Kent Community Safety Partnership
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MEDWAY COMMUNITY SAFETY PARTNERSHIP

Domestic Homicide Review

Salome

January 2021

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 7th November 2023

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1. Introduction

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Salome, a resident of Kent, prior to her death in January 2021. On that day, police officers attended the property and found that the victim had sustained fatal injuries including an extensive cut to her throat. Ahmed was arrested for murder and was subsequently charged and remanded in custody.

1.2 This DHR examines the involvement that organisations had with Salome, a North African woman and Ahmed, a North African man, (both in their 50s), between 12 December 2017 and Salome's death.

1.3 The Independent Chair, Kent and Medway Community Safety Partnerships, and all panel members extend their most sincere condolences to Salome's family and friends.

1.4 This review began in June 2021, following a decision by Kent Community Safety Partnership after discussions and research received from the core group panel it was confirmed that the case met the criteria for conducting a DHR. That agreement had been ratified by the Chair of the Kent Community Safety Partnership. The Home Office was notified of the decision to proceed with a DHR on the 4th June 2021. The Independent Chair liaised with the Senior Investigating Officer and Family Liaison Officer to make the family aware of the DHR process that was beginning, and to establish when and how best to make contact. Following this, a formal written letter notifying the family of the DHR was sent in July 2022.

1.5 This report has been anonymised and the personal names contained within it are pseudonyms, except for those of DHR Panel members.

1.6 In order to respect the wishes of the family, the ethnicity of the individuals who are subjects of the review is not specified within the report but explained as North African and British. The cultural background of the two individuals has not been made specific to protect the family. This decision was taken following contact with the family who asked the reviewer not to seek out any culturally specific groups due to the identifiable factors within the review.

2. Confidentiality

2.1 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

2.2 Dissemination is addressed in Section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Salome's sister.

2.2 Details of the deceased and perpetrator:

Name (Pseudonym)	**Gender**	**Age at time of death**	**Relationship to deceased**	**Ethnicity**
Salome	F	50s	*Deceased*	North African
Ahmed	M	50s	*husband and perpetrator*	North African

2.3 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	**Relation to deceased:**	**Relation to perpetrator:**
M	sister	Sister-in-law
S	mother	Mother-in-law
K	N/A	friend

3. Timescales

3.1 This review began on 11 June 2021 which was then followed by the panel meeting on four occasions before concluding on 7th November 2023. There was a delay due to awaiting the outcome of the criminal trial and access to Salome's family.

4. Methodology

4.1 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Salome and/or Ahmed. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

4.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Salome or Ahmed during the period covered by the review.

4.3 In addition to IMRs, one organisation provided a Supplementary Report in relation to questions about their contact with Ahmed.

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4.4 Each IMR included a chronology and analysis of the service provided by the agency submitting it. The IMRs highlighted both good and poor practice and identified areas for improvement for the individual agency.

4.5 Any issues relevant to equality, i.e., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation were identified within the IMRs.

5. Terms of Reference

5.1 The Review Panel first met on 11 June 2021 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence.

5.2 Background

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 29 April 2021. It agreed that the criteria for a DHR have been met. That agreement has been ratified by the Chair of the Kent & Medway Community Safety Partnership and the Home Office has been informed.

5.3 The Purpose of a DHR

a) 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;

b) 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;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) 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;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

5.4 The Focus of the DHR

This review will establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Salome.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this DHR will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

The full subjects of this review will be the victim, Salome, and the alleged perpetrator, Ahmed.

5.5 Key Lines of Enquiry

These included:

a) Cultural awareness- were practitioners mindful of any specific issues in relation to Salome's role as a carer for Ahmed's dementia diagnosis, despite their marriage breakdown, in the context of their North African culture?

b) Agency responses to domestic abuse disclosures by men

c) Hearing the voice of the informal carer- how did practitioners ask Salome about what she wanted in her life- was she assumed to be Ahmed's carer? Did she have a way out?

d) Covid-19 pandemic – what impact did the pandemic have on the services and opportunities for support for Salome and Ahmed?

5.6 Specific Issues to be Addressed.

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

a) Were practitioners sensitive to the needs of Salome and Ahmed knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

b) Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Salome and Ahmed? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Salome and/or Ahmed subject to a MARAC or other multi-agency fora?

c) Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

f) When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

g) Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

h) Was this information recorded and shared, where appropriate?

i) Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

j) Were senior managers or other agencies and professionals involved at the appropriate points?

k) Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

l) Are there ways of working effectively that could be passed on to other organisations or individuals?

m) Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Salome and Ahmed and promote their welfare, or the way it identified, assessed, and managed the risks posed by Ahmed? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

n) Did any staff make use of available training?

o) Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

p) How accessible were the services to Salome and Ahmed?

q) How did agencies seek to offer Salome an ongoing carer's assessment and support as Ahmed's condition deteriorated?

r) When Ahmed sought help from services between in January 2021, what risk assessment was undertaken to support both him and Salome?

s) What impact did the Covid-19 Pandemic have on the provision of services to Salome and Ahmed?

6. Involvement of Family Members and Friends

6.1 Salome's family received the Home Office DHR leaflet and were informed about the DHR. They were made aware of the advocacy offered by Advocacy After Fatal Domestic Abuse (AAFDA). The police Family Liaison Officer (FLO) facilitated contact with the family. This enabled the family to contribute to the terms of reference. The family were consulted when the Panel was attempting to gain input from a specific cultural perspective. The family view was that it would invade their privacy to have inclusion of a specialist from their culture on the Panel. (Salome's sister later spoke to the Independent Chair and explained that Salome viewed herself as a totally British woman who socialised across multiple cultures.)

6.2 The Independent Chair delayed direct contact with the family due to them awaiting the trial for Ahmed and on the advice of the Senior Investigating Police Officer. Subsequently, Salome's sister was contacted by the Independent Chair to offer the opportunity to have a conversation and to meet the review panel. Initially, the family declined any involvement with the panel due to the outcome of the trial which they were trying to come to terms with. They felt unable to talk about their loved one at the current time. They were offered the opportunity to contact the police FLO.

6.3 Following the incident, Ahmed attempted to harm himself and was deemed to not be medically fit to stand trial. The panel considered whether it would be essential for the Chair to speak to Ahmed in relation to the DHR. In light of his dementia, meaning that he might not be able to understand what had happened, and the subsequent deterioration of his health, the panel concluded that involvement in the review could have a negative impact on Ahmed's health and wellbeing. The panel acknowledged that this would mean that, without the family wanting to contribute at that time also, the review would miss the voices of Salome and Ahmed. Nevertheless, this was agreed as the necessary approach. In terms of Ahmed, there had been agency involvement in the days preceding the incident which demonstrated how he was functioning at the time. In relation to Salome's voice, the panel has been very mindful to consider her, despite limited information about her.

6.4 There was an indication that Ahmed had friends in the local area. However, the names of the friends were not known by the agencies contributing to the DHR. There was one friend of Ahmed's who was involved in the police investigation. However, due to the ongoing trial the panel did not see it as appropriate to attempt to contact her. Once the trial was concluded it was agreed that the Independent Chair would not reach out to Ahmed's friend in respect to Salome and her family.

6.5 Once the DHR was near completion (in early 2023), the Independent Chair contacted Salome's sister again. On this occasion, Salome's sister agreed to speak to the Independent Chair to go through the learning identified. A date was arranged for Spring 2023 and resulted in an extremely illuminating conversation. Salome's sister expressed agreement with the focus on dementia and carers. However, she stated that the focus on culture was incorrect, as Salome had viewed herself as British. It was apparent that neither Salome nor Ahmed had been confined to a strict North African culture; they embraced multicultural Britain. This led to the reviewer making amendments to the findings and recommendations relating to culture.

6.6 The amended report was shared with Salome's sister in October 2023. She thanked the Independent Chair for communicating with her and sharing the report. However, she did not want to pursue further discussion as she was still grieving.

7. Contributing Organisations

7.1 Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR Panel. None of the IMR authors or the senior managers had any involvement with Salome or Ahmed during the period covered by the review.

7.2 Each of the following organisations contributed to the review:

Agency/ Contributor	Nature of Contribution
Kent Police	IMR and panel member

Agency/ Contributor	Nature of Contribution
Kent & Medway NHS and Social Care Partnership Trust (KMPT)	IMR and panel member
Kent and Medway Clinical Commissioning Group*	Facilitated GP IMR and supplementary report, panel member
Area A Housing Department	IMR and panel member
Kent County Council Adult Social Care	Panel member for safeguarding advice
Oasis	Specialist Advice for Domestic Abuse and panel member
NHS England and Improvement South East Mental Health Homicide Lead	Mental health and dementia advice

* As of July 2022, the Kent and Medway Clinical Commissioning Group (CCG) became the Integrated Care Board (ICB).

8. Review Panel Members

8.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Salome and/or Ahmed. It also included a senior member of the Kent Community Safety Team, a representative from KCC's adult social care services and an independent advisor from a Kent-based domestic abuse service.

8.2 The members of the panel were:

Agency	Name	Job Title
Independent	Nicola Brownjohn	Chair and author
KCC Community Safety	Kathleen Dardry	Community Safety Practice Development Officer
Kent & Medway Integrated Care Board (ICB, formerly the Clinical Commissioning Group)	Zoe Baird /Lisa Lane	Designated Safeguarding Nurses

Agency	Name	Job Title
Kent Police	Ian Wadey / Mike Brown	Detective Inspector
Area A Council	Jo-Anna Taylor	Community Services Manager
Kent County Council Adult Safeguarding	Catherine Collins	Adult Strategic Safeguarding Service Manager
KMPT	Alison Deakin	Head of Safeguarding
Oasis	Deborah Cartwright	Independent Domestic Abuse Specialist

8.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Salome or Ahmed. The panel met on five occasions during the DHR. The terms of reference were set on 11th June 2021. The IMR review meeting was held on 22nd October 2021, followed by a meeting to discuss the first draft of this report on 28th January 2022. A second draft meeting was held on 14th October 2022 after the trial came to a conclusion. A final meeting was held on the 13th January 2023 to discuss and agree recommendations and amendments.

