SAFER CROYDON PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the Death of Adult D

October 2016

Independent Chair and Author of Report: Mark Yexley

Associate, Standing Together Against Domestic Violence

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1. Preface

1.1. Introduction

1.1.1. In October 2016 Adult E telephoned the police and informed them that she had murdered her mother through giving her an overdose of insulin and smothering her at their family home in Croydon. The police and ambulance attended the house and found Adult E with the body of her 77 year old mother, Adult D. Adult D was taken by ambulance to hospital, but was pronounced dead on arrival. As a result, Adult E was arrested and upon arrest it was apparent to the Police that she had been subject to a psychotic episode. Adult E was charged with Adult D's murder and was later made the subject of a mental health order after she admitted Adult D's manslaughter.

1.1.2. As Adult E was a close family member to Adult D and they were living in the same household, the incident was considered to be a Domestic Homicide. The Safer Croydon Partnership (Community Safety Partnership) commissioned a Domestic Homicide Review (DHR) as required by Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.3. This report of a Domestic Homicide Review examines agency responses and support given to Adult D, a resident of Croydon, prior to the point of her death at home in October 2016.

1.1.4. The Review will consider agencies contact and involvement with Adult D and Adult E from October 2014 to the date of Adult D's death.

1.1.5. In addition to agency involvement, the Review also aims to examine Adult D's and Adult E's past to identify any relevant background or trail of abuse before the homicide. This may include whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the Review seeks to identify appropriate solutions with the aim to preventing similar events happening in the future.

1.1.6. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. The Review Panel have approached this Review openly to seek those lessons and to act upon them.

1.1.7. This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.8. The Review Panel expresses its sympathy to the family of Adult D for their loss and thanks them for their contributions and support throughout this process.

1.2. Timescales

1.2.1. The Safer Croydon Partnership, in accordance with the December 2016 *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, commissioned this Domestic Homicide Review. The Home Office were notified, by the Croydon Adult Safeguarding Board, of the decision to hold a DHR in writing on 13 April 2017.

1.2.2. Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR in May 2017. The completed report was handed to the Safer Croydon Partnership in October 2019.

1.2.3. Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was an initial delay of seven months by the Safer Croydon Partnership in designating the case to be a Domestic Homicide and commissioning a chair. There was an additional substantial delay in the submission of the IMR covering GP Primary Care. As part of the process of engagement with the perpetrator, Adult E was viewed as key. It took some time to progress to a point where Adult E was fit be interviewed in hospital. The interview with Adult E revealed that the family were regular worshippers at their parish church which resulted in further delay in order to facilitate contact with the family's priest. Throughout the process the Chair tried to engage with the family of the victim. Apart from Adult E, none of Adult D's children wanted to be involved in the DHR process. The chair eventually spoke to Adult E's husband, Adult F, in July 2018. This interview with Adult F was essential in understanding the family history and provided information that was valuable to the DHR. A further panel meeting was held and there was a long delay in the response to some actions. There was also an extended delay in the reviewing the final draft of the report. Throughout the process agencies have been mindful of the need to progress single agency recommendations in a timely manner.

1.3. Confidentiality

1.3.1. The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals and their line managers.

1.3.2. This Review has been suitably anonymised in accordance with the 2016 guidance. The specific date of death has been removed and only the independent chair and DHR Panel members are named.

1.3.3. To protect the identity of the victim, the perpetrator and family members the following anonymised terms have been used throughout this Review:

1.3.4. The victim: Adult D

1.3.5. The perpetrator: Adult E

1.3.6. The perpetrator's husband: Adult F

1.3.7. The only engagement with the family has been through the husband of the perpetrator, son in law of victim, Adult F. Whilst it is often considered desirable to use pseudonyms for the adults named in a DHR, this needs to be done with sensitivity. In this case it was not thought appropriate, by the chair, to randomly choose names or to rely on the perpetrator's husband to suggest names.

1.4. Equality and Diversity

1.4.1. The Chair of the Review and the Review Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process.

1.4.2. Considering what was known about Adult D and Adult E at the start and throughout the Review, the following characteristics / additional vulnerabilities were considered relevant to understand and analyse:

- Age
- Disability
- Race
- Sex / gender

1.4.3. The Review Panel decided that additional expertise would be required to effectively conduct the review. The panel was expanded to include members from the local BME Forum, and Non-Government agencies providing support on the areas of age and mental health.

1.4.4. The following issues have also been identified as particularly pertinent to this homicide:

- Mental health of Adult D and Adult E
- Adult D's disability and being cared for at home
- Adult E's position as a carer
- Ethnicity of Adult D and Adult E
- How the combination of any of these factors would impact either Adult D or Adult E

1.4.5. Consideration was given by the DHR Panel as to whether either the victim or the perpetrator was an 'Adult at Risk'. The Review Panel concluded that this would be a key line of enquiry for the Review.

1.5. Terms of Reference

1.5.1. The full Terms of Reference are included at Appendix 1. This Review aims to identify the learning from Adult D's case, and for action to be taken in response to that learning, with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2. The DHR Panel comprised of agencies from Croydon, as the victim was living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established. They were informed of the nature of the review, their participation was requested and the need to secure their records.

1.5.3. At the first meeting, the DHR panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from October 2014 to the date of the homicide. This date was chosen as it covered the period of Adult D's and Adult E's most significant contact with agencies. There had been no other safeguarding concerns raised before this two year period and agencies were asked to summarise any contact before this time.

1.5.4. *Key Lines of Inquiry:* The DHR Panel considered both the 'generic issues' as set out in the 2016 Guidance and identified and considered the following case specific lines of inquiry:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Adult D / Adult E and wider family.
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.

- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations' access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
- Analyse how the particular of the victim being cared for at home, age, undiagnosed mental health conditions, disability, gender and ethnicity would affect the response of services as individual or combined factors.

1.5.5. The DHR Panel felt that the membership would cover many of the areas, but not all. It was decided that further expertise was required to help understanding on the issues of age, ethnicity and mental health within the local community. The independent chair sought the expertise of AgeUK, Croydon BME Forum and Hear Us. These agencies contributed to the review from the second meeting onwards, supporting the IMR review and overview report.

1.6. Methodology

1.6.1. Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The 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; and emotional.*
Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." [1]

1.6.2. This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the *Domestic Violence Crime and*

[1] See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf [accessed 8 November 2017]

Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Adult D and/or Adult E. Three agencies submitted IMRs and chronologies, and one agency provided information only due to the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

1.6.3. *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The majority of IMRs received were timely, comprehensive and enabled the panel to analyse the contact with Adult D and/or Adult E, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Three IMRs made recommendations of their own organisation and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this Review.

1.6.4. *Other Information:* The chair accessed the following additional sources when compiling the overview report: - Defence statement of Adult F, *Families' and carers' handbook* SLaM 2010, *Handbook for Families and Carers* SLaM 2011-2012, Croydon Health Services *Interpreting Handbook – Interpreting Services Guide for Staff 2016,* Croydon Health Services internal action plans, as well as Care Quality Commission (CQC) reports for Croydon University Hospital, SLaM and GP Practice.

1.7. Contributors to the Review

1.7.1. The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Croydon Family Justice Centre
- London Borough of Croydon – Adult Social Care
- London Borough of Croydon – Housing Services
- NHS England
- Victim Support

1.7.2. The following agencies had contact with the family during the period under review, or held relevant information, and their contributions to this DHR are:

Agency	**Contribution**
Croydon Health Services (CHS)	IMR and chronology
Croydon Clinical Commissioning Group (CCG) (for the General Practice)	IMR and chronology
Metropolitan Police Service (MPS)	Report and Chronology
South London and Maudsley NHS Foundation Trust (SLaM)	IMR and chronology

1.8. The Review Panel

1.8.1. The Review Panel Members were:

Panel Member	**Job Title**	**Organisation**
Shade Alu	Director of Safeguarding	Croydon Health Services (CHS) NHS Trust
Caroline Birkett	Head of Service	Victim Support
Rachel Blaney	Lead Nurse for Safeguarding Adults at Risk	Croydon Clinical Commissioning Group (CCG)
Andrew Brown	Chief Executive	Croydon BME Forum
Nicky Brownjohn	Head of Quality and Regional Safeguarding Lead	NHS England
Brian Calvert	Safeguarding Lead	Age UK
Helen Kelsall	Deputy Director of Quality for the Directorate of Psychological Medicine and Older Adults	South London and Maudsley (SLaM) NHS Foundation Trust
Alison Kennedy	Operations Manager	Croydon Family Justice Centre
Estelene Klaasen	Designated Nurse for Adult Safeguarding	Croydon Clinical Commissioning Group (CCG)

Yvonne Murray	Head of Tenancy and Caretaking	London Borough of Croydon - Housing
Tim Oldham	Group Coordinator	Hear Us
Sean Olivier	Safeguarding Coordinator	London Borough of Croydon - Adult Social Care
Carl Parker	Partnership & Analyst Officer	London Borough of Croydon – Safer Croydon Partnership
Russell Pearson	Review Officer	MPS – Serious Crime Review Group (SCRG)
Tony Reseigh	Detective Inspector	Metropolitan Police Service (MPS) – Croydon Borough Community Safety Unit (CSU)
Charmaine Wiggins	Independent Chair Safeguarding	London Borough of Croydon - Adult Social Care
Mark Yexley	Independent Chair	Standing Together Against Domestic Violence

1.8.2. *Independence and expertise*: Agency representatives were at the appropriate level for the Review Panel and demonstrated expertise in their own areas of practice and strategy, and were independent of the case.

1.8.3. The Review Panel met a total of three times, with the first meeting of the Review Panel in August 2017. There were subsequent meetings in November 2017, and October 2018.

1.8.4. The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.9. Involvement of Adult D's Family

1.9.1. The Safer Croydon Partnership notified the family of Adult D in writing of their decision to undertake a review. The Chair of the DHR and the panel acknowledged the important role that Adult D's family could play in the review. From the outset, the panel decided that it was important to take steps to identify and then attempt to involve any family, friends and wider community.

