REPORT INTO THE DEATH OF MRS LOWE

Executive Summary

REPORT PRODUCED BY GRAHAM BARTLETT

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Mrs. Lowe, a resident of the Isle of Wight, prior to her being found dead, along with her husband Mr. Lowe, on 20th June 2016. The review will consider agencies contact/ involvement with Mrs. and Mr. Lowe from 1st April 2011 to the 20th June 2016.

1.2 The circumstances of the deaths are that police were called to Mrs. and Mr. Lowe's address just after 7am on Monday 20th June 2016. A neighbour had found a note on the front door of the house instructing that the police be called.

1.3 Officers attended and found the house insecure albeit both the front and rear doors were intact and there were no signs of a break in or disturbance.

1.4 Upon entry, officers found the body of Mr. Lowe hanging by the neck by a rope that was tied to the upper landing bannister. A stepladder beneath him was in a position that indicated it could have been kicked over. A note was found on the stairs by the officers indicating Mr. Lowe had killed his wife, Mrs. Lowe, due to her mental illness and his difficulty in caring for her.

1.5 Officers then found Mrs. Lowe dead on the sofa in the lounge, lying on her back covered in a blanket. She appeared to have injuries to the back of her head.

1.6 Enquiries with neighbours revealed that Mr. Lowe had last been seen the previous afternoon while Mrs. Lowe was last seen alive late afternoon three days before the deaths.

1.7 On the day after the deaths were discovered a Home Office Pathologist conducted post mortem examinations on Mrs. and Mr. Lowe. The cause of death for Mrs. Lowe was established as neck compression. The cause of death for Mr. Lowe was established as ligature suspension.

1.8 Inquests into the deaths concluded that Mrs Lowe was unlawfully killed and Mr Lowe took his own life.

1.9 The Domestic Homicide Review Panel and the Isle Of Wight Community Safety Partnership offer their sincere condolences to Mrs. and Mr. Lowe's family and friends on their sad and tragic loss.

2. Process of the Review

2.1 This review was commissioned at a meeting of the Isle of Wight Community Safety Partnership on the 23rd June 2016 in line with the Multi Agency Guidance for the Conduct of Domestic Homicide Reviews 2013[1]. The chair and author was appointed shortly afterwards and the review started immediately. It should be pointed out that in December 2016 HM Government published revised Multi Agency Guidance but in light of this review being commissioned some six months beforehand, this review complies with the 2013 Guidance. Consideration was given by the Isle of White Safeguarding Adults Board (SAB) as to whether to undertake a Safeguarding Adults Review (SAR). It was agreed that the SAB would be represented on the DHR panel to ensure that the necessary consideration was given to Mrs and Mr Lowe's care and support needs and whether Section 42 of the Care Act 2014 applied to them and to avoid parallel processes.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

2.2 Mr Graham Bartlett was appointed to chair and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd and Independent Chair of Brighton and Hove Local Safeguarding Children Board. He also Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards. He has completed the Home Office on line training for independent chairs of Domestic Homicide Reviews and has the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing a number of Domestic Homicide Reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for the city of Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight.

2.3 A Domestic Homicide Review panel was established which set the terms of reference for the review and whose report this is. The Panel comprised:

Graham Bartlett	Independent Chair and Reviewer
Amanda Gregory	Isle of Wight Council (IOWC) – Regulatory and Community Safety Services Manager
Helen Turner	IOWC - Community Safety Operations Manager
Sarah Johnston	IOW NHS Trust
Claire Foreman	IOWC – Interim Director Adult Social Care
Jane Janvrin	IOW Community Rehabilitation Company
Val Bell	IOWC Housing
Su Tomkins	IOW NHS Trust
Mark O'Sullivan	IOW Age UK
Maggie Bennett	Independent Homes Association
Mandy Tyson	IOW Clinical Commissioning Group
Bruce Marr	Independent DA Advisor
Ruth Attfield	Hampshire Constabulary

2.4 The specific terms of reference set for this review to consider were:

- Whilst Mrs. Lowe had no known contact with any specialist domestic abuse agencies or services, the review will consider whether there was any history of domestic abuse involving Mrs. Lowe and/or Mr. Lowe and therefore whether there were any warning signs.

