Protective Services Report

Prepared for: [redacted]

Title: Coroner Ellery's letter – Christine WILLIAMSON (deceased)

Prepared by: [redacted]
T/Detective Chief Inspector PVP

Introduction

This report seeks to provide a detailed response to Coroner Ellery's letter to West Mercia Police dated 18.12.13. West Mercia has a duty to respond by 12.02.14, under paragraph 7, schedule 5 of the Coroners & Justice Act 2009 and regulations 28 & 29 of Coroners (Investigations) Regulations 2013.

The inquest concerning Mrs Williamson commenced on 13th November 2012 and concluded on 16th December 2013.

The conclusion of the inquest was '*the deceased died from a physical assault from her husband who by reason of his lack of mental capacity was unaware of his actions or its consequences. If earlier action had been taken the deceased may have been protected and her death preventable'.*

Background Information

Mrs Williamson was 62 years old when she died on 31st October 2012, following an assault upon her by her husband who was suffering from advanced onset of Alzheimer's dementia. The medical cause of death was determined as subdural haematoma following mild blunt head trauma.

[redacted] was unaware of his actions and was removed from the family home on 18th October 2012 following the incident. He was admitted to a local Psychiatric Unit and was subsequently sectioned under Section 3 of the Mental Health Act 1983.

In September 2013, the Crown Prosecution Service made the decision that no further action would be taken against [redacted] due to his medical condition. Plans are being made to move him to a secure hospital.

Due to the circumstances surrounding this incident Telford and Wrekin Community Safety Partnership deemed a Domestic Homicide Review (DHR) appropriate and appointed [redacted] as the independent chair.

DHR

The police Independent Management Review (IMR) was conducted by the Major Crime Review Team (MCRT). It was established that West Mercia Police had three contacts regarding the Williamson family between July and October 2012.

Contact 1 – 8th July 2012
Police received a call from Shropdoc (out of hours GP) who were attending the address following a report of an assault, requesting a police escort. Intelligence checks were conducted with no risk factors identified.

As a result the decision was taken in conjunction with Shropdoc not to deploy officers to the incident as it was known that there was a dementia suffer at the address and attendance may aggravate the situation.

MCRT concluded that attendance was required in these circumstances, with the submission of a crime report for the alleged assault and vulnerable adult incident. As this information had not been recorded it could not be readily available to staff attending any similar incident at a later date.

Contact 2 – 19th August 2012
Police received a call from a neighbour reporting that screaming and shouting could be heard from the address. Staff attended and established that [redacted] was a former police staff member and made enquires to ascertain whether WMP occupational health would be able to offer any assistance.

A vulnerable adult incident was submitted but no DASH risk assessment. The vulnerable adult report highlighted the violence suffered by Mrs Williamson; it recorded her ongoing medical complaints, described her as 'tearful' and 'desperately' requiring assistance.

MCRT concluded that a DASH risk assessment was required however this omission was minimised as the vulnerable adult incident was actioned by the Protecting Vulnerable People department, referring to Adult Social Services in a timely manner. As contact 1 had not been recorded adequately contact 2 was not identified as a repeat incident.

Contact 3 – 18th October 2012
Mrs Williamson contacted police reporting that her husband had assaulted her by pushing her to the ground, jumping on her back and riding her as if she was a horse. During this event [redacted] hit his wife about the head.

Officers attended and witnessed [redacted] in an agitated manic state. The ambulance was called checked Mrs Williamson and transported [redacted] to hospital where he has remained since. Mrs Williamson refused to make a formal complaint of assault against her husband (she signed an officer's pocket note book to that effect) and refused to be taken to hospital for a more thorough examination.

MCRT concluded that force policy was followed in this incident with the completion of all requirements.

Coroners – Matters of Concern

During the inquest the Coroner raised concerns that there was a risk future deaths will occur unless action was taken. The matters are detailed in section 5 of his letter.

1. A referral and assessment could have been made before or after April 2012, but most notably on or around 2nd – 4th April 2012 when the deceased GP made a direct referral to social services.

This matter was not reported to Police. The first contact with the Williamson family was 8th July 2012. Evidence was heard at the inquest suggesting that the GP was aware of domestic violence since December 2011, where bruising to Mrs Williamson was photographed at the surgery.

2. Had such an earlier assessment as a vulnerable adult been made then discussions would have taken place with all concerned with everyone having significant information sharing it with others.

The earliest opportunity for Police to have made any referral to partner agencies was 8th July 2012; however this was not completed until the second interaction on 19th August 2012.

3. The DHR recommendations are endorsed.

DHR – Recommendations and West Mercia Police Response

The DHR did not make any specific recommendations for West Mercia Police. There are four 'All Agency' recommendations:

Recommendation 1 – Risk Assessments
All Agencies must review their assessment and management of risk for service users, their carers and significant others in their guidance for staff and provide an analysis of its effectiveness and how it is being monitored.

Response: This recommendation does not appear to be wholly relevant to West Mercia Police. Risk Management Plans are used pro-actively to effectively manage risk, overseen by supervisors to ensure focus is maintained.

Recommendation 6 – Domestic Violence

All agencies must ensure that there are improvements in service responses for all domestic violence victims (both adults and children), all relevant staff to attend multi-agency training programme based on the DASH model.

Response: This recommendation is not relevant to West Mercia Police as all operational staff are trained in the DASH risk assessment process. There are policies and procedures in place to guide staff and the DASH risk assessment process is utilised. This process is regularly audited by the Business Assurance

Team with appropriate learning disseminated to staff. A reminder regarding the requirement to complete DASH, Crime Reports and Vulnerable Adult documentation will be provided to all operational staff. This will be completed by 31.01.14.

Recommendation 7 – Support Services
All agencies need to review their service responses to people who suffer from Alzheimer's and other Dementia Diseases and their Carers. This should be done in partnership with groups such as the Alzheimer's Society who have significant knowledge and understanding of the issues.

Response: MCRT commented that current training delivered to operational staff when dealing with vulnerable adults deals with mental health issues as a whole and does not individualise conditions such as Dementia and Alzheimer's.

The recognition of a vulnerable adult by Police Officers and staff is considered sufficient to trigger a referral process for specialised assistance.

The tactical equality and diversity advisor has recently attended a Dementia Friends workshop to scope the feasibility of additional awareness sessions. This is captured within the Warwickshire and West Mercia Mental Health Delivery Plan (action 18) with a completion date of 01.09.14

Recommendation 8 – Support Services

A joint working group to be developed involving all agencies to address the increasing prevalence of dementia to identify the manifestation of harm to themselves or others and management plans to address these issues.

Response:
The arrangement of a joint working group will be tasked by the Safer Communities Partnership to the Safeguarding Adults Board. West Mercia Police will ensure full participation from specialist staff from the Protecting Vulnerable People Department. Details are currently awaited regarding the date of the first meeting.

Conclusion
The matters raised as a result of the DHR will be actioned as detailed above.

This will be monitored until completion and discharged via the Strategic Oversight and Scrutiny Group, chaired by Assistant Chief Constable.