicator Toolkit

identify previously unknown victims of domestic abuse who live fairly isolated lives.

4. That Citysafe, ensures that its, and all agencies domestic abuse training, covers the doubling of risk of domestic abuse faced by females who have long term disabilities or illnesses.

5. That Liverpool Clinical Commissioning Group reinforce with GPs the need for them to consider the impact of a person being cared for, when the carer discloses difficulties in coping, and whether the circumstances require a referral to adult social care to ensure the person being cared for is safe.

6. That Citysafe explore with the Department for Work and Pensions, Liverpool Clinical Commissioning Group and Liverpool Adult Social Care the feasibility and circumstances of when the Department for Work and Pensions could make referrals to those organisations for people in receipt of carer's allowance.

# 18 Appendix A

Open-source pictures of Sarah's living conditions