- How opportunities to 'routinely enquire' as to any domestic abuse, sexual violence or carer stress[2] experienced by the victim or perpetrator were or were not identified and used by professionals and what was the outcome.

- Whether professionals took opportunities to consider the health and wellbeing of Mrs. and Mr. Lowe as a couple as well as individuals, including any dependencies they had on one another and their capacity to manage those.

- Whether there were opportunities for professionals to refer any reports of

[2] the emotional and physical strain of **caregiving**. It can take many forms. For instance, you may feel: Frustrated and angry taking care of someone with dementia who often wanders away or becomes easily upset.

domestic abuse or sexual violence experienced by the victim or committed by the alleged perpetrator (towards Mrs. Lowe or any other partner) to other agencies and whether those opportunities were taken.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mrs. Lowe, the alleged perpetrator or the dependent children that were missed or could have been improved.

- Whether there were any barriers or disincentives experienced or perceived by Mrs. Lowe or her family/ friends/colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide and what they did or did not do as a consequence.

- Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.
- Whether Mrs. Lowe had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on her likelihood of seeking support in the months before she died.

- Whether the homicide could have been accurately predicted and prevented.

In addition:

- The review will give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services on the Isle of Wight.

The period set for the review to consider was 1st April 2011 and 20TH June 2016.

2.5 Following the decision to commission this Domestic Homicide Review, Isle of Wight Council wrote to the following agencies requesting they return Summaries of Involvement to help the panel understand which agencies had relevant involvement with Mrs. Lowe and/ or Mr. Lowe within the time period of this review:

- Isle of Wight Community Rehabilitation Company
- Department of Work and Pensions
- Hampshire Constabulary
- Island Recovery Integrated Services. (IRIS)

- Island Refuge
- Isle of Wight Adult Social Care
- Isle of Wight Age UK
- Isle of Wight Citizens Advice Bureau
- Isle of Wight Clinical Commissioning Group (CCG)
- Isle of Wight Community Watch
- Isle of Wight Council Children's Services
- Isle of Wight Council Community Safety
- Isle of Wight Council Housing
- Isle of Wight Fire and Rescue Service
- Isle of Wight Mental Health NHS Trust
- Isle of Wight NHS Trust
- National Probation Service
- Spectrum Housing

2.6 Having considered these Summaries of Involvement, it was decided that the following agencies would be asked to submit Individual Management Reviews:

- Isle of Wight CCG - Primary Care
- Isle of Wight NHS Trust
- Isle of Wight Fire and Rescue Service
- Isle of Wight Age UK

2.7 The authors of the IMRs are, as far as possible, independent in accordance with the guidance.

2.8 The objective of the IMRs, which form the basis of this DHR, is to give as accurate an account as possible of what originally transpired in an agency's response, to evaluate it fairly and, if necessary, to identify any improvements for future practice. IMRs also propose specific solutions, which are likely to provide a more effective response to a similar situation in the future. The IMRs have assessed any changes that may have taken place in service provision during the timescale of the review and considered if further changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse

2.9 This report is based upon those IMRs, a review of the statements taken by the police, interviews with Mrs. and Mr. Lowe's son and daughter and considerations of the DHR Panel.

2.10 The report's conclusions and recommendations are the collective views of the Panel, which has the responsibility, through its constituent agencies, for implementing the recommendations.

3. Findings of the Review

3.1. From all of the information gleaned from family, professionals, friends and neighbours there was no suggestion that there was any history of domestic abuse between Mrs. and Mr. Lowe or involving either of them with anyone else.

3.2 The only possible sign was Mr. Lowe's mention in a letter, in 2008, to his GP that he was "looking for domestic trouble" and to "ask his wife." Given that no one enquired further about this it is not possible to understand what this comment referred to. This was a missed opportunity. However, from everything else considered by this review, there was no evidence to suggest that it revealed that domestic abuse was, or was at risk of, occurring. This was the one opportunity to 'routinely enquire' whether domestic abuse was a factor in the lives of Mrs. Lowe or Mr. Lowe.