1.9.2. It was agreed to approach one of Adult D's daughters and her two sons, for whom contact details were held by police. Initial contact was made through the police Family Liaison Officer (FLO) who then provided contact details to the chair. Letters were then sent directly to each family member.

1.9.3. Letters invited participation at a time and in a way of the contacts' choosing (e.g. a face to face meeting, telephone conversation or a letter), and emphasised that their participation was voluntary. The Home Office leaflet about Domestic Homicide Reviews was included, along with information about the support offered by Advocacy After Fatal Domestic Abuse (AAFDA).

1.9.4. Upon sending the letters, there was no response from the victim's children and so the chair followed this up with phone calls. The chair telephoned the victim's eldest son, who confirmed that he had received letters from the chair concerning the review and stated that he did not want to speak to the chair or have any support. He declined the offer to have a face to face meeting with the chair and noted that he was happy for the chair to approach other members of the family. He said that he did not want to see the final report or speak any more about his family, he was informed that he could contact the chair at any time if he changed his mind and there was no further contact. The chair also telephoned another son of the victim, to which the telephone was answered by a woman. The chair introduced himself and asked to speak to Adult D's son. The woman said that the son would not speak to the chair and the family did not want to speak to him, she suggested the chair could speak to Adult E's husband, Adult F. A further telephone message was left for Adult D's daughter and to date there has been no response.

1.9.5. Following an interview with Adult E, the perpetrator, the chair made contact with the local parish priest for the family. The parish priest met the chair of the DHR and supported the review.

1.9.6. The limited engagement with Adult D's children, as next of kin, steered the chair towards speaking to the perpetrator's husband, Adult F. A letter, and leaflets offering support were sent to Adult F and he agreed to meet the chair at his home in July 2018. He was supportive of the DHR process and provided valuable information on the background of his wife and her mother.

1.9.7. The panel would like to extend their thanks to the family priest and Adult F for supporting this DHR process.

1.10. Parallel Reviews

1.10.1. *Criminal investigation*: The police investigation and criminal trial process was completed in July 2017, when Adult E pleaded guilty to manslaughter and was given an indefinite Hospital Order. This was before the first meeting of the DHR and there were no issues concerning disclosure that impacted on the review.

1.10.2. *Coroner*: After a full criminal investigation and prosecution, the Coroner decided that no inquest would be held.

1.10.3. *Croydon Health Services (CHS)*: Adult D's presentation to the Emergency Department on the date of her death was reviewed as part of the Trust's mortality review process. The case was noted as an out of hour's cardiac arrest and a potential homicide. There were no separate concerns recorded and the case was noted that the police and coroner had been informed of the case being a probable homicide.

1.11. Chair of the Review and Author of Overview Report

1.11.1. The Chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored eleven DHRs. Mark is a former Detective Chief Inspector with 34 years' experience of dealing with domestic abuse and was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent reviews of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

1.11.2. Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that

agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.11.3. STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews.

1.11.4. *Independence:* The chair retired from the police in 2011. He has no current connection with the London Borough of Croydon or other agencies mentioned in the report. Whilst serving in the police, he was never posted to Croydon Borough.

1.12. Dissemination

1.12.1. The following recipients have received/will receive copies of this report:

- Safer Croydon Partnership
- The Review Panel
- Croydon Safeguarding Adults Board
- Family of Adult D
- Copy to SLaM for medical notes of Adult E
- Standing Together Against Domestic Violence DHR Team

2. Background Information

The principle people referred to in this report						
Referred to in report as	**Relationship**	**Age at time of Adult D's death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability**
Adult D	Victim	77	South Indian	Roman Catholic	British Citizen	Dementia and Insulin dependent diabetic
Adult E	Daughter of Adult D and perpetrator of homicide	55	South Indian	Roman Catholic	British Citizen	Mental Health and Insulin dependent diabetic

2.1. The Homicide

2.1.1. *Homicide*: One afternoon in October 2016 Adult E called 999 and told the operator that she had just murdered her mother. She told the operator that she had given Adult D an overdose of insulin and smothered her with a pillow. Adult E then gave her address and said that she had decided to take her mother's life. She said that her mother had been unwell for a long time and a man, whom she named, had told her to kill her mother. Police officers were immediately sent to Adult E's home and arrived five minutes after the call was made. They were met by Adult E who told the officers that she had killed her mother. The officers found Adult D laying on the sofa covered head to toe with a blanket and not moving and officers started cardiopulmonary resuscitation (CPR) on Adult D. Adult E told them that it was pointless as she had killed her mother over an hour before. London Ambulance Service paramedics arrived at the house and established that Adult E had used an insulin pen to inject Adult D and she told them that she had set the dial to maximum. Adult D was taken by ambulance to hospital where there were further attempts to resuscitate her. On arrival at the hospital Emergency Department (ED) resuscitation efforts continued but the ED team were unable to revive Adult D and she was pronounced dead in the ED.

2.1.2. Adult E was arrested and taken into police custody where she told the police that she had previous mental health problems in the 1990s, when she had attempted suicide. The

custody healthcare professional considered that Adult E presented with a psychotic fixation on a man 'X', whom she had never met and she heard his voice in her head. It was established that Adult E's husband was on holiday in India at the time of the incident. She was seen by the duty forensic psychiatrist and she was considered fit to be detained and interviewed under criminal justice procedures. An appropriate adult was called to act on behalf of Adult E. Adult E told the appropriate adult that X had told her to kill her mother and was now telling her to kill her husband and son. Adult E was then legally represented and refused to be interviewed by police. Extensive enquiries were made and it was established that the man X, described by Adult E, did not exist.

2.1.3. Adult E was charged with the murder of Adult D and was admitted to a secure mental health unit under South London and Maudsley NHS Foundation Trust (SLaM). As part of the criminal justice process Adult E was interviewed by psychiatrists on behalf of the CPS and the defence. During her interviews she maintained that she had killed her mother by using an overdose of insulin. In the summer of 2017 Adult E appeared before the Central Criminal Court and pleaded guilty to the manslaughter of Adult D on the grounds of diminished responsibility and the plea was accepted. Adult E was sentenced to be subject to a Hospital Order with a Restriction Order under Section 41 Mental Health Act 1983.

2.1.4. Post Mortem: An initial post mortem examination was carried out but further scientific tests were required to establish cause of death, due to Adult D's long term diabetic needs. The additional analysis revealed that Adult D had an elevated level of insulin in her body consistent with an overdose. There was no evidence of any previous physical abuse and Adult D appeared well cared for.

2.2. Background Information on Adult D and Adult E

2.2.1. **Background information relating to Adult D:** Adult D was born in India and was 77 years old at the time of her death and her first language was Malayalam and was of the Roman Catholic faith. Her husband was in the British Navy and came from Kerala, South India. When Adult D met her husband she was living in Malaysia and a citizen of that country. The couple married and they had seven children, five sons and two daughters. In the late 1960s Adult D's husband moved to England and Adult D remained in Kerala with the couple's children as Adult D had a large family home in Kerala. Adult D's husband later left the Navy, choosing to remain in England, and found work as a mechanic on the railways. He bought a property for the family in Croydon, Surrey and around 1980, Adult D was

planning to bring her children to join her husband in the UK, when her husband was killed in an accident at work. Adult D brought her children to the UK for the funeral and then began living in the home purchased by her deceased husband. Adult D's children lived with her and would occasionally return to India.

2.2.2. In the mid 1990s Adult D moved into a flat owned by her eldest daughter Adult E and her husband Adult F and Adult D's British family home was sold. In 2002 Adult D moved with Adult E's family into a house in Croydon. During this time period, two of Adult D's sons died.

2.2.3. Adult D did not work, instead she looked after Adult E and Adult F's home, cooking for the family whilst they were at work. This arrangement continued until Adult D's health deteriorated.

2.2.4. **Adult D's health:** Whilst Adult D was living with Adult E, she developed a number of chronic health conditions. She was an insulin dependent diabetic and had mobility problems, she was a wheelchair user when outside the home and was helped with transport to medical appointments by her son-in-law, Adult F. Adult D was known to be suffering from dementia and it appears that Adult D was reliant on Adult E for her caring needs at home noting Adult E as her main carer. Adult E was sometimes supported in Adult D's care by her sister. Shortly before her death, Adult D was diagnosed with cancer. Adult E was not formally recorded as a carer for her mother. Adult E was noted as her mother's medical notes as her 'next of kin'.

2.2.5. **Background information relating to Adult E:** Adult E is of the Roman Catholic faith and worshipped on a regular basis at her local church. She speaks English fluently and is married with two children who were aged 30 and 29 at the time of the homicide.

2.2.6. Adult E was born in Singapore when her family was living there and her father was in the Navy. She was the second eldest of seven children. In the late 1960s Adult E moved with Adult D and siblings to Kerala, whilst her father worked in the UK. When Adult E lived in Kerala she met her future husband Adult F. Adult F lived in the same village and attended the same college as Adult E. After her father's death in the UK Adult E travelled to the UK with Adult D and lived in the home purchased by her father.

2.2.7. Adult E was aged 19 when she moved to the UK. Adult E was later bequeathed the family home in Kerala and this remains a family property to this day. After moving to the UK, Adult

E worked as a nurse in a psychiatric hospital in Surrey. Adult E married Adult F and returned to live in Kerala between 1984 and 1988 where they had two children. In 1988 Adult E returned to the UK with her children, leaving her husband in Kerala. Adult F eventually joined his wife in the UK in 1990. When they arrived in the UK, the couple lived in Adult D's home. In 1994 Adult E and Adult F had their own home and Adult D moved to live with them. Adult E later worked with a friend who was a foster carer. In 2002 Adult E and Adult F bought their house in Croydon and Adult D lived with them. After this time Adult D's health deteriorated and Adult E stopped work to care for Adult D full time.

