SOUTH CAMBRIDGESHIRE
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
INTO THE DEATH OF JW
IN MAY 2018

INDEPENDENT REVIEW PANEL
CHAIR AND AUTHOR,
RAY GALLOWAY

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1. Acknowledgement

1.1. It is very important for us to recognise that this report relates to the life of a person that was valued and loved by his family and friends and that his loss has caused them great sadness. We can only hope that our efforts to learn from JW's death have not added to their trauma and distress.

1.2. To enable the report to be produced the various agencies have gathered, and shared, sensitive and personal information under conditions of strict confidentiality; balancing the need to maintain the privacy of the family and the need for agencies to learn lessons that relate to their practice.

1.3. The support of JW's wife and family is very much appreciated and, also, their forbearance with regard to the time taken to collate all of the necessary information and present it in a way, via this report, that can be easily understood and act as a learning reference for the future.

1.4. It is important to acknowledge, also, that this report will become public, as is required by the Home Office.

2. Introduction

2.1. At 06.16am, on a morning in May 2018, the East of England Ambulance Service were called to an address in Whittlesford, Cambridge to a report of a man having suffered a cardiac arrest.

2.2. The property is the home of JW's son and daughter-in-law, LW and PW, both of whom were present at the address. It was LW that had called the ambulance, upon finding his father unconscious on a sofa in the conservatory that is situated at the rear of his property, after getting up for work.

2.3. LW had left his father, sat in the conservatory with a glass of wine, the previous night, when he had retired to bed at about 9.30pm.

2.4. Following emergency medical treatment by the paramedics, JW was conveyed by ambulance to Addenbrookes Hospital, Cambridge.

2.5. JW was known to have consumed at least one glass of wine and enquiries at the scene, prompted by the paramedics, established that it was likely that he had also consumed an unknown amount of liquid morphine and other prescribed drugs.

2.6. The remnants of the drugs were found in the kitchen of the annex that he shared with his wife, BW, which was located in the rear garden of the property occupied by his son and daughter-in-law.

2.7. Despite the best endeavours of the medical staff, JW died at Addenbrookes Hospital later that same day, his death being pronounced at 4.01pm. The cause of his death was recorded as multiple organ failure, which was secondary to mixed drug toxicity.

2.8. An inquest was subsequently held into the death, chaired by Mr David Heming, the Senior Coroner for Cambridgeshire and Peterborough. The coroner returned a verdict of suicide.

3. Timescales

3.1. On 4th August 2018, the Head of Public Protection for Cambridgeshire Constabulary notified the Chair of South Cambridgeshire Community Safety Partnership of the death of JW, which had occurred in May 2018.

3.2. He undertook this notification as he believed that the circumstances of the death, and its background, fulfilled the criteria for a Domestic Homicide Review (DHR), in accordance with s9(3) of the Crime and Victims Act 2004.

3.3. After consideration of the information received a decision was taken, by the South Cambridgeshire Community Safety Partnership, that a Domestic Homicide Review should be commissioned.

3.4. The review began with a panel meeting on 26th November 2018, when Terms of Reference were discussed, and chronology reports commissioned from all relevant and identifiable agencies. Subsequent panel meetings have been held on 26th February, 29th April, 18th June and 22nd August 2019.

4. Confidentiality

4.1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

4.2. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased person will be referred to by first name or initials as appropriate to the narrative.

4.3. At the request of the family, initials will be used for the wife, son, daughter-in-law and a close family friend of JW and his wife, who provide most of the personal background information that is contained within the report:

4.4. BW, JW's wife
4.5. LW, JW's son
4.6. PW, JW's daughter-in-law
4.7. CA, Friend

4.8. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Either secure networks were in place (GSI, PNN) and adopted (CJSM) or papers shared with password protection. A copy of chronologies and IMRs was provided to all panel members for review and discussion.

5. Terms of Reference

5.1. The DHR will seek to understand:

5.2. Whether improvement in any of the following could have led to a different outcome for JW:

5.3. Communication and information sharing between services with regard to the safeguarding of adults.

5.4. Communication and information sharing within services.

5.5. Whether the work undertaken by services in this case is consistent with each organisation's:

5.6. Standards of professional practice and standards of organisational practice.

5.7. Domestic abuse policy, procedures and protocols.

5.8. Safeguarding policies.

5.9. Whether the work undertaken by services in this case is consistent with partnership and/or multi agency:

5.10. Standards of professional practice and standards of organisational practice.

5.11. Domestic abuse policy, procedures and protocols.

6. Scope of the Review

6.1. The scope of the DHR embraces the respective responses of the relevant agencies and includes any contact or referrals, relating to BW, from 1st January 2013 onwards.

6.2. It will seek to understand what decisions were taken and what actions were or were not carried out and establish the reasons for those decisions.

6.3. In particular, the following areas will be explored:

6.4. Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with BW.

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

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

6.7. The quality of any relevant assessments undertaken by each agency in respect of BW and whether mental capacity issues were considered for BW.

6.8. The effect of care giving in the marital relationship and the contribution it may have made to the death.

6.9. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

6.10. Whether practices by all agencies were compliant with the Equality Act and, as such, sensitive to the ethnic, cultural, linguistic, religious identity and disabilities of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately, and recorded.

6.11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner, and what was the outcome of any escalation.

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

7. Involvement of Family, Friends and Neighbours

7.1. The author has made three visits to the family of JW, including his wife, son and daughter-in-law. They all supported and embraced the objectives of the DHR and provided their consent for relevant records to be accessed and used for the purposes of its effective completion.

7.2. Whilst they supported the DHR process, neither the family of JW, nor his widow, wanted the involvement of any other support agency or organisation, having been provided with that option by the Chair and Author during the personal visits that he made to their home. Regular contact was also maintained, via telephone.

7.3. Access to support material and advice was explained, such as the services of AAFDA, and links to the online Home Office guidance. Whilst the available support, advice and guidance was acknowledged by the family, it was clear that they did not wish to take advantage of its availability.

7.4. A close neighbour, a retired GP, was visited and spoken to, at some length, by the Chair and Author. The neighbour visited the couple most days and knew them both well.

7.5. It is the hope of the whole Review Panel that, in our efforts to learn the lessons from the tragic loss of JW, that we do not add to the distress of his family.

8. Contributors to the Review

8.1. Key managers, from each of the agencies with whom JW and his wife interacted, contributed to the panel meetings and review of this case. Where the involvement of the respective agencies was considered to be relevant to the objectives of the review, those managers have completed Individual Management Reviews, the key elements of which are summarised in this report.

8.2. Professional opinion and advice was also gathered from the Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership, Cambridge Women's Aid and, also, from the Cambridgeshire, Peterborough and Norfolk branch of 'Caring Together' (formerly The Carer's Trust).

8.3. A valuable contribution to the review was also made by Age UK, for which the author is grateful.

8.4. Consultation was undertaken, by the Chair and Author, with the Cambridgeshire and Peterborough Coroner's office.

9. The Review Author

9.1. Ray Galloway was appointed by the South Cambridgeshire Community Safety Partnership as the independent chair of the DVHR panel and he is the author of the review document.

9.2. He is a former Detective Superintendent in North Yorkshire Police, where he served for seven years, having worked the previous 24 years of his service in Merseyside Police.

9.3. Ray fulfilled the roles of Head of Major Crime, Head of Serious and Organised Crime and Director of Intelligence. He is a highly experienced and fully accredited Senior Investigating Officer, having led numerous investigations relating to offences such as homicide, kidnap and a whole range of other serious crimes.

9.4. He also has extensive experience of safeguarding related issues, including domestic abuse.

9.5. Upon leaving the police service Ray directed the independent investigation into the abusive activities of Jimmy Savile in Leeds. He also co-authored the public report.

9.6. Following on from the publication of that report, Ray directed the NHS Savile Legacy Unit, which oversaw, and quality assured more than 30 independent investigations into Savile at NHS Trusts around the country.

9.7. Ray regularly presents to safeguarding conferences regarding the lessons to be learnt from the Savile investigations.

9.8. In addition to being the Chair and/or Author of other DHRs, and involvement in several Mental Health Homicide Reviews, Ray has also undertaken independent investigations for a number of commercial organisations, for charities and for the Church of England.

9.9. He has no association whatsoever with South Cambridgeshire District Council or with any agency that is relevant to this review.

10. Methodology

10.1. Under section 9 of the Domestic Violence, Crime and Victims Act, 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by South Cambridgeshire District Council.

10.2. In November 2018, Ray Galloway was appointed to act as the Independent Chair of the DVHR Panel, and as the report author. Tony Hester supported throughout, in the role of process manager and Secretary to the Panel.

10.3. This review was commissioned under Home Office Guidance, issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (Appendix 3).

10.4. The following policies and initiatives have also been scrutinised and considered:

10.5. Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016.

10.6. Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016.

10.7. HMIC (Her Majesty's Inspectorate of Constabulary) Reports: 'Everyone's business: Improving the police response to domestic abuse' 2014 and 'The Metropolitan Police Service's approach to tackling domestic abuse' 2014.

10.8. South Cambridgeshire District Council website and related services.

10.9. Such is the extent to which the lives of JW and his wife were entwined, that it would be neither credible, nor appropriate, to undertake this review without full reference to both.

10.10. The key issues that are highlighted within the review relate significantly to BW, as well as JW, such was the extent to which their lives, and their involvement with the relevant agencies, overlapped.

10.11. It is within this context that regular reference is made in the review to BW and, at times to the records that relate to her, to ensure that relevant and important context is highlighted and understood.

10.12. The decision to embrace the records and interventions relating to BW was unanimously agreed at the second panel meeting, of 29th April 2019.

11. Equality and Diversity

11.1. Consideration was given to the nine protected characteristics under the Equality Act 2010 in evaluating the various services provided. All concerned are White British and JW is male.

11.2. Extensive discussion was undertaken at the panel meetings to determine whether any evidence was apparent that would suggest that JW or BW had been the victim of discrimination, or received a lesser quality of service, due to their various health conditions, their frailty and/or their advanced age.

11.3. The relevant legislation that provided the context for the panel was The Care Act 2014, The Disability Act 2016 and The Equality Act 2010.

11.4. Police and partner agency enquiries established that there was a history of domestic abuse between JW and his wife, the most recent known incident having occurred the day before his death. It is within that context that a Domestic Homicide Review was proposed, as detailed below.

11.5. Research indicates that older people are not being represented in domestic abuse services, for a wide variety of societal and attitudinal reasons, with very few cases being considered at Multi Agency Risk assessment Conferences. *(Safe Later Lives. Older People and Domestic Abuse 2016).*

11.6. To place the suicide into some form of national context, in 2018 three quarters of the total of 6507 deaths by suicide registered in the UK were those of men. *(ONS, Suicides in the UK, 2018 registrations).*

11.7. Of those suicides 21 per 100,000 were men aged over 90 years of age, which represented part of an increasing trend, with the suicide rate for males aged 75 years and over being 32% higher than in 2017. *(ONS, Suicides in the UK, 2018 registrations).*

11.8. In 2019 just over 13% of suicides recorded in the UK were men and women over 90 years of age, with suicide rates tending to increase in the oldest age groups for both men and women *(ONS 2019).*

11.9. Whilst a verdict of suicide was recorded at the Coroner's Inquest relating to JW's death, no note or other indication was left and, thus, the reason for his suicide was never definitively established. There was no sound basis to conclude that the primary factor that led to JW taking his own life was the fact of his abusive relationship with his wife.

11.10. Whilst both JW and his wife suffered from ill health and a lack of mobility, neither were registered as disabled. He cared for the needs of his wife. They were both very elderly and suffered from significant physical impairments that caused each of them pain and discomfort whilst also limiting their mobility. They both had mental capacity, yet both had care and support needs.

11.11. The key question for the panel was whether the gender, age, health conditions, limited mobility and the domestic situation of JW and his wife influenced how the various agencies dealt with them and the support that they were offered.

11.12. The detail of what considerations were applied will be addressed in the respective sections that relate to each of the agencies involved, and then brought together in the report conclusions and recommendations.

11.13. It is clear is that the respective perceptions of JW and his wife, with regard to their own personal wellbeing, were detrimentally influenced by their health conditions in that they could both feel down about their quality of life and, in JW's case, about what he perceived as his related inability to care for his wife effectively.

11.14. What was difficult to determine was the extent to which the inability of JW and his wife to manage their physical limitations and their pain had any influence on their behaviour, especially towards each other.

11.15. Such was the limited size of their home, and their respective limited mobility, it was inevitable that any difficulty or frustration that either of them experienced as a result of their inability to venture beyond their domestic setting was likely to manifest itself in tension in their relationship.

11.16. Whilst their son provided evidence to the review that his parents had always had something of a verbally robust relationship, the worsening of the relationship into physical abuse came about only after his father lost the ability to drive and to leave his home.

11.17. It is that which appears to be the catalyst for the abusive behaviour that was to bring JW and his wife to the attention of the police and, in turn, several other public agencies, although they both already had a long history of contact with health services.

11.18. JW and his wife had been married for nearly 70 years and their home, which was a purpose-built annex, was situated in the large rear garden of the property owned by his son and his wife. Further detail is provided in Section 15, below.

11.19. Whilst such an enduring relationship does not prevent the relationship from being abusive, it was clear to the author upon visiting the family, and a long-standing friend and neighbour who visited every day, that there was an absolute commitment to each other and their marriage.

11.20. The physically abusive aspect of their relationship had developed only in the latter years of their marriage as both parties had struggled with their own health and care needs.

11.21. Whilst the author did not specifically discuss the views of BW with regard to their marriage, when he visited her in her home, it was clearly evident from the discussion that she had enjoyed her long marriage to JW and missed him greatly.

11.22. From the conversations held with the family, and BW herself, it was evident that the abusive incidents of 2018 were not representative of what had otherwise been a mostly happy and harmonious relationship.

