Safer Somerset Partnership

Domestic Homicide Review

Victim – 'Margaret' who was killed in October 2020

Independent Author – David Mellor BA QPM

Report completed on 8th August 2022

1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Margaret, a resident of Somerset prior the homicide in which she was unlawfully killed by her husband Gerald in October 2020.

1.2 In addition to agency involvement the review will also examine past events to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to improve safety in the future.

1.3 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.

1.4 On 7th December 2020 the chair of the Safer Somerset Partnership decided to commission a Domestic Homicide Review (DHR) in respect of the homicide of Margaret.

1.5 The DHR Panel determined that the review would consider agency contact/involvement with Margaret and Gerald which occurred between January 2019 – the year in which family members began to notice delusional behaviour from Gerald - and Margaret's death in October 2020. Events which are of relevance to the review which occurred outside this timeframe have also been considered, although agency contact with Margaret and Gerald was quite limited.

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

DHR Timescales

1.7 This review began on 9th February 2021 and was concluded on 7th May 2022. Working with the daughter and son of Margaret and Gerald to enable them to read and comment on the final draft DHR report and incorporate their further comments then took until late July 2022. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. The completion of this review was delayed primarily because Gerald was considered to be unfit to plead and so the trial was delayed to allow time for the possibility of recovery and for assessments of his mental health to be carried out. Additionally, arranging the involvement in the review of the victim's son has been slightly complicated by the fact that he lives outside the UK.

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms will be agreed with Margaret's family and used in the report to protect the identity of the individuals involved. At the time of the homicide, the victim Margaret was 77 years old and Gerald was 78. Both are/were White British.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. In this case the two adult children of Margaret and Gerald face having to come to terms with the loss of their mother, at the hands of their father, after the couple had been married for over four decades. The Safer Somerset Partnership wishes to express sincere condolences to the family and friends of Margaret.

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 Methodology

3.1 On 6th November 2020 Avon and Somerset Constabulary referred the case to the Safer Somerset Partnership for consideration of holding a DHR. On 7th December 2020 the chair of the Safer Somerset Partnership decided that the circumstances of the death met the criteria for a Domestic Homicide Review.

3.2 The DHR has been conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with the victim, the victim's families and the perpetrator. The authors of the IMRs had the discretion to interview members of staff if this was required.

3.3 The IMRs were scrutinised by the DHR Panel and further information was requested where necessary.

Contributors to the DHR

3.4 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.

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

The DHR Panel Members

3.6 The DHR Panel consisted of:

Name	Organisation and role

Natalie Giles/James Dore	Service Manager/Strategic Manager, Somerset Integrated Domestic Abuse Service (The You Trust)
Suzanne Harris	Senior Commissioning Officer Interpersonal Violence, Safer Somerset Partnership (SCC Public Health)
Serena Mees	Paramedic/Named Safeguarding Professional, South Western Ambulance Service NHS Foundation Trust.
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.

3.7 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.

3.8 The adult daughter and son of Margaret and Gerald were invited to contribute to the DHR. The relevant Home Office DHR leaflet was shared with them. The daughter was supported throughout the DHR process by a Victim Support Homicide Worker. As the son lives outside the UK, he was not eligible for assistance from Victim Support. The daughter contributed by telephone and video conferencing. The son contributed by video conferencing and email. The daughter and son were updated on the progress of the DHR and a copy of a late draft of the DHR report was shared with them. They were provided with sufficient time to read and reflect on the report and provided comments and observations which were then incorporated into the final DHR report.

Author of the overview report

3.9 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

3.10 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.

3.11 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.

3.12 He has no connection to services in Somerset.

Parallel reviews

3.13 No inquest is to be held in respect of Margaret's death. The Coroner has advised the DHR that in the circumstances he has concluded the inquest process by way of indefinite adjournment.

Equality and diversity

3.14 The protected characteristics relevant to the victim are addressed in Paragraphs 6.6 – 6.10

Dissemination

The DHR report has been disseminated to the following groups:

i. Safer Somerset Partnership
ii. Somerset Safeguarding Adults Board
iii. Somerset Domestic Abuse Board
iv. Avon and Somerset Police Crime Commissioner
v. Domestic Abuse Commissioner

4.0 Involvement of the family of Margaret and Gerald.

4.1 Both the adult daughter and son of Margaret and Gerald contributed to the review. The daughter spoke to the independent author by telephone because of Covid-19 restrictions then in place. The son lives outside the UK and he spoke to the independent author by video conferencing. The adult daughter was consulted on pseudonyms to be used for her parents and requested that traditional English names be used.

4.2 The daughter said that her mother was a 'force of nature', a 'hoot' and someone who loved people. She said that she was definitely a 'people person'. She had a lot of friends, many of whom she had kept throughout her life. She kept in touch with people. The daughter added that her mother loved to talk – adding 'perhaps a little too much at times!' She said that her mother could be quite forceful at times. She was really involved in the local community and had been a member of the Parish Council. She was very active.

4.3 The daughter said that her mother was sympathetic to people who were having a hard time and had a really 'good heart'. However, she never let anything get her down and adopted a 'stiff upper lip' approach. She wouldn't talk about things which might be upsetting her and wouldn't let anyone see that she was having a bad time. Her motto was that 'you've just got to get on with things'. She would say that she was born during World War II and had come through that experience and post-war food rationing.