9. Independent Chair and Author

9.1 The Independent Chair, who is also the Author of this Overview Report, is Nicola Brownjohn. Nicola is a registered nurse who has worked in safeguarding for 20 years. She has extensive experience of strategic multi-agency partnership work which has enhanced domestic abuse knowledge which has included commissioning of domestic abuse prevention programmes and leading on domestic homicide reviews, on behalf of the NHS. Since November 2019, Nicola has worked independently advising strategic safeguarding partnerships and undertaking audits and learning reviews in relation to domestic abuse and safeguarding. She has completed the Home Office DHR training and has completed all Kent County Council training required to undertake the role of Independent Chair.

9.2 The Independent Chair role is to provide assurance that the approach into undertaking the review has been transparent to allow the family to be confident that their questions have been fully explored and that the agencies involved

commit to taking forward their learning from the review to prevent future deaths from domestic homicide.

9.3 The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review, other than in relation to Safeguarding Adult Reviews she has chaired since 2020.

10. Other Reviews/Investigations

10.1 For this case, there were the following reviews/investigations:

- Criminal trial
- Police Complaints review
- KMPT serious incident review
- NHSEI Mental Health Homicide Review (not undertaken due to this DHR taking place)

11. Publication and dissemination

11.1 This overview report will be published on the websites of Kent and Medway Community Safety Partnerships.

11.2. Family members will be provided with the website addresses and offered hard copies of the report.

11.3 Further dissemination will include:

a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway ICB and the Office of the Kent Police and Crime Commissioner amongst others.
b. The Kent and Medway Safeguarding Adults Board.
c. The Kent Safeguarding Children Multi-agency partnership.
d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

12. Equality and Diversity

12.1 The DHR panel addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race and ethnicity, religion and belief, sex, and sexual

orientation) as prescribed in the public sector Equalities Act duties and considered if they were relevant to any aspect of this review.

12.2 The review considers whether access to services or the delivery of services were impacted upon by such issues, and if any adverse inference could be drawn from the negligence of services towards persons to whom the characteristics were relevant.

12.3 The relevant protected characteristics identified as requiring specific consideration were:

- Sex: Salome was a female and Ahmed is a male.
- Age: Both Salome and Ahmed were adults in their 50s.
- Marriage: Salome and Ahmed were married but not living as such.
- Race: Both Salome and Ahmed were of North African heritage.
- Religion/Belief: Salome felt responsible for Ahmed, but this was inherent to her, and not a cultural expectation.
- Disability: the panel were of the opinion that Ahmed's diagnosis of dementia required specific consideration.

12.4 The DHR Panel sought contributions to reflect the cultural background of Salome and Ahmed. The panel respected the family view not to utilise a domestic abuse specialist from the appropriate culture, as the family view was that their community was too close for anonymity to be preserved. In fact, the family subsequently confirmed that Salome and Ahmed were not culturally impacted by their North African origins. They lived a British way of life. The panel though did keep in mind the potential for agency responses to be influenced by related assumption or bias.

12.5 The panel included a domestic abuse specialist based in Kent. In regard to dementia and mental health, NHS England provided expertise outside of the panel, via email.

13. Background Information

13.1 Salome was living in her property, owned for several years, when she was killed.

13.2 On a mid-morning in January 2021, police received simultaneous calls from a neighbour and from Ahmed's friend. The neighbour stated there was a woman

outside Salome's home crying hysterically shouting for the door to be opened or she would call police. The friend who was outside the house, contacted police in tears stating Ahmed had called her saying he had killed Salome.

13.3 When police arrived, they found Salome in the downstairs of the house. She had sustained fatal injuries, including a knife wound to her neck.

13.4 The confirmed cause of death was due to blunt force trauma and an incised wound to the neck.

13.5 Salome owned the property and Ahmed lived in the house as well. They moved into the property in 2013.

13.6 Salome had moved to the United Kingdom as a young child and had been brought up within the British culture. She was a successful businesswoman, loved music, painting, and sewing. She returned to her home country to live and work around the start of the century, in order to get a feel for the culture. She met Ahmed in 2009 and they married. In 2011, they moved to the UK to live. In 2013, Salome sold her previous property and bought the house in Kent. Following the move, the couple's relationship broke down. Salome had wanted Ahmed to move out. They remained living in the same house but, reportedly, lived separate lives, with Ahmed as Salome's tenant.

13.7 It was at this time that Ahmed became unwell and was diagnosed with dementia. According to Salome's family, she felt responsible for him and so he remained in the home, with Salome as his carer.

13.8 Following Salome's death, Ahmed was charged with her homicide. A trial of fact took place on 2nd April 2022 where the jury agreed that Ahmed was responsible for Salome's death. Ahmed is currently in a mental health unit.

14 Chronology

14.1 In December 2017, Ahmed had his dementia annual review with a GP. At this appointment, the GP noted that Ahmed's dementia was getting worse and so made a referral, for an assessment of his memory and cognition, to the Mental Health Team, via the Single Point of Access (SPoA). It was noted that Ahmed and Salome lived in the same house but separately.

14.2 Following the referral, Ahmed was contacted on 14 December 2017 via telephone for screening by a SPOA practitioner. Ahmed reported that he had not noticed too many changes to his memory and that Salome was supporting him with meal preparation due to risks of him managing alone. He stated that he required prompts with personal care. The practitioner documented that Ahmed struggled with screening over the telephone, English was not his first language and that there was evidence of expressive and receptive aphasia. Ahmed agreed to attend an appointment to review his memory difficulties and identify support. Ahmed asked the SPoA practitioner to contact Salome with the appointment details. Following this screening, SPOA referred him to Area A Community Mental Health Service for Older People (CMHSOP).

14.3 Late December 2017, Ahmed attended Area A CMSHOP on his own for an initial assessment. Ahmed reported a slight decline in his short-term memory in recent months. He stated that he had good and bad days, that sometimes he functioned as if nothing was amiss but that at other times, he felt quite confused. Ahmed described uncertainty over his home situation. His stated that Salome had plans to move and so he was unsure what the future held for him. Ahmed also stated that he was in a stable routine but was unsure how he would cope without Salome's support and company. He described a degree of conflict between them and felt some of this was due to his memory deficits. Telephone Contact with Salome was attempted in order to establish further information regards accommodation and ongoing support required. These were unsuccessful and a letter was then sent requesting contact.

14.4 Salome contacted Area A CMHSOP in January 2018. She relayed a number of frustrations to the practitioner, that Ahmed thought he was doing everything right but, in fact, was not, that he was not listening to her, was not supposed to use the kitchen but was going down and using it at night, used the cooker when he knew he should not, would not bathe, eat or clean his environment without prompting, abide by or respect her wishes/routines, was difficult to break from his routines and that he left the house/environment dirty/unclean. Salome asked if the CMHSOP would be able to advise on strategies so that Ahmed could heed advice more willingly. Salome stated that she was *'taking on more and more'* and that it was increasingly impacting her life and additional responsibilities (e.g., sick mother in

London). Salome confirmed that she was looking to sell the property but that it was not on the market as further renovation/repair needed to be done.

14.5 Salome did not support a referral to social services for fear that Ahmed would be placed in residential care. She requested support with a life skills course for Ahmed to learn how to do things, and the identification of strategies by a professional. The practitioner explained the nature of disease progression, namely that dependence on others was increasingly likely. In his contact note, the practitioner also questioned whether Salome fully understood the implications of Ahmed's condition and services available. Salome expressed that she wanted to move but this was not imminent and that if strategies worked, perhaps co-habitation might continue for a little longer.

14.6 Following the contact, the case was discussed in Multi-Disciplinary Team meeting (MDT). The Plan was for an Occupational Therapy (OT) assessment to take place and advise on strategies and a note was put by the KMPT practitioner to be mindful that Salome's expectations may need to be managed.

14.7 Ahmed was reviewed by the consultant psychiatrist in March 2018. Both Ahmed and Salome attended the appointment. Ahmed expressed that he had a fluctuation in his abilities around memory, communication and managing his life. There were small changes with regards to his memory and he noticed particularly that he struggled to speak French compared to other languages he spoke. Ahmed's understanding continued to remain a problem and he encouraged people to talk slowly to him. He managed most of his personal care without any difficulty and he needed supervision and prompting with most of his domestic activities of daily living, e.g., finances, shopping, cooking, and laundry. All this was being managed by Salome. Salome expressed that Ahmed had limited understanding into variation of his bills and that these needed to be paid. She also stated that his ability to budget was causing a bit of stress between them.

14.8 The management plan, shared with the GP, was to refer Ahmed to post diagnostic groups, cognitive stimulation groups and carers groups in order to help him find out more about what support there was in the community; to enable Ahmed to draw up a routine so that he could do tasks by himself in order for him to regain his skills and gain a sense of achievement; for Ahmed to continue to do things for himself

and remain independent at home for longer with supervision. It was noted that Salome was not moving out of area and would continue to monitor Ahmed.

14.9 The Consultant discussed the need for a Social Services referral, but Salome reportedly stated that they did not want that to be done at this point in time.

14.10 The Consultant noted that Ahmed's scores on ACE III[1] had definitely deteriorated from 80 to 65 over a couple of years which was in keeping with his diagnosis. The Consultant concluded that he did not need to see Ahmed again but would review if needed.

14.11 During 2018, Salome had reported Ahmed missing, stating she was concerned for him as he had dementia. He had failed to return home from the pub the previous evening. Police enquiries were underway to locate him when he arrived home stating he had stayed at a friend's the previous night. No concerns for his welfare were raised at the time by the attending police officers.