2.2.8. **Adult E's health:** Adult E was an insulin dependent diabetic and had experienced mental ill health in the 1990s and that resulted in her attempting suicide. She had not been seen by any healthcare agencies concerning her mental ill health since the 1990s. The first time that any agency was aware of her current mental health condition was when she was arrested for killing Adult D.

2.2.9. **Synopsis of relationship between Adult D and Adult E:** Adult E had lived with Adult D for most of her adult life. Adult D lived in Adult E and Adult F's home after her family home was sold and the profits were shared between the family. Whilst Adult D was in good health she looked after the home whilst her daughter and son-in-law worked. Later as her health deteriorated Adult E became a carer for Adult D. Adult E took on this responsibility as Adult D's eldest daughter and there was no evidence to show that this was not a caring relationship and it appears that Adult D was physically well-cared for. There had been no previous concerns of abuse within the family and no information has arisen since the death to indicate that there were any long standing problems. There was also no evidence of any financial problems within the family.

3. Overview and Chronology

3.1. Information from Adult D's Family

3.1.1. The chair of the review contacted all of Adult D's children who declined to assist the review. It was suggested by the family that the chair should approach Adult E's husband, Adult F. It was also known that Adult F was the main family contact for the police throughout the criminal investigation.

3.1.2. The chair arranged to interview Adult F who was supportive of the review. In addition to being interviewed, Adult F volunteered his personal statement provided to his wife's solicitor for the criminal proceedings. The statement and the interview from Adult F provided a great deal of information on the family history and helps to inform the background of Adult D and Adult E detailed earlier in Section 2.2 of this report.

3.1.3. Adult F met Adult E as neighbours in India and they attended the same college. After Adult E came to England with her family she would write to Adult F and they decided to get married. Adult F said that he had a good job in India, so Adult E went back to join him. By 1986 they had two children and came to visit family in England. Adult E was very attached to Adult D and stayed in England. It was decided that Adult F would join his family in the UK and he eventually came to England in 1990. He said that he noticed a difference in Adult E when he arrived and she was not the same person, he thought there may have been someone else in her life, but things later settled down and Adult F joined the police service.

3.1.4. In 1996 Adult F was contacted at work and was told that his wife was in hospital, having taken an overdose. Adult E was transferred to a Mental Health unit, she had been 'sectioned' and he witnessed her shouting a lot. He said that he was not told what was happening with his wife. She was in hospital for around a month and upon returning home, she was soon back to normal. Adult F said that he was not informed of his wife's diagnosis or any medication that she was taking. Adult F said he thought Adult E had some sort of depression. During this time Adult D was looking after Adult E whilst her husband was at work.

3.1.5. At this time they had bought a house and Adult E's mother had moved in with the family. Adult F explained that it was part of their culture that a mother would live with her eldest daughter.

3.1.6. Adult F was asked if he noticed changes in her behaviour, to which he said that she sometimes behaved like a different person and looking back there were more problems than they realised at the time. He mentioned a time when he was due to go to India for an operation and Adult E sat up in bed on the day and said that she could not come and sat staring at him.. On another occasion, their son had a minor accident in his car. The other driver came to the family home to exchange details, Adult E ran outside the house and started screaming. A brother of Adult E committed suicide and shortly after that another brother died from a heart attack, as a result, Adult E became very depressed. On one occasion Adult F found his wife knocking on the neighbour's front door complaining that there was noise coming from the house, Adult F stated there was no noise. Adult F said "Ninety nine percent of the time she was perfect and even if we reported anything I don't think people would have thought there was anything wrong with her because most of the time she was so normal".

3.1.7. Adult E sometimes said that men were telling her to do things. On one occasion it was said to be Tony Blair and on other occasions it was Mr X. Adult F made the link between Mr X and a doctor that he suspected that she was seeing when she was an auxiliary nurse.

3.1.8. Adult E had previously worked as an auxiliary nurse but had not been working for six to seven years before Adult D's death. She had also worked helping a friend who ran two foster care homes.

3.1.9. Adult F did not recall any friction between Adult E and Adult D. Adult F described Adult E wanting to take care of Adult D. Adult F described how Adult E met Adult Ds care needs such as assisting Adult D to come downstairs which could at times take around 30 minutes and always being available to assist Adult D. Adult F also detailed how they had a specialist medical bed installed for Adult D as well as extending the house and installing a downstairs shower so that Adult D could spend all day downstairs. Adult F described occasions where Adult E had arguments with Adult D where Adult D had defecated herself and Adult E had asked Adult D to make her aware when this had happened so that she could help. Adult F detailed how Adult E always wanted to stay with Adult D.

3.1.10. When asked about Adult D's diabetes medication Adult F said that the GP 'pestered Adult E about the medication all of the time'. Adult F stated that Adult E had always prepared insulin for her and her mother and had done so for some time. Adult F often took Adult D and Adult E for medical appointments by car. Two weeks before Adult F was due to travel to India in 2016, Adult E rang 999 to state that Adult D was unwell and she was advised to

call her GP. The GP came to the house and told Adult E that Adult D was very ill and only had three months to live. They took Adult D to hospital and discovered that she had lung cancer where they said that the hospital would not resuscitate Adult D in the future.

3.1.11. About two months before Adult D's death, Adult E had an argument with her son-in-law. There was a disagreement over the fitting of a kitchen and Adult E began shouting at her son-in-law saying that he had stolen her daughter. Adult F also recounted a time when Adult E had called his work and they could not understand what she was saying, he went home and there was nothing wrong with her. Adult F said that his wife was not a violent person and people could verbally shout at each other but he had never seen violence towards Adult D or himself.

3.1.12. Adult F was asked if he knew who he could go to for help if he had concerns about his wife's mental health. He said that he knew all about how to refer someone, through his job as a police officer. He was aware of SLaM and through his work he had previously reported people to the GP and someone was once 'sectioned' after he had referred them. He said "I know about procedures with these things but Adult E did not seem like she had a problem".

3.1.13. At the time of Adult D's death Adult F was in India. He called Adult E on the day from a market and asked her if she wanted any spices and he said that they had a normal conversation.

3.1.14. Adult F was thanked for his openness and support with the DHR. He was reminded that there were support services available for relatives if he wanted to access support and he declined.

3.2. Information Known to Agencies Involved

3.2.1. The timeframe for the Review was October 2014 to the date of Adult D's death. Two agencies held information about Adult D and Adult E from that time. Another agency held information on Adult E before the review period, but it was deemed relevant as background to this report.

Agency	**Adult D**	**Adult E**
Croydon Clinical Commissioning Group (for the General Practice)	Y	Y
Croydon Health Services NHS Trust	Y	Y
South London and Maudsley NHS Foundation Trust (SLaM)	Y	Y

Total Agencies: 3		

3.2.2. The main contact with health care agencies often involved Adult D as a patient and Adult E as her carer. The report will therefore outline a combined chronology of their contacts with agencies.

3.3. Chronology of Agency Contact with Adult D and Adult E

3.3.1. All of the agency contact between Adult E and Adult D was with NHS primary care, local hospital and mental health trust. Adult E and Adult D were registered separately with the agencies, but this chronology will consider contact with both people. At many appointments Adult D would have been accompanied by her daughter Adult E. There are some occasions where contact shows Adult D's daughter being present, it is not always clear whether the daughter present is Adult E or her other daughter.

3.3.2. The first significant contact came in 2012 when Adult D's GP referred her to the Croydon memory service of South London and Maudsley (SLaM) Mental Health Trust. Adult D was 73 years of age at the time.

3.3.3. The first appointment with SLaM staff was a home assessment in March 2012. There was an interpreter booked for the appointment, but they did not attend. As a result, the staff member focused on Adult E's needs as a carer. The services of social care were explained but Adult E declined these. A follow up visit took place with an interpreter, where Adult D was assessed and a report considered her family circumstances. The assessment recommended an MRI scan of the head and the report was sent to the family GP.

3.3.4. Adult D did not attend for the MRI scan, however patients are not obligated to undergo this test. The cognitive testing of Adult D showed a significant cognitive decline to indicate a diagnosis of dementia. The cognitive testing results were reviewed by the multi-disciplinary team and a diagnosis of Unspecified Alzheimer's disease was confirmed. Adult D was seen at home and provided with the diagnosis and appropriate support was provided. Adult D had no further contact with the Croydon Memory Service.

3.3.5. In January 2013 a GP referral was made to the Older Adults Community Mental Health Team (CMHT). There were concerns that Adult D had paranoid ideas. A home visit was planned for the next month. An assessment was carried out and it considered that Adult D

did not require further CMHT support. It was noted by the IMR Author that an interpreter does not appear to have been used in the assessment and the results of the assessment was provided to the referring GP. Adult D was noted to have still been able to cook and she was able to meet her own basic care needs. There was no further contact between SLaM and the family until Adult E was admitted to hospital after her arrest for killing Adult D.

3.3.6. Later in 2013 both Adult D and Adult E attended their GP practice for diabetic reviews. The GP records show that Adult E was identified by the GP as Adult D's main carer. Both Adult D and Adult E attended regular appointments at Croydon University Hospital (CUH) diabetic clinic between 2013 and 2015.

3.3.7. In 2014 Adult D was seen at CUH Diabetic Clinic and diagnosed with Non-Proliferative Diabetic Retinopathy, eye problems linked to long term diabetes. A referral was also made to the District Nursing service by the GP, due to Adult E's concerns with Adult D's health.

3.3.8. In September 2014 Adult D was seen at home by her GP. The GP conducted a dementia annual review, a medication review, and a personal risk assessment for Adult D during the visit it was recorded that Adult D was aware of her diagnosis of dementia, diabetes and vision loss. The dementia care plan was agreed and reviewed. It was recorded that her daughter was her full time carer.

