DHR W06 2020

Domestic Homicide Review into the death of 'Rose' and her husband 'John' both aged 66 years

Report by: Malcolm Ross M.Sc.

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TESTIMONY TO ROSE AND JOHN

Testimony to Rose and John from Rose's family

I knew Rose before she became a couple with John. Rose had many issues in her life but always seemed to get past them. She was a caring loving person and would always do her best when possible. She was close to her family siblings and especially her younger brother they always kept in contact.

Rose was my maid of honour at my wedding in 1980. I knew Rose and John for 40 plus years, they both had very troubled lifestyles and both on drugs when meeting. John was more the heavy drinker than Rose. Drink and drugs turned them into different people both physically and mentally and would both become aggressive physically and verbally with each other.

Despite having drug and alcohol addictions plus health issues they were very loyal and extremely devoted to each other, sometimes inseparable.

I have many happy memories of Rose and John especially in the earlier years. Friday nights was darts night, and we would go to the public house for a drink and a darts match with the family. They were both lovely and caring people towards other people. John was very good at making furniture from old bits of wood and their house was full of furniture John had made. Rose was extremely good at knitting and craft work she would knit teddy bears etc. and send them to charities. Rose taught John to knit. Rose and John were very close, often talking and texting every few days. Sometimes happy and sometimes both very low. I don't want to paint a picture of them always unhappy and on drugs because this is not true. It seems a lot more mental health was affecting them both in the last few years.

I always believed they would both end their life together because they couldn't live without each other they often talked about ending their life. It is my opinion both drugs, mental health, health issues and believing there was no way out of the situation contributed to both taking their life's.

Testimony from John's family

John was a brilliant brother, loving and caring he enjoyed his life and was a joker and had many friends. There were five of us kids in the family, myself the oldest John next then two younger brothers and our sister who is the youngest. We all got along together as you do growing up.

When John was older and left to start a life with Rose. Over time he became very distant with the family and started to see and speak to us less and less, which was very hard but we understood that this was just how he wanted his life to be. He dedicated his life to caring for Rose as any loving partner would but ultimately it impacted far too much on his own mental health.

We will all miss him so much.

List of Abbreviations

²gether	NHS Foundation Trust that provided mental and social health care services
A&E	Accident and Emergency
AMHAT	Acute mental Health Assessment Team
ASC	Adult Social Care
CBS	Central Booking Service – NHS
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CWPT	Coventry and Warwick Partnership Trust
DASH	Domestic Abuse Stalking and Harassment – risk assessment form
DHR	Domestic Homicide Review
EDT	Emergency Duty Team – Social Services
G.P.	General Practitioner
HAU	Harm Assessment Unit – Police
H.M. Coroner	Her Majesty's Coroner
HOG	Home Office Guidance
IAPT	Improve Access to Psychological Therapies
IMR	Individual Management Review
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conference
NEOP	North Older People Team of Social Services.
OPAT	Outpatient's Parenteral Antibiotics Therapy
PVP	Protecting Vulnerable Persons (Unit) –Police
SWCSP	South Warwickshire Community Safety Partnership
SWCSPB	South Warwickshire Community Safety Partnership Board
STORM	System for Tasking & Operational Resource Management – Police Command and Control System
SWFT	South Warwickshire NHS Foundation Trust
UTI	Urinary Tract Infection
WDC	Warwick District Council
WMAS	West Midlands Ambulance Service

SOUTH WARWICKSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW 06

INTO

THE DEATH OF 'ROSE' AND 'JOHN'

BOTH AGED 66 YEARS

The Domestic Homicide Review Panel express their sincere condolences to the family of Rose and John.

Family members have agreed on the use of the pseudonyms Rose and John.

1. Introduction

1.1 This Domestic Homicide Review (DHR) deals with the death of a 66-year-old woman, Rose and her 66-year-old husband, John who were both found hanged in their home. They were pronounced dead at the scene. A Police investigation commenced. H.M. Coroner for Warwickshire was informed. A postmortem revealed that both Rose and John had died from hanging.

1.2 The South Warwickshire Community Safety Partnership (SWCSP) was informed by Warwickshire Police of the deaths, and it was considered that the circumstances met the criteria for a Domestic Homicide Review which was confirmed by the Home Office on 5th January 2021. At this stage the DHR pertained to Rose as the Victim. Due to her mobility problems, it was thought that John may well have assisted her in the act of suicide. As the review progressed however, information came to light to suggest that Rose was the dominant of the two and controlled John significantly. In light of that information the DHR panel decided that there was domestic abuse from both Rose and John and the Home Office was informed in April 2021 that both Rose and John should be considered victims of abuse. The Home Office agreed.

1.3 H.M. Coroner held an inquest on both Rose and John and determined that both had taken their own lives by suicide, and both had intended to do so.

1.4 The SWCSP DHR Panel held an initial meeting in November 2020, and identified agencies that potentially had contact with both Rose and John prior to their deaths and the agencies were asked for details of their involvement with them.

1.5 The SWCSP and the report author have had continued contact with family members. They were provided with details of the Home Office Guidance and also an AAFDA leaflet offering support. The family members chose not to seek support from any support service.

2. Purpose of the review

2.1 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9, a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011 and reviewed in December 2016[2]. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"*

2.2 Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[3], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that 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*
> - *financial*
> - *emotional*

2.5 In December 2016, the Government again issued updated guidance on Domestic Homicide Reviews especially with regard to deaths resulting from suicide. The guidance[4] states:

> 'Where a Victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.'

2.6 The guidance[5] defines coercive and controlling behaviour as:

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[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.
[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8
[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 15 page 8

'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."

2.7 The circumstances of both Rose and John's deaths met the criteria under this guidance.

2.8 Such Reviews are not inquiries into how a Victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a review is to:

- Establish what lessons are to be learned from the 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 the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all Victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse: and
- Highlight good practice

3. Process of the Review

3.1 The South Warwickshire Community Safety Partnership Board (SWCSPB) was notified of the death of the couple by Warwickshire Police. The SWCSPB reviewed the circumstances of this case against the criteria set out in Government Guidance[6] and decided on 26th November 2020, that a Review should be undertaken, initially with regard to Rose as the victim and John being the perpetrator. This was on the basis that the initial hypothesis was that John must have at least assisted Rose to take her own life due to her mobility problems and the physical effort it would have taken her to take the final act of her death. However, as information was obtained from agencies and friends and relatives, it became apparent that Rose may well have been the dominant partner and instances of her controlling John and abusing him came to light. The DHR panel then took the decision to consider both of the couple as 'victims'. The Home Office was informed and agreed with that decision, hence both of their names appear in the title page of this report.

[6] Home Office Guidance 2016 Page 9

3.2 The Home Office was notified of the intention to conduct a DHR on 25th January 2021, Guidance[7] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. On the 25th March 2022, the Board approved the final version of the Overview Report and its recommendations.

4. Timescales.

4.1 The review commenced on 5th January 2021 with the appointment of the Independent Author and Chair of the Review Panel. The Home Office were notified in April 2021 of a possible delay in the review process because of the Review Author being warned to give witness evidence in a criminal trial at the Crown Court which potentially could have been for several weeks' duration.

5. Scope of the review.

5.1 This review will cover the period from 1st January 2011, that being the year that the deceased moved into their last accommodation until the date of the couple's death.

6. Confidentiality

6.1 Confidentiality was observed throughout the review process in relation to information being obtained from agencies and family members. Information was shared with only those that needed to know. Both Rose and John were white British citizens, and both were 66 years of age at the time of their deaths.

7. Terms of Reference

7.1 The Terms of Reference for this review can be found at Appendix No 1.

8. Methodology

8.1 The methodology used in this review is set out at paragraph 2 of the introduction. This is a unique review in that initially only Rose was considered as a 'victim' but as information was gained it was clear that both Rose and John were to be considered 'victims' in this review.

8.2 Some of the Individual Management Reviews (IMRs) authors conducted interviews with practitioners which is the usual practice in DHRs.

9. Involvement with family, friends, and colleagues.

9.1 Efforts were made at an early stage to identify family and friends of both Rose and John. Relatives of Rose were written to seeking engagement with the review process, and after some time contact was made and they agreed to engage with the review. There is evidence of Rose having two daughters from her first marriage. It is also suggested that one of the daughters had attempted to make contact with Rose at some stage before her death, but efforts to trace either daughter have been fruitless.

9.2 In relation to John, with the help of the police, contact was made by the Author with two of John's sisters, who engaged with the process and attended a virtual meeting with panel members.

[7] Home Office Guidance 2016 pages 16 and 35

9.3 The Review Author has also made contact with members of the Salvation Army, the Night Shelter, and other similar charitable organisations that John had access to whilst he was temporarily homeless periodically.

9.4 Accounts given by family and friends are contained in the section 'Views of family and friends'.

10. Contributors to the Review

10.1 Ten agencies confirmed contact with either Rose or John and they were asked to secure their files in preparation of the submission of an Individual Management Review (IMR) or a helpful report.

10.2 The following agencies were requested to submit an IMR

- Adult Social Care (ASC)
- Clinical Commissioning Group (CCG)
- Coventry and Warwickshire Partnership Trust (CWPT)
- South Warwickshire Foundation Trust (SWFT)
- Warwickshire Police
- West Midlands Ambulance Service (WMAS)
- Warwick District Council (WDC)

10.3 All IMR Authors confirmed their independence in that they had no practitioner dealings with either Rose or John.

10.4 Helpful reports have been received from:

- Helping Hands
- Leamington Winter Support (LWS) Night Shelter
- Salvation Army

11. Review Panel Members

11.1 In accordance with the statutory guidance[8], a panel was established to oversee the process of the review. Mr Ross chaired the panel and also attended as author of the overview report. Other members of the panel and their professional responsibilities were:

- Marianne Rolfe – Head of Health and Community Protection, Warwick District Council
- Cheryl Bridges – Community Safety Manager, Warwickshire County Council
- Jonathon Toy – Group Manager, Trading Standards and Community Safety, Warwickshire County Council
- Elizabeth Young – Community Safety Manager Warwick District Council
- Emma Guest – Domestic Abuse Commissioner, Vulnerable People, Strategy and Commissioning, Warwickshire County Council
- Rupert Pullin – Operations Manager, Adult Social Care, Warwickshire County Council
- Julie Vaughan – Lead Nurse for Adult Safeguarding, Safeguarding Team, Coventry and Warwickshire Partnership Trust
- Maxine Nicholls – Lead Professional for Safeguarding Adults, South Warwickshire Foundation Trust until July 2021 – Head of Safeguarding (Children and Adults) Coventry and Warwickshire Partnership Trust from July 2021.

[8] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2013 revised 2016

- Penny Wilson – Named Nurse Domestic Abuse South Warwickshire NHS Foundation Trust
- Fran Walsh – Named Professional for Safeguarding, Coventry and Warwickshire Clinical Commissioning Group
- Jim Essex – Police Staff Manager, Statutory and Major Crime Review Unit, Warwickshire Police
- Julie Timerick – Detective Constable, Warwickshire Police
- Rachel Shuter – Service Manager Refuge Domestic Abuse Warwickshire
- Elaine Wallace – Housing Needs Manager, Warwick District Council
- Stavroula Sidiropoulou – Domestic Homicide Review Officer, Warwickshire County Council
- Malcolm Ross – Independent Chair and Author, Domestic Homicide Reviews
- John Ross – Independent Chair and Author, Domestic Homicide Reviews (Observer) (attended first two meetings),

11.2 All panel members confirmed they had no direct involvement in the case, nor had line management responsibility for any of the practitioners involved. The panel was supported by a DHR administration officer. The business of the panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of the review having been undertaken. The DHR panel met on the following occasions:

- 20th January 2021 (virtual meeting due to Covid19)
- 8th February 2021 (virtual meeting due to Covid19)
- 30th April 2021 (virtual due to Covid 19)
- 10th June 2021 (virtual due to Covid19)
- 16th July 2021 (virtual meeting due to Covid19)

12. Independent Author

12.1 The Home Office Guidance[9] (HOG) requires that:

> *"the review panel should appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on IMR's and any other evidence the review panel decides is relevant"*, and *".. the review panel chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review".*

12.2 The Independent Author, Mr Malcolm Ross, was appointed at an early stage of this review. He is a former Detective Superintendent with West Midlands Police where, as a Senior Investigating Officer, he was responsible for the investigation of around 85 murders many involving domestic abuse. Since retiring in 1999, he has 23 years' experience in writing over 80 Serious Case Reviews, and post 2011, performing both roles of Chair and Author on over 60 Domestic Homicide Reviews. Prior to this review he has had no involvement either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the preparation of the report and recommendations.

13. Parallel Reviews

[9] Home Office Guidance 2016 page 12

13.1 Warwickshire Police commenced an investigation into the deaths of Rose and John. It was determined that there was insufficient evidence to suggest that there had been an unlawful act, and this event was considered to be a possible double suicide.

13.2 HM Coroner for Warwickshire was informed and held an inquest in relation to both deaths and determined that both Rose and John were found hanging in their home had intended to take their own lives by suicide.

14. Equality and Diversity

14.1 Home Office Guidance[10] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

14.1 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

14.2 The review gave due consideration to all of the Protected Characteristics under the Act.

14.3 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

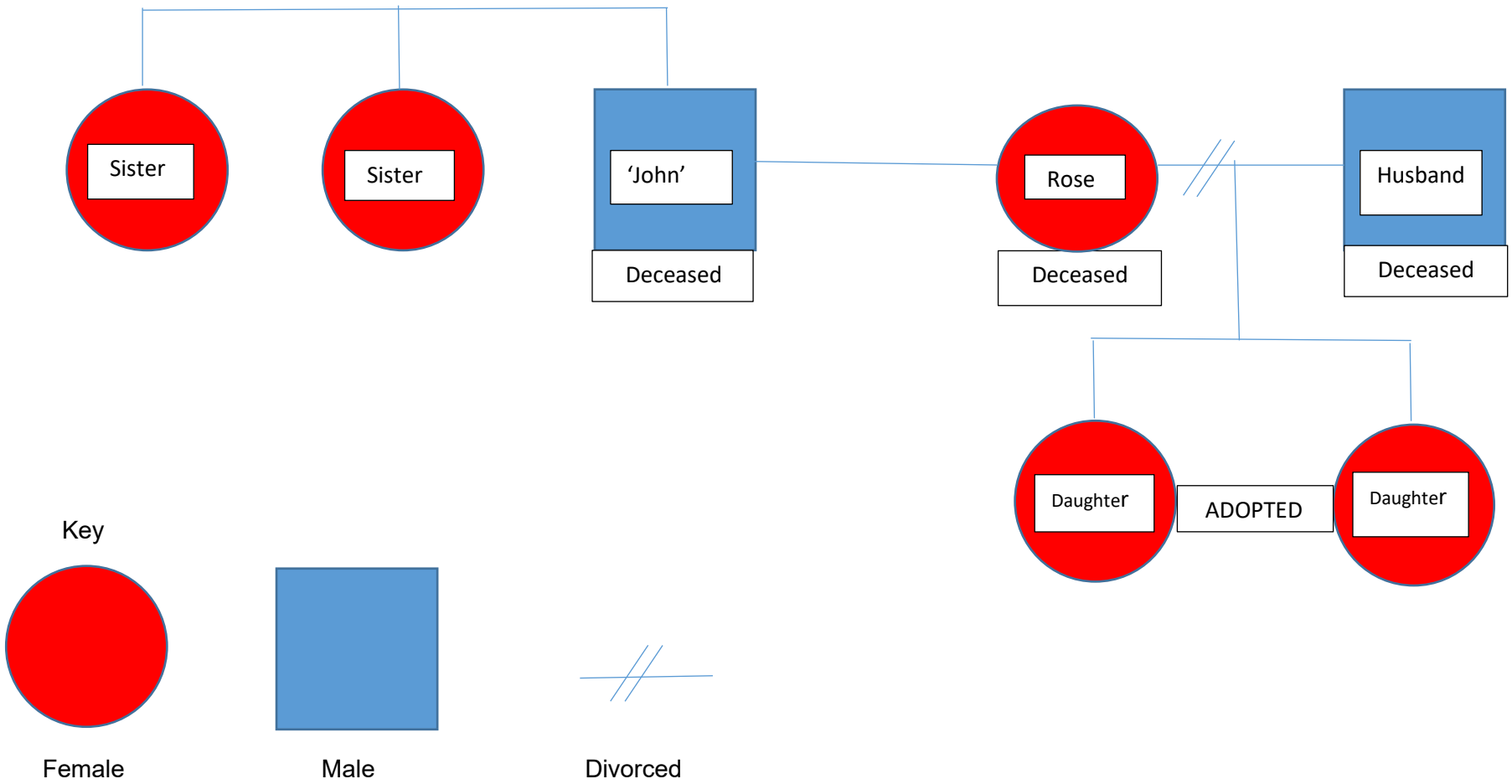
14.4 There was nothing to indicate that there was any discrimination in this case that was contrary to the Act, whilst appreciating that Rose and John had significant medical needs of their own and information from health agencies adequately illustrate how they were both supported with the needs.

