OPEN

BRIEFING REPORT

Scrutiny Committee

26 June 2025

Domestic Homicide Review - Mr and Mrs S

Report of: Helen CHARLESWORTH-MAY, Executive Director, Adults Health and Integration

Report Reference No: SC/02/25-26

Purpose of Report

1 The purpose of this briefing report is to inform the Corporate Leadership Team and Committee Members, about the Domestic Homicide Review following the murder and suicide of Mr and Mrs S who both died in March 2021. The Review was commissioned by the Safer Cheshire East Partnership in 2021, signed off by SCEP on 27/4/23 and approved by the Home Office on 3/4/25. The Report is now ready to be published on the Councils Website.

2 The purpose of a Domestic Homicide Review is to:

3 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.

4 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.

5 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a

co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

7 A DHR is not an inquiry into who is culpable, this is for the court or coroner to decide.

8 One of the objectives of the Councils Corporate Plan is for Cheshire East to be a place where a “Everyone feels safe and secure, difference is celebrated, and abuse and exploitation not tolerated”. Therefore, it is important to look in depth at the circumstances leading to this tragedy and the lessons learned and what has been implemented since the Review.

Executive Summary

9 The full Domestic Homicide Review Report is found in the supporting documentation. It will be published on the Safer Cheshire East Website and should be read in conjunction with this Briefing Paper.

10 Mrs S was 81 when she died and had been diagnosed with Dementia in 2016. Mr S was 83 and was his wife’s full time Carer. They had been married for 60 years and prior to moving to Cheshire East, Mr W had been a Farmer. They have 4 adult children who contributed to the DHR. In March 2021 Police attended the house to find both deceased. Margaret had been murdered by her husband, who then committed suicide. They died during the COVID pandemic.

11 Statutory Guidance produced in 2013 defines the criteria for undertaking a Domestic Homicide Review as follows:

12 Under section 9(1) of the 2004 Act, domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he2 was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

13 To note that the scope and definitions relating to DHRs is currently under review and will become known as Domestic Abuse Related Death Reviews. This is due to the high numbers of cases involving suicide, where a person has been subject to Domestic Abuse and has taken their own lives because of the abuse. In the case of Mr and Mrs S the original criteria were in situ at the time of their death.

14 Mr and Mrs S were known to statutory services in both Staffordshire and Cheshire East. It is important to hear the voice of family members who contributed to the Review and said:

15 “Our Mum was an extremely creative person. As a young Mum she sewed beautiful clothes for her children. Mum was a skilled cook and loved hosting dinner parties. She also found time to attend College to develop her cooking skills.

16 Mum was busy in the community; she was an active member of the WI and an active member of a bowling club. She was a member of an Art Club for many years and was an accomplished artist in watercolour, pastels and acrylics

17 In her working career Mum was ahead of our time in her work rehabilitating people with mental health issues, where she passed on her skills of cooking and homemaking to vulnerable people

18 Mums main work in life, apart from bringing up four children, was to support Dad in his business. She was self-taught in bookkeeping and accounts and managed all the finances of the business.”

The concluding comments were agreed by all four siblings:

19 Dad was totally devoted to Mrs S. He was her principal carer and thought that he could look after her best of all.

20 Mrs S had numerous health issues and Dad found it increasingly frustrating to get a doctor’s appointment which was exacerbated by the Covid epidemic

21 We believe that in the last week of dad’s life he had come to the realisation that he couldn’t care for Mrs S much longer and that she would have to go into a home. He couldn’t bear to be separated from her

22 His actions on the day of the incident were completely out of character for our father who was caring, loyal and devoted

23 We all agree that the Covid pandemic greatly affected our Parents’ social life as many of their elderly visitors did stop visiting for many months

24 We felt that Dad was possibly taken advantage of by a health care system that if he was willing to carry on, then they didn’t need to help.”

25 The DHR Review panel met 8 times to consider how Agencies worked with Mr and Mrs S. The Review made 7 recommendations which will be

highlighted later, together with the actions that have been completed since the conclusion of the Review.

Background and Context

26 Key findings from the Home Office analysis of domestic homicide reviews: September 2021 to October 2022 Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK considered 129 completed DHR's referred to the Home Office Quality Assurance Panel, involving 132 victims.

27 In the 129 DHRs reviewed there were 132 victims: 24% had a familial relationship with the perpetrator(s), for 50% the relationship with the perpetrator was partner or ex-partner. Twenty-six per cent were victims who died by suicide.

