Domestic Homicide Review
Bridget/2017
Executive Summary

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Commissioned by:
Kent & Medway Community Safety Partnership
Medway Community Safety Partnership

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1. The Review Process

(*In this report the real names of all persons involved have been anonymised)*

1.1 This domestic homicide review (DHR) examines the circumstances surrounding the death of Bridget White in Kent.

1.2 The review panel considered which family members, friends, and members of the community should be consulted and involved in the review process. The panel was made aware of the following family members and friends. All of the names of family and friends have been anonymised.

Name	Relationship with Bridget White
Michael White	Husband
Stephen White	Son
Michelle Smith	Daughter
Sarah Simpson	Friend
Karen Middleton	Friend
Jackie Moore	Friend

1.3 Following a meeting of the Kent and Medway Domestic Homicide Review Core Panel on 10th October 2017, it was agreed that the criteria for a Domestic Homicide Review (DHR) had been met and the chair of the Community Safety Partnership duly notified who agreed to hold a DHR.

1.4 This Overview Report is an anthology of information gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Bridget White and/or Michael White between 1st of January 2010 and Bridget's death.

1.5 The report also addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) prescribed within the Public sector equalities act duties, and considered if they were relevant to any aspect of this review. 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.

1.6 A letter was sent to senior managers in each of the agencies, bodies, or organisations identified within the scope of the review, requesting the commissioning of the IMR's. The aim of the IMR is to:

a. Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (i.e. culture, leadership, supervision, training etc.) to see whether the homicide indicates that practice needs to be changed or improved to support the highest standards of work by professionals.

b. Identify how and when those changes or improvements will be bought about.

c. Identify good practice within agencies.

d. The IMR is written by a member of staff within the organisation subject to review, and by someone who has not had involvement with anyone subject of the review. It is signed off by a senior manager of that organisation before being submitted to the DHR review panel.

2. Contributors to the Review

2.1 The review panel consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Bridget White and /or Michael White. This included a senior member of Kent County Council Community Safety team. In addition, a senior member of a Domestic Abuse Charity was invited to sit on the board.

2.2 The members of the panel were:

Susan Harper	Kent Police
Cecelia Wigley	Kent & Medway NHS & Social Care Partnership Trust
Daniel Lee	Kent & Medway NHS & Social Care Partnership Trust
Tracey Creaton	NHS Clinical Commissioning Group
Claire Axon–Peters	NHS Clinical Commissioning Group
Andrew Rabey	Independent Chair
Priscilla Tsang	Kent County Council, Community Safety
Susi Thompson	Private Healthcare Provider
Mark Hutcheon	Domestic Abuse Services & Support
Henu Cummins	Domestic Abuse Services & Support
Janet Guntrip	Kent County Council, Adult Social Care & Health
Catherine Collins	Kent County Council, Adult Social Care & Health

2.3 The Independent Chair of the review panel is a retired senior Police Officer since 2014. He now volunteers in the charitable sector and is a trustee for two charities,

one of these being a domestic abuse charity. He has no connection with Kent County Council or any of the services contributing to this report. He has experience and knowledge of domestic abuse issues and legislation, along with a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in serious crime investigation, reviews, multi-agency panel working groups and the chairing of strategic and multi-agency meetings.

2.4 The Hospice that supported Bridget during her cancer treatment was visited by the Independent Chair, and information was provided by the Care Director regarding their engagement and the support they provided.

3. Terms of Reference for the DHR

3.1 Background

3.1.1 The Criminal Investigation timeline informs us that Police attended the home of Bridget and Michael White as a result of a call from their neighbour. Michelle Smith also made repeated unsuccessful attempts to contact her parents. The neighbour, who had become concerned that she had not been able to contact Bridget or Michael on the phone, had gone to the house, let herself in and found a note. The note said not to go upstairs but to call the Police. Attending Police Officers found Bridget deceased in her bed and Michael beside her with wounds. It became apparent that Michael's injuries were self-inflicted, and the initial belief was that Bridget had died as a result of her long-term cancer illness. Michael was taken to hospital where he later told a hospital psychiatrist that he had suffocated his wife. Michael later explained in interview with the Police that Bridget had attempted to take her own but had been unable to do it. She became distressed and Michael stated that following multiple requests from Bridget, he had carried out the action to help her and bring about her death. Michael made various attempts to take his own life but was unable. Police Officers also found notes at the house setting out their joint intention to take their own lives.

