Safer Somerset Partnership

Domestic Homicide Review Executive Summary

Victim – 'Margaret' who was killed in October 2020

Independent Author – David Mellor BA QPM

Report completed on 8th August 2022

Contents	Page No
Introduction	3-4
Terms of Reference	4-6
Summary chronology	6-10
Key issues arising from the review	10-15

Conclusion	15-16
Lesson to be learnt/recommendations	16-17
References	17
Glossary	

1.0 Introduction

1.1 This report is an Executive Summary of a Domestic Homicide Review (DHR) undertaken by the Safer Somerset Partnership following the homicide of Margaret (a pseudonym chosen following consultation with her family).

1.2 During the early hours of 29th October 2020, Gerald unlawfully killed his wife Margaret by repeatedly stabbing her in the bedroom she occupied in the family home. The post mortem found that her death was caused by a stab wound to her left arm severing the brachial artery. Gerald contacted the ambulance service who alerted the police. The police

arrested Gerald at the scene and he was later charged with his wife's murder. Gerald was subsequently assessed as being unfit to enter a plea or stand trial because of his delusions, cognitive impairment and disordered thinking. No criminal trial was therefore possible, but in January 2022 a jury determined that Gerald did the act alleged (stabbed Margaret causing her death) and he received an indefinite hospital order with a restriction under Sections 37 and 41 of the Mental Health Act.

1.3 The DHR process began on 7th December 2020 when the chair of the Safer Somerset Partnership decided to commission a Domestic Homicide Review (DHR) in respect of the homicide of Margaret. All agencies that potentially had contact with the victim and/or perpetrator prior to the homicide were contacted and asked to confirm whether they had involvement with them. The agencies which confirmed contact with the victims and/or perpetrator and were asked to secure their files.

Contributors to the DHR

1.4 The following agencies provided Individual Management Reviews to inform the review:

- Avon and Somerset Constabulary
- NHS Somerset Clinical Commissioning Group (CCG)
- Somerset NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust (SWASFT)

Royal Devon and Exeter NHS Foundation Trust provided a short report.

1.4 The authors of each IMR were independent in that they had had no prior involvement in the case.

1.5 Margaret and Gerald's adult daughter and son contributed their accounts to the review.

The DHR Panel Members

1.6 The DHR Panel consisted of:

Name	Organisation and role
Natalie Giles/James Dore	Somerset Integrated Domestic Abuse Service (The You Trust) Service Manager/ Area Manager
Suzanne Harris	Safer Somerset Partnership (SCC Public Health) Senior Commissioning Officer
Serena Mees	South Western Ambulance Service NHS Foundation Trust, Named Safeguarding Professional

Emma Read / Julia Mason	Deputy Designated Nurse Adult Safeguarding, NHS Somerset Clinical Commissioning Group (CCG) /Designated Nurse Adult Safeguarding, NHS Somerset CCG.
Heather Sparks	Named Professional for Safeguarding Adults, Somerset NHS Foundation Trust
Samuel Williams	Detective Chief Inspector, Avon and Somerset Constabulary.
David Mellor	Independent Chair and Author.

1.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions; 9th February, 20th April, 20th July 2021 and 11th March 2022.

Author of the overview report

1.8 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has nine years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

1.9 The independent chair and author David Mellor was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

1.10 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

1.11 He has no connection to services in Somerset.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

- Establish what lessons are to be learned from the Domestic Homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- 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 inform national and local policies and procedures as appropriate.

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

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

- Highlight good practice.

2.2 The case specific terms of reference are as follows:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Margaret or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.
    - In the context of the rural community in which Margaret lived

- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse in rural locations such as where Margaret lived.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively. This is to include the impact that the Covid-19 pandemic may have had on agencies from March 2020 to Margaret's death in October 2020.

- Consider the routes available for people to share concerns they have about the mental health of a family member and whether there is a need to raise public awareness of any such routes.