14.12 In November 2018 an OT visited the home to complete an activities of daily living assessment, however this was unsuccessful as no one was home. There was no answer on Ahmed's phone.

14.13 In December 2018, Ahmed was visited at home for an OT assessment. Ahmed and Salome were present. They voiced similar concerns and frustrations outlined in previous contacts regarding Ahmed presentation and effects of this. Salome described Ahmed apparent inability or unwillingness to modify his behaviours. She cited the example of him using the kitchen at all sorts of hours (day or night) and leaving a mess behind him (for her to clean up). Salome advised he was unsafe in the kitchen and required supervision. She described him as having moments/days when he was 'very low' and other times when he was 'manic'. Salome also described Ahmed as having 7 personalities (a shy one, a childlike one, a rude one, etc). Ahmed acknowledged this. Salome also described how the first changes in Ahmed's cognitive function and character started in 2013/14. She confirmed that their partnership had ended around that time, and then they moved from London to Kent. The OT asked Ahmed directly if he held out hope of rekindling the

[1] ACE III = Addenbrooke's Cognitive Examination which is a cognitive screening instrument used to assess attention, memory, verbal fluency, language and visuospatial abilities (Hodges). Noone, P. (2015) Addenbrooke's Cognitive Examination-iii. *Occupational Medicine*. vol 65. pp418-420. https://doi.org/10.1093/occmed/kqv041

relationship and he expressed that he did. Salome indicated she was surprised by this. Salome also expressed frustration with Ahmed and how this was to the point that she had asked Ahmed to leave. Salome expressed guilt and fear about her feelings and fear that Ahmed would end up somewhere entirely inappropriate if Social Services got involved. A further visit before Christmas was offered but they requested a visit in the new year this was to be arranged.

14.14 In January 2019 Salome telephoned CMHSOP to inform the team that she could not cope with being Ahmed's carer anymore as he did not listen, he was rude, disrespectful and she wanted him out. She was tearful on the phone. She asked for a call back for some advice. The CMHSOP duty worker attempted to return her telephone call but there was no answer. Further attempts were made on later that week, to no avail. It was noted that there was a planned appointment with the occupational therapist (OT) the following week and therefore no further action was taken.

14.15 During the OT visit in January 2019, Ahmed spoke about his living situation and particularly his relationship with his Salome. It was clear that things remained difficult between them, and Ahmed felt guilty for the 'trouble' he was causing i.e. not being able to do things Salome wanted. Ahmed felt it would be better if he moved out but stated that he 'has nowhere to go, and no-one else'. The OT noted that from his Activities of Daily Living (ADL) assessment, he observed no deficits in Ahmed's performance. The OT also documented that he had the impression Ahmed was quite low in mood, with a degree of helplessness due to an inability to change his circumstances. The OT also noted that he had the impression Ahmed wished to rekindle his relationship with Salome and was possibly grieving for his loss.

14.16 In February 2019 Ahmed was discussed at a Multidisciplinary Team (MDT). It was agreed for an outpatient appointment to be arranged with the consultant psychiatrist.

14.17 In March 2019 Ahmed attended an appointment for completion of a cognitive assessment. Prior to the testing, Ahmed reported that he had felt that he was a burden to Salome and so had found accommodation with a friend. He had stayed there for 10 days but then Salome suggested he returns to her home. Ahmed was glad to return and relayed that he had struggled greatly to be apart from her.

Stating, “You know...she is the only one I have in the world...I have no family...no-one, just her”.

14.18 In March 2019 Ahmed was seen for an outpatient appointment with the consultant psychiatrist with Salome in attendance. It was noted that Ahmed’s presentation was more changeable, he was more labile in his mood. It was thought this change was the main factor causing the breakdown of his relationship with Salome. Salome was still supporting him but found it difficult at times. There was no reported suicidal ideation and thoughts of harming others by Ahmed. The main risk was noted as self-neglect and no support due to the risk of carer breakdown.

14.19 During this time Ahmed was also undergoing investigations of his brain and an MRI had been arranged. However, when he saw the Consultant Psychiatrist in June 2019, he admitted that he had not attended the scan appointment. Therefore, it was rearranged.

14.20 A Consultant Psychiatrist reviewed the MRI scan results in October 2019. The report concluded ‘Findings are those of right Fronto- extra-axial mass which is possibly a small meningioma[2] for further evaluation with contrast enhanced MRI’. The plan was to refer to Neurology and for Ahmed to be seen for an outpatient appointment to discuss the results.

14.21 In December 2019 Ahmed was reviewed by the consultant psychiatrist. The purpose of the review was predominantly to feedback the results of the MRI. Within the radiology report it had recommended that a contrast MRI be completed for further evaluation of the meningioma. The request for a further MRI was made and it was planned for Ahmed to be reviewed again in eight weeks’ time. However, this did not happen.

14.22 Ahmed had not received an Annual Review in 2018 by the GP but had one late 2019. The GP noted that Ahmed was doing well and had attended the appointment alone.

14.23 In April 2020, Ahmed was contacted by telephone by a nurse working in the CMHSOP. The purpose of the telephone call was to check on his wellbeing and whether any external support services were needed. Ahmed reported that he was

[2] A benign brain tumour. https://www.nhs.uk/conditions/benign-brain-tumour/

staying at home all the time because he enjoyed just being at home. He stated that Salome was living with him and took care of him. Ahmed reported no symptoms of COVID-19 and stated that he was feeling well. The clinician then spoke to Salome who confirmed that she was doing the shopping, cooking, prompting personal care and medication pick up for Ahmed. Salome stated that Ahmed rented a room in her house, and she was looking after him. She reported coping well and stated that she was not in need of any additional support with caring for Ahmed. Salome was provided with the local CMHSOP phone number in case she needed to contact the team.

14.24 In June 2020, Ahmed was contacted via telephone to review and agree his care plan by the nurse from the CMHSOP. Ahmed expressed that he wanted support with his memory problems and for a lack of motivation. The nurse recorded that Ahmed was awaiting an outpatient appointment with the consultant psychiatrist once the results of the contrast MRI scan were known.

14.25 In September 2020, Ahmed was contacted for review by a nurse within the CMHSOP. Ahmed answered the call but did not appear to be able to hear the nurse. As a result, the nurse recorded a plan to attempt to review again within the next three weeks.

14.26 Later in September 2020, the nurse successfully contacted Ahmed by telephone in order to complete a review. Ahmed and Salome were present during the review. It was noted that Salome was still supporting Ahmed by explaining anything he did not understand. A mental state examination was completed. Ahmed's speech was noted to be slow with fairly minimal answers. He reported to have ongoing processing difficulties and low mood which may have explained this. On describing his mood, Mr Ahmed confirmed he felt down sometimes as he had been expecting the worst with COVID-19. Salome reported that she thought Ahmed was depressed, noting that his mood was up and down, sometimes he was happy and sometimes he was very down. Ahmed reported no anxiety or issues relating to his appetite but did note that he did not sleep well. He reported that he slept a lot through the day and stayed up late at night. No abnormal perceptions were noted and in relation to his cognition, no significant change was reported. Salome asked the nurse to speak much slower and explain what was meant a bit more. Ahmed was able to understand better when the nurse spoke slowly and clearly. Ahmed 's physical and social health was reviewed, and no concerns were raised. In relation

to his support network. Ahmed confirmed that Salome was supportive and that he had some good friends but tended not to mix with people during the pandemic.

14.27 The risk assessment for Ahmed was reviewed. In relation to safeguarding, no concerns were raised. In relation to any risk to himself, to others or from others Ahmed denied any thoughts or risk of harm. The possible risk noted for him was potential self-neglect due to his difficulties managing his day-to-day activities and his reliance on Salome who supported him. Salome was recorded as a protective factor for Ahmed, and it was noted that she was supportive.

14.28 The nurse contacted the GP to request that he be reviewed with consideration given to treatment options for his low mood. The nurse reported that Ahmed had been offered contact details for counselling services, but this had been declined.

14.29 In October 2020, the GP undertook a telephone call with Ahmed to assess his mood. It was noted that he was in a low mood but was supported by his ex-partner. Shortly after this the GP received a letter from the Consultant Psychiatrist, discharging Ahmed back into the care of the GP. It was noted that Ahmed had no thoughts of harming himself or others.

14.30 In November 2020, Salome and Ahmed reported a female acquaintance (K) of Ahmed's on two occasions for harassment and damage.

14.31 In November 2020, Ahmed was reviewed by the consultant psychiatrist, via a telephone call due to the COVID-19 pandemic. During the review Ahmed stated that he felt down and low because of his health. He admitted to having a cough for which the GP had sent him for an x-ray of his chest, and he was awaiting the results. He admitted to smoking around one packet of cigarettes every day but due to the cough he had reduced it by half. Salome continued to support him. He also had a few friends who helped him. He was not on any medication. He stated that his memory continued to remain the same and had not deteriorated. His weight was stable, but he stated that he was not eating properly. He had the occasional night when he did not sleep. There were no thoughts of harming himself or others.

14.32 Following the telephone review, the Consultant Psychiatrist did not feel putting Ahmed on any psychotropic medication would be beneficial. No further appointments to see Ahmed were made and he was discharged back to the care

of the GP, with the note that Ahmed could be re-referred in 18 months or sooner if his symptoms deteriorated.

14.33 Late January 2021 Ahmed attended the local police station front counter reporting he wanted to leave his wife (Salome) and seek alternative accommodation. He disclosed that whilst arguing with Salome in relation to finding other housing, she had pushed him in the face. It was reported that he had no visible injuries and would not discuss this issue with the officer further, he did not want anything done in relation to this incident.