3.3 This was not followed up or even referred to again. It could have meant different things but the fact that it appeared not to trigger curiosity in anyone is a cause for concern. This was of even greater concern as a month previously Mr. Lowe had insisted being present during a routine consultation with Mrs. Lowe when she presented with a dry cough. Some perpetrators of domestic violence prevent their victims attending medical appointments alone to discourage them from revealing the abuse they are suffering. There was nothing to suggest that was why Mr. Lowe was determined to attend that appointment but, once the surgery received his letter with the "domestic trouble" comment, the two events should have been put together and efforts made to ascertain whether Mrs. Lowe was safe.

3.4 It was notable, however, that there seemed to be no other efforts by Mr. Lowe to prevent Mrs. Lowe being alone with professionals, friends or family. In fact he was very happy for her to go to the shops alone and to go for a walk with the Care Navigator. This may indicate that he did not fear she would reveal that she was suffering from violence and abuse and, the evidence considered by this review points to the conclusion that she was not.

3.5 There were missed opportunities to consider how Mrs. and Mr. Lowe were managing to care for one another while each was living with deteriorating health. Mrs. Lowe's dementia was undiagnosed as the only assessment of her revealed she had 'mild cognitive impairment.' On the other hand, Mr. Lowe was well known to primary care, urology and oncology and each knew that he was getting sicker.

3.6 He was well known for declining various treatments, procedures and services and, given he had capacity, his wishes were respected. However, no one seemed to ask the question as to how he was being cared for. Nor did anyone re-consider Mrs. Lowe's diagnosis and wonder whether she was able to meet Mr. Lowe's care needs or whether he could meet hers; no carer assessment was carried out in respect of either.

3.7 Both Mrs. and Mr. Lowe hid their worsening situation from everyone, except their family and immediate next-door neighbours. They were adamant as to what help they would and would not entertain and even their son and daughter struggled to persuade them to accept even the most basic support.

3.8 Therefore no one else recognised that they were struggling. Even if they had it may have been that they would have rejected offers of support. However, it did not occur to anyone to enquire how they were coping, nor to consider their complex care and support needs and how they might be addressed.

3.9 While efforts were made to meet Mr. Lowe's physical health needs and, on one occasion, Mrs. Lowe's mental health needs little consideration was given to the dependencies they had on one another.

3.10 Had annual health checks been in place for either, had professionals looked at their socioeconomic and domestic circumstances, how their care and support needs were being met and carried out carers assessments, they may have uncovered a couple struggling to look after one another as each of their health deteriorated.

3.11 Had greater efforts been made to learn the perspectives of their family, this may have provided those charged with meeting their health and wellbeing needs a richer understanding of how both Mrs. & Mr. Lowe's capacity to care for each other was diminishing.

3.12 Between them they were seen by primary care, psychiatric services, urology and oncology in relation only to their conditions and not their wider circumstances. No one joined the dots that their needs were not being met.

3.13 An exception to this was Isle of Wight Fire and Rescue Service and Age UK Isle of Wight who recognised that there were deeper needs than those directly caused by Mr. Lowe's cancer. However, to Age UKIW, Mrs. Lowe presented better than she did to her family and neighbours and Mr. Lowe appeared to be managing. Notwithstanding that, the Care Navigator did offer a whole range of services the vast majority of which were declined.

3.14 This review is not asserting that it would have been easy to persuade Mrs. & Mr. Lowe to accept additional support to enhance their health and wellbeing, certainly not since Mrs Lowe made it clear she did not want help and her husband reluctantly supported her views They had a history of preferring to meet their own needs and did not welcome help from outsiders. However, with the notable exception described at para 3.13 and the efforts of the family to encourage them to accept help, no professional looked at the couple in the round and was curious whether their needs were being met and if not how they could be.