4.4 The daughter said that her mother would seek help for any personal health problems but wouldn't discuss these issues with her children because she wouldn't want to worry them.

4.5 The daughter felt that, in her view, her father had become increasingly depressed over a number of years and had become increasingly withdrawn. She recalled that a few years ago her father had told her how worried he was that he may be losing his memory. But after that he never mentioned the issue again.

4.6 The daughter said that her father also had really acute arthritis in his feet which meant that it was too painful for him to walk the short distance into the village. He had always enjoyed spending time in his workshop inside their garage but this had been affected by the pain in his feet. She said that her mother would go to more and more social events on her own - ostensibly because of the pain in her father's feet.She said that her father used to do odd jobs for friends and neighbours but she recalled being surprised when he was unable to properly repair a mirror for someone as he had always been such a perfectionist.

4.7 She said that when she visited her parents, she would often sit up late at night and talk with her father but during the years prior to her mother's death, she said that she and her father would just sit in silence. She felt that he had 'lost his spark' and no longer appeared to be interested in anything or able to find pleasure in anything anymore. As a result he had begun spending an increasing amount of time watching the TV. She added that it became increasingly difficult to draw her father out. For a time she couldn't get him to talk about anything at all. But when she began talking about her cats – because she knew that her father liked cats – he became really animated, talking about cats from his childhood. However, she said that, in general, her father didn't like talking about his childhood which she understood to have been 'very traumatic'.

4.8 The daughter said that other family members noticed her father's decline. She recalled her uncle staying with her parents in 2018 and telling her that her father seemed really withdrawn.

4.9 She recalled that in the last decade her father had never smiled on a family photograph. He had also begun to struggle to play games because he could no longer follow the rules.

4.10 The daughter said that her father stopped driving at some point prior to 2020. She recalled being a passenger when he pulled his car out into the path of an oncoming car. Prior to that, she said her father had been a really good driver. She said that her father drove much less after this 'near-miss' - apart from short journeys to the local shops - although she wasn't sure whether it was the 'near miss' was the key factor in his driving less. For longer journeys her mother would always drive their car.

4.11 Despite her mother being quite guarded about talking about her own health issues or any worries she might have, the daughter expressed surprise that her mother had not said more to her about what was going on with her father. Her mother limited her comments to observing that he was being 'difficult' or becoming 'forgetful'.

4.12 The daughter told her mother in early 2020 that she was worried about her father as he seemed to be becoming delusional and she said that her mother's response was that he was fine but that by spending too much time in front of the TV he wasn't stimulated enough and the daughter was 'not to worry'. The daughter feels that her mother may have been 'in denial' about her father's declining mental health. She felt that her mother would rather not think about 'anything happening' to her father because if her mother was left on her own she wouldn't be able to

afford to continue to live in the family home. She said that her mother loved where she lived and that the house, and the idyllic location, were very important to her. Her mother was very emotionally invested in the house partly because it had originally belonged to her own parents.

4.13 She said that her mother and father were not well off. They both lived off their state pensions and that her mother's state pension was quite small as there had been many years during which she had not been in paid employment because she had cared for her children full time. The daughter said that her parents lived a very frugal lifestyle by necessity.

4.14 She said that her mother wasn't very patient with her father as his mental health declined. She said that he would say something which was 'quite ridiculous' and her mother would tend to 'snap back' at him and tell him that what he had said was 'silly' and 'not true'. The daughter observed that this type of response from her mother would make her father really frustrated and so the daughter advised her mother to adopt a more patient approach.

4.15 The daughter said that her parents were not communicating with each other very well. She said that they had always argued a lot, adding that they had been 'winding each other up' for years. She said that that was how they were together. However, she felt that things had worsened over the year prior to her mother's death. She said that her mother wasn't sympathetic to her father – not that she didn't care – but she thought everyone should be like her and just 'get on with it'.

4.16 The daughter said that she had first become aware of her father's delusions following his cancer diagnosis in August 2019. Prior to his first operation in September 2019, he began saying that the consultant was going to take his whole tongue out, that life would not be worth living if this happened and so he was going to refuse the operation. When she went to stay with her parents over Christmas 2019, she said her father had become 'obsessed' with avoiding certain foods – caffeine, chocolate and all fruit except apples – because of his prescribed medication he said. The daughter said that this really 'wound her mother up' and so she asked their GP for advice and was told that her father could eat anything he wanted. The daughter elaborated on this during a subsequent conversation with the independent author by saying that her mother was so annoyed by Gerald's refusal to eat certain foods that she may even have taken the packets of Gerald's medication into the GP practice. In the absence of Gerald's consent to share his medical records with the DHR, his GP practice felt able to provide only an overview of his medical history and so it has not been possible to confirm if there is any record of any approach to his GP as described by their daughter. The daughter also recalled her father claiming that his body was 'eating itself' and that his body was full of tumours which would

necessitate a series of operations over the forthcoming year. From around March 2020 she said that her father said he wasn't allowed to drink alcohol. The daughter said she didn't know whether this was true or was something her father had imagined.

4.17 She said that when the Covid-19 pandemic began, her father said he was really worried about becoming infected as he claimed not to have an immune system as a result of his treatment for the cancer of the tongue. His daughter said that she didn't believe him because the cancerous part of his tongue had been removed without the necessity for treatment which could have affected his immune system.