15. Dissemination

15.1 Copies of the Overview and Executive Summary of this report have been provided to panel members and members of the Community Safety Partnership as well as to the Home Office Pre-Quality Assurance Assessment Panel. Family members have seen a draft of the report to ensure accuracy of the facts contained therein and will be provided with a final version just prior to publication.

[10] Home Office Guidance 2016 page 36

GENONGRAM


Sister
Sister
'John'
Deceased
Rose
Deceased
Husband
Deceased
Daughter
ADOPTED
Daughter
Key
Female
Male
Divorced

16. Summary

16.1 This Domestic Homicide Review concerns the death of a couple who had been married for approximately 40 years. Each of them had medical issues and it is known that Rose had a history of alcohol and illicit drug abuse as well as a mental health history. According to John's sisters, John also used illicit drugs and alcohol.

16.2 Evidence from health agencies support the fact that Rose had threatened or attempted to end her life in the past. It is also known that on one occasion, about 10 weeks before their actual deaths, John stopped a passer-by in front of his house, handed the man a note which stated that there was to be a suicide and to call the police. The police and health agencies attended and found both John and Rose alive. It was clear however, that the couple needed some assistance as they were finding life hard to cope with. Coventry and Warwickshire Partnership Trust (CWPT) staff attended and following an assessment, decided there was no need for mental health service follow up. A senior police officer arranged for numerous officers to contact the couple over that weekend to ensure their safety and offer support.

16.3 A lady who regularly delivered prescribed medicine and medical support equipment to the house, entered the house, and found Rose and John hanging from a loft hatch in one of the ceilings in their ground floor flat.

16.4 Found at the scene were two sets of small step ladders. Both Rose and John had some form of noose around their necks. Also at the scene, police officers found 4 written notes details of which are contained in the summary of events.

16.5 In these circumstances it is impossible to say what actually happened moments before the death of the couple, whether one of them prepared the other, whether they prepared themselves. Whether one of them helped the other onto the steps and who stepped off the steps first are questions that will never be answered.

16.6 From information gleaned from agencies, family and friends, it would appear that prior to their meeting, John was a fun loving, family orientated man who was well regarded by his sisters.

16.7 Prior to Rose meeting John, information indicates that she had been married and had two young daughters. Her husband died and at some stage the daughters were adopted at an early age. It appears that there was no contact post adoption for years between the daughters and their mother but there is a suggestion that one of the daughters attempted to contact her mother not long before her mother's death. Neither of daughters could be traced to be invited to engage with this review.

16.8 According to John's relatives, once they were married the couple's lifestyle changed in that they ignored the rest of the family and moved from the Coventry area into Warwickshire. One of John's sisters indicates she had not seen her brother for 10 years, when he suddenly turned up at her house saying that his wife had thrown him out of the house, and he was sleeping on park benches. This apparently was not an infrequent situation.

16.9 Evidence from the local Salvation Army and Homeless agencies suggest he was a regular attender at night shelters, and he often slept on benches in a local park. However, information from people he spoke to indicates that John was extremely fond of his wife and would do anything to help her with her serious mental ill health.

16.10 Evidence from one of the homeless hostels indicates that John would sleep rough and away from home for anything between one day and two weeks whilst Rose was having one of her 'episodes'. He would only return when she asked him to, but he would phone her every day and make sure she was alright. On occasions, he stated he would never

want his own tenancy as he couldn't leave his wife as she needed him. A manager of another shelter described John as 'an absolute pleasure to have around and mostly in a joyful mood, known to them for his singing'.

16.11 John would report to shelter staff that Rose would get verbally and physically aggressive towards him which would lead to her throwing him out on the streets. He said that after a few weeks, when she had calmed down and had taken her medication, she would allow him to return home. It appears that she was often non-concordant with her medication. It is also apparent that John would attend soup kitchens for periods of sometimes between 3-6 months. The staff at the soup kitchens said that if they noticed he hadn't attended they assumed his wife had let him back into the house.

16.12 The Review Panel have received a significant amount of information about Rose's medical conditions and treatments she underwent. However, information regarding John's medical conditions is not so detailed as agencies had far less relevant information on record.

17. Chronology and sequence of events

17.1 The scope of this review is from the 1st January 2011, that being the year that the deceased moved into their last accommodation to the date of the couple's death. The integrated chronology for this case is 115 pages of information.

17.2 There are issues of interest prior to the start date of the 1st January 2011 which are worthy of brief mention.

17.3 In 1987, John's GP Medical records indicate that he had been known to have an opiate drug dependency. He would have been in his 30's at this time, and a year later in 1988, he was diagnosed with chronic depression and anxiety which continued into 1993.

17.4 In March 2006, Rose's brother took his own life by hanging. In June 2007, Rose reported to her General Practitioner (GP) that she had been sexually abused by her grandfather and two uncles. There is nothing to indicate any follow-up support being provided to John or Rose on those occasions.

17.5 In December 2009, GP records for Rose indicate that she had been subject to child abuse by her father for a period of nine years. She had two children (girls) with her first husband, but these had been adopted shortly after their birth. Her GP records indicate that at this time she was suffering with acute psychotic state and had a history of illicit substance misuse, alcohol dependency, eating disorders and had made several suicide attempts. There is nothing to indicate any support services were offered to either Rose or John.

17.6 On 1st November 2010, CWPT records indicate a history of mental ill health for Rose with delusion, paranoid ideation, and command hallucinations. She believed John was the Antichrist and wanted to 'knife him'. It is noted that her mental health was exacerbated by alcohol and amphetamine use. She also had physical health problems.

17.7 CWPT records contain information of Rose receiving community support from the Community Mental Health Team (CMHT) as well as getting daily support from a Community Psychiatric Nurse (CPN).

17.8 The record also indicates that at this time in November 2010, John was living away from home as Rose told him she couldn't cope with him. Rose reported that she felt that John was jealous of her relationship with her dentist. There is nothing to suggest that there was a relationship between Rose and her Dentist.

17.9 In January 2011, Rose reported feeling better and told CWPT that her mental health problems did not overly trouble her. However, by April 2011, her mental health had

deteriorated significantly. Animosity towards John had increased, and she had again thrown him out of the flat. She reported she had not taken any anti-psychotic medication for a few weeks but had been using amphetamine. It was clear at a subsequent home visit that Rose had not been concordant with her medication.

17.10 By mid May 2011, a CPN reported that Rose's mental health had improved considerably and although she had allowed John back into the flat, she reported that she had turned against him because he would not provide her with any more amphetamines.

17.11 By July 2011, Rose was quite disturbed again and had told John to leave. She again accused John of being an Antichrist and had paranoid ideas about him.

17.12 In August 2011, Rose did not attend her Care Programme Approach (CPA)[11] Review meeting and CWPT decided to discharge her from the Community Mental Health Team and her case was closed. She had no more contact with Mental Health Services from that date in August 2011 until July 2012.

17.13 In July 2012, CWPT Crisis Team contacted Rose. She had self-referred to the Crisis Team feeling low and depressed and not knowing what to do. She reported being disabled and unable to leave the house because John was not allowing her to use her mobility scooter. She had stated the scooter was in her flat, but John was refusing to make it available for her to use.

17.14 Rose stated that she couldn't cope with John 'going off' and 'clearing off' to walk around parks and streets of Leamington. She said that he didn't do anything around the home, he was verbally abusive towards her, he prevented her from talking to neighbours and she claims he would hide bills that were in her name so they wouldn't get paid.

17.15 Rose reported that John had sexually abused children some years ago, but she was not sure if it was still happening. She did admit that she had no direct evidence to confirm these facts and she stated that she was abused as a child by her father. Rose reported to the Crisis Team that she did not feel at risk from John, but he was a controlling person. No imminent risks were identified, and a follow up appointment was made. She was given contact details for a mental health helpline.

17.16 The following day, another CWPT home visit took place and Rose reported that John was staying at the Salvation Army Hostel in Leamington and sleeping rough in the park. She said that she would not let him back into the flat and she wanted to end the relationship. She was offered information regarding Mental Health Matters and also domestic abuse agencies, but she intimated that she would not be calling these support services. She would however contact the Crisis Team if she felt it was necessary. She made an allegation that she was only taking half a dose of diazepam as John had sold some of her medication. Rose was encouraged to consider contacting the diabetes nurse for a review.

17.17 Five days later in July 2012, another home visit was made. This time both Rose and John were present. Rose reported that they had reconciled, and they were trying to make things work.

17.18 On the 16th September 2012, Rose called the Police saying there were seven people inside her flat who had come through her television and they were trying to hand her over to a vicar. She threatened to jump out of the window from the first floor if the Police didn't attend. The Police spoke to the Crisis team at the local hospital and were told they had no dealings with Rose since July 2012. When Police arrived at the flat,

[11] The care programme approach has been introduced to improve the delivery of services to people with severe mental illness and minimise the risk that they lose contact with mental health services.

they found that Rose had barricaded herself into the property. The Ambulance and out of hours GP were asked to attend and the incident was tagged for The Protecting Vulnerable People Team and the Safer Neighbourhood Team.

17.19 The incident was also tagged as a STORM[12] incident for the attention of the Police Harm Assessment Unit. The following day, an out of hours GP made a call to Rose to make a medication review. The GP spoke to John who told him that Rose was better and resting but she was unable to talk about the previous day's events and she described that day as a 'bad one'. She declined a home visit but agreed to have a telephone conversation the following day.

17.20 On the following day, the Crisis Team called Rose who reported everything was fine between her and her husband and a home visit was arranged for the 25th September 2012. At that meeting Rose said she was getting on much better with her husband and her main concern was her physical health and that she would require no more crises follow ups and that if she needed help, she would ring for support. The CWPT case was closed.

17.21 In February 2013, Rose self-referred to the Crisis Team. She reported being scared of John who was threatening her, and she was distressed about their relationship. She was reluctant to call the Police when she was advised to do so, and she declined a home visit. She was however allowed time to vent her thoughts and feelings.

17.22 In March 2013, Rose reported hearing voices and she requested a medical review and also to see a CPN. She stated that all her previous thoughts of John were as a result of her mental health and that their relationship was improving. She was seen alone on this occasion, and she spoke about her childhood abuse but declined to talk to therapy support services.

17.23 In May 2013, the Adult Safeguarding Team called the Crisis Team stating that Rose had disclosed several areas of concern about her husband and that he was selling her medication, driving without insurance and watching children in the park. The Crisis Team Nurse considered that when Rose was unwell, she would become suspicious about John. Rose was offered an appointment for a mental health assessment, but she declined and said she would call the Crisis Team if she felt the need.

17.24 On the 24th May 2013, an unannounced visit from CWPT found John back home and they apparently reconciled. Rose was referred to an Independent Advocate for support regarding accommodation as she was struggling with the stairs. There was no risk identified during the visit and Adult Social Care Safeguarding Team were advised of this meeting. There being no further role for the Crisis Team, the case was closed.

17.25 On the 31st August 2013, Police were called to central Leamington Spa to two men with a knife, one being John, who were fighting. Both men were arrested for an affray and John received a Police caution.

17.26 On the 2nd October 2013, the Crisis Team called Rose after being contacted by John who was concerned as he was unable to talk to Rose. Rose told the Crisis Team that John had not been living at the flat for some time and that he controlled her, told her when to eat and sleep, and on occasions he would get angry which frightened her. Rose considered that she was better without John being at home. She was advised to call the Police if she felt unsafe but declined further support. She reported that she had been offered a two-bedroom ground floor flat. CWPT's case was closed.

[12] STORM – **S**ystem for **T**asking and **O**perational **R**esource **M**anagement – a Police Command and Control System

17.27 In October and November 2013, Rose failed to attend podiatry appointments.

17.28 On the 24th February 2014, Rose contacted the Crisis Team. She told them that she and John had broken up three weeks previously as he had been selling his medication and he had bought several items using her name for which she now has bills. He was now living in the Salvation Army Hostel. Although John had not directly threatened her, she reported feeling threatened by him. She stated she had no plans in getting back with John and she was advised to contact the Police if she felt threatened. Referrals were made to '2gether' [13] and the Community Psychiatric Nurse.

17.29 Rose was spoken to again by the Crisis Team in early March 2014 where she disclosed that she had changed her mind about feeling unsafe and threatened by John but nonetheless she did not wish to get back together with him at that time. She stated she did not feel the need for Crisis Team support but agreed to call them should she change her mind.

17.30 Two days later, Rose failed to attend another podiatry appointment and she was discharged from the service.

17.31 On the 12th May 2014, a neighbour called the Police as she could hear a female screaming for help from Rose's property. The neighbour could hear somebody screaming 'you've killed her'. The Police attended and spoke to Rose who was alone in the property and had been dreaming. To reassure her, Police Officers searched the flat and the incident was tagged for the Harm Assessment Unit (HAU).

17.32 On the 25th June 2014, a member of staff from 2gether contacted the Crisis Team. It was reported that Rose had alleged that John had been trying to get access to her flat and had hit her in the face. Adult Social Service Safeguarding Team were informed and were investigating. Rose was again advised to call the Police if she had further concerns. There is nothing to suggest the Police were informed of Rose's allegation.