3.3.9. During 2015 there were four home visits made to Adult D, these were due to her decreased mobility, frailty, poor diabetic control and deteriorating vision. It was recorded that Adult E was aware of her diagnosis of dementia, diabetes and vision problems. The were no records of any discussions with Adult E concerning her support networks or a referral for a carer's assessment. There were records of personal risk assessments being completed for Adult D and home visits by the GP to Adult D during 2015 as it was apparent that she was becoming more housebound. Whilst Adult D did not attend her GP practice, both she and her daughter Adult E did attend CUH for diabetic podiatry appointments at regular intervals throughout the year. In October of 2015 Adult E had a diabetic assessment at CUH and no concerns were noted.

3.3.10. In January 2016 Adult D's GP reviewed her care plan and noted that she was being looked after by her daughter. A home visit was made as part of the review where the GP discussed with Adult D's daughter her poor diabetic control and other continued issues. Referrals were made to the District Nurse and Continence Service.

3.3.11. When the Clinical Nurse Specialist (CNS) from the Continence Service followed up the referral, she was told by Adult D's daughter that Adult D was not incontinent. The records do not show the name of the daughter who was spoken to.

3.3.12. The panel made further enquiries about this contact. It was established that the original nurse could not access original notes. However, from memory, the nurse confirmed the continence service did send a further letter informing Adult D that they would be conducting a home visit. The nurse visited and there was no reply, the nurse believed there was someone home. A letter left at the home asking for a new visit to be arranged. There was no further contact.

3.3.13. In April 2016 Adult E had a diabetic consultant review where the clinician recorded that Adult E was a pleasant patient. Adult E reported that she felt well and had less episodes of low blood sugar. All of her blood tests were in the normal range and there was no record made of any concerns for Adult E's mental health.

3.3.14. In July 2016 Adult D had an ultrasound of the abdomen to investigate complaint of increasing abdominal pain but there was no abnormality detected.

3.3.15. At the end of July 2016 Adult E attended the Emergency Department of CUH, with a foreign body in her thumb, as she had injured it whilst at home and there were no other concerns recorded. Adult E also had a podiatry appointment in August 2016 and there were also no additional concerns noted.

3.3.16. On 3 September 2016 Adult D was admitted to CUH following a fall at her home. Adult D was noted to have a limited command of English and a history was taken from her daughter. There was no evidence that staff tried to speak to Adult D alone and the name of the daughter was not noted. The daughter reported that Adult D had had an unwitnessed fall at home and she had been falling more since mid-July 2016. A social history was provided by the daughter and it was stated that Adult D manages all activities of daily living with the support of her daughter. When asked by staff, the family stated that they preferred that Adult D was cared for at home. The panel could not establish from records which member(s) of the family were involved in the discussions with medical staff. Adult D had a head CT scan and there were no signs of injury but there were signs of ischaemic (insufficient blood) changes. The day after admission, Adult D had an X-Ray of her shoulder as she was suffering from pain. There were no injuries found, but the X-Ray revealed abnormalities of the lung.

3.3.17. On 5 September 2016 Adult D was discharged from hospital with a discharge plan which included the completion of a course of anti-biotics. An appointment with the Acute Care of the Elderly clinic was made and an appointment for Adult D's lungs to be checked in four weeks. Adult D's discharge diagnosis was listed as:- benign essential hypertension; sepsis; weakness as a late effect of stroke; personal history of stroke; pre-existing diabetes mellitus; unspecified dementia (disorder). The IMR author notes that the weakness of a previous stroke and dementia would have contributed to Adult D's vulnerability.

3.3.18. On 21 September 2016 Adult D came to the Emergency Department of Croydon University Hospital following an assessment from her GP. The history was taken from Adult D's daughter and it was noted that Adult D was able to nod and smile, but not answer questions coherently. It appeared that Adult D could nod or disagree with short questions but difficulty in communicating was possibly exacerbated by her limited English. Adult D's daughter said that Adult D had become more forgetful and displaying odd behaviour at home, such as putting her socks out of the window and leaving the gas stove on. On that date the daughter had noticed that Adult D was increasingly drowsy and complaining of neck pain. The GP was called to Adult D's home and the GP referred Adult D to the Emergency Department where she was later admitted to hospital.

3.3.19. On 26 September 2016 an ultrasound of Adult D's chest revealed abnormalities. As a result of tests, the medical team felt that they were suggestive of cancer. The medical staff requested that Adult D's daughter be present as Adult D did not speak English.

3.3.20. On 29 September 2016 a CT scan of Adult D's chest showed that she was not recovering as expected from the chest infection. Doctors considered that she had primary lung cancer that had spread to the lining of her lungs. The consultant explained to Adult D's daughter (FP) that they were considering that Adult D had lung cancer, but further tests and a biopsy would be required. It was discussed whether the family would be able to bring Adult D to an outpatient clinic. FP did not want Adult D to know about the possibility of cancer as she worried a lot and might get depressed. The consultant explained that Adult D would have to know as she had to undergo a biopsy and her consent would be required. FP commented that her sister Adult E was in charge of Adult D's care and would sign all consents without her knowing, as they did not want to worry their mother. The consultant discussed treatment but said that Adult D was unlikely to be a candidate for chemotherapy. An agreement was made between the doctor and FP that no resuscitation would be beneficial to Adult D.

3.3.21. During the stay in hospital Adult D was reviewed by a dementia specialist nurse and she was deemed to be positive for delirium on admission. Delirium would be established by asking a patient simple questions and responses would have included elements of confusion. It was noted that Adult D would benefit from a GP review following discharge. Adult D was discharged on 30 September with a discharge diagnosis listed as:- community acquired pneumonia; pleural effusion; and suspected lung cancer.

3.3.22. At the start of October 2016 Adult D attended a clinic appointment for lung cancer. She was described as a frail old lady with a history of having had a stroke (Cerebrovascular Accident - CVA) and dementia. An outpatient appointment was planned for November 2016.

3.3.23. Adult D's hospital discharge was followed up by a GP practice review of her medication. Ten days before her death the GP recorded a telephone conversation on a follow up post discharge from hospital. The record did not show the parties to the conversation and what was discussed.

3.3.24. The final contact with Adult D was when she was brought to the Emergency Department of CUH in cardiac arrest, after being given an insulin overdose and smothered. Resuscitation was unsuccessful and Adult D died in the Emergency Department. The case was referred by CUH to the coroner as a probable homicide.

3.4. Interview with Adult E

3.4.1. Adult E was interviewed in the secure unit of her Mental Health Trust. The meeting took place after many months of liaison between the DHR chair and her clinical team. The meeting was recorded in writing and a member of her caring team was present with Adult E throughout. At one point in the interview Adult E took a break and spoke to her consultant psychiatrist, who provided support. The panel wish to extend their thanks to all of the staff at SLaM for their commitment to the DHR process whilst always focusing on Adult E's best interests.

3.4.2. Adult E said that her mother had been living with her for five years at the time of her death. She described Adult D's health needs. She had dementia, diabetes and had developed lung cancer. Adult E said her only health problem was diabetes and that she was Adult D's main carer, but sometimes her brother CP and her sister FP would help when they could.

Adult E would take Adult D to all medical appointments and they would go to the appointments by car and be given a lift by Adult E's husband or other family members. She said that Adult D spoke 'Indian' but she could understand what the doctors told her but could not reply in English. She said that Adult D took insulin once a day, 8ml or 10ml and Adult E would dial up the amount in the pen and Adult D would self-administer in the stomach. She said that Adult D did not go out much and did not like using her wheelchair. She said that Adult D did have friends from Kerala, but she did not go out of attend any groups. Adult D would sometimes go to church with Adult E and her husband. They knew the local priest well but would not seek support from the church, if she needed support then they would 'keep it in the family'.

3.4.3. Adult E was asked if she ever asked any other agencies for support with Adult D. She said that towards the end she would ask a nurse to come and help her and would sometimes call an ambulance if her mother fell, Adult D would often sustain injuries as a result of falling. Adult E said that she felt capable of looking after her mother and she had worked as a carer for 12 years. She had worked in an old people's home and had lots of experience working with people with dementia. She was asked if she ever argued with Adult D. She said that she did sometimes, but not for 'bad reasons'. Adult E described arguments where Adult E had become frustrated with Adult D for defecating and disposing of nappies via the toilet. Adult E stated that she did not feel that Adult D was a burden.

3.4.4. When asked in interview if anything had frustrated Adult E on the day of MD's death Adult E admitted to murdering Adult D. Adult E described calling the police and admitting to killing Adult D. Adult E justified her behaviour detailing how Adult D was vulnerable and experiencing ill health which resulted in Adult D frequently in and out of hospital and on occasion not wanting to eat.

3.4.5. Adult E said that there had never been any violence between her and Adult D and Adult E had not suffered violence herself. Adult E felt that if she was not coping then she could have told her husband. She said there were no financial stresses and they owned three houses. She described Adult D as a very nice person who worked hard and loved to cook for her family. When asked if she had any stresses in her life, Adult E said 'Only x blackmailing me, he wanted me to say that my family were bad people'. It should be noted that x is the person that Adult E heard when she had her psychotic episode and killed Adult D. Adult E was thanked for her help with the review.

3.5. Any other Relevant Information

3.5.1. **Metropolitan Police Service.** The Metropolitan Police Service provided a written report to the DHR. The report outlined the circumstances of the homicide and the results of a search of police databases. The police confirmed that none of the parties concerned had any criminal record before the homicide. There were no incidents involving close family members and there were no matters recorded that would indicate any safeguarding concerns on any member of the family.

3.5.2. **SLaM.** In addition to their IMR, the chair was provided with information from SLaM outlining additional training provided to staff on Domestic Abuse. This training was delivered after the period of contact with Adult D. The training was delivered to community service staff across all four boroughs and a record was kept of all staff attending. Information on the new carers handbook that is currently in use was also provided by SLaM.