3.15 There were no reports or suspicions of domestic or sexual violence being experienced by Mrs. Lowe nor perpetrated by Mr. Lowe, on her or anyone else, so no opportunities existed and thus none missed.

3.16 Other than the matter referred to previously at paras 3.2 and 3.3, there were no opportunities for agency intervention related to domestic abuse thus none that were missed or could be improved.

3.17 There was no evidence or suspicion, prior to the homicide, of any domestic abuse having been experienced or suspected in this case so family and friends had no opportunity to report it to any agency.

3.18 There was no reason to consider that Mrs. Lowe would have sought support from any domestic abuse services. Had she been experiencing any violence and abuse, a perfect opportunity to ask about what options were available to her was when she went for a walk with the Care Navigator, without Mr. Lowe. It was clear during that time they spoke freely and the CN repeated several support options she may wish to consider. None of these were specialist domestic abuse services as there was no reason to think they were needed. However, it is reasonable to predict that despite both Mrs. and Mr. Lowe being reluctant to accept services if ever Mrs. Lowe felt she needed such support that was the moment she might have asked.

3.19 When asked, the family – who do not live on the Isle of Wight – did not know which agencies they would have contacted had they been worried that Mrs. Lowe was experiencing domestic abuse. However, they said they would have carried out an internet search to find out.

3.20 The provision of domestic abuse services on the Island is chiefly through Island Refuge and Outreach Services. A simple Google search identifies, through the Isle of Wight Council website, the nature of domestic abuse, basic safety measures people can take and available help lines including Island Women's Refuge and Outreach team, Police Public Protection, National Domestic Abuse Helpline, Broken Rainbow (for LGBT victims) and Men's Advice Line.

3.21 Mrs. and Mr. Lowe had been married for fifty-five years and there was no evidence of either being in any other relationship at all during that time. There is no evidence of Mrs. Lowe having experienced domestic abuse prior to her relationship with Mr. Lowe or at any other time.

3.22 Mr. Lowe was very sick and his wife's mental health was deteriorating. All those who knew them spoke of a loving couple who were determined to support each other and were, perhaps, too proud to accept outside help.

3.23 Mr. Lowe was becoming very concerned how Mrs. Lowe would be cared for should he have to go back into hospital. He suspected that if he did, he would be unlikely to come out. Mrs. Lowe had, for a long time, dismissed the option of moving into residential care, and suggestions that any other form of care be considered were rebuffed.

3.24 It seemed that the options for caring for Mrs. Lowe were diminishing and this may well have played heavily on Mr. Lowe's mind but at no time did he appear to be considering killing his wife or himself. Family members are now of the view that he did what he did as he loved his wife so much and could not bear the thought of her suffering or being unhappy while he was in hospital or after he died. They never considered he would harm Mrs. Lowe.

3.25 While there were missed opportunities to understand and to attempt to meet their changing care and support needs, nothing seen or suspected by anyone who met or saw Mrs. and Mr. Lowe over the period of this review indicated that Mr. Lowe had an intention to kill his wife nor that he had a suicidal ideation. There was no reason for them to have suspected that to be the case

3.26 Based on previous attempts to avail Mrs. and Mr. Lowe with supportive services it is unlikely that, even if more had been done to offer them support, they would have accepted it.

3.27 Therefore based of everything available to this review, there is no evidence to suggest that this homicide was either predictable or preventable.

4. Good Practice Points

4.1 The Isle of Wight Fire and Rescue service enable their 'Isle be Safe and Well' referrals to be made by trained staff acting in a personal as well as professional capacity in appropriate cases. Other agencies would be well advised to ensure their staff are enabled to act in this way**.**

4.2 The arrangements between Isle of Wight Fire and Rescue Service and Age UK Isle of Wight to directly support those found to be in need, appear to be simple, timely and effective allowing older residents to access a range and variety of services to enhance their health, wellbeing and quality of life.

5. Lessons Learned

5.1 Some Primary Care practitioners have a poor knowledge base or understanding of the prevalence and risk factors for Domestic Violence and do not routinely enquire whether it is a factor in their patients' lives. This may be a consequence of there currently being no mandatory training regarding domestic violence within primary care on the Isle of Wight.