3.2 Events surrounding the death of Michael White

3.2.1 Whilst this was not part of the review it is felt important to state that following Bridget's death Michael became very depressed and underwent treatment to help him manage his grief associated with the circumstances and the loss of Bridget. It was apparent when speaking to the friends of Bridget and Michael, as well as the staff who treated Bridget, that they were a devoted couple and loved each other very much. The Police investigation into the circumstances surrounding Bridget's death had determined that Michael should attend court. In March 2018, Michael took his own life.

3.3 The Purpose of the DHR

3.3.1 The purpose of this review is to:

i. Establish what lessons are to be learned from the death of Bridget White in terms of the way in which professionals and organisations work individually and together to safeguard victims.

ii. Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.

iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

v. Contribute to a better understanding of the nature of domestic violence and abuse; and

vi. Highlight good practice.

3.4 The Focus of the DHR

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

3.4.2 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.

3.4.3 If domestic abuse was identified, this review 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. In particular, 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 take into account 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.

3.5 Methodology

3.5.1 Independent Management Reports (IMRs) must be submitted using the templates current at the time of completion.

3.5.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Bridget White in circumstances relevant to domestic abuse or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not had any direct involvement with Bridget White, Michael White, or any other family members. The reviewer cannot be an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

3.5.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

3.5.4 Each agency required to complete an IMR must include all information held about Bridget White and Michael White from the 1st of January 2010 until April 2017. If any information relating to Bridget White being a victim, and Michael White being a perpetrator, of domestic abuse before the 1st of January 2010 comes to light, that should also be included in the IMR.

3.5.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Bridget White and/or Michael White. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2015, X was cautioned for an offence of shoplifting).

3.5.6 Any issues relevant to equality, for example disability, cultural and faith matters should also be considered by the authors of IMRs. If none are relevant, a statement to the effect that these have been considered must be included.

3.5.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

3.6 Specific Issues to be addressed

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

i. Were practitioners sensitive to the needs of Bridget White and 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?

ii. Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Bridget White and Michael White. (as applicable)? 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 Bridget White subject to a Multi agency risk assessment conference? (MARAC)?

iii. Did the agency comply with information sharing protocols?

iv. 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?

v. 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?

vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Bridget White and Michael White (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?

vii. Were senior managers or other agencies and professionals involved at the appropriate points?

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

ix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Bridget White and promote their welfare, or the way it identified, assessed and managed the risks posed by Michael White? Are any such lessons case specific or do they apply to systems, processes and policies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

x. How accessible were the services to Bridget White. (as applicable)?

xi. To what degree could the death of Bridget White have been accurately predicted and prevented?

xii. Why was the cause of Bridget White's death undiscovered until the disclosure of his involvement by Michael White?

xiii. Were the care needs of Bridget White adequately assessed and also the needs of her husband Michael White as a carer to her.

4. Summary Chronology

4.1 In 2010 Michael was admitted to hospital having taken an overdose of drugs prescribed to him to treat depression. Michael gave the reason for his overdose as a three-year history of night sweats, Insomnia, and headaches. Following his discharge from hospital Michael sought psychiatric treatment which remained ongoing until Bridget's death.

4.2 Between 2012 and 2015 Bridget had difficulties and discomfort through a bowel condition. In November 2015 following ongoing tests Michael and Bridget were told that she had widespread cancer which could not be cured. A Nurse from the local Hospice met with Bridget and Michael to give advice and offer ongoing support which was agreed. It was also established that Michael would be Bridget's carer. In December 2015, Bridget commenced chemotherapy together with a variety of other treatments associated with her condition.

4.3 It was noted by Michael's psychiatrist that Michael was struggling to cope with Bridget's worsening condition. He worked with Michael to develop coping strategies in a bid to support Michael in dealing with Bridget's inevitable worsening condition and ultimate death.