11.23. The panel found no evidence that, whilst the proximity of a family support network was a factor in the considerations of agencies such as the Police, the GP and Adult Social Care, it significantly inhibited the appropriate offer of support or respite.

11.24. On occasion, JW's daughter in law would accompany him to visit the GP which provided a tangible example that a support network was in place and was accessible.

11.25. The existence of the support network, including its proximity, is likely to have had some contributory influence on the fact that the care needs of JW or his wife never seem to have been made a priority by any agency, although that assertion must be considered within the context that both JW and his wife consistently declined the offers of help and support given to them.

11.26. The only aspect of the processes, protocols, procedures and risk assessments that were used, with regard to JW and his wife, which were considered to have fallen short of what may be considered to be a reasonable and objective standard, and potentially discriminatory, related to the scoring matrix used within the DASH framework.

11.27. That issue is addressed within the body of the report and is the subject of Recommendation 1.

Dissemination

11.28. The intended recipients of this report, once approved by the Home Office Quality Assurance Panel, are listed at Appendix 2.

12. The Review Panel Members

NAME	AGENCY/ROLE
James BAMBRIDGE	Review Officer, Investigation Review Team, Cambridgeshire Police
Helen DUNCAN	Head of Adult Safeguarding/Principal Social Worker, Cambridgeshire County Council and Peterborough City Council
Carol DAVIES	Designated Nurse, Safeguarding Adults, Cambridgeshire and Peterborough CCG
Tracy BROWN	Adult Safeguarding Lead, Cambridge University Hospitals NHS Foundation Trust
Paul COLLIN	Head of Adult Safeguarding, Cambridgeshire and Peterborough NHS Foundation Trust
Amanda WARBURTON	Partnership Officer, Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership.
Chris PARKER	Chair, South Cambridgeshire Community Safety Partnership
Vivian BECK	Service Manager, Age UK
Miriam MARTIN	CEO, Cambridgeshire, Peterborough and Norfolk 'Caring Together'.
Linda COULTRUP	Named Nurse, Safeguarding Adults, Primary Care, NHS Cambridgeshire and Peterborough CCG.
Kathryn HAWKES	Community Safety, South Cambridgeshire District Council
Jason CLARKE	Community Safety, South Cambridgeshire District Council
Angela STEWART	CEO, Cambridge Women's Aid
Ray GALLOWAY	Independent Chair and Author of Report
Tony HESTER	Independent Manager and Panel Secretary

13. Parallel Reviews

13.1. An Inquest was held on 14th September 2018, following which a verdict of Suicide was recorded.

14. Background Information and Chronology

14.1. JW and BW, aged 92 years and 90 years old respectively at the time of his death, had been married for nearly 70 years. Despite the longevity of their marriage it had, according to their son, always been something of a verbally robust relationship with arguments and disagreements a regular feature of daily life.

14.2. JW and his wife lived in a purpose-built annex that had been constructed in the back garden of their son's property, which had previously been their own home before they gave it to their son and his wife in 2009. This followed a health scare for BW, in the form of a heart attack.

14.3. The annex is situated within a generous garden, in which JW enjoyed tending to the plants and shrubs and feeding the birds. He also liked to get out and about by going for a walk or a drive. However, as JW grew older his health deteriorated and his personal mobility became restricted, including the fact that, about three or four years ago, he lost his confidence to drive, and he also became unable to walk far at all.

14.4. These restrictions on his mobility meant that JW no longer had the opportunity to spend some time alone, beyond his domestic environment, which is something that he both enjoyed and valued. Prior to their deterioration in health JW and his wife used to have a very active social life, with lots of friends. He would sing in a local pub, and she would love to dance. In more recent year's BW liked to knit and watch television whilst JW enjoyed sitting quietly and watching the birds in the garden.

14.5. As their age advanced, both JW and his wife suffered from a series of significant health ailments and conditions, that caused them virtually constant pain, and they had both been hospitalised due to ill health. Indeed, on several occasions over recent years they had both, but especially BW, made remarks that suggested that they were each finding life to be, at times, intolerable.

14.6. Both were prescribed a whole range of medication, including liquid morphine, which they would either self-administer or JW would give to his wife, as part of his role as her primary carer.

14.7. A consistent theme of the review was the fact that JW wanted to remain in his own home and for his wife to accept care provision, due to his own limitations, but his wife appeared to show little insight with regard to his physical inability to provide her with the care that she needed.

14.8. Although JW and BW's son and daughter-in-law lived immediately adjacent to them, they were both still in full time employment. Therefore, whilst they would call in regularly to check on the well-being of JW and his wife, their work commitments meant that they did not play any significant role in terms of caring for the elderly couple.

14.9. The fact that JW could no longer get out and about certainly led to an increase in tension between him and his wife. There was no longer an opportunity for him to relieve any of the domestic pressure that may have built up between them by going out for a walk or a drive. In effect, they were living together, all day every day, in a very small property. BW described it as being 'shut in together' and 'in each other's faces' resulting in a feeling of social isolation.

14.10. The result was an escalation in the gravity of their disputes which, previously, had primarily been verbal in nature. This escalation reached the point where they would sometimes strike each other, often with their walking sticks, and push each other over.

14.11. This behaviour reached the extent where it came to the attention of the local police, their first involvement being in October 2013, when a neighbour reported seeing an argument between the two in which BW was seen striking out at JW with a broom.

14.12. Some 6 months after that incident the police were called to an episode of bad driving, reported by witnesses, which turned out to be JW driving to a hospital, about 10 miles from his home, in which he had formerly worked. This followed an argument with his wife. No formal police action was taken.

14.13. No further matters came to the attention of the police until 2018, when four incidents required their attention within the space of 6 weeks, three of which occurred within a 12-day period at the start of February 2018.

14.14. They all involved allegations of assault, with one incident resulting in JW being taken to a police station, interviewed and a crime formally recorded against him for assaulting his wife. 'Adult At Risk' referrals were submitted in each case by the officers that attended the respective incidents. The latter incident of the four, which occurred in March 2018, involved BW taking an overdose of prescribed medication which, ultimately, resulted in her being hospitalised for several days.

14.15. It was following another dispute, which is believed to have involved BW striking her husband with a walking stick, that, at about 9.00pm on an evening in May 2018, JW came to the door of the conservatory that is situated at the rear of the bungalow occupied by his son and daughter-in-law. The two properties are linked by a short, paved path.

14.16. JW asked his son if he might sit in the conservatory as he had been arguing with his wife. His son agreed to his father's request, thinking nothing of it as his parents would regularly argue between themselves and had done so for as long as he could remember.

14.17. One thing that his son did notice as being unusual that evening was the fact that his father was carrying a glass of wine with him as he entered the conservatory. JW was not a person that drank a significant amount of alcohol, his only regular consumption being two glasses of wine with his midday meal. However, the son did not ask his father why he was drinking that evening.

14.18. JW initially sat himself down in a chair in the conservatory and, about 30 minutes or so later, his son went off to bed as he was up early for work the next day. As LW retired to bed his father was laid on the sofa in the conservatory. His son thought nothing more than his father had made himself comfortable for the night.

14.19. The following morning, LW rose at about 5.30am and, upon checking in the conservatory, he saw his father still laid on the sofa. As he went in to check on him,

he noticed that he had vomit around his mouth and, when he shook him, he could not be roused.

14.20. LW immediately called 111, as his previous experience was that this provided the fastest emergency response, and, as his wife spoke to the operator and relayed instructions, he carried out CPR on his father. When the paramedic crew arrived, they took over and it was at this point that they queried with LW as to what his father had taken, in terms of medication.

14.21. As no medication was evident in the conservatory this prompted LW to go to the annex, where he found an empty bottle of liquid morphine and a packet of tablets next to the draining board. These were provided to the paramedics and JW was subsequently transferred to Addenbrookes Hospital.

14.22. Despite the best efforts of the medical staff JW did not recover from his overdose of medication and passed away at 4.01pm later that day. The cause of his death was recorded as multiple organ failure, which was secondary to mixed drug toxicity.

15. Individual Management Reviews (IMR)

15.1. A timeline which embraces the involvement of all relevant agencies can be found at Appendix 1 to the report.

15.2. The Individual Management Reviews, completed by key managers within the respective agencies involved, have been set out, in turn.

16. Cambridgeshire Police IMR

16.1. There were six separate engagements between JW, BW and the police, in the form of the Cambridgeshire Constabulary that are relevant to this review. Two incidents that were the subject of police attendance occurred in 2013 and 2014 respectively, whilst the latter four all occurred, within a relatively short period of time, in 2018.

16.2. On 17th October 2013, a neighbour reported an incident in which an elderly man and woman were arguing, with the woman reported to be striking out at the man with a broom.

16.3. The couple in question were JW and his wife, BW. As the altercation was taking place, their daughter-in-law arrived home. Police officers attended as a result of the call, preceded by paramedics.

16.4. No arrests were made but consideration was given with regard to the welfare of BW, in particular, and, whilst it was concluded by the attending professionals that she should be assessed at hospital, it was her stated preference for her GP to visit her at home instead.

16.5. As BW was considered to have capacity her decision was respected and she was not taken to hospital. It is claimed that Vulnerable Adult referrals were made by the police, relating to both JW and BW, although no formal record of the referrals can be produced.

16.6. On the 24th April 2014, officers were called to attend Fulbourn Hospital, where JW had driven to from his home, a distance of about 10 miles.

16.7. Staff at the hospital were alerted to his bad driving and were concerned for his safety and for his mental health, especially as it transpired that he thought that, as a former employee, he could secure support at the hospital. They took care of him until the police attended and established that he had driven there following an argument with his wife.

16.8. JW had worked at the hospital some years previously, hence his decision to drive there anticipating that he might be able to get some help in coping with his wife, with whom they witnessed him arguing, over the phone, and becoming distressed. He was taken home by officers, who spoke to BW and members of the family.

16.9. Officers submitted a Domestic Abuse DASH risk assessment, graded as a standard risk, identifying both JW and BW as victims. The attending officers also submitted a Vulnerable Adult referral, citing the arguments between the couple that were caused as a result of BW asking for her husband's help.

16.10. The referrals highlighted the fact that JW was struggling to provide adequate care for his wife, due to his own frailty, indicating that both she, and his health, were suffering as a direct consequence. This police action is considered to be both appropriate and proportionate in the circumstances, reflecting mature and informed observations by the officers.

16.11. There was then a period of almost four years before JW and BW have come to the attention of the police again.

16.12. On 1st February 2018, officers attended at their home address, following a referral from paramedics who were in attendance in support of BW, who had recently been released from hospital having suffered a heart attack.

16.13. BW alleged that her husband had slapped her around the face with a wet flannel because she was crying due to the distress and discomfort from her medical conditions. As a counter to that, JW alleged that he had slapped his wife because she had squeezed his testicles, after he had found her distressed in the bathroom.

16.14. Officers assessed that the conflict had arisen due to the strain of the situation on both of them, due primarily to their respective ailments and their age. Neither party supported the police taking any further action. Adult At Risk and, also, DASH risk assessments were undertaken.

16.15. Just a few days later, on 5th February 2018, a similar incident occurred at the home address, after ambulance control referred a call to the police that had initially been made to them by JW.

16.16. JW had alleged that his wife was trying to stop him from calling an ambulance for her. He was struggling to cope with his wife, who was in constant pain, and he believed she should be in hospital and not at home.

16.17. Officers attended and spoke to their adult son, who suggested that his mother was misrepresenting what was happening between his parents to a number of agencies. His belief was that this was in order to paint his father in a bad light.

16.18. The officers observed that BW's behaviour was demeaning and belittling to her husband, which appeared to affirm what their son was saying. JW commented that the situation with his wife was getting worse and that he felt unable to cope with her. Adult At Risk and DASH risk assessments were undertaken.

16.19. One week later, on the 12th February 2018, police were again called to the address, to a report from JW that his wife had hit him repeatedly with a walking stick.

16.20. His wife made a counter-allegation that her husband had pushed her over, causing her to bruise her hand. He had left, and gone into his son's house, which is adjacent to his own property, by the time that the officers arrived.

16.21. Upon inspection BW had a visible minor injury, as a result of which the decision was taken to take JW into a local police station, where he was interviewed. An added benefit of this action was that it provided an immediate resolution to the conflict and an effective safeguarding intervention.

16.22. During interview JW admitted that he had pushed his wife over because she was hitting him with her walking stick and, whilst a crime report was recorded for the assault by JW on his wife, no crime was recorded relating to his original allegation. A DASH risk assessment was undertaken, classified as medium, along with an 'Adult At Risk' referral.

16.23. The level of concern felt by the officers attending the incident is reflected in the fact that they contacted the MASH, directly, to establish whether any emergency options were available to support JW. They were advised that nothing could be done at that time.

16.24. The consistent theme that was emerging within the police referrals was one of concern, with regard to JW's ability to effectively sustain his caring role for his wife, within the context of his own frail health, as a very elderly person himself. The following comments, taken from the police referral, are representative of the concerns being highlighted,

16.25. *"The concerns I have for BW and for JW aren't about domestic incidents, it is due to a lack of care. JW is responsible for BW's care needs that would be a lot to deal with for a young man who was fit and healthy. He needs more help with his wife's care and sometime apart. Currently they spend all day, every day, together and you can see it is getting to them."*

16.26. It is also evident from the referrals that JW's son and daughter-in-law, both of whom worked full time, felt unable to make any meaningful impact on the care regime.

16.27. On the 13th March 2018, JW made an emergency call to the police, stating that his wife had taken an overdose and was unresponsive. Police attended at his home, alongside paramedics.

16.28. JW indicated to the officers that his wife had taken an overdose of morphine and that she had instructed ‘do not resuscitate’. The incident record reveals that BW became abusive to the paramedics that were treating her when she came round from her initially unconscious state, and that she, also, claimed that she had a DNR in place, that she wanted to die and that she should be left alone.

16.29. Both claims relating to the DNR were incorrect and their comments did not serve to influence the actions of the health professionals at the time. Thus, BW was revived, given counteractive medication and taken to hospital for further treatment.