3.5.3. There was no evidence of any referral being made to Adult Social Care.

3.5.4. **Croydon Health Services.** As part of the DHR process Croydon Health Services provided a copy of the *Interpreting Handbook – Interpreting Services Guide for Staff 2016*. The guide is very clear on how to establish whether interpreters are needed and how to obtain, face to face or language line services. The handbook highlights how using relatives as an interpreter can appear more convenient. It goes on to highlight how using family as interpreters can inhibit a patient from disclosing past events of an embarrassing or intimate nature, it can lead to the withholding of information on side effects, be used to protect a patient from bad news and can hide possible abuse.

3.5.5. **Croydon BME Forum.** During the DHR process the panel were informed that the Local Authority have established new roles linked to improving services for BME women in the borough. The aim of the post is to increase the awareness and knowledge for the community in Croydon, Bromley and Lambeth around domestic abuse and other related topics. This work would include providing training and awareness sessions and workshops to statutory, voluntary and private sector organisations and local community groups.

3.5.6. **Parish Church** During the interview with Adult E she stated that the family were regular worshippers at their parish Roman Catholic Church. The chair was able to speak to the parish priest in a face to face meeting.

3.5.7. The priest has been at the parish for five years and knows the family of Adult D. The church has a congregation of around 2000 people and around 700 have South Asian origins. He said that he knew the family as part of his large congregation but did not have much individual contact until after the death of Adult D. He said that he did not know the family well enough before Adult D's death to know whether Adult D had any problems with language. He said that he was not aware of any particular health problems within the family before the death of Adult D. He also stated that he often provides support to families with significant health problems and mentions this in his sermons. He often goes to the homes of people who have serious health problems. The family never came to him for help or support and very much kept themselves to themselves. The priest was asked about how he would deal with any reports of domestic abuse or concerns on mental health. He said that he had established links with the local authority and had been involved in joint events to address domestic abuse. He would support and encourage people in seeking help from agencies or reporting. He was also aware of his obligations under the Children's' Act. He also stated that he, and colleagues, were experienced in dealing and supporting people with Mental Health concerns. The priest thanked the chair for his work and appreciated the value of DHRs. He said he will continue to be there for the family if they needed him.

4. Analysis

4.1. Domestic Abuse/Violence and Adult D

4.1.1. The only known evidence of domestic abuse from Adult E towards Adult D was the homicide itself. The deliberate administration of an overdose of insulin and the smothering by Adult E on Adult D was the cause of her death and clearly falls within the definition of domestic abuse. The review has not been able to establish whether Adult D was a victim of domestic abuse before her death.

4.1.2. In this case the victim had a number of appointments with healthcare professionals and hospital admission during the period under review. Whilst these would have normally provided an environment where a person could disclose abuse or concerns about the behaviour of her carers Adult D did not have an independent voice with those treating her. She was not afforded the opportunity to speak through an independent interpreter.

4.1.3. It is clear from speaking to Adult D's son-in-law that he did not witness any abusive behaviour towards Adult D. It is also known that Adult F was not at home all of the time and the abuse that lead to Adult D's death took place whilst he was out of the country.

4.2. Analysis of Agency Involvement

4.2.1. The IMRs and the DHR panel considered the following key lines of enquiry:

- Analyse the communication, procedures and discussions, which took place within and between agencies.
- Analyse the co-operation between different agencies involved with Adult D / Adult E and wider family.
- Analyse the opportunity for agencies to identify and assess domestic abuse risk.
- Analyse agency responses to any identification of domestic abuse issues.
- Analyse organisations' access to specialist domestic abuse agencies.
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
- Analyse how the particular of the victim being cared for at home, age, undiagnosed mental health, disability, gender and ethnicity would affect the response of services as individual or combined factors.

4.2.2. The areas of analysis were considered by the IMR authors and the panel. Where themes or wider issues emerge these are addressed in section five.

4.2.3. Where learning has been identified by agencies, their recommendations are summarised in this section and listed after the conclusion of the report.

4.3. Croydon Clinical Commissioning Group (General Practices)

4.3.1. The Clinical Commissioning Group (CCG) completed an IMR on behalf of the primary care General Practice. Both Adult D and Adult E were registered with the same GP practice for the period under review. The IMR showed that there had been regular contact with both Adult D and Adult E during the timeframes considered by this DHR. The majority of appointments for Adult D took place in the presence of Adult E and were invariably instigated by Adult E. The patient record for Adult D shows Adult E as her main carer.

4.3.2. The IMR shows that Adult E was subject to regular contact with the GP and she was seen in her home. There were regular reviews of medication, treatment and care plans. From the middle of 2015 there were an increasing number of home visits. At this point there was an opening to investigate Adult E's capacity to care for Adult D. This was a missed opportunity to consider a carer's assessment for Adult E.

4.3.3. During 2016 healthcare interventions were increasing for Adult D and there were also concerns on Adult E's personal diabetic compliance. There was a need for district nursing services and Adult D was admitted to hospital for falls. As Adult D's health deteriorated there would have also been more demands on Adult E as her main carer. There was no evidence that Adult E's role as a carer was assessed. There was no referral to occupational therapy to consider Adult D's home environment, there was no falls assessment and no formal carer's assessment for Adult E.

4.3.4. The final GP contact came in October 2016, when a review of medication was recorded. A telephone conversation was noted as a follow up, three days after Adult D's discharge from hospital. The notes do not record who the telephone conversation was with.

4.3.5. Whilst there was a number of contacts between Adult E and the GP, there were no concerns noted on her mental health.

4.3.6. The medical records also show that Adult D's first language is recorded as Malayalam. Throughout the contact with the GP there is no record that the services of an interpreter was ever used by the GP to communicate with Adult D.

4.3.7. The CCG IMR states that medical records clearly show that, in 2015, Adult D was said to be aware of her diagnosis of dementia, diabetes and deteriorating vision, and yet there is no record that her mental capacity was considered or assessed.

4.3.8. In relation to Adult E it does not appear that her role as a carer was ever fully considered by the GP practice. The GP records show that Adult E had the long term health condition of diabetes and was not fully compliant with her own treatment. The GP practice relied upon Adult E as the main carer for her mother. Adult D had the same medical condition as her daughter, in addition to other chronic healthcare needs. Whilst the situation may not have permitted the employment of a more reliable carer to help managing diabetes, it should have been risk assessed. The CCG IMR noted that there was no record of discussions with Adult E about support networks, such as family and friends. There was no record that Adult E was considered for a carer's assessment.

4.3.9. Since 2013 both Adult E and Adult D were known to the GP for long term diabetic treatment. They also continuously attended the CUH Diabetic Clinic. The IMR reviewer considered the routine health interventions and increasing home visits to Adult D as appropriate. There were regular reviews of medication for both Adult D and Adult E.

4.3.10. There were also documented reviews of treatment and care plan, but there may have been a missed opportunity to consider the needs of Adult D and Adult E using a multi-disciplinary meeting. The IMR reviewer assessed that both Adult E and Adult D should have been considered as 'adults at risk' under the Care (Act) 2014.

4.3.11. There was no evidence to suggest that the GP practice was aware of any incidents of domestic abuse or the need for any safeguarding referrals. However, there is also no evidence that the practice staff had engaged with any form of safeguarding training. The practice safeguarding policy was written in 2016 and reviewed in 2017 and referred to children, there is no reference to domestic abuse or associated referral pathways. This is of particular concern given that the victim and perpetrator of another domestic homicide in 2016 were registered with the practice.

4.3.12. In order to provide effective healthcare and to fully consider the needs of a patient there needs to be good communication between doctor and patient. It is very clear that without the use of an interpreter we have no way of knowing whether Adult D was living within a caring environment. Although the IMR author identified Adult D as a vulnerable adult, the GP practice had not identified her as such. If she had been then there may have been more awareness of the need to have an interpreter. Whilst we can see that Adult D was a vulnerable adult with complex health needs and we have no way of knowing whether her GP considered if her daughter was treating her well. We do know that Adult E had problems with her diabetic control. We do not know whether Adult E, who later killed Adult D with insulin, was administering insulin to her effectively before the day of her death. In effect Adult D had no voice in her interaction with a GP practice, who knew that English was not her first language.

4.3.13. In considering Adult E's mental health it is appreciated that the GP practice had no cause for concern. One fact that cannot be overlooked is that Adult D could well have been aware of her daughter's mental ill health and would have had no way of communicating this to her GP or nurse.

4.3.14. Recommendations were made in the IMR to address the learning.

4.4. Croydon Health Services (CHS) NHS Trust

4.4.1. Croydon Health Services completed an IMR. The contact between Adult D, Adult E and the Trust was through attendance at a number of specialist clinics and the Emergency Department of Croydon University Hospital (CUH).

4.4.2. Diabetic and Podiatry services had regular contact with Adult D and Adult E as outpatient clinics during the review period. There were no concerns raised on safeguarding issues. There were no concerns noted on Adult E's behaviour or mental health.

4.4.3. All of the contact with CUH considered by the IMR took place after Adult D had been diagnosed as having dementia in 2012. The IMR reviewer could find no evidence to indicate that the Mental Capacity Act was used to assess Adult D's capacity to consent to any treatment or procedures. There was no evidence presented to show that any other person had power of attorney over Adult D.

4.4.4. Although Adult D was seen by podiatry services on more than five occasions there is no record of an interpreter being used to communicate with Adult D. There was also an occasion in December 2014 where Adult D was subject to an intimate examination, without reference to an interpreter beforehand. There is no evidence that Adult D's capacity was assessed at any point by the trust staff.

4.4.5. Capacity needs to be considered as an ongoing matter and this was never done. There were no records of any concerns on safeguarding recorded.

4.4.6. In January 2016 Adult D had been referred by her GP to the trust continence service. The CNS followed this referral up with Adult D's daughter, the identity of the daughter was not recorded. The daughter told the CNS that Adult D was not incontinent. The rationale for not providing continence services, after a clinician made a referral, without discussing the case with a patient is not recorded. The CNS wrote a letter regarding home visits. It is not recorded that the letter was translated in order that Adult D could read it, or that the offer of translation was made. Consideration needs to be given that Adult E could have been using controlling behaviour in restricting access to an NHS service that could help Adult D with matters that would affect her personal hygiene and dignity. This could also be a means of the daughter potentially restricting the movement of Adult D from her home.