14.34 Whilst at the Police Station Salome reportedly rang Ahmed and they spoke in the officer's presence. The officer did not know what was said as they spoken in their native language. After some conversation with Ahmed the officer contacted Salome to understand her account of the circumstances. Salome expressed concerns for Ahmed's mental health and vulnerability and agreed to attend the Police Station to collect him. Ahmed stated he did not want to return to the home and left the Police Station stating he would stay at the beach for the night.

14.35 Ahmed was reported to leave the police station abruptly and officers were concerned about his welfare, as Salome had told them about the dementia. Ahmed was recorded as a missing person and located some two hours later.

14.36 The officers who located him spent some time speaking with him. They had been made aware that he had dementia and was considered vulnerable. They noted that Ahmed had food, drink, a sleeping bag, and a bag of clothing. Whilst he communicated with them, this was difficult at times as they describe him as going off on tangents and on occasion spoke in broken English. He was negative in some respects when speaking of Salome describing her as narcissistic and alternatively explaining how she had helped and supported him.

14.37 When Ahmed was located, he was described as presenting very well and appearing capable of looking after himself and meeting his own needs. He reportedly informed the police officers that he had £500 cash on him. He did not present as having dementia and 'came across as of sound mind'. He was deemed to be well and in line with his wishes was escorted to a local hotel where he booked a room for two nights with the intention of attending the local Council on the Monday morning to seek assistance in gaining alternative accommodation.

14.38 Two days later Ahmed telephoned SPoA to request support and requested to see the consultant psychiatrist. During the call, Ahmed expressed that he had been married for 12 years and that Salome was manipulative. He referred to her as a psychopath and a narcissist. He stated that he was 'broken physically, mentally, morally and spiritually.' He lost everything he had, and she gained. Ahmed also expressed he had recently seen some information on the internet that had woken him up to this situation. He was now looking for help.

14.39 Ahmed went on to explain that he had left the house he shared with Salome 2 days prior to the call and had gone to the police station. The police then contacted Salome, and she had requested that they meet. Ahmed did not want this to happen or for the police to inform her where he was. The police took Ahmed to a local hotel, and he had been staying there since. Ahmed said that he needed support with housing and benefits as he had nothing, and she had one million pounds in the bank after using him. He re-iterated he needed support from everyone as he was "broken". Ahmed stated he had not been able to sleep for the last three days due to the trauma he had suffered and had just been crying. He feared that his wife wanted to have him admitted to a mental health hospital because he was 'crazy', but he said he was not.

14.40 Ahmed disclosed that he had dementia, and that his wife had used this diagnosis as a tool to further manipulate him. He stated he felt like he was dead and that he needed someone to give him breath to live. He stated that he was not suicidal, claiming that life was God's and therefore not his to take. He confirmed that he was not actively religious but had his beliefs. Ahmed was asked if he had thought to harm others and he stated *"no never, I would not harm anyone*". He said Salome was aggressive, beat him and treated him like a dog. Ahmed expressed that when he first met Salome, she was very supportive but that was no longer the case. He stated that they did not have any children and that he was glad of this as they would only have been other victims for her. He was reported to say that he had escaped to save his life because Salome wanted to kill him.

14.41 The call handler asked Ahmed to hold while she spoke with the nurse on shift. He remained on hold for around ten minutes. Following discussion with the nurse the call handler returned and said that the nurse thought that Ahmed would benefit from social care input and perhaps some talking therapy. Ahmed responded by re-iterating that he needed somewhere to live and someone to really understand what

he was saying and believe it. He expressed that Salome was evil but did not show this to others, she made herself out to be the victim when she wasn't. The call handler stated she would text Ahmed with contact details for services that could support with housing and benefits. Ahmed said he was sorry that he was not able to finish his story.

14.42 The SPoA call handler advised Ahmed to contact SPoA again if needed or if his mood declined and that the issues expressed were not mental health problems. Ahmed was sent contact details for Insight healthcare, Mental Health Matters and Live Well Kent. The call handler recorded in the progress notes that there was no further role for SPoA, and the contact was closed.

14.43 On the same day, Ahmed contacted the GP surgery to make an appointment.

14.44 The following day, Ahmed contacted the local housing team, and reported that he had been abused by his landlord and asked to be housed. The call handler advised that he needed a police reference number and so Ahmed was reported to say that he would go back to the police station the next day. There was no further contact.

14.45 Three days later police received calls from neighbours and Ahmed's friend who was reported to be outside the home of Salome and Ahmed shouting for Ahmed to open the door. She reported to the police that Ahmed had called her saying he had killed Salome.

14.46 Officers gained entry to find Ahmed downstairs and Salome in a nearby room with fatal injuries. Ahmed was arrested and subsequently charged with the murder.

15 Overview

15.1 Salome was not well known to agencies in her own right, but rather as Ahmed's carer, or wife. There is no record of her ever having reported that she was a victim of domestic abuse. She was known to mental health services as Ahmed's carer. She was known to the police due to reporting Ahmed as missing in 2018 and then in January 2021, when Ahmed reported that Salome was abusing him.

15.2 As no referrals were made to Adult Social Care by partners agencies at the time, neither Ahmed or Salome were offered any Care Act assessments (for Ahmed's care and support needs, or for Salome as an unpaid carer, respectively). From the

information reviewed it is possible Salome may have believed a referral to adult social care could risk Ahmed been placed in a home. Salome, in her role as an unpaid carer could have also been referred by partner agencies direct to the local carers organisation[3].

15.3 In January 2019, the KMPT Occupational Therapist explored Ahmed's living situation with him. The OT concluded that Ahmed: *'was quite low in mood, with a degree of helplessness (inability to change his circumstances) and guilt (at making Salome's life hard). I also feel that he wishes he and Salome's relationship could be rekindled (hence is possibly grieving for his loss).'*

15.4 In September 2020, Ahmed presented with low mood. His GP noted that he had declined the offer for counselling services and sought specialist advice regarding potential medication. In November 2020, he was reviewed by the Consultant Psychiatrist and discharged back to the GP.

15.5 Mental Health and GP services interacted with both Ahmed and Salome. There were offers of referrals to social care to provide support for Salome in her caring for Ahmed. However, it was reported that Salome repeatedly declined the referrals to social care as she did not want to see Ahmed placed in a home.

15.6 There is no evidence that Salome was offered a carer's assessment by social care to explore what she needed to support her. From the information reviewed, there is an impression that Salome may have assumed that a social care referral would only result in Ahmed being placed in a home. There is no evidence of how Salome was given information to enable her to understand the wider social care options.

15.7 From the reports of the agencies involved with Ahmed, there were varying records regarding the relationship between the two individuals. Records suggest that Salome described herself as Ahmed's ex-wife, his landlady or carer, at various points during the years leading to the incident.

15.8 For Salome and Ahmed, there appears a picture of two people who had been a couple but had drifted apart. However, they remained connected in a country where

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[3] https://carersek.org.uk/professionals

Ahmed had no other family and was reliant on Salome for his accommodation and support.

15.9 There was no evidence of any practitioner asking Salome and Ahmed about a Lasting Power of Attorney (LPA) [4]. There were indications that Ahmed could still make his own decisions regarding his health care, but it was not clear how this was achieved in terms of his finances.

15.10 Days before the incident Ahmed had approached services, namely the police, Mental Health Single Point of Access (SPoA) and the local housing team. He reported that he was a victim of abuse and wanted rehousing. However, Ahmed had then returned home.

15.11 Apart from Ahmed's report to the police five days prior to the incident, that he was a victim of domestic abuse, there was no indication within any agency report, that domestic abuse was occurring within the home. However, there were records of the stress and strain of Ahmed's diagnosis, on the relationship in 2014.

15.8 The outcome of the incident was that Salome died due to extensive knife wounds. Ahmed was arrested and charged with homicide. He was subsequently deemed not fit to stand trial. However, Ahmed was found responsible for Salome's death and placed in a secure mental health unit.

16 Analysis

16.1 Context

16.1.1 Agencies became involved with Salome and Ahmed in 2014, following concerns raised by Salome, that Ahmed was struggling to understand and process information and had some difficulty in how he functioned at home. This had meant that Ahmed was unable to continue working. Following the initial assessments of Ahmed's memory and cognitive impairment, he had been discharged from the mental health service into the care of the GP. The GP was required to undertake

[4] Lasting Power of Attorney- an adult, with mental capacity, can legally appoint an attorney to help to make decisions or make decisions on their behalf when they do not have the mental capacity to do so themselves. https://www.gov.uk/power-of-attorney

an annual review to include how Ahmed was coping, how safe he felt at home and any needs that Salome had, as his carer.[5]

16.1.2 The analysis focuses on how and why decisions were made by services from December 2017 until the day of the incident. This timeframe was chosen by the panel due to acknowledgement of changes in policies and procedures over long periods of time, and more multi-agency involvement during this time.

16.1.3 There were no reports of domestic abuse in the home until January 2021. The only agency involvement with the couple, before that time, was in relation to Ahmed's diagnosis of frontotemporal dementia and his care and support needs.

16.2 Cultural considerations

16.2.1 From the chronology and IMRs, there was an absence of evidence of practitioners considering the cultural background of both Ahmed and Salome, and the impact of the breakdown of their marriage on their relationship. There was an acceptance, by professionals, of Salome's willingness to continue to care for Ahmed, without a thorough and ongoing check on her needs as a carer.

16.2.2 There was a clear message that Ahmed wanted to rekindle their marriage, but this was not assessed in regard to Ahmed's mental wellbeing, memory, and cognitive deterioration, brought on by the dementia.

16.2.3 In consideration of why professionals did not explore Salome and Ahmed's relationship, it is not clear whether this was due to not giving enough attention to the needs of both individuals and insufficient understanding of the cultural expectations.