3.0 Summary chronology

Background information (Paragraphs 3.1 -3.5)

3.1 Margaret and Gerald had been married for over 45 years. Margaret and Gerald moved to a Somerset village in 2002 at the time of their retirement. They lived in a house previously owned by Margaret's father. Their two children – a daughter and a son – had reached adulthood many years earlier and were no longer living at home. Margaret was very well known in the local community and had served on the Parish Council for many years. She was described by the local County Councillor as 'a busy lady who loved helping people and was involved in pretty well everything that happened in the village'.

3.2 At the time of her death Margaret was 77 years of age and in recent years she had experienced a range of health issues common in people of her age. She was being prescribed medication for raised blood pressure and raised cholesterol.

3.3 At the time of Margaret's death, Gerald was 78 years of age and had experienced a range of health issues common in people of his age. His children have advised the review that acute osteoarthritis in his feet caused him pain and restricted his mobility and other activities. This does not appear to be confirmed by any diagnosis although an earlier endarterectomy could have resulted in a denseness and stiffness in his legs, although this

appeared to resolve itself at that time. The son said that he prompted his father on more than one occasion to talk to a doctor about his feet but that his father had said his feet were 'flat' and 'worn out' from playing sports when he was younger, that there was 'no point' in seeing a doctor as they 'could not do anything', and that he 'will not take pain medication'. He was prescribed Amlodipine 5mg once daily, Losartan 100mg once daily and Prazosin 1mg at night, all for hypertension.

3.4 In her contribution to this review, Gerald's daughter stated that her father had been severely depressed for a number of years after being made redundant and having to manage on a smaller pension than he had anticipated, had become increasingly withdrawn, experienced a degree of memory loss and around the time a carcinoma on his tongue was diagnosed in September 2019 he had become delusional, in that he exaggerated the extent of the surgical intervention necessitated by his diagnosis and began imagining symptoms and effects of the diagnosis. However, Gerald's patient records contain no details of any cognitive or mental health issues and no references to anxiety or stress.

3.5 Prior to the homicide, no incidents of domestic abuse in Margaret's relationship with Gerald had been reported to any agency. Their contacts with agencies almost exclusively related to health matters, the majority of which were routine in nature. Their daughter has informed the review that her parents' relationship had become strained. She said that they had always 'wound each other up' verbally but that her father's cognitive decline had exacerbated tensions as he was unwilling to seek help and her mother's responses to Gerald's memory problems sometimes appeared to cause frustration on his part. Additionally, whilst Margaret had fully entered into all aspects of life in the village, Gerald was much more withdrawn. The impact of the restrictions introduced as a result of the pandemic had affected Margaret's life very substantially and resulted in them spending much more time in each other's company than they had previously been accustomed to.

3.6 In June 2019 Margaret saw the practice sister at her GP surgery for a hypertension review, during which she was examined, her medication reviewed and physical activity, alcohol and lifestyle were discussed. Margaret was noted to be concordant with her medication and eating a sensible diet.

3.7 At the end of August 2019 Gerald was diagnosed with oral cancer and underwent surgery in which part of his tongue was removed. He was referred to the Maxillofacial team at Exeter Hospital on 3rd September 2019 and was seen by the Maxillofacial consultant on 30th September 2019 and at this appointment the decision was made to operate. He was accompanied by Margaret. There was also a discussion about the option of post-operative adjuvant radiotherapy, which reduces the risk of the cancer returning following surgery and therefore increases the patient's chances of survival – but Gerald declined this as he said he did not want to experience the side effects.

3.8 Gerald was admitted to Exeter hospital for the surgery to remove the cancer from his tongue on 3rd October 2019 and discharged home on 11th October 2019. He was reviewed in outpatients on 21st October 2019 to follow up on his surgery and oversight of his care was

then returned to Musgrove Hospital in Taunton. Exeter hospital documented that Margaret attended appointments with her husband and visited when he was in hospital.

3.9 During October or November 2019 Gerald saw his GP for post-operative acute urinary retention. This was the last in-person contact Gerald had with his GP prior to Margaret's death.

3.10 Between late October and December 2019 Gerald was seen by a speech and language therapist on five occasions. The purpose of the appointments was to provide Gerald with advice on eating and drinking following the partial glossectomy. The first of the appointments was a home visit and Margaret was present.

