



**WOKINGHAM**  
**BOROUGH COUNCIL**

# **Wokingham Community Safety Partnership**

## **DHR Overview Report Executive Summary**

**Chair**

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## **1. Introduction**

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected deaths of Adult A & B in Earley, Berkshire in September 2013. The Office for National Statistics places Earley within the Reading/Wokingham Urban Area. For the purposes of local government it falls within the Borough of Wokingham and outside the area of Reading Borough Council.

The DHR was commissioned by the Community Safety Partnership of Wokingham Borough Council (WBC). On 28<sup>th</sup> September 2013, both Adult A and B were found deceased at their home address by their daughter. The cause of both deaths was found to be as a consequence of insulin administration.

## **2. The DHR process**

The decision to undertake the DHR was taken following instruction from the Home Office on 1<sup>st</sup> September 2014.

Prior to commencement of the DHR numerous discussions were held between the Chief Executive of the Council, who chairs the CSP, and the DHR Unit, regarding the scale and scope of this review. This was based on the Coroner's verdict, the prior completion of a formal review under the auspices of the Adult Safeguarding Board, and the sensitivities relating to the position of the sole surviving relative, the couple's daughter, who was shocked and distressed to learn that a further examination of the circumstances of her parents' death was to be undertaken.

It was agreed, through these discussions, that a proportionate approach would be appropriate, in relation to the DHR, and that it should build on, rather than ignore or replicate, the Adult Safeguarding Board review. Decisions taken regarding the chairing and membership of the sub-group overseeing the production of the DHR, and regarding the 'reach' of the investigations, were framed in this context of proportionality.

A panel of agency representatives was formed and an independent author was appointed. Individual Management Reports (IMRs) were requested from the

agencies that had been in contact with or providing services to both Adult A and Adult B

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both Adult A and Adult B.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

The DHR Panel received and considered IMRs from the following agencies:

- Age UK Berkshire
- NHS Wokingham CCG – General Practitioner
- Wokingham Borough Council – Health & Wellbeing
- Royal Berkshire NHS Foundation Trust
- Thames Valley Police
- South Central Ambulance Service

### **3. Views of the family**

The independent author of the Overview Report interviewed Adult A and Adult B's daughter (Adult C). The purpose of this discussion was to follow-up on the correspondence from the DHR panel about the process and to gather any further relevant and helpful information about Adult A and Adult B that might assist the DHR.

Adult C provided helpful background and insights in to her parents lives, their circumstances in the period leading up to the incident and her views about the interventions and actions of those agencies with which her parents had contact.

### **4. Conclusions**

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by Adult A and Adult B's daughter, the panel has drawn the following conclusions:



*The panel concludes that* there is no evidence to substantiate any incidents of domestic abuse. Although the GP IMR suggests a change in Adult B's behaviour, describing it as "irritability/violent" the IMR makes no link between this and any examples of domestic abuse. The GP involved was clear that there was no indication that the relationship between Adult A and Adult B was abusive in any way. The discussions with Adult A and Adult B's daughter explored this matter and no examples of domestic abuse were reported. On this basis the panel concluded that there was no evidence to confirm any incidents of domestic abuse in this case.

*The panel concludes that* the systems, policies and processes of the NHS and WBC did not impact directly on the incident itself. There are examples of confusion and lack of clarity which may have delayed engagement from professionals, but there is no evidence to indicate that these contributed to the deaths of Adult A and Adult B.

*The panel concludes that* there was a lack of consideration by professionals of the interaction between the physical health and mental health and wellbeing of Adults A and B. Although there is no evidence to indicate that this contributed to the incident, it is an area of practice that requires improvement.

*The panel concludes that* the engagement of the Occupational Therapist was one that sought not only to gather information to make an accurate assessment of Adult A's needs, but that the OT attempted to gain a wider picture of her circumstances.

*The panel concludes that* the engagement of professionals could have been more proactive and should have ensured a clearer expression of the choices and options available to Adult A in her caring role.

*The panel concludes that* recognition of the caring role of Adult A was not sufficiently or adequately assessed or understood.

*The panel concludes that* professionals need to take greater account of the new contract between them and customers or patients. The promotion of increased levels of self-care and self-management are right and proper, but should not blur or dilute the statutory responsibilities of public bodies and their staff.

*The panel concludes* that the DHR process, while enabling further review and the identification of some, limited new information, may not always be the most appropriate process for review of this type of case.

## **5. Predictability and preventability**

The panel has considered whether the deaths of Adult A and Adult B could have been predicted or prevented. Based on the information provided, and the analysis of that information, there is no evidence to indicate that any professional could have foreseen the actions that lead to Adult A and B's death. Their daughter is also of this view.

No evidence could be found to substantiate any history of domestic violence or abuse. Although the GP IMR indicates that Adult B's behaviour had become more erratic and that he had at times become "irritable/violent". The panel, as with the IMR, found no detail about the exact nature of this and there is no evidence to indicate that it took the form of domestic abuse. The GP involved stated that during the IMR process, that on the occasions that she saw the couple together or when she saw either party alone, there was no indication that the relationship was abusive or violent.

There is no indication that the actions taken by Adult A and Adult B had been discussed with anyone other than each other.

On the basis on the information reviewed, the panel believes that the incident was neither predictable or preventable.

## **6. Recommendations**

The IMRs contained their own recommendations and these are set out in the main Overview Report. The DHR panel made five recommendations arising from the review:

1. We recommend that a work programme be undertaken within health and adult social care to raise awareness and understanding of the links and impact of older age in relation to the mental health and well being of older people in order that professionals may be better equipped to conduct more holistic assessments of customers/patients needs.
2. We recommend that the definitions of vulnerability utilised by health and adult social care be reviewed to ensure their compliance with national policy and that front line staff are provided with updated information about that definition.
3. We recommend that systems and processes for referral to adult social care are regularly reviewed to ensure fitness for purpose and that they are well understood by all agencies, including those in the voluntary sector.
4. We recommend that the NHS England regional team work with SCAS to develop their understanding of conducting IMRs to an appropriate standard and that SCAS then embed this within their operating policies.
5. We recommend that the appropriateness of the use of the DHR process in cases where individuals have taken a decision mutually end their lives, is considered by policy makers nationally to ensure a proportionate and appropriate response to any future instances such as that examined by this review.