SHEFFIELD COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review: Executive Summary

Robert

Died September 2018

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

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Psychiatrist and Systemic Psychotherapist, on behalf of Older Mind Matters Ltd.

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1. The Review Process

This summary outlines the process undertaken by Sheffield Community Safety Partnership domestic homicide review panel in reviewing the homicide of Robert, who was a resident in their area.

The following pseudonyms have been in used for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of family members:

Victim	Robert	Male	85	White British
Perpetrator	Joan	Female	83	White British

Criminal proceedings were completed in summer 2019. The perpetrator was found guilty of manslaughter by reason of diminished responsibility at Sheffield Crown Court in March 2019. She was sentenced to a Section 37 Hospital Order under the Mental Health Act 1983 in June 2019 and transferred to a Mental Health Unit.

The process began with an initial meeting of a Consideration Panel of the Community Safety Partnership on 18 October 2018 when the decision to hold a domestic homicide review was agreed. Thirty-eight agencies that potentially had contact with Robert and Joan prior to the point of Robert's death were contacted and asked to confirm whether they had involvement with the couple. Four of the five agencies who were initially thought to have had contact with the victim and/or perpetrator subsequently confirmed contact and were asked to secure their files.

2. Contributors to the Review

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

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

Individual Management Review authors were independent of any direct involvement with or supervision of services involved in this case.

3. The Review Panel members

The Review Panel met on the following dates: 30 November 2018 (prior to appointing the Independent Chair/ Author); 12 February 2019; 28 May 2019; and 22 July 2019.

All panel members were independent of any direct involvement with or supervision of services involved in this case.

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

4. Author of the Overview Report

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

from NHS roles and developed a portfolio career. She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews. She has no connections or ties of a personal or professional nature with the family, with the Community Safety Partnership, or with any other agency participating in this review.

5. Terms of Reference for the Review

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

The purpose of the Domestic Homicide Review is to:

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

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

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

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

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

- Highlight any good practice.

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

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

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

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

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

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

Any obvious failings identified:

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

Similarities with other Domestic Homicides in Sheffield or elsewhere

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

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

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

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

5.2 Equality & Diversity

The perpetrator was deaf in one ear.
Age
The victim was male

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

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

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

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

5.5 Agencies required to contribute

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

South Yorkshire Police - only contact was on the day of the incident - only a short statement required.

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

Consideration will be given to voluntary sector involvement.

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

5.7 Individual Management Reviews and chronologies
Use of consistent templates
Anonymisation - agreed that the subjects will be known as:
Victim Robert
Perpetrator Joan
Workers should be referred to by (simplified) job titles, not names.
Password to be used as necessary for any agencies without secure email.

5.8 Family members, friends, colleagues and employers: It is very important to hear the voices of family and friends if this is possible and they are willing to participate. Immediate family - two adult children and grandchildren. Both adult children and older grandchild to be asked via the Family Liaison Office to be involved in the review if they so wish, after the trial or when police allow. Interviews with family will be conducted by the chair and DHR co-ordinator, via the Police Family Liaison Officer. It was agreed to ask them about other friends who might be willing to be involved.

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

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

6. Summary Chronology

6.1 Summary of events

In autumn 2018, South Yorkshire Police responded to a 999 call from a woman stating that she had stabbed her husband. Police officers attended the relevant address; where a man (Robert) was pronounced dead at the scene. The caller (Joan) was arrested and a murder investigation commenced. Joan was remanded in Prison. A post mortem examination found that Robert died as a result of three stab wounds.

The couple involved had been married for 60 years and were living independently at the time. Only the GP practice had contact with them, and most of their contacts with primary care were unremarkable and for routine reasons or minor physical illnesses.

Neither Robert nor Joan had been seen by a GP since 2010, and Adult Social Care and Adult Safeguarding had no knowledge or record of either party. In particular, there were no contacts suggesting that either Robert or Joan was subject to domestic abuse, although neither Robert nor Joan was asked about domestic abuse or coercive control. No issues or problems were known to the Department of Work and Pensions. South Yorkshire Police were involved with the couple only on the date of the death.

Following the homicide, Joan was taken to the Emergency Department at a local General Hospital in Police custody. She was assessed by nursing and medical staff with two Police Officers present, and was deemed by staff to be exhibiting a grief/ stress response. There was no evidence of acute physical illness and a CT scan of her head revealed only mild global cerebral atrophy (a mild degree of shrinkage), thought to be in keeping with her age. She was discharged into Police custody.

During Police interviews Joan was asked about the nature of her relationship with Robert. Throughout questioning she repeatedly stated that there had been no previous domestic violence. She recalled two incidents during their marriage: Joan said that Robert had once hit her, this having happened when they were courting 60 years ago. She said that he had threatened her 15 years ago, but had not actually hit her. Referring to the stabbing, Joan stated that she didn't know why she did it.

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

Joan was found guilty of Manslaughter by diminished responsibility in March 2019, and received a Section 37 Hospital order under the Mental Health Act 1983[1] in June 2019.

6.2 Background

Joan and Robert met in a pub when Joan was about 19 or 20 and Robert was 21 or 22. They both worked all their lives. Robert was an architectural technician, who worked for himself towards the later stages of his working life. Joan was an administrative assistant, running the office at a service station. They lived in Sheffield all their lives, and moved into the house, where they were living at the time of the incident, when they married. They had two children who both went to local schools and later to University. The couple functioned as a team and were "fiercely independent", remaining fit into their 80s. Neighbours described them as a "lovely couple". They had a lot of friends from their years of attending jazz clubs and visiting local pubs but their social network was shrinking as contemporaries died. Over the last couple of years, both Joan and Robert were maybe getting a bit frailer but remained remarkably fit and did not require any help with daily activities. Joan was driving right up till the incident. They would take the bus into town to go shopping and/ or have a pub lunch, or drive out to more rural pubs for lunch. They also enjoyed looking after their garden.