3.11 In late October Margaret saw her GP with right shoulder pain which she attributed to the amount of driving she had been doing as she had been transporting Gerald to hospital appointments in Exeter and visiting him during his admission. In all, Gerald attended eleven hospital appointments during this period, although not all of them were at Exeter hospital, which is over an hour's drive from their home. It appears that Gerald had given up driving, other than short distances to the local shops, by this time.

3.12 During February 2020 Gerald contacted the Oral and Maxillofacial team at Exeter Hospital to say that he was worried about another 'lump' -presumably on or near his tongue, which was found to be a granuloma – a type of rash – caused by rubbing against his dentures. It is presumed that this would have been a telephone contact.

3.13 On 23rd March 2020 the Prime Minister announced that people should only go outside to buy food, to exercise once a day or to go to work if they absolutely could not work from home as a result of the pandemic. This first Covid-19 'lockdown' lasted until 4th July 2020 although the restrictions gradually eased prior to that date.

3.14 On 20th May 2020 Gerald again contacted the Oral and Maxillofacial team with what he thought was a further 'lump' but it was concluded that there was no evidence of recurrence. Given the Covid-19 restrictions, it is assumed that this was a telephone consultation.

3.15 On 22nd June 2020 Margaret had a telephone consultation with the GP practice sister as she was concerned about her cholesterol and the possibility that it could be rising. The practice sister provided reassurance after establishing that Margaret continued to maintain a healthy diet and continued to take statins. The practice sister advised that all patients who were overdue a hypertension review would be seen in-person as soon as this could be done safely.

3.16 On 30th September 2020 Margaret's delayed annual hypertension review took place at the GP practice. She was noted to be eating a sensible diet and largely cooking from scratch. Margaret was also noted to be 'quite active' with gardening, house work, caring for her husband and walking.

3.17 On 12th October 2020 Margaret had a telephone consultation with her GP about pain in the palms of her hands. The GP documented that Margaret had osteoarthritis in her hands and that the pain in her palms was due to flexor tendon involvement. Margaret said she was concerned about rheumatoid arthritis but the GP felt that simple wear and tear was a more likely cause. However, full blood tests were arranged which found no abnormalities.

3.18 Also on 12th October 2020 a new three tier system for Covid-19 restrictions were announced in England and many regions in the North of England immediately entered the highest tier of restrictions. There were ongoing discussions about the need for a second national lockdown in England although this was not announced until 31st October 2020 – two days after Margaret's death.

3.19 The subsequent murder investigation disclosed that on Monday 26th October 2020 Gerald told his next door neighbour that he was very worried about a debt of £22,000 which would result in his and Margaret's eviction from their home on Thursday or Friday of that week. The neighbour stated that he provided Gerald with advice and reassurance.

3.20 At around 10.10pm on Wednesday 28th October 2020 Gerald rang the same next door neighbour and again appeared very preoccupied about the implications of the £22,000 loan, saying that a man was threatening to come and take their furniture and put Margaret and himself out on the street. The neighbour added that Gerald asked for help in finding somewhere to stay. Gerald then said that Margaret would like to speak to the neighbour and he put her on the phone. The neighbour stated that Margaret said she thought that Gerald was 'unstable' and 'losing it a bit'. The neighbour asked Margaret if she would like him to visit but she replied that there was no need for this. Gerald then came back on the phone and told the neighbour that auditors were visiting him at 7am the following morning and the neighbour said that he would visit Gerald in the morning and attempted to provide further reassurance before the call ended.

3.21 Shortly after 3am the following morning (Thursday 29th October 2020) ambulance control notified the police that Gerald had phoned them from his home address to say that he had tried to murder his wife, Margaret, by stabbing her several times. A nearby police patrol attended the Margaret and Gerald's home address and found the front door open. Margaret was located with Gerald in an upstairs bedroom with a number of visible stab wounds and was bleeding profusely. One officer removed Gerald to a different bedroom whilst the other officer administered first aid until the ambulance crew arrived a very short time afterwards. The ambulance crew began CPR but were unable to save Margaret who was pronounced dead at the scene shortly before 4am.