16.30. JW further claimed that his wife threatened suicide on an almost daily basis and that she regularly tried to steal his morphine medication. On this occasion she had threatened to take an overdose, and, in frustration, he admitted that he had said to her; “go on then”. BW was taken to hospital as it was believed that she had made a genuine attempt to take her own life.

16.31. The attending officers submitted an ‘Adult At Risk’ referral, indicating that, in their considered view, JW could not adequately meet his wife’s care needs due, primarily, to his own physical frailty. No DASH form was submitted.

16.32. Once again, the thematic consistency of the referrals is evident: JW’s perceived physical inability to properly meet the care needs of his wife and her vulnerability as a consequence of that fact.

16.33. It was in the afternoon of the day of JW’s death that the police were notified by the hospital, via the MASH, of him having passed away at Addenbrookes Hospital, him having been admitted earlier that day.

16.34. Due to the fact that the notification included details that JW and his wife had been beating each other with walking sticks the previous day and, also, that there was a recent history of domestic abuse allegations, a senior detective was notified.

16.35. Limited enquiries were made both at the hospital and at the home address of the deceased, as a result of which it was concluded that JW had deliberately taken his own life via a fatal overdose of prescribed medication.

16.36. It was determined that the death was not suspicious, and the investigating officers completed a sudden death referral for HM Coroner.

16.37. A post-mortem examination was conducted on 14th May 2018 and the subsequent toxicology report detailed the findings, that JW had an extremely high concentration of prescription drugs in his bloodstream, including a level of morphine that was approximately eight times the amount that would be likely to be fatal.

The toxicology results supported the original hypothesis of suicide and served to inform the conclusion of the subsequent Coroner’s Inquest held some four months later, in September 2018.

17. GP Practice IMR

17.1. The GP records for both JW and his wife were extensive, dating back to 1961. Only selected events, within the agreed parameters of January 2013 – May 2018, are highlighted as being potentially relevant to this review.

17.2. The majority of GP consultations for JW related to the management of the symptoms associated with the recurrent and enduring medical conditions that he was experiencing, including many efforts to try to reduce his experience of pain.

17.3. Unfortunately, while some medication regimes brought him some relief, this seemed rather intermittent and none resulted in a completely pain-free life.

17.4. The records indicate that JW would over-medicate himself at times, in an effort to ease his discomfort. He also became increasingly immobile and, together with his caring responsibilities for his wife, he clearly had a heavy burden to manage, in addition to his own ailments.

17.5. In May 2014 he made a call to a GP who was familiar with their relationship, saying he could not cope with BW any longer. He said that she hurt him, not physically but mentally, always being nasty to him. He said that he needed support but claimed that his wife always refused help. He was advised to contact Social Services for advice.

17.6. Three months later, in July 2014, during a home visit by one of the GP's, JW's desperation is evident when he remarks that, 'She is not dying quickly enough', referring to his wife, who was the subject of the visit. There is no evidence that this remark was explored further by the GP at the time.

17.7. In December 2015 a discussion took place, hosted by a GP, with JW and his daughter-in-law. The focus of the discussion was BW, and how it was felt by JW, that her demands were excessive and stressful for him, making him feel unwell.

17.8. The GP explained the confidentiality restrictions that applied to their discussion, in that they couldn't discuss another patient without their specific consent and proposed a further, joint discussion to address the matters at hand. However, it appears that the proposed discussion never did take place.

17.9. In January 2018 JW's daughter-in-law again expressed her concern that he was not fit to care for his wife, and even queried his ability to care for himself effectively. There is no record of any response to that expression of concern to the GP, nor is there any apparent recognition that it had been expressed previously by the same person.

17.10. It was in February 2018 that the first contact from Social Services was made to the GP, following a referral from the police. Social Services had been refused consent by JW to visit the home address and their enquiry to the GP was focused on the issue of capacity. They were advised that mental capacity was intact.

17.11. On 1st March 2018 there was a telephone call between GP and Adult Social Care, relating to S.42 safeguarding enquiries, the catalyst for which was reports from the Police and Ambulance Services.

17.12. It was initially thought that, in terms of the abuse that was taking place, BW was the victim and JW the perpetrator. However, following discussion it became apparent that that was not always the case, that the situation between the couple was more nuanced in terms of who may perpetrate the abuse.

17.13. JW was due to be discharged from hospital that day. His wife was continuing to be very demanding, unpredictable in her behaviour and impulsive, even over little issues. She was recorded as refusing the offer of care.

17.14. Options had been given to JW, such as respite care, reablement or for him to move out of his home, but he chose not to embrace any of them. It was noted that he felt that he had no real option but to go back home, but that he did not want to.

17.15. On 14th March 2018, during a home visit to JW, whilst BW was in hospital having taken an overdose, he told the GP that he felt exhausted as BW was not allowing him to rest at night or in the daytime.

17.16. The records note that JW said he was very anxious about his wife coming home as he felt that he could not cope with her behaviour any longer. His daughter-in-law, PW, was again present during the visit.

17.17. During a home visit by the GP on 29th March 2018, a neighbour who was present shared with the GP that BW pokes JW, shouts at him and generally gives him a hard time.

17.18. The GP explained to JW that he was very concerned about his welfare and asked for his agreement to make a safeguarding referral, but JW declined to provide his consent and no referral was made.

17.19. BW also had a number of long-standing health problems and, in common with her husband, she took a significant amount of medication, including potent pain relief. She was also noted to overmedicate at times, judging by the number of occasions when her medication had, according to her notes, ‘run out early’.

17.20. There were occasions when BW admitted to taking excessive quantities of morphine syrup of her own volition, and there are several intentional suicide attempts recorded, involving medication that was accessible at home.

17.21. From a psychological well-being point of view, a range of anxiety and depressive symptoms were noted, and the extremes by which her angst was manifested, such as screaming and crying, seems to have been viewed as not unusual.

17.22. There were also a number of occasions when BW was very distressed, and was reported as behaving in an aggressive and, apparently, unreasonable manner to others. This brought her mental health, overall, into question but, whilst she was treated for chronic anxiety and depression, she was not diagnosed with any other mental illness.

17.23. The consistent theme from the records is one of JW enduring relentless pain and reducing personal mobility whilst also shouldering the burden of fulfilling the role of primary carer to his very ill wife.

17.24. Whilst sound medical support was consistently provided, and accepted, by JW, he declined to allow referrals to be made to partner agencies who may have been able to offer other forms of support, despite his pleas that he was unable to cope with caring for his wife and the demands that she placed upon him.

18. Adult Social Care IMR

18.1. Following a referral from the police JW was contacted via phone on 7th February 2018. The Social Worker explained why she was calling and asked if she could visit. This request was declined by JW as he felt that he did not need any support.

18.2. This was despite the fact that the referral highlighted that his wife did not give him any respite and that there had been numerous call outs to the police. JW was also offered support to spend the night elsewhere but chose not to take up the offer. BW was also consulted and decided not to embrace the offer.

18.3. The case notes record that, whilst the family were supporting with shopping and medication, they were struggling with the broader demands of the couple. There is no evidence that a Carer's Assessment was offered at the time.

18.4. There is evidence of the GP being consulted and the application of the 'Making Safeguarding Personal' principle. The risk to JW at this time was acknowledged but it was felt to be reduced as BW was in less pain and carers were being accepted by her and were visiting daily. As a result, the S.42 enquiry was closed in relation to JW, at his own request.

18.5. A new S.42 enquiry was started less than a week later, on 13th February 2018, following another referral which involved a possible criminal offence. This led to a home visit, two days later. Again, multiple options were explored but all were not taken up by either JW or his wife, with little apparent compromise evident.

18.6. Ten days later, on 25th February 2018, after being hospitalised with the flu, JW persistently stated that he did not want to return home to his wife unless more care was in place. However, it was clear from the communication with his wife that she did not accept that he was unwell and not coping. She refuted the need for more care.

18.7. On 28th February 2018, JW had the opportunity to disclose the extent and the impact caring for his wife was having on him. This was in an environment away from her, where he was free to talk. A range of options were explored with him, including moving out of the home permanently.

18.8. JW did not agree to any of the protective options and opted to return home with no care in place, stating that he did not want the social work team to visit again. Given his choice a safety plan was discussed. He did not meet the threshold for MARAC.

18.9. Concerns were discussed with his daughter-in-law who, once again, revealed that she and her husband were affected by the frequent conflict. Despite this they still agreed to be included in the safety plan and agreed to offer some respite to JW.

18.10. On 1st March 2018 one of the social workers shared her concerns with the GP and asked the GP to support the safety plan, provide a carer's prescription for JW and for his wife's mental health to be assessed.

18.11. On 13th March 2018 BW was admitted to hospital following an overdose. The alleged reason was attributed to her husband 'goading her'. This incident led the family to say that they were moving away as they could not cope. This potentially increased the prevailing risk.

18.12. A call was made to JW, who again expressed his concern about his wife returning home, as he felt she would blame him for her taking the overdose. Respite is again discussed, which he seemed to agree to. It was requested that his wife was not to be discharged until her mental health had been assessed.

18.13. On 16th March 2018 the hospital insisted on discharging BW as, following their assessment, it had been determined that she had capacity and they considered that she had no care and support needs, although it was evident that differing views prevailed regarding BW's needs, apparent carer strain and likely further domestic conflict.

18.14. Notwithstanding that difference of opinion, a safety plan was formulated to deal with BW's return home, together with a visit from the mental health crisis team. Again, when contacted, JW insisted that he did not need respite.

18.15. On 10th April 2018 the outcome of the S.42 enquiry was recorded. JW was still not wishing to embrace offers of support and the prevailing risks remained. JW was recorded as having capacity. Nothing was further recorded on JW until the day in May 2018, when he was admitted to Addenbrookes Hospital following an intentional, and ultimately fatal, overdose.

19. Addenbrookes Hospital IMR

19.1. JW and BW attended Cambridge University Hospitals (CUH) for care and treatment over a significant number of years, JW having six separate admissions between May 2013 and December 2017.

19.2. For the purpose of this review, the focus has been on their treatment during the agreed time parameters, commencing in January 2013. A significant proportion of the featured notes relate to BW. This is to ensure that relevant context is made clear and to ensure that the matters relating to JW are better understood.

19.3. A review of the relevant records revealed no concern, in relation to Domestic Abuse or Safeguarding matters, for either party, prior to January 2018.

19.4. Following BW's admission with a chest infection, on 12th January 2018, there is reference made by the Safeguarding Team that, unspecified, safeguarding concerns, apparently initiated by the police, had been investigated by the Local Authority Community Safeguarding Lead.

19.5. Reference is made to the fact that the Speech and Language Therapist had sought to engage with BW's family, but they did not wish to engage as they did not want to be involved in what were termed 'medical issues'. On 25th February 2018 JW was admitted with rheumatic pain, at which time he disclosed that his wife was physically and verbally abusing him. He complained of 'carer burnout' as he was her primary carer, although he declined the offer of carer assistance.

19.6. The next day, 26th February 2018, Ward N2 rang the CUH Adult Safeguarding Team to establish if a Safeguarding Referral had been raised. The Nurse in Charge was advised that a community safeguarding referral had been raised on 15th February 2018 regarding the same issues. The Nurse in Charge was advised to make another referral.

19.7. On 27th February 2018, JW was transferred to Ward D7 and the Medical Registrar was advised to complete a Safeguarding Referral to ensure that the hospital social workers could liaise with the community social worker. However, the Hospital Adult Safeguarding Team have no record of receiving this referral.

19.8. On 1st March 2018, JW was discharged. He had declined Adult Social Care's offer of reablement or respite care. The Community Plan was for the GP to arrange urgent respite for him, in case the domestic situation with his wife deteriorated further. An urgent mental health assessment for BW was also to be arranged by the GP.

19.9. Less than two weeks later, on 13th March 2018, BW was admitted after taking an overdose of Oramorph, which she had been prescribed for hip pain.

19.10. The following day, BW was reviewed by Liaison Psychiatry and it was noted that she had previously overdosed in 2008 and that, over the last month, there had been three calls to the police about domestic violence between her and her husband.

19.11. The next day, 15th March 2018, the Staff Nurse recorded that a hospital safeguarding referral had been sent; However, the Adult Safeguarding Team have no record of a referral for this admission. The Liaison Psychiatry Team reviewed BW and found that she had mental capacity for discharge, so she was referred to the Crisis Team in the community.

19.12. A note, made on 20th March 2018 by Adult Social Care, recorded that BW had been stockpiling her morphine prior to her admission. A Community Adult Safeguarding referral was raised as it was apparent that the Crisis Team had been leaving medication in an egg cup despite the previous overdose.

19.13. A week later, on 27th March 2018, Adult Social Care records state that JW's GP had sent a letter stating that he would not allow his wife to return home, due to her emotional abuse of him.

19.14. The following day, 28th March 2018, Liaison Psychiatry noted that JW had no legal basis upon which to prevent his wife from returning home, as no criminal allegation had been reported to the police.

19.15. The next day, 29th March 2018, a conversation between the Nursing staff and the Crisis Resolution Home Treatment Team is recorded and details the fact that, as BW

intended to self-discharge, without carers, and that a medication dispenser was now in place, they would not follow up as BW's mental health was stable.

19.16. That same day, a Social Worker noted a conversation with JW who said he didn't want his wife back, as he was worried that she would overdose again as she would have access to the morphine that is prescribed to him. A decision was taken not to discharge BW until a care package was in place.

19.17. On 25th April there is a record from Adult Social Care that the medication dispenser (Pivotell) had failed and that they would not be able to provide a care call for night medication. It was 4th May 2018, before a twice daily care package was put in place and BW was discharged. Four days later, at 07.41am on 8th May 2018, JW was admitted to the hospital having taken the overdose that would, subsequently, prove fatal.

19.18. Prior to his death, a bedside conversation with BW and her son, LW, is noted. In that conversation BW explained the events of the previous day, when JW is alleged to have physically assaulted her with a walking stick, after an argument between them had escalated. BW pointed to a black eye and a dressed gash on her arm as evidence of her allegation.

