DOMESTIC HOMICIDE REVIEW

Executive Summary

ISLE OF WIGHT COMMUNITY SAFETY PARTNERSHIP

Mrs Fleming

Author – Graham Bartlett

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1. INTRODUCTION

1.1. This report of a domestic homicide review examines agency responses and support given to Mrs Fleming, an 83-year-old British female resident of the Isle of Wight, prior to her death on 31st August 2015. When she died she showed signs of severe neglect/ self-neglect.

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

1.3. The subjects of the review are:

Victim	**Name**	Mrs Fleming
	Age at Death	83
	DOD	31/08/2015
Victim's Son	**Name**	Mr Fleming
	Age at Death of Mrs Flemming	57
	Relationship to Victim	Son
	Charge(s)	1) Gross Negligence (Involuntary) Manslaughter 2) Causing the death of a vulnerable adult Acquitted of both

1.4. The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 states that a domestic homicide review must be held where the circumstances in which a person aged 16 or over has died and the death had, or appears to have, resulted from violence, abuse or neglect by—

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

1.5. The purpose of a DHR is 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;
- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children, by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

1.6. The initial pathology report into Mrs Fleming's death, in 2015, did not enable the police to regard that the case met the criminal threshold.

1.7. The initial post mortem results identified the cause of death as:

- 1a) Bilateral pulmonary thrombosis
- 1b) Left side deep vein thrombosis
- 1c) Immobility

With coronary artery disease as a contributory factor.

1.8. The pathologist took the view that Mr Fleming had done "a really good job of keeping Mrs Fleming clean" and paid tribute to the level of care he had provided. She concluded that there was no indication of a lack of care.

1.9. In October 2015 the police investigation was concluded and Mr Fleming was informed that no further action would be taken against him in relation to the death of his mother.

1.10. Following contact from the Coroner's office in 2017, in December 2017 the death was reinvestigated by Hampshire Constabulary Major Investigations Team.

1.11. Following the engagement of a second expert, a consultant geriatrician, a further opinion was provided. This said that Mrs Fleming died of a pulmonary embolism caused by prolonged immobility. The geriatrician continued *'The available evidence suggests the patient lacked mental capacity due to chronic medical disease; with likely additional mental disease (such as dementia or depression.)… Post Mortem examination showed evidence of malnutrition, and skin ulceration due to fixed abnormal neck position with underlying deep bone damage. Earlier medical intervention … could have prevented Mrs Fleming's death. In my professional opinion, Mr Fleming should have sought medical support at an earlier stage and by refusing to take this course of action, he severely neglected the welfare of his mother.'*

1.12. This re-investigation has resulted in the CPS decision for charges of Gross Negligence (Involuntary) Manslaughter and Causing the death of a vulnerable adult to be brought against Mr Fleming. In November 2019 he was acquitted of those charges after a trial at Winchester Crown Court.

1.13. This case was referred to the Isle of Wight Safeguarding Adults Review sub group for consideration in January 2018. Due to only health agencies being involved it was

considered that the statutory criteria for a Safeguarding Adults Review[1] was not met. A review of health services involvement has been undertaken by the Named GP for Safeguarding and learning identified.

1.14. This review has been shared with the Community Safety Partnership (CSP) for their information and consideration. Given this case involved an allegation of abuse and neglect by Mr Fleming towards Mrs Fleming, it was rightly understood to fall under the definition of domestic abuse. As Mrs Fleming is believed to have died due to that abuse and neglect, notwithstanding there was only one agency involved, it also fell under the definition for a domestic homicide review.

1.15. The CSP received the referral for a DHR from the police on 31 January 2019, this was considered by the CSP on 13 February 2019 and partners agreed for a DHR to be commissioned.

2. TIMESCALES

2.1. This review began in February 2019 and was concluded in January 2020. The reason for there being so long between Mrs Fleming's death and the commissioning of this review was due to the initial investigation showing no criminal offences disclosed. This position was reviewed following the Coroner's intervention, the police re-investigation and the Crown Prosecution Service's decision that Mr Fleming was to be charged as highlighted above. There then followed the Safeguarding Adults Board considerations and subsequently the CSP.

3. CONFIDENTIALITY

3.1. Whilst key issues have been shared with organisations, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were approved by the Review Panel.