4.4 In March and April of 2017 Bridget's condition worsened with associated illness, pain, and discomfort. She was given additional medication and support to maintain a comfortable lifestyle. During this time Bridget sought Medical support frequently both at a private healthcare provider and with local GP services.

4.5 In April 2017 Police attended the home address of Bridget and Michael. They found Bridget dead and Michael beside her with a knife in his abdomen also believed to be dead. It was quickly established that Michael was alive and an Ambulance was called.

4.6 At the scene two notes were found, together with blood staining and other knives, all considered being associated with Michael's attempt to take his own life.

4.7 The attending Duty Police Inspector determined that the death of Bridget was not suspicious; this was ratified by an attending Detective Inspector.

5. Key Issues arising from the Review

5.1 There is no evidence or information available to the review panel from agency contacts, family or friends that would indicate that Bridget was a victim of domestic abuse at the hands of Michael prior to the events that led to her death. Similarly, there is no evidence or information to suggest that Michael had been a domestic abuse perpetrator prior to the actions which caused Bridget's death. Coercion and Control were considered as being aspects of concern within their relationship and extensive questioning around this aspect of Domestic Abuse with both long term friends and family identified that there was no evidence to support this view. The only query about the relationship came from Michael's psychiatrist who felt Michael should devote more time to Bridget so that they would enjoy a "rich retirement lifestyle". Their friends described them as having a close and loving relationship, which had spanned 55 years. Staff supporting them throughout the cancer treatment witnessed them as a caring and devoted couple. The circumstances outlined in this report relate to Bridget's illness, the pain and distress she was enduring, Michael's distress in witnessing this and his concerns about being on his own. These are considered to be the significant and pivotal factors that led Michael to take the actions he did, which ultimately brought about Bridget's death.

5.2 The review of the chronology identifies that the GP's supporting Bridget and Michael were very pro-active in the care that they provided to them. The evidence indicates a holistic care approach that was patient led, and the practice acted as a liaison between the various services used by both Bridget and Michael. There were incidents where Bridget had declined the advice of doctors, and the doctors had clearly respected her decisions, even when they felt this was not in her best interest.

5.3 The review looked carefully at the Care Act 2014, in particular the opportunity to carry out a needs assessment for Bridget, as well as a needs assessment for them as carers. Bridget was regularly assessed by surgeons, GPs, palliative care nurses both within the private and public health sector. The review agreed that there were numerous missed opportunities for discussing a referral to the local authority for an assessment. While it may be fair to conclude, based upon the evidence and knowledge we have of Bridget and Michael, that they would have declined this, it is essential that carer's needs are identified and explored, and this should be an integral part of practice. In this situation both Bridget and Michael were carers of each other, and as such had very individual needs. If they had been in agreement with a referral they may have benefited from an independent assessment.

5.4 The review identified that a significant factor was the assessment made by the out-of-hours GP in April 2017. It is evidenced that the GP was aware that Bridget had been receiving chemotherapy for a year and was presenting with symptoms that may have been suggestive of obstruction. As a result of the triage an agreement with Bridget was made that he would not list her for a home visit at that point as the new medication had not yet fully had a chance to take effect but that if her condition

worsened, she was to phone again via the 111 service and a face to face assessment would then be required. This plan of treatment was reasonable considering the short history of the symptoms provided to the clinician and the fact that the medication had been taken for less than 24 hours. The clinical presenting picture at that time was not a typical picture of an obstruction but safety netting took place to ensure a face to face review if the symptoms persisted. The triage GP decided that a home visit was not necessary at that time and the provisional diagnosis was that the vomiting was likely to be secondary to the chemotherapy. Advice was given to call back if the vomiting did not settle. If further information had been offered or sought by targeted questioning or if Bridget's medical history of constipation and bowel obstruction had been visible to the clinician as special notes using ShareMycare, he may have attended the home and gained a more holistic overview of the circumstances and come to a different decision. Bridget could have been admitted to hospital earlier and her symptoms alleviated more quickly and things may not have escalated as they did. It is evidenced that when she attended the private healthcare provider hospital the next day she was distressed, tearful and in pain. It is fair to conclude that this would have had a significant impact upon Michael's emotional wellbeing, distress and sense of coping.