4.18 The daughter also felt that the Covid-19 restrictions had an impact on her parent's relationship in that most of her mother's activities outside the home had been curtailed following the first England lockdown which began on 23rd March 2020 and her parents were spending a lot more time together.

4.19 The daughter maintained contact with her parents by phone during the first Covid-19 lockdown and so she was unable to visit them during the period between March and September 2020.

4.20 The daughter said that when she was able to visit again in September 2020, her father really made an effort although this seemed quite 'forced'. On this occasion she had taken her boyfriend along with her. She went on to say that her father would 'put on a front' with people outside the family. She felt that most people who knew him in the village would perceive him as polite, helpful but quiet.

4.21 The daughter said that her last contact with her mother was by phone on 24th October 2020 and the call raised no fresh concerns.

4.22 The daughter said that she had been worrying about her father's mental health since the tongue cancer diagnosis. She had discussed her concerns with her mother who told her that she didn't want her daughter to speak to their doctor. The daughter resolved to 'give it another year' before contacting her father's GP. She said that she knew that 'there was something badly wrong with her father's brain'. She reiterated that her mother felt that people with mental health problems should just 'get on with it' and didn't appreciate how serious her father's declining mental health could be.

4.23 The daughter went on to say that her father was very reluctant to see his GP. She explained that he had had a surgical procedure over thirty years earlier which

he said had 'gone wrong' and this had left him with a deep mistrust of health professionals from that point on.

4.24 Reflecting on her parent's relationship in the two years prior to her mother's death, the daughter said that it had got to the point where her father didn't really speak to her mother and had become increasingly withdrawn from her. The daughter recalled her mother saying to her that the tablet she had bought her as a gift several years before had become her 'best friend', which the daughter understood to be a comment on the distance which had developed in her parent's relationship. When she read the final draft of this DHR report, the daughter recalled that when she was staying with her parents over Christmas 2019 she had a conversation with her father during which he became extremely frustrated with her mother and said that his only options were 'divorce or suicide'. The daughter recalls that when she said to her father that he shouldn't take his own life, he said that he had only been joking. However, the daughter said that she had been very concerned about what he had said to her.

4.25 However, the daughter was very clear that she was aware of no domestic abuse in her parent's relationship, adding that her mother was 'too free willed' to be controlled by her father. Although her father had always had a tendency to be 'grumpy', she said that he had never been violent towards her mother and that because there was no prior history of violence, she (the daughter) had been struggling to come to terms with the circumstances of her mother's death. The daughter added that she hadn't been worried about any threat of violence to her mother arising from her father's delusions.

4.26 She said that her parents were not a couple who would reach out to services to help them in any way. She said that they were very proud and very stubborn people. Both were very private and her mother, in particular, would 'put on a front' to indicate that everything was OK.

4.27 Reflecting on the tragic events, the daughter said that she had been wanting to phone the GP on behalf of her father for some time, but was concerned that, even if she did this, he would probably have refused to go and see the GP. She felt that her father needed some form of review of his mental health and wondered whether people should have routine mental health checks as they got older. She added following the assessments her father had been undergoing since her mother's death, he had been diagnosed with Alzheimer's. She also wondered if there could be more information for people who are worried about family members and want to try and get them help against their wishes. She felt that there should have been a way to prevent or slow down her father's decline in order to prevent the man he was becoming the man he is now.

4.28 She said that since her mother's death, she had been made aware that her mother spoke to some friends in a 'Scrabble group' in the week prior to her death about trying to get her father to see a doctor. Her daughter felt that confiding even this limited information was out of character for her mother and so she (the daughter) felt that her mother must have become worried about her father. The daughter said that she had also been made aware that her parents had contacted their next door neighbours on the evening before her mother's death (see Paragraphs 5.21 and 5.22).

4.29 The son of Margaret and Gerald largely echoed his sister's comments although his contact with his parents had primarily been by telephone given his residence outside the UK and the restrictions on international travel introduced from March 2020. The son said that his father had a 'tough' childhood (in which his mother died when he was a boy) and didn't obtain any qualifications.

4.30 The son said that his father had been forced to retire earlier than he would have wished by the liquidators of the company he was employed by at that time, leaving him with a smaller pension than he had anticipated. The son felt that his father never really recovered from this setback and suffered with depression as a result. The son felt that his father's depression was more severe than his parents acknowledged and may have worsened over recent years, though the possible worsening was not entirely clear due to Gerald's reluctance to acknowledge or discuss personal problems.

4.31 The son felt that his father had struggled to adjust to retiring to the Somerset village. He felt that he not really made friends and despite the fact that rugby had been his passion he had not gone to watch the rugby team which played in the nearby town. However, he had absorbed himself in some of his hobbies such as woodworking.

4.32 The son said that arthritis in his father's feet had reduced his mobility so that he couldn't stand for long or walk very far because of the pain. This stopped him doing some of the things he enjoyed doing and so he increasingly spent his time watching TV.

4.33 He felt that his parents weren't very good at communicating with each other in a sensitive way and if either of them was experiencing any problems, the other would generally respond by telling them to 'deal with it'. He said that neither parent was particularly good at listening and they had argued about apparently trivial matters for his (the son's) entire life.