20. Cambridgeshire & Peterborough NHS Foundation Trust IMR

20.1. The CPFT had contact with both JW and BW during both March and April 2018. However, it was solely BW that was their patient, clinical services not being provided to JW. Notwithstanding that fact, it is considered relevant and proportionate context, to refer to the treatment of BW, and her interactions with the Trust, during the said period.

20.2. When admitted to Addenbrookes on 14th March 2018, after taking an overdose of Oramorph, BW explained that her husband had goaded her to take the medication as she had threatened to take her own life following an argument.

20.3. She claimed to have had the intention of committing suicide, that she "had had enough" and had nothing left in her life, having not felt well for many years. Various care solutions were discussed with her, but she declined these suggestions as either unworkable or unpalatable.

20.4. By the following day, BW was considered well enough for discharge and a care package was considered. The Older People's Crisis and Home Treatment Team was to provide support on discharge. Following assessment, she was regarded as having capacity to make decisions and, thus, she was discharged on 16th March 2018.

20.5. On 19th March 2018, a call was received from reablement staff that JW and his wife were hitting each other with their walking sticks. The Community Psychiatric Nurse rang the couple, who blamed each other. A variety of options were offered. All were declined.

20.6. On 20th March 2018, BW was again taken to Addenbrookes, this time with a pre-existing serious medical condition. She was seen by a consultant psychiatrist in the Liaison Psychiatry team, and she expressed a wish to die and said that her son had encouraged her. She was fully oriented. The psychiatrist felt that:

20.7. *Her relationship with her husband is characterised by frequent conflict, irritation and frustration but a wish not to be separated from him. She also presents with low mood and a wish for death which appears to be at least partly driven by her current social circumstances, though she is not receptive to practical changes she might make to improve these. She currently expresses two parallel but opposing wishes, for her son to support her wish to end her life and for her husband to try to prevent her if she tries to.*

20.8. In light of this assessment, it was decided to contact the CPFT Adult Safeguarding Team, but there is no record of this actually happening. However, it is likely that, as JW was perceived to be the victim and BW was not subject to the Care Programme approach. The concern would have been directed to the Cambridgeshire County Council MASH Safeguarding Team, which was already aware of the case.

20.9. There is a record of discussion with the MASH, where it was noted that JW was not referred to MARAC as his DASH (Domestic Abuse, Stalking and Honour Based Violence) score was only 10, whereas a score of 14 is the minimum referral requirement. Notwithstanding that threshold score, professional judgement with regard to any perceived risk to the victim, may also be used for scores under 14.

20.10. On the 26th March 2018, a professionals meeting was held, although it is not recorded who actually attended, and it was agreed that a care package was required for BW, incorporating a safety call and arrangements to administer medication. It was noted that her daughter-in-law, PW, had expressed a wish not to be contacted about her care. The risk assessment included, *"volatile relationship with husband, risk of overdoses. BW will need to have medication locked, as well as husband."*

21. Analysis

21.1. The analysis section of the review document takes advantage of the specific and relevant professional knowledge of the respective IMR authors, as a means of complementing the analytical and strategic overview of the report author.

22. Cambridgeshire Police Analysis

22.1. It is apparent that the officers that have attended the various incidents have found it difficult to definitively determine who was the perpetrator and who was the victim of any abuse that had occurred.

22.2. Despite that difficulty there is no evidence that the gender, age, disability, or any other characteristic of those involved influenced their actions in a way that could be considered as unfair or inappropriate.

22.3. Whilst taking into account the limited range of options that are available to Police Officers in such circumstances, it is evident from the number and the narrative content of the referrals that were submitted, that proper consideration was given to the age and care needs of JW and his wife.

22.4. Consultation with the son and daughter in law, by the police officers that attended at the incidents and, subsequently, by the author, found that there was no consistent evidence of coercive control.

22.5. Whilst, according to the family, it was BW who was, most commonly, likely to prompt a verbal argument, over matters as relatively trivial as the remote control for the tv, there was no similar theme in terms of who may then become physically abusive. BW was also witnessed by police officers to seek to belittle JW in their presence, a fact that they included in their referrals.

22.6. In terms of the physical conflict, it was very much a case of bidirectional abuse. As will be seen, below, in the detail of the incidents that the police attended at their home, it was often a case of counter allegations being made after arguments had taken place that resulted in them both been physically abusive to each other.

22.7. The attending police officers are not health professionals with a professional knowledge relating to specific care and support needs yet more than one referral made reference to the belief of the officers that such support was required.

22.8. In the incident of October 2013, the police and attending professionals concluded that BW was safe within her own home. She was also deemed to have capacity. There were no offences requiring any further police involvement or investigation.

22.9. The attending officers did not submit a DASH risk assessment, despite that fact that there was an inference of there being a domestic background to events, however, they do claim to have submitted a vulnerable adult referral, although no record of that referral can be found.

22.10. In respect of the incident of the 24th April 2014, JW was taken home by officers, who spoke to his wife and members of the family. The officers submitted a domestic abuse DASH risk assessment, nominating both JW and his wife as victims, identifying that there was no apparent violence but that this was a verbal disagreement. This was graded as being a standard risk.

22.11. The attending officers also submitted a Vulnerable Adult Referral, which cited that arguments between JW and his wife were occurring as he was struggling to provide adequate care to her due to his own frailty, indicating that their health was suffering as a consequence.

22.12. The attending officers made it clear as to where their concerns were within the referral, which was good practice. The officers took no further action following the referrals, as there were no offences that had been committed. The incident and referrals were appropriately supervised in accordance with policy.

22.13. Between April 2014 and February 2018, there are no records of any incidents being reported to the Cambridgeshire Constabulary, either directly or by partnership or agency referral, concerning either JW or his wife that are of relevance to this review.

22.14. In relation to the incident of the 1st February 2018, this was recorded by the police as a crime of Common Assault. There was an emerging picture of antagonism between JW and his wife and the concerns of the attending officers with regard to aspects of their care started to emerge. One officer remarked;

22.15. *“The concerns I have for BW and JW aren’t about domestic incidents, it is due to a lack of care”.*

22.16. Contact was made with the care provider to ensure that they were aware. An Adult at Risk referral was made and a DASH risk assessment undertaken. No further action was taken against JW who, on his part, had explained to the officers what had taken place and his wife had declined to co-operate with the officers in investigating the alleged assault.

22.17. Just 4 days later, on 5th February 2018, officers attended another domestic incident which appears to have arisen as a consequence of JW having made efforts to phone for an ambulance, as he felt that his wife needed hospital treatment, but she prevented him from doing so. The officers witnessed BW being particularly demeaning and belittling towards JW.

22.18. This incident prompted a DASH risk assessment, in respect of JW, graded as a medium risk. In the referral the section concerning suicidal and depressive thoughts was endorsed with the following remark from JW, *"It is getting worse. I can't cope anymore. I am 91 years old and not very mobile".*

22.19. Just one week later, on 12th February 2018, police officers were called to a report from JW that his wife had hit him repeatedly with a walking stick. BW made a counter-allegation that he had pushed her over, causing her an injury to her hand. She did have a visible bruise to her hand.

22.20. The officers decided to remove JW from the scene of conflict, and they took him, voluntarily, to a local police station where he was subject of a short interview. The primary rationale for this action was to secure an immediate safeguarding intervention and prevent further confrontation, until their family was in a position to return to the home and help to manage any ongoing risk of conflict.

22.21. In interview, JW admitted that he had pushed BW over because she was hitting him with her walking stick. He was returned to his home by officers and, although a crime report was recorded for common assault, with BW as the victim, no further action was taken in view of the circumstances. An adult at risk referral and a DASH risk assessment were made. The risk was graded as medium. No further police action was taken.

22.22. One month later, on 13th March 2018, police attended another call from JW that his wife had taken an overdose. He advised the attending paramedics and police officers that his wife had requested that she not be resuscitated. However, as this instruction was not on her medical record, they continued with emergency treatment and she was stabilised and taken to hospital. No action was taken with regard to JW's actions.

22.23. JW told the officers that BW threatened suicide on almost a daily basis and often tried to take *his* prescribed morphine. On this occasion he claimed that she had threatened to take an overdose and he admitted that he had said to her; *"go on then*", as opposed to taking her threat seriously, given her propensity to make empty threats.

22.24. It is believed that it was about an hour that had elapsed between his wife ingesting the medication and him calling the police, not the ambulance service which would have been more appropriate in the circumstances.

22.25. Following consideration of JW's actions, in seeking to prevent or influence the intervention of the paramedics before his wife regained consciousness, it was concluded that he had no criminal culpability. No further evidence was available to the DHR with regard to how the officers at the scene sought to determine JW's reason for making the comments that he did, other than their own perception.

22.26. What was determined is that the decision was taken by a supervisory officer without any consultation with the senior detective that was 'on call' at the time, which may have been a more prudent course of action, notwithstanding the fact that his comments did not influence the response of the health professionals treating his wife.

22.27. Whilst the comments of his wife served to confirm her wish not to be resuscitated, the fact that JW's claim was factually incorrect and, also, the fact that he made the comments when she was unconscious should have resulted in his intent being the subject of more significant investigative scrutiny than it was.

22.28. Officers made an Adult at Risk referral, highlighting BW's illness, frailty and her confused state. In addition, they articulated that they considered that JW was unable to cope with her needs. The footnote comment was *"both are struggling as they receive no care from anyone"* No DASH risk assessment was recorded on this occasion.

22.29. The referral comments highlighted the following; *"She has a lot of medical issues causing her a lot of pain but refuses treatment as she wishes to die. Her and her husband are too frail to care for each other and have a very temperamental relationship. Previous referrals support this".*

22.30. The police sent two notifications, four days apart in February 2018, to Cambridge Women's Aid (CWA), as per the agreed process where a DASH form does not result in a score that represents a high risk. CWA provide outreach support for medium and low risk cases in City, South and East Cambridgeshire.

22.31. The two notifications included the multiple health ailments and also reflected the complexity of the domestic situation, indicating that JW and BW were, respectively, both perpetrator and victim and that the identified abuse issues were being exacerbated by their respective care and support needs.

22.32. The notifications also included the fact that BW was constantly belittling and putting her husband down, with the likelihood that her behaviour was probably influenced by her own pain and distress, having only recently discharged herself from hospital.

22.33. Details of squabbles over the television remote control that have then escalated into walking sticks being used to strike each other have evidenced the nature of the relationship between JW and his wife.

22.34. Whilst there was no specific request for a domestic abuse agency, such as CWA, to become involved the latter notification included the fact that the latest argument had resulted in BW sustaining an injury to her hand and JW being interviewed at the police station about the incident.

22.35. Social Services, in the form of Adult Social Care were already involved with both JW and BW, as were medical and mental health services. It is within that context that

CWA considered the abusive situation and any potential additional benefit that they could offer.

22.36. It was concluded by CWA, that, recognising the ongoing involvement of Social Services and Health Services, it did not appear to be a situation where Women's Aid had a role to play in which they could add value.

22.37. It was the existing and relevant involvement of the other agencies that was the primary rationale for CWA not also becoming involved themselves. Whilst CWA had initial concern for BW, it was apparent that she had not given her consent to being contacted, although it was not possible in the review to definitively establish if the specific support of Women's Aid was ever offered to her.

22.38. This decision was also informed by the fact that JW had been accused of abusing his partner, BW, and the fact that the abuse appeared to be linked to issues relating to ill health and perceived struggles to get care, in addition to the then CWA policy that they did not generally work with male perpetrators of domestic violence.

22.39. Whilst CWA do work with men, in some circumstances, they do not do so if the man in question is believed to be either the primary or co-perpetrator of abuse as, due to the gendered nature of much domestic abuse, it is considered that their involvement may increase the risk to the female partner.

22.40. In the notifications that were provided to CWA, it was reasonable for them to be believe it to be the case, that JW was, at times, considered to be the perpetrator of abuse as abusive behaviour was evident from both parties.

22.41. The CWA decision not to become involved was not specifically conveyed to the MASH, although this was not unusual as the MASH is not considered to have the capacity to record what actions have or have not been taken on cases that have been assessed as medium risk.

22.42. The decision taken by CWA was not considered by the panel to be a missed opportunity to intervene and prevent the suicide. The motivation for JW's suicide was never established and both he and his wife had consistently and tenaciously declined virtually all offers of support and respite.

22.43. The repeated decisions by BW and JW not to embrace offers of support and/or respite was part of the consideration applied by CWA as they reasonably sought to deploy their skills and resources where they were most needed and could add best value. Whilst it would have been prudent for CWA to establish more accurately the extent to which Social Services and Health were engaged with JW and his wife, it is not considered by the panel to be a reasonable conclusion that an offer of support from CWA would have been influential in preventing JW's subsequent suicide.

22.44. The consistent assessment of the police officers who attended the most recent reports of abuse, in the three-month period before JW's death, was that the bidirectional abusive behaviour that was occurring was a consequence of the care needs that emanated from the poor health of the two parties and JW's frustration at not being able to effectively care for his wife.

22.45. The environment that was identified by the police officers, several of whom, according to the family, spent a significant period of time at the property to ensure they understood the context of, and the background to, the abusive behaviour was not one of a relentlessly abusive relationship. It was one in which both parties were acutely frustrated with their own frailties and the associated pain that they were both suffering and those frustrations had begun to manifest themselves in relatively minor physical conflict, such as pushing and shoving.

22.46. It was clear that the intersectionality of age, physical health and, from the perspective of feeling frustrated at not being able to get out as often, mental health was having a debilitating effect on the couple and impacting upon their behaviour towards each other.

22.47. The various referrals, from different officers, highlight the care needs of the couple, as opposed to the need for the intervention of DA focused agencies. It is clear that they believe that the abusive behaviour is a consequence of the care needs and it is the latter that should be the multi-agency priority.