28 The average age of familial abuse victims was 55 years, older than the average age of familial perpetrators which was 35 years. Intimate partner victims were on average younger (38 years) and younger than preparators (43 years). The average age of victims who died by suicide was 36 years.

29 Where victims were in an intimate partner relationship or who had died by suicide, 86% and 88% respectively were female. This was different where there was a familial relationship where 53% of the victims were female.

30 Considering nationality, 69% of familial victims were British; 80% of intimate partner victims were British and where the victims died by suicide 91% were British.

31 Of the 132 cases eleven per cent of victims had been identified as being carers. There is a variation between the types of victims: 22% of familial victims were carers, whilst 11% of those in an intimate partner relationship were carers. None of the victims who died by suicide were identified as carers.

32 Of the seven victims who were carers, three of the seven familial victims and one (of the seven) intimate partner victims had received a carer's assessment.

33 The DHR panel for Mr and Mrs S also considered research relating to incidents occurring when people are over 60 published by Professor Benbow at Chester University and relevant themes.

34 How does age relate to the risk of domestic homicide? The analysis suggested that there is insufficient evidence to conclude that ageing, per se, is a significant risk factor. The significant factor that emerges

from their analysis is the role of assumptions and stereotypes about older age which influence risk assessments and the management of potentially abusive situations.

35 The role of stereotypes and myths about dementia The research conducted by Professor Benbow noted that Dementia featured in six of the homicides they reviewed. They noted that there are myths expressed about dementia in relation to DHRs, in particular an assumption that people with dementia are aggressive and violent towards others and that, as a result, more domestic homicides are likely in future since the population of people with dementia is projected to increase.

36 The researchers did note that there is also an opposing myth, that people with dementia are not capable of predetermined acts of violence and this area needs further research.

37 The role of caring The research team led by Professor Benbow suggested that being cared for may be as stressful as doing the caring. In addition, a caring situation changes power dynamics between the individuals involved and involves dependency and loss of autonomy. Sometimes the situation is complex as both people involved are caring for one another, or a person might identify as a carer but the person they care for might dispute this. All these factors affect the relationship.

Briefing Information

38 The key themes which emerged from Mr and Mrs S mirror those highlighted in the research above. However, each set of circumstances are unique and the impact on families and friends and professionals cannot be underestimated.

39 Mr and Mrs S moved to Cheshire East in 2016 to be closer to family members. They lived at their previous address for over 30 years and received daily support from a Care Agency, which enabled Mr S to continue work. But this changed when they moved as Mr S wanted to care for his wife and subsequently, soon experienced a sense of isolation, which was exacerbated by Mrs S's deteriorating Dementia and the impact of COVID. They had one phone and no internet facilities, which indicates the pitfalls of Digital Exclusion. In Mr S's Carers Self-Assessment said, "Mrs S was ashamed of her illness and will not socialise".

40 Mr S rarely left his wife, and the impact of caring affected his health and well being and contact with friends. Following a visit to see a Care Home he did tell his daughter that should his wife go into a Care Home, the impact would be greater for him, thereby indicating the pain, guilt and loss associated with a relative moving into full time care – (like having children removed/placed in care.)

41 There is evidence that Statutory Services did provide advice and made offers of support to Mr and Mrs S, including Occupational Therapists and Dementia Reablement Services. However, Mr S often declined to accept formal support, preferring to make private arrangements, and giving the false impression to Professionals that he was coping. As a "Self-Funder", Mr and Mrs S did not have access to regular Adult Social Care Reviews, thereby missing out on checks and monitoring about how he was coping/changes in need.

42 Whilst the Panel sought confirmation from the General Practices who were responsible for her care, and they confirmed that – certainly from a medicines management perspective – Mrs S received care in accordance with the relevant NICE guidance. The family of Mr S and Mrs S noted that caring for someone with dementia requires more than medication and felt that the fundamental elements of care – for example the relatively simple task of 'sitting with' Mrs S – were missing from her case and from her care.

43 Mr and Mrs S's family felt that services had left their dad to carry on alone, and the DHR Review highlighted the need for a more assertive approach.

44 Any Carer Stress that was identified was in the context of the move to new accommodation and was not sufficiently explored. Neither was the risk associated with Self Harm or Suicide.

45 Professionals did not seek the views of Mrs S, due to her Dementia Diagnosis, and relied on Mr S's reports instead. There were missed opportunities to complete Mental Capacity Assessments and consider Best Interest Decisions and deploy an Advocate for Mrs S.