4.34 The son said he had never seen any domestic abuse (physical or emotional) in his parent's relationship. He elaborated that while his parents had a knack of irritating each other and being argumentative, they were both equal in this regard and neither parent exerted any degree of coercion, control, or emotional pressure on the other. He explained that they appeared to become more irritable with each other in their latter years, likely exacerbated by the increased amount of time they spent together after Gerald retired.

4.35 The son said that the surgery on his father's tongue had been successful but he felt that his father had been adversely affected by the stress of the process of diagnosis, treatment and recovery. He went on to say that it was around this time that he first heard his father say something which did not accord with reality. The son said he was speaking to his father on the phone and his father said that he was having his entire tongue removed, at which point his mother came on the phone to say that this was wrong, that she had been with Gerald at the consultation with the surgeon so she knew what the surgeon said and reassured him (the son) that his father was going to have a fairly minor operation, was not going to lose his tongue, and would be fine. The son couldn't recall any further delusional comments but added that his father had never been that conversational on the phone and tended not to talk for very long.

4.36 The son said that his father's memory may have declined but that he had not seen much direct evidence himself; rather, he was aware from speaking with his sister that she has seen some evidence, and that his father had expressed to her worries about his memory. The son explained that his father didn't seek help because he didn't really trust doctors and if a family member pestered him about it, he would just 'dig his heels in' as he could be quite stubborn.

4.37 The son said his mother had felt rather isolated during the first Covid-19 lockdown. She had been unable to meet friends or participate in activities or worship at the Catholic Church in the nearby town. He felt that his mother became worried about his father during the last year of her life, but he said that she was never one to 'dump problems on others'.

4.38 The Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews stresses the importance of situating the review in the home, the family and the community of the victim to help understand the victim's reality. The DHR Panel therefore decided to involve the Catholic Church at which Margaret worshipped and the village Parish Council of which Margaret had been a member.

4.39 The Priest of the Catholic Church at which Margaret worshipped and the safeguarding co-ordinator for the Diocese to which the Church belonged spoke to

the independent author via video conferencing. The Priest said that he knew Margaret well as she regularly attended Sunday Mass and helped out with sales, with serving tea and coffee and the like. However, the Priest was well aware that the focus of Margaret's community work revolved around the village in which she lived.

4.40 The Priest reflected on the profound impact of the first Covid-19 lockdown on his church. The church initially closed altogether in March 2020 and only began admitting worshippers for Mass in early to mid-August 2020 although the church had opened for individuals to attend for private prayer two or three weeks prior to that. During lockdown the Priest said he maintained contact with the most vulnerable parishioners by telephone. He said that these were largely people who were housebound. He added that he wouldn't have thought of ringing Margaret, implying that she was a very self-sufficient person with a reputation for helping others rather than needing help herself. He remembered that Margaret returned to the church after it became possible to admit worshippers once more and he said he recalled seeing her at Sunday Mass two or three weeks before her death.

4.41 The safeguarding co-ordinator for the Diocese said that she was supported by two safeguarding officers in the Diocese, and they link in with the volunteer parish safeguarding representatives. Scenario based training is provided for all members of the clergy. She said that there had historically been a particularly strong focus on safeguarding children but more emphasis had recently been given to safeguarding adults including initiatives such as 'Dementia Friendly Churches'. Disclosures of domestic abuse by parishioners, although specifically mentioned in training and subject of awareness posters within parishes appeared to be quite rare. (There may be an opportunity for Safer Somerset to reach out to the churches to raise their awareness of domestic abuse services).

4.42 A member of the Village Parish Council, who was elected at the same time as Margaret in 2011, and described herself as a friend of Margaret, contributed to this review by telephone conversation with the independent author. She said that Margaret had been a very active member of the Parish Council, retiring from that role in 2017.

4.43 The Parish Councillor said that if a resident was suffering domestic abuse the most obvious avenues for a confidential discussion – outside of family members and friends - were the GP practice or the Village Agent. She felt that confidentiality would be difficult to maintain if a victim turned to informal sources of support as everyone knew your business in the Village, joking that there was a well used 'rumour and gossip line'.

4.44 The Parish Councillor said that the population of the village had been very compliant with the restrictions introduced during the first Covid-19 lockdown and so residents had become very isolated physically. She said that all Village activities came to a halt. She said that residents hardly saw each other for months. The Parish Councillor said that she spoke to Margaret on one occasion during the pandemic and she (Margaret) said she hated it, because she had lost her sense of freedom. The Parish councillor was aware that Gerald had been ill and felt that he and Margaret must have had a hard time during the pandemic.

4.45 Margaret and Gerald's daughter and son were provided with an opportunity to read and comment on the final draft of the DHR report. They made several helpful observations and provided some additional information. The involvement of the daughter and son in this DHR has been extremely valuable and has been a significant factor in enabling substantial learning to be derived from a case in which Margaret and Gerald had limited contact with agencies prior to the homicide. Both the daughter and the son commented that they thought the DHR report was excellent, but the daughter went on to observe that although domestic abuse is a prominent issue for a DHR report to consider, domestic abuse 'had nothing to do with her mother's death' and she didn't feel it was appropriate for Margaret's death to be 'lumped in' with 'male on female violence' as the case is more complex than that and that her mother's death was 'very much a result of mental illness'.

4.46 The DHR Panel decided not to invite Gerald to contribute to the DHR given that he had been diagnosed with organic delusional disorder and dementia and was considered to be unfit to plead in any criminal trial.