22.48. In the tragic occurrence of the day of JW's death, the initial notification to the police was reported into the MASH late in the afternoon. Whilst JW was not pronounced dead until 4.01pm, he had been admitted to hospital more than nine hours earlier from his home address, at which there had been a very recent history of domestic abuse.

22.49. This included an incident, just the day before, in which both JW and his wife were believed to have beaten each other with their walking sticks. The police log that was created for the death made reference to that incident of the day before.

22.50. In view of the recent history of domestic abuse allegations a senior detective was notified, who then managed the investigation into the death to ensure that there was no indication of it being a suspicious death that may have been the result of a criminal act. Consequently, the 'sudden death report' was completed by detective officers involved in that investigation.

22.51. The senior detective who oversaw the investigation has been consulted. An issue of note was highlighted when it became evident that the officer in question had had no previous dealings with cases of suicide where there was a known background of domestic abuse and was not aware of the latest Home Office Guidance, published in December 2016.

22.52. As the initial investigation into the death determined that there were no suspicious circumstances, a referral to the Community Safety Partnership was not made at that time and the matter was dealt with as a Coroner's investigation.

22.53. The wider implications of apparent suicides, where there is potentially a Domestic Abuse background, is subject of further comment and a review recommendation. It is not completely clear at what point in the police investigation that the hypothesis of suicide was embraced, as JW is not known to have ever previously talked of taking his own life.

22.54. According to his son's statement, it seems likely that the original suspicion of the death being a suicide originated from the paramedics who attended the emergency call as they asked him what his father had taken, suggesting that they suspected that he had taken something that had provoked his unconscious condition on the sofa.

22.55. This is notable as they had actually been advised that the call was to a person that had suffered a cardiac arrest, not an overdose. Alternatively, it may be that such a question, as that which was asked of the son, is routine when it is evident that the patient has been vomiting, as JW had.

22.56. Notwithstanding the potential for the hypothesis of suicide to have been embraced prematurely, there is no subsequent evidential basis to believe that JW's death was in any way suspicious or involved a criminal act by a third party.

GP Practice Analysis

22.57. Despite his frequent interactions with their GP Practice, it cannot be determined with certainty as to precisely what issues contributed to JW 's death.

22.58. According to the GP records both he and his wife caused significant concern, but they consistently chose not to embrace the many offers of referrals for further assistance or, if they did accept an offer, they later discontinued or retracted. This resulted in a situation where clinicians may have felt impotent in terms of their ability to provide help or support as that support could not be imposed.

22.59. Despite both JW and his wife suffering from chronic, long-term conditions, they still acted, in some capacity, as carer to each other, although it seems that JW carried the greater responsibility, due to his wife's deteriorating vision.

22.60. It would appear that although a range of staff in the GP practice knew, or knew of, JW and his wife, no one person had enduring oversight of the overall unfolding situation.

22.61. This is a common experience for most patients nowadays, in that an appointment or consultation could be with any one of a number of different GPs, nursing staff or health professionals. It is less likely that a named GP will always respond to the same patient(s), although, as a matter of good practice this should be aspired to.

22.62. The most effective method of securing an understanding of a patient is to review their records, which, for clinical conditions, the current record keeping system captures well, by means of automated coding. This enables clinicians to quickly assimilate the key problems and concerns for a patient and enables the presenting problem to be factored into the history.

22.63. The nature of the consultation records in the General Practice in question were such that the version in use at the time did not contain many data collection fields that would enable easy capture and recall of domestic abuse, safeguarding and social problems as opposed to clinical ones, and the development and use of relevant coding has not been very effective until recently.

22.64. This lack of an overview may have contributed to individual practitioners seeing each event in relative isolation, rather than having an awareness of the broader situation and circumstances.

22.65. It was only in February 2018, following contact from the Ambulance Service, that the records at the practice were coded to include issues such as, 'Emotional Abuse', 'Stress at Home', 'Social Problems' and chronic 'Relationship Problems (with spouse)' for the first time. Furthermore, these issues were noted on JW's records only, not those of his wife.

22.66. It would appear that the GP Practice itself had not explored the issue of Domestic Abuse with JW or BW directly. Albeit the behaviours exhibited were extreme at times, actually conceptualising the behaviours of JW and his wife, towards each other, as Domestic Abuse does not appear to have happened.

22.67. This may have been because other agencies involved were perhaps thought to be leading on this and doing so already, for example, Adult Social Care.

22.68. The few entries in the GP records that do allude to the experience of domestic abuse are largely when recording the actions of another organisation, such as the Ambulance Service, or responding to enquiries from the Local Authority when they were conducting their Section 42 Safeguarding enquiries.

22.69. For example, when the GP practice was contacted by Adult Social Care, as part of their Section 42 safeguarding enquiries, the reply was clear, that domestic abuse had not been witnessed by GP practice staff themselves.

22.70. Whilst this is true it raises the question about the understanding of domestic abuse, and why the abusive events that regularly took place between JW and his wife did not appear to have been considered as such. The potential for abuse was never explored.

22.71. There is no evidence that the issue of either party potentially over medicating at home was addressed by the GP Practice, despite it being recorded in the patient notes. This issue should have been the focus of more attention when one considers the nature of the medication in question and the potential consequences of its misuse.

22.72. Regarding mental capacity, all assessments concluded that there was no deficit in that area. Therefore, however sensible or logical the options being presented to either JW or his wife appeared to be, both parties continued to make decisions that may have been considered unwise by others.

22.73. Before the language of Domestic Abuse began to be a feature, there were many references to marital disharmony, arguments, disagreements, frustrations with their own health, and views expressed about difficulties with managing life generally.

22.74. When the descriptor 'Domestic Abuse' became associated with JW and his relationship with his wife, more latterly, it was initially contextualised with the assumption that JW, as the male, was the perpetrator.

22.75. This was not always the case as it is evident that both parties were both victim and perpetrator at times. The fact that it was later realised that BW was also, at times, a perpetrator seems to have presented a real challenge to agencies as to how to manage the situation, especially in light of the resistance to offers of help made to either one, or both.

22.76. JW's daughter-in-law sometimes accompanied him, and his wife, to appointments. This included a discussion with a GP that took place in December 2015, and at which she was present.

22.77. This conversation involved JW talking about the demands placed upon him, in terms of caring for his wife, as being excessive to the point of causing him stress and making him feel unwell.

22.78. That conversation may have been an opportunity to take a more complete, a more holistic view of the situation, as opposed to the limited view that appears to have been applied.

22.79. This is one of the few occasions when a broader overview, where issues that are common to both patients and influence their respective well-being, were proposed for consideration. However, it appears that the proposal was resisted in the name of patient confidentiality and the suggested joint discussion never took place.

Addenbrookes Hospital Analysis

22.80. Safeguarding concerns were raised by CUH staff on the two admissions prior to JW's death, in May 2018. Also, when BW had required inpatient admission, in March 2018, similar concerns had been raised.

22.81. The first admission of those that appear relevant to the review, occurred on the 12th January 2018, when BW was admitted with a chest infection. The Speech and Language Therapist (SALT) noted that the family did not wish to be involved with 'medical issues'.

22.82. The SALT does not indicate why the family felt this way, nor does that ever seem to be explored. Safeguarding concerns that had been raised prior to BW's admission were followed up by the community team. She was discharged on the 30th of January 2018.

22.83. Only 26 days later, JW is admitted to the hospital and discloses that his wife is abusive as well as revealing that he is experiencing difficulty with carer burnout, exacerbated by her refusal to accept community care.

22.84. Prior to admission JW had sold his car, due to his reduced confidence in driving, and he stated that the demands of his wife had resulted in him not going to the GP about his health concerns.

22.85. Throughout this admission JW spoke frankly about the nature of his relationship with his wife. Although, on admission, there was evidence of his difficulty in pain management, throughout his admission his intense stress at home is noted as his primary complaint.

22.86. He explains that what he referred to as the ‘volatile’ nature of his wife is lifelong but is becoming more difficult to manage as he becomes frailer and her behaviours escalate. He is quick to point out that his wife is “sharp as a shilling” and has no issues with memory loss; however, mounting levels of aggression from his wife leave JW protecting himself with his walking frame from increasing physical attacks.

22.87. A social worker had a discussion with JW around increasing his wife’s care calls to three times a day, but he fears that this will not lessen the demands that she places on him. The social worker discussed options with him to reduce his stress at home, including reablement care and respite, but both were declined.

22.88. Throughout, it is clear that JW has the mental capacity to engage in all aspects of this decision making and the notes of his wife’s admission, on 12th January 2018, reveal that safeguarding concerns were initiated by the police. Notwithstanding that fact, CUH have no record of any contact from the police regarding the couple on either BW’s admission, in January 2018, or on JW’s admission in February 2018.

22.89. On the 13th of March 2018, BW was admitted following an overdose at home. The attending ambulance service made a safeguarding referral to social care, which is the correct pathway for a safeguarding referral, both in 2018 and at present.

22.90. Upon admission BW disclosed to a registrar that JW had ‘goaded’ her into the overdose. This disclosure did not prompt a safeguarding referral due to the ambulance service’s prior referral, of which the ED registrar would have been made aware. In line with the relevant process, the Registrar simply noted the conversation within the electronic medical record.

22.91. The Liaison Psychiatry Team, which is based at CUH but employed by Cambridge and Peterborough Foundation Trust (CPFT), reviewed BW on the 14th March, which is the standard process following an overdose admission. It was noted that BW had overdosed in 2008, and that the police had been contacted three times in the month prior to her admission, in relation to domestic abuse concerns. There was no suggestion that the domestic abuse had culminated in BW’s most recent overdose, but it was evidence of the tense home environment, and her relationship with JW.

22.92. On the 15th of March 2018, a staff nurse documented that a safeguarding referral was made, although the CUH safeguarding team have no record of this. At the time the pathway involved referrals being faxed to both CUH safeguarding team as well as social care discharge planning team.

22.93. The pathway has since been updated to an electronic referral system. In any event, the ambulance service’s prior referral would have alerted the social care discharge planning team. As such, the lack of nurse referral is of little practical consequence.

22.94. The liaison psychiatric team reviewed BW for a second time and recorded that she had mental capacity for discharge and could be seen by the crisis team in the community. BW was insistent on leaving hospital as she was worried about her husband, JW. Attempts were made to delay the discharge by encouraging BW to wait until PW and LW returned from a weekend away.

22.95. Also, JW had mentioned his reluctance for his wife to come home, in an earlier conversation with a staff nurse, due to ‘needing a rest’. Several discussions took

place between social care and the medical and nursing teams looking after BW. There appeared to be a level of frustration evident during these exchanges as BW was deemed to have mental capacity and, therefore, there was no obvious legal framework that could be utilised to prevent her from leaving hospital.

22.96. Four days after her discharge, BW is readmitted with a medical issue not related to her prior admission. It is documented in the notes. by a member of the social care team, that BW had been stockpiling morphine. However, there were no concerns recorded or expressed at this time that this would present a risk to JW. A multi-agency safeguarding hub (MASH) community safeguarding referral was made, in relation to domestic abuse.

22.97. The following day the GP sent a letter stating that JW wouldn't allow his wife home due to her emotional abuse of him. A member of the liaison psychiatric team noted that there was no legal framework to prevent BW from going home as JW had not pressed charges in relation to the abuse.

22.98. JW expressed his concerns that BW would take his prescribed morphine. At the time CUH had no evidence that JW had any intention on taking excessive quantities of the morphine himself.

22.99. On the day of his death, JW was admitted following his lethal overdose. The ambulance crew reported that the previous night JW and BW had been hurting each other and JW said that 'he wanted to die'. It is unclear from the documentation how, or from where, the ambulance crew ascertained this information.

22.100. There is no evidence that the altercation that was referred to in the bedside conversation of that afternoon, between BW and her son, was out of character for the couple, or particularly robust in nature. The family was then informed that JW had suffered multi organ failure and was unlikely to survive.

22.101. At 1601 JW passed away.

23. Cambridgeshire & Peterborough Foundation Trust Analysis

23.1. BW was initially seen in Addenbrookes hospital on 14th March 2018, following her admission after taking an overdose.

23.2. She stated that the incident started with her peeling the potatoes and struggling to take the eyes out due to her poor vision. JW took them from her, and she said that she then retorted. This has then started an argument, during which she threatened to take her own life, and she later reported that her husband has then goaded her and said, "go on take it".

23.3. After drinking the Oramorph BW has lay down on her bed. She reported that she thought she had taken enough to end her life and that she had the intention of committing suicide. Her husband has then called her son and they telephoned for the police and ambulance.

23.4. Potential care solutions, such as attending clubs in the day for some independent activity, were discussed with BW but she declined these suggestions as either unworkable or unpalatable.

23.5. The psychiatric assessment of 20th March 2018, when she expressed a wish to die, was entirely proper and necessary.

23.6. On the 29th March 2018, it was decided that Crisis and Home Treatment Team (CRHTT) support for BW was not required upon discharge as:

23.7. "*She is mentally stable and there were no concerns over her cognitive abilities; Mrs W has capacity to decline package of care, pivotel has been organised, will be delivered by community pharmacist later."*

23.8. There was no further contact until 24th April 2018, when BW was again seen by the same Consultant in Liaison Psychiatry. No psychiatric interventions were required.

23.9. It appears that JW 's death occurred within the context of a relationship that he and his wife both found intolerable, but could not leave, in which there had been domestic abuse, and in which their living accommodation was perceived, by some, as so small as to be a contributory factor to their stress.

23.10. However, when the home environment was visited by the author, it was a perfectly adequate, well-appointed and immaculately maintained property with a large back garden that was overlooked by full length windows in the lounge.

23.11. There was no evidence at all, of any inadequacies within the home that may have been the result of a lack of income, capability, or support.

23.12. There is no clear understanding as to why both JW and BW consistently chose not to embrace the offers of support. There is no evidence or suggestion that either of them had had a negative experience in the past, with regard to their interaction with any of the professional care agencies, and the basis for their decisions was not detailed on the case notes.