4.4.7. Medical records do not reveal the identity of the daughter who refused the support of the continence service. We do know that Adult D was living with Adult E and Adult F at this time. During interviews for this review, both Adult E and Adult F have independently made reference to Adult Ds incontinence as being a stressor and cause of argument.

4.4.8. In July 2016 Adult D was seen by Radiology Services for an ultrasound scan to investigate abdominal pain. There is no evidence to show that Adult D understood fully what procedure was taking place or that she was given an interpreter to enable her to discuss her own symptoms or causes.

4.4.9. When Adult D was admitted to CUH following a fall at home at the start of September 2016 staff noted her limited command of English and took a history of Adult D's increasing number of falls from her daughter. The reviewer does not know who this daughter was. There appears to have been no consideration that injuries to Adult D could have been of a non-accidental nature or the result of neglect. Whether the falls were accidental may have been established by speaking to Adult D, in the absence of her daughter, with support from an interpreter. This was a missed opportunity to explore whether there were any safeguarding concerns for Adult D.

4.4.10. Following another admission, after a GP referral, in late September it was noted that Adult D was not able to answer questions coherently. It is not known if this was due to her mental health, another medical cause or because she was not given access to an interpreter. It appears that the history was again taken from her daughter, and the identity of the daughter was not recorded. It was during this admission that the concerns about Adult D having lung cancer were raised. It is known that Adult D's other daughter was present on at least one occasion when the consultant discussed needing consent from Adult D to conduct a biopsy. The response from the other daughter was to state that her sister Adult E would sign all consents without Adult D knowing, as they did not want to worry her.

4.4.11. The panel considered that if Adult E was signing all consent forms for her mother it was effectively removing Adult D from all of the decisions affecting her life. All important matters were being dealt with behind her back. There was no effort made to engage with Adult D at all.

4.4.12. An agreement was made with FP that no resuscitation would be beneficial to Adult D. The IMR reviewer noted that this was a missed opportunity to conduct a best interest meeting in line with CHS Do Not Attempt Resuscitation (DNAR) policy which made reference to the Mental Capacity Act (2005). It is the view of the panel that this was a cause for concern.

4.4.13. Throughout all of Adult E's appointments as a patient and a carer there were never any concerns recorded about her mental health. She had presented to a number of medical professionals, as a patient and a carer and at no point was there any mention of any of the odd behaviour that she had demonstrated in the presence of her husband.

4.4.14. Consideration is given as to whether the trust would have responded appropriately to safeguarding concerns. CHS cannot state with confidence that Adult D did not try to express any concerns about her care at home or the mental state of her main carer. The trust had the most recent contact with Adult D in the month before her death. We do know that at the time of her death she had not suffered any recent injury. Adult D would have also been subject to physical examination at the trust in the months before her death and no injuries were noted.

4.4.15. Medical staff treating Adult D have been considered to be acting in Adult D's best interests. The staff have not been shown to be acting with the consent of Adult D. The lack of

assessment for capacity and the failure to use an interpreter give serious cause for concern.

4.4.16. The CUH trust have contracts for interpreting services. The lack of translation from Malayalam to English was not recorded as being an issue for the trust. Without the use of this service, Adult D could have been subject to medical tests without knowing why.

4.4.17. Statistically people from South Asia are up to six times more likely than the general population to have type II diabetes than the general population. The hospital does have translation services in place to support medical services, but this case shows that they have not been used.

4.4.18. Apart from one occasion where the name of Adult D's daughter FP was recorded, there was no record made by the trust of the name of the person who was present with Adult D. During Adult E's interview she stated that she took her mother to all hospital appointments, but this cannot be confirmed. The fact is that the hospital has no record of the identity of the person interpreting and for a vulnerable patient this causes major concerns for the safeguarding procedures and safe practice. It should also be noted that the medical experts stated that another family member should not have been providing consent for Adult D at hospital. This DHR has demonstrated that the trust were not responsive to the needs of a vulnerable person at risk. The IMR showed good practice by the hospital staff in the medical and nursing management of Adult D. However, the reviewer did not find any evidence of communication directly with Adult D to ascertain her wishes and feelings. The IMR reviewer could not find any documented evidence that the Mental Capacity Act (2005) was applied during clinical practice. The capacity of an individual to consent to a procedure should have been considered for every different procedure and on each occasion that treatment was offered or provided. It is considered good practice to note which family members are present at a medical meeting but not policy. Notes may mention a 'daughter' but when a patient has more than one daughter then the identity cannot be established.

4.4.19. The staff were assured by the family that they were managing and that they did not require formal carers' involvement in caring for Adult D therefore no referrals were made to Adult Social Care. The panel considered that there were no concerns raised at medical appointments that would have triggered a carer's assessment and referral to Adult Social Care (ASC). It should be noted that there was no ASC contact with this family.

4.4.20. Whilst the areas of serious concern on consent and capacity may be a matter for CHS Trust, the potential for Adult D to be correctly identified as a Vulnerable Adult is also a matter for this DHR. Adult D had accessed a number of services within the trust and she was never given the opportunity to clearly express her own views on her care or treatment. There is no evidence to show that Adult D would have had the opportunity to voice any concerns, to CHS staff, if she had been subject to abuse at home.

4.5. South London and Maudsley NHS Foundation Trust (SLaM)

4.5.1. SLaM completed an IMR for the DHR process. The reviewer completed a comprehensive report for the panel. The IMR covered the initial referral to the Croydon Memory Service by Adult D's GP in 2012. The contact with SLaM fell outside the timescales set in the Terms of Reference for this DHR. The initial referral from 2012 was included as it evidenced the point at which Adult D was known to have dementia.

4.5.2. After the referral Adult D was seen at home by SLaM staff. On the first visit to Adult D the booked interpreter failed to attend. The member of staff used that opportunity to assess the needs of Adult E as a carer. The subsequent visit included an interpreter. The cognitive testing showed significant cognitive decline. The Multi-Disciplinary Team (MDT) established a diagnosis of dementia. The diagnosis, that relied heavily on cognitive testing of Adult D, was made after using an interpreter. It should be noted that the follow up visits with Adult D by the Community Mental Health Team did not involve the use of an interpreter.

4.5.3. SLaM contact with their patient Adult D and carer, Adult E, ended in 2013 when her case was referred back to her GP.

4.5.4. A review of Adult D's notes has shown that there were no recorded indicators of domestic abuse. The IMR shows that appropriate referrals were made to support agencies and there was clear communication with Adult D's GP practice.

4.5.5. Although the last SLaM contact was at least three years before Adult D's death, they have used the DHR process to review their current systems and processes around carers and domestic abuse. The reviewer was able to provide the chair with up-to-date copies of carers information packs and copies of presentations used in domestic abuse training of

staff. Due to the length of time between the last contact with Adult D and her death it is not intended to analyse further the actions of SLaM staff.

4.5.6. This DHR is particularly pertinent to SLaM as they are now responsible for the long term care of Adult E. A copy of this report will be forwarded to be held as part of Adult E's personal records with SLaM.

4.6. Equality and Diversity

4.6.1. The DHR Panel identified the following protected characteristics of Adult D and Adult E as requiring specific consideration for this case, including how they may have intersected: - sex (Adult D and Adult E); age (Adult D): disability (Adult D and Adult E) race (Adult D and Adult E). In addition, these following factors were also considered: - mental health (Adult D and Adult E); and carer at home (Adult E).

4.6.2. **Sex:** This factor is relevant due to the nature of domestic homicide. Women are more at risk of domestic homicide than men, in this case the perpetrator was a woman. Whilst most perpetrators are men, this does not affect the fact that Adult D's sex alone places her in a group more vulnerable to domestic abuse.

4.6.3. **Race:** This is a significant factor in the case. The initial panel meeting identified the need to involve the lead from the Croydon BME Forum to assist the review. Both victim and perpetrator were of South Indian origin. Race and ethnicity have been shown to potentially impact on an individual's ability, willingness and confidence to engage with services, and to impact on how someone is treated by professionals. In this case the victim was unable to clearly express herself in English. It is apparent that some services did not have effective protocols to ensure that translation services were available. The family have also explained that the family traditions of their culture, as the eldest daughter of Adult D there was an expectation that Adult E should have Adult D live with her family. At the outset Adult D was supportive of Adult E and her husband whilst they worked. Later in life Adult E cared for Adult D at home without seeking support from outside the family. It was accepted that this was what she should do. It should be noted that Adult E did not express any concern about her role as a carer.

4.6.4. **Age:** The review has examined contact with Adult D since she was in her early seventies. The panel considered her age as a key factor in the review from the outset, and sought to seek the expertise of AgeUK to support the DHR process. Whilst being older may not in

itself make a person vulnerable it was a factor in this case when considered with Adult D's other health concerns. Adult D's frailty due to her age combined with her medical conditions of diabetes, dementia and finally lung cancer made her reliant on her carer and extremely vulnerable. This vulnerability and reliance on her daughter to administer insulin enabled her daughter to kill her using prescribed medication available to her.

4.6.5. **Mental Health:** The review has shown that agencies were aware of Adult D's mental health needs. The panel secured representation from a local specialist mental health service user group, Hear Us, to fully support the DHR process. Adult D was diagnosed with dementia aged 73. This was identified as a factor that needed special consideration from the start of the review. The review was able to reflect on the services of the mental health trust, who made the first diagnosis of Adult D's dementia.

4.6.6. Adult E's undiagnosed mental ill health is the most significant factor in the homicide of Adult D. At the time of killing Adult D she was having a psychotic episode, and the frailty of Adult D increased Adult E's ability to kill Adult D with no known resistance. Adult E is now subject to a Mental Health order and is in a secure and caring environment.