17.33 On the 8th August 2014, Rose called the Police saying, 'he won't leave me alone'. She was distressed and breathless, but she hung up and called back a few minutes later and said she was in danger because of her husband but she did not know where he was. She thought he was in the park. It appears she was talking about past incidents. The local Safer Neighbourhood Police Officer spoke to Rose's social worker who said that she would visit the following day. It was noted by the Police that there were no offences disclosed and that when the situation got difficult at home, John would go for walks which he had done that day. The incident was tagged for the Harm Assessment Unit.

17.34 On the 29th September 2014, Rose's social worker contacted the Police saying that Rose had called her at 11am to say there was a doctor in the flat and a man was trying to kill her. However, she was alone in the flat. Rose also said the man was going to kill her sister and that John had run off with his girlfriend. The social worker was unable to contact Rose. Police attended but couldn't get any response. The Police left the scene, and another call was made from the neighbour who said that Rose was in the house but wouldn't open the door as she thought she was going to be taken away. Rose had told the neighbour that she had received a letter which told her that she was going to be taken away to die. Police attended again and called for an Ambulance who spoke to the Crisis Team. Rose was given medication and arrangements were made for a Crisis team nurse to attend that evening.

17.35 At 9pm that evening, a Crisis Team member called the Police asking for assistance. Rose was extremely psychotic and agitated. The Crisis Team had planned an

[13] 2gether NHS Foundation Trust (2gether) - an NHS Foundation Trust that provided mental and social health care services

assessment on Rose with medical staff who were due to arrive at 10pm. They wanted Police attendance at 10pm to assist in detaining Rose. Police told them that a new shift were starting at 10pm and officers would be there at 10.30pm. At 9.06pm, a CPN rang the Police to say she was present with Rose, the Crisis Team member and a GP. Rose had run out of the house towards the main road without any shoes on. All of the people in the house were unable to stop her. It was their intention to leave a plan for Rose and to go back to the hospital to do the paperwork. The Police could contact them there when Rose was found. They did not feel comfortable waiting in Rose's flat for the Police whilst the flat was empty. An officer managed to speak to a member of the Crisis team before they left the property and the Police were advised where they should take Rose when they had found her.

17.36 The Police escalated this incident to a high-risk missing person and requested the Police helicopter and dogs to assist in the search. Rose was found at 10.30pm. Police were requested to take Rose to place of safety suite as staff could not wait in her flat whilst police were looking for her. The Police were advised that Rose could be detained under Section 136 Mental Health Act and be taken to a place of safety. The centre where the Police were advised they should take Rose when they found her, then advised that they did not have any spare capacity so she was taken to the A&E of the local hospital. Rose was sectioned just after 11pm. Finally, at 3.20am on the 30th September 2014, she was transported to the centre initially suggested. Adult Social Care Safeguarding Team raised concerns that Rose had made allegations of domestic abuse from her husband at this time. Because Rose was known to make these allegations when she was unwell the duty social worker reported that no further action would be taken but the case would be discussed with senior managers and the Crisis Team would be notified of the decision regarding any action that would be taken.

17.37 At some stage after this, Rose was discharged and shortly after 6.20am the same day an elderly neighbour of Rose phoned the Police to say that Rose had turned up outside. She couldn't get into her flat as she didn't have the key and she had wandered off towards some fields. The Police control room called the Caludon Centre[14] who confirmed that she did have a key when she left. The Police were advised by the Caludon Centre to liaise directly with the Crisis Team. The Caludon Centre told the police that Rose had been assessed but the Crisis Team didn't believe she could be sectioned. There was no more for the Police to do, and no further police action was taken.

17.38 A short time later on the 30th September 2014, the Crisis Team visited Rose, and John was present. Rose reported having hallucinations the day before, grieving for her niece who had recently passed away and that she suspected she had a chest infection. John agreed to make an appointment for Rose to be seen by her GP. Rose refused to have a medical review as she was getting support from her GP.

17.39 On the 29th November 2014, a woman phoned the Police reporting that her partner had been punched in the face by John. This apparently happened because the person assaulted, and his family lived above Rose and John's flat and children of that family had been slamming doors, so John had gone upstairs and punched the occupant's partner in the face. The man assaulted did not want to pursue a complaint and wanted the matter dealt with as a community resolution. John accepted the resolution and apologised to the neighbour. The matter was recorded as a crime.

17.40 Just after 10.00pm on 10th March 2015, Rose phoned the Police. She was not making much sense but reported that 'they' had killed her husband. She was shouting for her

[14] The Caludon Centre is a purpose-built facility, based on the University Hospital Coventry and Warwickshire (UHCW) site, providing inpatient and outpatient adult mental health care, and learning disability inpatient services.

mother and she stated that someone was outside shouting for her baby. She added that someone was going to hang her.

17.41 Eight minutes later a further call was received by a neighbour. Rose had entered the neighbour's house with a knife. The neighbour was scared as she knew Rose had mental health issues. Rose was talking about someone who had killed her husband and had hung him.

17.42 Officers attended and requested an Ambulance. Rose went voluntarily in the Ambulance for a mental health assessment. Rose was referred to the Integrated Practice Unit (IPU) of the Mental Health Recovery Team. Following the assessment, she declined a referral to the Recovery Partnership for support regarding amphetamine use. Due to her mental health improving she was deemed not to require a mental health follow up.

17.43 Just before 7pm on the 25th May 2015, Rose called the Police stating a man was sitting in a car outside her flat and that he had a stick with number 7 on it and an infra-red light. She said she had already put a knife up to him. Police put a note on the log that Rose was psychotic. However, they attended and requested an Ambulance. It was deemed she lacked capacity and required treatment so further officers were called to get Rose into the Ambulance as she had become aggressive. A Vulnerable Adult incident was created, tagged for the Harm Assessment unit and a referral made to mental health services. Rose's neighbour reported the incident to the housing authority.

17.44 Rose was admitted to hospital and discharged on the 27th May back into the care of her GP.

17.45 At 3.32am on the 14th June 2015, Rose called the Police again stating 'they' have surrounded her house and there were giant fish bowls. She then terminated the call. At 3.55am hours the same morning she rang again saying there were people outside her house who were trying the get her. She said that John was coming from Leamington and he would be there soon. The call was terminated and resulted without Police deployment. The incident was tagged for PVP (Protecting Vulnerable Persons) and no referrals were made.

17.46 At 3.22am on 5th July 2015, Rose called the Police saying there were men in her room, standing in her window playing with her clock. She included there were two women there also. It was noted that she had a history of psychotic episodes and the incident was closed without Police deployment. The incident was not tagged for PVP or HAU and no referrals were made.

17.47 At lunchtime on 18th July 2015, Rose called the Police reporting a burglary at her property. Police attended and found there had not been a burglary but Rose had thrown her purse at John and it was assumed he had taken her purse when she had asked him to leave. The incident was tagged to PVP and a referral made to Mental Health Services.

17.48 Just before 8pm on the same day Rose again called the Police reporting men outside who had come to harm her. She was scared and wanted Police attendance. The Police told her they would pass her number to the Crisis Team and they would contact her. Rose called again just after 9.00pm saying no one from the Crisis Team had called her. She was confused and refused the offer of an Ambulance and said she would contact the Crisis Team herself.

17.49 During August in 2015, Rose called the Police on several other occasions alleging people were at her home to harm her.

17.50 An Ambulance attended an incident on the 22nd August 2015 which she declined, but the Ambulance crew did persuade her to take her medication and she calmed down. On all three occasions referrals were made to mental health services.

17.51 The chronology for Rose indicates that she did not have any contact with mental health services between December 2015 and the 10th March 2016 apart from a referral on 21st December.

17.52 Police received two calls just after midnight on the 21st December 2015. A Police call handler tried to converse with Rose but she became hysterical. She made five calls in quick succession. An Ambulance was called to attend but she refused to answer the door to the crew. She insisted the Police attend, which they did. It appears she had become confused by reflections of a lamp in her window. Another referral was made to mental health services.

17.53 South Warwickshire Foundation Trust's records indicate that Rose had a long history of treatment by the continence team, but records show that she frequently failed to attend for appointments. Such was the case on 20th January 2016 where she was discharged from the service due to lack of contact.

17.54 On the 11th March 2016, Rose called the Police saying there was a white van outside her house and noises and lights coming out of her television. She was advised to call the Crisis Team but within 9 minutes was complaining they hadn't attended and she accused the Crisis Team of pretending they were dead. She complained of a teddy bear hiding in the corner and a lion was in the other corner. The matter was left with the Crisis Team. However, at 5.00am the following morning Rose called the Police to say her brother-in-law (deceased) was in the room. The Crisis Team were contacted again.

17.55 Rose's mental health problems continued throughout April 2016 where she complained to the Crisis Team that John goads her to stab him and that he had been controlling her throughout their marriage. She admitted using 'speed' at that time and she said that John was not present but when he returns home she would 'kill him'. It was clear to the Crisis Team that Rose's mental health was deteriorating.

17.56 She made two further calls in the remainder of April complaining that John was controlling and manipulative and that she felt sorry for him, but part of her would want to kill him. Rose agreed for a referral to be made to Age Concern and she was given information about the services that could be offered by Cruse and the Samaritans. The entry in the chronology for the 24th April 2016 ends with a comment 'no further planned contact from the Crisis Team. Case closed'.

17.57 Just before 8.00am on the 9th May 2016, neighbours of Rose called the Police. They reported that she was outside her address dressed only in her nightie banging on people's doors and windows with a kitchen knife in her hand shouting 'he killed her'. John was not at home and was believed to be in Leamington. The Police attended along with an Ambulance. Rose calmed down and no further action was taken. The Police made a referral to the HAU.

17.58 The Police were called again on the 18th July 2016 by neighbours reporting that Rose had gone to the home of an elderly man and she was trying to get into his house. Rose had left the scene by the time the Police attended but had left blood on a door handle, so they went to Rose's address. The door was open and a bus pass with blood on it was found. Rose had apparently taken the dog for a walk. There was no sign of John. Rose was found nearby and was having breathing difficulties, so an Ambulance was called. Another referral was made by the Police to the HAU.

17.59 Just after 1.00pm on the 19th July 2016, a neighbour phoned the Police saying that Rose was threatening to jump from her second-floor flat window. She was shouting and screaming that there was a beast in the kitchen. Other neighbours called the Police. Many of the neighbours were elderly people in their 80's who were terrified by Rose's behaviour. Police attended but she refused to let them in saying that she was self-harming, so they forced entry. Rose wanted to leave the house and go outside, and once outside she was detained under section 136 Mental Health Act 1983. She was taken to a local mental health facility. Attempts were made to contact John by the Police making enquiries with the local Salvation Army. They were told that John often slept rough to get away from Rose.

17.60 Rose was admitted to hospital and a Consultant Psychiatrist reported that her mental health had deteriorated due to amphetamine use. To support that a neighbour of Rose entered her flat later that day to feed the dog. The neighbour reported to the Police that she had found white powder in an ashtray which she believed to be drugs. Rose was discharged on the 25th July 2016.

17.61 Rose didn't have any further contact with mental health services between 25th July and 31st August 2016.

17.62 On the 21st August 2016, John was witnessed in an apparent drunken state to get into a motor vehicle in Leamington. Officers tried to stop him, but he drove off at speed through red traffic lights and mounted the kerb. When he was eventually stopped, he was found to be in possession of an axe, a 7" kitchen knife and a dumbbell. He was arrested for being in possession of offensive weapons and for dangerous driving. He denied the weapons were offensive saying he used them to repair vehicles and he didn't want to leave them at the flat. He was reported for the driving offences.

17.63 There are six incidents recorded regarding Rose on 1st September 2016, starting in the early hours of the morning when she reported to the Police that people were trying the get into her house. She called again just before 8am saying that someone was outside her flat trying to hurt her. An hour later, GP records indicate that she was complaining that her television was rigged, and she was surrounded by knives. By lunchtime, GP records indicate that she was feeling better, but she declined to visit her GP. At 9.30pm the same day, she told the Police that people were sitting outside her flat looking for John. A call handler could hear her talking to herself mentioning jumping out of the window. At 11.00pm the Crisis Team were requested by the Police. On arrival she appeared to be lucid and that she felt fine and there was no need for any hospital treatment. The result of actions throughout that day were several referrals by the Police to mental health services and an urgent referral made by her GP to psychiatry.

17.64 The GP made a referral to Community Mental Health Team on the 24th October 2016 as Rose was saying that she was upset with her husband and she wanted to die, but she was not suicidal. She was visited at home later that day by CMHT. She was found screaming and shouting at her husband. There is nothing to indicate that the CMHT instigated a safety plan at this stage.

17.65 Nothing of note occurred until 21st November 2016 when a home visit from CWPT was made. Both Rose and John were present. She admitted using amphetamines as a coping strategy but denied any recent substance use. She declined psychological support although admitted occasionally hearing voices. She indicated her main stress trigger was anxiety caused by arguments between her and John. She said her pain from her physical health issues sometimes made her feel like she wanted to end her life. There is nothing to indicate that anything was done about her pain.

17.66 Rose found her dog to be her main protective factor and John explained that because of her physical mobility problems she was unable to use her mobility scooter. She said she understood that she could contact the Crisis Team whenever she needed them.

17.68 Just before 7am on the 19th December 2016, Rose called the Police saying someone was in her flat and someone was going to take her away. The Police attended together with an Ambulance. Rose voluntarily went to A&E and was left with security. Police removed three knives from the coffee table in her flat. A referral was made to mental health services.

17.69 Rose was seen in A&E and it was determined that her acute behavioural disturbance was likely to be secondary to illicit drug use. She disclosed her last use of amphetamine sulphate was in July 2016 and that John had moved out of the flat the previous week. She was referred to the Crisis Team but also to the Mental Health Acute Team for a mental health assessment. Later that day she was seen by the Crisis Team at home in the presence of a friend who told the Crisis Team that Rose emptied medication capsules and put amphetamine into them. Rose said she was happy that John had left but unhappy that he would not be paying the rent. Her friend offered to help. Rose declined further support from the Crisis Team and the case was closed.

17.70 During the afternoon of 18th January 2017, Rose called the Police saying she was scared about a yellow van parked outside. Police attended and called an Ambulance as Rose was struggling to breathe. By the time the Ambulance had arrived, her breathing was fine. They made a referral to the Crisis Team. However, at 6.00pm a neighbour called the Police in tears. She had been sitting with Rose awaiting the Crisis Team from the earlier call when suddenly Rose became aggressive and threatened to stab the neighbour. Police attended. Rose calmed down and the Crisis Team deemed her safe to be left at home.

17.71 During May 2017, Rose had several hospital appointments around cardiology, tests for bowel cancer and in June, a cardiac catheterisation. Rose failed to attend for a flexible sigmoidoscopy.[15]

17.72 Rose made one call in February 2018 to the Police concerned about disco lights from next door but cleared the line before any details could be taken.

17.73 From March 2018 to May 2018, Rose had contact with the continence team. She was discharged from this service on the 22nd May 2018 for ‘equipment only care’.

17.74 In October 2018, Rose’s GP and a consultant cardiologist agreed that Rose no longer needed cardiology support and she was discharged from that service. She would, however, remain under the care of respiratory medicine.

17.75 On the 23rd March 2019, a neighbour told the Police that Rose was at their door claiming ‘two big guys’ were after her and that her brother had been to her house in a big van. The Crisis Team attended and took Rose home. There was no further action from the Police other than to make a referral to mental health services and complete an adult risk assessment.