5.0 Chronology/Overview

Background information (Paragraphs 5.1 -5.5)

5.1 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'.

5.2 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.

5.3 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.

5.4 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 the 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 (Paragraph 4.16). However, Gerald's patient records contain no details of any cognitive or mental health issues and no references to anxiety or stress.

5.5 Prior to the homicide, no incidents of domestic abuse in her relationship with Gerald had been reported to any agency. As stated, 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.

5.6 In January 2019 Margaret saw her GP to report hearing loss in her left ear. She was documented to 'adamantly decline' steroid treatment which the GP explained was 'her only hope' if the hearing loss was a 'nerve problem'. An emergency ENT referral was made which disclosed nothing abnormal.

5.7 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.

5.8 At the end of August 2019 Gerald was diagnosed with oral cancer and underwent surgery in which part of his tongue was removed.

5.9 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.

5.10 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.

5.11 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.

5.12 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.

5.13 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.

5.14 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.

5.15 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.

5.16 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.

5.17 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.

5.18 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.

5.19 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.

5.20 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.

5.21 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.

5.22 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.

5.23 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.

5.24 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.

5.25 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.

5.26 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.

5.27 Toxicology concluded that there was no evidence that Gerald had consumed an appreciable amount of alcohol - or had used any drugs, other than his prescribed medication prior to the homicide of Margaret. Gerald's GP practice had previously documented his alcohol consumption to be 21units/week.

6.0 Analysis

6.1 In this section each of the case specific terms of reference questions will be addressed.

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.

6.2 The knowledge of the victim of the types of behaviour included within the Home Office definition of domestic abuse is not known. During contact with the Village Parish Councillor and the Diocese safeguarding lead there was an awareness that domestic abuse was not limited to violence. Margaret's daughter and son appeared to have a good understanding of the dynamics of domestic abuse and both were adamant that there had been no violence or controlling behaviour by their father towards their mother prior to the homicide. When she read the final draft of this DHR report, Margaret and Gerald's daughter reiterated her view that there was no domestic abuse in her mother and father's relationship.

6.3 There is no record of Margaret disclosing domestic abuse to any professional, although there is no documentation to suggest that professionals took the limited opportunities they had to enquire about her relationship with Gerald. Had they done so, it seems unlikely that Margaret would have been particularly forthcoming given the description of her approach to life shared with this review by her daughter (Paragraph 4.3).

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

6.4 This is usually a very relevant question to ask in Domestic Homicide Reviews, particularly as the range of civil and criminal interventions available to practitioners has increased in recent years. There is an increasing need for professionals to develop what is sometimes referred to as 'legal literacy' in the domestic abuse field. This point was recently reinforced by a joint investigation by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), the IOPC and the College of Policing in response to a police super-complaint submitted by the Centre for Women's Justice. The super-complaint expressed concern that the police were failing to use protective measures – such as pre-charge bail with conditions and restraining orders – in cases involving violence against women and girls. The joint investigation found that there were good examples of the police making effective use of these

measures, particularly when supported by legal advice. However, the joint investigation also found there was a lack of understanding within police forces over how and when to use protective measures, which meant that support for victims was sometimes not good enough – and could lead to women and girls being harmed, or victims being less likely to report crime in the future (1).

6.5 However, in this case no reports of domestic abuse were received by any agency and so there was no opportunity to consider civil or criminal interventions.

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**

6.6 The equality and diversity issues which could be considered to apply to Margaret are age and gender.

Age

6.7 Margaret was 77 at the time of the homicide. *Safe Later Lives: Older people and domestic abuse* (2016) found that surveys and studies, such as the Crime Survey for England and Wales - which excluded consideration of victims of domestic abuse aged 60 or above until 2017 and even now does not consider victims beyond 74 years of age - and awareness raising campaigns which consistently focussed on younger victims and perpetrators reinforced a false assumption that domestic abuse ceased to exist beyond a certain age (2).

6.8 Research also shows that older victims of domestic abuse are likely to have lived with the abuse for prolonged periods before getting help (3), and they may perceive there to be more at stake after a lifetime of shared history and possessions, financial issues which over time have become interlinked and a fear of any change to long term family dynamics. Over many decades the victim may have internalised the abuse and concluded that 'this is just the way it has always been'. Additionally older victims are likely to have grown up during a time when the home was regarded as a private domain and it would have been socially unacceptable to discuss matters which occurred behind closed doors. As previously stated this review has received no information to indicate the presence of domestic abuse in Margaret and Gerald's relationship prior to the homicide although their daughter has described a relationship which had gradually deteriorated to the point where her father didn't really speak to her mother and had become increasingly withdrawn from her (Paragraph 4.24). Additionally, the understandable difficulties Margaret appeared to

experience in adapting to what appears to have been an undiagnosed cognitive decline in Gerald may have created an ongoing tension in their day to day relationship.