23.13. There was some concern within the Trust that discharge arrangements were not in place following BW's discharge from hospital on 16th March 2018. However, there is a clear history of offers of help being declined by both JW and BW.

23.14. On this occasion, she sought discharge from hospital before support could be arranged. It is clear that BW had capacity to make such decisions.

23.15. The full nature of the relationship with their son and daughter-in-law does not appear to have been explored, although the son did visit daily and provide some care. A carer's assessment does not seem to have been considered.

24. Adult Social Care Analysis

24.1. From the information and notes reviewed, it would appear that the social care interventions were undertaken in a timely manner.

24.2. Whilst the proximity of the annex property, in which JW and BW lived, to their son and daughter-in-law's home was noted at the outset of ASC involvement and was considered to be something of a protective factor, there is no evidence that it went on to influence their response unduly.

24.3. The first Adult at Risk referral was received on the 7th February 2018, and was responded to on the same day, but input from Social Services was declined.

24.4. The second Adult at Risk referral was received on 13th February 2018 and was again responded to on the same day.

24.5. All discussions and actions have been recorded on the appropriate documentation, which preceded the current electronic system.

24.6. Risk and DASH assessments were completed but they did not meet the MARAC threshold. What is not clear is whether a carer assessment was ever offered, there is no evidence that it was, beyond assessment forms being sent to JW for him to complete.

24.7. There is no evidence that any follow up was made with JW when he did not return the assessment forms, to offer him any assistance that may have been needed to complete the forms accurately. An assessment would have been appropriate as it is recorded in referrals and agency notes that JW has expressed, on multiple occasions, his difficulties in caring for his wife effectively.

24.8. Although no formal Carer's Assessment was undertaken, it is evident that the impact of JW's caring role and the behaviour of his wife was explored with him, but what he wanted was for her to accept care which would then reduce the demands upon him, but this proved to be unachievable.

24.9. The practical outcome was that no action was taken as JW would not agree to any care proposal. Although the 'Making Safeguarding Personal' process was followed and took into account the wishes of JW, the outcome that it achieved, did not improve the situation nor reduce the risk that sustained.

24.10. As it was, in light of the concerns that existed relating to the caring role and domestic abuse, reablement was offered to both parties. This was, sometimes, initially accepted and, on other occasions, not embraced. Support was offered to JW, in the form of community and day services. Again, that support was not embraced.

24.11. Other living options were explored with him, as well as planned and emergency respite offered. What he consistently expressed was his wish for his wife to accept care in her own right, to relieve him of his caring responsibilities.

24.12. JW demonstrated a good understanding of his wife and was able to express how her behaviour impacted on him, but she showed little insight into the impact the caring role had on him. Even when he was unwell, she refused to believe he was not capable of caring for her or himself.

24.13. From February to May 2018, the social care records reflect a host of agencies are involved with BW, both in the community and during her hospital admissions too.

24.14. The period from 20th March to 4th May 2018, when BW was an inpatient, is when partnership working appears to be somewhat disjointed and lacking cohesion. It lacks purpose in terms of robust care and planning to support BW and respond to her, should she experience difficulties and, or, crisis.

24.15. In this instance it is likely that the Hospital Team would have been the appropriate service to have coordinated such professional meetings, due to BWs length of hospital admission.

24.16. There are multiple examples of her case notes referring to significant risks, such as stockpiling medication, overdoses or an abusive home environment, which would have benefited from a collective consideration and assessment.

24.17. One clear example is a case note of 13th March 2018, which states, unambiguously:

24.18. *'Patient has taken an overdose of morphine. There are frequent domestic disputes between patient and husband'.*

24.19. Principle 3 of the Mental Capacity Act 2005 (unwise decision making) appears to be an intrinsic theme, with regard to BW, when making decisions with regard to self-discharging from hospital, returning to live in her home despite risk of domestic abuse occurring, carer strain and breakdown.

24.20. Within the prevailing context of frequent domestic abuse between the couple, particularly in 2018, it is highly likely that a more personable, direct contact may have been beneficial, and in a time frame that reflects promoting proactivity and making safeguarding personal.

24.21. Research undertaken for the English Longitudinal Study of Ageing revealed a variety of factors that may inhibit older people from accepting support. They include what some people believe is the stigma that is attached to ageing and a perceived loss of independence.[1]

24.22. Further potential inhibitors include a desire to prove that they can look after themselves and do not need support from external agencies.

24.23. It was the general view of the panel that it was this that was the most likely reason for JW and BW deciding not to accept the care that was offered to them, especially as they had their son and daughter in law living next door. However, that view was not supported by documentary evidence or any clearly expressed view of any of the parties involved.

24.24. There is no evidence that the section 42 enquiry proceeded to any coordination of a planning meeting or safeguarding meeting. The coordination and management of any adult safeguarding concern raised, required an experienced practitioner.

24.25. Co-ordination of such meetings may have been helpful, under the statutory framework of adult safeguarding, for the purpose of management oversight, multi-agency support planning and risk management.

24.26. Practices by all agencies, within the context and framework of the Equality Act, with regard to ethnic, cultural, linguistic and religious identity does not appear to have been an issue.

[1] English Longitudinal Study of Ageing 2020

24.27. BW's age must be considered in terms of how agencies responded with regard to the domestic abuse experienced. It is reasonable to consider the question as to whether agency interventions, and coordination of the domestic incidents, would have been dealt with more effectively had she been a younger adult, but there is no tangible evidence that her age was an inhibitor to the options provided to her.

24.28. BW's son and daughter-in-law were not communicated with, despite agencies identifying them both. Longer-term abuse was clearly having a negative impact upon them both. It is not clear why was this not addressed via a more proactive approach.

24.29. The ability to engage more effectively with the son and daughter-in-law of the couple was limited as it was clear that the situation was putting a strain on them and they had their own work commitments. Whilst it would have been useful to benefit from their personal experience of the relationship between JW and BW and to secure an informed understanding of their domestic environment and situation, it was clear that any personal support that the couple could provide was very limited.

24.30. This was especially so as ASC records indicate an understanding that, despite the proximity of their respective homes, fractures existed in the various relationships which would serve to minimise the potential protective influence of that proximity.

25. **Good Practice**

25.1. The GP practice was responsive to the many, sometimes 'emergency', calls made to them by JW and his wife. Home visits were often requested and made at short notice in response to 'crisis' as well as urgent medical need. Efforts were also made to offer some element of consistency in terms of which clinicians responded.

25.2. The GP records indicate that both parties could, on occasion, be rather demanding and non-compliant. Given the frustrations staff may have felt, it is clear that great care and tenacity was applied to try and offer the best service to the patient.

25.3. Alternative options were offered, and suggestions made, as to a wide range of possible solutions to some of the more, apparently intractable, issues, such as the management of pain symptoms. The police officers who attended the various domestic disputes did recognise that the issue went beyond physical and verbal confrontation and had its basis in matters of care and support. Proactive and prompt contact was made with those providing care as a means of seeking to improve and resolve the situation.

25.4. In relation to JW, there is sound evidence that the principles of 'Making Safeguarding Personal' were applied and he was consulted, on many occasions, around his wishes with options for managing the risks being explored. He was spoken to when he was alone and in a safe environment (hospital) and his wishes recorded.

25.5. Reponses to safeguarding concerns were actioned in a timely manner. A DASH form was completed on at least two occasions which afforded an opportunity to explore the impact of the Domestic Abuse on him and, with his consent, share it with a relative who was able to confirm that it was an accurate picture of the situation.

25.6. A safety plan was agreed and shared with the GP with a request for a mental health assessment of BW. Concerns were, with the consent of both parties, openly explored

with the Social Worker. Information around capacity is well recorded and there is evidence of relevant professionals being consulted. The Reablement Team who were supporting the couple stayed involved longer than the physical needs of the couple required, due to the risks they had identified. There is good evidence of the reablement workers raising concerns with the GP and other agencies regarding risks to both parties, for example, with regard to access to morphine.

25.7. The Crisis and Home Treatment Team (CHTT) responded proactively as did the Joint Emergency Team (JET).

25.8. The assessment of the Liaison Psychiatry Team was of good quality.

26. Lessons Learned

26.1. JW and his wife had been registered patients at the GP practice for decades. There was evidence in the records that theirs was a long-standing fractious relationship but 'normal for them'. It is likely that knowledge of the issues in the relationship were known anecdotally by a wide range of the practice staff, but not often recorded, on the assumption that this was already known and well-established fact.

26.2. In retrospect it can reasonably be concluded that, if the incidents of domestic abuse had been recognised as such, and highlighted in the GP records in some way, staff may have been better able to see the circumstances as a connected series of events rather than as isolated incidents, although it is important to highlight the fact that the panel found no evidence that this lack of recognition was influenced in any way by the advanced age of JW and his wife.

26.3. While it is acknowledged that the focus of a GP practice must primarily be on meeting the health needs of its patients, there are circumstances such as these where the management of the responses made could be more co-ordinated.

26.4. When patients are allowed to self-medicate at home, control measures should be in place to ensure that over medication does not take place and, should it be suspected, positive steps are taken to prevent harm and/or abuse to the patient(s) and any other relevant third party.

26.5. It is evident that the police investigation at the home address was limited in its scope, with a particular omission being the fact that JW's wife was not spoken to about her husband's death. When the context of a physical confrontation having taken place between the two of them, only the day before, is considered, this is a line of enquiry that it may have been advisable to pursue.

26.6. The fact that JW sought to find sanctuary in his son's conservatory the previous evening suggests that some form of conflict had occurred between he and his wife. The specific detail of that conflict is not known, but it is believed that it involved a strike to the head with a walking stick, which caused an injury to him.

26.7. This, in addition to the recent overdose by his wife, following which JW encouraged those attending to her not to intervene, are relevant contextual incidents that it would have been appropriate to investigate further.

26.8. The fact of the short timescale within which police intervention was required at four separate incidents, three of which involved overt domestic abuse, and one which involved a deliberate overdose, may reasonably have been expected to prompt a professional judgement, by the officers attending and those considering the subsequent referrals, that the sustaining risks were more significant than appear to have been recognised.

26.9. On several occasions comments relating to them experiencing domestic abuse were made by JW about his wife, and vice versa, where the opportunity to ask more appropriate and relevant questions could have been taken.

26.10. The lack of such respectful professional curiosity or challenge may have been due to a variety of reasons; however, a more positive and proactive approach is likely to have secured a more positive outcome.

26.11. All frontline Domestic Abuse and Sexual Violence staff have, since this incident, received training in Suicide Prevention and Male Victims of Domestic Abuse. In addition, a male Independent Domestic Violence Advocate (IDVA) is to be recruited.

26.12. Whilst it is recognised that real clarity can be difficult to achieve, the complexities that exist in situations where bi-directional abuse is taking place were not fully recognised or addressed. This was particularly so in terms of identifying the most appropriate steps to take with regard to support and/or sanction.

26.13. It is essential that a sustained and meaningful professional effort is made to understand why a person, who has indicated a willingness to accept support, then retracts that willingness. Only then can any potential inhibitors to a free and informed choice be identified and addressed.

26.14. When having mental capacity to make decisions is established, there is potential for agencies to be too quick to accept that fact, at face value, rather than seeking to develop their understanding of why a decision, however apparently unwise, has been made. It may be that mistaken perceptions can be corrected and potential inhibitors to seeing and accepting support as a positive option can be removed.

26.15. Despite JW and BW having hospital admissions, within a close time frame of one another, and having mentioned the abusive aspects of their relationship during their respective admissions, including detailing the abuse and the restrictions of their home environment, they were still treated as very separate individuals when they were admitted to hospital.

26.16. More consideration could have been given to their shared experience of their home environment and how their individual admissions impacted heavily upon each other.

26.17. Throughout their hospital admissions there were a number of safeguarding referrals made by CUH staff, social workers and police. Yet, despite the fact that their home environment was becoming more unstable, there did not appear to be an escalation in the way those safeguarding concerns were treated.

26.18. There is no evidence of a co-ordinated, multi-agency meeting to explore ways to best support JW, in particular, in his challenging carer role.

26.19. There may have been reluctance for various agencies to support JW and BW more effectively due to the recurring confirmation of their respective mental capacity.

26.20. Mental capacity was not in question for either party, so the responsibilities of the respective agencies sustained. More creative approaches and/or proposals may well have ensured JW felt supported in a way that suited him better.

26.21. Whilst there is clear evidence of multi-agency involvement; Police, Social Care, Ambulance, GP, MASH, Care Agency, Reablement, Mental Health Team, including crisis team, JET team and Discharge Planning, there was a lack of co-ordination of information, which led to a lack of understanding of the extent and nature of the risk.

26.22. A multi-agency meeting, where the risks could be openly discussed, including the reluctance of both parties to engage and accept support, would have been beneficial and improved risk assessment and planning.

26.23. The overarching question that remains is why no single agency was not more tenacious in seeking to understand the underlying reasons for both parties making the consistent decision not to take up the various offers of help. The dovetailing of relevant information between the agencies could have created a more informed and up to date understanding of the relationship, the abusive behaviour, the home environment and the respective care needs of the couple.

26.24. The report entitled, 'Standing Together' (Oct 2019), which sought to analyse Domestic Homicide Reviews in London and identify key learning points, highlighted the benefits of a Coordinated Community Response (CCR) to domestic abuse.

26.25. A CCR is based on the principle that 'no single agency or professional has a complete picture of the life of a domestic abuse survivor but many will have insights that are crucial to their safety.'[2]

26.26. Whilst this case involved bi-directional abuse it is clear that a sharing of information, via a multi-disciplinary discussion, is likely to have secured a more effective understanding of what could have been done to stop the abuse and achieve positive progress.

26.27. Between February and May 2018, there was increased activity and lost opportunities to work with both parties. Whilst in hospital, in February 2018, JW was reluctant to go home, unless BW accepted more care. This would have been an appropriate time to coordinate and convene a meeting.