3.2. The IMRs will not be published but the redacted overview DHR report and Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

3.3. The content of the Overview Report and Executive Summary is anonymised in order to protect the identity of the victim, relevant family members, staff and others, and to comply with the General Data Protection Regulations. All names contained, other than professionals, are pseudonyms.

3.4. Mrs Fleming's family have been given the opportunity to read a draft copy of this report and will be provided a final copy two weeks before publication. They did not wish to view it, saying that they wanted to put the matter behind them.

4. TERMS OF REFERENCE

4.1. The specific terms of reference set for this review to consider are:

- Whilst Mrs Fleming had no known contact with any specialist domestic abuse agencies

[1] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

or services, the review will consider whether there was any history of domestic abuse involving Mrs Fleming and Mr Fleming and therefore whether there were any warning signs.

- How opportunities to 'routinely enquire' as to any domestic abuse, neglect, self-neglect, sexual violence or carer stress experienced by the victim or family of were, or were not, identified and taken by professionals and what was the outcome.
- Whether professionals took opportunities to consider the health and wellbeing of **both** Mrs Fleming and Mr Fleming and whether either needed carer support in their role towards the other
- Whether there were opportunities for professionals to refer any reports of domestic abuse, neglect, self-neglect or sexual violence experienced by the victim to other agencies and whether those opportunities were taken.
- Whether there were opportunities for agency intervention in relation to domestic abuse, neglect or self-neglect regarding Mrs Fleming or Mr Fleming that were missed or could have been improved.
- Whether either Mrs Fleming or Mr Fleming had care and support needs, whether as a consequence of those care and support needs either suffered abuse or neglect (including self-neglect) and if so the nature and quality of the single and/ or multi agency response to that, including how their wishes and feelings were taken into consideration.
- Whether there were any barriers or disincentives experienced or perceived by Mrs Fleming, Mr Fleming or their family/ friends/colleagues in reporting any abuse, neglect or self-neglect, including whether they knew how to report 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 abuse, neglect or self-neglect, relating to Mrs Fleming or Mr Fleming, 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, neglect or self-neglect, their families, friends or perpetrators.

Additional lines of enquiry

- The review will consider any equality and diversity issues that appear pertinent to the victim, victim's family 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.

4.2. The time period to be reviewed was agreed as being 31st August 2012 to 31st August 2015.

5. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

5.1. Mrs Fleming had no social contact with anyone other than her son. When spoken to by the police following these events, some neighbours believed she had already died.

However, her cousin who lives nearby, her niece and a local gardener were interviewed.

5.2. Mrs Fleming's cousin was provided with the Home Office leaflet, offered specialist and expert advocacy, specifically Advocacy After Fatal Domestic Abuse – she declined -, and updated regularly including the sharing of the Terms of Reference.

5.3. It is important to understand that Mrs Fleming was not close to any family member, except her son, and even her cousin said that she did not see her for months at a time. There were no other family members therefore, other than the cousin, with whom the review could consult, and she was clear that she was not close to her.

5.4. A decision was taken by the panel not to interview Mr Fleming until after the trial. This decision was taken on the basis that the police had provided the extensive record of his interview which took place immediately after his mother died and this is comprehensive enough to understand his perspectives. Once acquitted, Mr Fleming was contacted twice through his solicitor to ascertain whether he wished to contribute to this review. The review received no reply to either contacts so took the view that he did not wish to.

6. CONTRIBUTORS TO THE REVIEW

6.1. Initially, the following agencies were required to submit Summaries of Involvement to allow the panel an opportunity to understand the nature and scope of their involvement with Mrs Fleming and/ or Mr Fleming during the time period under review.

- Age UK Isle of Wight
- Department of Work and Pensions
- Hampshire Constabulary
- Isle of Wight Council – Adult Social Care
- Isle of Wight Council – Housing
- Isle of Wight Fire and Rescue Service
- Isle of Wight NHS Trust – Hospital Services
- Isle of Wight NHS Trust – Mental Health Services
- Red Cross
- Primary Care 'Practice Q'

6.2. Having reviewed the summaries of involvement at the initial panel meeting on the 13th March 2019, it was established that the only agencies to have had any involvement with either Mrs Fleming or Mr Fleming during the period were Primary Care 'Practice Q' and St Mary's Hospital. Both of these providers had been subject to the review undertaken by the Named GP for Safeguarding and that report served as the IMR.