3.22 Gerald was arrested and transported to the Bridgwater Police Centre where he was seen by the Advice and Support in Custody and Court Team (ASCC) for a mental health screening assessment. Gerald was noted to be tearful and remorseful for what he said he had done. The assessment noted that he had no previous mental health history or any known risk to self. Gerald reported some suicidal thoughts when he was made redundant

several years previously and suicidal ideation during the evening prior to the death of Margaret, adding that he lacked the courage to end his own life. He said he had never self-harmed. There was some indication of delusional thinking in that he said his rationale for killing Margaret was in order to protect her from loan sharks, although it was not possible to fully explore this issue within the limitations of the screening assessment. Gerald reported some short term memory loss which he attributed to aging.

3.23 Due to Gerald presenting with low mood, the ASCC team requested that when he was remanded in custody, he should be placed on an Assessment, Care in Custody and Teamwork (ACCT) which is the care planning process for prisoners identified as being at risk of suicide or self-harm.

4.0 Key issues arising from the review

Role of delusional disorder in domestic homicides

4.1 During the period he spent on remand in a medium-secure hospital awaiting trial, Gerald was diagnosed with organic delusional disorder and dementia. Two assessments of Gerald were completed by a Consultant Forensic Psychiatrist, who concurred with the above diagnoses. She concluded that, from the available collateral history, it appeared that cognitive problems started at some point prior to the homicide. Additionally, she concluded that Gerald developed an acute organic delusional disorder secondary to the cognitive impairment, with persecutory and nihilistic beliefs about having no money, being forced to live in penury, and Margaret being taken and harmed by money lenders. The Consultant Forensic Psychiatrist went on to note that at the time of his admission to hospital following the homicide, Gerald had other bizarre delusions about having killed other people in response to them trying to harm or kill him. The Consultant Forensic Psychiatrist found that the evidence suggested that Gerald was both acutely psychotic and cognitively impaired at the time of the homicide and that his acts were driven by his delusional beliefs.

4.2 Therefore, Gerald unlawfully killed his wife Margaret whilst driven by a persecutory delusional disorder. His daughter and son became aware of Gerald’s delusional thinking from around the time of his diagnosis for cancer of the tongue in September 2019. This change in behaviour caused them concerns and Gerald’s daughter in particular began to consider how she might obtain help for her father. However, she was aware of her father’s longstanding reluctance to engage with health professionals and was unable to persuade her mother Margaret that some form of health intervention was necessary. The depth of Gerald’s psychological problems was well hidden and neither his daughter or son had any inkling that their father’s delusional thinking could put their mother Margaret at risk of harm from him. As stated, there is no indication that any professional became aware of Gerald’s delusional beliefs prior to the homicide.

4.3 Delusional disorders are rare with an estimated 0.2% of people experiencing it at some point in their lifetime (1). The most frequent type of delusional disorder is persecutory.

Anger and violent behaviour may be present if someone is experiencing persecutory, jealous or erotomanic delusions.

4.4 The decline in Gerald's cognitive abilities began some time prior to the homicide but this was not picked up on by any of the professionals who came into contact with him in primary or specialist care. However, his adult children state that Gerald had a longstanding mistrust of health professionals and may have been quite guarded about the information he shared with them.

4.5 It is not known why Gerald's delusions became so powerful that they began to so dominate his thinking that he arrived at the decision that he must kill Margaret – and apparently himself, although he was unable to go through with taking his own life – in order to spare her the consequences of being evicted from the home which the review has been told Margaret so treasured. Margaret and Gerald's next door neighbours became aware of Gerald's worries that an unpaid debt would inevitably lead to his and Margaret's imminent eviction and attempted to provide advice and reassurance. They did not seek help from services but they should not reproach themselves for this. Clearly Gerald was behaving very unusually but there is no suggestion that he did or said anything which suggested he might feel compelled to kill Margaret or take his own life.

4.6 This is an unusual case. The independent author is aware of cases in which children have been harmed or killed as a result of extreme religious beliefs or delusions but it is understood that a domestic homicide arising from delusional disorder is very rare. Given their role in quality assuring DHRs, the Home Office may be able to advise on whether there have been any similar cases.

4.7 It is important that the role that a delusional disorder played in this domestic homicide is widely disseminated. There may also be merit in commissioning research into the risks which people with persecutory delusional disorders may present in an effort to identify indicators of risk to self and others so that professionals are better equipped to prevent future tragedies.