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

Robert is described as being "as sharp as a nail" with no cognitive problems and a mild-mannered and calm personality. Robert's attitude was we're fine, keep your nose out! Joan is profoundly deaf in one ear following mastoid problems[2] in childhood and an operation at age 12. She is partially deaf in the other ear. As a result of her deafness, she lip-reads, and sometimes family members are not sure whether she has heard them. She has never shown any signs of being impulsive or quick tempered in the past, and there were few indications of her health changing prior to the incident. No-one was unduly concerned, but family and neighbours had noticed that she was a bit more forgetful over the previous 2 years and not hearing as well as she did in the past.

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

7. Key issues arising from the review

7.1 *Incidents coming "out of the blue":* This homicide appeared to come "out of the blue" and was a complete shock for the family, who had never been aware of any violence between the couple. No previous incidents of domestic abuse involving either party were known to agencies or to family; there was no evidence of suspicious injuries incurred by either party or of coercive control; the couple were relatively physically fit for their ages, and were managing independently in their own home. However, during the criminal justice proceedings, it emerged that Joan had been diagnosed with behavioural variant frontotemporal dementia (bvFTD)[3].

7.2 Older adults not in contact with their GPs: The couple concerned in this DHR were not in contact with their GP or with other services and information about them was limited.

7.3 Behavioural variant Fronto-temporal Dementia (bvFTD) and aggression/ violence: FTD is relatively rare, and behavioural variant FTD is the most common of three variants. It often starts with changes in a person's personality and behaviour. The Author understands that evidence was given in court that Joan had shown some personality and behaviour changes prior to the homicide that are compatible with the diagnosis of behavioural variant FTD, and that it was suggested that impulsive behaviour and loss of self-control may have been relevant to the homicide.

7.4 Early diagnosis of dementia: any minor changes in Joan's personality and behaviour pre-dating the homicide had not been seen as significant by those in a position to observe them. Early diagnosis may be particularly difficult in FTD and there is no specific treatment for bvFTD.

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

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

7.4 Psychiatric assessment of Alleged Perpetrators: Joan was not seen and assessed by mental health staff in the Emergency Department after the homicide. In the Emergency Department no evidence of acute medical illness was found and she was thought by staff to be exhibiting appropriate grief/ stress response to the incident. The Panel was told that psychiatric assessment would only have been triggered by evidence of a psychiatric illness.

7.5 Issues relevant to conducting DHRs: Several issues relevant to conducting DHRs were identified, including: when asking alleged perpetrators for access to information it may be helpful to ask for access to defence reports; when alleged perpetrators have established cognitive problems approaches to them concerning their involvement in the DHR and access to their information need to be cognisant of and compliant with mental capacity legislation; the distress to families is considerable, likely to persist beyond the completion of criminal justice proceedings, and likely to affect their involvement in DHR processes despite expressed willingness to be involved; difficulties in contacting a Perpetrator in prison.

7.6 Events after the death: This Review does not cover the period following Robert's death, and the family's concerns about how their mother was treated in the judicial system fall outwith the terms of reference. However, the Panel feel that it is important to acknowledge the family's concerns.

8 Conclusions

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

There was no evidence of domestic abuse, violence or coercive control prior to the homicide (although neither of the couple was asked directly).

The couple at the heart of this DHR was living independently: only the GP practice had contact with them, but they were rarely seen, and most of their contacts with primary care were unremarkable and for routine reasons or minor physical illnesses.

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

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

9 Lessons to be learned

9.5 Incidents that come "out of the blue": Incidents that come out of the blue may arise on a background of subtle or minor changes that have not been seen as significant by those in a position to observe them.

9.6 Older adults not in contact with their GPs: Both Robert and Joan had less contact with their GP practice in later years and it was suggested by the Panel that, when older adults become less engaged, this might trigger the exercise of

professional curiosity and further enquiry, including consideration of whether those concerned might lack the capacity to decline the offer. People may also be influenced by those who accompany them to appointments so it is important to record whether people attend alone or accompanied and, if accompanied, by whom they are accompanied. This is particularly important in connection with possible domestic abuse and when capacity might be impaired.

9.3 Behavioural variant fronto-temporal dementia: BvFTD may present with symptoms that are not regarded as typical of what would be expected, eg by people who are more closely acquainted with Alzheimer's disease.

9.3 Early diagnosis: It is unlikely that an early diagnosis of Joan's condition would have prevented what happened, although it would/ should be followed by a care planning process including risk assessment. Robert and Joan were not seen by their GP in the lead up to the incident and it is unlikely that Joan's condition would have been diagnosed, even if she had been seen, unless Robert had been alert to, and appraised the GP of, changes in his wife: it took specialist input, time and further investigations to clarify the diagnosis.

9.4 Barriers to accessing services: The main barrier to accessing services was probably that the couple were staunchly independent and did not see a need for outside help.

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

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

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

10 Recommendations from the review

10.1 Single agency recommendations

Sheffield CCG

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

The GP practice has a robust system to invite patients for their Annual Review however there was no assessment of Robert and Joan's capacity to understand the impact on their health of declining to attend appointments.

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

10.5.3 Accompanying persons: Sheffield CCG will encourage clinicians in GP practices to document who each patient attends their appointments with. This has an impact on the ease of enquiring about domestic abuse.

10.2 Multiagency recommendations

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

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

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

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

10.2.5 Recommendations for future DHRs:

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

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