16.2.4 Initially, the panel considered Salome and Ahmed through an intersectional lens, in terms of potential cultural aspects of their lives[6]. However, during the conversation with Salome's sister, the reviewer was advised that Salome viewed herself a British and that neither she nor Ahmed were impacted by North African cultural expectations. The reason Salome felt responsible for Ahmed was due to her own views. Her sister described her as '*kind to a fault'.*

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[5] https://www.england.nhs.uk/publication/dementia-good-care-planning-information-for-primary-care-and-commissioners/ 2020 (update)

[6] https://www.un.org/womenwatch/daw/csw/genrac/report.htm

16.2.5 An expectation to take on the responsibility of caring for family members was not considered by practitioners when offering a referral to Social Services. Salome expressed the concern that she did not want Ahmed placed in a home. There was no explanation of the types of services available to the two individuals. Had this been taken forward with Salome, she might have been able to agree some respite care or plan for a time when she could not provide the care she wanted for Ahmed.

16.2.6 Local Safeguarding Adult Reviews and Domestic Homicide Reviews have highlighted that there should be greater focus on the needs of the person providing the care. This is in the context of the professional sight on the needs of those undertaking an unpaid carer role, and to what extent this is caring is out of a feeling of obligation. However, professionals need to have the time, and knowledge of the offer, to discuss options with carers.

16.2.7 Between 2017 and 2020, there were conversations with Salome to offer referrals for additional support. However, she clearly indicated a view that the only option would be that Ahmed would be placed in residential care, which would make her feel guilty. This view was not challenged at any point. This also meant that, when there was the evidence that the two individuals were struggling with each other, no plan was discussed for Ahmed's future with him or Salome.

16.2.8 Salome's family reported that she had not been able to divorce Ahmed as they had married abroad, and it would have been difficult to do. However, she reported to professionals that the marriage was over, yet there was a lack of questions about why she was providing the care for Ahmed and how her feelings towards him would impact on the care.

16.2.9 It is important to note that Ahmed has no family to speak for him. He came to the UK in his 40s and became unwell shortly after. He was reliant on Salome as the person who knew him, for accommodation and support. Indeed, he had significant care and support needs which he could not manage alone. Once he had been diagnosed with dementia, he was unable to work. He was at risk of abuse or neglect which should have been recognised, and checked, by practitioners at times of contact, to ensure he felt safe. When he reported abuse and conflict in January 2021, there should have been a safeguarding referral made to ensure that he was protected and the offer of domestic abuse support.

16.3 GP Management of frontotemporal dementia (FTD)

16.3.1 The GP role was to manage the dementia and facilitate Ahmed and Salome's access to other services. The GP did refer to the mental health team when any deterioration of memory and cognition was noted for Ahmed.

16.3.2 A key GP role was to undertake annual reviews of Ahmed to assess his progress and wellbeing. An annual review of a patient with a long term, degenerative condition such as dementia, provides a vital opportunity to complete a holistic assessment of the individual to identify any changes in needs or support and to check that the person feels safe at home. The Quality and Outcomes Framework (QOF)[7] requires face-to-face care planning with the patient and, with the patient's consent, to invite the carer. This provides opportunity to review both patient and carer's needs, as well as offering a carer's health check. It is understandable that annual reviews were undertaken remotely in 2020, due to the Covid-19 pandemic. However, the GP IMR found that, prior to this time, reviews were not completed to the standard expected.

16.3.3 In 2019, there was a recommendation in a Kent and Medway DHR[8] that GPs should refer to the Dementia NICE pathways so that they follow good practice to do carers' assessments. Carers should be invited to health reviews yearly and to also review how this is affecting their physical and mental health. This would have been expected to be actioned in 2020, even if just remotely. The previous annual reviews of 2017, 2018 (not undertaken) and 2019 were non-compliant with the NICE guidance[9].

16.3.4 When reviews were completed by phone, it was not demonstrated how the GP established what Ahmed wanted to talk about, what was working well, what was not working and what Ahmed wanted to change, as would be expected under good care planning for dementia[10].

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[7] https://www.england.nhs.uk/publication/good-care-planning-guide-for-dementia-case-study-example-qof-annual-review-templates/ 2017

[8] Kent and Medway (2019) DHR Dorothy https://www.kent.gov.uk/about-the-council/partnerships/kent-community-safety-partnership/domestic-homicide-reviews

[9] NICE guidance Dementia: assessment, management and support for people living with dementia and their carers NICE guideline [NG97]Published: 20 June 2018

[10] https://www.england.nhs.uk/publication/dementia-good-care-planning-information-for-primary-care-and-commissioners/ 2020 (update)

16.3.5 The GP IMR did find that there were repeated references to support being offered. Salome repeatedly declined social services involvement, however, there was no mention of a formal offer of carer assessment. Salome had been noted by the mental health team as believing that social services would place Ahmed away if they were involved. There is no sense of anyone providing Salome with appropriate information about the support options that social care could offer. It would have been expected that the GP, or Mental Health practitioners, would be able to explain this, or seek advice from adult social care.

16.3.6 The GP noted that Ahmed declined the offer of counselling services for low mood in September 2020 and was seeking specialist advice regarding potential pharmaceutical pathways. The advice was that this would not be likely to be beneficial. However, there did not appear to have been an assessment of what Ahmed wanted to do about the low mood or what he thought could help him. Nor was there follow up with Ahmed and Salome regarding this issue.

16.3.7 The annual review should include a welfare check to ensure that both the person with dementia and their carer feel safe and well.[11]

16.3.8 Ahmed was transferred between the GP and mental health services to the point that it was not clarified who the single practitioner was who coordinated his care. It could be assumed that this was the GP, but that was not clarified in any documentation.[12] It would have been of benefit for this to be made clear in records, to ensure that the GP was fully aware of any changes in Ahmed's condition.

16.3.9 The NICE guidance sets out the need for individualised care of a person with dementia including: recognising the human value of people living with dementia (regardless of age or cognitive impairment) and their families and carers; the individuality of people living with dementia, and how their personality and life experiences influence their response to dementia; the importance of the person's perspective; and the importance of relationships and interactions with others to the person living with dementia, and their potential for promoting wellbeing.[13] There is

[11] https://www.alzheimers.org.uk/get-support/help-with-dementia-care/gp-annual-review-person-dementia#content-start
[12] https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#care-coordination
[13] https://www.nice.org.uk/guidance/ng97/chapter/Person-centred-care

limited evidence of an individualised care plan for Ahmed that fully addressed the impact of the relationship with Salome.

16.3.10 In Ahmed's case, he and Salome appeared to be trapped in a relationship that Salome did not want, but she felt a responsibility to Ahmed. Meanwhile, Ahmed seemed confused about his life and was struggling to cope with his situation.

16.4 Support for carers

16.4.1 There was evidence that Salome was offered advice about support but when she declined this was not explored and there was no consideration of offering her an assessment of her needs which might have provided her with an opportunity to share her views on being Ahmed's carer, without him present.

16.4.2 This meant that agencies were non-compliant with the NICE guidance for dementia[14]. This sets out the need to offer carers education about dementia, the changes to expect and the way to respond to any change in behaviour. Ahmed reported, in the days prior to the incident, that he thought Salome was mishandling his finances. Had Salome been asked about this, she might have been able to understand that those with dementia can express suspicion about their finances.

16.4.3 The KMPT IMR, demonstrated that some practitioners noted that Salome was unrealistic about Ahmed's condition and advised that this should be addressed in future contacts. However, despite the account that Ahmed had low mood and that the relationship was strained, the work needed to be done with Salome does not appear to have been achieved. This led to her being left isolated. If she did not understand the reason for Ahmed's behaviour, then she was at risk of exacerbating the situation in her response.

16.4.4 Salome and Ahmed reported that they were no longer living as a couple. However, there was no evidence that either was asked about the arrangement for the care of Ahmed. He was not asked if he wanted to be cared for by Salome. He was reported, at times, to want to maintain a relationship with her, whilst at other times he reported that he wanted to live elsewhere. Meanwhile, there seemed to be assumptions made that Salome would provide the care for Ahmed. There were

[14] https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#supporting-carers 20 June 2018

records of Salome being offered a referral for support from adult social care, but no clear conversation to gain her views about the extent to which she was willing to provide the care for her ex-partner. There should have been a clear record within assessments and annual reviews that both parties were in agreement about the care provision.

16.4.5 There were missed opportunities to effectively utilise the system of regular reviews to assess the impact of dementia on the individual and their carer.

16.4.6 The lack of focus on the impact of caring for someone with a mental illness has been addressed in a previous Kent DHR Leanne 2019. This found that domestic abuse, when someone is taking on the responsibility of a carer, can dominate their life. The DHR recommended that professionals need to 'understand the difference between carer support and responding to domestic abuse and the role of the nearest relative' for a person with mental health needs.[15]

16.5 Mental Health Service management of changes to Ahmed's condition

16.5.1 The KMPT IMR noted that Ahmed expressed on more than one occasion that he felt helpless, he had no one to turn to and that he did not think he had other sources of support. The IMR author identified, that there should have been more discussion with Salome and Ahmed to explain the options for additional support. This would have enabled an informed decision about social services support.

16.5.2 The IMR also questioned the extent to which practitioners discussed the options for social service support with Ahmed himself. The IMR author noted that, despite Ahmed's cognitive impairment, there was no indication that he lacked mental capacity to make decisions about his own care and support. The IMR commented that KMPT staff seemed to only be able to see Salome as a protective factor and did not explore Ahmed's views on this. Until the days immediately preceding the incident, Ahmed did not report concerns regarding the care he received from Salome, but there was the knowledge that they did not have mutual views of their relationship.

[15] https://www.kent.gov.uk/about-the-council/partnerships/kent-community-safety-partnership/domestic-homicide-reviews

16.5.3 The KMPT IMR noted the Consultant Psychiatrist view was that Ahmed was clear in what he wanted and needed. The Consultant stated that those with FTD have well preserved memories.