5.2 Following a new diagnosis of cancer, Primary Care practitioners do not always regularly review patients' physical health, mental health, mental capacity or wellbeing. This misses the opportunity to address any changing needs, care plans, requirements or support especially where the patient's main carer develops their own care and support needs.

5.3 In the case of some patients over the age of 75, some named and accountable GPs do not meet their contractual requirements in respect of undertaking full physical assessments and holistic reviews of their care requirements, undertaking medication reviews and co-ordinating a multi agency care package that meets their needs.

5.4 In some cases, mild cognitive impairment in the older population can be seen as a static state rather than the onset of dementia and worsening mental health. The consequence of this is a lack of further review or the provision of information should symptoms deteriorate. Had Mrs. Lowe's health check been in place, this may have been picked up.

5.5 The principles of the Care Act 2014 in identifying, assessing and supporting carers' health and wellbeing needs is not fully embedded across the Isle of Wight health and social care system, potentially leaving some without the necessary support and information they require to provide care, especially when they have their own care and support needs.

5.6 There may be a lack of awareness of the role and function of the Vulnerable Adults Panel on the Isle of Wight. This may mean that those people who fall below the safeguarding threshold, yet still have needs, are not considered in a multi agency environment potentially leaving them vulnerable.

5.7 While memory service assessments are undertaken in a timely way and at the patient's home, they do not take into consideration the needs of carers nor provide guidance as to how to seek help should symptoms deteriorate or care needs are no longer able to be met.

6. Recommendations

6.1 Primary Care practitioners should be reminded of the importance of recording all patient interactions, of any nature, in the individual patient record so as to provide a full record of care and communication occurs.

6.2 That Isle of Wight Clinical Commissioning Group, in conjunction with NHS England, develop mandatory workforce development measures for Primary Care to ensure that the knowledge and understanding of the prevalence and risk factors around domestic abuse are fully understood enabling them to embed the NICE Quality Standards on Domestic Violence and Abuse into practice.

6.3 That Isle of Wight Clinical Commissioning Group, supported by NHS England, remind Primary Care practitioners of the importance of leading the arrangements for regular multi disciplinary reviews of the treatment and care and support needs of patients with new diagnoses of cancer based upon assessments of their holistic health and wellbeing and that of any carers.

6.4 That NHS England, supported by the Isle of Wight Clinical Commissioning Group, develop robust mechanisms to assure that the contractual requirements regarding the function of named and accountable GPs are adhered to fully so that this cohort of potentially vulnerable people receive co-ordinated and tailored health care which meets their changing needs.

6.5 General Practices across the Isle of Wight should adopt the principals of The Gold Standard Framework so that they are able to offer integrated and co-ordinated end of life care which meets the wishes and needs of their patients and their families.

6.6 Linked to Recommendation 4, NHS England supported by CCG should ensure that older patients who have a diagnosis that may indicate a progressive illness, including but not restricted, to dementia have information provided to them should their symptoms worsen and have their condition and care and support needs regularly reviewed.

6.7 That the Isle of Wight Safeguarding Adults Board works with the Health and Wellbeing Board to adopt the Memorandum of Understanding suggested in 'An Integrated Approach to Identifying and Assessing Carer Health and Wellbeing' in order to demonstrate commitment to the duties of co-operation and promotion of wellbeing, as well as the wider commitment to identifying, recognising, assessing and supporting Carers.

6.8 That agencies on the Isle of Wight ensure that professionals who encounter those people with safeguarding needs that may fall below the eligibility threshold are aware of the Vulnerable Adults Panel, are familiar with its role and function and are trained so as to be confident in identifying relevant cases and making referrals to it.

6.9 Isle of Wight mental health and learning disabilities services should ensure that all assessments take into account the needs of carers and, where appropriate, referrals to carers' support agencies should routinely be offered as well as information regarding available services and pathways should the patient's condition deteriorate or needs change.