17.76 A neighbour again called the Police on the 27th May 2019, stating that Rose was outside their house with no shoes on stating she had been poisoned. Police attended and took Rose home. Rose was described as ‘mumbling and talking no sense at all’. An Ambulance was called. Police found knives in the house and in the garden, and an air weapon on the floor of the lounge. Police disposed of this with her consent. She

[15] Flexible sigmoidoscopy looks inside the rectum (back passage) and the lower part of the large bowel (sigmoid colon). This is where the majority of polyps (none-cancerous growths) and lower bowel cancer start.

was taken to the local hospital. A urine drugs screen proved positive for amphetamines, methamphetamine (crystal meth) and benzodiazepines.

17.77 Whilst in hospital, Rose disclosed historical child abuse, allegedly perpetrated by John. The ward sister advised her to report the allegation. Police records note that whilst in hospital she claimed that John was abusing a neighbour's children, but she couldn't say anymore because John would kill her. She was discharged from hospital with a Crisis Team follow up.

17.78 Upon her discharge, Rose knocked the door of a random house. The occupant invited her in for a cup of tea. Rose said the Police were looking for her. After Rose had left, the occupant called the Police. Rose was seen at home by the Police where she denied making any allegations against John earlier that day.

17.79 Between May 2019 and the end of December 2019, there are numerous entries from SWFT regarding a general treatment and health issues for Rose including routine podiatry appointments and several Ambulance responses to Rose who was short of breath.

17.80 In January 2020, Rose was admitted to hospital for investigations into abdominal pain and suffering from anxiety, depression and suicidal ideations.

17.81 Whilst in hospital, on the 25th January 2020, John was allowed to stay with her. However, just after 10.00pm that day, the hospital called the Police as it was alleged that John had dragged Rose out of bed, and she had discharged herself. The hospital complained that John was verbally abusive towards staff. Due to operational demands, Police were unable to attend until 6.00am the following morning where they saw Rose at home. She said she wanted to leave hospital and that John hadn't dragged her anywhere. The hospital confirmed that she did not need to return for further treatment.

17.82 Throughout the remainder of January, February and March 2020, SWFT made a number of entries in relation to Rose and her appointments, and also being admitted to hospital for a urinary problem but being discharged the next day. One entry in February relates to John telling his GP that he was suffering from insomnia due to the stress of his wife.

17.83 Rose took an overdose on the 13th April 2020 after having a 'feeling in her head'. She took 50 paracetamol tablets. Rose was referred to the Acute Mental Health Assessment Team (AMHAT) who advised a referral to Adult Social Care as Rose had disclosed to staff that she and John had intended to overdose together, but it was only Rose who took the overdose.

17.84 The chronology details numerous appointments with either hospitals or GPs for Rose, but of interest, on the 26th June 2020, John called the GP saying he was anxious and worried that Rose had got cancer. He made the point of saying 'she did not want to take an overdose' on several occasions. Also contained in the GP records is a comment in July 2020 from Rose's Social Prescriber to the effect that Rose has had contact from her daughter who she has not seen for 40 years. Rose described the contact as being emotional but wonderful.

17.85 During July 2020, Rose showed she was depressed and anxious. The delay in her urology treatment was not helping and she sought support from the Crisis Team. She was concerned that she may have dementia.

17.86 On 23rd July 2020, Rose called an ambulance. She had severe abdominal pain and vomiting. The ambulance attended and it was determined that a move to hospital was not required. She did, however, quiz the ambulance crew on the symptoms of a number of aliments. John was present at the time and told the ambulance crew that

Rose shows a pattern of anxiety and concerns about her health in the evenings and the mornings. Rose was seen the following day by her GP and Rose stated that she 'wished she was not here' but said she would not act upon those thoughts. She described her dog and husband as her protective factors.

17.87 On 24th July 2020, Rose again called an ambulance complaining of vomiting and feeling no better. She was taken to hospital and admitted for investigation. She had urine retention. She was discharged on 27th July. Her condition was reviewed and there were no concerns raised, albeit Rose was found to be anxious and she was eager to be discharged.

17.88 On 30th July 2020, a telephone assessment of Rose's condition was conducted by CWPT Recovery Team. The nurse spoke to John who was tearful because Rose was so unwell. Rose said that she felt very unwell and she was waiting for the GP to call her back regarding the removal of her catheter due to recurrent bladder infections. She felt that she had lost the will to live but stressed that she had no plans to end her life. Both Rose and John agreed to contact services if they felt they needed support.

17.89 Later that same day, Rose called for an ambulance. She had shoulder pain and was anxious about antibiotics she was taking for her bladder infection. The ambulance crew discharged her into the care of her husband.

17.90 Rose called for an ambulance twice more over the following 6 days with stomach pain and suspected appendicitis. On the second occasion she was admitted to hospital for investigation. She was discharged the following day, 7th August 2020 after her catheter had been removed for a trial period.

17.91 Another Recovery Team Assessment was carried out on 13th August 2020. Both Rose and John declined the offer of a care package saying that they didn't want anybody to come to the house. John did however agree to a Carer's referral as he was getting older and having to care for Rose whilst supporting her with her physical and mental health problems.

17.92 Rose continued to have problems with her catheter and on 18th August 2020, an ambulance was called to Rose who, it was established, had a Urinary Tract Infection. She was admitted to hospital. She was treated and discharged later the same day. It was decided that Rose needed emotional support as she and John had many physical health worries and they were socially isolated. During the remainder of August 2020, there was significant contact with Rose due to her problems with her catheter.

17.93 John called the Central Booking Service (CBS) at CWPT on 2nd September 2020, and reported that he was unable to cope and he needed someone to talk to. He said that things had got too much for him and he didn't know what to do.

17.94 Later on 2nd September 2020, a triage nurse from Mental Health Services called the police saying that she had been speaking to John. He had said that he was going to kill both himself and also Rose if he 'couldn't find a way to solve this' problem. The nurse had tried to speak and take details from John for a referral and John had ended the call saying that he was being a pain. Rose could be heard in the background saying that they needed help.

17.95 Police and ambulance attended to their home. John said that he had been sitting at home for months on end and he was struggling. He said that he had no intention of harming himself or Rose. An Adult Risk Assessment was completed which was graded as Standard. No referrals were made. The ambulance staff considered that John was fine and they didn't have any concerns for his welfare and that John and Rose were

looking after each other. A referral was made to MIND[16]. MIND attempted to contact Rose and John but their phone was constantly engaged.

17.96 During the morning of 9th September 2020, John made a telephone self-referral to the CBS. Rose could be heard in the background saying that they could not cope. John said that that were in a very bad place and they could not see a way out of it. John needed someone to talk to as things were too much for both him and Rose. He said he didn't know what to do and that it would kill them if they were to be apart from each other and they needed to stay together. John said it was 'constant worry, torment, suffering and pain'. A referral was passed to a CBS Nurse to triage. It was clear that they were desperate.

17.97 By the afternoon of 9th September 2020, the Mental Health Team called the GP to report that Rose was screaming with abdominal pain and saying that they cannot cope. They were seen by the CRISIS Team and there were no mental health issues identified. A note says, 'seen already by CRISIS Team after husband threatened to kill her.'

17.98 Police records show that at 4.35.pm on 9th September 2020, John ran out of his house and handed a note to a passing workman. The note said, 'Please phone CRISIS 406741, Suicide about to happen. Do not phone. Knock the door'. The workman immediately called the police who attended as an emergency. The officers who attended concluded very quickly that there were significant concerns for both Rose and John as they were making preparations to end their lives. The officer asked for the Mental Health Triage car[17] to attend and for EDT (Emergency Duty Team – Adult Social Care) to be informed. The officer wanted advice and support as she had no power to take either Rose or John to hospital as both of them had capacity to make their own decisions. They were in their own home also. EDT decided to hold an urgent meeting the following day. The CPN in the triage car was content with that decision. The police officer present raised a Vulnerable Adult log for both Rose and John and an Adult Risk Assessment was graded as 'high'. The couple had made a double noose from rope and decking and attached it to a loft hatch. Both were acknowledged to have significant medical and mental health needs and that John was Rose's carer. However, her conditions were having a negative impact on his mental health.

17.99 On Thursday 10th September 2020, a Consultant Psychiatrist emailed the police demanding to know why John had not been arrested for attempting to murder his wife, Rose. The police replied that this was a safeguarding issue and no offences had been identified. The matter was considered by a Detective Chief Inspector who agreed with the decision made.

17.100 On the evening of 10th September 2020, a member from EDT who had dealt with the call the previous evening, spoke to a Detective and said that he had made an urgent safeguarding concern for Adult Social Care but could not see what had been done or if there was a plan. He had raised the issue with his supervisor and he asked the Detective to visit the home of the couple and to ask them what outcomes they would like to see. It was stressed that if they both had capacity then legal advice would need to be sought.

17.101 A Detective Officer went to the home address of the couple at 9.45pm that day and obtained an account of events from Rose. She explained that she had been asking for

[16] Mind is a mental health charity in England and Wales. Founded in 1946 as the National Association for Mental Health. Mind offers information and advice to people with mental health problems and lobbies government and local authorities on their behalf.

[17] Mental Health Triage Car – a police vehicle with a police officer and a qualified mental health worker (CPN) on board that responds to incident involving mental health issues.

help for months and she wanted to see a Social Worker. Her GP had 'put her on tablets'. She said that she wanted to die with the pain she was in and she had slept on the sofa for a year because she could not get comfortable in bed. She felt let down by St. Mary's Lodge[18] who did not help when she needed help. She said that whilst she and John had been together for too long, they could not live without each other. She reported that she had said to John, 'Can't you suffocate me?' He had said 'No' but then attempted to do so but couldn't go through with it. She explained that she no longer felt suicidal and that she was desperate for her operation to take place. She mentioned her brother who had recently taken his own life because he couldn't live without his wife. No more details are known about that.

17.102 Rose was asked about the nooses that had been found and she explained that they had done that while talking about her brother. She said that it was a silly idea and that they didn't mean anything by it. They had made them a couple of days before. They were afraid of dying and would not do it again. She was looking forward to having her colostomy bag removed, which was to be at the end of September and that they had a lot of living to do after that. She had been promised medication that would help with her pain.

17.103 The officer considered asking John to go to the police station to be interviewed about what he was said to have done, but the officer and the Senior Mental Health Practitioner present thought that would be detrimental to Rose's health. However, there is nothing recorded in CWPT records to indicate that the mental health practitioner advised that taking John to be interviewed would be detrimental to his mental health or that this would have an impact on both Rose and John.

17.104 On 11th September 2020, a Multi-agency Adult Safeguarding Strategy Meeting was held to consider the welfare of both John and Rose. The consensus was that the crisis had passed and that Rose was in a better place mentally with the operation to look forward to. It was decided that they would benefit from a Social Worker to arrange emotional support and this was to be actioned on the following Monday. A Safeguarding Enquiry (pursuant to Section 42 Care Act 2014) was opened by Adult Social Care. There being no Social Services provision over the weekend apart from EDT, police officers were tasked to carry out welfare checks over the period of 11th, 12th, 13th, and 17th September 2020. A Detective Chief Inspector had oversight of this arrangement and she was concerned that the couple needed some contact with agencies over the weekend. A trigger plan was created by the police and all calls to the address were deemed to be of an urgent nature. They were visited on four occasions over the weekend and found to be safe and well on each occasion.

17.105 The couple were visited by Adult Social Care on Tuesday 15th September 2020. Rose said that she felt better after the Crisis Team and Police intervention over the weekend adding that she didn't want to die and did not think that they would go through with it, meaning the suicide.

17.106 From 15th to 29th September 2020, the couple had contact on several occasions with Adult Social Care and their GP. Rose in particular appeared to be more positive, feeling better and less stressed. However, on 30th September 2020, Rose attended at a Day Surgery for Cystoscopy and a catheter insertion. She disclosed to staff that she wanted to die and that John does not want to live without her. She said that they had planned that John will strangle her and then take his own life. Ward staff contacted

18 St Mary's Lodge – a Psychiatric Outpatients Hospital

SWFT Safeguarding Team for advice which was that Adult Social Care and the family GP to be informed.

17.107 SWFT Records indicate that a referral was made to District Nurses from the local hospital for Rose to ensure that she was coping post her discharge from hospital.

17.108 On 5th October 2020, John contacted their GP and asked for Pregabalin pain relief for himself for ankle swelling and pain and also for Rose for her thigh pain.

17.109 Rose was seen again on 7th October 2020 by a Social Worker who reported that Rose was low in mood and having thoughts about ending her life, although she said that she had no intention of doing so. A DASH[19] form was completed which scored low and no need for a MARAC[20]. IAPT[21] was discussed with Rose but she declined that service.

17.110 Rose was supported with her catheter over the next few days and she was discharged from Cardiology care back to the care of her GP on 12th October 2020.

17.111 On 12th October 2020, Rose was spoken to by her Social Worker. She was not well mentally or physically. She asked for some support, but she was unsure what kind of support she wanted. She was advised to call her GP. The following day, still stressed and down, Rose was again offered the services of IAPT by her Social Worker, but again she declined. Over the next week Rose was supported with her catheter almost daily. On 18th October 2020, Rose called for an ambulance regarding her catheter which was leaking and she also reported bowel problems. She was taken to hospital and discharged later that same day.

17.112 On 20th October 2020, the family's GP and Rose's Social Worker spoke. They discussed the possibility of a Social Prescriber to look after Rose and the Social Worker indicated that there was no role for safeguarding and Adult Social Care. Adult Social Care had only been providing temporary support to Rose and were considering closing Rose's case.

17.113 On 21st October 2020, Adult Social Care held a peer group review meeting. Closing the case was again discussed. Rose had been assessed by the Older Persons Team as having no care and support needs. Again, IAPT was discussed but the meeting was told that Rose had declined that. Notes of the meeting state that both Rose and John were negative about their views about their lives and they both struggle to see any positives.

17.114 On 23rd October 2020, a District Nurse attended the family home. Rose was distressed and disclosed previous suicidal attempts. She was feeling depressed. The District Nurse suggested a referral to Mental Health Services but both Rose and John declined that suggestion. The District Nurse contacted Rose's GP. Both Rose and John consented to a referral being made to a Dietician and Continence Team.

17.115 On 26th October 2020, Rose was seen by her GP. She had been having panic attacks all over the weekend. The GP increased her medication and discussed Rose with a psychiatrist. John was also seen on the same day. He too was suffering panic attacks and he said that he couldn't cope with what his wife was going through. He explained that he wished 'they were both not here' and explained that he had tried to smother Rose in the past. The GP discussed the situation with the Crisis Team who would assess the situation. Adult Social Care reviewed the information and determined that Rose was not at immediate risk from John. Rose was assessed by NEOP[22] and

[19] DASH – **D**omestic **A**buse **S**talking and **H**arassment risk assessment form
[20] MARAC – **M**ulti **A**gency **R**isk **A**ssessment **C**onference
[21] IAPT – **I**mproving **A**ccess to **P**sychological **T**herapies
[22] NEOP – North Older People Team of Social Services (used to be North East People Team)

assessed as not having eligible needs for care and support. It was pointed out that Rose had declined IAPT support and John had declined support from the Carers Trust. However, it was recorded that an attempt would be made the following day to revisit the offers of support with both Rose and John.