16.5.4 However, there was the opinion that Ahmed appeared, in January 2021, to be mentally unwell and, therefore, should have been referred for ongoing treatment. Yet this would have been out of the scope of practice of the SPoA call handler who spoke to him.

16.5.5 What was within the scope of practice of the SPoA call handler, was the need to recognise that Ahmed's disclosure of abuse needed a safeguarding referral in line with KMPT's and Kent and Medway Multi-Agency safeguarding adults' policies. However, this was not recognised and is thought to be due to Ahmed being a man, and so not being considered as a potential victim of domestic abuse, and due to his dementia diagnosis. The KMPT IMR noted that following the patient safety review, there was communication across the Trust to highlight males as possible victims of domestic abuse.

16.5.6 It was clear that Ahmed made a disclosure of domestic abuse and was asking for someone to listen to him and help him. The KMPT IMR author considered that the assumption that his disclosure was linked to his dementia diagnosis was discriminatory and indicates inequality in practice. It is of concern that someone with a mental illness might be less likely to be believed and then not safeguarded. However, in Ahmed's case both KMPT and the police missed his disclosure, rather than it being an issue of not believing him. It is positive that KMPT have taken this forward throughout their training to ensure that all staff are aware that all safeguarding concerns must be taken seriously.

16.5.7 The patient safety investigation for KMPT also found that Ahmed had asked to see his psychiatrist, but this was declined. It is vital that those who need the support of mental health services are able to self-refer to an appropriate service when they need help. In Ahmed's case, this should have been the CMHSOP. The patient safety investigation concluded that there was a missed opportunity to review a potentially deteriorating patient when Ahmed had phoned the SPoA just days before Salome was killed.

16.5.8 It is acknowledged that those with FTD can present as clear and focused. This can mean that practitioners can miss the signs of deterioration and need to be extra vigilant about any concerns raised by the individual. This has been identified in other DHRs. For example, in the Sheffield DHR Robert[16], his wife was found to have killed him, yet there was no evidence of domestic abuse previously. The couple had lived independently and had little contact with services. However, following the incident the wife was diagnosed with FTD. The DHR commented that "*FTD is not a common condition, probably accounting for fewer than 1 in 20 cases of dementia. People often think of dementia as being about memory problems, but in this condition the main symptoms often present initially as changes in the person's personality and behaviour, such as a loss of inhibitions, where the person behaves in a way that is regarded as socially inappropriate or acts in an impulsive manner that may be out of character for them. There is a possible connection between FTD and aggression/violence."*

16.5.9 The management of FTD is recommended as including[17]:

- Finding support groups for the individual to share their experiences.
- Follow a daily routine to help the individual feel more relaxed.
- Avoid triggers such as changes to routine, misunderstanding, boredom.
- For the carer to understand that the individual will not be intentionally causing upset or offence.

16.5.10 From the information considered for this DHR, there was insufficient evidence that Salome had been supported to fully understand Ahmed's changing behaviour. Once the Covid-19 pandemic restricted their lives, this left both Salome and Ahmed in a difficult situation, with increased pressure on Salome to be able to manage Ahmed's care and support needs.

16.6 Indicators of domestic abuse

16.6.1 The work of the services involved with Salome and Ahmed did not identify any indicators of domestic abuse. There was no evidence until January 2021, of any coercion and control by either of them. In January 2021, there were indicators of abuse, but only reported by Ahmed, not Salome. Johnson (2008, p74) describes how the focus on power and control in defining domestic violence and abuse can

[16] Robert-DHR-Learning-Brief-Final.pdf (sheffielddact.org.uk)

[17] https://www.dementiauk.org/about-dementia/types-of-dementia/frontotemporal-dementia/#managing

mean that those experiencing Situational Couple Violence (SCV) do not think they need help.[18]

16.6.2 Ahmed had asked for help, but Salome had not. Yet the level of care she needed to provide for Ahmed would have placed a strain on her, their communication, and safety. This was in evidence when Salome had, in January 2019, told professionals she could no longer cope with Ahmed. She had told her family that she did not want to be Ahmed's carer as it was causing her too much stress. Salome stopped talking to her family and friends. They had tried to give her advice which she would not accept.

16.6.3 Salome had expressed fear that any social service involvement would lead to Ahmed being placed in a care home. Yet, in 2021, Ahmed reported that Salome was threatening to have him put in residential care. Ahmed had previously reported how Salome was his life and the only person he had. Therefore, both of them appear to have been trapped in a situation neither could manage on a long-term basis.

16.6.4 Salome's death was as a result of a violent domestic abuse incident. However, she had never alerted anyone that she was a victim of domestic abuse prior to her death. Rather, it was Ahmed who had reported, just days before the incident, that he was suffering abuse from Salome. Ahmed had told professionals that Salome meant everything to him. Salome seemed to feel responsible for him. Her sister described how Salome could not leave Ahmed as that was just the way she was, and he would not survive without her. Salome had told her family *'I am responsible for him'*. It is not known what conversations or conflict occurred prior to the incident. However, Salome's sister informed the Independent Chair that the relationship had become toxic. Salome's mental health was deteriorating. She was angry and shouting constantly, which was a transformation of how she had previously been; a fun loving, bright, sociable woman. Salome had told her family that Ahmed had changed personality and was verbally abusive and not pulling his weight at home. Salome had asked Ahmed to leave a few days prior to the incident and that led him to approach services for help.

[18] Johnson, M. P. (2008) *A typology of domestic violence*. Boston: Northeastern University Press. p74.

16.6.5 The DHR panel decided there was a need to consider both individuals equitably within the review. Salome's sister agreed with this response as she viewed the relationship between Salome and Ahmed had become mutually toxic prior to the incident. There was a criminal investigation into Salome's death. The outcome was that, although it was concluded that Ahmed was responsible for Salome's death, he was not well enough to stand trial. This has had a significant impact on Salome's family as they were unable to gain answers into why their loved one died in such a traumatic way. They had not initially felt able to discuss Salome's life or contribute to the panel. It was decided that it would not be appropriate to speak to Ahmed due to the deterioration in his health following the incident.

16.6.6 Dr Neil Websdale[19] recently presented research, yet to be published, looking at 100 fatality reviews (e.g., DHRs) featuring dementia from the US and UK. A very small number showed any history of intimate partner violence.

16.6.7 It is challenging to use the concept of coercive control when considering the 'control' of a carer towards an individual with dementia, or to consider domestic abuse by an individual with dementia who is displaying increasing symptoms of aggression or violence. The DHR Chair would question whether these situations can be defined as domestic abuse or, more appropriately, the consequences of missed opportunities to provide effective care and support, and the stressfulness of caring for someone.

16.6.8 This raises the question as to whether homicide cases involving dementia, where there has been no history of domestic abuse, should be solely under the remit of a DHR. It is the view of this DHR Chair that such cases should also be considered under the safeguarding legislation, S44, to ensure that learning is taken forward to refocus the care and treatment approach for those diagnosed with FTD, and their carers. In Ahmed's case, he seemed to be bounced from mental health to GP, whereas, both he and Salome, might have gained more support and recognition of their changing needs, had there been more consistency of service.

16.6.9 The DHR panel includes individuals who are involved in the Kent and Medway Safeguarding Adults Board and the safeguarding issues have been addressed.

[19] Meet the Director - National Domestic Violence Fatality Review Initiative (ndvfri.org)

16.6.10 Given the awareness of the increasing number of adults with dementia, the largest being in North Africa,[20] it is important that needs of adults with dementia, and those caring for them, are addressed to ensure that they are not left isolated and at risk of harm.

16.6.11 There has been a DHR in Kent and Medway with similar themes to this review; domestic abuse and mental health needs of women from ethnic minority households.[21]

16.7 Response to disclosure of domestic abuse

16.7.1 In January 2021, Ahmed approached the police and reported that he was being abused by Salome. The Police IMR concluded that the police officers involved in hearing Ahmed's disclosure did not provide the required level of service. The incident was reviewed, and performance failures addressed by the Kent Police Professional Standards Department.

16.7.2 Ahmed contacted the housing team. It would be expected that an adult with care and support needs, reporting abuse, would be prioritised for temporary housing to ensure their safety. The housing IMR acknowledged that this needs to be addressed within supervision and training of workers.

16.7.3 Had there been recognition of Ahmed being a potential victim of abuse then there could have been exploration of the needs of both individuals.

16.7.4 No agency referred for specialist DA support or advice. Ahmed approached housing for a safe place to stay. However, evidence of abuse is required by the team in order to provide temporary accommodation. Yet Ahmed had care and support needs and was indicating that he needed help. He should have been considered as being in need of safeguarding and, as such, should have had a referral to the Local Authority safeguarding team for a care and support needs assessment.

[20] Estimation of the global prevalence of dementia in 2019 and forecasted prevalence in 2050: an analysis for the Global Burden of Disease Study 2019. The Lancet Public Health. Vol. 7. Issue 2. Published Jan 06 2022. https://doi.org/10.1016/S2468-2667(21)00249-8

[21] Kent Community Safety Partnership DHR Simran 2019

16.7.5 Ahmed was Salome's tenant and, as such, could have been considered as being threatened with homelessness as per the Housing Act 1996 part Vii Homelessness.[22]

16.7.6 Across services, when Ahmed reported domestic abuse there is a risk that he was not viewed in the same way that a woman would have been in the same position. This is of considerable concern. Had there been more scrutiny and action taken to safeguard Ahmed, then there would have been greater opportunity to explore the situation with Salome, which could have elicited any concerns she had about her own safety.