Recommendation 1

That Safer Somerset Partnership write to the Home Office to recommend that the role that delusional disorder played in this domestic homicide is widely disseminated. It is also recommended that Safer Somerset Partnership proposes that the Home Office considers commissioning research into the risks which people with persecutory delusional disorders may present to themselves and others in an effort to identify indicators of risk, particularly escalating risk so that professionals are better equipped to prevent future tragedies.

Suicidal thoughts

4.8 When seen by the Advice and Support in Custody and Court Team (ASCC) for a mental health screening assessment, Gerald reported some suicidal thoughts when he was made

redundant several years previously and suicidal ideation during the evening prior to the death of Margaret, adding that he lacked the courage to end his own life. In her contribution to the DHR, Margaret and Gerald's daughter said that her father had briefly spoken about suicide as an alternative to divorce after becoming frustrated with Margaret. He made these comments during a conversation with his daughter over Christmas 2019, ten months before Margaret's death. When his daughter challenged him over his comments he said that he had only been joking, but the daughter has advised the DHR that she was very concerned about what he said. There is no indication that any professionals became aware of Gerald expressing suicidal thoughts prior to the death of Margaret.

Routine Enquiry of older people

4.9 'Routine Enquiry' entails automatically asking people if they are experiencing domestic abuse with every initial/new contact with a service, if safe to do so. There is no indication that any 'Routine Enquiry' question was asked of Margaret. As previously stated there is no indication that Margaret was a victim of domestic abuse prior to the homicide. However, GP contacts such as her September 2020 hypertension review could have been an opportunity for a suitably worded 'Routine Enquiry' to have been considered which could have given her the opportunity to discuss any concerns about Gerald's memory problems and delusional behaviour which might have led to some form of help being offered. Having said that, Margaret and Gerald's adult children's account suggest that both Margaret and Gerald may have been extremely reticent about seeking or accepting help.

4.10 However, the opportunity to consider 'Routine Enquiry' for 76 year old Margaret highlights the extent to which the possibility of domestic abuse in the relationships may be overlooked. Somerset CCG has advised this review that it is considered good practice to make 'Routine Enquiry' at antenatal and post-natal checks, contraceptive review, treatment of sexually transmitted infections, unplanned pregnancies and when the person presents with medical symptoms that cannot be explained. As stated, the majority of these events are likely to take place at a much earlier stage in the life of a victim of domestic abuse.

4.11 It is therefore recommended that Safer Somerset Partnership seeks assurance from primary and secondary care providers that policy documents relating to 'Routine Enquiry' make explicit reference to the risk of domestic abuse and possible mental health concerns in older people and provide examples of the types of interactions with older people when 'Routine Enquiry' could be considered.

Recommendation 2

The NHS Somerset ICB will gain assurance from primary and secondary care providers that policy/ guidance documents relating to Domestic Abuse and 'Routine/ clinical Enquiry' make explicit reference to the risk of domestic abuse and possible mental health concerns in older people and provides examples of the types of interactions with older people when 'Routine / clinical Enquiry' could be considered

Advice for people worried about a family member's mental health and wellbeing

4.12 Margaret and Gerald's daughter was becoming increasingly worried about her father's mental health and wellbeing but unsure of how to raise her concerns with services in contact with him. This seems likely to be a situation which many families may wrestle with. The daughter wondered if there could be more information for people who are worried about family members and want to try and get them help – possibly against their wishes.

4.13 During the course of this review, action has been taken to provide links from the Somerset Safeguarding Adults Board web pages to Somerset NHS Foundation Trust advice on how carers/family members can access help and to SIDAS (Somerset Integrated Domestic Abuse Service). As previously stated, Open Mental Health offers support 24 hours a day, 7 days a week to ensure that any adult living in Somerset struggling with poor mental health can access the right support at the right time (2). There would be merit in a public information and awareness raising campaign, including the promotion of Open Mental Health, particularly as agencies continue to address the medium and longer term impacts of the Covid-19 pandemic including the impacts on mental health and wellbeing.