26.28. There is a significant body of recorded evidence of JW's feelings with regard to his relationship with his wife and what he wanted to happen, but the respective views of BW were not consistently captured, only in the time of a crisis. There is evidence that JW was physically abusive to BW and, therefore, obtaining her views around their relationship may have led to a more informed and appropriate response.

26.29. In 2014 it was accepted that BW did not want to engage with Cambridgeshire and Peterborough NHS Foundation Trust staff, on the basis of JW's telephone call. It may

[2] Standing Together, (Exec Summary, Pg6, Oct 2019)

well be that she was in agreement with this. However, that decision should have been confirmed directly with BW herself.

26.30. In relation to a carer's assessment for JW, there is documented evidence of the relevant forms being sent out to him, but never completed or returned. There is no evidence that a more proactive and supportive approach was taken and a face-to-face carer's assessment offered.

26.31. Where there is a significant body of evidence recorded by a number of agencies with regard to the impact that supporting the couple was having on the wellbeing of their daughter-in-law, there is no evidence of a carer's assessment being offered to her, to inform and enhance the understanding of her ability and/or willingness to offer support.

26.32. It is sometimes unclear whether individuals have care and support needs. This is particularly so when there is more than one person, in this case a couple, who may both be at risk. This introduces the potential for at least one person's risk or needs to be overlooked, overshadowed by the other or not identified as meeting, Care Act defined, safeguarding thresholds in their own right.

26.33. Under the Care Act 2014 a person meets eligibility for adult safeguarding intervention if they have care and support needs, whether the Local Authority are meeting those needs or not, which make them unable to protect themselves from abuse, and that may include the person who is fulfilling the caring role, not just the person being cared for.

26.34. As part of a S.42 enquiry a home visit was undertaken and both parties spoken to, together. This was a possible missed opportunity to secure a better understanding of the situation as, whilst it may have been productive, neither party had the chance to discuss without the other partner being present.

26.35. BW had said she wanted matters to be discussed together but there is no evidence that JW was consulted. There is a reasonable expectation, in such domestic abuse or complex relationship situations, that people will be provided with the opportunity to be spoken to on their own.

26.36. Greater consideration could have been given to why JW and BW's son and daughter-in-law were so reluctant to engage in discussions surrounding medical treatment plans or discharge planning.

26.37. Whilst there is no tangible evidence that the advanced age of both JW and his wife, and the fact that they had proximate and accessible family support, was influential in terms of the prioritisation of their case, or otherwise, it is reasonable to assume that such factors were considered.

26.38. The fact that the 'high' threshold was never reached, with regard to MARAC referrals, may have contributed to the lack of referrals to domestic abuse support agencies, despite there being four reported incidents of domestic abuse within a short period of time. Had that threshold been reached, and more professional curiosity applied, and a MARAC referral made, it is reasonable to believe that a broader, and more focused, perspective may have been applied by a range of agencies and a better understanding of the needs of JW and/or his wife established.

26.39. The audit trail of referrals appears to be an area in which improvements can be made. In more than one agency, primarily the Police and Addenbrookes Hospital, the records contained claims that referrals had been made, yet no such referrals could be located or identified.

26.40. Whilst record keeping systems will never be infallible, and are vulnerable to user error, a clear audit trail, that allows for the recovery of key documents, is an achievable objective for all public agencies.

26.41. The importance of taking social stressors into account in care planning and discharge planning decisions should not be underestimated. The relationship between JW & BW was, at times, exceedingly fraught and their relatively small domestic accommodation seems to have exacerbated this.

26.42. There appears to have been problems with discharge planning, with regard to the arranging of medication for BW, on 16th March 2018. This process needs to have clarity in terms of the provision and management of medication.

26.43. The perceived existing involvement of other agencies in a case, and the extent of that involvement, should be confirmed prior to decisions being made with regard to the appropriateness of a further agency becoming involved, or deciding not to.

26.44. Inter – agency liaison is crucial to determine whether an abusive relationship involves a perpetrator and a victim or whether there is a complexity that results in both parties being both victim and perpetrator. Such knowledge will influence the care, support and intervention options that are considered to be appropriate.

Conclusions

26.45. Any suggestion that JW would take his own life was neither reasonably foreseeable nor predictable. The greater apparent risk related to his wife who had both expressed her intention to take her own life and actually taken two previous overdoses, with one such occasion being only weeks before his death.

26.46. There is no sound basis for concluding that JW took his own life primarily as a result of the abusive relationship that he had with his wife. The issues of his own poor health, his Carer responsibilities and his inability to get out of his home environment, in his car or walking, are also likely to have been contributory factors.

26.47. As was the case with the police investigation and the coroner's Inquest, the DHR process did not identify any evidence that suggested a causal link between the abusive relationship of which JW was a part and his subsequent suicide.

26.48. More effective and informed management of the abusive relationship, which had developed between JW and his wife, is more likely to have been achieved via a meeting of the various agencies involved.

26.49. Insufficient, sustained and co-ordinated multi-agency focus was applied to a situation in which bidirectional abuse was taking place. Had such a focus been applied, a better understanding of the relationship and, in turn, the care and support needs of both parties, is likely to have been achieved.

26.50. The lack of co-ordinated attention by those agencies that could provide support in cases of domestic abuse is particularly relevant when one considers the fact that a number of incidents of abuse were reported within a short period of time.

26.51. The co-ordination of knowledge, resources, skills and problem-solving proposals is likely to have enhanced the potential to identify and progress opportunities to secure a positive outcome. Relevant information could have been shared and creative solutions identified and acted upon.

26.52. However, any such meeting must be considered within the context that neither party was found to be lacking in mental capacity, and both consistently chose not to embrace offers of support, in whatever form. Therefore, it is unclear as to whether either party would have chosen to embrace any alternative proposals, in any event.

26.53. There is no clear evidence to inform an understanding as to why both parties chose not to sustain any initial willingness to accept support offered to them from a variety of agencies. It is apparent that insufficient professional curiosity was demonstrated to establish why such decisions were consistently made but ,without that evidence, informed conclusions cannot be drawn.

26.54. There is no clear evidence that either party was the subject of any form of inequality that could have influenced their respective decisions not to embrace the support offered by any of the agencies with whom they interacted.

26.55. Current safeguarding systems are reliant on a person being identified as having care and support needs, whether that be a victim of abuse or a carer. If that assessment of their potential vulnerability is not made, then significant options may not be considered. It is essential that it is identified when a person has care and support needs that render them unable to protect themselves from abuse.

26.56. Current care and support systems do not work effectively when a person is identified as both a victim and a perpetrator of domestic abuse, as in this case. Such cases are not uncommon and assessment systems and policies would benefit from being more flexible.

26.57. The fact of JW ’s completed suicide was not due to any specific shortcoming or failure by any individual agency, nor group of agencies. JW appears to have come to the tragic conclusion that his life was intolerable and acted upon that.

26.58. The various agencies faced the difficult situation in which JW, especially, would express his frustration and, at times, desperation at the demands placed upon him by his wife, and his role as her primary carer.

26.59. Creative and reasonable care and respite options were presented to him, such as when he was approaching discharge from hospital, but he consistently took the decision not to embrace them despite, initially, giving them some consideration.

26.60. There is little doubt that the mobility restriction that was suffered by JW, when he lost the ability to drive and to walk any significant distance, resulted in an increase of the domestic tension between he and his wife.

26.61. It is clear that JW and BW had always had what their son described as a 'verbally volatile' relationship, and that the increasing distress felt by him was evidence of his lessening resilience to her challenging character, coupled with her behaviour becoming more extreme over time.

26.62. Although it is unlikely that professionals could have changed the nature of their relationship, it is clear the JW did not feel satisfied with his home life. There may have been an acceptance by agencies that this was an unchangeable situation as this was 'how they had always been'.

26.63. It is not clear if a conversation was ever had with BW about her behaviour and the impact this was having on her husband. It may have been helpful for professionals to work more creatively and consider a more personal approach, which did not rely on already established pathways.

26.64. Perhaps more consideration could have been given to recognising JW as a victim of domestic abuse and whether different support options may have been offered.

26.65. It is apparent that, between the agencies, a lot was known about the nature of the relationship between JW and BW. It is clear that the issues that were the catalyst for conflict between them reached crisis point on a number of occasions, and then subsided again, before becoming a recurring pattern over the latter years of their relationship, and most specifically in the period that followed JW losing his ability to drive and venture beyond their home.

26.66. The normalising of domestic abuse in this way, in that it was becoming expected that the couple behaved in this abusive way towards each other, seems to have limited the opportunities for engagement with domestic abuse support services, which could have supported a more positive outcome. However, whilst there is no definitive evidence to this effect, it may also be that the advanced age of both parties inhibited any referral to such agencies, that may, otherwise, have been considered.

26.67. Whilst Cambridge Women's Aid were notified of the abusive relationship, the fact that they did not offer their services to either party cannot reasonably be considered as a missed opportunity to intervene and prevent the suicide. The decision by the agency was fully rationalised and it is also relevant to recognise that the motivation by JW to take his own life was never definitively established, which prevents any informed conclusions from being drawn as to why he chose to do so.

26.68. The decision by Cambridge Women's Aid not to offer their services, following two notifications from the police with regard to the abusive relationship, was not a refusal to provide a service. The decision was explained and rationalised within the context of their policies and their perception that the agencies already involved were the most appropriate and relevant to the prevailing circumstances.

26.69. The DASH scoring system may be considered to be disproportionately weighted towards those with children, to the potential detriment of the elderly. The weighting of the system may benefit from a review to ensure that all relevant risks are proportionately and fairly considered.

26.70. The case highlights significant 'unwise decision making' from both parties. The case also highlights the complexities of working within family relationships where there is

a well-established history of conflict in a relationship in which both parties are dependent upon one another. It amplifies the importance of professionals coming together.

26.71. The discharge planning process, in respect of the arranging of medication for BW on 16th March 2018, was not managed efficiently. The following day a Community Psychiatric Nurse from the CRHTT visited and found there was no evidence of a care package for BW being in place.

26.72. On her discharge from CRHTT, on 29th March 2018, BW's mental state was stable and her cognition clearly intact. The decision to discharge her seems reasonable in terms of her mental health.

26.73. Whether any intervention aimed at improving the quality of their relationship or alleviating their social stressors would have been acceptable or successful is debateable. However, there does not seem to be any record of this being offered or attempted.

27. Recommendations

27.1. Following a pilot in Cambridgeshire, commenced in August 2001, the standard DASH risk indicator checklist has been amended to take into account the risks faced by older victims. It is recommended that the outcomes of that amendment are reviewed and, if they are positive, then consideration be given to it being embraced on a permanent basis by all relevant agencies. The pilot has been extended to July 2022.

27.2. Guidance is required relating to the potential requirement for a Carer's Assessment be undertaken when a person registers with their GP as a Carer. This guidance could be provided via the Home Office 'Safe At Home' project which is considering the issues relating to both paid and family carers who are abusive to the person they care for.

27.3. Greater procedural clarity is required with regard to what can be done in the circumstances in which a victim of domestic abuse, who meets the Adult at Risk threshold, chooses to decline support that is offered to them.

27.4. Greater procedural clarity and training is required, for the police and their partner agencies, with regard to relationships that involve situations of bidirectional abuse. Options that embrace support, education and, if necessary and appropriate, sanction should be included within that training and procedure.

27.5. Cambridge University Hospital (CUH) to review the process used to monitor referrals to ensure that, when the safeguarding team advise staff to make a referral, that advice is followed up, if a referral is not received. *(Completed by 31st January 2020).*

27.6. The GP practice to consider how they could, more effectively, manage and retain oversight of complex cases where safeguarding concerns exist. *(Completed by 31st January 2020).*

27.7. The GP Practice should ensure that an effective policy is in place to address any concerns that a patient may be self-medicating beyond prescribed dosages. Any such policy should include the detail of how and when such concerns may be shared

and addressed with other agencies as a means of ensuring the wellbeing of the patient(s) concerned.