4.6.7. **Disability:** From medical records and discussions with Adult D's family it is clear that she had limited mobility for some time before her death. She had difficulties using stairs and her family had made adjustments to the home to support her. Adult D was close to becoming housebound and primary care GP appointments in the time leading up to her death were by way of home visit. On all hospital visits Adult D was taken by her family. Given the level of expertise from medical professionals and non-government organisations on the DHR it was considered that there was no further expertise required for the review.

4.6.8. Whilst the protected characteristics of the case were considered individually, the DHR panel endeavoured to consider how the combination of these factors could affect Adult D in her dealings with services. Adult D was a woman in her seventies with multiple serious health concerns, heavily reliant on her daughter for care and unable to clearly voice any concerns without the use of an interpreter. The review has sought to consider Adult D's perspective at all stages of the DHR process.

5. Conclusions and Lessons to be Learnt

5.1. Conclusion

5.1.1. It is clear in this case that Adult D was subject to domestic abuse from her daughter, Adult E, resulting in her death. That abuse is known to be through the act of giving a lethal overdose of insulin. In August 2016 Adult D was in a vulnerable position, with multiple serious health conditions. It is tragic that at the same time her daughter experienced a psychotic episode, whilst she was alone caring for Adult D. The availability of insulin, that was there to maintain Adult D's health, was utilised by her daughter who was experiencing mental ill health to cause Adult D's death.

5.1.2. It is not the purpose of this review to attempt to predict whether Adult D's death was preventable given the information that was available at the time. This review seeks to learn lessons from Adult D and Adult E's contact with statutory agencies. Through this learning, the review aims to improve services and promote understanding of abuse with a view to preventing harm in the future.

5.1.3. This process has enabled the DHR panel to examine the policies and procedures for safeguarding adults within a number of agencies. The family had limited contact with statutory agencies and these have all been NHS services. The review has established some areas for improvement in safeguarding protocols and training within primary care. Consideration is given to these in the single agency recommendations.

5.1.4. A key issue for this review has been the recognition of the language and translation needs of a vulnerable patient. There was a great reliance on the family to act as interpreters when they accompanied Adult D to medical appointments. An interpreter was used in her initial memory assessment in 2012 and all NHS services record Adult D's language as Malayalam. In the following four years there was no recorded use of an interpreter to communicate with an adult at risk who was experiencing increasing health needs. This included practitioners assessing Adult D's capacity to consent to medical procedures or to inform her of terminal medical conditions. Whilst these matters raise serious internal concerns for the services involved in healthcare, there is a direct impact on the ability of those services to effectively safeguard a vulnerable person.

5.1.5. The ability of Adult D to understand the nature of any treatment and to be able to repeat back that information, to medical professionals, is a key element in determining her

capacity to consent to treatment. It does not appear that an assessment was ever made of her capacity, despite having formal diagnosis of serious health conditions. The combination of her dementia and inability to express herself in English ensured that she effectively had no voice in her dealings with statutory agencies and was merely a body to be treated.

5.1.6. We do not know whether Adult D was a victim of domestic abuse from her daughter in the time leading up to her death. We do know that Adult D had no effective voice when she was seen by agencies outside her family. If she had wanted to tell others that her daughter, was behaving strangely, had mistreated her or that she was giving her the wrong doses of insulin, NHS staff would not have been able to hear those concerns. Adult Ds interaction with healthcare professionals was all managed by her family, and her primary carer was the daughter who would later kill her.

5.1.7. Another key factor in this case has been the perpetrator's undiagnosed mental illness. Adult E's husband had previous concerns about his wife's mental well-being but not enough to feel justified in referring her for support. Whilst Adult D's family had seen that Adult E occasionally behaved in an unpredictable manner, she was never known to have previously experienced a psychotic episode. Adult E spent every day with her mother Adult D, there is no evidence that Adult D told her son-in-law that she had concerns for her daughter. We do not know whether she disclosed any concerns to the wider family.

5.1.8. Adult E's husband had dealt with people with mental ill health in a professional context, but he did not consider that his wife's behaviour warranted any form of intervention. Her husband did know of his wife's previous mental ill health that required her admission to hospital, but this was over 20 years ago and he was not made aware of her diagnosis.

5.1.9. Whilst the public are encouraged to recognise the symptoms of serious physical illness, the same cannot be said for mental ill health. It must be considered that Adult E had a number of interactions with healthcare professionals as a patient and as Adult D's carer and there were never any signs of Adult E showing any behaviour that would cause concerns.

5.1.10. Whilst Adult E was not formally recorded as a 'carer' by health services she was shown as her next of kin. All major decisions concerning Adult D's care were channelled through Adult E and other children of Adult D deferred to Adult E. Whilst Adult E appeared to be coping with the complex healthcare demands of her mother, she was never offered a Carer's Assessment and her own support networks were never assessed by her GP.

5.1.11. Healthcare services aim to work with a 'triangle of care' between healthcare provider, patient and carer. In a case where there should have been channels of communication between three parties. In this case healthcare agencies accepted that the patient's communication with the healthcare provider was managed by her carer. We have since discovered that the 'carer' part of that triangle, Adult E, had an undiagnosed serious mental illness. This review has demonstrated that agencies need to ensure that clear lines of communication between the agency, patients and carers are established. These need to be documented and checked regularly to maintain robust safeguarding for adults in all cases.

5.2. Lessons to be learnt

5.2.1. The lessons identified by the chair and Review Panel are:

Lesson 1. *Responding to the diverse language needs of patients to ensure clear communication with healthcare agencies. There is potential for abuse to be hidden from agencies with safeguarding responsibility.*

- It is essential that the all patients have the opportunity to communicate effectively with those managing their healthcare and making critical decisions. It is known that domestic abuse can often be revealed or disclosed in healthcare settings. It is therefore important that patients with specific communication needs should have access to interpreting services that are independent from family and friends.

5.2.2 ***Lesson 2.*** *Focus on the needs of and capacity of vulnerable persons ensuring that their views are considered and safeguarding concerns can be voiced in privacy.*

- Consideration needs to be given to the capacity of a person to consent to medical care at all times. When a person has mental ill health, it does not automatically mean that they do not have mental capacity. This case has shown that a vulnerable patient's voice was not heard by those treating her. She was of an age, where it seemed acceptable for her children to speak on her behalf. Care should be person focussed and in this case it appears that Adult D was completely overlooked as a person with agency over her own body. Adult D was effectively a 'body' and did not provide any informed consent to medical procedures over many years.

5.2.3. ***Lesson 3.*** *Consider the welfare including physical and mental health of persons caring for vulnerable persons*

- The role of a carer is an important asset to the NHS as well as the people that they care for. A person performing the role should be formally assessed and recognised. Carers should receive appropriate support and checks on their own welfare. There needs to be consideration of the stresses on the carer and how that may impact the person they are caring for.

6. Recommendations

6.1. Recommendations from Agency IMRs

6.1.1. This Review expects that all Review Panel member agencies will share the learning internally with all levels of staff once the DHR is published.

6.1.2. Following each recommendation, in italics, is an update on progress.

6.1.3. **Croydon Clinical Commissioning Group (on behalf of the General Practice):**

The practice should review the recording and consideration of the compliance with the Mental Capacity Act (2005) and Best Interest Decisions

The practice must update their knowledge and understanding of adults at risk

The practice to review their utilisation of interpreters

The practice should update their knowledge on assessments of the needs of carers

The practice should review their safeguarding policy with the support from the CCG Safeguarding Team and incorporate Domestic Abuse including referral pathways.

The practice should identify a DASV Lead

The practice must attend CCG Safeguarding Training, Updates and Workshops and other learning opportunities within the borough.

6.1.4. **Croydon Health Services:**

The Trust must ensure the application of the Mental Capacity Act is embedded in all practice appropriately including fully documenting mental capacity assessments and Best Interest Decisions.

The Trust must ensure that all staff use the interpreters/language line when there is a language barrier, in line with Trust guidance.

6.1.5. **South London and Maudsley NHS Foundation Trust (SLaM):**

The MHOA&D Clinical Academic Group should ensure that staff are aware of the process for booking an interpreter and that all non-English speaking patients to be offered the opportunity to meet clinical staff with a trained interpreter.

The Community Mental Health Teams have received additional training on identifying signs of domestic abuse and appropriate liaison with social services.

6.2. Overview Report Recommendations

6.3. The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Croydon Partnership within six months of the review being approved by the partnership.

6.4. **Recommendation 1**: Croydon Clinical Commissioning Group and Croydon Health Services ensure that referral protocols between primary care, and specialist services include reference to the language needs of patients.

6.5. **Recommendation 2**: Safer Croydon Partnership work with statutory healthcare agencies and local NGOs to implement an initiative raising awareness of mental health and consider the role of carers when safeguarding adults. This will include the promotion of Non-Government Organisations supporting older adults and people with disabilities.

6.6. **Recommendation 3:** Croydon BME Women's Project work in partnership with local statutory healthcare providers and Non-Government organisations to support training for staff.

6.7. **Recommendation 4:** Croydon CCG, CHS and SLaM ensure that the learning from this case is disseminated to practitioners.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Adult D and Adult E following the death of Adult D on 25th October 2016. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1) To review the involvement of each individual agency, statutory and non-statutory, with Adult D and Adult E during the relevant period of time October 2014 – date of Adult D's death (inclusive). To summarise agency involvement and analyse any significant events prior to the death of Adult D.

2) To 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.

3) To 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.

4) To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

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

6) To contribute to a better understanding of the nature of domestic violence and abuse.

7) To highlight good practice.