Recommendation 3

That Safer Somerset Partnership promotes a public information and awareness raising campaign to provide advice on the support available to people who are worried about the mental health or wellbeing of a family member, including promotion of the support provided by Open Mental Health.

4.14 When she read the final draft of this DHR report, Margaret and Gerald's daughter said that she felt that the public information and awareness campaign should not be limited to Somerset as she said that she was sure there were many people concerned about the mental health of their loved ones across the UK.

Outreach to victims of domestic abuse in rural or semi-rural areas

4.15 Margaret and Gerald lived in a rural location as do 19% of the population of England (3). *Health and Wellbeing in rural areas* (2017), a report produced by the Local Government Association and Public Health England, found that whilst health outcomes are more favourable in rural areas than in urban areas, broad brush indicators can mask small pockets of poor health outcomes. The report identified a number of health risks in rural areas including:

- Changing population patterns, including outward migration of young people and inward migration of older people, are leading to a rural population that is increasingly older than the urban population, with accompanying health and care needs. This is reflected in the age profile of Margaret's GP practice.
- Sparsity and the increasing scarcity of public transport links have a significant impact both on daily living costs of rural households and on access to services. Driving

Gerald to hospital appointments in Exeter appears to have taken a physical health toll on Margaret.

- A combination of the older demographic and the unavailability of high speed broadband and mobile phone networks are leading to an increasing digital gap between urban and rural areas. This is made more serious by the growing number of important services, increasingly including health-related services, that are available online.
- Rural areas have worse access in terms of distance to health, public health and care services. Longer distances to GPs, dentists, hospitals and other health facilities mean that rural residents can experience 'distance decay' where service use decreases with increasing distance. However, Margaret and Gerald did not appear to experience 'distance decay' in terms of their access to primary and secondary health services.
- Rural social networks are breaking down with a consequent increase in social isolation and loneliness, especially among older people. The fact that social isolation influences health outcomes in its own right suggests that this and the emotional and mental wellbeing of people in rural areas is an important and hitherto neglected area in the promotion of public health. Margaret was very engaged in the activities of the community – although the Covid-19 restrictions had imposed substantial limitations - but Gerald may have become more isolated and withdrawn. They may have become isolated from each other within their relationship. Their daughter recalled Margaret telling her that the tablet her daughter had bought her as a present was her 'best friend'.

4.16 The DHR has been advised of the work being done by SIDAS (Somerset Integrated Domestic Abuse Service) to reach out to victims of domestic abuse in rural and semi-rural areas. It is recommended that Safer Somerset Partnership ensures that sufficient focus on the provision of support to victims of domestic abuse in rural and semi-rural areas continues.

Recommendation 4

That Safer Somerset Partnership ensures that sufficient focus on the provision of support to victims of domestic abuse in rural and semi-rural areas continues.

Working with Churches on domestic abuse

4.13 The DHR author had a valuable conversation with the Priest of the Catholic Church at which Margaret worshipped and the safeguarding lead for the Diocese to which the Church belongs. It was clear that the Church took their safeguarding responsibilities extremely seriously and were engaged in further strengthening their approach to adult safeguarding and domestic abuse. The Church was a significant part of Margaret's life as it is for many others. There may be an opportunity for Safer Somerset to reach out to churches on an ecumenical basis to raise their awareness of domestic abuse services.

Recommendation 5

That Safer Somerset reaches out to churches on an ecumenical basis to raise their awareness of domestic abuse and the support available to victims of domestic abuse.

4.14 The learning from this DHR suggests a useful public recommendation should be made on continuing to work on challenging the stigma associated with disclosing mental health problems given that this stigma may persist a little more stubbornly in older people.

Recommendation 6

That the Safer Somerset Partnership shares this DHR report with Somerset Health and Wellbeing Board and Integrated Care Partnership (Committee in Common) in order that they can consider how the learning from this DHR may contribute to the public health objectives of promoting better health. In particular, to consider how to promote open conversations about emotional health and wellbeing with older people and their families in an effort to address any residual stigma which may be affecting discussions about mental health issues with older people and to promote choices which prevent, delay or seek to ameliorate indications of cognitive decline.