27.8. The GP practice to define the circumstances under which they would cross reference, or link, the records of two or more patients, registered with the same practice, in circumstances where safeguarding concerns relate to all parties. *(Completed by 31st January 2020).*

27.9. GP Practice staff to receive training on the recognition of indicators of domestic abuse, together with the local support agencies and services that are available. The training should also include effective recording and onward referral processes. *(Completed by 10th September 2020).*

27.10. GP Practice staff to be able to record, and review, Systm One data relating to domestic abuse being experienced by patients. *(Completed by 31st January 2020).*

27.11. Relevant training to be provided to Cambridgeshire Police duty managers, to ensure that, when officers attend apparent suicide incidents, initial enquiries take into account any indication of domestic abuse or violence and, if they do, to refer such cases to the Duty Senior Investigating Officer for further evaluation. *(Completed 31st March 2020)*

27.12. Cambridgeshire County Council and Peterborough City Council Adult Social Care to review the current Carers Guidance, by 31st January 2020, with specific regard to Section 42 of the Care Act, 2014, and ensure that it is clear as to the point at which risks to Carers would need to be investigated under a Section 42 Safeguarding Enquiry, and the expectations from the multi-agency working within such an enquiry. *(Completed by 12th March 2020)*

27.13. Cambridgeshire County Council and Peterborough City Council Principal Social Worker to hold a Practice Event, by 31st March 2020, to share the learning from this Domestic Homicide Review, embracing the Good Practice identified and the importance of effective multi agency working. *(Completed 9th March 2020)*

27.14. Cambridgeshire County Council and Peterborough City Council Adult Social Care Services to strengthen the support to carers, as part of mainstream practice, to consolidate the fact that all front-line practitioners have received one off workshop training since this incident. *(Completed by 31st January 2021).*

27.15. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) staff to seek consent or refusal of services directly from the patient rather than from relatives. *(This guidance is to be included in the Q3 "Learning the Lessons' bulletin of 2019. The Head of Adult Safeguarding and the Head of Learning and Development are to be the lead managers).*

27.16. The Discharge Planning policy of Cambridgeshire and Peterborough NHS Foundation Trust staff is to be reviewed to ensure that it reflects the fact that it considers the effect of social stresses in care planning and in discharge planning. *(The Director of Nursing and Quality will be the lead manager and the review will be undertaken during the next revision of policy).*

27.17. During the discharge planning process, absolute clarity should be achieved with regard to the arrangements for the provision and administration of medication. *(This guidance is to be included in the Q3 "Learning the Lessons' bulletin of 2019. The Head of Safeguarding and Chief Pharmacist will be the lead managers).*

28. Secretary to Panel

28.1. The role of Secretary to the DHR Panel was undertaken by an independent person. Tony Hester has over 30 years Metropolitan Police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

28.2. Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

28.3. His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

28.4. Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

Appendix 1

TIMELINE OF EVENTS – COMMENCING JANUARY 2013			
DATE	**EVENT**	**OUTCOME**	**COMMENTS**
2009	JW and his wife (BW) move into purpose-built annex in the garden of the house that they had passed on to their son and his wife.	Separate dwellings but family support immediately available.	-
October 2013	First report to the police of Domestic Abuse when neighbour witnesses BW striking her husband with a broom.	Officers attend. No formal action taken.	-
24th April 2014	JW drives to a hospital that was a former place of work asking for support following an argument with his wife.	JW was taken home by the police and both were identified as victims in the DASH risk assessment that was submitted, graded as standard risk.	-
May 2014	JW contacts his GP stating that he could not cope with BW any longer. The notes reflect that he is becoming increasingly immobile and that, on occasions, he would over medicate himself.	JW was advised to contact Social Services for advice and support.	-
July 2014	During a GP home visit, JW reflects that his wife 'is not dying quickly enough'.	-	-
December 2015	A discussion takes place between JW, his GP and his daughter in law in which he states that he felt the demands of his wife were excessive, making him unwell.	The GP proposed a discussion that would include BW. That discussion never took place.	-
12th January 2018	BW admitted to hospital with chest infection. Reference is made in the notes that, unspecified, safeguarding concerns, apparently initiated by the police, had been investigated by	-	-

	the Local Authority Community Safeguarding Lead.	-	-
January 2018	JW's daughter in law contacts the GP to state that, in her opinion, JW could not care for his wife effectively.	No record of any response is made.	-
1st February 2018	Following a report of a domestic dispute, officers attend and receive counter allegations of assault, from JW and BW, against each other.	Adult 'at risk' referrals were made to the DASH team.	A crime of Common Assault was recorded against JW with regard to this incident. No further action is taken.
5th February 2018	Following another report of a domestic dispute, officers attend at the home address. BW is in constant pain and JW was struggling to cope with the situation. Officers witness BW being demeaning and belittling towards JW.	Adult 'at risk' referrals were made to the DASH team. JW is graded as medium risk.	LW advised the officers that he felt his mother was misrepresenting the situation in order to present his father in a bad light.
February 2018	Social Services contact the GP, querying the issue of mental capacity as they had received a referral from the police.	Social Services are advised that mental capacity is intact.	-
7th February 2018	Following a police referral, JW is contacted via phone by Social Services who ask for consent to visit. The request for consent is declined.	JW is also offered respite care but refuses. BW also refuses. The case notes reflect that LW and his wife are struggling to cope with the demands of his mother and father. The S.42 is closed with regard to JW.	There is no record of a Carer's Assessment being undertaken.
12th February 2018	Following a report of a domestic dispute, as a result of which BW is found to have a minor injury to her hand, JW is taken to a police station and interviewed. A crime is recorded against him for assaulting his wife. He claimed that she had been striking him with her walking stick.	Adult 'at risk' referral is made, graded as a medium risk. Crime of assault recorded against JW.	-

25th February 2018	JW is admitted to hospital with rheumatic pain. He discloses that his wife is physically and verbally abusing him and complains of what is recorded as 'carer burnout'. He repeatedly states that he does not want to return home to his wife unless more care is in place.	A range of respite options are discussed with JW but he declines them all and opts to return home.	A safety plan is discussed but JW does not meet the MARAC threshold for further care. JW's son and daughter in law agree to be part of the safety plan.
26th February 2018	The Nurse in Charge of the ward called the Adult Safeguarding Team of the hospital to establish if a Safeguarding Referral had been raised.	The Nurse in Charge is advised that a Community Safeguarding Referral had been raised on 15th April. She is advised to raise a further referral.	-
1st March 2018	JW is discharged from hospital, having declined offers of reablement or respite care from Adult Social Care Services.	The Community Plan was for the GP to arrange urgent respite for him and arrange an urgent mental health assessment for BW.	-
1st March 2018	Telephone contact between GP and Social Services relating to a S.42 investigation. The concerns of Social Services are relayed to the GP and a request made for the safety plan to be supported and a carer's assessment undertaken.	It became apparent from the conversation that the initial perception that BW was always the victim was not accurate.	There is no record of a Carer's Assessment being undertaken.
13th March 2018	BW takes an overdose of prescription drugs, (Oramorph) for which she is hospitalised for several days. She alleges that JW goaded her to take the drugs as she had threatened to take her own life following an argument. She had been prescribed the medication to deal with hip pain.	Adult 'at risk' referral is made which indicates that the attending officers consider JW to be incapable of meeting the care needs of his wife due to his own frailties. A call is made to JW to, again, discuss respite options, which he seems to agree to.	JW advises attending paramedics that a DNR protocol was in place, as they were treating his wife. No such protocol was in place on her medical record so emergency treatment was applied and she was revived. It was later determined that he had no criminal culpability.

	JW advised officers that his wife threatened suicide on an almost daily basis and often tried to take his liquid morphine.	-	-
14th March 2018	Following review by Liaison Psychiatry it becomes apparent that BW had previously overdosed in 2008 and that the police had attended her home address, on three occasions in the last month, to deal with domestic disputes with her husband.	The next day the Staff Nurse records that a Safeguarding Referral has been sent.	The Adult Safeguarding Team for the hospital have no record of that referral.
14th March 2018	During a home visit, whilst his wife is in hospital, JW tells the GP that he feels exhausted and was anxious about his wife leaving hospital and returning home.	-	-
15th March 2018	The Liaison Psychiatry Team review BW and determine that she has mental capacity for discharge.	BW is referred to the Crisis Team in the community.	-
16th March 2018	BW is discharged from hospital after their assessment determines that she has no care and support needs. The Older People's Crisis and Home treatment Team was to provide support on discharge.	BW returns home to the same, strained, domestic environment.	It is evident that differing opinions prevailed relating to the care and support needs of BW.
19th March 2018	Reablement staff report that JW and BW were hitting each other with their walking sticks. The Community Psychiatric Nurse rang the couple, who blamed each other. All variety of options were offered but all were refused.	-	-
20th March 2018	BW is again taken to Addenbrookes, this time with a pre-existing medical condition. She is fully oriented and expressed a wish to die.	A Community Safeguarding Referral is raised.	There is a record of a discussion with the MASH and it was noted that JW was not referred to MARAC as his DASH

	Adult Social Care record that BW had been stockpiling morphine prior to her hospital admission. It had also become apparent that the Crisis Team had been leaving medication in an egg cup, despite her previous overdose.	-	score was only 10, whereas 14 is the minimum for a referral requirement.
26th March 2018	A professionals meeting is held where it is agreed that a care package is required for BW, incorporating a safety call and arrangements to administer medication.	Improved inter-agency liaison and co-operation.	-
27th March 2018	Adult Social care records state that JW's GP had sent a letter stating that he would not allow his wife to return home, due to her emotional abuse of him.	-	-
28th March 2018	Liaison Psychiatry note that JW has no legal right to prevent his wife from returning home.	-	-
29th March 2018	A discussion between the Crisis Resolution Home Treatment Team and the nursing staff is recorded and details the fact that, as BW intended to self-discharge, without carers, and that a medication dispenser was now in place, they would not follow up as her mental health was considered to be stable.	JW tells a Social Worker that he is concerned that his wife will overdose again. A decision was taken not to discharge BW until a Care Package was in place.	BW is not discharged until 4th May 2018.
29th March 2018	During a GP home visit a neighbour discloses that BW gives JW a hard time, often poking him and shouting at him.	The GP asks JW for his consent for a safeguarding referral to be made, but he refuses.	-
10th April 2018	The outcome of the S.42 enquiry is recorded. JW was still refusing respite support and the risks in the relationship sustained. JW was recorded as having capacity.	-	-

25th April 2018	Adult Social Care records show that the medication dispenser had failed and that they would not be able to provide a care call for night medication.	BW's discharge is further delayed.	-
4th May 2018	A twice daily care package is put in place.	BW is discharged.	-
May 2018	BW strikes her husband with a walking stick during an argument. This leads to JW asking his son if he can sit in his conservatory with a glass of wine, which he is allowed to do.	JW stays in the conservatory overnight and takes an overdose of drugs.	-
May 2018	Call made to Ambulance Service by the son of JW, who had found his father unconscious on a sofa in the conservatory of his home. It was believed likely that JW had consumed both alcohol and liquid morphine.	Paramedics attended and conveyed JW to Addenbrookes Hospital.	-
May 2018	Despite the efforts of the medical staff JW was pronounced dead at 4.01pm.	Death of JW.	-
4th August 2018	Cambridgeshire Police notify Cambridgeshire Community Safety Partnership of the death of JW.	The decision to commission a DHR is taken.	-
26th November 2018	The first DHR Panel meeting is held.	DHR process commences.	-

Appendix 2

Dissemination list

Jessica Bawden	Director of External Affairs and Policy, Cambridgeshire and Peterborough Clinical Commissioning Group
Matt Staton	Education Team Leader, Cambridgeshire County Council
Ed Miller	Cambridgeshire Fire and Rescue Service
Nick Skipworth, Paul Rogerson, Rachel Gourlay, Louise Williams, Alasdair Baker	Cambridgeshire Police
Leigh Roberts	Senior Research Analyst, Cambridgeshire Research Group
Harriet Ludford	Research Analyst, Cambridgeshire Research Group
Liz Bisset	Interim Director of Housing, South Cambridgeshire District Council
Lina Nieto	Elected Member, Cambridgeshire District Council
Susie Talbot	Public Health Commissioning Team Manager
Office of the Cambridgeshire Police Crime Commissioner	-
Anna Bradnam	Elected Member, South Cambridgeshire District Council
Claire Daunton	Elected Member, South Cambridgeshire District Council
Elaine Matthews	Strengthening Communities Manager, Cambridgeshire County Council
Emma Carter-Knight	Operational Manager, Environmental Health, South Cambridgeshire District Council
Jo Curphey	Deputy Director BeNCH (Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company)
Matthew Ryder	Probation Service
Taffie Chirowodza	Public Health, Cambridgeshire County Council
Vickie Crompton	Cambridgeshire County Council Domestic Abuse and Sexual Violence Partnership

Appendix 3

Terms of Reference

Domestic Homicide Review Panel – South Cambridge District Council CSP
JW who took his own life in May 2018

Context

In May 2018 JW died in Addenbrookes Hospital following a self-administered overdose of prescribed medicine.
JW lived with his wife, BW, in a bungalow at the rear of a property owned by his son and daughter-in-law Cambridge.
On an evening in May JW had called into his son and daughter-in-law and asked if he might sit in their conservatory as he had been arguing with his wife. He carried with him a glass of wine which his son noted as unusual as his father did not drink much.
The following morning his son found him comatose, still in the conservatory. An ambulance and EMS attended, and he was transported to Addenbrookes Hospital where as stated, he died. Cause of death being multiple organ failure as a result of a prescribed medicine overdose.
Initial contact with his son and daughter in law reveals that there was a history of verbal abuse by both JW and BW against one another and that this had transformed into physical abuse over the last four years.
A Safeguarding Adult Review was instigated but the decision was subsequently made to hold a Domestic Homicide review, given the circumstances of their relationship.

Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

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

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

6. Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

Terms of Reference for Review into the death of JW

1. Could improvement in any of the following have led to a different outcome for JW, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults.
   b) Communication and information sharing within services.

2. (1) Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Standards of professional practice and standards of organisational practice
   b) Domestic abuse policy, procedures and protocols
   c) Safeguarding policies

   (2) Whether the work undertaken by services in this case are consistent with multi agencies:
   d) Standards of professional practice and standards of organisational practice
   e) Domestic abuse policy, procedures and protocols
   f) Safeguarding policies

3. (1) The response of the relevant agencies to any contact and referrals from 1 January 2013 relating to JW. It will seek to understand what decisions were taken and what actions were or were not carried out and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with [insert names]
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any relevant assessments undertaken by each agency in respect of JW.
   e) Whether mental capacity issues were considered for JW
   f) The effect of care giving in the marital relationship and its contribution to the death

   (2) The response of the relevant agencies to any contact and referrals from 1 January 2013 relating to BW. It will seek to understand what decisions were taken and what actions were or were not carried out and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with JW

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
d) The quality of any relevant assessments undertaken by each agency in respect of his wife BW.
e) Whether mental capacity issues were considered for BW
f) The effect of care giving in the marital relationship and its contribution to the death.

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic, religious identity and disabilities of the respective individuals as well as any other protected characteristics as defined by the Equality Act, and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner, and the outcome of any escalation.

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

Terms of Reference from Home Office Guidance

1.1 To identify the best method for obtaining and analysing relevant information, and over what period prior to the death to understand the most important issues to address in this review and ensure the learning from this specific incident and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified.

1.2 To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion.

1.3 To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel.

1.4 To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required.

1.5 To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence

Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings.

1.6 To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review.

1.7 To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs.'

1.8 To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the incident (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it.

1.9 To identify how the review should take account of previous lessons learned in the South Cambridge District Council and from relevant agencies and professionals working in other Local Authority areas.

1.10 To identify how people in the South Cambridge District Council gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

1.11 To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations.

1.12 Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system.

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned.

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences.

e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level.

Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.