6.3. The lead reviewer interviewed Mrs Fleming's named and accountable GP, her cousin, niece and her gardener. The police provided the review with statements from medical staff at Practice Q as well as those from her cousin and gardener. Efforts were made to establish whether any local service providers such as refuse collectors or post-delivery staff held any relevant knowledge but they had nothing to add.

7. THE REVIEW PANEL

7.1. Mr Graham Bartlett was appointed to chair the Domestic Homicide Review panel and be the author for this review. He is the Director of South Downs Leadership and

Management Services Ltd. He Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards and, until recently, was the Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has completed the Home Office online training for independent chairs of Domestic Homicide Reviews and the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing six Domestic Homicide Reviews and is currently lead reviewer for a serious case review and a safeguarding adults multi agency review. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for 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.

7.2. The panel comprised the following members:

- Graham Bartlett - Independent Chair
- Amanda Gregory - Isle of Wight Council (IOWC) Chair of Community Safety Partnership
- Helen Turner - IOWC Community Safety
- Christine Charnley - IOWC Safeguarding
- Jeff Walls - Isle of Wight (IOW) Fire and Rescue
- Mandy Tyson – IOW Clinical Commissioning Group
- Lucy Slaterpartridge – IOWC Domestic Abuse Project Officer
- Emma Coleman - IOW Local Safeguarding Adults' Board
- Rosie Price - IOW NHS Trust Safeguarding
- Maria Blazeckova - IOWC Safeguarding
- Dr. Alison Robins - Named GP IOW Clinical Commissioning Group (now no longer in that role.)
- Mark O'Sullivan - Age UK Isle of Wight
- Ruth Attfield - Hampshire Constabulary
- Tracey Webb - IOW Fire and Rescue Community Safety

7.3. Whilst all represent their own agencies, none were directly involved in the services provided or the supervision of those providing services to any of the subjects of the review.

7.4. The panel met twice on 13 March 2019 and 12 September 2019 and contributed virtually to the review as well.

8. BACKGROUND INFORMATION

8.1. Mrs Fleming was found dead in her home on 31st of August 2015. She was white, British and was 83 at the time of her death and lived with and was cared for by her son, Mr Fleming, also white British.

8.2. The Ambulance crew found Mrs Fleming extremely malnourished and emaciated. She weighed just 38kg. As a result of concerns regarding the condition in which she was living and her physical state, police were contacted and Mr Fleming was arrested on suspicion of neglect.

8.3. Mrs Fleming was skeletal in appearance with multiple scabs and scars apparent on her skin. She also had several ulcerated areas on her body which were weeping and in need

of medical attention. She was dressed in clothes which were too big for her and were stained with fluid from the weeping sores on the left side of her neck and wet with urine. Her hair was unkempt and had clearly not been brushed or washed. There were no signs of any physical injury consistent with physical abuse but there were concerns about neglect and whether this contributed or hastened her death.

8.4. It was identified that Mr Fleming had not attempted to get any services to help him with Mrs Fleming's care, or seek medical assistance when her condition deteriorated. In the last few years of her life, Mrs Fleming was incontinent and there was an overpowering smell of ammonia in her room. Mr Fleming said during the police interview that he tried to cope with his mother's ill health but it was all too much for him and he felt unable to seek help. There was no suggestion of intent, malice or any financial abuse.

8.5. The house was very poorly maintained and severely neglected. The property was extremely filthy and the walls were brown with mould with the wallpaper peeling off. The house looked very unkempt and smelled of mouldy dirt mixed with urine, faeces and parts of it were rotting. The whole property was in a state of disrepair with a leaking roof and extremely overgrown garden. The house appeared to be infested by vermin.

8.6. Neighbours did not see Mrs Fleming for over two years and some presumed she died some time ago. A cousin, who lives nearby, had not seen Mrs Fleming for some months and had raised concerns with the GP regarding Mr Fleming`s capacity to deal with his mother's ill health on three occasions. A gardener did attend the house more recently and noted that Mrs Fleming was in the same chair and believed that she may not have left it for over a year. He attended the GP surgery along with Mrs Fleming's cousin to voice his concerns twice.