Gender

6.9 Margaret's daughter has advised this review that her mother's state pension was quite small as there had been many years during which she had not been in paid employment because she had cared for her children full time (Paragraph 4.13) and worked part-time thereafter. Although it has not been possible to fully verify this, Margaret's pension may have been affected by not paying National Insurance during the years in which she was the primary carer for her children or possibly paying only what was known as 'married woman's stamp'. By pooling their state pensions, Margaret and Gerald were only able to live quite frugally and both seem likely to have been unable to afford to live separately from one another in any comfort. As such they were financially dependent on each other. Margaret and Gerald jointly owned the house in which they had been living for a number of years prior to the homicide. The house had been willed to Margaret and her two siblings by their father and Margaret and Gerald had bought out her siblings' shares in the property with the proceeds from the sale of their previous home.

6.10 Gendered views of where principle responsibility for caring for children lay and the role of the woman as the 'homemaker' would have been more pronounced when Margaret gave birth to her children and had the potential to diminish her financial independence during those years of her life. However, Margaret's children have advised the DHR that inheritances she received enabled her to maintain a degree of financial independence.

The context of the semi-rural community in which Margaret lived

6.11 Assumptions about older people and domestic abuse referred to above may have affected the extent to which professionals enquired about whether Margaret could be a victim of domestic abuse. And had Margaret wished to disclose domestic abuse these assumptions by professionals may have represented a barrier to even raising the issue.

6.12 '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. In their contribution to this review, Somerset CCG advised that GPs undertake consultation with people for a wide range of health needs and unless there are any other suggestions of domestic abuse, the GP would not make a routine enquiry about

domestic abuse with all patients presenting with every health needs. The CCG went on to advise that it is 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. Whilst this is accepted, the majority of the points at which 'Routine Enquiry' would be asked relate to the earlier years of an adult's life. There don't appear to be the same number of recognised opportunities to apply 'Routine Enquiry' to an older person. In Margaret's case, GP contacts such as the September 2020 hypertension review could have been an opportunity for a suitably worded 'Routine Enquiry' to have been considered. The notes of the interaction indicate that it was an holistic face to face contact in which good rapport was established.

6.13 As stated, Margaret and Gerald lived in a rural location as do 19% of the population of England (4). *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.

6.14 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 which has a higher than average number of patients aged over 65 which equates to 32% of the practice population compared with the local average of 24% and national of 17%.

- 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, such as job search opportunities, banking and increasingly, 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. Different models of service delivery may be needed for rural areas, including new models of workforce development. These also include the development of rural hubs providing a range of services, and more services provided on and through the internet. 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'.

6.15 The *Health and Wellbeing in rural areas* report briefly touched upon improving outcomes for victims of domestic abuse in rural areas, citing a review of domestic abuse support conducted by Warwickshire County Council in 2010. The review specifically considered the needs of rural communities and noted that the rurality of some districts affected access to centres offering support to victims of domestic abuse. The review cited research that some victims of domestic abuse living in rural areas valued health practitioners, particularly GPs, in providing confidential and safe services for victims and went on to highlight the benefits of nearly all the county's GP practices adopting the IRIS (Identification and Referral to Improve Safety) programme, which is a general practice based domestic violence and abuse support and referral programme.

6.16 In 2019 the National Rural Crime Network published a report on domestic abuse in rural areas entitled *Captive & Controlled* (5). The National Rural Crime Network seeks greater recognition and understanding of the impact of crime in rural areas and is supported by 30 Police and Crime Commissioners and police forces in England and Wales. The report is informed by a literature review and interviews with over 60 victims but unfortunately is written in a rather lurid tabloid style. However, the report contains some findings which appear credible:

- Leaving an abusive relationship may generate a higher degree of upheaval in rural areas as it may be necessary for a victim and their children to

completely depart from a rural community, potentially necessitating disruptive changes to employment, schooling etc.

- It may be more difficult to access in-person support from suitably trained and experienced workers in rural areas.

- Should a victim seek help, maintaining confidentiality may be more challenging in rural areas - where communities may be more tightly knit - which could compromise the safety of the victim. In Margaret's case, she was quite a prominent member of her local community having served on the Parish Council, which could have presented a barrier to her sharing personal information with others, had she wished to do so.

- The report suggests that domestic abuse patterns in rural areas differ from urban areas in that the abuse may be perpetrated over a lengthier period and be less likely to necessitate an immediate response.

6.17 Since there is no indication that Margaret was a victim of domestic abuse prior to the homicide, the above factors may not have applied to her personally, but they could be factors which increase the risks for victims of domestic abuse who live in rural areas.

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

6.18 A manager of rural IDVA (Independent Domestic Violence Advisor) services in Somerset contributed to this DHR. She stressed the importance of outreach given that physically locating IDVAs in rural communities is part of the SIDAS service. To this end, she said that the Dragonfly Project – which aims to develop community-based support for people affected by domestic abuse and trains Dragonfly champions to provide a listening ear and link to domestic abuse service so that people who are geographically isolated have access to help – was implemented in Somerset, although the funding ended in November 2021 and the service is no longer provided. However, SIDAS provides IDVA and DVA services to everyone eligible, regardless of demographics. She said that the Dragonfly project had been successfully initiated with a focus on providing information and advice and training to the proprietors/people in authority in places to which victims who may be subject to coercion and control would probably be 'allowed to go' such as hairdressers and churches.

6.19 She also drew attention to Health Advocates who had been recruited to provide training and support to staff in GP practices - including 'Routine Enquiry' -

and are available to provide direct support to victims of domestic abuse when admitted to hospital. However, due to the Covid-19 pandemic restrictions, the work of the Health Advocates has primarily centred around hospital settings. The funding for the Health Advocate roles ends in March 2022.