17.116 On 27th October 2020, a Social Worker made a face-to-face visit to both Rose and John. Rose reported feeling anxious and not sleeping. She thought her GP had not been helpful. She became tearful and was wishing that she was dead and that she would therefore no longer be in pain. John said that he had spoken to his GP the previous day as well as the Mental Health Team and had 'lost his rag' with them. Rose requested to go into a 'unit' to stabilise her mental and physical health but she was told that there is no such unit available. It appeared that Rose was overwhelmed by physical health issues and pain. The Social Worker explained to Rose that her concerns were her physical and mental health and also explained the role of Adult Safeguarding Team. Accordingly, the Social Worker's advice was that Rose's case would be closed. Rose and John were again offered support from IAPT and Carers Trust and again they both declined. They were advised that they could contact Samaritans, the Crisis Team, Mind, Age UK and Mental Health Matters. They were left with contact numbers for all of these agencies.

17.117 During the morning of 28th October 2020, Adult Social Care contacted Rose and explained that her case was to be closed as there was no further role for the Safeguarding Team. It is noted that Rose appreciated that. At 2.50pm the same day, Rose called an ambulance. She was experiencing breathing difficulties and she was anxious and was concerned that she had an infection. On arrival of the ambulance crew, John became aggressive and at one point ordered them out of the house. The situation was calmed down and Rose was taken to hospital. She was admitted to a ward and diagnosed with Hyponatremia secondary to fluid intake, a collapsed lung and a respiratory tract infection.

17.118 During the early hours of 29th October 2020, Rose refused to allow ward staff to follow the procedures regarding controlled medication and at 11.04am it was noted that Rose had suicidal intent. Attempts were made to call a psychiatrist. An hour later, Rose was seen by a psychiatrist who considered that she may have low grade learning disability and a very poor understanding of her own illness and health and that she needed regular reassurances regarding her mental health and medical conditions. The psychiatrist prescribed an increase in her Pregabalin to help with her anxiety.

17.119 On 30th October 2020, Rose was discharged from hospital and a routine home visit by the District Nurse was arranged. There were no concerns noted and another home visit was arranged for 7 days' time.

17.120 Rose's Social Prescriber called at the home address to deliver medical supplies, as she had done so for many months. She let herself into the flat and found both Rose and John hanging from the loft hatch. Police and an ambulance attended. Both were pronounced dead at the scene. Several suicide notes were found addressed to family members and one was addressed to a Detective Officer who had visited them over the weekend in September. That note said 'Sorry Mark Detective. No drugs involved. Been 3 years. Numbers in phone are old ones. Just prescription 10 past 6'.

17.121 A police investigation commenced but no information could be gained from house-to-house enquiries and no information could be gained from relatives. A Post Morten examination was conducted on Rose and it was found that her hair had been tangled in the knot of the noose which may have indicated that she had not tied the knot herself. A Postmortem was also conducted on John. Both had died from hanging. H.M Coroner for Warwickshire held an inquest into their deaths and determined that both had taken their own lives by suicide and both had intended to do so.

18. Views of family and friends

18.1 Rose had a brother who is married. His wife made contact with the review author in October 2021 as a result of a letter sent in August 2021. Rose's sister-in-law explained Rose and John met in a pub and started going out and eventually married. She said that John was more into alcohol than Rose and he did use drugs. Rose was into drugs more than John. They used to get their drugs from friends they knew. The sister-in-law said that Rose had been married previously but her husband died after using drugs. Rose had two daughters. Both girls were removed from her after the death of her husband because of her drug use and she could not cope.

18.2 The sister-in-law would contact Rose and John on a regular basis to make sure they were OK. She said that Rose was a strange person. Rose was always immaculate, very particular about how she looked. The garden was always precise. Rose was devoted to John until she took drugs and then things changed between them. Rose would order John out of the house for days/weeks at a time and he would go and live in a park in a nearby town. John would frequent the Salvation Army place and food/ night shelters. When Rose felt better, she would allow him back home. John was also devoted to Rose, and he would do anything he could to please her. The sister-in-law recalls how Rose had her teeth removed because they were decayed. John felt sorry for her and had his teeth removed even though there was nothing wrong with them.

18.3 The sister-in-law said that Rose would often text her brother and say things like "people are moving my bins around" and ask him to go over and see her but he was too unwell himself.

18.4 The sister-in-law said that at 08.35, two days before Rose and John died, Rose texted her brother a message that said, 'I love you [Full name]'. It is clear to the sister-in-law that Rose knew what was about to happen. She said that from a young age Rose would tell her that she would die by committing suicide. Rose's brother and sister died by hanging many years ago.

18.5 According to the sister-in-law Rose and John could not live without each other but they were both disturbed people because of their drug use. They both rejected help. If one had been admitted to hospital and died the other one would have taken their own life.

18.6 Rose accused her own father of sexual abuse but according to John told the sister-in-law that did not happen – Rose made the accusation up.

18.7 The sister-in-law said that both Rose and John were volatile people. She said that she had witnessed Rose throw a chip pan of hot fat over John and on another occasion, she saw John try to push Rose's head into a fish tank because he was annoyed, she had been talking to someone else.

18.8 The sister-in-law said that Rose thought she had cancer and believed that she was dying from that illness. She is of the opinion that Rose knew what was happening and would have been going along with taking her own life.

18.9 John had two sisters and the Report Author made contact with them in February 2021. Both were willing to engage with the process and gave some history of the relationship between them and John but also between John and Rose.

18.10 The first sister spoken to said that John and Rose had been out of her life for many years. She went 10 years without seeing John and Rose when suddenly one day John appeared at her front door. The sister said she didn't recognize him until he spoke. They swapped phone numbers. John told the sister that he had been kicked out of his family home by Rose. The sister said that John had really changed.

18.11 The sister commented that when she and her sister cleaned the house out after the deaths, she was surprised there was no sign whatsoever of any alcohol or drugs other than prescribed medication. She knew that John was an alcoholic and had been for many years. She said that he had received treatment and he had been subject to reviews for his alcoholism every now and again.

18.12 The sister described how Rose phoned her on a couple of occasions saying she wanted to finish it all. John also said that he had had enough, and the sister told him not to be silly. She said that she thought that John had numerous issues in relation to his health and with Rose.

18.13 Rose used to throw John out of the house frequently and when the sister was cleaning the house out, she found two sleeping bags, one for winter use, and one for summer use. She is of the opinion that John 'got out of the way' and slept rough.

18.14 The sister describes that John thought the world of Rose who was very poorly, and Rose had said that the hospital couldn't do anything else and that she would not take any more medication. The sister thinks that she was psychotic and if Rose had been put somewhere (hospitalized), that both of them would still be alive.

18.15 The sister described John to be a funny man and always joking and doing stupid things to shock people but nonetheless he was controlled by Rose during the forty years they were together. She said that before John met Rose, he was her big brother and she looked up to him. She described him as being a 'smashing brother', but once together they took themselves away from the family. She said how she would visit and knock the front door knowing that the brother and his wife were in, but they pretended to be out and didn't answer the door. In their early relationship the sister described how they became very religious and were 'Bible bashers'. She didn't know which religion they followed. At that time, they lived in a flat in Coventry but moved to Warwick and she lost contact with her brother.

18.16 The sister is aware that Rose used illegal drugs years ago but didn't know if she continued until recent times or whether John participated in illegal drugs as well. She described how Rose had been married before she met John. Her first husband had died due to something to do with drugs. Rose had two girls by her first husband, but they were adopted at a very early age and the sister wasn't aware of this for many years.

18.17 The sister knew about John sleeping in parks and gardens. She is of the opinion that Rose had been mentally ill all of her married life and she thinks it might have been drug related. She described how she would see Rose on occasions and Rose would be totally happy but the next day she would be down and depressed. In cleaning out the house the sisters found masses of tobacco and cigarette papers.

18.18 The second sister was spoken to by the Report Author a few days later. She stated she had not had contact with John or Rose for years. There had been no fall out, but John and Rose had cut off the contact. She describes John and Rose as being reclusive and it wasn't until recently (shortly before their deaths) that this sister made contact and she realised how bad the situation with John and Rose was and how poorly Rose in particular had become. The sister knew that Rose had health problems.

18.19 She said that John and Rose had lived together for over 40 years. They got married without telling any of the family, they didn't want any contact with any family members and John didn't even attend the funerals of his mother and father.

18.20 Prior to meeting Rose, John really loved his parents and his granny. John's sister said that John and Rose thwarted any attempt of a family member to contact them even to the lengths of changing their telephone number if they thought a family member was

able to contact them. As far as the sister is aware Rose had no contact with her family either and the family consider that in hindsight both of them may have had mental health issues.

18.21 It is this sister's opinion that Rose was the instigator of what happened. She thinks that Rose kept John away from his family. She recalls the last time she had telephone contact with them and describes that both of them were in a very distressed state. John was talking about taking their own lives and the sister tried to talk him out of that. Rose was crying saying she couldn't take anymore. The sister desperately wanted to go to them to help but she had no access to a car and she lived many miles away. She described how she spoke at length to John and thought that she had talked him out of it. John described how he had tried to suffocate Rose but couldn't go through with it. The sister told John that he shouldn't think of doing such things and that Rose needs to get help. John said that he had tried to do that. John said that Rose had a bag for her bladder, she had COPD[23] and couldn't breathe properly. The sister told him that both of those illnesses were controllable. John said that he couldn't cope, and the sister told him that Rose needed help and John could not solve Rose's problems. He said that he would be locked up for murder if he went through with it. John told her that he had put a rope up in the loft and was going to do it. According to the sister, she told him to get help, she thought again that she had talked him out of it. All of this was a few weeks before the deaths.

18.22 The following day, the sister again called John and both he and Rose seemed to be different people, more positive. John said he was going to get help and sort things out and they were both feeling better. Both of them told the sister that they felt better after talking to her the previous day and the following day after that conversation, the sister received a big bunch of flowers from John and Rose. The sister thought that she had achieved something. For the next few days, the sister continued to contact them by phone and John seemed fine and he was arranging for help.

18.23 Both sisters continued to ring John and Rose but there was no contact. The sisters spoke together and said they would have to go to John's address, but it was too late.

18.24 The sister is of the opinion that what happened was planned. There were letters left for various people after their deaths. She sorted paperwork out at John's house and it appears that John and Rose had plenty of help from paramedics, hospitals, Police, etc. The sister is aware that Rose had a constant supply of medical equipment and medication and in clearing the house out after their death's she and her sister found dozens of unopened boxes of equipment stored in the disabled shower. She described hundreds of pounds worth of equipment in unopened boxes which the sisters returned to staff at a local chemist for destruction.

18.25 The sister believes that Rose had a drug problem and that John was involved with that. She is also aware that Rose would tell John to leave the house and he would have to go to the Salvation Army for a night shelter and even sleep on a park bench in local parks in Warwick. One of the letters that was left was addressed to the manager of the Salvation Army and another one was addressed to a man who used to use the night shelter that John went to. Both John and Rose were cremated without a service or anyone present and John left instructions for his ashes to be scattered in the park where he slept on a bench.

18.26 Mention has been made of John attending the local Salvation Army support charity. The Report Author sought the views of the manager of the Salvation Army project that John attended.

[23] COPD Chronic Obstructive Pulmonary Disease

18.27 The Manager said that she had worked at the Way Ahead Project for 6 years and had known John all of that time. John would attend the Project every 6 weeks or so. He would say that he knew when he had to get out of the house because Rose was psychotic and he could tell the signs when it was time for him to leave.

18.28 Some years ago John said that Rose had got up in the night, got a knife and stabbed John in his leg. She would just lose it. She had suffered from childhood abuse and trauma and would have psychotic episodes. When John would leave her, it would be for a few weeks, and he would attend the Project or go to Helping Hands or the Soup Kitchen for food and shelter. He would also sleep rough in the park and Gardens. However, every day he was away from home he would go to the Project and use the phone there to ring Rose to make sure she was alright. If she didn't answer he would worry about her until he could speak to her. He adored her and would do anything for her. Sometimes he would go home to make sure she was OK and shout through the letter box to her. She would not let him in and he used to go back to the Project. On other occasions Rose would phone the Project asking if John was OK. She would speak to the manager who never met Rose but spoke to her. Once that happened the Manager would know it was time for John to go home and it was safe for him to do so.

18.29 The last time the Manager saw John was in March 2020 before the lockdown. She didn't hear from him all through the summer but in October she was told that someone had seen him in Warwick on a mobility scooter and she thought he had been given new transport.

18.30 The Manager asked John if he was getting better and he replied that he was not getting out much lately, but he knew just when to leave. On the whole he was getting better. The Manager said that both John and Rose took up using the drug Speed. John didn't want Rose to use it because he knew what it did to her. It made her psychotic. She said that if Rose took Speed, John would be out of the house by the weekend because she was acting so badly.

18.31 The Manager confirmed that John adored his wife and continually worried about her. While he was on the streets, John used to drink heavily but he didn't drink while he was at home. He used to say that when she kicked him out, he was free. The Manager didn't think that Rose drank alcohol, she used Speed and had her prescribed drugs. When asked if she thought that Rose was ever violent towards John the Manager said she never had those concerns. Even when John was OK living at home with Rose, he used to attend the Project to collect food vouchers.

18.32 The Manager knew John was very popular with staff and clients at the Project. He had lots of friends.

18.33 John left letters addressed to the Manager and to a friend, another Project user. The letter to the Manager talked about being sorry and thanked her for the years of support she had given him. He asked her to ensure that he and Rose and the dog Lilley should have their ashes scattered together. (Apparently Lilley had died some time ago and John and Rose had Lilley's ashes at home ready to be scattered.) He asked her to make sure he and Rose were cremated. He ended the letter 'Love You'.

18.34 John used to say that Rose was so tortured in her mind and she would not get better. The Manager said that she used to talk to John about him getting his own place, not leaving Rose, but his own place where he could go when he was thrown out by Rose. John would say that he didn't want to do that as it would mean interfering with the benefit money for Rose and she would lose money. The Manager said that she knew he would never leave Rose. The Manager thinks that the situation was that Rose had had enough and John could not live without her, and it was a joint decision. The

manager was aware that there was a note on the front door telling the lady who takes the medication to Rose to call the police and not to go in.

18.35 Another friend of John that the Author spoke to was the Manager of a charity 'Helping Hands'. He worked in the shop at Helping Hands Charity and had known John for 4 years. John used to come into the shop for food and use the soup kitchen when his wife had thrown him out onto the streets. The Manager was aware that John's wife was ill, physically and mentally and used to have bouts of anger.

18.36 John used to sleep rough. He had sleeping bags from the charity and he used to use local night shelters as well. He knew that John loved his wife but there were problems between them. He described how John was on painkillers because he had a leg and back injury which meant that he sometimes couldn't walk and had to be helped along. When he was on the streets John was a heavy alcohol drinker, but everyone liked him very much. He was very popular with other charity users. John was always happy, especially when he had taken a drink. His wife would 'blow her top' and be violent towards him at times. His wife could be very nice and then flip and John couldn't take it and that is when he used to leave and go on the streets.