16.8 Missed Opportunities

16.8.1 Between 2017 and October 2020, health professionals were involved with Ahmed and Salome. During this period there was no evidence that professionals were aware of any domestic abuse or serious concerns about the safety of either individual. However, there were missed opportunities to fully inform Salome of the likely deterioration of Ahmed's condition and how that could affect his personality and behaviour. This meant that Salome could be seen to have unrealistic expectations of Ahmed and what support options were available. There were also some indications of the relationship breaking down, although professionals were reassured by Salome that they could continue to live together. Her sister told the reviewer that Salome would not take any advice and felt responsible for Ahmed and could not leave him, despite the relationship having become increasingly fraught.

16.8.2 In November 2020, there were reports of harassment by a female friend of Ahmed's. This was at a time when health professionals were aware that Ahmed was reporting a low mood. Yet they did not know about the harassment and there was no contact with Salome to consider how she was coping with Ahmed. The police were informed, by Salome, that Ahmed was vulnerable and undertook a visit to the home to gather all details. Although this was good practice, there was no consideration of the opportunity to ask for Ahmed's permission to check with health professionals about his needs, particularly in light of Salome reportedly informing them that Ahmed was living with her because he had nowhere else to go.

[22] https://www.legislation.gov.uk/ukpga/1996/52/part/VII

16.8.3 Ahmed and Salome came to the attention of the police in January 2021, when Ahmed reported domestic abuse. There was no contact made with health professionals, despite the report that Ahmed had dementia. This was a missed opportunity to establish how Ahmed's care and support needs were being met, how Salome was managing as his carer, and to check if there was any previous knowledge of domestic abuse. This was recognised by the police as being a service failure and has since been investigated by the Professional Standards Department. Intertwined with this missed opportunity, is that of the Mental Health SPoA who were informed by Ahmed that he had contacted the police. This was a key point for there to be immediate communication between health and police.

16.8.4 During the same period, Ahmed contacted the local housing team and reported abuse by his landlord. The response was the need for a police reference number, rather than any exploration of the circumstances and supporting an individual reporting domestic abuse.

16.9 Professionally Curious Practice

16.9.1 Professionals are expected to use their training and skills to continually observe and re-evaluate the information they have been provided to enable them to fully comprehend the situation and to make decisions on any actions required, i.e., professional curiosity. However, to be able to practice professional curiosity effectively, practitioners need a supportive, flexible environment, with access to good supervision to be able to critically reflect on their observations and assessments.[23] [24] In the case of Ahmed and Salome, the focus in assessments was on Ahmed's dementia and Salome's acceptance in supporting him. This meant that there was limited focus on their relationship, why they were no longer living as a married couple and what impact this would have in the long term.

16.9.2 Despite there being no reports from Salome that she was a victim of domestic abuse prior to the incident, there were missed opportunities when professionals could have undertaken greater examination of the indicators that the situation was not safe for either Salome or Ahmed.

[23] Revell, L. Burton, V. (2016) Supervision and the Dynamics of Collusion. *The British Journal of Social Work*. Vol.46. Issue 6.

[24] Thacker H, et al. (2019) Professional Curiosity and Partnership Work. *The Journal of Adult Protection.* Vol. 21, iss 5. P252-267.

16.9.3 In the years prior to Salome's death, there were several incidents that were viewed as low level concerns. For example, in 2018, Salome reported to the police that Ahmed was missing. He was found and there were no concerns for his welfare. However, it was known that he had dementia. Salome's report was that he was her housemate. There was no curiosity as to what the care arrangements were and no follow up. Health involvement during 2018 noted Salome as Ahmed's ex-wife and the OT had noted Salome's frustration. Had there been conversations between the police and mental health team at the point of Ahmed going missing, then this might have enabled more exploration with Salome about how things were progressing.

16.9.4 Subsequently, in 2019 the OT noted that Ahmed was reporting 'feeling guilty for the trouble' he was causing. This did lead to discussion in the MDT, and it was noted that Salome had said that Ahmed had a bipolar diagnosis. However, this was not explored and there is no record of this diagnosis. He was followed up by a psychiatrist to whom Salome described Ahmed as having '*several personalities'*. Salome was reported to say that previously Ahmed had been a gentle and polite person. At this point professionals were being told by Salome that she could not cope, and that Ahmed displayed low or manic moods. This was an opportunity for considering the options for support with Salome. Instead, the plan focused on functional investigations, i.e., an MRI brain scan to check for an underlying cognitive disorder. There was no record of anyone asking more questions about how Salome was coping for a period of 11 months, by which time Salome said she was coping. Although professionals ensured that Salome had a contact in case she was not coping, her response seemed to be taken at face value only.

16.9.5 In September 2020, again Salome raised concerns about Ahmed, reporting that he seemed depressed, with his mood up and down. This was confirmed by Ahmed. Although medication and counselling were offered, Ahmed refused. However, there was no evidence of a professional checking with Salome on how she could manage any changes in Ahmed's mood.

16.9.6 Given what was known to health professionals by November 2020, there were missed opportunities to gain a multi-agency assessment of the situation as

Salome and Ahmed came to the attention of the police between November 2020 and January 2021.

16.10 Impact of dementia on domestic abuse

16.10.1 The focus of professionals was Ahmed's dementia and its progression. This meant that there was insufficient consideration of what Salome told them about not being able to cope with his changed behaviour. There were no questions as to what Salome's experience was when Ahmed had his 'manic' moods.

16.10.2 In the same way, Ahmed's own experience was not questioned sufficiently when he reported that Salome had been abusive to him. Professionals seemed to make the assumption that this was due to dementia, rather than domestic abuse.

16.11 Labelling of those with a diagnosis of dementia

16.11.1 Professionals working with those who have a diagnosis of dementia must provide a person-centred approach to prevent the dementia being a label that excludes the individual and their carer from society. In Salome and Ahmed's situation, neither was fully understood by professionals. Iliffe and Manthorpe (2004) identified the need for professionals to recognise the diversity of those affected by dementia, not solely ethnic diversity but cultural practices, social support, and coping mechanisms.[25] This suggests the need for professionals working with those who have a diagnosis of dementia to be able to fully understand how the person has lived and their wider support networks. NHSE (2017) states that personalised care and support planning requires the professional to focus on the impact of an individual's life and family situation on their health and wellbeing, and to make plans to resolve any issues.[26] This will enable individualised short-, and long-term planning for the care of the individual.

16.12 Impact of the Covid-19 Pandemic

16.12.1 Between March 2020 and January 2021, services moved to virtual contact for individuals. Ahmed received phone calls from mental health services, although in the days prior to the incident he was able to be seen in person by the police. The view of the panel was that the outcome for Salome would not have been changed if Ahmed had been seen face to face by the mental health services in 2020.

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[25] Iliffe, S. Manthorpe,J. (2004) The debate on ethnicity and dementia: from category fallacy to person-centred care? Aging & Mental Health. 2004; 8(4), 283–292. https://doi.org/10.1080/13607860410001709656

[26] NHS England » Personalised care and support planning

16.12.2 During 2020 there was a national lockdown between March and June, which meant that families were restricted in what they could do outside of the home. This would have placed pressure on Salome being alone with Ahmed during that time. In the summer of 2020, restrictions started to lift but then, in December 2020, Kent was faced with a tier 4 lockdown level. This meant that Salome and Ahmed were again restricted from socialising with others which would have placed additional stress on their relationship.

16.13 Good Practice

16.13.1 In January 2021 Ahmed went to the police station to report domestic abuse. Following the report, he stated that he did not want to go home and left. It was good practice that there were missing person enquiries to trace him due to concerns about his vulnerability.

16.13.2 There was good practice in the CHMSOP MDT when considering the need to manage Salome's expectations about Ahmed's condition, and also the follow up when practitioners were not able to gain access to Ahmed and Salome. This meant that there were opportunities for them to ask for help.

17 Conclusions

17.1 Salome's death could not have been predicted. There were no indications that she had been victim of domestic abuse prior to the day of her death. Certainly, her sister informed the reviewer that Salome had not been a victim of domestic abuse. However, there were significant indicators of the stress she was under in caring for Ahmed. The reason for her refusal of a referral to social services was not questioned. This could have provided her with support and the opportunity to stop being Ahmed's carer. Yet, there was no recognition that Salome might have been minimising the challenges she faced in order to avoid Ahmed being taken into residential care, rather than being able to see that a home care package might be possible.

17.2 Salome's misunderstanding of the extent of Ahmed's condition on his capacity to function was recognised but not explored with her. Had this been done, she might have been able to accept support in his care.

17.3 Ahmed reported that he was being abused, yet the possibility of him being a victim was hidden due to the focus on his dementia and gender. Had this been explored then there would have been the opportunity to fully assess Ahmed's needs and safeguard him, whilst also assessing Salome's needs as his carer.

17.4 The potential for domestic abuse to be occurring in a household of with older adults did not appear to have been part of the assessments and contacts undertaken by practitioners. Bows (2018) suggests that, nationally, older people are traditionally seen as a low risk for violent crime. Yet, 1 in 4 domestic homicides involves an older victim.[27]

17.5 The DHR panel has had considerable debates about the needs of both Salome and Ahmed. The victim in this DHR is Salome and the panel has fully acknowledged the harrowing circumstances of her death. However, the panel has also discussed the situations in which Ahmed either reported he was a victim or that there were indicators that he could have been someone with care and support needs, with the carer making decisions about the support he received.

17.6 It is acknowledged that the DHR panel has had the benefit of hindsight and seeing the information of all agencies together. However, the approach the panel has taken has been to consider what was known at each critical point in the chronology. This demonstrates that, although the traumatic outcome could not have been predicted, there could have been more professional assessment and reflection on the circumstances in which the two individuals functioned. Salome's sister affirmed the panel's approach.

17.7 What this review has shown is that this case is not unique within DHRs and the learning from this case could have the impact of preventing future homicides involving individuals with dementia.