46 All case records need to be accurate, robust and completed in a timely way.

47 <u>Recommendations:</u> The DHR did include areas of good practice and projects that were initiated during and post COVID. The Review also made several multi agency recommendations which can be seen at the end of the full Report and in the 7-minute briefing. These include the following.

48 Carers identification and recording by all agencies

49 Completion of Carers Assessments

50 Dementia Awareness Training

51 Legal literacy – particularly using the Mental Capacity Act

52 Suicide Awareness – including its impact

53 Assertive interventions by Professionals, rather than leaving people alone

54 Recognition of Domestic Abuse in the context of Dementia or other longer term conditions vs Carer Stress

55 Actions: The Safer Cheshire East Partnership seeks assurances from Partner Agencies about their responses to the learning from DHRs and oversees Action Plans. Whilst the Home Office approved the publication of this DHR in April 2025, the following actions have already been put into place.

56 The development of the Risk Identification Checklist for Older People

57 Guidance, Toolkits and Training on safeguarding and domestic abuse – Approved by the SAB – including bespoke Training during Adult Safeguarding Week November 2023.

58 Improved support provided for carers within Cheshire East – All Age Carers Strategy/Training/Carers Hub

59 The development of a programme of intelligence gathering, learning and professional development concerning domestic violence, suicide, suicidality, and mental health

60 Referral pathways between the Mental Health café and the Domestic Abuse Hub

61 Mental Capacity Act Training and Resources

62 CEC contributed to the LGA Guide - Carers and Safeguarding – A briefing for those who work with Carers

63 CEC - Suicide Prevention/Strategy including Training, Resources and Awareness raising.

64 Care Act Refresher Training

65 Briefings and Training to Practice Managers/Practitioners based on Mr and Mrs S

66 The Dementia Strategy is being refreshed.

67 The Panel and Cheshire East wishes to record its condolences to the family of Mr S and Mrs S for their loss.

68 Dementia – of all types – is becoming a critically important issue, in terms of both the high personal and social costs related to the disease, and the wider impact on the health and care system.

69 The Department of Health report, published in 2009, suggested that demographic changes within the UK will drive significant growth in the number of people with dementia. This will occur even though the percentage of older people developing some types of dementia (particularly vascular dementia) may decline as a result of reductions in hypertension and other dementia related risk factors[1].

70 Research suggests that approximately one in four patients in acute hospitals have dementia – and that these needs are not currently well responded to. Additionally, the cost of dementia will rise by 61 per cent to £24 billion by 2026 (at 2007 prices), with most of this cost being met by social care and by individuals and families rather than the NHS.

Implications

Monitoring Officer/Legal

71 There are no legal implications for this Report

Section 151 Officer/Finance

72 There are no financial implications for this Report.

Policy

73 There are no Policy implications for this Report

74 These statutory duties underpin Cheshire East's ambition to protects children, adults and families from abuse, neglect and exploitation.

Commitment 1: Unlocking prosperity for all	**Commitment 2: Improving health and wellbeing**	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

75 The learning from this report is relevant to all.

Human Resources

76 There are no HR Resource implications to this report. However, it should be noted that the findings should be accepted by Cheshire East Council and Best Practice principles will be applied to our work with Carers, whether independent or as family members.

Risk Management

77 There are no implications for Risk Management in this report.

Rural Communities

78 There are no specific implications for rural communities. However, the report highlights the impact of isolation when caring for a relative with a long-term condition, particularly if living in a rural setting and without internet access.

Children and Young People including Cared for Children, care leavers and Children with special educational needs and disabilities (SEND)

79 There are no implications for Children or Young People in this report.

Public Health

80 The impact of long-term caring can have a negative impact on health and wellbeing. The learning from this Report is relevant to Cheshire East's Suicide Prevention Strategy.

Access to Information	
Contact Officer:	Sandra Murphy – Head of Adult Safeguarding Sandra.murphy@cheshireeast.gov.uk
Appendices:	7-minute briefing  7 minute briefing - Mr and Mrs S 1.docx DHR Overview Report

	DHR for Mrs S Final March 2023.docx
Background Papers:	Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK Adult social care and safeguarding during COVID-19: a large-scale mixed methods study COVID-19 adult safeguarding insight project - third report (December 2021) | Local Government Association Click to edit Master title Support for carers of adults Carers and safeguarding: a briefing for people who work with carers | Local Government Association