5.5 The review identified that the care and support of both Bridget and Michael by hospital staff at the private healthcare provider was responsive, sensitive, and caring. The staff were described as going above and beyond their duties and responsibilities.

5.6 The review identified that Kent Police has a policy which outlines the process of investigation when a death occurs. It defines the different pathways to follow if the death is classified as sudden (of natural causes), or suspicious (where the cause is uncertain). It is the initial findings of the attending officers, or the information provided by a member of the public that determines how the death is classified and the process that follows. A suspicious death requires the attendance of a Detective Inspector, trained in the Investigation of serial crime and serious crime, and ensures that a full and rigorous investigation is completed regarding the cause of death. In the circumstances of Bridget's death there were a number of factors that were identified but overlooked and led the Inspectors to classify her death incorrectly. The CSI identified that there was further injuries to the body, but other evidence in relation to her illness, blood stained knives, the two notes left within the house, and the report from the neighbour, appears to have had more influence over this decision. These factors were however significant enough to have raised questions about how Bridget's death occurred. A recent Home Office study: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/484298/Report_into_the_2012_FSR_FP_Audit_Publication_copy_pdf.pdf

This looked at decision making at the initial scene of unexpected deaths identifies that a cognitive bias has led attending Police Officers to sometimes overlook certain evidence, and in those situations failed to recognise some triggers that would raise concerns. The report states,

"One factor which appears from the data available to be a significant issue is the lack or poor inspection of the body at the scene of death by the first attending officers. There is some evidence that even though there were visible marks indicating possible violence in many cases decisions were made not to treat the death as suspicious. In five cases there appears to be no inspection of the body at all. There may also be a tendency to treat deaths of elderly people as less suspicious for understandable reasons. One senior Police Officer stated that in their experience what tends to happen at the scene is that first attending officer makes up their mind as to whether the death is suspicious or not, sometimes believing the first account they are given. A cognitive bias (Forensic Science regulator, 2014; Kahneman, 2011) is then potentially adopted by the investigator with regard to any new evidence which comes forward and also when briefing senior officers and the coroner"

5.7 This interesting study does clearly resonate with this case and whilst initially attending officers were focused upon the medical help for Michael, it is possible that a misdirected cognitive bias led to them overlooking evidence that was at odds with a natural death. Whilst the overall outcome in this case was not significantly affected, due to the disclosure made by Michael at the hospital, it raises a practice issue that needs to be addressed.

5.8 Bridget and Michael's son, Steven was concerned at the lack of information available to the public in relation to assisting suicide. The National Health Service (NHS) via their public facing website provides information about Euthanasia and assisted suicide. (**www.nhs.uk>conditions>euthanasia and assisted suicide**) The information clearly defines euthanasia and assisted suicide; it outlines the law in the UK, and the different types of euthanasia classifying voluntary and non voluntary euthanasia. This is a complex area, fraught with ethical and legal issues for professionals to discuss with families, as assisting suicide is illegal in the UK. However, there is a useful and informative website provided by the NHS available that people can view.

6. Conclusions

6.1 There is no evidence or information available to the review panel from agency contacts or friends that Bridget was a victim of Domestic Abuse, and before the actions that led to her death, neither was Michael a perpetrator of abuse against her.

6.2 Bridget and Michael were a devoted and private couple. They had a close network of friends but chose to manage their difficult health needs independently. It is the

conclusion of the review that their deaths were not as a result of any individual or agency failing. Their independent and self-directing nature meant that they chose to use private health care to deal with these issues and unless necessary, did not engage in the use of Public Services. They often chose not to engage with the services from the Hospice and their nature meant that they wanted to manage independently. What was clearly strength and resilience as a self-directing couple meant that they did not access support that was available and would have assisted them at the end of Bridget's life. This includes the use of anticipatory pain relief that was available for her as prescribed by her GP. Ultimately these decisions led to the very tragic circumstances where Michael took Bridget's life and then attempted to take his own.