17.8 The DHR panel were aware of another DHR involving an individual diagnosed with dementia and their carer.[28] It is crucial that the learning from these DHRs is taken forward to establish a system in which there are assessments of both the

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[27] Bows, H. (2018) Domestic Homicide of Older People in the UK (2010-2015) https://www.dur.ac.uk/resources/law/research/domesticabuse/homicidebriefingnote.pdf

[28] Kent and Medway Community Safety Partnership. (2018) Sylvie Domestic Homicide Review.

individual with dementia and their carer to ensure that they are able to express their wishes, fears, and concerns for their future.

17.9 This DHR demonstrates the risks of services with pathways that do not promote a personalised approach to the individual with care and support needs. This leads to transactional contacts between the professional and the individual, or carer. This leads to the missed opportunities to undertake thorough assessments and work collaboratively to develop a plan of care for the individual.

18 Lessons to be Learnt

18.1 Professionals working with those taking on 'informal' caring responsibilities for another person, must be able to consider the needs of the carer without bias in relation to gender and ethnicity.

18.1.1 It is vital that assumptions are not made about women caring for 'husbands', especially if it is reported that the marriage or partnership has ceased.

18.1.2 Agencies should promote, with their staff, the use of the frameworks of the Care Act 2014[29] and NICE guidance for dementia[30], to support them in working with carers effectively.

18.1.3 The recommendations from the 2018 DHR Sylvie should be reiterated to all agencies working with individuals who are receiving support from informal carers. These recommendations were shared with the Kent and Medway Safeguarding Adult Board to link with their work on carers' assessments.

18.2 Those who work in public services must have knowledge and skills in recognising potential victims of domestic abuse, without bias in relation to gender, religion, ethnicity, age, mental health or disability.

18.2.1 This is important to ensure that assumptions are not made about who a person is and the circumstances that can place them at risk of harm.

[29] HM Govt. Care Act 2014. c23.s1(2)
[30] https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#supporting-carers

18.2.2 Agencies should promote the understanding of intersectionality, to support staff in avoiding the labelling of individuals and ensure that assessments are person-centred.[31]

18.3.3 The categories and systems can be described as[32]:

- Social identities- woman, ethnicity
- Sociodemographic categories of gender, ethnocultural
- Social processes (e.g., gendering and racializing)
- Social systems (patriarchy and racism)

18.3.4 In addition, the age of an individual should not influence whether they are asked about domestic abuse as a routine enquiry. Agencies should emphasise, within domestic abuse training, the need to consider the risks of domestic abuse in households where there is someone whose behaviour is changing due to dementia or other health conditions.

18.3 Those working with individuals with care and support needs, and their carers, must be able to recognise, and respond appropriately, to indicators of domestic abuse such as disclosures of a carer not being able to cope.

18.3.1 It is important that professionals undertake holistic assessments for those individuals who have complex care and support needs. This will enable the inclusion of the carer views, needs, and any risks to either the carer or the individual to whom they are providing care.

18.4.2 Situational couple violence (SCV) can be described as escalating violence due to the dynamics of the relationship and wider issues in which a couple find themselves. Johnson states that this type of domestic abuse is not caused by any coercive control by either partner.[33] Violence does not always appear as a routine part of a couple's relationship in situational couple violence. Johnson recognises that all couples can experience conflict rather than one controlling partner.[34] Johnson[35], also states that SCV is the most common type of partner violence which

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[31] UN Gender and racial discrimination: Report of the Expert Group Meeting) https://www.un.org/womenwatch/daw/csw/genrac/report.htm

[32] Dhamoon, R. K. (2011). Considerations on mainstreaming intersectionality. *Political Research Quarterly*, *64*(1), 230–243.

[33] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press. pp60-62.

[34] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press. p63.

[35]Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press p108

does not involve one controlling the other but there may be more '*gender symmetry'* that is not seen within intimate partner violence, with coercive control.

> *'The violence is situationally provoked, as tensions or emotions of a particular encounter lead one or both of the partners to resort to violence.'*[36]

18.4.3 This type of domestic abuse relates well to Ahmed and Salome's situation, as far as the information available to the panel would suggest. There had been no report of domestic abuse until just a few days before the incident. However, the couple were in a situation not within their control and so was known to have its challenges. Johnson suggests that:

> *'Sometimes the root cause lies in chronic sources of stress and conflict in the couple's life that are no fault of their own; sometimes it lies in the psychological problems of one member of the couple'*[37]

18.4 Those working with individuals with care and support needs, due to dementia, must be able to recognise, and respond appropriately, to indicators of safeguarding risks.

It is crucial that professionals recognise the impact dementia can have on the relationship between the individual and those who care for them.

18.4.1 The frequency of reviews should be responsive to the needs of all individuals diagnosed with dementia. It is important that a review date is set when the initial care plan is agreed. As a minimum, the plan should be reviewed annually (any reviews should always include the person living with dementia and their family/ carers to reflect changes in needs and wishes, although this should be separately to promote an openness from all parties.[38]

18.4.2 Professionals should be able to have the time, and skill, to explore with the individual and their carers how they manage their life, on a day-to-day basis, and their plans for the future. For an individual who has been diagnosed with dementia,

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[36] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press p108
[37] Johnson, M. P. (2008) A typology of domestic violence. Boston: Northeastern University Press p70.
[38] https://www.england.nhs.uk/publication/dementia-good-care-planning-information-for-primary-care-and-commissioners/ 2020 (update)

there needs to be professional understanding of what they want from their life in the long term. For the carer, there needs to be ongoing clarification that they are willing to continue to provide the care, are able to do so, and that they comprehend how the individual's condition will progress. The NICE guidance 97 (2018) sets out the need to involve people living with dementia in their care, using modified ways of communication and a structured tool to assess the likes, dislikes, routines and personal history of a person living with dementia.[39] This provides a platform from which a professional can undertake their exploration to ensure that the individual and carer are united in their situation.

18.4.3 Good practice when assessing the needs of an individual who has been diagnosed with dementia is to find out about their personality and their history.[40] This can help practitioners to use as a benchmark for any behavioural or mood changes noted at a later stage. It can also help the practitioner to ask the question about any previous domestic abuse.

18.5 National action is required to address the evidence that dementia is featuring increasingly in DHRs and Safeguarding Adult Reviews (SARs)

18.5.1 There is research being undertaken by Dr Neil Websdale in the United States of America looking at fatality reviews which includes those cases where dementia is a feature.[41]

18.5.2 In Kent and Medway, as nationally, there continue to be learning reviews featuring dementia.[42] These reflect the behavioural changes that can occur for some individuals with dementia or the impact on the informal carers. This suggests that there needs a change of approach to the care of someone with dementia to promote their safety.

18.5.3 The Department of Health and Social Care (DHSC) to consider the extent to which DHRs reflect issues with dementia and to develop a response.

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[39] NICE (2018) Dementia: assessment, management and support for people living with dementia and their carers.
[40] Dementia Action Alliance Gloucester et al. *Dementia and Domestic Abuse.* https://www.fdean.gov.uk/media/lg4d0mg0/dementia-and-domestic-abuse.pdf
[41] Meet the Director - National Domestic Violence Fatality Review Initiative (ndvfri.org)
[42] https://nationalnetwork.org.uk/search.html#stq=dementia&stp=1

19 Recommendations

19.1 The Review Panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1.	Agencies should promote the use of the frameworks of the Care Act 2014 and NICE guidance for dementia, to support them in working with carers effectively.	KMPT, Primary Care
2.	Revisit the following recommendations from the DHR Sylvie and report to the KMSAB and KCSP on progress with changing practice: A) *That someone diagnosed with dementia should be offered a one-to-one discussion shortly after diagnosis so that their hopes, wishes, fears and concerns can be recorded in an assessment that can be referred to throughout the duration of their illness. This can be updated as circumstances change.*	KMICB
	B) *That provision is made for carers to be spoken to on their own about how they are managing/coping. This should be a structured conversation where a realistic assessment of capability is made according to the pressures that the individual carer is subject to and include the offer of a carer's assessment. Any decision to complete the carer's assessment or not should be accurately recorded. The agency most familiar with the carer should offer the session. The suggestion should always be made to a carer that they could work with an advocate if that would be helpful to them.*	KCC ASC

	Recommendation	Organisation
3.	Agencies should promote the understanding of intersectionality, to support staff in avoiding the labelling of individuals and ensure that assessments are person-centred.	All agencies
4.	Domestic Abuse training should emphasise the importance of holistic assessments for those individuals who have complex care and support needs. This will enable the inclusion of the carer views, needs, and any risks to either the carer or the individual to whom they are providing care.	All agencies
5.	The frequency of Dementia Annual Reviews should be responsive to the needs of all individuals diagnosed with dementia. Reviews should always be with the person living with dementia and their family/ carers to reflect changes in needs and wishes	Primary Care
6.	Department of Health and Social Care (DHSC) to consider the extent to which DHRs reflect issues with dementia and to develop a response.	Department of Health and Social Care (Via the DA Commissioner)

GLOSSARY

Abbreviations and acronyms are listed alphabetically. The explanation of terms used in the main body of the Overview Report are listed in the order that they first appear.

Abbreviation/Acronym	Expansion
CSP	Community Safety Partnership
DA	Domestic Abuse
DHR	Domestic Homicide Review
GP	General Practitioner
IMR	Independent Management Report
KCC ASC	Kent County Council Adult Social Care
KMICB	Kent & Medway Integrated Care Board
KMPT	Kent & Medway NHS & Social Care Partnership Trust
KMDASG	Kent and Medway Domestic Abuse Steering Group
NHS	National Health Service
SPoA	(KMPT) Single Point of Access

Domestic Abuse (Definition)

The definition of domestic violence and abuse states:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

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.