6.20 She said that there was an emphasis on identifying 'safe meeting spaces' in rural communities which might be the GP practice – if there is one – but could also be a pharmacy, a school, a church or even a room in a public house providing confidentiality wasn't compromised.

6.21 She drew parallels between some fairly closed communities in rural areas such as Gypsy Travellers and more remote farming communities and some of the characteristics of so-called Honour Based Violence, in particular the extent to which bringing perceived shame on one's family or community or seeking help from outside that community were seriously frowned upon. Working with victims from communities such as these required quite a high level of skill and tenacity, which is provided by the SIDAS service.

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.

6.22 There is no indication that the interventions, care and treatment and support provided to Margaret and Gerald was other than consistent with each organisation's current professional standards and domestic abuse policy, procedures and protocols.

6.23 However, a challenge to the primary and specialist care services in contact with Gerald was whether there were any opportunities to pick up on the indications of cognitive decline, depression, withdrawal from aspects of his life and delusional thinking which his daughter had observed. However, his daughter also referred to her father's 'deep mistrust' of health professionals (Paragraph 4.23) which may have resulted in Gerald being careful not to give any indication that his emotional wellbeing and mental health was other than satisfactory. He had no contact with his GP practice for almost a year prior to the homicide. However, he twice contacted the Maxillofacial team at Exeter hospital following the surgery on his tongue to express worried about further 'lumps' on his tongue. These may have been opportunities to explore how Gerald was feeling but it is assumed that both contacts were by telephone and that the primary focus would have been on obtaining and assessing the information provided by Gerald.

6.24 Turning to 'safeguarding adults', one of the six key principles which underpin safeguarding adults work is prevention - in that it is better to take action before harm occurs. Gerald's needs were becoming more complex, and with the benefit of hindsight, his mental and physical health appeared to be on a downward trajectory. Unfortunately, the indications of declining health did not become apparent to health professional in contact with him and if information had been sought about Gerald from Margaret, who was documented by the speech and language team to be his 'carer'*, she would probably have downplayed her husband's declining health on the basis of the information their adult children have shared with this review.

*Whilst Margaret provided informal care and support to Gerald, she was not offered a carer's assessment or in receipt of carer's allowance. Research commissioned by Carers Week 2020 estimated that there are 13.6 million unpaid carers in the UK, of whom 4.5 million had started providing care since the beginning of the pandemic (6). 'Unpaid care' is defined by Carers Week 2020 as 'helping someone who could be finding it hard to manage because of mental or physical illness, needing extra help as they grow older or because they have a physical or learning disability'.

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.

6.25 Information sharing between agencies in respect of both the victim and perpetrator appears to have been in accordance with expected practice. No agency received any information from which they could have perceived Gerald to present a risk to Margaret prior to the homicide.

6.26 The Advice and Support in Custody and Court Team (ASCC) mental health screening assessment noted that Gerald had no previous mental health history or known risk to self. However, he 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 (Paragraph 5.25). Gerald's suicidal ideation during the evening prior to the homicide may well have increased the risk to Margaret. No professional was made aware of Gerald's suicidal ideation and there is no indication that he discussed suicide with the next door neighbour he contacted twice during the days prior to the homicide.

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.

6.27 Gerald's daughter was becoming increasingly worried about her father's mental health and wellbeing and has advised this review that she was really unsure of how to raise her concerns with services in contact with him. She said that she felt that 'there was something badly wrong with her father's brain' but after receiving no encouragement from her mother to approach his GP practice, the daughter resolved to 'give it another year'. However, the daughter was concerned that, even if she did contact her father's GP, he would probably have refused to go and see the GP.

6.28 This was a difficult situation for Gerald's daughter, and a situation which many families may wrestle with. Reflecting on the tragic events, the daughter felt that her father needed some form of review of his mental health and wondered whether people should have routine mental health checks as they get older. She also wondered if there could be more information for people who are worried about family members and want to try and get them help against their wishes. When she read the final draft of this DHR report, Margaret and Gerald's daughter said that this was the most important issue for her, adding that she felt that family members should be able to contact GPs directly if they have concerns about a family member's mental health problems. She supported the proposal for a public information campaign about this, adding that, even now she was not sure what avenues are open for someone who is worried about a family member or close friend's mental health. She said that she believes that her mother's death might have been prevented if she had been able to obtain appropriate help for her father.

6.29 The DHR Panel felt that this was an important issue and that agencies may need to review the information they provide to family members who are worried about the mental or physical health of a family member and feel that some form of intervention is necessary. In Somerset, valuable advice is available online but it was questioned whether members of the public would be able to readily access this advice. Action has since 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) which is welcomed. Additionally, 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 (7). Open Mental Health is an alliance of local voluntary organisations, the NHS and social care, Somerset County Council, and individuals with lived experience of mental health. Perhaps a public information and awareness raising campaign could be of benefit, particularly as agencies address the medium and longer term impacts of the Covid-19 pandemic including the impacts on mental health and wellbeing.

6.30 The Advice and Support in Custody and Court Team (ASCC) mental health screening assessment disclosed some indication of delusional thinking in that Gerald said his rationale for killing his wife was in order to protect her from loan sharks. It was not possible to fully explore this issue within the limitations of the screening assessment, but the police investigation confirmed that Gerald appeared to be affected by delusional thinking at the time he stabbed his wife (Paragraph 5.25).