6.3 The GP practice displayed good practice by acting as a single point of contact and effectively coordinating their private health care with public agency support as required. The GPs provided a clear route for communication between services. They held and shared appropriately essential data on both Bridget and Michael in a format that was easy to access and understand.

6.4 All agencies recognised the impact Michael's caring responsibilities were having on him but did not fully comply with the Care Act 2014.

6.5 Police Officers initial attendance following Bridget's death failed to display an appropriate level of professional curiosity upon being presented with facts. This led to a failure to declare the death as suspicious in line with Kent Police Policy.

6.6 The private healthcare provider care staff demonstrated good practice in their care of Bridget and Michael who received sensitive, responsive and genuinely caring support.

6.7 The actions of the out-of-hours Doctor failed to fully recognise the early signs relating to Bridget's ultimately diagnosed condition based upon initial presenting triage obtained information. Following the initial triage, he and Bridget agreed that a home visit was not required and that she would call back if her condition worsened. If the Doctor had sought further probing history with regard to Bridget's condition or had further information made available to him through on screen web based platforms used commonly for palliative care or specialist conditions, then he may have taken a different view and carried out a home visit at this earliest opportunity. This may have led to a different diagnosis and hospital admission.

7. Lessons to be Learned

7.1 This report does not identify any lessons that relate specifically to domestic abuse or the prevention of domestic homicides. This is primarily because there was no evidence that Bridget was a victim of domestic abuse during the period covered by the review, nor was Michael a perpetrator against her prior to the incident that caused her death.

7.2 The Care Act 2014 was amended to include the assessment of carers. This elevated the needs of the carer to be equitable to the needs of the cared for and entitled them to an independent assessment. This report identified that at key times this opportunity was missed. At times Michael expressed that he was struggling to cope with the increasing demands of Bridget's illness and was worried about his ability to cope. At these times an individual and independent carer's assessment should have been offered.

7.3 The initial attendance of the Police to Bridget's death lacked a level of professional curiousity. Police Officers attending should put aside assumptions, specifically in this case relating to the age of the victim and her illness and consider all of the information available before reaching a final decision. The information provided by the CSI was considered but dismissed without a rational reason being documented.

7.4 The out-of-hours Doctor was unable to fully evaluate the eventual seriousness of Bridget's condition due to a lack of detailed information available or obtained. This information could have been available by a web-based system called ShareMycare. The out of hours provider in this case provides access to a system for CCGs engaging in out of hours services, allowing information to be recorded and shared about patients with specialist conditions and needs. In this case that service was not used, and the provider indicates is rarely used by those agencies that have been provided access to it. In addition, in some areas dependent on local CCG arrangements, a Primary Care Management System (PCMS) and a Medical Interoperability Gateway (MIG) can be available for the visibility of summary of care records, medications, allergies and recent investigations, however it appears this was not visible to the clinician on this case from the notes reviewed. Had this ShareMycare system been used to transfer to the out of hours service any complex or specialist care information the Doctor would have been more aware of Bridget's ongoing treatment and difficulties she had concerning obstructions to her bowel. Equally had the Doctor demonstrated greater professional curiosity and asked more in-depth questions about Bridget's condition and treatment he may have gleaned a greater understanding. In either case had better access to information been available or sought, the Doctor may have concluded a more holistic view of her condition was required and therefore undertaken an earlier home visit.

7.5 The panel has outlined 4 recommendations based upon the findings of the IMRs and reports submitted.

8. Recommendations from the Review

8.1 The review panel made the following four recommendations from this DHR:

	Recommendation	Organisation
1.	Ensure staff awareness of the impact of being a carer and when the need for a carer's assessment is required. (Kent & Medway Safeguarding Adults Board (KMSAB), GPs and Local Hospice.)	and CCG
2.	To ensure staff awareness of the Care Act 2014 and the need for carer's assessments is provided where appropriate.	Private healthcare provider
3.	To ensure that awareness training around cognitive bias is provided to all Police Officers who attend sudden or suspicious deaths, highlighting the findings of the report *"a study into decision making at the initial scene of unexpected death"*	Kent Police
4.	To examine how specialist patient information can be made available to Out of Hours Services.	CG