8.7. Mrs Fleming was registered with Primary Care 'Practice Q' since 1967. She was last seen by the practice nurse in 2010, however, as she suffered with chronic ulceration of her lower legs, migraines and high blood pressure, she continued to be prescribed Pizotifen and Bendroflumethiazide (the prescription being picked up by her son), this was issued regularly without review.

9. Conclusion

9.1. This review was unusual as it showed just one agency had opportunities to recognise that Mrs Fleming's health and living conditions were deteriorating and that her sole close relative, Mr Fleming, either could not or would not seek support to provide her with effective care or to access medical provision.

9.2. Exploration and analysis of each of the Terms of Reference point to primary care having had multiple opportunities to, either react to the specific alerts / concerns raised on three separate occasions or proactively consider Mrs Fleming's health and wellbeing holistically in discharging their contractual obligations. This is particularly important as the NHS is in a time of transitioning to an out of hospital model of care which is based on primary care coordinating all care in the community around an individual based on their specific needs. This requires the Named GP to be considering the social determinants of health and their impact on the individual to ensure they are afforded the most appropriate intervention and support.

9.3. Mr Barry and Mrs Curtis were as diligent as any lay person could be expected to be in highlighting their concerns to Mrs Fleming's own GP practice. On each occasion they were effectively told that it was none of their concern and that if Mrs Fleming wanted help she would ask for it. There seemed to be a culture that services could not be offered unless they were requested by the intended recipient, in case they in some way offended or imposed on them. There was no evidence that anyone at the practice had either assessed Mrs Fleming or knew her well enough to presuppose she would reject offers

of support or that, with capacity, she had knowingly dissented.

9.4. It may be the case that the practice did not have the resources to carry out a home visit themselves but it is unfathomable why they did not raise a safeguarding alert to Adults Social Care, or at least seek advice. Instead they did nothing and the situation perpetuated unchecked. Doctors and other healthcare professionals have a duty to be alert to signs of domestic abuse. This includes elder abuse and this duty was not discharged in respect of Mrs Fleming.

Recommendation 1

Isle of Wight CCG should work with all Primary Care Practices to ensure that all communications and contacts regarding a patient and their carer are documented in patient records using the appropriate READ codes.

Recommendation 2

The Isle of Wight CCG should also assure itself that, where there are concerns regarding a patient having unmet care and support needs, the record is brought to the attention of the Named and Accountable GP for them to coordinate services and using, the Decision Support Guidance[2], raise a safeguarding concern with the local authority.

Recommendation 3

The Isle of Wight CCG should assure itself that each primary care practice has an effective and up to date safeguarding policy which all staff are familiar with and which guides them on what to do if they have a safeguarding concern.

9.5. Primary Care Practice Q had several opportunities through their contractual arrangements to proactively assure themselves that Mrs Fleming's health and wellbeing needs were being met. Had they carried out medication reviews or NHS Health Checks these may have highlighted risk factors and opportunities for support and intervention ,either for Mrs Fleming or for Mr Fleming, for himself or as a carer.

9.6. Had they taken any of these opportunities and ensured that either they, or another professional, actually visited Mrs Fleming they would have seen her situation for what it was. It would have been very apparent to anyone seeing the house, that Mrs Fleming was being neglected and Mr Fleming, as her carer, was the person neglecting her – whether he realised that or not – and that he was also self-neglecting.

9.7. In terms of the efforts to contact Mrs Fleming and Mr Fleming, they were administrative rather than patient-centred. The letters regarding hypertension, sent in 2013, received no response and were marked "exemption reported" stating Mrs Fleming had "informed dissent" because she had failed to respond. This assumed Mrs Fleming received the letter, was able to read and understand it, process it and formulate a response which she was then able to communicate with a full understanding of the potential consequences of opting out. Rather than filing this as, effectively, no further action, a discussion regarding her living situation may have triggered concerns and not following this up was a missed opportunity to assess her care needs and identify potential risks

[2] https://www.iowsab.org.uk/wp-content/uploads/2019/05/IOWSAB-Decision-Making-Guidance-and-Tools-Version-2.pdf

and vulnerabilities.