6.31 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.

6.32 Delusional disorders are rare with an estimated 0.2% of people experiencing it at some point in their lifetime (8). 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.

6.33 No professional appears to have become aware of Gerald's delusional thinking. The only opportunity for professionals to have picked up on this issue was when Margaret may have sought the advice of her GP practice to dispel Gerald's erroneous belief that the medication prescribed to him prevented him from eating certain foods. However, at that stage Gerald's delusions were merely a source of frustration for Margaret and would not have indicated that he could present a risk to self or others.

6.34 When seen by the Advice and Support in Custody and Court Team (ASCC) for a mental health screening assessment (Paragraph 5.25), 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 (Paragraph 4.24). 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.

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

6.35 This is usually a valuable question to ask in a DHR but does not appear relevant to this case.

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

6.36 This is usually a valuable question to ask in a DHR but does not appear relevant to this case.

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

6.37 This is usually a valuable question to ask in a DHR but does not appear relevant to this case.

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.

6.38 No agency perceived, or had reason to perceive, Margaret to be an adult at risk. Gerald began to experience cognitive decline and started to present with delusional behaviour but there is no indication that services and agencies became aware.

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.

6.39 See earlier consideration of the extent to which the 'protected characteristics' set out in the Equality Act applied to the victim (Paragraphs 6.6 to 6.10).

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.

6.40 The review has received no indication that organisational change was a factor which affected the response of agencies to the victim or perpetrator in this case.

6.41 The Covid-19 pandemic has had a profound impact on the population as a whole and on how agencies provided services during periods when it was temporarily unsafe to provide the majority of in-person services. The DHR has been advised that in Somerset a framework to inform the local response to domestic abuse was developed at the outset of the pandemic which included a multi-agency recovery plan. A key part of this framework has been the development of a multi-agency scorecard through which areas of demand could be identified and also compared with pre-pandemic demands. This work has been overseen by a multi-agency group (which is a sub group of the Somerset Domestic Abuse Board) which has benefitted from excellent participation from a wide range of local agencies. In addition to this, the multi-agency group commissioned a multi-media publicity campaign 'No Closed Doors 2020' to help ensure the public knew services were still available and how to contact them (#NoClosedDoors2020 media centre (somersetsurvivors.org.uk)).

6.42 The restrictions imposed in the first England lockdown meant that both Margaret and Gerald's contacts with health professionals were by telephone rather than in-person. Margaret's hypertension review was delayed as a result and she rang her GP practice in June 2020 to express some anxiety about her cholesterol level rising. This may have been an indication of increased concern about her health during a period in which she would have been much less active in terms of exercise and engagement in her usual wide range of community and social activities. Margaret's opportunities to contribute to community life and worship at the Church she attended were curtailed for several months. The Village Parish Councillor who contributed to this review said that Margaret told her that she hated the first Covid 19 lockdown. She and Gerald would have spent more time in each other's company than they had previously been accustomed to, which may have exacerbated the tensions in their relationship described by their daughter and son in their contributions to this review.

6.43 The prospect of a second Covid-19 lockdown was looming at the time of the homicide and could conceivably have been a factor which affected Gerald's mental health and wellbeing at that time. The most recent progress report on the England suicide prevention strategy identified two categories of individuals for whom the onset of the pandemic has exacerbated risk factors:

- those for whom the pandemic has exacerbated existing problems, and
- those for whom the pandemic has resulted in significant and specific new issues which are known drivers of suicide such as job loss, unmanageable or mounting debts as a result of reduced income, bereavement and loneliness or social isolation (9).

The pandemic may have exacerbated what Gerald's daughter and son feel was an undiagnosed depression.

Good Practice

6.44 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 (Paragraph 6.41)

7.0 Conclusion

7.1 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.

7.2 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.

7.3 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.

8.0 Lessons to be learnt and recommendations

8.1 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.

8.2 On the basis of assessments of Gerald carried out since the homicide and from the accounts provided to the DHR by his son and daughter, Gerald appears to have been affected by a decline in his cognitive abilities for some time. This was not picked up on by any of the professionals who came into contact with Gerald 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.

8.3 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.

8.4 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.

8.5 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.

Routine Enquiry of older people

8.6 In Margaret's case, GP contacts such as the September 2020 hypertension review could have been an opportunity for a suitably worded 'Routine Enquiry' to have been considered (Paragraph 6.13). As previously stated there is no indication that Margaret was a victim of domestic abuse prior to the homicide. However, a suitably worded 'Routine Enquiry' question 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.

8.7 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.

8.8 It is therefore recommended that NHS Somerset ICB 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

8.9 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.

8.10 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. 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.

8.11 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

8.12 The DHR has been advised of the work being done by SIDAS to reach out to victims of domestic abuse in rural and semi-rural areas. It is recommended that Somerset County Council Public Health (as commissioners of specialist domestic abuse services in Somerset) ensures that sufficient focus on the provision of support to victims of domestic abuse in rural and semi-rural areas continues.

Recommendation 4

That Somerset County Council Public Health 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

8.13 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 (Paragraphs 4.39 – 4.41). 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.

Promoting better health of older people

8.14 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.

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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.

Appendix A

Single Agency Recommendations

There are no single agency recommendations in this case