Good Practice

4.15 Given the lack of contact with agencies by Margaret and Gerald it is difficult to identify good practice in this case.

- The ASCC conducted a thorough and sensitive assessment of Gerald after his arrest including documenting his vulnerabilities which helped to ensure appropriate support thereafter.

- The Somerset framework to inform the local response to domestic abuse during the pandemic including the 'No Closed Doors 2020' campaign.

5.0 Conclusion

5.1 Margaret was unlawfully killed by her husband Gerald who stabbed her to death in their family home whilst acutely psychotic and cognitively impaired. The killing of his wife Margaret was driven by his delusional belief that he was in debt which put him and his wife at imminent threat of being evicted from their home and that it was necessary to kill Margaret to spare her from freezing to death, being raped by gangsters or being eaten by animals. The police investigation disclosed that neither Gerald or Margaret were in debt although they lived a fairly frugal life.

5.2 There is no evidence of any domestic abuse reported to agencies prior to the homicide or subsequently disclosed by family members. It appears that Gerald's cognitive ability may have been in gradual decline for some time and that he began presenting with delusional

behaviour around the time of his diagnosis and treatment for cancer of the tongue around a year prior to the homicide. In the days preceding the homicide, Gerald's delusions crystalised into a fear of imminent eviction as a result of a debt, which he shared with his next door neighbours who attempted to provide advice and reassurance. Gerald had been reluctant to seek professional help for his cognitive decline and no service became aware of his delusional behaviour.

5.3 Despite Margaret and Gerald's fairly limited contact with agencies, there is learning from this DHR in the following areas:

- the risk to self and others which people who develop a delusional disorder may present,
- the need to raise awareness of the support and advice available to family members who are worried about the cognitive decline of a family member and
- the value of 'routine enquiry' of older people about domestic abuse or family worries.

6.0 Lessons to be learnt and recommendations

Role of delusional disorder in domestic homicides

Recommendation 1

That Safer Somerset Partnership write to the Home Office to recommend that the role that delusional disorder played in this domestic homicide is widely disseminated. It is also recommended that Safer Somerset Partnership proposes that the Home Office considers commissioning research into the risks which people with persecutory delusional disorders may present to themselves and others in an effort to identify indicators of risk, particularly escalating risk so that professionals are better equipped to prevent future tragedies.

Routine Enquiry of older people

Recommendation 2

That Safer Somerset Partnership seeks assurance from primary and secondary care providers that policy documents relating to 'Routine Enquiry' make explicit reference to the risk of domestic abuse and possible mental health concerns in older people and provides examples of the types of interactions with older people when 'Routine Enquiry' could be considered.

Advice for people worried about a family member's mental health and wellbeing

Recommendation 3

That Safer Somerset Partnership promotes a public information and awareness raising campaign to provide advice on the support available to people who are worried about the

mental health or wellbeing of a family member, including promotion of the support provided by Open Mental Health.

Outreach to victims of domestic abuse in rural or semi-rural areas

Recommendation 4

That Safer Somerset Partnership ensures that sufficient focus on the provision of support to victims of domestic abuse in rural and semi-rural areas continues.

Working with Churches on domestic abuse

Recommendation 5

That Safer Somerset reaches out to churches on an ecumenical basis to raise their awareness of domestic abuse and the support available to victims of domestic abuse.

Promoting better health of older people

Recommendation 6

That the Safer Somerset Partnership shares this DHR report with Somerset Health and Wellbeing Board and Integrated Care Partnership (Committee in Common) in order that they can consider how the learning from this DHR may contribute to the public health objectives of promoting better health. In particular, to consider how to promote open conversations about emotional health and wellbeing with older people and their families in an effort to address any residual stigma which may be affecting discussions about mental health issues with older people and to promote choices which prevent, delay or seek to ameliorate indications of cognitive decline.

References

(1) Retrieved from https://www.psychologytoday.com/gb/conditions/delusional-disorder

(2) Retrieved from https://openmentalhealth.org.uk/

(3) Retrieved from https://www.local.gov.uk/publications/health-and-wellbeing-rural-areas

Glossary

Domestic violence and abuse is 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
- economic
- 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 a continuing 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.