Role of the DHR Panel, Independent Chair and the CSP

8) The Independent Chair of the DHR will:

a) Chair the Domestic Homicide Review Panel.
b) Co-ordinate the review process.
c) Quality assure the approach and challenge agencies where necessary.
d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9) The Review Panel:

a) Agree robust terms of reference.
b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Safer Croydon Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

***Safer Croydon Partnership*:**

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.

c) Forward Home Office feedback to the family, Review Panel and STADV.
d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

10) The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government 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; and emotional.
Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

11) The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Adult D and the Adult E (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
12) The Review Panel identified the following protected characteristics of Adult D and of Adult E as requiring specific consideration for this case; sex, age, disability, carer, and race.
13) The following issues have also been identified as particularly pertinent to this homicide: mental health, age, disability, carer at home, gender and ethnicity

Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' – a person "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and: Has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

14) Abuse is defined widely and includes domestic and financial abuse. The other crucial difference from the previous definition is that the duties apply regardless of whether the adult lacks mental capacity" (Section 42 Adult (Care Act 2014). The conclusion was that Adult E was at risk at the time of her death.

15) If this is the case, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

16) *Expertise:* The Review Panel will therefore invite Hear Us to the panel as an expert/advisory panel member to the chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide.

17) If Adult D and Adult E have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities. The following person/agency will be invited to contribute to the review to represent the voice of this community: AgeUK, Hear Us and Croydon BME Forum.

18) The Chair of the Review will make the link with relevant interested parties outside the main statutory agencies.

19) The Review Panel agrees it is important to have an intersectional framework to review Adult D and Adult E's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

20) If there are other investigations or inquests into the death, the panel will agree to either:

a. Run the review in parallel to the other investigations, or
b. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.
c. It will be the responsibility of the review panel chair to ensure contact is made with the chair of any parallel process.

[Criminal trial disclosure dealt with in disclosure paragraph below]

Membership

21) It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

22) The following agencies are to be on the Review Panel:
a) Croydon Clinical Commissioning Group (CCG) (to represent the GP practices)
b) Croydon Health Services NHS Trust
c) London Borough of Croydon - Adult Social Care
d) London Borough of Croydon – Safer Croydon Partnership
e) London Borough of Croydon Housing
f) Croydon Family Justice Centre
g) Victim Support
h) South London and Maudsley (SLaM) NHS Foundation Trust
i) Metropolitan Police Service (MPS) – Croydon Borough Community Safety Unit (CSU)
j) MPS – Serious Crime Review Group (SCRG)

23) As set out in paragraph 16 the following will contribute to the review as experts:
a) Hear Us
b) Age UK
c) Croydon BME Forum

Role of Standing Together Against Domestic Violence (STADV) and the Panel

24) STADV have been commissioned by the Safer Croydon Partnership to independently chair this DHR. STADV have in turn appointed their DHR Associate Mark Yexley to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Administrator will provide administrative support to the DHR and the DHR Team Manager Gillian Dennehy will

have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the STADV DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

25) Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

26) Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Adult D and Adult E during the relevant time period:

a.GP

b. Croydon Health Services

c. Adult Social Care

d. Housing

e. SLaM

f. MPS – SCRG (IMR or report as appropriate)

27) Further agencies may be asked to completed chronologies and IMRs if their involvement with Adult D and Adult E becomes apparent through the information received as part of the review.

28) Each IMR will:

- Set out the facts of their involvement with Adult D and/or Adult E;
- Critically analyse the service they provided in line with the specific terms of reference;
- Identify any recommendations for practice or policy in relation to their agency;
- Consider issues of agency activity in other areas and review the impact in this specific case.

29) Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Adult D and Adult E in contact with their agency.

Key Lines of Inquiry

30) In order to critically analyse the incident and the agencies' responses to Adult D and/or Adult E, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Adult D / Adult E and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Analyse how the particular of the victim being cared for at home, age, undiagnosed Mental Health, disability, gender and ethnicity would affect the response of services as individual or combined factors.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

31) Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Croydon Partnership on their action plans within six months of the Review being completed.

32) Safer Croydon Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

33) The review will sensitively attempt to involve the family of Adult D in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of Police Family Liaison Officer.

34) Adult E will be invited to participate in the review, if it is felt appropriate by those managing her care.

35) Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

36) The Review Panel discussed involvement of other informal networks of the Adult D/Adult E and agreed it was proportionate to the DHR to invite the following persons. No informal networks have been identified at the initial panel meeting. This situation will be kept under review.

Media handling

37) Any enquiries from the media and family should be forwarded to the Safer Croydon Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Safer Croydon Partnership will make no comment apart from stating that a review is underway and will report in due course.

38) The Safer Croydon Partnership is responsible for the final publication of the report and for all feedback to staff, family members and media.

Confidentiality

39) All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

40) All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

41) It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

Disclosure

42) The Criminal Investigation and trial was completed before the DHR process and there are no known disclosure issues for Criminal Justice purposes.

43) The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:

a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'. The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs (Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.

b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
    - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
    - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being

disclosed, with the exception of the following relevant situations – where they can be demonstrated:

i) It is needed to prevent serious crime

ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

Appendix 2: Action Plan for Overview Report Recommendations

No	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
Croydon Clinical Commissioning Group (on behalf of the General Practice) (6.1.3.)							
	The practice should review the recording and consideration of the compliance with the Mental Capacity Act (2005) and Best Interest Decisions						
	The practice must update their knowledge and understanding of adults at risk						
	The practice to review their utilisation of interpreters						
	The practice should update their knowledge on assessments of the needs of carers						
	The practice must attend CCG Safeguarding Training, Updates and Workshops and other learning opportunities within the borough.						
Croydon Health Services: (6.1.4.)							
	The Trust must ensure the application of the Mental Capacity Act is embedded in all practice appropriately including fully documenting						

	mental capacity assessments and Best Interest Decisions.						
	The Trust must ensure that all staff use the interpreters/language line when there is a language barrier, in line with Trust guidance.						
South London and Maudsley NHS Foundation Trust (SLaM): (6.1.5.)							
	The MHOA&D Clinical Academic Group should ensure that staff are aware of the process for booking an interpreter and that all non-English speaking patients to be offered the opportunity to meet clinical staff with a trained interpreter.						
	The Community Mental Health Teams have received additional training on identifying signs of domestic abuse and appropriate liaison with social services.						
Overview Report Recommendations (6.2)							
1.	Croydon Clinical Commissioning Group and Croydon Health Services ensure that referral protocols between primary care, and specialist services include reference to the language needs of patients	Place 'are you safe' posters with top 5 languages in GP practices in the borough.		All GP practices in Croydon were provided with posters and small business cards to display.	CCG - EK	Jan 2020	There are also DASV leads in 83% of all GP practices. The leads are responsible for disseminating info about da in Croydon.

		Implement IRISi					Update 2020: IRISi has been funded for 12 months in Croydon. There are two Advocate Educators supporting GP practices who sign up to the training. The practice involved in this case has signed up for training.
2.	Safer Croydon Partnership work with statutory healthcare agencies and local NGOs to implement an initiative raising awareness of mental health and consider the role of carers when safeguarding adults. This will include the promotion of Non-Government Organisations supporting older adults and people with disabilities.						
3.	Croydon BME Women's Project work in partnership with local statutory healthcare providers and Non-Government organisations to support training for staff.	Refer to BME forum	Email sent to Andre Brown,CEO				Update 2019 – This group has been disbanded due to funding. The introduction of IRISi will support GP practices who require training around DASV. The BME forum in Croydon continue to work in the borough supporting black,

							Asian and other ethnic minority women and also drive forward projects which support professionals to better understand the needs of women who share this heritage.
4.	Croydon CCG, CHS and SLaM ensure that the learning from this case is disseminated to practitioners.	DASV Coordinator will share this report with all panel members including Croydon CCG, CHS and SLaM	Email sent will be sent after publication				

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1 June 2020

Dear Ms Goodwin

Thank you for submitting the Domestic Homicide Review (DHR) report (Adult D) to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 22 April therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA panel found this to be a clear, insightful and easy to read report. They noted that the report demonstrates good analysis and effective probing of agencies, with good lessons learnt and strong recommendations. The report did well to review equality and diversity issues, including around sex, race and ethnicity. The Panel commended the panel composition, noting the representation from the BME service and Age UK and the efforts to engage the family and the family priest. They also noted that the author/chair has a clear understanding of issues around patient voice/mental capacity and is very knowledgeable of the issues surrounding domestic abuse

The QA Panel felt that there are some aspects of the report which may benefit from further revision but the Home Office is content that, on completion of these changes, the DHR may be published.

Areas of final development include:

- Point 32 – under heading development of action plan, you may wish to remove the word alleged as the person was convicted.
- It would be helpful to include an explanation for the time delay between the date of the homicide 25/10/2016 to the first notification to the Home Office 13/04/2017. There was no explanation given about this seven month delay.
- 3.3.2 and 3.4.2 uses the initials of the siblings of Adult E
- The Panel suggested the use of pseudonyms as initials make the report difficult to follow at some points. This can also help to humanise the report.
- The Panel felt that there could be an opportunity within the Actions to engage with the Church to widen the message about general help and support for carers or those being cared for, including domestic abuse support.
- The Panel suggested that there could be a recommendation for agencies around patients who regularly have falls to allow that individual a private and confidential space where they are asked how they sustained their injuries and give them the opportunity to disclose any abuse.
- The review could benefit from references where statistics are referred to (for example, at 4.6)
- The report would also benefit from further exploration of economic abuse, including how the perpetrator was being supported as this could highlight further vulnerability of the victim.
- It would appear that the GP practice did not formally recognise the perpetrator as a carer, and it would be helpful to have referenced in the report whether the GP practice had a register of carers. This could be a recommendation for them to ensure that carers are recorded on that register.
- The Panel also recommended that report provides assurance that action has been taken to embed learning from DHRs in the GP practice, in light of their involvement in a previous DHR.
- The Panel suggested that you may wish to consider a recommendation around challenging the 'keeping it in the family' concept, perhaps through a culturally sensitive awareness-raising campaign.
- The final report does not appear to have been shared with the perpetrator's husband who contributed. If the report has been shared, this should be reflected.
- The Action Plan should contain all the agency recommendations and should be adequately completed.
- There are a number of typos and formatting errors which needs to be addressed.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The Home Office believes it helpful to sight Police and Crime Commissioners (PCCs) on DHRs in their local area, and this letter will therefore be copied to your local PCC for information.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel