Routledge Studies in Criminal Behaviour

FATAL FAMILY VIOLENCE AND THE DEMENTIAS

GRAY MIST KILLINGS

Neil Websdale

Fatal Family Violence and the Dementias

This book explores dementia-related aggression, violence, and homicide through a detailed analysis of "gray mist killings." The term gray mist killing refers to intimate partner homicides (IPHs) committed by spouses/partners suffering from dementia, homicides of dementia sufferers committed by their caregiving spouses/partners or other family members, and IPHs attributable to the complications of caring for a co-resident family member suffering from dementia.

Killings by people with dementia raise questions about the role of biological, psychological, and sociological forces. This book therefore encourages discussions around the relative weighting of these interrelated forces, and why the criminal justice system and the courts have a hard time handling these killings. It also adds to our understanding of the social responses to people with dementia, the orchestration of services, the nature of caring, and the interaction between sufferers and those familial, community, and state actors that provide support and care. The vividly detailed case studies (from the US, UK, and Australia) uniquely inform criminological debates about violence, homicide, and the social responses to these complex phenomena. They are organized around the apparent motives for the killing, such as mercy, theft, prior intimate partner violence, mental illness, and exhaustion. The social responses of families, communities, and state actors are examined and contextualized against what researchers and dementia specialists suggest are promising or best practices for intervention. Apparent triggers or circumstantial precipitants for the killings invite discussion of signals, risks, and preventive interventions. The book culminates in an attempt to make sense of gray mist killings, as well as a discussion of broader implications and significance in relation to globalization, violence against women, the rising prevalence of the dementias, declining birthrates, climate change, and sustainable economic development.

Drawing from a variety of disciplines, this book will be of great interest to students and scholars of criminology, sociology, psychology, psychiatry, anthropology, gender studies, social work, law, public policy, and gerontology. It should also appeal to judges, prosecutors, lawyers, social workers, gerontologists, law enforcement, adult protective services, physicians, psychologists, and psychiatrists.

Neil Websdale is Director of the Family Violence Center at Arizona State University and Director of the National Domestic Violence Fatality Review Initiative (NDVFRI). He has published work on domestic violence, the history of crime, policing, social change, and public policy. His books include *Rural Woman Battering and the Justice System: An Ethnography* (1998), which won the Academy of Criminal Justice Sciences Outstanding Book Award in 1999; *Understanding Domestic Homicide* (1999); *Making Trouble: Cultural Constructions of Crime, Deviance, and Control* (co-edited with Jeff Ferrell, 1999); *Policing the Poor: From Slave Plantation to Public Housing* (2001), winner of the Academy of Criminal Justice Sciences Outstanding Book Award in 2002 and the Gustavus-Myers Center for the Study of Bigotry and Human Rights Award in 2002; *Familicidal Hearts: The Emotional Styles of 211 Killers* (2010). Professor Websdale's social policy work involves helping to establish networks of domestic violence fatality review teams across the US and elsewhere. His extensive fatality review work has contributed to the NDVFRI receiving the prestigious 2015 Mary Byron Foundation Celebrating Solutions Award. He has also worked on issues related to community policing, full faith and credit, and risk assessment and management in domestic violence cases. Professor Websdale trained as a sociologist at the University of London, England, and currently lives and works in Flagstaff, Arizona.

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For Molly and for Kyrie and James. Two ends of a curious continuum.

“Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans everything.”

from W. Shakespeare (*As You Like It*, II, vii, 163–166. Spoken by Jaques, Act 2, Scene 7)

“Attention is the rarest and purest form of generosity,”

from (S. Weil to J. Bousquet, April 13, 1942, in
S. Petrement, Simone Weil: A Life).

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Preface

The sun was setting over the north Norfolk coast of England. Andrew and I were walking toward Cromer. It was a stunningly beautiful late afternoon in August. The beach was practically deserted. We talked as the sun turned slowly orange over the cliffs. Our topics varied. His retirement, his interest in early modern English history, his family, my family, our interest in poetry, and how we spend our days now. The topic of my work came up, and I started to explain this book project. Over the last decade or so, a number of dementia-related family killings have come to my attention in my role as the director of the National Domestic Violence Fatality Review Initiative (NDVFRI), a technical assistance project generously funded since 1999 by grants from the US Department of Justice, Office on Violence Against Women.

Knowing a close and dear family member of mine, Rita May, a pseudonym, had developed dementia, he asked me if Rita May's dementia contributed to my writing the book. I answered Andrew as best I could by saying that it surely did, but in ways I did not understand. That influence was likely a mélange of the direct, the oblique, the opaque, and the subliminal. Personal experience often informs our work, and in my case, that has turned out to be true. Rita May's father killed her mother just before VE (Victory Europe) Day. People celebrated VE Day on May 8, 1945. It marked the Allies' formal acceptance of Germany's unconditional surrender and thus the official end of World War II. He killed her in their family home. The coroner's inquest concluded that the death was accidental. He had been cleaning the trigger of a shotgun when it discharged, killing her instantly. He had apparently been under the impression that the gun was not loaded. Rita May, age 12 at the time, was in an upstairs bedroom with her younger sister. She came downstairs to witness the scene, a scene that would haunt her for the rest of her life. Her sister remained upstairs. Some years ago, Rita May's sister died of complications associated with Parkinson's disease. Did the shooting somehow contribute to the neurodegeneration the sisters experienced in later life? Rita May's deterioration over the last few years and my involvement with it suffuse what follows.

The book therefore reflects personal and professional interests. I found it best to tell the story of fatal family violence and the dementias through case studies. The book is a narrative about the bite of dementing illness on a particular cohort of families in three developed democratic societies: the US, UK, and Australia. The subtitle, *Gray Mist Killings*, intrafamilial killings of or by people with dementia, reflects my uncertainties about dementing illness, those subject to it, and those involved in what are often deeply troubling lives. In many cases, the profound disruption of social life is disturbing long before the denouement of the homicide.

As we approached Cromer, we picked up the pace. We had been lost in conversation, the vast expanse of sand and sea, and perhaps what Freud called an oceanic feeling, something limitless, unbounded. At the same time, we were also a little anxious about the incoming tide, a metaphor perhaps for our own aging. Among other things, we discussed physicalism, the idea that everything is physical and there is nothing beyond. In the study of the dementias, physicalism manifests as biological determinism.

The pages that follow reflect my personal discomfort with physicalist explanations and biological determinism. My unease with these explanations stems not from the insignificance or irrelevance of physical phenomena for the study of violence and dementing illness. On the contrary, the physical and biological aspects of dementing illness strike me as profoundly important. Clearly, the physical degeneration of the brain and nervous system contributes greatly to the disruption of social life and all of its attendant agony and heartache. However, physicalist explanations do not go far enough, and we run into the problem of what philosopher Joseph Levine calls the explanatory gap. This gap, fissure, or chasm, depending on your view, describes our inability to know how words, smells, sounds, and other subjective experiences, in short, sentience, derive from neuronal activity. As they say on the London underground, we must “mind the gap.” My narrative style and concern with the ash of everyday experience is an attempt to mind the gap, to approach it, rather like a nerve impulse draws near to a synapse.

Many academic journals traffic in quantitative data and empiricism. Yet there is a danger amidst all this garrulous talk of variables that we might lose sight of, downplay, or simply ignore the inconvenient complexities of social life and human interaction. We talk of “controlling for” this context or those social circumstances, of confounding variables, as if these phenomena are mechanical parts of a machine. It is as if social life comprises an endless series of binaries. Such approaches are especially concerning when we are tackling emerging topics such as fatal family violence and the dementias. My reading of the files suggests that human interactions and the sociohistorical contexts within which they take place deeply affect the course of dementing illness. I hope my narration of cases of homicide and the dementias might inform later more scientific analyses of these concerning phenomena.

The pages that follow render problematic false binaries such as the biological and the social, history and society, the physical and the mental, the mind and the body, and remembering and forgetting. The result falls well short of anything definitive. Hopefully the book provides a segue into more comprehensive multidisciplinary studies of the pressing global problem of dementing illness and our responses to it and people like Rita May.

Acknowledgments

Many people involved in reviewing fatal family violence influenced the pages that follow. I want to acknowledge the help and influence of the late Matthew Dale, Joan Eliel, Cynthia Rubenstein, Frank Mullane, Greg Giangobbe, Ray Chaira, Mark Perkovich, and James Rowlands. I also thank all those who spoke with me off the record about the cases I narrate in de-identified form. If those key informants read what follows, they will know who they are and that I am indebted to them. Many thanks to the editorial team at Routledge: Lydia de Cruz, Morwenna Scott, Medha Malaviya, and Sathyasri Kalyanasundaram. My friend, Virgil Hancock, helped enormously by generously providing me with research studies, educating me about psychiatry, and sharing insights about his work spanning three decades with the violently mentally ill. Tori Vnuk furnished expert copyediting and many helpful insights into the material. I thank her greatly. She is a rare talent. My running partner, Jim Novak, listened to much of the manuscript as it unfolded. I thank him. My friendship with Andrew Bush spans six decades. He turned me on to sociology in the first place, and our interactions over the years have fed many of my interests. I thank him from the heart. Mia, Mihai, Kyrie, and James helped in ways I cannot explain. The lives of my mother, Molly, and my sisters, Judy and Jill, permeate the pages. I owe them more than I can put into words. My wife, Kathleen Ferraro, read and critiqued the manuscript and gave insightful feedback. I am indebted to her for so much more than that feedback, especially for the many years of walking in the sacred pine forests of northern Arizona in near silence.

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Part 1

Mere Oblivion

1 Gray Mist Killing

Seeming Obliviousness

The shabbily dressed man stood at a busy junction in North London. He had dementia. Daily, he held a utensil in his hand, usually a fork. Sometimes energetically, other times calmly, he waved the fork high in the air as vehicles passed. The astute reporter of this behavior noted the man's seeming obliviousness to people who passed by him.[1] Eventually, the strange man disappeared. The obituaries recalled that he had been a psychoanalyst and a brilliant musicologist. His work sheds light on how Beethoven and Mozart composed their music. Was the man conducting a symphony of traffic? Did the rush of traffic speak to him musically? How did those passersby interpret what he was doing? Was he a mad old man? A dangerous homeless person? Strange episodes like this mirror millions that happen regularly in homes and care facilities across the world. Some are not as benign and harmless as the man directing the traffic.

Spiked Railings

Visiting a cousin in England, I had occasion to walk around a small village that dated from Anglo-Saxon times. Flint, a form of the mineral quartz, peppered the walls of its rounded church tower. A large deciduous tree at the church boundary kept the tower company. Amidst dark green grass, orderly rows of headstones stood at attention. A cobbled path wended its way to the back of the church. A black iron fence with spiked railings separated the church from the quiet street. Weeping willows hung heavy at the edge of the village pond. The pond formed an almost perfect circle. The village had a primary school, a post office, a grocer shop, a pub, and a butcher's shop. The butcher's shop sold pheasants, the most popular game quarry in England.

We learn from the UK Domestic Homicide Review (DHR) report that Henry and Gloria Michaels (pseudonyms) had called the village home for half a century.[2] They bought a house, raised two children, and lived frugally, growing food in their garden. Henry was an avid hunter. Their children described a happy childhood. The couple apparently got along well, reportedly never arguing in front of their children. Later, both children would enjoy successful professional careers. The children remained in the area as adults.

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In his late seventies, Henry developed dementia, most likely dementia with Lewy bodies (DLB).[3] The dementias are not diseases. Rather, they are general terms for the "impaired ability to remember, think, or make decisions" that interferes with everyday life.[4] Henry had developed what I will refer to throughout as dementing illness.[5] The day before he killed Gloria, then age 76, a neighbor intervened when Henry accused her of stealing money. He had wandered over to a neighbor's house carrying a large amount of cash. Henry told the neighbor he had dementia and was afraid of being robbed. The neighbor called the police. Police arrived. By that time, Gloria had joined Henry. The money Henry was carrying was locked up for safekeeping in the neighbor's gun cabinet. The officer walked Gloria and Henry home, noting that by then Henry had calmed down.

The next day, Henry used two long kitchen knives to stab Gloria multiple times in the head and neck as she tried to exit their home. A couple, neighbors, saw him standing in the doorway to the house. Gloria was lying on the ground. According to the neighbors, Henry then walked back to the kitchen and came out with two blood-stained knives. Neighbors called the police. Upon arrival, Henry told them, "She won't need an ambulance." He then proceeded to stab her three more times in the neck. Armed police then arrived. Henry refused to put down the knives. He tried to stab himself in the chest. Henry told them, "She's dead. Just shoot me." At one point, he put the knife on Gloria's neck, and an officer fired a rubber bullet into Henry's stomach, disabling him.

Police arrested him for murder. Henry was detained in a secure mental health facility. A psychiatrist assessed him as unfit to stand trial. The jury took less than 20 minutes to conclude that Henry killed Gloria. The judge imposed a hospital order under the Mental Health Act, and Henry was again detained in a secure mental health facility.[6]

Just over four years before the killing, Henry raised concerns about his memory with his general practitioner (GP). The GP arranged for a memory test involving the Test Your Memory (TYM) instrument. Henry scored 42 out of 50, suggesting memory loss.[7] The GP ruled out reversible causes of cognitive decline such as a urinary tract infection (UTI) or vitamin B deficiency.[8] The couple agreed to monitor Henry's memory and report back to the physician if symptoms worsened. The initial assessment, therefore, did not rule out a diagnosis of dementia. Within a month, Henry returned to the GP to request medication to help with his memory problems. At this point, the GP referred Henry to the memory clinic for a more detailed workup. Henry reported feeling low and anxious, affective states attributed to his growing loss of physical independence. The memory clinic suggested a diagnosis of mild cognitive impairment (MCI) as a result of anxiety and depression. The clinic's report advised him to try anti-depressants if his symptoms did not improve over time.

Knowing that Henry had suffered a number of losses over previous years, his GP offered him anti-depressants. These included early retirement and the loss of his role as provider, giving up his motorcycle, and relying on his wife to drive him around. His disabilities required him to give up using his guns and going on hunts. About three years before killing Gloria, a friend of 25 years noticed Henry's deteriorating memory. Henry had called the friend because he had stripped down his gun and did not know how to put it back together. Given Henry's experience with guns, putting the gun back together "should have been second nature to him."[9] Another significant loss involved moving into sheltered housing and leaving the cottage he had helped renovate and the vegetable plot he enjoyed. Additionally, Henry experienced the deaths of his beloved hunting dogs and the loss of various hobbies and activities he enjoyed. Nevertheless, he declined the offer of antidepressants. He was reluctant to discuss personal matters, so his GP did not offer any form of psychological intervention or talking therapies.

Other medical problems followed. Within a month of receiving the MCI diagnosis, Henry visited his GP surgery complaining of double vision.[10] He was diagnosed with two cataracts and referred to the neurology department for an MRI brain scan to rule out other possible problems. Within two months, the cataracts were removed. The GP received a letter from the department stating the MRI brain scan was normal. The scan did not, therefore, reveal any brain shrinkage consistent with advancing dementia. A couple of months later, Henry reported reduced mobility due to knee pain. He also told his GP he was having panic attacks and vivid dreams about concentration camps. On waking, Henry often failed to recognize his wife or his surroundings. At times, he experienced hallucinations. When he had nightmares, he disturbed Gloria's sleep. He also had REM sleep disturbances. Consequently, Henry and Gloria would nap during the day.

The research literature on DLB contains similar case reports of misrecognition of spouses and/or caregivers, sleep deprivation, and violent dreams. Cipriani et al. report a case study involving a patient with DLB who had a rapid eye movement sleep behavior disorder (RBD).[11] The man hit his wife on the head and threw objects at her during sleep. They cite other research involving a man who held his wife in a headlock and "attempted to throw her head down toward the foot of the bed."[12] Upon waking, the man reported a dream where he was making a touchdown. They caution several sleep disorders, especially with patients with dementia, "have a potential for violent behaviors directed to oneself, other individuals or to objects, without awareness of the action and with complete amnesia of the episode on awakening."[13]

About nine months before the killing, Henry visited the GP surgery in a tearful and anxious state. He reported worsening memory and greater dependence on Gloria. The GP prescribed escitalopram (5 mg) for Henry's depression. However, within a few weeks, the GP discontinued the antidepressants because their usage corresponded with the increasingly vivid anxiety-provoking dreams and hallucinations. The GP prescribed lorazepam for Henry's anxiety. The hallucinations and anxiety apparently lessened.

About five months before killing Gloria, Henry complained that his memory was worsening. Over the three-and-a-half years since having the first TYM test, his score has declined from 42 to 36/50. Henry's GP reported possible Parkinsonian features and hallucinations.[14] The GP referred Henry to the specialist dementia diagnostic service, but the consultant for the service first wanted Henry assessed for Parkinson's disease.[15]

The Lewy Body Society (UK) notes the difficulty of diagnosing DLB. The diagnosis requires specialist skills in old-age psychiatry or neurology. Specifically,

> If the physical symptoms precede the cognitive symptoms by one year, a diagnosis of Parkinson's will be made; if the onset of cognitive symptoms precedes or starts at the same time the physical symptoms commence it is considered to be DLB.[16]

In Henry's case, the most likely diagnosis was DLB. Successful treatment apparently relies on an accurate diagnosis.

The assessment concluded that Henry had evidence of cognitive decline, hallucinations and gait disorder (mild Parkinsonism), REM sleep problems, olfactory disturbance[17] and arthritis in his left knee. The university consultant arranged an outpatient MRI brain scan and suggested a trial on rivastigmine.[18] The communication to the community psychiatric team from the consultant suggesting the use of rivastigmine was delayed for seven weeks, the reasons for which remain unclear. The outpatient MRI brain scan revealed global atrophy (shrinkage) of the brain and a single micro-hemorrhage. The DHR concludes, "Rivastigmine should be given to people with mild to moderate dementia with Lewy Bodies. It is unfortunate that Henry Michaels did not get the opportunity to benefit from this medication prior to the fatal stabbing."[19] Regarding the delay, the DHR notes, "[A]n error in data entry or just an oversight. Prompt receipt of this referral could have sped up the diagnostic process and led to a timelier intervention."

It lies beyond the scope of this study to weigh the various arguments about the efficacy of using rivastigmine in cases of DLB with Parkinsonian symptoms such as those evident in *Michaels*. Rather, my interest is to point out the potential significance of the communication breakdown in responding to Henry with this drug intervention. I return to this matter in Chapter 7. Suffice it to say that research evidence in the form of a large (N = 120) randomized, double-blind, placebo-controlled, international study found patients taking rivastigmine had less apathy and anxiety and fewer delusions and hallucinations than controls.[20] Data addressing how such drug interventions might reduce violence toward self and others appears lacking.

Five days before her death, Gloria accompanied Henry to the GP surgery. Both she and Henry reported being increasingly distressed by Henry's symptoms including his slow movements and speech and nighttime hallucinations. The GP committed to "chase the mental health team"[21] and the next day questioned the delay in intervening with Henry. He received the explanation that a routine referral (Henry's case was not flagged as high-risk) would typically be assessed within two weeks. But time was moving fast in Henry's case.

As noted earlier, on the day before the killing, Henry turned up at a neighbor's house with a wad of cash. He was deeply disturbed by the prospect of being robbed and had accused Gloria of trying to steal his money. Neighbors called the police. Gloria went to the neighbor's house, and the officer and Gloria took him home. The next day, he knifed Gloria to death.

The Michaels DHR found no conclusive evidence of a prior history of intimate partner violence and/or abuse (IPV/A). The report did question whether Gloria would have felt comfortable disclosing any such abuse. At the trial of the facts, the Michaels adult children both told the court that their parents' marriage was a happy one, with no suggestion of domestic violence.[22] The couple lived in social housing, and the warden call system reported no previous sign of IPV/A. Descriptions of Gloria and Henry comport with their children's interpretation that there was no IPV/A. One of Henry's friends saw him as "a very gentle person." The community considered him "blunt but wise . . . fair minded and direct." Henry wrote poetry. He encouraged Gloria to pursue new interests outside of their home once the children left. Everyone the DHR team interviewed described Gloria as "fiercely independent."

Based on interviews with family and friends, the DHR team noted the traditional gender roles to which Henry and Gloria appeared to adhere. The reviewers observed that such role adherence is not uncommon among older people in rural communities, "but are now understood to be indicative of a level of coercion and control." Two examples stood out for reviewers as possible signifiers of Henry's control or undue influence over Gloria. First, prior to her marriage to Henry, Gloria enjoyed coach holidays with her girlfriends from work. She had one particularly close friend, Barbara, who she knew from school and work. Barbara and Gloria met only once after Gloria married Henry. Apparently, Henry and Barbara did not get along, so Gloria never saw her friend again. Indeed, Barbara died of cancer the year before Henry killed Gloria. Second, Gloria took the bus to her own mother's funeral because Henry would not have liked her accepting a ride from her brother-in-law.

From the review, Henry emerges as "the dominant one in the couple's relationship." However, the report describes Gloria as always maintaining her independence "with her own interests and hobbies." The couple's desire to live privately, keeping their doors closed so they would not be overheard by neighbors and eschewing village gossip, "might suggest that the couple had something to hide."[23] But the DHR notes that both Henry and Gloria grew up in small rural communities and remained keen to preserve their independence from potentially nosy neighbors. The question, which the team could not answer, was whether their privacy involved Henry coercively controlling Gloria. The proposal that keeping their doors closed might spell abuse is interesting and may appear strange to some readers. It may reflect a tendency on the part of some DHR team members to imply abuse existed, thus turning this case into yet another tragedy that speaks to the evils of domestic violence.

During the four years after his initial diagnosis, the couple became increasingly private. Gloria eschewed offers of professional help. Apparently, she hid Henry's diagnosis of MCI and his worsening health from her sister. Henry tired quickly, so she put the children off visiting because he could not cope. Gloria's caring responsibilities increased as his disease worsened.[24] Six weeks before her death, Gloria saw her GP in the surgery without Henry present. The GP encouraged her to accept support in caring for Henry, specifically offering to make a referral to an admiral nurse.[25] Gloria declined the offer. However, the police officer who was at the house for the call the day before her death wrote,

> Gloria is Henry's only carer and appears to be struggling slightly. She states she is finding it harder to cope. Henry seemed quite upset and frustrated about his dementia. I have suggested Gloria go back to her doctor and ask for help looking after Henry.[26]

It is possible that the day before her death, Gloria turned a corner and was not only willing to acknowledge her compromised situation but also prepared to seek help. Sadly, her family opined that had she accepted professional help for Henry, "then the fatal stabbing may have been prevented."[27]

There is no evidence Henry Michaels had a history of violently abusing Gloria. It appears as if Henry killed Gloria in a state of confusion, perhaps during a dissociative episode, psychotic break, or a state of transitory delirium. We cannot rule out the possibility that Henry killed someone he thought was an imposter, someone who was not his wife but someone who he thought would steal his money, persecute him. Imposter syndrome is sometimes called Capgras syndrome (CS) or misidentification syndrome. At the crime scene, he told responding police as he stood over Gloria, "She won't need an ambulance" and "She's dead." Was Henry using the pronoun "she" because he no longer recognized Gloria and thus did not use her name?

Henry Michaels committed what I refer to in this book as a *gray mist killing*, a killing of or by a person/people with dementia (PWD), usually committed in or around the family home by a family member, usually a spouse/partner. Men commit nearly all gray mist killings and women comprise their principal victims, a fact of considerable analytical import.[28] The term might also be used to describe the killing of or by a PWD living in a nursing home or specialist care facility. My focus is on fatal family violence, of which Henry and Gloria's case serves as but one example among a convenience sample of 100 cases.

Existing Research

In the last century or so, researchers have documented a small number of gray mist killings. PWD was the subject of all these reports. It was only much later that caregiving killings also attracted attention. Dr. W. C. Sullivan, Medical Superintendent of Broadmoor Asylum, England's oldest high-security psychiatric hospital, wrote *Crime and Insanity*, published in 1924. In a chapter entitled "Crime and Senile Insanity," readers learn, "In instances where the dementia is profound, the homicidal act may be committed in a sudden impulsive outburst without any antecedent or accompanying evidence of related delusional ideas."[29] He narrates two cases, which I now summarize.

H Y, age 78, was a gardener who murdered his wife, 77, and son. He became "enfeebled" in mind a few years before the killing, having delusions about his wife's sexual behavior with their son. H Y claimed his wife had repeatedly attempted to poison him and "that she had put a 'cinder,' specially shaped, into his hash in order to choke him."[30] He heard voices telling him to kill his wife and son and to commit suicide. Sullivan informs readers H Y "got up one night, in obedience to these voices, split his wife's head open with an axe, and stabbed the son in his bed."[31] Upon admission to Broadmoor, he was diagnosed as "demented," but he was still able to give a lucid account of his murderous acts.[32]

In another case, readers learn of E L, a 69-year-old engineer, who attempted to kill his wife and then himself. Sullivan notes that about two years before the crime, "he began to be very querulous and fretful, with signs of failing memory and slowing thought. He also hinted vaguely at suspicions of his food being drugged and of things being stolen from his house."[33] Over time, he began to question his wife's movements. E L started obsessing about her behavior for some months before trying to kill her by slashing her throat with a razor and then cutting himself with it. In the aftermath of the crime, E L reported that the idea to try to kill her came to him "a few moments before he attacked her."[34] E L said "he had been brooding over her conduct, and . . . knew she had been misconducting herself with different men for the past two years."[35] Sullivan notes E L had no proof of her perceived infidelities.

The so-called delusional jealousy in the cases of H Y and E L appears as part of the psychopathology of dementia.[36] Such delusions, until recently often seen simply as "false beliefs," are also present in cases of intimate partner homicide (IPH), where paranoid abusers make unsubstantiated accusations regarding the sexual infidelity of their spouses/partners.[37] However, a growing body of phenomenological research seeks to understand delusions above and beyond them being merely "erroneous beliefs."[38]

Delusions of infidelity also feature in cases of murder-suicide.[39] Physician Philip Lecso reports a murder-suicide case perpetrated by a 67-year-old man who killed his live-in partner before taking his own life. Microscopic examination of the man's brain tissue revealed "a florid number of senile plaques and neurofibrillary tangles in the frontal lobes, left temporal lobe and hippocampus."[40] According to Lesco, these pathological findings confirmed the man's Alzheimer's disease (AD). Neighbors reported the man misplacing personal items and accusing his partner of stealing from him. The man's ex-wife reported significant behavior changes about two years before the killing. Notably, he had trouble adding numbers, became forgetful, and got lost while driving. Investigators found no history of mental illness, violent behavior, or substance abuse. In conclusion, Lecso cautions, "Demented patients are prone to sudden outbursts, and, with their high prevalence of delusional and paranoid ideation, they are at high risk of injuring caregivers and family members."[41]

A case study of a severely demented man who killed his wife has similar themes and more.[42] Those who knew him described Mr. X, age 78, as overbearing, possessive, and very jealous of his wife but also very dependent upon her. When police arrived at his house in May 1998 after receiving a call from his concerned niece, they found Mr. X confused, disheveled, frail, agitated, and aggressive. Mrs. X was deceased. She had severe head and chest injuries. In follow-up interviews with investigators, Mr. X spoke minimally. His speech was mostly nonsensical and he complained of a buzzing in his ears. Mr. X first had contact with mental health services about 40 years prior to killing his wife. At that time, he was diagnosed with "chronic anxiety state." He received electroconvulsive therapy and psychotherapy. In 1983, Mr. X cut his throat in a serious attempt at suicide. Once confined to a psychiatric facility, his likely diagnosis included a "chronic neurotic disorder with a more recently superimposed severe dementia of Alzheimer's type."[43] Notably, for our purposes, observations during his post-homicide treatment referenced his agitation and occasional physical violence, mostly directed toward female members of staff and female patients, some of whom he apparently mistook for the wife he had killed. Mr. X was also observed to be domineering and overbearing toward women and, at times, sexually inappropriate. I return to the apparent gendered directionality of anger and hostility in Parts 2 and 3.

Richard-Devantoy and colleagues report a killing similar to the one Henry Michaels committed.[44] Mr. A killed his wife at their home by stabbing her multiple times. Prior to the killing, he experienced delusions that his wife was persecuting him. Mr. A's act was apparently unplanned. He had no criminal record, psychiatric disorders, alcohol abuse history, or known dementia. However, in his first neuropsychiatric exam conducted nine months after the homicide, he received a diagnosis of moderate Alzheimer's disease (AD) with a moderate dysexecutive syndrome. Dysexecutive syndrome, sometimes known as frontal impairment, frontal lobe syndrome, or executive dysfunction, refers to a dysregulation of executive functions in the brain. It is associated with damage to the frontal lobe and typically involves emotional, motivational, behavioral, and cognitive difficulties. It may involve extreme emotional symptoms, including disinhibition of anger, excitement, sadness, or frustration. Richard-Devantoy et al.'s report of Mr. A's homicide suggests an important role for brain damage in the commission of violence and homicidal behavior.

Relatedly, Rayel and colleagues report the case of a man, age 86, with dementia who shot and killed his ex-wife.[45] In the year preceding the killing he became increasingly forgetful and his personal hygiene worsened. The man also developed the delusion that he and his former wife were still married, that she should not be living with her new husband, and that she was sleeping around. He denied any history of neuropsychiatric illness or psychiatric treatment, drug abuse, or suicidality. However, he did have a prior criminal history including 22 arraignments. These were for unnatural acts (sex offenses), breaking and entering, carrying a dangerous weapon, and failure to pay child support. In total, he spent three years in state prison for stealing a car and carrying a dangerous weapon. Although he denied a history of domestic violence, he had apparently threatened to kill his ex-wife a number of times while they were married. There were also allegations that he had molested one of his daughters.

Rayel and colleagues note that the man had significant vitamin B_{12} deficiency and that he tested positive for syphilis. They contend the extant literature contained "no report discussing dementia secondary to an infectious or nutritional origin leading to severe violent behavior."[46] The researchers warn of the difficulty determining the predominant cause of dementia because "B-12 deficiency and syphilis have been reported to cause cognitive impairment in the absence of neurologic deficits."[47] Sundakov-Krumins and colleagues caution that Rayel and colleagues' conclusion that the dementia was due to B-12 deficiency and syphilis omits other possible contributors such as head injury, alcohol use, and possible cerebrovascular disease.[48]

Ticehurst and colleagues detail the case of Mr. T, a 69-year-old man with vascular dementia (VaD) who killed his wife.[49] His court-commissioned psychiatric assessment identified a focal area of atrophy near the anterior portion of the left temporal lobe, as well as multiple focal areas of hyper-intensity in the cerebral white matter. The man's verbal memory was impaired, he showed evidence of cognitive decline, and he had compromised social functioning. He also had cluster headaches, problems with a heart valve, a previous traumatic splenectomy, and a cholecystectomy, and a gastric hemorrhage caused by non-steroidal anti-inflammatory medication.

Family members observed personality changes after he retired, nine years before the killing. They noted that he became more self-absorbed and less able to accept blame or responsibility. Two years before the killing, he began to exercise poor judgment in minor business dealings. He showed no history of delusions, alcohol abuse, morbid jealousy, depression, or suicidality. However, he was a domestic violence offender of long standing. Mr. T explained his violence and abuse as a response to his wife's provocations.

Ticehurst and colleagues' contribution is an important one since it illustrates the complex mélange of biomedical and social-psychological themes. This complex mélange emerges through many of the gray mist killings that appear in Part 1. It also emerges to a limited degree in media coverage of gray mist killings. These accounts do not usually benefit from the rich biomedical, psychological, and sociological information that detailed case reviews offer. They nevertheless communicate important case themes that inform public knowledge about the dementias. A recent case example illustrates.

Karlan Denio, age 62, had frontotemporal dementia (FTD). Just before a planned family Thanksgiving Day gathering in 2022, he killed his wife of 41 years, Connie Denio. In so doing, he dismembered, disemboweled, and beheaded her before cutting his legs and neck.[50] He later died of his injuries. Family members arriving at the family home in Albuquerque, New Mexico, found Karlan sitting on a bed. His dead wife was laying on the floor in the same bedroom. Readers of initial media accounts learn Karlan received the diagnosis of FTD two years prior to killing Connie. They also learn it is a "disease that can manifest in dramatic personality changes, emotional withdrawal and other mental health issues."[51] Three weeks later, another media account informs readers that Karlan was suspected of killing Connie "in the midst of a mental health crisis."[52]

The Denio killing and others like it I explore recall homicides labeled as red mist killings. Forensic psychiatrist Richard Taylor describes red mist killings as being rooted in "extreme anger or in the 'red mist' of overwhelming rage."[53] For example, the BBC reports the case of Christopher Watt, age 32, who claimed he was overcome by a "red mist" of rage that immediately preceded him punching, kicking, and stamping Robert Cunningham in the head, killing him. In court, Christopher stated, "The red mist came over me and I remember stamping all over his head."[54] A witness testified that Watt " 'lost control' while kicking the victim and stamping on his face as he lay in bed."[55]

Adrian Howe's red mist case illustrations include a man killing his wife, who had left him. He apparently "just boiled over in a red haze" and choked her to death. In another case, Les Humes knifed his wife to death in front of their four children. Les reported being "in a red mist." He had "lost it totally." Les elaborated, "It's like they say, you can see a red mist, I was bellowing like a bull."[56] Red, the color of blood and danger, conjures up all kinds of horrors.

A Note on Language and Ways of Knowing

I use the expression *gray mist killing* for many more reasons than the coincidental fact that we are often dealing with gray hair, deteriorating or atrophying gray matter, graying societies, and gray lives. I am well aware my language runs the risk of feeding into, and perhaps reinforcing, harmful stereotypes about older people, among which I include myself. Doubtless, some would like to corral or cancel such language.

The caring professions often use what is referred to as the "strengths perspective" which "demands a different way of looking at individuals, families, and communities. All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and distorted these have become through circumstance, oppression, and trauma."[57] From this perspective, using adjectives like "deteriorating" or "atrophying" to describe gray matter might appear pejorative. For some, the words "deteriorating" or "atrophying" might appear cold, uncaring, and negative. For others, these words accurately capture what happens to diseased brain tissue. Following the writing of some neurologists, I use "deteriorating or atrophying" because they accurately convey the decrease in gray matter and any implications it might have for neural connectivity and human communication.[58] I am not arguing that the deteriorating or atrophying gray matter is the sole cause of the behavioral and psychological symptoms of dementia (BPSD).

Some might prefer a more "sanitized" or neutral word such as "diminished." My language comes from the case files I mine, potential pock marks and all. In particular, it draws on the words of PWD and people caring for them, treating them, and autopsying them. Many PWD, especially in the earlier stages of their neurocognitive decline, are aware that they are socially stigmatized, and that their identities are increasingly diminished and devalued. The language of "gray mist" does not deny the humanity of PWD and the social stigma they feel, nor does it downplay their suffering, fear, confusion, rage, anxieties, and, at times, terror. Rather, it asks whether the "strengths perspective" on neurocognitive decline might reflect a culture of denial, repression, condescension, and/or paternalism toward the graying of societies.

The language of gray mist accommodates other questions. We wrestle with whether PWD eventually "disappear," especially when they seem to no longer recognize people, particularly their loved ones and other caregivers. In Chapter 4, we will encounter a grand jury that refused to indict a man who said he killed his wife out of a sense of "mercy." In this landmark so-called mercy killing case, Hans Florian shot his wife, Hannie, to death. Speaking for the grand jury, the foreman, John Morris, opined that Hans had lost all ways to communicate with Hannie. Morris noted, "Sure we knew he pulled the trigger. But the question is 'Pull the trigger on what?'"[59]

Some might abhor the use of the word "mercy" in cases like *Florian*. Others, the *Florian* grand jurors for example, apparently used "mercy" because, for them, it most accurately described Hans Florian's act of killing. These are difficult and painful issues, especially for family members with a loved one with dementia.

In exploring the narratives of service providers, family members, and significant others of those afflicted with AD, Jaber Gubrium examines how "folk understandings were used to construct two inner worlds—the disintegrating mind of the disease sufferer, and the developing thoughts and feelings of the caregiver."[60] He notes the contrasting stories of participants in support groups of people caring for family members with AD. Some of those stories invoked what Gubrium refers to as the "empty shell" metaphor, used to convey "a complete lack of subjectivity. Stories detailed a person who was no longer there, only 'someone they once knew.'"[61]

A weeping support group member, Richard, says "I'm losing more of her [his demented wife] every day. She's just drifting away from me. I can see it."[62] Another group member, Karen, concurs, "I agree one hundred percent. Some of 'em just drift away from us. No matter how hard you try to reach them, it just isn't gonna work. Mind's just gone."[63] Wilma has a different take on things. "If you can't communicate the usual way, I say try another way. Words aren't everything, you know. That old noodle doesn't just disappear. We all have the gift of touch and that doesn't leave us till we're dead and buried. Empty shell? Don't believe it. What do the doctors know? They're right in there somewhere. Maybe they're lost because the brain ain't sparkin or something, but they're there."[64]

The interpretations of support group members like Richard and Karen are closer to those expressed by jury foreman John Morris. These are not isolated sentiments concerning the shell-like, hollowed-out nature of PWD. We find them expressed by perpetrators, too, and we must interpret them with considerable caution.

For example, Robert Benjo, age 82, killed his wife, Peggy, age 76.[65] She had had surgery for colon cancer, had lost a lot of weight, and had AD. According to Robert, she was ashamed that she had become incontinent. Their family doctor, Humberto Dominguez, testified that the killing was an act of mercy. He told the court that "she was in a lot of pain" and that "she wanted to die."[66] Robert told the court, "Last I recall of her, she was a shell of a woman."[67] Furthermore, we learn from media coverage that Robert was "cleaning up after her and trying to feed her, though she was wasting away and losing her mind."[68] Yet, information from the police report notes Robert "did advise that the victim was able to walk, clean the house, use the bathroom unattended, and shower unattended."[69] Clearly, there is a range of empty shell/human husk stereotypes from PWD who do not recognize loved ones and who need their jaws pried open to eat (Hannie Florian), to those who are ambulatory and able to clean themselves and their homes (Peggy Benjo).

Wilma's position, as Jay Gubrium describes, appears to differ considerably from that of jury foreman John Morris or gray mist killer Robert Benjo and is closer to my own experience of communicating over many years with someone I know and care for with AD and VaD. My language throughout remains cognizant of these differing, socially situated perspectives. It is as dangerous to deny, repress, or cancel the metaphoric language of empty shells as it is to dismiss the ministrations of chaplains who perceive dementia patients as "pregnant with psychosocial longing."[70]

The cases I explore are riddled with metaphors and interpretations of the worlds of PWD. Better to deal with them, discuss them, synthesize them, and use them to arrive at more considered interventions in what might be potentially violent, dangerous, or homicidal cases.

Notwithstanding these sensibilities and the various landmines of the culture wars, I use the words "gray mist" for a very specific reason. The expression conveys the inevitable uncertainty about what drove the fatal family violence in the dementia cases. Were the peculiar characteristics of the neuropathology the principal driver of the homicide? Was the killing perpetrated during a psychotic break? What was the relative importance of PWD perceiving they had been slighted, hurt, insulted, disrespected, or shamed? Does dementia alter gray mist killers' sense of humiliation, amplify it, make it more likely to manifest as homicidal violence? Does such humiliation potentiate any pre-existing aggression, frustration, hostility, irritability, and violent tendencies among PWD? What role, if any, did dementia medications play in the killing? In cases where caregivers killed, were the exhaustion, desperation, and depression the causal driving force? Or did merciful thinking comprise the root cause? Was any such merciful thinking misguided altruism or love? Pent-up rage?

The vast majority of spouses/partners with dementia do not kill and neither do caregivers of spouses/partners with dementia. So, is the neuropathology the principal driver? Is it a combination of the neuropathology and social triggers? What might the relative weighting be between neuropathology and social triggering? These questions are rhetorical; it is not as if we can set up random control trials or quasi-experimental designs to answer them. Nevertheless, given our current state of knowledge, some themes appear more pronounced and seemingly less in need of empirical testing.

The complexity grows when we add the problems of recall and memory. By definition, gray mist killers with dementia have a hard time remembering what they have done. In a number of cases, it appears that they do not even know they have killed their spouses. These are not unusual problems in the field of criminology and the study of homicide where researchers have to weigh the possibility of malingering or confabulation. Malingering refers to offenders who fake accounts of their killings, perhaps, in their view, to make themselves look better. Confabulation refers to the creation of false memories in the absence of an intent to deceive. Individuals who confabulate do not know they are conveying inaccurate information. We might add similar caveats when discussing caregivers who kill, although the reasons for any malingering or confabulation are usually not linked to known dementia symptoms.

Whether someone is deemed fit to stand trial is no simple black-and-white matter. Rather, the determination assumes various shades of gray. These uncertainties and fuzzy boundaries also pertain to concepts concerning intent, responsibility, sanity, and victimization. Just as it is difficult to know the neuropathology in any one perpetrator with dementia, so too is it difficult to know whether homicides happened during delusions, hallucinations, or dissociative states. Given many PWD drift in and out of these various states, we are not dealing with black-and-white determinations. Psychoses are clearly interspersed with periods of lucidity of varying lengths. Did Henry Michaels kill in a psychotic state only to return to lucidity to inform bystanders his victim would not need an ambulance? Was he suffering from delirium, an acute confusional state associated with an underlying medical disorder such as a urinary tract infection (UTI) or vitamin B_{12} deficiency? Did he know he was killing Gloria, or was he killing an imposter? Was he malingering? Confabulating? A bit of both? Consequently, the criminal justice system and courts in the US, UK, and Australia have a hard time making sense of these cases. Do we need to build specialized courts to deal with cases involving neurocognitive decline in a manner akin to specialty courts such as those dealing with drug addiction or domestic violence?

We miss much because the run-up to the killing occurs mostly behind closed doors. This problem plagues the research into IPV/A. It is made worse by the serious memory loss among perpetrators with dementia. Additionally, the full picture of neuropathology is hidden by the skull and backbone. Confirmation awaits the autopsy, which only records the condition of the brain and nervous system at the time of the autopsy, not at the time of the killing. This is to say nothing of the fact that it is not customary practice to dissect the brains of PWD who have been killed, let alone share the outcomes of any such autopsies with the research community.

Other uncertainties, gray areas, warrant mention. These include the unsettled debates among scientists about what causes the dementias,[71] whether mental disorders correspond to real biological conditions, if and how medications work, and the degree to which social responses to PWD trigger aggression and violence. These uncertainties create an epistemological haze or fog. The word "gray" works well here.

The domestic violence fatality reviews I draw upon add to the uncertainty. These reviews analyze deaths caused by, related to, or somehow traceable to domestic violence. Reviewers try to develop preventive interventions.[72] Reviews are basically interpretations of interpretations. There is an understandable guardedness on the part of some families, agencies, stakeholders, and organizations serving the elderly about how much to share, what positive public memories might remain if compromising details are disclosed, and so on.

None of what I have said should detract from the observation that sometimes the gray mist killings look very much like their red mist cousins. As we will see, the dementia-related overkill cases, like that involving Henry Michaels, with overwhelmingly excessive, frenzied, bloody injuries and death look very much like red mist killings. But in general, the expression "gray mist killing" suffices. It avoids the vivid, lurid, dare I say, sensational blood spatter gestalt of the language of red mist. Rather, it describes the slow burn, the diurnal shades of gray that accompany the deterioration of neurons and the sad disintegration of what some refer to as identities, hearts, minds, souls, spirits, and consciousness. The "slow burn" is common in dementia cases. The fact that only a few cases end in known gray mist killings warrants our attention. These killings might increase because of projected demographic changes. Before discussing demographic changes, a further word regarding language is in order.

My use of the language of the case files, particularly in relation to drug treatments for dementia, does not mean I take for granted the efficacy of such medications. I am especially cautious in relation to two mental conditions that feature prominently, psychoses and depression. As Andrew Scull observers, "The drugs revolution has been vastly oversold. The problem is not only that antipsychotics and antidepressants are not psychiatric penicillin but also that the symptomatic relief that these drugs provide to some (very far from all) of those to whom they are prescribed often comes at a very heavy price indeed."[73] We must ask in the case of PWD whether part of that price is aggression, violence, and homicidal behavior.

Relatedly, medical discourses within the case studies rely heavily on the language of psychiatric diagnoses. Mental disorders appear as "real" phenomena. They supposedly reflect precise clusters of signs, symptoms, and behaviors, usually presumed to have their causal origins in physical pathologies within the human body, especially the brain and nervous system. However, with many mental disorders, it appears our actual understanding of these physical pathologies remains speculative. The gray mist case files contain numerous examples of the cloudiness of these definitional boundaries and the leakage of signs, symptoms, and behaviors between diagnostic categories.

There is a strong element of "faith" amidst all this talk of science, random controlled trials, quasi-experimental designs, and the like. If we have faith in the scientific method, we will eventually uncover the precise biological underpinnings or physical/biochemical causes of mental disorders. We will then be able to treat them with greater pharmaceutical precision and bill for that treatment in ever more detailed, exact, and thus seemingly legitimate, and, for the cynic, lucrative ways. The creeping hegemony of biological reductionism in the treatment of mental disorders, its utility to big pharma, and its increasing marginalization of social and historical context and meaning is a major cause for concern. As Scull points out, the new biological reductionism in psychiatry dates from the early 1980s and the publication of the third edition of the *Diagnostic and Statistical Manual third edition* (*DSM III*). It superseded the psychoanalytic paradigm that reigned supreme in the US in post-World War II.[74]

Ironically, in the case of the dementias, biological causes loom justifiably large, albeit in the absence of precise causal mechanisms and hence potential cures. I return to these matters shortly. Nevertheless, it is impossible to understand the gray mist killings without combining the biological with the social and the historical. My language therefore avoids fetishizing psychiatric classifications rooted in biological determinism. At the same time, I acknowledge the pivotal importance of biological factors in the development of the dementias. My approach therefore recognizes the inextricable interweaving of biological, social, and historical forces.

Knowledge Gaps

Donna Cohen, a pioneer in elder abuse research, observes, “Little is known about the prevalence and clinical patterns of severe violence leading to death perpetrated by individuals with Alzheimer’s disease (AD) and related dementias.”[75] Recent reviews of the relationship between the dementias and homicide point to the paucity of the extant research and the various limitations of the few studies that do exist.[76] Also, we know little about cases where caregivers kill PWD, although there is a substantial research literature about non-fatal violence and abuse directed at PWD.[77] Presciently, Cohen observed that with the exception of psychosis, “many of the psychiatric symptoms and behavioral disturbances in early and middle stages of Alzheimer’s disease result when patients, family members, and health care professionals are unable to perceive and cope successfully with the deterioration or reactions to the deterioration.”[78]

The dearth of knowledge about dementia-related, interpersonal killings reflects bigger gaps in our knowledge about the murder of and by the elderly. Dobash and Dobash lament there is “very little detailed evidence about the circumstances of these killings and even less about the characteristics of those who commit these murders.”[79]

Canetto notes the limited information available about mercy killings.[80] She suggests we might learn more if we could interview significant others and review a range of personal records. Fatality review data in the UK, and, to a lesser extent in the US and Australia, enable us to do that, opening up information about physical and mental health. Indeed, some research suggests psychiatric morbidity features prominently among older homicide offenders.[81] However, as Bourget and associates indicate, “research on the prevalence of psychiatric morbidity in the total population of elderly offenders is extremely limited.”[82]

The shielding of physical and mental health information, particularly in the US, limits our ability to assess the relationship between mental health, violence, and homicide. The UK DHR data go some way toward plugging this gap. Additionally, I use publicly available court transcripts from 11 Australian cases that contain rich information about dementia, mental disorders, and gray mist killing.

MacPherson and colleagues point out that domestic homicides of older women involve three competing fields of knowledge: social gerontology, which informs older adult mistreatment or elder abuse, geriatrics, which informs older adult protection, and the domestic violence movement, which informs IPV/A. The elder abuse field focuses on any relationship type. For MacPherson and colleagues, the comprehensive scope of relationship types militates against examining the “coercive power dynamics in intimate partner relationships.”[83] In general, these authors argue that IPV/A and IPH directed at older women have received scant attention in the research and policy literature.

Aims and Approach

One of my principal aims is to open up discussion of dementia-related killings in families. It is impossible to do this without information about the often closed or isolated workings of families and the various responses of communities to those families. Hence, my convenience sample comes from the US, UK, and Australia. These countries are open, seemingly functional democracies that allow for the careful, albeit in many cases limited, review of family killings. Acemoglu and Robinson remind us that these democracies have inclusive political and economic institutions (free markets, level playing fields of sorts, workers relatively free to pursue occupations suited to their talents, an openness to technological innovation, incentivizing climates, educational systems, the honoring of contracts, and strong private property rights), a centralized state, an adherence to the rule of law, and relative prosperity.[84] It is among these democracies that we are most likely to find more detailed, publicly available information about the gray mist killings.

My case studies, wherever possible, narrate people's lives, and their being in the world, not just their neuronal decline, their failing short-term memories. This is consistent with my previously published work concerning familicide, in which I mapped emotional biographies, situating violent and homicidal acts amidst the human life course and its social and cultural moorings.[85]

As neurologist Oliver Sacks puts it in relation to Jimmie G., a patient with Korsakoff's syndrome, another memory disorder, "A man does not consist of memory alone. He has feeling, will, sensibilities, moral being—matters about which neuropsychology cannot speak."[86] Sacks acknowledges his instinctual tendency to see Jimmie G. as being a lost soul. However, when placed in situations that evoked his emotional and spiritual sides, Jimmie G. seemed to awaken as his mood became more animated. Sacks criticizes the tendencies of empiricism to deny or ignore these aspects of Jimmie G.'s being. Empiricism, he comments, "takes no account of the soul, no account of what constitutes and determines personal being. Perhaps there is a philosophical as well as a clinical lesson here: that in Korsakov's, or dementia, or other such catastrophes, however great the organic damage . . . there remains the undiminished possibility of reintegration by art, by communion, by touching the human spirit."[87]

Another aim is to contribute to multidisciplinary research regarding interpersonal violence, elder abuse, and elder homicide.[88] Inevitably, killings by PWD raise questions about the role of biological, psychological, and sociological phenomena. The book adds to our understanding of the social reaction to PWD, the orchestration of services, the nature of caring by family and community, and the spirals of interaction between PWD and familial, community, and state actors that provide support and care.

Relatedly, another aim is to revisit the many issues raised by recent studies of the biological factors that correlate with and might cause crime.[89] In a sense, the gray mist killings may appear to be ideal cases to explore the role of biological forces, such as brain and nervous system damage, in driving homicidal violence. However, as we will see, the picture is more complicated.

One Hundred Cases: A Quick Preview

In addition to a formal diagnosis of dementia before or after a homicide, I used two inclusion criteria to build my convenience sample. First, the gray mist killing had to have occurred in the last 40 years. Second, sufficient information about the case had to exist in publicly available documents. These two inclusion criteria guaranteed that cases were drawn from the same time period and contained sufficient, if not plentiful, information. In analyzing the 100 cases, two graduate students independently recorded the responses to a coding instrument. We compared their interpretations with my own before reaching a conclusion about principal reasons and motives for killing.

I use catchy subheadings drawn from the language of the case files to introduce the case studies. These draw on rich information, often including extensive media coverage, police reports, trial transcripts, psychiatric and social services reports, detailed UK DHR reports, significant case review reports, and other sources, including observations from key informants who talked under guarantee of confidentiality. As noted, even though the documentary information I use is publicly available, I narrate the UK and Australian case studies using pseudonyms so as to preserve the confidentiality and privacy of the parties. This is because the publicly available files in these cases provide very detailed personal information that is potentially humiliating to surviving family members. The US cases the media cover are more easily obtainable and usually more superficial and less compromising in their level of personal detail, with the media coverage mostly not going beyond any publicly available court documents or police reports. In these US cases I therefore use real names.

In what follows, I analyze 100 gray mist killings involving perpetrators with diagnosed dementia, perpetrators who kill someone with diagnosed dementia, and outlier cases that do not fit in either of these categories.[90] The 100 cases hail from the UK (35), the US (54), and Australia (11). All 95 of the spousal and intimate partner relationships in the gray mist dataset involved heterosexual couples. All but one of their corresponding IPHs involved couples where one (91 cases) or both (three cases) spouses/partners had dementia. In the one exception, discussed in Chapter 6, a husband killed his wife after she confronted him about stealing money from her father with dementia who was living with them.

There were only five family killings. A father killed his daughter and a grandfather killed his granddaughter. Both men had dementia. Two men killed their mothers. Both mothers had dementia. In the fifth case, a granddaughter killed her grandmother who had AD. Since this case exemplifies the relationship between theft, fraud, and dementing illness, I explore it in detail in Chapter 6.

Men perpetrated 94 percent of the 100 gray mist killings. Most of the 100 cases involved cohabiting (90 percent), married (88 percent) couples. Among the 90 killings involving cohabiting couples, men committed 85. Homicides mostly took place in the victim's home. Just under a quarter of the cases took the form of homicide-suicides. Two distinct similarly sized subgroups of gray mist killers emerge: perpetrators who had dementia (54 percent) and perpetrators who were caregivers (44 percent). The two "outliers" that make up the 100 cases concern the granddaughter, Beverly Richmond, who brutally killed her grandmother with AD and the husband, John Weir, who killed his wife after she confronted him about stealing from her father, a PWD, who was living in their home. Neither perpetrator had dementia nor acted as a caregiver.

Victims clustered heavily (93 percent) in the 60–89 years age range. Where data was available on the length of the spousal or intimate partner relationship (N=61), just over four-fifths spanned more than 40 years. Nearly all victims were Caucasian/white. Overkill cases involved excessive violence above and beyond that required to kill and/or five or more injuries such as stab wounds, bullet wounds, or blunt force traumas. Twenty-eight of the 100 gray mist killings involved this excessive violence.

The above impressions reflect broad trends from a convenience sample. It is likely that with dementia-related killings in general, killings by caregivers are more likely to go undetected than killings perpetrated by PWD. Significantly, women may be more likely than men to commit these perhaps more discrete killings, a point I revisit in later chapters.

Ninety-four of these 100 cases were IPHs in which one (91) or both (3) spouses/partners had dementia.[91] IPH comprises the principal focus of the case studies in Part 2, "Homicide Chronicles." Slightly more perpetrators had dementia (52 out of 94 or 55 percent) than served as caregivers (42 out of 94 or 45 percent). In just over a quarter of cases (26 percent), perpetrators committed suicide, although the homicide-suicides cluster heavily in the caregiver-perpetrator subgroup.

The form of killing was readily available in all 94 cases. A little over a quarter of them (28 percent) died in what are considered overkill cases. As we will see later, overkill cases cluster heavily among the perpetrators with dementia, raising important questions about whether they experience psychotic breaks, something akin to a frenzied state. This phenomenon dates back at least as far as medieval England. It was documented in Chaucer's *The Canterbury Tales*, noted by historians documenting violent killings in fourteenth century England and in my work on early twentieth-century familicide in the US.[92]

Shooting comprised the most common method of killing.[93] The preponderance of cases from the US likely skews the data in that direction because of the greater availability of firearms.[94] It seems, bluntly, that perpetrators used what they could to kill.

Of 54 perpetrators with dementia, 52 (47 men, five women) killed spouses/intimate partners and two killed other family members.[95] Of 44 family member caregivers, 42 killed spouses/intimate partners and two sons killed their mother.[96] Of two "outlier" cases, a granddaughter killed her grandmother who had dementia and from whom she had stolen money, and a husband killed his wife who had discovered him stealing from her co-residing father who had dementia.

There are four "overlap" cases, three from among the 54 perpetrators of dementia and one from the 44 family member caregivers. In three of these overlap cases, both perpetrators and decedents had dementia.[97] I included all three of these overlap cases in the perpetrator with dementia category because their dementia was advanced and none of them were primary caregivers. In one case, Kenneth Burton killed his wife, Sally, who did not have dementia but was bedbound from a terminal illness. In the aftermath of the homicide, Kenneth was diagnosed with early-stage dementia. *Burton* therefore fits best, although not neatly, in the caregiver category.

Map of the Book

The remaining chapter in Part 1 "Mere Oblivion," provides a brief introduction to dementing illness. Chapter 2 examines the idea of mental disturbance before going on to consider our historical knowledge about dementia and geronticide (the killing of the elderly). I examine the dominant biomedical model that developed out of the scientific developments associated with Enlightenment thinking. Importantly, Chapter 2 also introduces sociological perspectives on the problems of the mind and mental illness. Having considered this range of perspectives, I discuss the aggression and violence associated with dementing illness before going on to raise crucially important questions about the possible erosion of personhood.

Part 2, "Homicide Chronicles," presents the cases involving dementing illness according to prominent case themes or seemingly principal motives or reasons for the killing. The case studies concern dementing illness and abnormalities of mind in Chapter 3, mercy and exhaustion in Chapter 4, prior violence and/or abuse in Chapter 5, and theft and fraud in Chapter 6. These prominent case themes are not mutually exclusive and there is much overlap between them. For example, the two perpetrators that feature in Chapter 6 concerning theft and fraud both had histories of mental health problems. In many of the cases involving mercy and exhaustion, eventual perpetrators were found to have suffered from depression, not necessarily clinically diagnosed. I make no apologies for the leakiness of these loose analytical boundaries. The prominent themes I highlight are rooted to some degree in the extant research literature. More importantly, the themes or emphases provide ways of exploring these strange and hitherto little-studied cases.

Chapter 3, "Dementing Illness and Abnormalities of Mind," explores the cases involving mental illness, disturbance, or disorder. The bulk of the chapter focuses on PWD who killed family members, mostly spouses/partners. However, I also include coverage of caregivers who the courts later deemed to have suffered from an abnormality of mind or other mental disorder at the time they killed a family member, nearly always a spouse or partner, with dementia. The term abnormality of mind appears in the gray mist files and refers to abnormal behavior, usually transient or temporary, that may or may not include a specific mental disorder but nevertheless constitutes a form of fleeting mental illness/disturbance or distress, that violates social and/or legal norms, and that contributes to and/or provides a context for understanding the commission of the homicide.

Chapter 4 explores the inextricable interweaving of mercy and exhaustion found at the root of nearly all the caregiver killings. Men committed all 44 of these killings. I suggest there are many more so-called mercy and exhaustion killings than meet the eye. Using case studies, the chapter examines the gendering of these killings, difficulties in caregiving, and the changing relationship between a caregiver and the spouse/partner with dementing illness. These caregiver killings did not reveal evidence of perpetrator psychoses, delusions, or hallucinations, although these symptoms are very difficult to identify. Most had depression. Some had complicating medical problems which made caring for their wives more difficult. Two had terminal illnesses. Evidence points to happy, devoted couples who valued their privacy. None of the mercy and exhaustion cases involved known prior histories of IPV/A or theft.

Chapter 5 focuses on prior violence and abuse (IPV/A) and opens with the empirical reality that histories of IPV/A precede the majority of IPHs. This does not appear to be the case in the gray mist killings committed by perpetrators with dementia. Neither does it appear to be the case where caregivers, mostly men, kill their spouses/partners with dementia. I use publicly available data to document known IPV/A in just 13 out of 54 cases where perpetrators with dementia, nearly all men, kill spouses or intimate partners. The vast majority of these 54 cases involved spousal relationships where family members, friends, and neighbors described couples as "normal," "loving," or "friendly." The case studies explore the confluence of prior IPV/A and dementia, paying particular attention to the context, form, and meaning of that IPV/A. I provide information about whether any IPV/A pre-dated the appearance of the BPSD.

The chapter raises questions about violence, abuse, and neglect over time. Does the fact that couples have been married for perhaps five, six, or seven decades have special significance? Does coercive control over greater periods of time render dementia more likely in those, largely elderly women, subject to such chronic abuse? Are those perpetrators, largely men, who mete out such coercive control more likely to develop dementia than men who do not, all other things being equal? Relatedly, if physical violence forms part of coercive control, does the form of that violence matter for the onset and intensification of the dementias? Are head injuries more significant than broken arm bones, punches in the stomach, serial strangulation, or sexual assault?

Chapter 6 concerns theft. Elderly family members with dementia often have savings, pensions, and/or social security benefits. They are vulnerable to fraud, embezzlement, and extortion. As dementia advances, skill with numbers often declines, making it more difficult to discern and remember any financial exploitation. In some cases, PWD have paranoid delusions regarding their money being stolen. The personalities of PWD may change. They may become increasingly hostile, less easy to be around, more difficult and expensive to care for, and deeply forgetful, especially in the short term. Their changing personalities and temperaments may make it easier to justify, rationalize, or excuse fraud, embezzlement, extortion and homicide.

Using DHR information, I examine two outlier UK homicides that contribute to our understanding of the role of theft, fraud, and embezzlement. As mentioned, the first involves a granddaughter who brutally killed her demented grandmother; the second involves a husband who killed his wife after she confronted him about stealing money from her father, who had dementia. These two cases exhibit themes present in a significant number of well-documented cases where people, mostly family, friends, neighbors, and acquaintances, defraud elders, especially elders with dementia. This is to say nothing of the mountain of cases that, for whatever reason, do not end up as part of the official record.

Part 3, "Contemporary Interventions," examines the ways societies treat or react to PWD. Chapter 7, "Problematic Contemporary Responses," uses case studies, largely drawn from the UK DHRs, to explore a selection of responses that may have contributed to the killings. I explore malignant practices and malignant social psychology, the specter of the nursing home, tricky diagnoses and treatments, siege mentalities, and what the sunny-side up caring professions refer to as "missed opportunities," as if the road to death through dementia were littered with promising possibilities.

Chapter 8, "The Fiction of Prediction: Risk and Danger," examines our best efforts to triage interventions and identify those cases that might involve aggression, violence, and homicide. My approach is through the literature on risk and risk societies. I suggest the risk discourse diverts attention away from the much bigger questions of societal interventions in cases involving PWD.

Part 4, "Toward a Global Understanding," puts the treatment of PWD into a broader perspective. Chapter 9, "Making Sense of Gray Mist Killings," commences from the level of the case studies and seeks to make sense of them. I use contributions from biomedicine, psychiatry, sociology, criminology, and other disciplines to explore the seeming eclipse of personhood, identities, and consciousness, and the relationship between this eclipsing and gray mist killings. I do not take notions of selfhood, personhood, identity, consciousness, and the soul for granted. Among other things, I problematize intent, motive, insanity, and responsibility and consider the roles of biological, psychological, social, and historical forces.

Chapter 10, "Global Implications," brings the themes together by highlighting the links between the dementia-related family killings and international issues, including international development, social Darwinism, increases in life expectancy, declining fertility rates, increases in the global prevalence of the dementias, and international attitudes and reactions to PWD.

Notes

1 N. Gerrard, "Words Fail Us: Dementia and the Arts," *The Guardian*, July 19, 2015, www.theguardian.com/culture/2015/jul/19/dementia-and-the-arts-fiction-films-drama-poetry-painting.

2 The DHR is a publicly available document that uses pseudonyms in an attempt to conceal the real names of the involved parties. For more information, *see* UK Home Office, Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016, 35. The cases I explore using DHR information, therefore, reside in the public domain. However, I use pseudonyms, often do not reference the precise age of the parties, frequently reference dates in general, and do not name specific geographical locations or criminal justice jurisdictions in order to preserve the confidentiality and privacy of the parties to the extent possible in DHRs. I adopt the same approach of using pseudonyms in the Australian court transcripts. The US confidentiality laws are tighter, and hence the US cases reported in the media and court have much less compromising information and none above and beyond that contained in media reports. In these US cases I therefore use real names.

3 For a discussion of the vivid visual hallucinations with dementia with Lewy bodies and particularly the paranoia accompanying delusional sexual jealousy, see C. D. Sibisi, "The Phenomenology of Delusional Jealousy in Late Life," *International Journal of Geriatric Psychiatry* 14, no. 5 (May 1999): 398–99, letter to the editor.

4 See Centers for Disease Control and Prevention, "Alzheimer's Disease and Healthy Aging: What Is Dementia?" last modified April 5, 2019, www.cdc.gov/aging/dementia/index.html#:~:text=Dementia%20is%20not%20a%20specific,a%20part%20of%20normal%20aging.

5 The term dementing illness remains problematic insofar as it implies an impairment above and beyond an agreed-upon threshold of mental functioning that remains unclear as populations continue to age.

6 Most people in the UK who receive mental health treatment in a hospital or another mental health facility do so voluntarily. In some cases, a person can be detained, also known as sectioned, under the Mental Health Act (1983) and receive treatment without their consent. The Act of 1983 forms the main piece of mental health legislation in the UK and deals with the assessment, treatment, and rights of people with a mental health disorder.

7 See Jeremy Brown, George Pengas, Kate Dawson, Lucy A. Brown, and Philip Clatworthy, "Self-Administered Cognitive Screening Test (TYM) for Detection of Alzheimer's Disease: Cross Sectional Study," *British Medical Journal (Clinical Research Edition)* 338 (June 2009), https://doi.org/10.1136/bmj.b2030. A TYM score of up to and including 42/50 detected 93% of Alzheimer's patients.

8 For a discussion of the role of vitamin B in neurodegenerative disease see S. N. Rai et al., "The Role of Vitamins in Neurodegenerative Disease: An Update," *Biomedicines* 9, no. 10 (October 2021): 1284, https://doi.org/10.3390/biomedicines9101284.

9 Language from the DHR report.

10 In the US, patients visit their doctor's office. In the UK, they visit their doctor's surgery. I retain the original language used in the review documents from each country.

11 G. Cipriani et al., "Violent and Criminal Manifestations in Dementia Patients," *Geriatrics and Gerontology International* 16, no. 5 (May 2016): 541–49, https://doi.org/10.1111/ggi.12608.

12 Cipriani et al., "Violent," 545.

13 Cipriani et al., 545.

14 These features include thought and behavioral changes and gradually progressive problems with movement, commonly a slowing of movements, tremors present at rest, and a vulnerability to falls. Dementia with Parkinsonism shares similarities with DLB, which also causes changes in thought, behavior, and mobility.

15 In the UK, a consultant is a senior doctor who has completed full medical training in a specialty subject matter area. Typically, consultants work in hospitals or community settings and have clinical responsibilities overseeing the work of junior doctors and administrative responsibilities.

16 "Science," The Lewy Body Society, accessed June 23, 2023, www.lewybody.org/about-lbd/science/. In Parkinson's disease, the Lewy bodies are found mostly in the substantia nigra, whereas in DLB the bodies are "more widely distributed throughout the cerebral cortex." According to the Society, Lewy bodies are "microscopic protein deposits in the brain associated with the death of cells. It is not yet known whether the Lewy bodies are the cause or effect of degeneration of brain cells. . . . They are present in the brains of people with DLB and Parkinson's disease." The Lewy Body Society. "Science."

17 Researchers have identified an association between olfactory dysfunction and cognitive decline. See, for example, R. S. Wilson et al., "Odor Identification and Decline in Different Cognitive Domains in Old Age," *Neuroepidemiology* 26, no. 2 (February 2006): 61–67, https://doi.org/10.1159/000090250; R. S. Wilson et al., "Olfactory Identification and Incidence of Mild Cognitive Impairment in Older Age," *Archives of General Psychiatry* 64, no. 7 (July 2007): 802–8, https://doi.org/10.1001/archpsyc.64.7.802; C.

S. Dintica et al., “Impaired Olfaction Is Associated With Cognitive Decline and Neurodegeneration in the Brain,” *Neurology* 92, no. 7 (February 12, 2019): 700–9, https://doi.org/10.1212/WNL.0000000000006919. For a firsthand account of olfactory disturbance, see D. F. McGowin, *Living in the Labyrinth: A Personal Journey Through the Maze of Alzheimer's* (New York: Delacorte Press, 1993).

18 Rivastigmine is used to treat mild to moderate Alzheimer's disease and Parkinson's disease. It can also be used to treat people with mild to moderate Lewy body dementia.

19 The DHR follows the UK National Institute for Health and Care Excellence (NICE) guidance regarding the treatment of dementia and provides specific guidance about rivastigmine, www.nice.org.uk/search?q=Rivastigmine.

20 I. McKeith et al., “Efficacy of Rivastigmine in Dementia With Lewy Bodies: A Randomized, Double-Blind, Placebo-Controlled International Study,” *Lancet* 356, no. 9247 (December 2000): 2031–36, https://doi.org/10.1016/S0140-6736(00)03399-7.

21 Language from the DHR report.

22 A trial of the facts tries to confirm the truth of the allegations against a defendant if they are deemed unfit to stand trial. It does not determine guilt or innocence.

23 Language from the DHR report.

24 The words caring and carer are used in the UK and Australia. The words caregiving and caregiver are used in the US.

25 Admiral nurses provide specialist support for families caring for a person or people with dementia (PWD). They offer one-to-one support, expert guidance, and practical solutions. In this case, the admiral nurse and CPN shared an office.

26 Language from the DHR report. In the UK and Australia, people who care for PWD are known as carers. In the US, they are known as caregivers. My usage of these words is consistent with the country from which the case originated.

27 Language from the DHR report.

28 In their systematic review of homicide and dementia, Sundakov-Krumins et al. note 86 percent of offenders were male (132/153). See T. E. Sundakov-Krumins, S. Lubbe, and A. P. F. Wand, “Homicide and Dementia: A Systematic Review,” *Dementia and Geriatric Cognitive Disorders* 51, no. 1 (April 2022): 3, https://doi.org/10.1159/000521878. From those sampled in the community as opposed to in institutional settings, the victim was a wife in 62 percent of cases (79/128).

29 W. C. Sullivan, *Crime and Insanity* (London: Edward Arnold and Company, 1924), 49.

30 Sullivan, *Crime and Insanity*, 53.

31 Sullivan, 53.

32 I use the language conventions of the day. To use the diagnosis “demented” was accepted practice at the time of Sullivan's publication. Nowadays, the preferred language is “a person with dementia.” The former is now seen as offensive because it is seen to apply a master label of “demented” when the dementing illness may only partially reflect a person's identity.

33 Sullivan, 54.

34 Sullivan, 54.

35 Sullivan, 54.

36 For a discussion of delusional jealousy, sometimes referred to as Othello syndrome, see G. Cipriani et al., “Dangerous Passion: Othello Syndrome and Dementia,” *Psychiatry and Clinical Neurosciences* 66, no. 6 (October 2012): 467–73, https://doi:10.1111/j.1440-1819.2012.02386.x.

37 N. Websdale, *Understanding Domestic Homicide* (Boston: Northeastern University Press, 1999).

38 See R. Ritunnano et al., “Subjective Experience and Meaning of Delusions in Psychosis: A Systematic Review and Qualitative Evidence Synthesis,” *Lancet Psychiatry* 9, no. 6 (June 2022): 458–576, https://doi: 10.1016/S2215-0366(22)00104-3. I am grateful to Dr. Virgil Hancock for sending me this article.

39 In his discussion of morbid jealousy, West asks whether such jealousy “can be regarded as an illness in itself, or whether such persons should be regarded under the headings of either schizophrenia or psychopathy. . . . In some male patients, jealousy amounts to a monomania and may be present in extremely irrational forms, without signs of schizophrenic disorder . . . and without the generalized impulsiveness and lack of social conscience of the typical psychopath.” D. J. West, *Murder Followed by Suicide* (Cambridge: Harvard University Press, 1967), 81.

40 P. A. Lecso, “Murder-Suicide in Alzheimer’s Disease,” *Journal of the American Geriatric Society* 37, no. 2 (February 1989): 167, https://doi.org/10.1111/j.1532-5415.1989.tb05878.x.

41 Lecso, “Murder-Suicide in Alzheimer’s Disease,” 168. The extant research literature reports these delusions of infidelity in both men and women. It remains to be seen whether they are found equally among men and women or whether they are socially patterned or reflective of deeper biologically based fears of infidelity among males. I am grateful to Kathleen Ferraro for raising this question.

42 S. Dinniss, “Violent Crime in an Elderly Demented Gentleman,” *International Journal of Geriatric Psychiatry* 14, no. 10 (October 1999): 889–91, case report.

43 Dinniss, “Violent Crime in an Elderly Demented Gentleman,” 891.

44 S. Richard-Devantoy et al., “Homicide and Dementia in Older Adults: The Key Role of Dysexecutive Function,” *Journal of Clinical Psychiatry* 71, no. 10 (October 2010): 1402–3, https://doi: 10.4088/JCP.10l06029oli.

45 M. G. Rayel, W. B. Land, and T. G. Gutheil, “Dementia as a Risk Factor for Homicide,” *Journal of Forensic Science* 44, no. 3 (May 1999): 565–67.

46 Rayel, Land, and Gutheil, “Dementia as a Risk Factor for Homicide,” 566.

47 Rayel, Land, and Gutheil, 566.

48 Sundakov-Krumins, Lubbe, and Wand, “Homicide and Dementia,” 9, table 1.

49 S. B. Ticehurst, I. G. Gale, and S. J. Rosenberg, “Homicide and Attempted Homicide by Patients Suffering From Dementia: Two Case Reports,” *Australian and New Zealand Journal of Psychiatry* 28, no. 1 (1994): 136–40, https://doi.org/10.3109/00048679409075855.

50 M. Reisen, “Man Accused of Killing, Dismembering His Wife,” *Albuquerque Journal*, November 25, 2022, www.abqjournal.com/2552971/man-allegedly-dismembered-wife-before-thanksgiving-gathering-at-west-side-home.html.

51 Reisen, “Man Accused of Killing, Dismembering His Wife.”

52 E. Kaplan, “Man Accused of Killing and Dismembering His Wife on Thanksgiving Dies,” *Albuquerque Journal*, December 15, 2022, www.abqjournal.com/2557768/man-accused-of-killing-his-wife-on-thanksgiving-dies-after-weeks-at-the-hospital.html.

53 R. Taylor, *The Mind of a Murderer: What Makes a Killer?* (London: Wildfire Press, 2021), 274.

54 “ ‘Red Mist’ Killer Jailed for Life for Kirkintilloch Murder,” *BBC News*, May 28, 2021, www.bbc.com/news/uk-scotland-glasgow-west-57282022. For an additional example, see “Christina Abbotts: Murder Accused ‘Blames Red Mist’,” *BBC News*, December 18, 2018, www.bbc.com/news/uk-england-sussex-46609496.

55 Red Mist Killer.

56 A. Howe, “ ‘Red Mist’ Homicide: Sexual Infidelity and the English Law of Murder (Glossing Titus Andronicus),” *Legal Studies* 33, no. 3 (Autumn 2013): 415, https://doi.org/10.1111/j.1748-121X.2012.00254.x. For additional context, see Howe, 407–30.

57 D. Saleebey, “The Strengths Perspective in Social Work Practice: Extensions and Cautions,” *Social Work* 41, no. 3 (May 1996): 297, www.jstor.org/stable/23718172.

58 Z. Wu et al., “Gray Matter Deterioration Pattern During Alzheimer’s Disease Progression: A Regions-of-Interest Based Surface Morphometry Study,” *Frontiers in Aging Neuroscience* 13, no. 593898 (2021), https://doi.org/10.3389/fnagi.2021.593898.

59 B. Bearak, “Few Go to Jail: Murder-or an Act of Compassion?” *LA Times*, October 6, 1985, www.latimes.com/archives/la-xpm-1985-10-06-mn-5761-story.html.

60 J. Gubrium, “Narrative Practice and the Inner Worlds of the Alzheimer’s Disease Experience,” in *Concepts of Alzheimer Disease: Biological, Clinical, and Cultural Perspectives*, ed. P. J. Whitehouse, K. Maurer, and J. F. Ballenger (Baltimore: Johns Hopkins University Press, 2000), 182.

61 Gubrium, “Narrative Practice and the Inner Worlds of the Alzheimer’s Disease Experience,” 192.

62 Gubrium, 192.

63 Gubrium, 192.

64 Gubrium, 188.

65 K. Kustura, “A Desperate Act,” *The Daytona Beach News-Journal*, October 11, 2015.

66 Kustura, “A Desperate Act.”

67 L. Lelis, “She Said, ‘I Don’t Want to Live This Way’: Mentally, It Was Depressing. I Just Did What I Had to Do,” *Orlando Sentinel*, January 24, 2009, www.orlandosentinel.com/news/os-xpm-2009-01-24-benjo24-story.html.

68 Lelis, “I Don’t Want to Live This Way.”

69 Case Number 080019157, Volusia County Sheriff’s Department, homicide investigation report, lines 20–21.

70 L. C. Harper, *On Vanishing: Mortality, Dementia, and What It Means to Disappear* (New York: Catapult Books, 2021), 90. For a fascinating treatment of issues related to legal capacity and human rights for people with psychosocial disabilities, see M. A. Stein et al., eds., *Mental Health, Legal Capacity, and Human Rights* (Cambridge: Cambridge University Press, 2021). It draws on fields such as law, psychiatry, public health, and public policy, and thus touches on many of the issues I address. However, it does not identify the dementias as psychosocial disabilities because the writers describe the dementias primarily as neurodegenerative conditions with multiple biological etiologies on page 2, footnote 1. Nevertheless, the arguments about humane treatment and the voices of people with disabilities are directly relevant to the issues raised in the gray mist killings.

71 Piller provides a discussion of signs of fabrication among research articles concerning the causes of Alzheimer’s disease. C. Piller, “Blots on a Field,” *Science* 377, no. 6604 (July 2022): 358–63, https://doi.org/10.1126/science.add9993.

72 N. Websdale, “Domestic Violence Fatality Review: The State of the Art,” in *The Handbook of Interpersonal Violence and Abuse Across the Lifespan*, ed. R. Geffner et al. (New York: Springer, 2022), 3093–115, https://doi.org/10.1007/978-3-319-89999-2.

73 A. Scull, *Psychiatry and Its Discontents* (Oakland: University of California Press, 2019), 211.

74 Scull, *Psychiatry and Its Discontents*, chapters 6 and 12. He describes the Neo-Kraepelinian psychiatry period, starting around 1980, as that time “when psychiatry is re-biologized, shifts drastically away from psychodynamic accounts of mental illness and psychotherapeutic approaches to treatment, and embraces the twin gods of psychopharmacology and an ever-expanding universe of psychiatric disorders defined purely conventionally and descriptively.” Scull, 186.

75 D. Cohen, “Violent Deaths and Dementia,” *Journal of Mental Health and Aging* 10, no. 2 (2004): 83–86, editorial.

76 Sundakov-Krumins, Lubbe, and Wand, “Homicide and Dementia.”

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82 Bourget, Gagné, and Whitehurt, “Domestic Homicide and Homicide-Suicide,” 306.

83 M. MacPherson et al., “Older Women and Domestic Homicide,” in *Preventing Domestic Homicides: Lessons Learned From Tragedies*, ed. P. Jaffe, K. Scott, and A. L. Straatman (London: Elsevier, 2020), 17.

84 D. Acemoglu and J. Robinson, *Why Nations Fail: The Origins of Power, Prosperity and Poverty* (New York: Crown, 2012).

85 N. Websdale, *Familicidal Hearts: The Emotional Styles of 211 Killers* (New York: Oxford University Press, 2010). Nikolas Rose makes a related point about finding ways to conceptualize mental health problems such as dementia, depression, and even schizophrenia in terms of “complex interactions across the life course between the individual and his or her milieu.” N. Rose, *Our Psychiatric Future* (Cambridge: Polity Press, 2018), 184.

86 O. Sacks, *The Man Who Mistook His Wife for a Hat: And Other Clinical Tales* (New York: Vintage Books, 1998), 40. Korsakoff’s syndrome affects memory. Jimmie G. effectively had few memories after 1945. It was as if his life stopped at that time. As Sacks indicates on page 47, the classic form involves the devastation of memory caused by the alcoholic destruction of the mammillary bodies. It appears to be associated with thiamine (vitamin B_1) deficiency, hence its links with alcohol abuse, dietary deficiencies, prolonged vomiting, eating disorders, or the effects of chemotherapy. Its incidence has declined markedly since the fortification of foods such as cereals and breads with thiamine.

87 Sacks, *The Man Who Mistook His Wife for a Hat*, 46.

88 As Eileen Crimmins contends, we have yet to realize the full potential of multidisciplinary approaches to understanding population-level trends in life expectancy. E. M. Crimmins, “Recent Trends and Increasing Differences in Life Expectancy Present Opportunities for Multidisciplinary Research on Aging,” *Nature Aging* 1, no. 1 (January 2021): 12–13, https://doi.org/10.1038/s43587-020-00016-0.

89 See, for example, A. Raine, *The Anatomy of Violence: The Biological Roots of Crime* (New York: Pantheon Books, 2013).

90 See Appendix, Table 1: Overview Characteristics of the 100 Gray Mist Killings.

91 See Appendix, Table 2: Overview Characteristics of the 94 Gray Mist Killings Involving IPH in Which Either or Both Spouses/Partners had Dementia.

92 One example is Hanawalt’s discussion of the frenzied ax killing in 1316 of four children by their mother, Emma le Bere. The coroner at the time described Emma as suffering

from an illness known as Frenesye. B. A. Hanawalt, *Crime and Conflict in English Communities 1300–1348* (Cambridge: Harvard University Press, 1979), 109. The le Bere family killing resembles the killing by Emma Cooper of her six children and her ailing husband, Daniel, before committing suicide. Local observers in Cadillac, Michigan, in 1908 noted Mrs. Cooper's insanity at the time of the killing. See Websdale, *Familicidal Hearts*, 76–81, for a discussion of the Cooper familicide.

93 See Appendix, Table 3: Method of Homicide in the 94 Gray Mist Killings Involving IPH in which Either or Both Spouses/Partners had Dementia.

94 Of the 94 cases, 51 hailed from the US, 32 from Great Britain, and 11 from Australia.

95 See Appendix, Table 4: Overview Characteristics of the 54 Gray Mist Killings by Perpetrators with Dementia.

96 See Appendix, Table 5: Overview Characteristics of the 44 Gray Mist Killings by Caregivers.

97 These cases involved the perpetrators Jim Norris, Ronald King, and Joe Withey [pseudonym].

2 Dementing Illness

A Brief Introduction

The Center Cannot Hold: Mental Disturbance

Many years ago, we sat in the interview room at the jail. The two of us were part of a defense team, so-called expert witnesses. The client, Ms. T, was facing the death penalty for murdering her husband. She entered the room in chains and sat opposite us. The bulky guard shackled her feet to a thick metal ring cemented into the floor. Her hands remained manacled; the cuffs were attached by another chain to a shiny, snug waist restraint. The jingle jangle of the chains informed our mutual greetings. It was our first meeting. Our conversation lasted six-and-a-half hours. It was my impression that during the life history interview, Ms. T's facial features and emotional demeanor changed four times. During these transitions, her eyes, skin, hair, and emotional energy altered. These shifts disturbed me. Was I witnessing demonic possession? Psychotic breaks? Dissociative identity disorder? A con artist? Psychiatrically speaking, Ms. T had a diagnosis of schizoaffective disorder.[1]

The details of the case need not concern us. Incarcerated for life but not on death row, Ms. T's privacy matters. Exhausted, my colleague and I debriefed on the way to a restaurant. I sheepishly shared my observations about Ms. T's disturbed affect. My colleague concurred. Yes, Ms. T's facial features had visibly changed form four times. Over wine, we agreed we had been in the presence of a person experiencing altered states of being. Whether Ms. T was in an altered state of being when she killed her husband is something we will never know.

Writing elegantly about her experience with schizophrenia, Elyn Saks, Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Law School, describes a psychotic episode as being like a "waking nightmare." She notes the "utter terror and confusion" and what she has come to call "disorganization."[2] "Your self loses coherence—it's like a sand castle with the sand being washed away. In short, the center cannot hold."[3] In a subsequent TED talk, she references her friend, Steve, a lawyer and psychologist. Saks tells the audience, "Steve has treated many patients with severe mental illness, and to this day he'll say I was as bad as any he had ever seen."[4]

Psychosis describes a loss of contact with reality involving a disturbance of thought and perception. Symptoms include delusions and hallucinations, inappropriate behavior, and incoherent or nonsense speech, sometimes called "word

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salad."[5] The phrase, "the center cannot hold," comes from a poem by William Butler Yeats, *The Second Coming*, first published in 1920. It was written against the backdrop of the end of World War I, the flu pandemic of 1918–1919, and the commencement of the Irish War of Independence in January 1919. It captures the malaise of the times. It opens as follows:

Turning and turning in the widening gyre
  The falcon cannot hear the falconer;
Things fall apart; the centre cannot hold;

For myself, the falcon turning in the widening gyre (swirl, strong current) and being unable to hear the falconer symbolizes the bird's growing instability and disconnection from its means of survival. The falconer provides food, care, and a sense of belonging.

Roughly seven years ago, one of my very old friends suffering from AD and VaD exhibited similar mental disturbances. Many PWDs develop such disturbances. They do so in a social context, in interaction with spouses/partners, other family members, caregivers, and the community writ large. Their seemingly personal struggles have thus increasingly become public matters and concerns.

We might invoke words such as madness, unreason, insanity, mental disturbance, or severe mental illness to describe some of the behavior and actions of some of those in the throes of neurocognitive decline. Symptoms associated with these labels often include hallucinations, delusions, psychoses, and other breaks with "reality." The disruptive effects of such a decline on social interaction depend upon the social contexts and circumstances within which the decline occurs and particularly the social reactions to it. We have known about older people with dementia for many millennia.

Dementia in History

As early as 2000 BCE, the ancient Egyptians, Greeks, and Romans knew that memory declined with age. Pythagoras (570–495 BCE) saw the last two stages of life, senescence (age 63–79) and old age (80 plus) as periods when both mind and body deteriorated. The word *dementia* derives from the Latin root *demens*, which refers to being out of one's mind.[6] For millennia, people believed that supernatural forces, the wrath of the Gods, and evil spirits caused disease and madness. Priests, shamans, and medicine men dispensed magical treatments. Departing from supernatural ideas about dementia, the Greek physician Hippocrates (460 BC–377 BCE), the father of medicine, thought that natural phenomena explained disease. Hippocrates attributed chronic disorders involving permanent problems with higher cognitive functions to cerebral impairment. Put differently, he thought brain pathology caused mental illness.[7] He recognized the brain as the most powerful organ in the human body, the seat of thought, learning, memory, and reasoning. Indeed, some have referred to Hippocrates as the forefather of modern neurology.[8]

We find one of the earliest documented uses of the word "dementia" in the book *Etymologies*, written in 560 CE by Saint Isidore, the archbishop of Seville, Spain. Saint Isidore's use of the word reminds us of the close links between madness, evil spirits, demoniacal possession and the potential magic of religious or supernatural intervention. Mad people, particularly if they were perceived as dangerous, were often handed over to the exorcist or the executioner. In pre-modern Europe, the mad were brutally punished, chastised, and killed for their transgressions. Less draconian but still injurious interventions included physical restraint and/or chaining. Pieter Spierenburg observes, "The first Dutch madhouses, established in the fifteenth century, were designated explicitly for the inmates whose families had been obliged to keep them in chains."[9]

PWD were subject to many harms and indignities including ridicule, ostracism, manacling, incarceration, exorcism, and execution. In *As You Like It*, William Shakespeare (1564–1616) wrote, "Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans everything."[10] In *King Lear* he captured the cognitive and affective decline of the condition with the words, "I fear I am not in my perfect mind. Methinks I should know you, and know this man."[11]

The term *dementia* appeared in medical discourse in Blancard's Physical Dictionary in 1726. There it referred to "extinction of the imagination and judgment."[12] The recognition of dementia as distinct from other forms of mental illness proved highly significant. The famous alienist and humanitarian reformer Philippe Pinel (1745–1826) distinguished four mental disorders (melancholia, mania, idiotism, and dementia), distinctions his students would refine over the decades.[13] For example, Etienne Esquirol (1772–1840) further refined the distinctions between dementia and congenital conditions. Among Esquirol's causes of dementia, we find unhappy love, unfulfilled ambitions, head injuries, and domestic problems.

During the upheaval of the French Revolution, we witness the beginnings of what would later be called the "moral treatment" of the mentally ill. As one of the early founders of modern psychiatry, Pinel provided detailed descriptions of dementia. In the 1790s, he supported the unchaining of the mad at the two main institutions in Paris that housed them, the Bicêtre (for men) and Salpêtrière (for women).[14] Robert Fleury's famous painting, *Pinel à la Salpêtrière*, depicts Pinel overseeing the removal of chains and fetters from female inmates, one of whom gratefully kisses his hand. In general, the work of Pinel and other reformers pointed to the futility of harsh treatment of the mentally ill.

German psychiatrist Emil Kraepelin (1856–1926) would include information on dementia cases in his landmark textbook, *Clinical Psychiatry*, published in 1912. He notes dementia patients "grumble, quarrel, curse, abuse those about them at every opportunity, and often threaten and become aggressive."[15] They would "fail to note details and to understand the connection of things that are complicated. They, therefore, become easily disoriented . . . they are drowsy, disinclined to think . . . patients are unable to change their viewpoints."[16] Patients have a "total inability to comprehend the views and conditions of others," a "susceptibility to delusional ideas," and "commonly believe that many things are done to annoy them and that their property has been taken from them . . . *Hallucinations* and especially *illusions* are common."[17] Readers learn,

> The *failure of memory* is always a prominent symptom, especially memory for recent events. . . . Patients forget where they were yesterday, or, where they have placed things . . . and even forget the names of old friends . . . *nocturnal restlessness is most characteristic.*[18]

Pinel and others' humanitarian ideas about the treatment of the mad and PWD spread to the US and Britain, where systems of asylums developed to house patients, treat them, and provide care. The asylums had many problems including unethical and harmful experimentation on inmates. They also proved expensive, a key factor in their decline after World War II. Starting in the mid-1950s in the UK and US, asylums and state hospitals gradually began emptying out mentally ill patients into communities. They also significantly reduced their intake of PWD. Families struggling with hostile, aggressive, bizarrely behaving, and potentially dangerous elders with dementia found it increasingly difficult to place them in an asylum or mental hospital. As Western populations aged and the prevalence of the dementias increased, options for full-time institutional care diminished, and families increasingly assumed the responsibility of caring for members with dementia. But what about non-Western societies and their handling of dementing illness?

Geronticide

As Jared Diamond points out, " 'old age' has to be defined by the standards of the local society, not by some arbitrary universal year count."[19] Life expectancy has increased in developed nations over the last century and a half. More people in developed countries are living into their eighties and nineties. However, as Diamond notes,

> The status of old people in Western societies has changed drastically and paradoxically within the last century . . . people live longer, old people enjoy better physical health . . . society can better afford to care for them. On the other hand, old people have lost most of the traditional usefulness . . . and they often end up socially more miserable while physically healthier.[20]

People's attitudes toward the elderly differ by time and place. Diamond informs readers of an acquaintance from the Fijian island of Viti Levu. The man had visited the US and was appalled at the dispatching of many older people to nursing homes. He told Diamond, "You throw away your old people and your own parents!"[21] Other traditional societies accord their elderly even lower status than Americans. He notes that some societies starve, abandon, or kill older people.

In *Geronticide: Killing the Elderly*, published in 2001, author Mike Brogden argues that societies have "regularly condoned the killing of older people."[22] Methods vary but he sees similarities between the elderly Inuit who is ritually abandoned on an ice floe, the pauper forced into the Victorian workhouse with inadequate provisions, and the poorer elderly female resident in a modern nursing facility denied "life-saving medication" due to discrimination.[23] He cites an example of elderly people with AD living in a care home being means-tested before being given care. Brogden quotes the chief executive of the Alzheimer's Disease Society saying, "It is unthinkable that a young person with CJD, another form of dementia, would be means tested for their care."[24] Often then, killing of the elderly, including PWD, takes the form of death-hastening rather than direct geronticide, sins of omission rather than commission.

Traditional societies appear to have distinguished between the "intact" and the "decrepit" elderly. The decrepit elderly includes those with physical and mental infirmities to a degree that members of those societies see such people as a liability. Writing in the 1950s, Leo Simmons put it bluntly, "Apparently all societies differentiate between old age in general and this pathetic plight in which the individual is regarded merely as a long-sufferer and a social obligation."[25]

Studies of traditional societies provide examples of the hastening of the death of those elderly seen as a liability. Such death hastening includes killing, abandoning, or forsaking them. These non-supportive treatments precipitated premature deaths. Maxwell and colleagues note that non-supportive treatments occur more often in societies without surplus production, for example, among hunter-gatherers. It is difficult to assess the meaning of such death hastening practices in traditional societies because they also had much higher rates of infant mortality and infanticide. In a sense, one might argue that in some cases hastening the death of some enabled others of reproductive age to better utilize scarce resources, thus ensuring the survival of the group.

Anthropologist Anthony Glascock reports cross-cultural survey data identifying death hastening behavior in half of 60 non-industrialized societies. For example, among the reindeer herding Chukchee of northeastern Siberia, "few die a natural death."[26] The infirm Chukchee elders perceived as a burden requests his or her own death. The oldest son, daughter, or son-in-law obliges by stabbing them in the heart with a knife.

In three societies among the 60, elders were beaten to death, in three they were buried alive, in two they were stabbed to death, and in one they were strangled.[27] The decision to remove the elder was made mostly within the family. According to Glascock, the children and their elderly family member jointly decided the right time to die. In two societies, the elder made this decision on his or her own. In most cases, the eldest son killed his parent.

The Lau of Southern Fiji survived through horticulture and fishing. When the headman of the Vandra-Vandra clan became enfeebled, he was taken to Taluma Islet and abandoned in the lagoon. A cave in the area was apparently filled with the skeletal remains of old people abandoned there.[28]

Barker's study in Niue, Polynesia, notes how some decrepit elderly qualify for medical care and attention while others do not.[29] Those left unattended or who received minimal care included those who "yelled constantly, swearing at neighbors and kin; those who fought all the time, hitting out at all and sundry; those who wandered away at all times of day and night; those who talked only of events in the remote past, who conversed with absent friends and long-dead relatives; those who stared vacantly about them, constantly drooled, or were incontinent."[30] Barker's description of problematic behaviors corresponds with that of some of those PWD documented in the gray mist cases.

In their cross-cultural analysis of motives for geronticide, Maxwell and colleagues found a strong correlation between complaints about the elderly and what the researchers interpreted as acts of mistreatment. Indeed, complaints were commonly used as justifications for mistreatment. Complaints included reference to physical weakness, senile deterioration, possession of only obsolete skills, acquisition of negative characteristics such as powers of witchcraft, lack of a family support network, loss of wealth, devalued appearance, and hoarding of power or wealth. Maxwell et al. used the term "contempt" to refer to the "sum of complaints made against the elderly as explanations for treating them poorly."[31] Among the 65 societies containing data about complaints and mistreatment of the elderly, physical weakness stood out as the most common complaint, being found in 23 societies. The researchers note that "this is greater than twice the frequency for any other single explanation of poor treatment."[32] Of the 13 societies in which people deliberately killed the elderly, they found that physical weakness was directly related to geronticide. They identified similar correlations for the abandonment of the elderly.

The limited anthropological data suggests that in traditional societies, especially hunter-gatherer, herding, foraging, and gathering, and those involved in shifting agriculture, the infirm elderly comprise an increasing burden, some might say threat, to the survival of the group.[33] They are increasingly less able to hunt, fish, move quickly, and generally contribute to the food supply, protection of the group, building shelters, and so on. One can imagine that any social esteem the elderly may have accrued due to their perceived experience and wisdom is slowly undermined as senility sets in, cognitive skills decline, and strange, potentially aggressive or obnoxious behaviors increase. Hence, the group gradually makes a collective or at least familial decision to deliberately kill, abandon, or forsake the infirm elderly person.

Some attitudes about dementia in developing countries, as in pre-industrial Europe, construed it as a form of possession by evil spirits. For example, in 2010, a 72-year-old Ghanaian woman, who likely had dementia, burned to death because she was perceived to be a witch. Madam Ama Ahima was coerced into confessing she was a witch, then doused in kerosene and set alight. She later died of her injuries. Newspaper photos of Ama's injuries caused widespread revulsion throughout the country. Comfort Akosua Edu of Ghana's Commission on Human Rights and Administrative Justice remarked, "The commission finds the action of the perpetrators of this atrocious crime as very barbaric."[34]

In another case the media mocked an elderly Ghanaian woman who was behaving like someone with dementia. The woman was "arrested" by villagers who claimed she had "fallen out of the sky" after running out of witches' gas. She had apparently been on a flying expedition with her coven when she fell under a tree.[35]

Investigative journalist, Cameron Duodu, asks why in both cases, people failed to recognize that these older women were exhibiting the symptoms of dementia. His answer is that significant portions of the Ghanaian population remain uninformed about dementia. Belief in witches is a prominent cultural theme in Ghana and other parts of Africa, reminding us that scientific knowledge about dementia must compete with folk understandings of dementia-like behavior.[36]

Similar examples of the intense stigmatization of elderly women with dementia hail from Nigeria. Chief Kikelomo Laniyonu Edwards returned to her native Nigeria after running three care homes for the elderly with dementia in England. She notes how these afflicted women were labeled as witches, mad people. One outcome of these beliefs is that women with dementia are hidden since "people don't want to marry into a family that has madness or witchcraft."[37] People fear being possessed by an evil spirit associated with the person with dementia.

The vast majority of the 100 gray mist killers committed homicide in the private setting of their own homes. Unlike death hastening in traditional societies or the industrial warehousing of the decrepit elderly, those in our sample who killed PWD did so on their own. Their decisions were private and often influenced by the specter of undesired nursing home care.

Among our selective gray mist sample, it is largely spouses/intimate partners, not adult children or other family members, who kill fellow spouses/partners with dementia. Such patterns of perpetration doubtless reflect the more privatized, nuclear family living arrangements in the US, UK, and Australia, particularly the centrality and intensity of companionate marriage. The private decision to kill may be made in conjunction with their spouses/partners in a handful of cases, although, as we have seen, this is difficult to determine.

The liabilities PWD presented did not stem from their inability to produce food, hunt, gather, or herd, although in some cases the inability of PWD to take care of their own needs appears to have played a significant role. In some cases, those who killed wives/partners with dementia likely considered the potential economic threat of paying for long-term care, the daunting prospect of medical/pharmaceutical treatments, and the various threats to their long-established home lives, their privacy, and their safe and familiar surroundings. As we will see in Chapter 7, many of these people were locked into their suffering through intense, intimate bonds characteristic of long-standing marriages emblematic of the cohort of which they formed a tiny part.

Biomedical Models

The writings of French philosopher and mathematician, Rene Descartes (1596–1650) strongly influenced modern medicine. Descartes famously wrote "cogito, ergo sum," Latin for "I think, therefore I am," a statement that invites the colossal question, what is consciousness? His Meditation 6 claimed the mind and body are distinct. It is to Descartes that we trace the classical formulation of the mind-body duality. For dualists, the mind is an immaterial, invisible, thinking entity or phenomenon and the body a material, visible, unthinking machine. In discussing the notion of mind, Descartes wrote, "It is certain that this me, that is my soul, by which I am what I am, is entirely and truly distinct from my body."[38] As George Makari explains, Descartes restricted the notion of "soul" to that "immaterial aspect of human beings that can think."[39] The soul was "God's gift to humankind, the very opposite of the body."[40]

Religious bodies such as the Catholic Church saw the mind, body, and soul as interconnected and sacred. For religious believers during feudal times in Europe, the soul was the source of life's meaning, instincts, and power of reasoning and will. Descartes's (Cartesian) dualism separated the mind and soul from what came to be seen as a machine-like body. Cartesian logic recognized the immateriality and immortality of the soul, a position that affirmed Christian ideology and the authority of the church. Effectively de-sacralizing the body helped free it from the various religious prohibitions against the dissection of previously hallowed corpses. Hence, the mechanical body has increasingly become the object of modern science.

Descartes' dualism helped facilitate the revival of anatomy. Autopsies began to reveal connections between malfunctioning body parts and causes of death. Whereas ancient physicians considered the whole body of patients, the scientific revolution of the seventeenth century resulted increasingly in physicians recognizing the importance of malfunctioning organs and tissues. Moreover, they used these localized pathologies for diagnostic purposes. The fitting of patient reports of illness into biomedical taxonomies of disease reduced illness to the increasingly minute levels of organ parts, cells, genes, and molecules.

For dualists the mind and the brain are distinct. The mind involves thoughts, intentions, memories, and feelings. The brain involves neurons, neurotransmitters, the neurovascular system that supplies oxygen and nutrients, and the glymphatic system that cleans it. Unlike dualists, the so-called physicalists or materialists see the mind as a product of the brain. Writing about the dualist separation of mind and body, neuroscientist Moheb Costandi comments, "Most modern neuroscientists agree . . . that the mind is made of matter and is a product of the brain."[41] Steven Pinker clarifies further, "The mind is not the brain but what the brain does, and not even everything it does, such as metabolizing fat and giving off heat."[42]

The nature of the mind and consciousness and why and how humans have subjective experiences have plagued philosophers for millennia. Philosopher David Chalmers referred to the "hard problem" of consciousness.[43] Steven Pinker sees the hard problem involving the phenomenon of "sentience."[44] Pinker points to one of the interesting scientific lessons of the mystery of sentience, that is, "the feeling of mystery is itself a psychological phenomenon, which reveals something important about the workings of the human mind."[45] For Pinker, Chalmers, and others such as philosopher Colin McGinn, the human mind is unable to solve the problem of consciousness. Others argue that everything including consciousness is reducible to its physical or material constituents. For Sue Blackmore, "[c]onsciousness is an illusion: an enticing and compelling illusion that lures us into believing that our minds are separate from our bodies."[46]

For Chalmers, the "easy problem" of consciousness concerns addressing cognitive functions by explaining physical systems or neural processes that accompany behavior. The easy problem concerns how sensory systems work and how the structure of the brain is associated with functional outcomes. Attempts to solve the easy problem have varied over the centuries. Some built analogs to illuminate the workings of the brain and mind.

Descartes likened the workings of the brain to the most complicated technologies of his day, clocks and moving statues, both controlled by hydraulic systems.[47] Descartes's hydraulic theory of how the brain works has been replaced by contemporary computational theories of the brain and mind. However, hydraulic theories of brain function still matter. Recently, a research team proposed a hydraulic resistance model to explain the removal of metabolic wastes in the brain. Schreder and colleagues suggest that the failure to remove brain metabolic waste may be linked to the patterns, relative numbers, and configurations of arterioles and venules in the brain.[48] The glymphatic system appears to remove metabolic waste from the brain in a manner akin to the way the lymphatic system cleans the body. The cleansing appears to happen most during sleep cycles and exercise. Animal model research points to links between the failure to remove harmful metabolites such as amyloid β and neurodegenerative disorders such as AD. One team of researchers suggests that the glymphatic dysfunction is linked to perturbed expression of the protein coding gene AQP4 (Aquaporin 4).[49]

Computational theories liken the mind to a computer handling big data or to artificial intelligence systems. Pinker opines, "Information and computation reside in patterns of data and in relations of logic that are independent of the physical medium that carries them."[50] Such analogies allow us to connect the "ethereal world of meaning and intention, the stuff of our mental lives, with a physical hunk of matter like the brain."[51]

Yet, what philosopher Joseph Levine refers to as the "explanatory gap" remains as an epistemological conundrum, a problem about ways of knowing how words, smells, sounds, and other subjective experiences, in short, sentience, come from neuronal activity.[52] Put differently, there is an apparent divide between the material workings of the brain and the subjective experience of those workings. Levine puts it as follows, "we have no idea, I contend, how a physical object could constitute a subject of experience, enjoying, not merely instantiating, states with all sorts of qualitative character."[53] And, "we do not have an explanation for the presence of conscious experience even in ourselves."[54]

For example, we might be able to explain the neurological sequences involved in someone being burned. However, the objective account of those neurological sequences does not explain our subjective experience of the pain of being burned. Simply put, how do we move from matter to feeling? For supernaturalists, what is it that shuffles among matter and etherealities such as energy, ghosts, or spirits?

The biomedical model has enjoyed much success and contributed greatly to human health, productivity, and longevity since the advent of modern agricultural production.[55] Life expectancies have increased significantly, especially in the developed world. The reduction or elimination of infectious diseases such as polio, tetanus, tuberculosis, pneumonia, influenza, hepatitis, measles, and smallpox was made possible by the recognition of and immunization against specific disease-causing agents such as viruses and bacteria. Another success story was the discovery of insulin which transformed diabetes from a deadly disease to a treatable albeit incurable condition. Public health developments also contributed greatly to human productivity, happiness, and longevity. Key among them were improvements in food production, nutrition, and hygiene. All of these developments represented major advances over attributing diseases to supernatural forces.

But biomedical models of diseases like Alzheimer's disease have their limitations. Disease differs from illness. Disease reflects organic malfunction in the body of which the patient may not be aware. Illness is the broadly conceived, socially and historically situated lived experience of that organic malfunction. The most common contributor to dementing illness, AD, involves neurodegeneration. As noted, its precise cause and hence potential cure await discovery. Dementing illness develops within social, cultural, and historical contexts and circumstances. If we are to make sense of gray mist killings, we must consider these contexts and circumstances in conjunction with and as an inextricably interwoven part of the material or physical aspects of neurodegeneration and neurochemical compromise. I write in this way because it is important to avoid, to the extent possible, falling into the mind-body trap that almost inevitably results in treating things mentally and physically as if they were distinct phenomena.

In the three high income democracies from which the 100 cases hail, biomedicine comprises the dominant way of knowing the dementias. Biomedical models explain neurodegeneration in terms of biological and material changes in the body. There is a powerful implicit understanding that the BPSD have their roots in biology and material pathologies. Given the history of "discovering" AD, the dominance of biomedical models makes considerable sense.

With respect to dementing illness biomedical models slowly emerged as the principal means of explanation. Max Bielschowsky (1869–1940) developed a novel silver impregnation technique for staining nerve fibers. Alois Alzheimer used Bielschowsky's staining method to identify pathological changes in brain neurofibrils and the "deposition of a peculiar substance in the cerebral cortex"[56] that were to become the hallmarks of a pathological condition later named Alzheimer's disease. The introduction of the electron microscope in the 1930s enabled the up-close viewing of plaques and tangles, major correlates of the dementias.

Over the last century or so, these scientific advances in fixation, staining, and magnification increased our understanding of the dementias. The rise of neurochemistry and the identification of neurotransmitters furthered our understanding at the molecular level, building upon advances in neuroanatomy and neuropathology.[57]

Alois Alzheimer's case notes on a patient in her early fifties, Auguste Deter, document her symptoms.[58] One of her earliest symptoms was a strong feeling of jealousy toward her husband. Her memory impairments increased rapidly. Auguste would get lost in her own home. She dragged objects back and forth. She hid herself. At times, she thought people were trying to kill her. Often, she would scream loudly for hours. After four-and-a-half years she died. Toward the end of her life, she was confined to bed, curled up in a fetal position and incontinent, suffering from bed sores. When Dr. Alzheimer autopsied her and stained her brain tissue, he found that neurofibrils and tangled bundles of fibrils had replaced her neurons. A quarter to a third of the neurons in her cerebral cortex evinced these pathological developments. Much nervous tissue had disappeared and strange deposits had accumulated in the cortex. These autopsy findings and their apparent relationship to her behavioral and psychological symptoms formed the origins of the modern biomedical understanding of AD and it corollary, dementing illness.

Contemporary biomedical research points to the cornucopia of behaviors and symptoms dementia patients face. These might include anxiety, emotional extremes, depression, irritability and agitation, aggressive and violent behavior, paranoia, delirium, substance abuse, personality changes, and various departures from accepted social conventions. They may also include less commonly understood symptoms. Apraxia is the inability to act when asked to do normal actions such as to cough or wink. Aphasia is the inability to speak or understand speech. Agnosia is the inability to sense visual, auditory, olfactory, gustatory, or tactile stimuli. For example, people would not recognize a spoon or pencil when they see it but could do so when they touch the object. Catastrophic reactions involve emotional or melodramatic outbursts or overreactions that might include physical violence, agitation, crying, or laughing. This is most common during assistance with personal care or during evening meals.[59]

Ballard and colleagues note psychosis occurs in the majority of people as their AD unfolds.[60] Notably, "psychosis is associated with increased subsequent dependency" and psychotic symptoms are often antecedent to or comorbid with other neuropsychiatric symptoms like agitation, aggression and depression."[61] However, it remains unclear to what extent psychotic symptoms among PWD are emblematic of dementing illness itself or, at least in part, a side effect of potential pharmaceutical interventions used to treat the symptoms of the illness.

AD spans 60–80 percent of all dementia cases, DLB 10–25 percent, VaD 10–40 percent, and FTD 10 percent. At least half of cases are mixed, evidencing combinations of these types.[62] Amyloid plaques in the brain, also known as senile plaques, comprise one of the principal biomarkers in AD. These sit outside of neurons within brain tissue. Sadock et al. observe, "The number and density of senile plaques present in postmortem brains have been correlated with the severity of the disease."[63] Neurofibrillary tangles consisting mostly of tau protein constitute another persistent neuropathological feature and biomarker of AD. They develop, in misfolded form, inside neurons and eventually kill the cells. Indeed, these tangles appear to have more of an effect on the development of the disease than the amyloid plaques. Both plaques and tangles must be present to diagnose AD. Other neuropathological disease features include neuronal loss (especially in the cortex and hippocampus), synaptic loss,[64] and granulovascular degeneration of the neurons.[65]

Sociological Perspectives on Problems of the Mind

Psychiatry and psychology have developed an ever-proliferating taxonomy of mental disorders to explain clusters of symptoms. Mental disorders refer to specific clusters of signs and symptoms, not their causes. Even if one assumes many of those causes lie in biology and material pathology, knowledge of them remains opaque at best. The language of mental illness and mental disorders permeates the gray mist case files in the US, UK, and Australia, hence my guarded use of these terms. For mental health practitioners, the language provides specific diagnostic categories within which to situate their clients/patients. In the courts, it offers a rationale and/or justification for determinations of fitness to stand trial, a frame of reference for assessing *mens rea*, or guilty mind, and information for sentencing decisions. In the US, in particular, the suspicious proliferation of psychiatric diagnoses increases the potential client base, enables practitioners to bill insurance companies for their various therapies, and has the tendency to frame mental illness in a manner that lifts it out of its social settings and historical contexts.[66]

Sociologists and others have questioned whether mental illness actually exists and whether the concept has legitimate meaning akin to physical illness. Some prefer the term "mental distress" to mental illness, a shift in emphasis that demedicalizes difficulties in thinking, feeling, and cognition, situating them more broadly in terms of human biography and life circumstances.[67] Sociological authorities on severe mental illness including the dementias acknowledge much remains unknown, puzzling, and mysterious.[68]

In the first edition of *Being Mentally Ill* in 1966, Thomas Scheff argued there is no such thing as mental illness. Rather, what psychiatrists label as mental illness is more aptly seen as bizarre behavior that does not make sense to others. Many people exhibit bizarre behavior at certain points in their lives, but few end up being labeled mentally ill. Scheff expressed concerns about the stigmatizing effects of labeling some people as mentally ill.

Other labeling theorists suggest that whether someone assumes the stigmatized status of "mentally ill" is mostly a product of successfully attaching the deviant tag. Howard Becker once opined,

> *social groups create deviance by making rules whose infraction constitutes deviance*, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is *not* a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an "offender." The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label.[69]

The deviant label assumes a "master status" and thus sets up self-fulfilling prophesies as others respond to the label and reinforce, amplify, or confirm it.

In *Asylums* in 1961, Erving Goffman wrote about the ways those labeled mentally ill were treated differently than those not so-labeled and treated in accordance with that label. His year or so of participant observation at the St. Elizabeth State Mental Hospital in Washington DC (1955–1956) yielded a detailed ethnography of what he called the deviant career of the involuntary mental patient, particularly the patient's interactions with staff. For Goffman, total institutions such as the asylum shape the identity of patients, forge their deviant careers, and confirm their stigmatizing labels. Some patients resist, at least for a time, the imposition of deviant labels.[70] Goffman defines a total institution as a "place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."[71] Elderly PWD might be housed in one of two such groups of total institutions, homes for the elderly perceived as incapable and harmless or mental hospitals which care for persons deemed incapable of looking after themselves and a threat to the community.[72]

Goffman's seminal work has been extended in light of new information. Matthew Gambino notes developments at St. Elizabeth's that reveal a more complex and nuanced institutional culture, which likely increased the engagement, opportunities for self-expression, and autonomy of patients. Given that *Asylums* became one of the rallying cries of the anti-psychiatry movement, Gambino's highlighting of the limitations of Goffman's analysis comprises an important corrective. He notes, "Goffman failed to appreciate fully the changes that were transpiring around him, and systematically underestimate the contributions of patients to a complex and multifaceted institutional culture."[73]

Seen through the lens of labeling theorists, the elderly dementia patient is a person who has been labeled as such, perhaps initially by family members, friends, neighbors, co-workers, and others, and later through more formal medical/psychiatric diagnoses and treatment. People in the same physical and mental condition who are not initially identified as a person with dementia may not see a physician and may avoid such labeling, at least for a while. Put simply, the label "person with dementia," or, more all-encompassing and stigmatizing, "demented person," is not simply a quality of their actions, cognition, and behavior but rather the outcome of naming them as such. It is also a product of the societies and historical epoch they inhabit. In many societies dementia is not recognized as a special status. Rather, it is seen as an inevitable part of the aging process.

A patient with dementing illness resident in a total institution in the 1950s may have, to varying degrees depending on the stage of debility, led an enclosed, formally administered round of life. But the fact remains that in families and communities they were likely also subject to stigmatization or worse, again depending on their behavioral and psychological symptoms. Writing just before Goffman began his ethnography at St. Elizabeth's, anthropologist Leo Simmons puts the dependency of the elderly into broad historical perspective. He notes that in pre-modern societies, few people lived to old age, regardless of their levels of debility. He observes,

> Apparently all societies differentiate between old age in general and this pathetic plight in which the individual is regarded merely as a long-sufferer and a social obligation. . . . The overaged, useless, or liability phase of senescence actually has had little significance for the simple societies which were never able to sustain more than a few really old people.[74]

However, for modern civilizations with greater life expectancies, the "helpless and hopeless period in life takes on paramount importance."[75] Regarding the human life cycle, Simmons comments, “life begins with the dependency of the young on those who are older, and it generally ends with the dependency of the old on those who are younger.”[76]

Some who have written about the history of asylums note their role included helping the mentally ill, protecting some of them from their own violent, destructive, and antisocial behavior, preventing them from hurting others, and thus limiting the much more likely possibility that others would hurt, mistreat, or marginalize them. As noted, the asylums, for all their well-documented problems, represented an advance, a way of delivering moral treatment. Prior to their emergence in America, Deutsch notes how the mentally ill were

> hanged, imprisoned, tortured. . . . Regarded as subhuman beings . . . chained in specially devised kennels and cages like wild beasts . . . incarcerated in workhouse dungeons . . . made to slave as able-bodied paupers . . . left to wander around stark naked, driven from place to place like mad dogs, subjected to whippings as vagrants and rogues.[77]

Structural sociologists explore social patterns across time and place. They look beyond amplifying spirals of social interaction between labelers and the labeled, regardless of whether those spirals develop within families, communities, or institutions such as asylums. Many recognize the existence of mental illness. These sociologists map the social and historical distribution of mental illness, pointing, for example, to the clustering of mental illness among more disadvantaged groups and the changing social responses to dealing with these groups of mentally ill people.

Andrew Scull notes the growing proportion of the senile and PWD among the ranks of the mentally ill in the first half of the twentieth century in the US. He attributes this rise to the decline of the almshouses and the limited sources of care and support for the elderly.[78] However, Scull explains the shedding of patients from mental hospitals in the US and the UK as part of the cost-saving measures of developing capitalist welfare states. Keeping dementia patients in asylums became too expensive in the post-World War II period. Hence, these asylums were gradually closed, replaced by what was supposed to be care in the community, care that never properly materialized.[79] These structural changes made it more difficult to place elderly family members with dementia in asylums or state hospitals, thus pressuring families to care for these elders within their own social circles.

Controversially, Thomas Szasz argues that mental illness is a myth. He contends that medical diagnoses refer to genuine diseases, but psychiatric diagnoses comprise stigmatizing labels. Szasz opines, “whereas in modern medicine new diseases were discovered, in modern psychiatry they were invented.”[80] For Szasz, mental illness was akin to witchcraft in that it enabled powerful groups to scapegoat the less powerful. In Europe, the Inquisition enabled religious authorities to identify and regulate heretics. As religious ideology was gradually replaced by medical science, the persecution of the mentally ill slowly replaced the persecution of the heretic or witch. Witches had served as scapegoats for crop failures, disease epidemics, and other calamities for roughly four centuries.

Szasz highlights the gradual segregating and classification of "raving lunatics, imbeciles, epileptics, paralytics, blind persons, cripples, people suffering from ringworm, incurables of all sorts."[81] He contends that the eventual nineteenth-century development of institutional psychiatry sorted, labeled, and scapegoated those deemed non-conforming, lazy, unproductive, or just plain undesirable. Szasz therefore traces the roots of modern institutional psychiatry to earlier theological movements aimed at purifying society, purging it of wayward or non-conforming members.

Michel Foucault situated the rise of modern psychiatry as part of a broader historical sweep toward the regulation of populations in the post-Enlightenment period. In the modern era, people increasingly became the objects of the specialized knowledge of the human sciences such as medicine, criminology, penology, and psychiatry. Knowing people in ever-finer detail became a means of controlling them, effectively establishing and consolidating norms of behavior. Regarding modern medicine, Foucault referred to this process of inspection and classification as the *medical gaze*. He and others have criticized the medical gaze for its reductionism and its failure to treat the patient holistically. Put crudely, the patient's report of illness was increasingly shoehorned into scientifically determined clusters of symptoms that correspond to specific disease types.

In *Madness and Civilization*, Foucault locates the initial rise of institutions to house problematic fringe people such as the idle, the unproductive poor, and lunatics in the mid-seventeenth century. This movement toward segregating seemingly problematic populations sharpened its focus in the nineteenth century. It was during this time he located the rise of psychiatry and asylums as means of exerting tighter controls on mad people. This deployment of the power of governmental regulation operated in tandem with the increasing expert knowledge about what it took to be "normal" in terms of the human body, soul, and behavior.

For Foucault, the rise of psychiatry was part of the gradual emergence of what he calls "un-freedom," a more insidious subterranean development that, ironically, accompanied the development of some modern democracies. Under this way of thinking, the reformers who claimed to be acting benevolently toward problem populations were, in reality, contributing to their confinement and regulation.

Foucault's attacks on Enlightenment thinking, rationalization, science, the notion of the individual, and the concept of social structure lie beyond the scope of these pages. Suffice it to say, his many critics have pointed out the weak empirical basis of his arguments. What Foucault referred to as the Great Confinement of the mad in Europe in the seventeenth and eighteenth centuries appears seriously exaggerated. For Scull, "Foucault seems . . . to ignore or misrepresent the disruptions and suffering madness brings in its train and more seriously still, to misconstrue many of the complexities that mark the tortured relationship between madness and civilization."[82]

Other writers have emphasized the importance of the genuine concerns of reformers to improve the lot of the mentally ill. The benevolence of reformers was not just a sop, a paternalistic and condescending ploy to exert greater control. Rather, it was often genuine at the same time as the outcomes were positive (e.g., provision of care, food, and shelter) and negative (e.g., dubious medical interventions such as lobotomies, electro-convulsive therapy, and blood-letting). Indeed, as David Garland points out, “it is perfectly possible to combine a desire for more humane treatment with a demand for greater control, and there is no reason why one should be reduced to the other.”[83]

In the aftermath of World War II and in tandem with the rise of psychotherapeutic interventions, other authors suggested a role for psychosocial factors in the development of dementia. David Rothschild, clinical director of the Worcester, Massachusetts State Hospital,[84] using the language of his day, highlighted the increasingly burdensome rates of admission of patients 60 years or older.[85] The great majority of these “old and broken-down persons” suffered from senile psychoses or psychoses with cerebral arteriosclerosis.[86] Their deterioration reflected irreparable cerebral damage. In asking how society might tackle the problem, Rothschild turned to research on the “normal” elderly. He noted among them those individuals who had “just as severe changes in the brain as patients with senile dementia.”[87]

These observations suggested that cerebral alterations might not comprise the only cause of dementia but that psychological factors also mattered. Possible candidates included “worry, anxiety over failure of health with advancing years, financial hardship, loss of relatives, personality defects.”[88] For Rothschild, addressing these concerns “through a broad program of mental hygiene for the older population groups . . . would amply repay us by diminishing, and perhaps ultimately reversing, the rising trend of admissions for the psychoses of later life.”[89]

An influential article in the *New York Times Magazine* also emphasized the role of psycho-social factors in senile dementia in the US. Physician David Stonecypher, who for many years had an active interest in the psychiatric problems of the elderly, wrote “Until recently it was widely believed that senility was the result of physical deterioration of the aging brain. But later studies—including autopsy investigations, cerebral blood supply studies and neurophysiological discoveries—have pointed rather to psychological factors.”[90]

Studies showed positive correlations between diagnoses of senile dementia or cerebral arteriosclerosis and divorce, death of a spouse, isolation, job loss, and retirement.[91] Simply put, potentially adverse social changes likely also influenced the unfolding of dementing illness. Later developments in the UK similarly emphasized the role of social factors, particularly the changing status of the growing number of elderly people in society.