18.37 The Manager had spoken to Rose briefly on a couple of occasions although he had never met her. She would phone the center and see if John was OK and would leave a message to tell John that he could go home now. The Manager describes John as being a very nice man, who spread joy to everyone around him and he will be sadly missed.

18.38 Rose had considerable contact with a local Pharmacist and a Social Prescriber. In order to understand their relationship with Rose the author spoke to both of these people who were very helpful.

18.39 The Social Prescriber explained that a Social Prescriber was someone, who is not medically trained and supports other health professionals to improve the health and well-being of patients with non-medical issues, such as loneliness, mood problems and financial problems, all of which can have a negative impact on a person's health.

18.40 Rose was referred as a patient who struggled with multiple complex needs, but a Social Prescriber would look at the holistic view of her situation which naturally included John. The Social Prescriber had been with Rose for some time before the first lockdown, visiting her regularly every 7 – 10 days but lockdown stopped that. During the summer of 2020 Rose had some medical intervention which stopped the Social Prescriber going/contacting her so regularly. Rose was aware that her health deteriorated during the summer of 2020.

18.41 Rose never spoke about her relationship with John and she used to focus on her pain and being so unwell all of the time. Her pain was caused by abdomen problems. The Social Prescriber would try to lighten her mood and to focus on the lighter, better things in life. Rose had an operation some time ago that didn't work very well, and she also had E. coli. She would say that she couldn't eat or drink. The Social Prescriber believed that years ago Rose and John used drugs.

18.42 The Social Prescriber said that John was a 'very, very nice man'. He was engaging and always attentive towards Rose. She describes a sort of co-dependency between them and, once the conversations got off the topic of Rose's pain, they were both nice people.

18.43 She said that Rose was a controller. John would never do anything to upset or displease her. If she was unwell and unable to get into bed she would sleep on the floor in the lounge and John would sleep next to her on the floor to be with her and look after her. He cared for her totally, but she said that Rose could be manipulative.

The Social Prescriber had no idea that John would be told to leave the house and go sleeping in the park or that he frequented soup kitchens or homeless shelters. Both of them idolized their dog.

18.44 Rose did not understand her complex health issues. John would speak to the Social Prescriber on the phone saying that he had been scared to go to sleep at night and that Rose was now asleep on the settee during the day. The Social Prescriber said that neither of them could cope without the other and she thinks they arrived at the conclusion that there was no alternative but to do what they did.

18.45 The Pharmacist had the following comments to make. He said that he had known both John and Rose since 2008 in a professional capacity. In his opinion, Rose was a recluse. She got John to do all the running about, but she would readily call the Pharmacy if there was something wrong with her medication or if there was something missing from her prescription. He said that he thought Rose knew the importance of taking her medication.

18.46 The Pharmacist said that he thought that John was a lovely man who thought the world of his wife and he would do anything for her. He took a lot of pressure from Rose, and he would carry the weight of running their lives. John would sometimes confide in the Pharmacist that he would sleep rough, which John saw as his own coping mechanism to deal with his wife. He would make sacrifices in order to help her. He lived for his wife. The Pharmacist, however, didn't think that John meant he was sleeping on park benches, rather he thought John meant sofa surfing. The Pharmacist was upset when he was told what John had been doing and felt that he should have done more for him. He said that Rose had both mental and physical health issues and thought that perhaps her physical condition overshadowed her mental health problems. He said that he spoke to their GP after the deaths.

18.47 The Pharmacist said that initially when he first met them, he thought that John was the controller because he would always collect prescriptions for his wife, but it was the Social Prescriber that told him that it was the other way round. The Social Prescriber knew them both better than the Pharmacist did.

18.48 On 10th June 2021, friends of John from the Salvation Army and a Night Shelter were invited to attend a virtual panel meeting. They described how John was a private person but on one occasion years ago, he started to talk about Rose and her medication, her being what he described as a schizophrenic person and how Rose would throw him onto the street when she was having 'one of her 'episodes'. They described how Rose stabbed John in the leg one night for an unknown reason. They said that John would go to the Salvation Army every 3 months or so when Rose had 'kicked him out'. While he was away from home, John would telephone Rose every day to ensure that she and the dog were well and OK. John would sleep in a park with another homeless man.

18.49 The friends had discussed with John the idea of him getting somewhere else to live when Rose told him to leave but he would not hear of it saying any such move would affect Rose' benefits. They were aware of the episodes of verbal aggression from Rose towards John, but John remained devoted to Rose and would do anything for her and once he was given the 'all clear' to go home he would get home as soon as he could to see Rose and the dog.

18.50 The friends described how John kept the garden in a pristine condition because he knew that made Rose happy. They described how Rose was in constant chronic pain and she would take amphetamine tablets with her prescribed medication to ease the pain.

18.51 The last time the friends saw John was during the winter of 2019. He had lost weight and was stooped because of back pain, but he was not interested in seeking medical help.

18.52 Later on 10th June 2021, another virtual panel meeting was held to which the sisters of John attended. They described how John changed from being a happy-go-lucky person to a much more private person when he met Rose. John didn't want any contact with his sisters and moved from where they all lived. They last spoke to John in September 2020, when he told them how ill Rose was and that neither he nor she could cope any more. He said that things were bad at home and they needed help. This shocked the sisters. They described how Rose took an overdose and had been taken to hospital. They believed that Rose had a big drug problem and they found masses of prescription drugs with Rose's name on after their deaths. They did not find any drugs with John's name on the box.

18.53 The sisters described how Rose and John met. They both lived in the same block of flats and they got together and got married. None of the family knew anything about the marriage, not even John's parents.

18.55 John was a mechanic before he married. He used to drink but he did not use drugs. Once he was married, he changed completely. The sisters did not realise how often he went to the Salvation Army for respite. One sister described how John appeared at her front door one day after years of not seeing him. He was unshaven with long hair. He used her bathroom and when he came downstairs, she described him as being a different person, chatty and pleasant. She later found white powder in her bathroom.

19. Analysis and recommendations

19.1 This review concerns the suicide of an elderly couple who were found hanged in their home. The initial Police enquiry considered whether both John and Rose had either taken their lives simultaneously, or one of them had assisted the other in their death and then taken their own life. This hypothesis was based on the apparent immobility of Rose and whether or not she would have been able to step onto a small set of steps in order to end her life. After an investigation, the Police were unable to conclude that any criminal act had taken place. The matter was referred to H.M. Coroner for Warwickshire.

19.2 There is a suggestion that Rose was a controlling influence on John and this review examined all of the information obtained from agencies, family, friends and colleagues to ascertain if the controlling behaviour by Rose on John met the definition of coercive and controlling behaviour as described by The Serious Crimes Act 2015.

19.3 That Act requires evidence of person (A) repeatedly and continuously engaging in behaviour towards another person (B) that is controlling and coercive and that that behaviour has a serious effect on (B). It is also required that (A) knows or ought to know that the behaviour will seriously affect (B). It is considered that the serious effect on (B) would cause (B) to fear, on at least two occasions, that violence would be used towards (B), and it causes (B) serious alarm or distress which has a substantial adverse effect on (B)'s day to day activities. (A) and (B) must be personally connected, i.e., in an intimate personal relationship.

19.4 There is no doubt that some if not all of this definition could pertain to the relationship between Rose and John, but it has to be considered at the same time that it was known that Rose had significant physical and mental health conditions to which her drug abuse exacerbated the situation between them.

19.5 There are numerous occasions described by friends and colleagues when Rose instructed John to leave the house or when John decided himself that it would be best

to leave. Evidence from staff at the Salvation Army Centre, the day centre, and other charitable organisations describe how John would say he had been 'kicked out' or that he had left temporarily of his own accord because Rose was unwell at a particular time.

19.6 It is also clear however, that John loved Rose and would do anything in her interests to look after her and he cared for her in the best way that he could. This often involved leaving the household when she was in a particularly depressed state. Leaving gave her space and time to recover and when she felt right, she would make a phone call to one of the centres and ask for him to come home.

19.7 Despite the definition as outlined in the Serious Crimes Act 2015, it could be argued that whilst Rose's behaviour caused John some distress and affected his lifestyle, her controlling behaviour would not have met the threshold required for the Serious Crimes Act 2015 offence as her actions may well have been affected by her drug use and her mental health issues.

19.8 There is no doubt that Rose had serious medical and mental health problems. She had been receiving hospital treatment for a variety of serious illnesses for some time. She had constant problems with her COPD urology conditions that often caused UTI's[24], incontinence and diabetes. She was also documented as having hepatitis C. She had been prescribed considerable medication for all of her illnesses. After her death family members discovered a vast amount of unopened boxes of that medication. Rose was on a waiting list for a long time for an operation on her bladder and she was in constant pain for which she tried to control by the use of illegal drugs.

19.9 The integrated chronology for this review amounts to over 160 pages, much of which refers to Rose's medical conditions and treatment but there is evidence on several occasions that when she was in hospital, she disclosed her inability to tolerate her medical conditions and that she was considering taking her own life. In September 2020, after being admitted to Hospital for an elective cystoscopy and a catheter insertion under general anaesthetic, she told a member of staff that she did not wish to live anymore and that she and her husband had decided on a suicide pact. Rose explained that if she died John would not be able to live without her. Whilst this conversation was quite rightly reported to SWFT Safeguarding Team, it was considered that domestic abuse was not a factor in their relationship. The same conclusion was arrived at by community staff who worked with Rose from June 2019 until her death and neither Rose nor John were considered a victim or perpetrator of domestic abuse. What is evident throughout, is their devotion to each other despite numerous periods when John left the house or was ordered to leave in the best interests of peace and space for Rose.

19.10 As a warning, Safer Later Lives[25] states:

> 'As a consequence of so few older victims accessing domestic abuse services, professionals tend to believe that domestic abuse does not occur amongst older people. …….. These assumptions may encourage health professionals to link injuries, confusion or depression to age related concerns rather than domestic abuse.

19.11 In April 2020, Rose admitted to hospital staff that she had taken 50 paracetamols in an attempt to overdose and that John was supposed to do the same but didn't. She was referred to and seen by AMHAT[26] and referred to Adult Social Care.

[24] UTI Urinary Tract Infection

[25] Safer Later Lives: Older People and Domestic Abuse Safer Lives October 2016

[26] Acute Mental Health Adult Team

19.12 There was a lack of professional curiosity shown among some health professionals and practitioners. Disclosures were made by Rose that she wished to end her life, that John was supposed to join with her taking overdoses but did not go through with it, and that John had tried to suffocate her at Rosey's instigation, but again did not go through with it. These incidents did not always result in positive action being taken such as referrals being made, consideration of domestic abuse being present in their relationship and consideration of an escalation to MARAC.

19.13 Professional Curiosity is an essential element required when disclosures are made of a concerning nature.

Recommendation No. 1.

The Clinical Commissioning Group to provide assurance and evidence to the South Warwickshire Community Safety Partnership that the training for all staff includes professional curiosity and holistic and person-centred assessment, to ensure that in such circumstances in the future, robust and immediate action will be taken to safeguard vulnerable individuals.

19.14 In September 2020, Rose reported to a member of hospital staff that she wanted to die and both she and John were going to hang themselves. This was referred to SWFT Safeguarding Team. Such information once received is expected to be shared with other professionals, for instance, the GP and community services (Health and Social Care), however on this occasion this information was not shared and therefore not available for community staff to see. The SWFT IMR identifies this issue as a need for further training that would assist staff in understanding the significance of high-risk disclosures such as this.

19.15 On several occasions during her visits to hospital, routine enquiry questions were asked of Rose as to whether there was any domestic abuse in her life. She always denied that there was and confirmed that she felt safe at home. It can also be said that there is little evidence of John disclosing physical abuse towards him from Rose.

19.16 South Warwickshire Domestic Homicide Review DHRW06, stresses the importance of each agency being confident that contacts are viewed as an opportunity to apply the best practice of "routine enquiry" into the possibilities of domestic abuse. The Safer Warwickshire Partnership Domestic Violence Strategic Review[27] embeds Routine Enquiry across partner agencies with the following recommendation:

> 'Ensure routine enquiry into DA history is built into standard practice within public sector and publicly funded organisations, with clear referral pathways into support services identified and utilised'

19.17 The Warwickshire Domestic Abuse Needs Assessment, published on 28th October 2021 made the following recommendation which has been endorsed by Warwickshire's Violence Against Women and Girls Board.

- Warwickshire Safeguarding Board to confirm what their expectations are in relation to training requirements of key agencies and roles on domestic abuse and risk assessment and safety planning.

[27] Safer Warwickshire Partnership Domestic Violence Strategic Review 2020 Joanne Sharpen AVA (Against Violence and Abuse)

19.18 All statutory agencies to review their current training offer on domestic abuse for staff and determine whether it meets their current and future needs

Recommendation No. 2.

The Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust to reassure the South Warwickshire Community Safety Partnership that the recommendation of the Warwickshire's Violence Against Women and Girls Board that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Social Prescriber, chronic pain and medication

19.19 Rose's support was a short-term care package, but there was recognition of the need for some form of on-going support, hence a Social Prescriber was arranged for her. Social Prescribers have an important role in the health care system, but in this case, it appeared that Rose's Social Prescriber was the sole individual making house visits to both Rose and John. The delivery of medicines and equipment is important but Social Prescribers are not trained or alert to the need to ask and observe signs regarding non-compliance with medication and therefore would be unaware of stockpiling particularly when pain and or mental health medication is involved. (It is known that the family members recovered a significant stockpile of unused medication from the home after the death of Rose and John).

19.20 Social prescribing complements other approaches, such as active signposting. This is a 'light touch' approach where existing staff in local agencies provide information to signpost people to services, using local knowledge and resource directories'[28]

19.21 Rose suffered from chronic pain for a long time caused by a combination of her numerous medical conditions. It is known that chronic pain is a significant risk factor for death by suicide. NICE[29] published guidance[30] for assessing and managing chronic primary and chronic secondary pain in people over 16 years of age in April 2021.

19.22 Rose had a complex medical history and there are 33 references throughout this report to her pain, many linked to different ailments and many acute rather than chronic. There is also reference to her self-management of her pain and it is clear that compliance with her medication was on her own terms, using prescribed and illegal medication.

19.23 Better oversight of her medication from health agencies may have helped professionals understand her physical challenges separately from her mental health ones. This is acknowledged with the development of the MARAM mentioned below. Good practice would have been for the GP surgery to have discussed and proactively managed them as part of their Multi Discipline Team meetings, which they now recognise and this has now been implemented for complex individuals, again mentioned below.

[28] NHS Social Prescribing www.england.nhs.uk/personalisedcare/social-prescribing

[29] National Institute for Clinical Excellence

[30] Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain NICE guideline [NG193] Published: 07 April 2021 and Guidance on Neuropathic Pain Sept 2020.

Recommendation No 3

The Clinical Commissioning Group and acute providers in Coventry and Warwickshire to give assurance to the South Warwickshire Community Safety Partnership that the NICE Guidance of 2020 and 2021 regarding the management of primary and secondary chronic pain and Neuropathic pain is being adhered to locally and that any learning from this Domestic Homicide Review is shared throughawareness raising and training.

19.24 The Review Panel requested that enquiries be made with CCG Pharmacy colleagues as to whether the assorted medication prescribed to Rose and to John could have impacted on their actions and the outcome of their lives. The opinion was that the prescribed medication could not be identified as an obvious cause for their actions.