9.8. When Mr Fleming disengaged from the specialist services this does not appear to have been proactively followed up or the reasons explored with him and thus was a missed opportunity. It may have triggered a more holistic review of his lifestyle and highlighted his role as a carer for his mother.

9.9. His blood monitoring was organised regularly but did not appear to have been actively followed up with advice and guidance or resulted in any medication alterations. Each result was marked as "*No action required."* This was possibly a missed opportunity to assess Mr Fleming's general health and wellbeing and may have been an indication that he was not coping or was self-neglecting. *Mr Fleming told the police that when he once made an appointment to have his prescription reviewed he was told it was not necessary as they would just keep issuing them.*

9.10. Primary Care Practice Q has put in measures to rectify these shortfalls now but it is not clear whether their impact on outcomes has been assessed.

Recommendation 4

Isle of Wight CCG should seek assurance in the form of an audit of primary care providers to demonstrate their alignment with best practice and guidance so as to safeguard against vulnerable patients, especially those with care and support needs, becoming invisible or not receiving the treatment and care they require. This includes all adults who have disengaged from LTC monitoring or medication reviews to have contact with a professional to document (signed) their informed dissent.

9.11. There was an assumption that Mrs Fleming had capacity to dissent or disengage from primary care services, even though she continued to be issued prescriptions. Whilst mental capacity should always be assumed, the complete absence of contact from her and the information provided to Primary Care Practice Q by Mr Barry and Mrs Curtis suggested she might need a care or mental capacity assessment. As she was never seen by any service this could not happen but, in line with the improvements made to ensure more robust follow up for annual health checks, these should include mental capacity assessments where appropriate, especially if the patient has a history of non-engagement and unmet care and support needs.

Recommendation 5

Isle of Wight CCG should seek assurance from Primary Care services that mental capacity assessments are completed where patients have disengaged or dissented from services, especially if those patients have unmet care and support needs as a consequence of disengagement.

9.12. The staff at Primary Care Practice Q have all received on line training in Safeguarding Adults, but there are concerns this is not up to date and does not include any updates on local policy and procedures. They have not, however, received training in Domestic Abuse. Primary Care is one of the services most likely to receive a first report of domestic abuse[3]. This therefore presents a risk of not spotting signs and symptoms and/ or understand pathways when patients display such indications.

Recommendation 6

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215635/dh_125938.pdf

That Isle of Wight Clinical Commissioning Group supported by NHS England, develop mandatory workforce development measures aimed specifically towards 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[4] into practice.

9.13. While Mr Barry and Mrs Curtis were proactive in raising their concerns with Primary Care Practice Q they may also have considered raising a safeguarding alert (now a Safeguarding Concern) with the Local Authority Adult Social Care. They did not know to do this and equally did not know how to escalate their report when it was clear nothing had happened. It's possible Mr Fleming did not know either. It is unknown why the practice did not explore or escalate the concerns raised and if there was, and is now, the understating of their roles and responsibilities in identifying and safeguarding vulnerable adults.

9.14. The Isle of Wight Safeguarding Adults Board (SAB) has clear guidance on its website[5] so the public can learn what to do if they are concerned. Other agencies and services, such as Adults Social Care and Health and Primary Care should replicate this guidance and include where carers can access support. The reach of this message can never be to saturation point but the SAB and agencies may wish to promote the advice in ways that reach as many population groups as possible.

Recommendation 7

The Isle of Wight Safeguarding Adults Board, and its constituent members, should review the spread and reach of messaging aimed at the public regarding what to do if they are concerned about an adult and around support available for carers. They should assure themselves that its reach is as broad and accessible to as many population groups as possible.

9.15. This was an unusual case involving one agency with a number of missed opportunities to recognise domestic violence. Mr Fleming was acquitted of any criminal responsibility for Mrs Fleming's death. However, a greater awareness and adherence to the GP contractual and best practice guidance and the roles and responsibilities of primary care practitioners in identifying DVA and escalating concerns could have resulted in a more proactive holistic assessment of both Mrs Fleming's and Mr Fleming's needs. This in turn may have ensured their individual care needs were met and the appropriate care and support provided.

[4] https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-75545301469381
[5] https://www.iowsab.org.uk/