Tom Kitwood opined in 1989, “It is now becoming clear that virtually all the losses and difficulties of later life are socially constructed.”[92] Kitwood challenged what he saw as the linear causal model in which brain pathology provides “a sufficient explanation of the dementing condition.”[93] For Kitwood, the psychological symptoms associated with dementia, such as impairments in attention, planning, judgment, emotional response, and memory loss, especially in the short term, did not match neuropathological changes evident upon autopsy. He pointed to significant declines in patients once they entered assisted living facilities, particularly if those facilities were under-resourced and impersonal. Kitwood also contended some PWD return to some functionality with intensive caring and support, so-called positive person work. Such changes suggest that psychosocial factors play an important role in the dementing illness.

As Kitwood notes, PWD are relatively powerless.[94] As such, they may be particularly susceptible to stigmatization and humiliation. Do perpetrators of homicide who have dementia kill, at least in part, because of what they perceive as inadequate, disrespectful, dehumanizing, and condescending social responses from family, community, and state? Are those few PWD who kill family members subject to what Kitwood terms "malignant social psychology and malignant practices"? Relatedly, do malignant social practices feature prominently in the killings of spouses/partners and other family members with dementia? Such spirals of malignant interaction are intense, insidious, and destructive. These spirals develop most commonly out of ignorance, preoccupation, or over-busyness.[95] Kitwood situates malignant social interactions within deeper cultural traditions that bureaucratize, routinize, and render impersonal the care of PWD.

Kitwood among others questioned the dominance of the medical model of the dementias—that is, understandings based wholly or principally on the process of neurodegeneration and the cognitive, psychological, and behavioral symptoms associated with it. Critics of the medical model found socially situated meaning in the behavior of PWD. Kitwood theorized that what he referred to as person-centered care based on psychotherapeutic principles could profoundly affect the behavior of PWD. Malignant practices worsened the disabling effects of the dementias.

Kitwood theorized that malignant practices were especially likely to play out in under-resourced long-term nursing care facilities for PWD. However, these practices can arise in all care situations, including those in private homes between spouses or partners. Only relatively rarely, Kitwood opines, do such bad practices stem from the active ill will of others. Put simply, many of the malignant practices unfold inadvertently and without malice. They may stem from a lack of specialist training knowledge among care professionals and family members. Regardless of the reasons for intensifying spirals of malignant interactions, the researchers note the importance of aggression and violence among those with dementing illnesses.

Dementing Illness, Aggression, and Violence

Compared with other forms of homicide, the gray mist killings are extremely rare. Much more common are the aggressive, agitated, frustrated behaviors and mental health symptoms such as delusions (seemingly false beliefs and associated complex meanings), hallucinations (seemingly false perceptions, e.g., seeing, hearing, and smelling things that other people do not and the multiple possible meanings associated with them), and psychoses (breaks with reality) common amongst PWD. One study notes aggression occurs in 30–50 percent of people diagnosed with dementia and 40–60 percent of PWD living in long-term care or nursing home settings.[96] Another found that 96 percent of the 99 subjects in their 10-year prospective study exhibited "severe or persistent aggressive behavior" during the course of their dementia.[97]

Sundakov-Krumins and colleagues point out psychosis features in approximately a quarter of cases in which PWD commit homicide.[98] They note psychotic symptoms including delusional jealousy, delusional misidentification attributed to prosopagnosia (an inability to recognize faces), and persecutory delusions. Twenty-one percent of patients with dementia studied at the University of Massachusetts Medical Center exhibited assaultive or violent behavior. More than half of them had angry outbursts. The severity of the dementia correlated with the presence and severity of assaultive behavior and violence.[99] Another study found violence among 19 percent of a similar sample of PWD.[100] A retrospective study of 183 PWD, found that 65 percent of the people exhibited aggression at some point during the course of the disease. Among these, 50 percent were verbally aggressive and 46 percent physically aggressive.[101]

Research clearly demonstrates that many who care for PWD experience troubling behavior from them such as physical violence, suspicion, and accusations. Agitation and aggression manifest at various points in different forms of dementia. Linda Ercoli, a practicing psychiatrist who works with dementia patients, notes many triggers for agitation and aggression.[102] These include fear, anxiety, unfamiliar surroundings, loud noises, frustration with tasks, physical discomfort, illness, depression, mania, anger, paranoia, and delusions. In FTD, these behaviors tend to surface in the early stages of the condition, as we saw in the case of Karlan Denio. Indeed, one of the gray mist killers we will meet in Chapter 3, “Dementing Illness and Abnormalities of Mind,” Pearl Padgett unexpectedly stabbed her husband to death while in the throes of what court experts testified was most likely a form of FTD. Aggression features are more common in the middle stages of AD. In DLB, aggression can manifest during sleep, with the person acting out dreams with violent themes. Often, the DLB patient has no memory of any violence. Tsai and colleagues report the case of a patient with VaD in whom Capgras syndrome developed with violence.[103]

Human Shells and Husks

For Chaplain Lynn Harper, Dr. Alzheimer’s case notes on Auguste Deter reflect a pejorative attitude. The notes stigmatize her condition as “psychosocial incompetence,” which, as Harper notes, was one definition of dementia at that time. Her rereading acknowledges Auguste’s “mental deficiencies,” but she opines that “many of her expressions, the feelings behind them, make good emotional and psychosocial sense, yet the doctor sees them as defective.”[104] According to Harper, “The treatment of Auguste Deter evidences a clinical, distant, depersonalizing approach to dementia.”[105] It is not clear how Chaplain Harper moves from the content of Dr. Alzheimer’s medical notes, themselves embedded in the medical parlance of the day, to this distant, depersonalizing approach.

Clearly, some behaviors exhibited by PWD cause disapproval, anger, and fear. Labels attached to PWD, especially in the later stages as self-identity diminishes, such as “vacant,” “possessed by evil spirits,” “witch-like,” or “irrational,” are all, to use Erving Goffman’s language, deeply discrediting.[106] As Stephen Post reminds us, barring a vegetative state or brain death, residues of humanity and identity persist and lucidity surfaces from time to time. For Post and others, modern Western societies overemphasize hypercognitive capabilities, rational thinking and memory.[107] AD and the dementias deprive people of these capabilities. However, human beings are much more than the sum of their cognitive capabilities and expressed or seemingly accessible memories. Selfhood only exists in relation to others and PWD have emotional and relational needs as well as expressive, imaginative, and unconscious dimensions that defy easy recognition.

According to Lynn Harper's view of PWD in twenty-first-century America, "we have simply replaced the superstitious *filling* of the person with demons, with a superstitious *emptying* of the person of intention and meaning."[108] That so-called emptying comprises a major part of the terror associated with a dementia diagnosis. Recalling the empty shell metaphors, cultural historian Jesse Ballenger contends the social anxiety and dread of dementia in the US is tied up with the "loss of the ability to independently sustain a coherent self-narrative."[109] Ballenger suggests that by the 1980s, "people with dementia were at the outer limits of stigma-characteristically represented as no longer 'really there,' as having somehow already died despite the troubling persistence of an animate body."[110]

The inextricable interweaving of body, brain, mind, and consciousness and the implications for the dementias and gray mist killings render our task daunting. If there is an explanatory gap between material and human sensation and feeling, then we must remain cognizant of the fact that social and historical forces exert an effect on our brains, thinking, and consciousness. For sure, the psyches of PWD are affected by human interaction. Even though the opinions and perspectives of PWD are underrepresented in the research literature, it is clear they often have an acute sense of their surroundings.

In a small-scale qualitative study of 21 PWD across five focus groups, people spoke of the experience of having their lives torn apart, the erosion of skills and personal narratives, stresses they experience from their families such as being prisoners of generally well-intentioned protectors, excessive tiredness linked to dealing with increasingly incomprehensible symptoms, and the loss of autonomy, dignity, and self-esteem.[111] We must consider the possibility that these and other adverse experiences of those with dementing illnesses manifest at the molecular or material level and contribute in some albeit rather mysterious way to homicide.

Notes

1 This disorder occupies the diagnostic space between bipolar disorder (formerly manic depression) and schizophrenia. It has elements of both these severe forms of mental illness—that is, mood swings (as in bipolar disorder) and hallucinations, delusions, and disordered thinking as in schizophrenia. Recent research suggests that bipolar disorder, schizophrenia, and schizoaffective disorder have genetic commonalities as well as similar signs and symptoms. For a discussion of schizoaffective disorder, see B. J. Sadock, V. A. Sadock, and P. Ruiz, *Synopsis of Psychiatry*, 11th ed. (New York: Wolters Kluwer, 2015), 323–27. For a discussion of the genetic influences on schizophrenia, bipolar disorder, and schizoaffective disorder, see A. G. Cardno and M. J. Owen, "Genetic Relationships Between Schizophrenia, Bipolar Disorder, and Schizoaffective Disorder," *Schizophrenia Bulletin* 40, no. 3 (May 2014): 503–15, https://doi.org/10.1093/schbul/sbu016.

2 E. R. Saks, *The Center Cannot Hold: My Journey Through Madness* (New York: Hachette Books, 2007), 351.

3 Saks, *The Center Cannot Hold*, 352.

4 E. Saks, "A Tale of Mental Illness – From the Inside," filmed at TEDGlobal 2012, www.ted.com/talks/elyn_saks_a_tale_of_mental_illness_from_the_inside?language=en#t-83580.

5 For discussions of psychosis mostly through the lens of psychiatric discourse, see the cases of Mary Barnes on pages 120–24 and Daniel Schreber on pages 146–66 in Roy Porter, *A Social History of Madness: Stories of the Insane* (London: Weidenfeld and Nicolson, 1987).

6 For the early history of dementia see F. Assal, "History of Dementia," in *A History of Neuropsychology, Frontiers of Neurology and Neuroscience 44*, ed. J. Bogousslavsky, F. Boller, and M. Iwata (Basel: Karger, 2019), 118–26; H. D. Yang, "History of Alzheimer's Disease," *Dementia and Neurocognitive Disorders* 15, no. 4 (December 2016): 115–21, https://doi.org/10.12779/dnd.2016.15.4.115.

7 F. Boller, "History of Dementia," in *Dementias, Handbook of Clinical Neurology 89*, ed. C. Duyckaerts and I. Litvan (Amsterdam: Elsevier, 2008), 3.

8 T. Breitenfeld, M. J. Jurasic, and D. Breitenfeld, "Hippocrates: The Forefather of Neurology," *Neurological Sciences* 35, no. 9 (September 2014): 1349–52, https://doi.org/10.1007/s10072-014-1869-3. The ancient Egyptians saw the heart as the center of thought.

9 P. Spierenburg, *A History of Murder: Personal Violence in Europe From the Middle Ages to the Present* (Cambridge: Polity, 2008), 155. The first European asylum devoted exclusively to the care of the insane was apparently built in Valencia, Spain, in 1408. See A. Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment From Colonial Times*, 2nd ed. (New York: Columbia University Press, 1949), 16.

10 Shakespeare, *As You Like It*, II, vii, 163–66. Spoken by Jaques, Act 2, Scene 7.

11 David Bevington et al., eds., *King Lear* (New York: Bantam Books, 2005), 3.2.49–60. References are to act, scene, and line. Cited in Assal, "History of Dementia," 120. My discussion of the history of dementia draws upon Assal's account.

12 Assal, 119.

13 "Alienist" is a former word for psychiatrist or someone who treated the mentally ill. The word derives from the Latin word Alius, meaning "other."

14 Prior to the French Revolution, the Bicêtre had the reputation of being one of the world's worst institutions for the mad. As Deutsch informs us, the inmates were "loaded down with chains and shackled to the floors and walls with irons, at the mercy of cruel attendants armed with whips and the authority to use them freely. Many of the attendants were convicts serving out their sentences in this horrible way." Deutsch, *The Mentally Ill in America*, 89.

15 E. Kraepelin and A. R. Diefendorf, *Clinical Psychiatry: A Textbook for Students and Physicians Abstracted and Adapted from the Seventh German Edition of Kraepelin's "Lehrbuch Der Psychiatrie"* (London: Macmillan, 1912), 373.

16 Kraepelin and Diefendorf, *Clinical Psychiatry*, 371.

17 Kraepelin and Diefendorf, 372 (italics in the original).

18 Kraepelin and Diefendorf, 372–73 (italics in the original).

19 J. Diamond, *The World Until Yesterday: What Can We Learn From Traditional Societies?* (New York: Penguin Books, 2012), 211.

20 Diamond, *The World Until Yesterday*, 236.

21 Diamond, 210.

22 M. Brogden, *Geronticide: Killing the Elderly* (London: Jessica Kingsley, 2001), 11.

23 Brogden, *Geronticide*, 11.

24 Brogden, 44. Creutzfeldt-Jakob disease (CJD) is a human prion disease, a neurodegenerative disorder that, like AD, leads to dementia. CJD is always fatal.

25 L. W. Simmons, "Social Participation of the Aged in Different Cultures," *The Annals of the American Academy of Political and Social Science* 279, no. 1 (January 1952): 43–51, https://doi.org/10.1177/000271625227900105.

26 A. P. Glascock, “By Any Other Name It Is a Killing: A Comparison of the Treatment of the Elderly in America and Other Societies,” in *The Cultural Context of Aging: Worldwide Perspectives*, ed. J. Sokolovsky (New York: Bergin and Garvey, 1990), 47.

27 Glascock, “By Any Other Name It Is a Killing,” 51.

28 L. Thompson, *Southern Lau, Fiji: An Ethnography* (Honolulu: Bernice P. Bishop Museum, 1940), 102 cited in A. P. Glascock, “By Any Other Name It is a Killing: A Comparison of the Treatment of the Elderly in America and Other Societies,” in *The Cultural Context of Aging: Worldwide Perspectives*, ed. J. Sokolovsky (New York: Bergin and Garvey Publishers, 1990), 47.

29 J. C. Barker, “Between Humans and Ghosts: The Decrepit Elderly in a Polynesian Society,” in *The Cultural Context of Aging*, ed. J. Sokolovsky, (New York: Bergin and Garvey, 1990), 295–313.

30 Barker, “Between Humans and Ghosts,” 301.

31 R. J. Maxwell, P. Silverman, and E. K. Maxwell, “The Motive for Geronticide,” in *Aging and the Aged in the Third World: Part 1*, Studies in Third World Societies 22, ed. J. Sokolovsky, (Williamsburg: William and Mary College, 1984), 70.

32 Maxwell, Silverman, and Maxwell, “The Motive for Geronticide,” 70.

33 For a general discussion, see Diamond, “The World Until Yesterday,” 214–17.

34 D. Smith, “Ghanaian Woman Burned to Death for Being a ‘Witch,’” *The Guardian*, November 29, 2010, www.theguardian.com/world/2010/nov/29/ghanaian-woman-burned-death-witch.

35 C. Duodu, “Why Are ‘Witches’ Still Being Burned Alive in Ghana?” *The Guardian*, December 31, 2010, www.theguardian.com/commentisfree/belief/2010/dec/31/ghana-witches-burned-alive-women.

36 Taylor notes that beliefs in evil spirits are held by up to 15 percent of Ugandans and up to 95 percent of people in Ivory Coast on page 154. He distinguishes between “normative” (religious and cultural) and “psychotic” beliefs in evil spirits. In reference to the post-partum murder committed by Ugandan mother Grace Kalinda, Taylor notes, “Her beliefs about witchcraft were psychotic and not culturally or religiously normative.” p. 156. Taylor, *Mind of a Murderer*.

37 A. M. Bissada, “Nigeria’s Elderly Suffering from Dementia, Not Witchcraft Says Activist,” *RFI*, updated March 12, 2019, www.rfi.fr/en/africa/20190310-nigerias-elderly-suffering-dementia-not-witchcraft-says-activist. A limited body of research addresses the influence of the belief in dementia as witchcraft, not disease, and PWD as witches. These beliefs remain widespread and affect the willingness of families to seek treatment for family members so afflicted. See J. Brooke and O. Ojo, “Contemporary Views on Dementia as Witchcraft in Sub-Saharan Africa: A Systematic Literature Review,” *Journal of Clinical Nursing* 29, no. 1–2 (January 2020): 20–30, https://doi.org/10.1111/jocn.15066; F. Mkhonto and I. Hanssen, “When People with Dementia are Perceived as Witches: Consequences for Patients and Nurse Education in South Africa,” *Journal of Clinical Nursing* 27, no. 1–2 (January 2018): e169–76, https://doi.org/10.1111/jocn.13909.

38 Cited in G. Makari, *Soul Machine: The Invention of the Modern Mind*. (New York: W. W. Norton, 2015), 28.

39 Makari, *Soul Machine*, 27.

40 Makari, 28.

41 M. Costandi, *Body Am I: The New Science of Self-Consciousness* (Cambridge: The MIT Press, 2022), 5.

42 S. Pinker, *How the Mind Works* (London: W. W. Norton 1997), 24.

43 D. Chalmers, “Facing Up to the Problem of Consciousness,” *Journal of Consciousness Studies* 2, no. 3 (1995): 200–19. Chalmers expanded on the problem of consciousness in his book, *The Conscious Mind: In Search of a Fundamental Theory* (New York: Oxford University Press, 1996).

44 Pinker, *How the Mind Works*, xi.

45 Pinker, xi.

46 S. Blackmore, *Consciousness: A Very Short Introduction* (Oxford: Oxford University Press, 2005), 130.

47 Michael O'Shea, *The Brain: A Very Short Introduction* (Oxford: Oxford University Press), 16. The statues were found in places like the royal gardens of Saint-Germain. They moved by virtue of water flowing through pipes inside the statue.

48 H. E. Schreder et al., "A Hydraulic Resistance Model for Interstitial Fluid Flow in the Brain," *Journal of The Royal Society Interface* 19, no. 186 (January 2022): https://doi.org/10.1098/rsif.2021.0812.

49 See, for example, M. K. Rasmussen et al., "The Glymphatic Pathway in Neurological Disorders," *Lancet Neurology* 17, no. 11 (November 2018): 1016–24, https://doi.org/10.1016/S1474-4422(18)30318-1.

50 Pinker, *How the Mind Works*, 24.

51 Pinker, 24.

52 J. Levine, *Purple Haze: The Puzzle of Consciousness* (New York: Oxford University Press, 2004), 76–80.

53 Levine, *Purple Haze*, 76.

54 Levine, 78.

55 Prior to this development, hunter-gatherers likely did not face the same threat from infectious diseases, in part because they were exposed to the viruses and bacteria associated with domestic animals. For a discussion of the adverse impact of settled agricultural practices on human stature and robusticity, see Mummert, A., et al., 2011, "Stature and robusticity during the agricultural transition: Evidence from the bioarchaeological record, *Economics and Human Biology*, 9, no. 3 (July 2011): 284–301. The authors note declining health from an increase in infectious disease and dental disease and a rise in nutritional deficiencies in 19 of the 21 societies studied. I am grateful to Tori Vnuk for alerting me to this line of research. It appears from recent anthropological evidence that members of hunter-gatherer societies could expect to live up to 70 years of age, perhaps a little longer. Kaplan and Gurven's analysis of human longevity among hunter-gatherers contradicts earlier research, which claimed that among early humans, few lived past 40 years and exceptionally few to 50 years. Among their sample of premodern populations, they found the average modal adult life span to be 72 years with a range of 68–78 years. See M. Gurven and H. Kaplan, "Longevity Among Hunter-Gatherers: A Cross-Cultural Examination," *Population and Development Review* 33, no. 2 (June 2007): 334, https://doi.org/10.1111/j.1728-4457.2007.00171.x.

56 A. Alzheimer, "A Characteristic Disease of the Cerebral Cortex," in *The Early Story of Alzheimer's Disease,* eds. K. L. Bick, L. Amaducci, and G. Pepeu (Padua: Liviana Press, 1907), 1–2. I am grateful to Dr. Virgil Hancock for alerting me to this collection and for the loan of his personal copy.

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63 Sadock, Sadock, and Ruiz, 706.