Warwickshire Police

19.25 Warwickshire Police has records dating back to 2008 in relation to Rose, mainly with regards to the Police being called to incidents involving Rose's mental health problems. In total, Warwickshire police dealt with 48 incidents involving Rose, John or both of them together.

19.26 It is worthy of specific mention that officers carried out welfare checks for both Rose and John in the week after the threat of suicide on the 9th September 2020. This was at a time when no other services from any agencies were available over the weekend period. There were also Police visits one evening during the period when a detective officer called at their house for a general chat to ensure they were safe.

19.27 During their dealings with Rose in particular, officers rightly made referrals to other agencies when they felt it was necessary, and on at least 20 occasions, incidents were referred to Mental Health Services by the Police Harm Assessment Unit. There were no incidents of domestic abuse reported to the Police and from the dealings that the Police had with Rose and John, neither of them considered themselves to be the victim of domestic abuse, notwithstanding Rose reporting that John did not allow her to talk to neighbours or use her mobility scooter.

19.28 Warwickshire Police has policies and procedures to deal with concerns and safeguarding for domestic abuse, all of which are available on the Forces intranet system. Information can be found regarding domestic violence, coercive and controlling behaviour, stalking, female genital mutilation, forced marriages, and honour-based abuse. Officers are well versed in the process around, and the submission of, DASH risk assessments and channels that can be taken to ensure the DASH process is implemented. The Force has dedicated domestic abuse units with properly trained, dedicated Police Officers.

19.29 In order to reduce the drain on reactive resources caused by the demand regarding people in mental health crisis, Warwickshire Police has created Mental Health Triage Teams which consists of two officers and a mental health nurse who would receive training in response to people with mental health issues. Having the nurse on board gives access to the necessary NHS records. This team is deployed to deal with any incident that may involve mental health issues. Since its inception, there has been an improvement in the appropriate use of Mental Health Act legislation.

19.30 The proposed concept of MARAM (Multi Agency Risk Assessment Meeting), is to assess the risk of vulnerable persons (over the age of 18) and to ensure there is a safety net in place to provide and offer support where necessary.

19.31 The persons concerned may not be accepting of help and the threshold for services has not been met. It will be a two-tier system with the majority of the work being dealt

with by the operational tier and a forum to agree and monitor actions set in a multi-agency environment which has the support of the majority of agencies.

19.32 Further information on MARAM will be forthcoming but clearly it is something that would have been of great benefit with a number of recent cases including this one.

19.33 Warwickshire Police IMR make five internal recommendations which include:

- The continued use of the Mental Health Triage Team
- The creation of the Adults at Risk Team who will manage risk using Problem Solving Plans
- To agree terms of reference/protocol between the Police and other agencies to ensure the most appropriate agency responds in a timely manner to calls for services.
- To create a clear indication of what is required of the Safer Neighbourhood Team Officers by either tagging or the use of the Storm Log (command control system)
- To ensure that 'adults at risk' or 'vulnerable adults' tool kits are readily available on the Force intranet system.

Coventry and Warwickshire Clinical Commissioning Group

19.34 The CCG IMR indicates that they had significant contacts with Rose during the period of the scope of this review which amounts to in the region of 700 consultations between 2011 and 2020.

19.35 Whilst John was also known to the CCG, the number of contacts with him was considerably less.

19.36 The physical health of Rose deteriorated in 2010 when John became her main carer. It is noted in patient records that the situation at home was volatile sometimes and she was known to take illegal substances. The couple were supported by mental health services over a period of many years, and it was known to the CCG that Rose ordered John to leave home for periods of time. Records indicated that she had expressed her wish to die and there are several entries about Rose being armed with knives in and around her house. Records also indicate that Rose had significant problem with urine infections which resulted in her being fitted with a catheter. Records indicated that her GP arranged for a Social Prescriber to support Rose. Rose also had contact with the Crisis Team. There is mention that Rose became concerned that she had dementia although there was no formal diagnoses.

19.37 It was Rose's abdominal and catheter problems that was the cause of most of the ambulance turn outs and the engagement with her GP and hospitals.

19.38 Throughout August and September 2020, John disclosed to his GP that he was 'at the end of his tether' and couldn't cope with his wife who wasn't sleeping and she was having suicidal ideations. He had sought assistance from the Crisis Team.

19.39 A note in September 2020 indicates that when John disclosed he was struggling, the Crisis Team had contacted the GP asking for more help from Health and the GP's note states that the Crisis Team considered there was no mental health issue and John and Rose had already been seen by the Crisis Team after an incident where John had threatened to kill Rose.

19.40 The CCG IMR indicates numerous lessons that have been learnt from this case which include:

- Both John and Rose had significant difficulties in their earlier years including abuse and drug dependence and Rose's diagnoses of psychosis may have impacted on their resilience and ability to cope with their deteriorating health. This was evidenced by increasing contact with many agencies.
- Whilst there were red flag warnings, i.e., previous overdoses (Rose) and suffocation attempts (John on Rose), they also demonstrated improving mental health on occasions which indicated a chaotic, erratic and changing picture.
- The GP practice was very responsive to the needs of both.
- On at least two occasions, the couple were in telephone contact with different GPs at the same time and it is not evident whether the practice was aware of this and took a joint management approach.
- There is no evidence of routine enquiry in relation to domestic abuse raised by the GPs.
- It is not clear how a decision was reached by Social Services that there were no safeguarding concerns.
- Rose's medication was changed by Rose and John without the GP being consulted.
- The lack of oversight of their care and medicine use may have affected the mental health of either or both Rose and John.
- On occasions, Rose was unwilling to accept help which may have improved her mental health/social support.
- The impact of the Covid pandemic restricting the number of face-to-face contacts contributed to a lack of oversight, possibly making them feel isolated.
- No one agency had clear oversight and took the lead to manage their complex situation.
- Despite so many agencies being involved, the interventions used did not keep them both safe and the degree of risk was underestimated.
- The availability of respite requested by Rose a week before their deaths may have been a timely intervention.

19.41 Primary Care internal recommendations:

- Review how vulnerable adults are identified and flagged within the practice.
- Review how processes for information sharing within the practice contributes to the ongoing management and timely referrals of vulnerable adults.
- Review processes for flagging patients with known previous drug dependencies and/or multiple medications.
- Review how escalations in number of patient attendances are picked up.
- Plan an update of Domestic Abuse Training for all staff using case study examples to embed routine enquiry into clinical practice.

Coventry and Warwickshire Partnership Trust

19.42 Coventry and Warwickshire Partnership Trust had known Rose since she was 15 years of age and that she had a significant long history of mental health problems. She also had a diagnosis of drug induced psychosis and paranoia. She was treated for a long

time for depression and had significant urinary problems which resulted in a catheter being fitted. This caused extensive health problems.

19.43 Rose had a long history of poor compliance of her medication and there is a suggestion that she would empty her medication capsules and fill them with amphetamine.

19.44 Records indicate that Rose sought support from the mental health Crisis Team when other appropriate support had been offered but decline. She was also referred to CRUSE bereavement support and domestic abuse services, Recovery Partnership, Mental Health Matters, Samaritans, and a variety of psychological support but Rose declined all of these offers preferring to rely on the mental health Crisis Team. It is noted in CWPT records that their life was sometimes in turmoil and John would leave at Rose's insistence. This was usually at a time when her mental health was deteriorating.

19.45 On one occasion in January 2020, during a telephone conversation with Rose and the Crisis Team, she disclosed physical and mental health problems and John could be heard in the background shouting 'just put the f*** down, I've had enough of these f***s'.

19.46 Despite disclosures and insinuation from both Rose and John of abusive behaviours from each other, their relationship was observed to be loving and supportive and there is evidence that John appeared to be very caring towards Rose, particularly in the last months leading to their deaths. The CWPT author is of the opinion that both Rose and John appear to have normalised these behaviours as they had been going for several years and were further complicated by Rose's use of illicit drugs and fluctuating mental health.

19.47 A DASH risk assessment form had not been introduced to CWPT before 2014 so none of the disclosures between 2011 and 2014 were assessed in that manner. There is evidence however, that Rose was offered information and telephone numbers to domestic abuse services, but she declined these always stating she would rather contact mental health Crisis Team. The risks to John from Rose were noted but these risks were not considered in the context of domestic abuse. Disclosures made after 2014 should have considered the use of a DASH form, but as domestic abuse was not considered within the context of their behaviour, this did not happen. However, identified risk factors were shared between CWPT professionals by a multi-disciplinary meeting and entering them on the Trust's electronic system. Externally, information was shared with other agencies such as the GP, Police, Ambulance Service, and Local Authority services.

19.48 From the review of this case, CWPT has put the following learning in place:

- CWPT now provide four-hour level 3 domestic abuse training modules for front line staff which includes the use of the DASH risk assessment form. All front-line staff are still receiving training at level 2 or 3 on domestic abuse and adult/child safeguarding.
- CWPT have worked with SWFT to deliver a level 3 safeguarding training package – Domestic Abuse and Older people.

19.49 The CWPT IMR makes one formal agency recommendation:

- CWPT level 3 domestic abuse/DASH training to be amended to include guidance for staff on managing disclosures made when an individual is unwell, ensuring that disclosures are revisited when the patient has improved. Staff to ensure that the needs of the other members of the household are also taken into consideration and appropriate support is offered.

South Warwickshire NHS Foundation Trust (SWFT)

19.50 Rose was known to SWFT in both the community and at Warwick hospital. During the scope of this review she had been under the care of Oral and Facial Services, Respiratory for Chronic Obstructive Pulmonary Disease (COPD), Cardiology for Single Vessel Coronary Disease, Obstetrics and Gynaecology for investigation, Urology for recurrent urinary tract infections (UTI's), Colorectal Services for investigations, outpatient parenteral antibiotics therapy team (OPAT) services for administering intravenous anti biotics, placed based team (Community nurse) for support with catheter care, Continence for support with incontinence and equipment, podiatry for foot associated with diagnosed type 2 diabetes, and dieticians for support with weight loss. She is also documented as having hepatitis C.

19.51 As in the CWPT IMR, records indicate that staff describe John and Rose as being devoted and besotted with each other and had openly stated that they could not live without one another. Rose was described as the more dominant of the two and John would do anything to make her happy and agree with everything she says. His focus was to support Rose's health needs.

19.52 Rose reported to different members of staff on separate occasions that she had been poisoned and that John had previously tried to strangle her. These allegations were discussed with her when she was not under the influence of illicit drugs and she retracted the allegations. Rose often stated that she did not wish to live and made suicide attempts which she attributed to her health problems and never to domestic abuse.

19.53 In September 2020, Rose stated to hospital staff that she did not wish to live anymore and that her and her husband had a suicide pact. This conversation was referred to SWFT Safeguarding Team. It is the accepted process to share such information with other professionals, for example, GPs, Community Services, Health and Social Care, but in this case, information was not passed to the community staff because the relevant form containing the details of the disclosure had not been uploaded onto the requisite system. This has been identified as a learning point and suggested that further training be implemented regarding the sharing of information and risk management.

19.54 The SWFT IMR indicates that a suitable environment existed when Rose was an inpatient, an outpatient or being treated in the community which enabled her to express her wishes and views and it would appear that Rose felt comfortable and safe doing so. It appears that as part of assessments in the community both Rose's physical needs and her mental health were assessed taking a holistic approach to patient care which takes into consideration health, care and support needs.

19.55 It is also evident SWFT staff appear to view Rose and John not as perpetrators or victims of abuse but as vulnerable individuals due to their circumstances.

19.56 SWFT IMR indicates that staff recognised any risks and escalated them appropriately but describes the lack of confidence to act autonomously as practitioners regarding the completion of a DASH risk assessment and referring to MARAC. To remedy this, SWFT from the 1st April 2021 have introduced mandatory DASH training and there is now a Named Nurse for Domestic Abuse and in addition to DASH training there is Domestic Abuse in Older Adults training.

19.57 The IMR makes two formal recommendations for SWFT:

- Review and inform staff of the process for Safeguarding advice forms

- A process for ensuring additional notes/risks are incorporated with original patient's admission notes for day surgery.

Warwick District Council

19.58 Warwick District Council returned the IMR indicating that there were 312 pages of records regarding housing benefit and council tax between 2010 and 2020 concerning Rose and John. There were a significant number of letters to and from the council to the couple, the vast majority concerning applications for alternative accommodation, housing benefit, council tax benefit and each application touched on the medical and mental health conditions of Rose and John's own health issues. There is nothing to indicate that anything other than the correct policy and procedures were adopted.

19.59 Whilst the IMR indicates that the case has not led to any specific learning, it reinforces the view that the Council are suitably equipped to deal with safeguarding concerns and refers to a specific safeguarding policy which is in force and applies to all Council staff, members, volunteers and contractors employed by the Council. The IMR confirms that all staff are now trained in relation to safeguarding which is conducted for the Council by a specialist training company.

West Midlands Ambulance Service

19.60 The IMR confirms that all policies, procedures and guidance tools were followed correctly by attending clinicians throughout their contact with Rose and John. WMAS have a clear and robust domestic abuse guidance document in place which is accessible to all staff alongside a single point of contact referral line.

19.61 WMAS contend there is no immediate learning from this review but stresses the replacement of level 3 safeguarding training for all paramedics commenced again in April 2021. This includes a section on elder domestic abuse and professional curiosity.

Warwickshire County Council Adult Social Care.

19.62 Adult Social Care were advised in May 2013 of a meeting between Rose and CWPT. She had been referred to an Independent Advocate for support regarding accommodation as she was struggling. There was no risk identified during the visit and Adult Social Care Safeguarding Team was advised of this meeting.

19.63 In June 2014, a member of staff from [2]gether contacted the Crisis Team. It was reported that Rose had alleged that John had been trying to get access to her flat and had hit her in the face. Adult Social Service Safeguarding Team was informed.

19.64 Adult Social Care became involved again with Rose and John in September 2020, as a result of the incident when a member of the public had been passed a 'suicide note' by John saying that, while he was not wishing to kill himself, he was at the end of his tether looking after Rose. It was subsequently discovered that there were two pieces of rope hanging from a loft hatch in their house. John later disclosed that he had tried to smother Rose with a pillow at her request and when that had been unsuccessful, the following day he had tried again this time with cling film wrapped around the pillow.

19.65 Warwickshire County Council support a multi-agency Suicide Prevention and Partnership. The focus of the Suicide Prevention Partnership is on wider population-level interventions to help reduce deaths by suicide rather than referrals for specific individuals. The Partnership advice to Adult Social Care in circumstances where they

become involved with those who take their own life by suicide or are at risk of suicide is to make an urgent referral into CWPT Access Hub or of course, call 999.

19.66 With regard to such circumstances the Partnership suggests that Ault Social Care staff are aware of the referral routes into CWPT and makes the following recommendation.

Recommendation No. 4

Adult Social Care to ensure that all their staff are made aware of the referral routes into Coventry and Warwickshire Partnership Trust, in cases where individuals are deemed at risk of suicide, by being trained appropriately in suicide prevention.

19.67 Following a visit to the couple on 11th September 2020 it was determined that there was no requirement for formal Adult Safeguarding Care Services but a Section 42 safeguarding enquiry to provide short term social care support would be opened.

19.68 On 7th October 2020, a DASH risk assessment form was completed that provided a low score. There was therefore no requirement to refer concerns to a MARAC. Later that month Rose was assessed by Warwick Older People's Team as having no care and support needs that required formal Adult Social Care support.

19.69 Rose was spoken to on a one-to-one basis only on two occasions. The first was an opportunity taken when John went into the garden for a smoke leaving Rose with the social workers, and the second a few days later when John was asked if he minded leaving Rose with the social workers and he left the room. On both of these occasions Rose was asked if she thought John would hurt her and she said that she didn't think that would be the case. There is nothing to indicate that John was spoken to on his own without Rose being present.

19.70 Neither Rose nor John were identified as being victims or perpetrators of domestic abuse, albeit Rose did say that John didn't like her seeing other people and she felt that he was controlling in some ways. She did say that she did not feel at risk with John in any way.

19.71 The Adult Social Care IMR author considers that it was clear that eligibility thresholds were not met in order for Rose and John to receive statutory services, however it was clear that they required support, albeit on an emotional level which was available via mental health and physical health organisations. Rose may have benefitted from talking to others who were experiencing the same types of physical issues associated with pain.

19.72 The Adult Social Care IMR makes 5 learning points:

- Rose was spoken to alone on two occasions and this could have been done on other visits
- There was a significant delay in the completion of the DASH risk assessment (4 weeks from the initial referral date). This delay may have altered the responses that Rose gave. The outcome of the DASH was a low score therefore no referral to MARAC was required or necessary. This learning applies to all agencies involved as any agency who visited Rose upon the initial contact could have undertaken the DASH risk assessment.
- The DASH risk assessment may not however have been the most appropriate tool to have used in this specific case, as Rose did not see herself as being a victim, her husband as being a perpetrator nor

consider herself subject to abuse. When working with individuals who are suicidal a tool such as STORM would be for more appropriate, this would have enabled a dialogue to open to explore suicidal intent and plans. Protective factors could have been established along with a risk management plan. Consideration could also have been given to a working with a risk tool, to explore thoughts relating to suicide thereby allowing Rose and John to establish how they would manage these risks in future.

- Online support groups and virtual support for them both could have been considered although other forms of support had been offered and were turned down and these did not appear to address the central issue of Rose's pain.

- Other community support networks could have been explored such as a visiting buddy, MIND Mental Health support workers, forums for people who experience specific physical health issues and associated pain, as detailed above.

19.73 It appears there could have been a stronger multi-disciplinary approach to consider Rose's clinical and social needs more holistically. For Rose there are clear impacts on her mental health from her physical health conditions but there is little evidence of physical health, mental health and social care practitioners having a collective conversation to review her situation. Given the level of complexity here this may have been beneficial.

Recommendation No 5

The Clinical Commissioning Group and Adult Social Care to consider the use of Multi-Disciplinary Team meetings in complex cases where there are mental health, physical health and social care needs, to ensure a full exchange of information between agencies regarding people at risk.

19.73 In addition to the comments made by Adult Social Care, a system called the Integrated Care Record (ICR)[31] has been introduced by Warwickshire County Council. It consists of two phases. Phase No.1 was introduced in January 2022 and is called 'Adult Social Care information being shared with health partners (NHS)'.

19.74 Phase No 2 was introduced in March 2022 and is called, 'Health information being shared with Adult Social Care'.

19.75 WCC is part of a joint project with the NHS to implement the Integrated Care Record. The ICR in its simplest form is a digital information sharing system that allows health and social care staff to access important information in customer records. If a patient has been admitted to hospital or had an appointment with a specialist and had to talk about their condition or illness to various people, the ICR simplifies the communication chain.

[31] ICR has gone live and is already showing improvements between agencies sharing information.

19.76 For Adult Social Care Staff, the ICR will be accessed directly from the customer records on Mosaic and will show a summary of health information that includes:

- which health professionals are working with the person
- the person's diagnosis
- information on medication
- discharge summaries.

19.77 WCC Adult Social Care information will be shared with the local NHS system so that the two agencies can work together more effectively. This would have been an important tool to share information about Rose and if similar circumstances arise in the future, patients like Rose will receive a far more cohesive treatment plan.

Independent Office for Police Conduct

19.78 Following the deaths of Rose and John, and because Warwickshire Police Officers had been in contact with the couple a short time before their deaths, Warwickshire Police rightly made a referral to the Independent Office of Police Conduct (IOPC). A comprehensive report was submitted by Warwickshire Police which was examined by a Senior Case Work Manager at the IOPC.

19.79 At the end of November 2021, the IOPC replied to Warwickshire Police. The IOPC had concluded that

> "There is nothing to indicate or suggest that any officer in their dealings with [Rose and John], behaved in a manner which would constitute criminal or misconduct proceedings."

The reply went on to say:

> "The actions of the police in this instance were caring and compassionate. They sought assistance from other agencies, putting a plan in place and clearly looked for longer term support for the couple." and…
>
> "This case clearly demonstrates the compassion and care displayed by the officers who had dealings with this couple prior to their demise. I feel that all officers should be commended for their diligence in the manner in which they dealt with the couple"

20. Conclusions

20.1 Both John and Rose were elderly people with significant medical health issues. Rose, in particular, used illegal drugs. Rose was ill for years with chronic pain and was waiting for hospital treatment. On occasions Rose found living with her painful conditions unbearable. Perhaps more action could have been taken by the GP or the hospital to reduce the pain Rose was experiencing.

20.2 Information from all that knew Rose and John commented on how, when things got too much for Rose, she would ask/tell John to leave the house. He would then sleep rough, sometimes for weeks at a time, before he was allowed back into the family home.

20.3 However there was a lack of professional curiosity shown by practitioners when Rose indicated that she wanted to end her life, and a more assertive response could have been shown towards the consideration of support for both her and John. Similarly, when Rose disclosed that John had tried to suffocate her, (at her instigation) and could not go through with it, there was another missed opportunity to take positive action. There were also missed opportunities to make Routine Enquiries of Rose when she attended at her many medical appointments and when it was discovered that she had been non-concordant with her medication.

20.4 The Overview Recommendations are made with a view to preventing these circumstances occurring again and for practitioners to be reminded of the importance of professional curiosity and routine enquiries.

20.5 The Individual Agency Recommendations are made in order to address those issues agencies have identified and the DHR panel endorses those recommendations.

Overview Report Recommendations

Recommendation No. 1. **Page 38**

The Clinical Commissioning Group to provide assurance and evidence to South Warwickshire Community Safety Partnership that the training for all staff includes professional curiosity and holistic and person-centred assessment, to ensure that in such circumstances in the future robust and immediate action will be taken to safeguard vulnerable individuals.

Recommendation No. 2. **Page 39**

The Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust to reassure the South Warwickshire Community Safety Partnership that the recommendation of the Warwickshire's Violence Against Women and Girls Board that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Recommendation No 3 **Page 40**

The Clinical Commissioning Group and acute providers in Coventry and Warwickshire to give assurance to the South Warwickshire Community Safety Partnership that the NICE Guidance of 2020 and 2021 regarding the management of primary and secondary chronic pain and Neuropathic pain is being adhered to locally and that any learning from this Domestic Homicide Review is shared in awareness and training.

Recommendation No. 4 **Page 46**

Adult Social Care to ensure that all their staff are made aware of the referral routes into Coventry and Warwickshire Partnership Trust, in cases where individuals are deemed at risk of suicide, by being trained appropriately in suicide prevention.

Recommendation No 5 **Page 48**

The Clinical Commissioning Group and Adult Social Care to consider the use of Multi-Disciplinary Team meetings in complex cases where there are mental health, physical health and social care needs, to ensure a full exchange of information between agencies regarding people at risk.

Individual Agency Recommendations

Warwickshire Police

- The continued use of the Mental Health Triage Team
- The creation of the Adults at Risk Team who will manage risk using Problem Solving Plans
- To agree terms of reference/protocol between the Police and other agencies to ensure the most appropriate agency responds in a timely manner to calls for services.
- To create a clear indication of what is required of the Safer Neighbourhood Team Officers by either tagging, or the use of the Storm Log (command control system)
- To ensure that 'adults at risk' or 'vulnerable adults' tool kits are readily available on the Force intranet system.

Primary Care

- Review how vulnerable adults are identified and flagged within the practice.
- Review how processes for information sharing within the practice contributes to the ongoing management and timely referrals of vulnerable adults.
- Review processes for flagging patients with known previous drug dependencies and/or multiple medications.
- Review how escalations in number of patient attendances are picked up.
- Plan an update of Domestic Abuse Accredited Training for all staff using case study examples to imbed routine enquiry into clinical practice.

Coventry and Warwick Partnership Trust

- CWPT level 3 domestic abuse/DASH training to be amended to include guidance for staff on managing disclosures made when an individual is unwell, ensuring that disclosures are revisited when the patient has improved. Staff to ensure that the needs of the other members of the household are also taken into consideration and appropriate support is offered.

South Warwick NHS Foundation Trust

- Review and inform staff of the process for Safeguarding advice forms
- A process for ensuring additional notes/risks are incorporated with patient's original admission notes for day surgery.

Warwickshire County Council Adult Social Care

- Rose was spoken to alone on two occasions and this could have been done on other visits

- There was a significant delay in the completion of the DASH risk assessment (4 weeks from the initial referral date). This delay may have altered the responses that Rose gave. The outcome of the DASH was a low score therefore no referral to MARAC was required or necessary. This learning applies to all agencies involved as any agency who visited Rose upon the initial contact could have undertaken the DASH risk assessment.

- The DASH risk assessment may not however have been the most appropriate tool to have used in this specific case, as Rose did not see herself as being a victim, her husband as being a perpetrator nor consider herself subject to abuse. When working with individuals who are suicidal a tool such as STORM would be for more appropriate, this would have enabled a dialogue to open to explore suicidal intent and plans. Protective factors could have been established along with a risk management plan. Consideration could also have been given to a working with a risk tool, as this would explore thoughts relating to suicide thereby allowing Rose and John to establish how they would manage these risks in future.

- Online support groups and virtual support for them both could have been considered although other forms of support had been offered and were turned down ad these did not appear to address the central issue of Rose's pain.

- Other community support networks could have been explored such as a visiting buddy, MIND Mental Health support workers, forums for people who experience specific physical health issues and associated pain, as detailed above.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

Safer Later Lives: Older People and Domestic Abuse Safer Lives October 2016

Safer Warwickshire Partnership Domestic Violence Strategic Review 2020 Joanne Sharpen AVA (Against Violence and Abuse)

Appendix No. 1

DHR W06

TERMS OF REFERENCE

1. Supporting Framework

1.1. The Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2. In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

A person to whom he was related or with whom he was or had been in an intimate relationship; or

A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3. Where the definition, set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

2. Purpose of the DHR

2.1. 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.

2.2. 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.

2.3. Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

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

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

2.6. Highlight good practice.

3. Methodology

3.1. This DHR will primarily use an investigative, systems focuses and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key frontline staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of the DHR

4.1. Deceased 1 Rose

4.2. Deceased 2 John

Timeframe

4.3. The scope of the DHR will be from 1st January 2011, (the year that the deceased moved into their last accommodation) to the date of death

4.4. In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case.

4.5. The Terms of Reference will be a standing item on the agenda of every panel meeting in order we can remain flexible in our approach to identify learning opportunities.

5. Agency Reports

5.1. Agency Individual Management Reports will be commissioned from:

- Warwickshire Police
- Warwickshire Clinical Commissioning Group
- Coventry and Warwickshire Partnership Trust
- Adult Social Services
- South Warwickshire Foundation Trust
- West Midlands Ambulance Service
- Warwick District Council

Other reports for those agencies having contact with the Victim and Perpetrator:

- Housing (Warwick District Council)
- Leamington Night Shelter
- Salvation Army
- Helping Hands

5.2. Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.3. Any references to the adults, their family or individual members of staff must be in full and later redacted before submission to the Home Office or published.

5.4. Any reasons for non-cooperation must be reported and explained.

5.5. All agency reports must be quality assured and signed off by a senior manager within the agency prior to submission.

5.6. It is requested that any additional information requested from agencies by the DHR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7. It is requested that timescales are strictly adhered to, and it should be noted that failure to do so may have a direct impact on the content of the DHR and may be referred to in the final Overview Report to the Home Office

5.8. Agencies will be asked to update on any actions identified in the IMR prior to completion of the DHR which will be fed into the final report. Updates will then be requested until all actions are completed.

6. Areas for consideration

Rose

6.1. Was deceased 1 recognised or considered to be a victim of abuse and did she recognise herself as being an object of abuse?

6.2. Did deceased 1 disclose to anyone and if so, was the response appropriate?

6.3. Was this information recorded and shared where appropriate?

6.4. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of both of the deceased?

6.5. When, and in what way, were deceased 1's wishes and feelings ascertained and considered?

6.6. Is it reasonable to assume that the wishes of deceased 1 should have been known?

6.7. Was deceased 1 informed of options/choices to make informed decisions?

6.8. Were they signposted to other agencies?

6.9. Was consideration of vulnerability or disability made by professionals in respect of the victim and perpetrator?

6.10. How accessible were the services for both of the deceased?

6.11. Were either deceased subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?

6.12. Did deceased 1 have any contact with a domestic abuse organisation, charity or helpline?

John

6.13. Was deceased 2 recognised or considered to be a victim of abuse and did deceased 2 recognise himself as being a victim of abuse?

6.14. Did deceased 2 disclose to anyone, and if so, was the response appropriate?

6.15. Was this information recorded and shared where appropriate?

6.16. Was anything known about deceased 2? For example, were they being managed under MAPPA, did they require services, did they have access to services.

6.17. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of both of the deceased?

6.18. Were services accessible for deceased 2? And were they signposted to services?

6.19. Was consideration of vulnerability or disability made by professionals in respect of deceased 2?

6.20. Did deceased 2 have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

6.21. Were practitioners sensitive to the needs of both of the deceased, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about either of the deceased?

6.22. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

6.23. Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

6.24. Did the agency have policy and procedures for risk assessment and risk management for domestic abuse (e.g., DASH) and were those assessments correctly used in the case of this victim/perpetrator?

6.25. Where these assessment tools, procedures and policies professionals accepted as being effective?

7. Engagement with the individual/family

7.1. While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

7.2. South Warwickshire Community Safety Partnership, through the Independent Chair, is responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon, this includes medical records of both of the deceased.

7.3. Firstly, this is in recognition of the impact of the death of both of the deceased, giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the

deceased helping the process focus on their perspectives rather than just agency views.

7.4. All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

8. Media Reporting

8.1. In the event of media interest, all agencies are to use a statement approved and provided by South Warwickshire Community Safety Partnership.

9. Publishing

9.1. It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

9.2. The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of South Warwickshire Community Safety Partnership and communicated to all relevant parties as appropriate.

9.3. Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

9.4. Whenever appropriate an ‘Easy Read’ version of the report will be published.

10. Administration

10.1. It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via secure email account (GCSX) or through the Local Authority’s Secure Communication System (SCS). Failure to do so will result in a data breach and must be reported to the Data Protection Commissioner.

10.2. The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.

HOME OFFICE LETTER