64 The synapse is the space/site between neurons (nerve cells) across or through which messages pass. Chemical synapses convert electrical signals into chemical information. Electrical synapses facilitate the speedy transfer of electrical signals between cells. As much as 50 percent of synaptic loss may occur in the cortex of dementia patients. Sadock, Sadock, and Ruiz, 706. For details on the role of synaptic loss in the dementias and directions to additional articles, see J. Subramanian and M. E. Tremblay, "Synaptic Loss and Neurodegeneration," editorial, *Frontiers in Cellular Neuroscience* 15 (2021): https://doi.org/10.3389/fncel.2021.681029.

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Part 2

Homicide Chronicles

3 Dementing Illness and Abnormalities of Mind

Mental illness features prominently in the gray mist killings, especially those committed by PWD. In the first and longer part of Chapter 3 (Perpetrators With Dementing Illness), I draw upon one case each from the UK, Australia, and the US in part to capture the range of publicly available information. All three case studies concern spousal victims. The dementing illness appears to have been chronic, worsening, disabling, and associated with the form of their neurodegeneration. It was interspersed with periods of relative lucidity of varying duration. In the case study from the UK involving Pearl Padgett, the periods of relative lucidity appear to have been extensive with only occasional flashes of dementing illness, none of which from the available record portended homicidal violence. In the Australian case concerning Eric Moseley, there appear to have been more outbreaks of anger and occasional assaultive behavior linked to his dementing illness. The US case study relies on limited media sources and only enables us to raise questions about the balance between dementing illness, lucidity, and homicidal violence. Such uncertainties reflect the generally limited nature of public knowledge in US cases, perhaps reflecting a greater cultural and legal concern to protect the sanctity of the supposedly autonomous self.

The second and shorter part of Chapter 3 (Caregiver-Killers With Abnormalities of Mind) addresses caregivers who kill. The courts deemed these perpetrators to have suffered a temporary abnormality of mind or other mental disorder at the time they were killed. The term abnormality of mind refers to abnormal behavior preceding homicide, that is usually transient or temporary, that may or may not include a specific mental disorder but nevertheless constitutes a form of passing mental illness/disturbance or distress, that contributes to and/or provides a context for understanding the killing. Therefore, unlike the various mental disturbances of perpetrators with dementia, the fleeting mental aberrancies associated with homicidal violence by caregivers provide legal mitigation, if not an understanding of the reasons for the killing. Their fleeting mental illness, framed in the language of a temporary abnormality of mind, almost assumes the form of a convenient get-out-of-jail free card that does not rise to the lofty heights of full exculpation. On the other hand, the homicidal violence of those plagued by dementing illness results in varying degrees of civil confinement and incapacitation that insulates them from criminal culpability.

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Perpetrators With Dementing Illness[1]

The Light Blue Cardigan

The large ambulance van was parked ominously in the driveway. Its pattern of alternating neon yellow and green rectangles harmonized with the neon yellow vest of the female paramedic, who was otherwise dressed in black. She stood upright against the front wall of the red brick semi-detached house, next to the front door. It was as if she was standing guard. A smaller ambulance car was parked parallel to the house on the rectangular patch of grass beyond the wall of the front garden. The mid-morning sky was partly cloudy, but the sunlight streamed strongly enough to give off dark shadows from the two vehicles. Various rectangular windows formed apertures at the front and side of the home, themselves surrounded by rectangular red bricks lined with cream-colored cement.

The rectangles, lines, and shadows convey a sense of order, symmetry, linearity, and coherence, qualities that belied what a judge would later refer to as the inexplicable killing that had just taken place inside. UK resident Pearl Padgett, shockingly stabbed to death Jim, her husband of roughly six decades.[2] After stabbing him, she called police to tell them, "I've just stabbed my husband, I think I've killed him."[3]

Pearl and Jim, both in their mid-eighties, had lived on the same street their entire married life. Neighbors knew them as a "lovely couple" and described their house as spotless. They often observed the couple in their garden, "always together." Pearl and Jim had remained fit and independent well into their eighties. They were unknown to police and social services, remaining, as neighbors described them, "fiercely independent."[4] Pearl prided herself on her ability to drive any vehicle and was driving the day of the killing.

Pearl's account of that fateful day notes she had just gone shopping. On returning home, she apparently told Jim she wanted to work in the garden. She reported Jim wanted to go out. They therefore disagreed over what to do next. Family members reported Jim had lost confidence in his driving ability, hence Pearl drove Jim everywhere. Pearl told police that Jim nagged her when he wanted to do something until she invariably relented and did what he asked. However on the day of the killing she walked into the kitchen, picked up a knife, and returned to the living room where she stabbed him to death.

Police checked their records for any prior domestic violence calls to the residence. They found none. Jim and Pearl's children and grandchildren all spoke of a happy, loving couple who enjoyed their retirement. During an interview, Pearl reported two incidents, many years previous, that suggested some early turmoil in their relationship. On one occasion, while they were courting, Jim slapped Pearl across the face. Pearl also claimed that 15 years before the killing, Jim had "approached her aggressively" and "threatened her."[5] On that occasion he did not hit her. The DHR did not report any incident of Pearl assaulting Jim.

One family member told police they thought Pearl had become more forgetful lately and that she might be in the early stages of dementia. Apparently, Pearl had mild confusion. However, it was difficult for family members to discern whether Pearl's slight deterioration was due to aging or the onset of dementia. The observations of the Padgett family members regarding Pearl's condition remind us of just how difficult it is to make sense of the notion of dementing illness. The term has become institutionalized and distinguished from mild cognitive impairment (MCI) through a battery of "credible" tests. However, since people are living longer, it is easy to see how family members might wonder whether occasional forgetfulness is just a part of regular aging, as opposed to something that has come to be called "dementing illness." Given confirmation of neurodegenerative conditions that lead to dementing illness must await autopsy and given in most cases of dementing illness there is no autopsy, one can see how people call into question the very notion of dementing illness. The dementing illness label becomes more suspicious still when one considers the illness is a money-maker for the owners of care homes, pharmaceutical companies, and a fleet of professional caregivers, medical professionals, gerontologists, psychiatrists, and neurologists.

Pearl and Jim's social circle had narrowed in the preceding years. In their younger days, the couple had enjoyed a wide social circle, linked to their many years of attending jazz clubs and visiting local pubs. Jim liked jazz.

Pearl had a number of neurological deficits from her childhood. She was profoundly deaf in her right ear following mastoid problems in childhood and an operation at age 12. She was partially deaf in her left ear. Over the years, Pearl learned to lip read. Her disabilities meant she missed a lot of early schooling. Another blow to Pearl happened when her father died at an early age. Additionally, Pearl reported having a congenital abnormality of her oral palate. She also wore bifocal glasses. Her hearing difficulties and memory problems seemed to worsen in the two years prior to the homicide. On reflection, family members told the DHR interviewers Pearl may have made a few inappropriate comments, but they could not give specific examples.

After arresting her, police took Pearl to a hospital emergency department for an assessment by medical staff. Two police officers stood by. Data from the emergency assessment informs us Pearl was "confused and appeared to have no awareness of the situation."[6] She was apparently oriented toward time and place. Although she was crying and clearly upset, she was able to hold a conversation. She asked to go home and could not recall why she was at the hospital. At another point during police interviews, she described her marriage as "convenient" and commented that Jim never loved her. Her negative comments, attributed to her emotional state at the time, did not comport with the views of any family members. Indeed, family members described such comments as an example of how Pearl would at times "drift from reality."[7]

Relatedly, Pearl reported she wanted to celebrate their 60th wedding anniversary just a month or so before the killing but that Jim did not want to do anything. Pearl declined an interview with the DHR team, so doubts remain about her paradoxical statements regarding their marriage of convenience, him not loving her, and him declining to celebrate their 60th wedding anniversary.

Pearl pleaded guilty to manslaughter by reason of diminished responsibility. She had originally been charged with murder, but based on medical reports, prosecutors accepted her manslaughter plea. In particular, psychiatric reports noted Pearl was suffering from a mental impairment at the time of the stabbing. She told detectives she snapped and felt like a different person as she stabbed Jim. The judge remarked that the neuropsychological testing provided the missing answers as to why Pearl killed Jim Padgett. For the judge, the inexplicable became explicable.

Medical experts opined Pearl had been suffering from unrecognized behavioral variant frontotemporal dementia (bvFTD) at the time she killed Jim. As the name suggests, the neurodegeneration occurs primarily in the frontotemporal regions of the brain. These areas primarily affect personality, behavior, emotional regulation, and language. The condition comprises up to 10 percent of dementia cases and is difficult to distinguish from AD. In AD, the neurodegeneration is more generally distributed through the brain. With FTD, the personality and behavioral changes might manifest before significant memory loss.

As a result of these medical opinions, Pearl was sentenced to a hospital order under the Mental Health Act and was to be treated at a specialist facility until such time as she was considered well enough for discharge back to the community. Her barrister told the court that Pearl had been an exemplary mother and grandmother who had acted out of character. Pearl was kind, caring, and extremely selfless and had never before displayed aggression. Echoing the words of defense counsel, the judge also noted how bvFTD could cause someone to act "completely out of character."[8]

Wearing a light blue cardigan and listening to proceedings from the dock, Pearl waved to her many family members in the public gallery. They blew kisses back. At this point, she had been imprisoned for roughly nine months. The judge sentenced her to a Section 37 Hospital Order under the Mental Health Act 1983 and transferred her to a specialist psychiatric facility (Facility A). The facility was over one hundred miles from Pearl's home and family. She stayed there for roughly three months.

Consultant psychiatrist Q saw Pearl at Facility A. Dr. Q sought an exact diagnosis to determine whether Pearl posed a risk to herself or others. Understandably, Dr. Q reported Pearl as distressed from her time in prison and away from her family. Dr. Q also noted Pearl had feelings of guilt. Dr. Q found no evidence of significant depressive symptoms. Pearl apparently appeared stable and responded to treatment. In terms of aggression, Dr. Q noted only one episode during which Pearl threw a plate because she did not like the way her toast had been prepared. Pearl stayed at Facility A for a shorter time than Dr. Q had expected. She was moved to a psychiatric facility (Facility B) much closer to her home and family. Her discharge notes include comments from Dr. Q that a definitive diagnosis of Pearl's condition and a thorough risk assessment would require "further investigations."

At Facility B, Pearl received treatment from Dr. G, a consultant psycho-geriatrician. Dr. G noted that Pearl eventually wanted to go home to the house where she had killed Jim. They discussed other options, including supported living and moving in with family members. Dr. G presented Pearl's option of moving back home as a gradual process. It included visits with treatment staff and checks on her emotional health. The decision to move Pearl home was also influenced by public health considerations at Facility B and the possibility that Pearl might fall prey to an infectious disease prevalent at the time. Due to prevailing public health concerns, Dr. G acknowledged that Pearl did not receive the same level of support normally available. Two months after she arrived at Facility B, the Section 37 hospital order imposed at the Crown Court was lifted with the proviso that she remained an "informal patient" and continued with the assessments.[9] Pearl was referred to the community mental health team (CMHT). Dr. G noted Pearl posed no apparent risk to herself or others. He did note she continued to express guilt and reported her commenting that she would never feel the same again. Dr. G stressed Pearl was "happy and keen to go home" and that she had shared various ideas about how she might live.[10] Significantly, referencing the various tests and scans completed in Pearl's case, he found no evidence of FTD to explain Pearl's act of killing her husband.

Pearl was discharged into community care. Given the prevailing infectious disease threat, authorities made a decision not to see Pearl face to face but rather to work with her over the phone. Her family, still grieving the loss of their father and grandfather, assumed responsibility for Pearl's care, part of which included looking for warning signs of Pearl posing a threat to herself or others.

Within a few months of her discharge into community care, Pearl committed suicide. At the coroner's inquest into Pearl's death, Dr. G stated that during her stay at Facility B, there were no reports of her losing control or any other explosive frontal-lobe-type symptoms. The outcome in *Padgett* raises many questions, a few of which warrant mention at this point.

The psychiatrists who treated Pearl after her release from prison did not diagnose the bvFTD thought earlier to explain her act of homicide. It was medical evidence of this condition that apparently informed the Crown, defense counsel, and the court to compromise and accept a plea of manslaughter on the grounds of diminished responsibility. Previous to this medical evidence, the Crown had considered proceeding with a murder charge. For the judge, the neuropsychological testing apparently provided key information.

Padgett invites discussion of the complexity of medical evidence in disposing of gray mist killings involving elderly perpetrators with dementia, and, especially in this case, bvFTD. Indeed, bvFTD is difficult to accurately diagnose.[11] The seeming discrepancy between the pre-trial medical evidence/diagnosis of bvFTD and the later, perhaps more considered, psychiatric opinions regarding Pearl's mental illness reflect this complexity. The emerging research on bvFTD points to an association between it and criminal behavior and suicidality. Both associations warrant note, although the research in both areas remains in its infancy.

Research indicates that people with FTD display higher levels of violence and physical aggression than AD patients. Liljegren and colleagues cite a German study with a prevalence rate for physical aggression among FTD patients of 32 percent.[12] One retrospective medical records study of 2,397 dementia patients found 204 (8.5 percent) had a history of criminal behavior that emerged during their illness. Of those dementia patients with AD, 42 of 545 (7.7 percent) exhibited criminal behavior. Significantly, of those with bvFTD, 64 of 171 (37.4 percent) exhibited such behavior. The criminal behavior with the bvFTD subset included theft, traffic violations, sexual advances, trespassing, and public urination.

Liljegren et al. note criminal behavior, including violence, may be the first sign/symptom of FTD.[13] This observation is particularly pertinent in Pearl Padgett's case and may also be relevant to the killing committed by Karlan Denio (see Chapter 1). Among the persons with FTD, the physical aggression tended to be more brutal than with people with AD. Significantly, the aggression occurred earlier in the disease process for people with FTD. Liljegren et al. give examples of this brutal violence. One patient tried to kick a pregnant nurse. Another tried to run over a police officer. Yet another made multiple attempts to strangle a sleeping patient and hit another with an iron pipe.[14] In many cases involving brutal violence, the perpetrator showed little or no remorse, often made light of the incident, and showed little empathy in general. Notably, Liljegren et al. comment, "The ability to verbalize that the actions are wrong while lacking remorse is a known clinical trait among patients with FTD."[15]

Using small samples of probable bvFTD cases (N = 35) and case controls (N = 25), Zucca and colleagues found a high risk of suicide among bvFTD sufferers.[16] As the researchers point out, this is likely the first study to assess suicidal behavior and suicidal ideation among bvFTD patients. In summary, 40 percent of patients with bvFTD showed suicidal ideation compared with only eight percent of controls and four attempted suicides compared with none of the controls. Patients with bvFTD showed higher levels of anxiety, depression, stress, and hopelessness compared with controls. In light of these findings, it is worth restating that both Karlan Denio and Pearl Padgett took their own lives.

A Little Dead Girl

Our next case, *Moseley*, hails from Australia and involves a man in his late eighties who killed his wife in her mid-seventies and then reported to a neighbor that there was a little dead girl in the house. At the time of the killing, the couple had been married for well over 50 years. By all accounts, the marriage was a happy one. Eric and Roberta Moseley emigrated from the UK to Australia, first settling in a suburb of Perth. Their two sons, Brad and Christian, completed their schooling in the Perth area before leaving home and pursuing their careers. Eight years before his father killed his mother, Brad and his family moved back to Western Australia and built a house. His parents liked the area Brad moved to and within a few years bought a house nearby.

Almost 30 years prior to the homicide, Eric suffered a heart attack. It inflicted permanent damage. Five years before he killed Roberta, doctors diagnosed Eric with VaD. They apparently told Brad that due to the damage from his heart attack, his father's brain was unable to receive sufficient oxygen. Consequently, Brad should expect the dementia to worsen. It worsened quickly, and Eric was soon unable to recognize Brad. His confusion increased. Eric apparently became physically violent in the year leading up to the killing. Until that time, Brad reported his father had not been violent to anyone within the family. On one occasion, Eric pushed Roberta who hit her head on a bedside table. After this incident, Brad noted Eric's behavior became "odd." The oddness was later associated with Eric's new medication. Once changed, his behavior apparently improved.

In the six months preceding the killing, neighbor Brenda became increasingly aware of Eric's growing confusion and his general deterioration. Brenda noted how Roberta managed his entire routine, including feeding him, administering medications, and taking him to appointments. It was Brenda who found Eric in the aftermath of the killing. She arrived home around 5:30 p.m. As she got out of her car, she could hear the front security door rattling at the Moseley residence. Eric was wandering around his front garden in a confused state. Brenda walked over. She found Eric struggling to open the door. He had the keys to the house in his hand. Eric apparently did not recognize Brenda. She asked him what was wrong. He told her, "There's a little dead girl in the house." Brenda reported that Eric seemed confused. She told him they would look into it.

Upon entering the home, she saw Roberta, lying on her back in the study with a pool of blood to the left side of her head. She summoned an ambulance and tried cardiopulmonary resuscitation, but Roberta was dead. When paramedics arrived, they asked Brenda if she had seen a knife. Brenda asked Eric the same question. He produced a knife and a pair of scissors. The postmortem examination revealed the cause of death was sharp force penetrating injuries to the neck and chest.

Court transcripts revealed more information about the day of the killing. Readers learn that Roberta called Brad and told him she needed to drop her car off at the repair shop. Brad said his mother asked him to "babysit" his father. He agreed and did so. Eric did not recognize Brad. Roberta returned from the repair shop around noon and took her husband home. According to Brad, his father seemed happy. Later in the afternoon his mother called and asked him if he wanted anything from the hardware store since she and Eric were going there to get some plants. It was not until early evening Brad learned of emergency vehicles at his parents' home. He rushed there only to grasp the magnitude of what had happened.

Police found literature concerning respite care on an office desk in the study where they found Roberta's body. Eric's defense attorney would later add that Roberta had also been looking at information about holidays. According to the defense attorney, Roberta's search for respite care and her seeming interest in holidays had led to a violent incident between them in the past. Had these interests fed into Eric's abandonment anxiety? His fear of rejection? Had Eric, in the seeming midst of his confusion, still had the wherewithal to plan to kill Roberta, only to lapse into a seemingly confused state in the aftermath of the act? Eric's potential drift in and out of seeming reason and lucidity stand in startling juxtaposition to notions of mens rea and criminal culpability.

The kitchen sink contained water. Roberta's glasses were folded on the drainer as if they had been cleaned and left to dry. When police arrested Eric, he was wearing a pair of shorts. A blood spot on those shorts had DNA that matched Roberta's. Piecing together what had happened proved difficult, and the court transcripts stress the reason for Eric's violent behavior "cannot be conclusively determined."[17]

Eric made a number of unsolicited statements to police after his arrest. These included, "I've killed her" and "I've done a terrible thing."[18] Investigators soon realized Eric was unable to understand the police caution that whatever he may say might be used against him, hence he was not formally interviewed. He was initially detained at the state's only secure forensic mental health facility. There he was seen by psychiatrist T. He remained only a short period of time. In her report, Dr. T noted no incidents of aggression or hostility. Indeed, Eric presented as "amiable and cooperative."[19] However, during his brief confinement he remained totally disoriented in time, place, and person. Dr. T noted no paranoia or psychosis. Eric "continually asked when his wife was coming to visit him."[20] He was deemed a low risk of harm to others although other patients posed a risk to Eric. His physical condition rendered him vulnerable to falls too. Indeed, he was unable to receive the level of care he needed in this setting and she recommended Eric be transferred to an old age psychiatric facility. She affirmed he was unfit to stand trial because of his advanced and irreversible dementia. Eric was released on bail to a secure mental health ward in a public hospital.

Dr. Z, a consultant psychiatrist at the public hospital, assessed Eric during his stay at the older adult mental health ward. Upon admission Eric was very confused and agitated. He attempted to abscond so was placed in a locked ward. There observers realized the full extent of his confusion and disorientation. Dr. Z observed that Eric mostly wandered around in a state of quiet contentment. However, he needed considerable prompting and supervision to get through the daily rhythms of life. He spent five days in the locked ward before being transferred back to the older adult mental health ward. Dr. Z noted only two episodes of aggressive behavior, the last of which involved Eric kicking and banging on the nurses' station door. Eric could give no explanation for his behavior and it seemed purposeless to observers. Staff responded to Eric's aggression through a combination of behavioral and pharmacological interventions. His only subsequent behavioral transgressions involved episodes of mild confusion upon nighttime waking and intermittent and inappropriate stripping off of his clothes.

Authorities transferred Eric to a locked unit at the same hospital for older adults with mental illness. In her report, Dr. V, a consultant forensic psychiatrist, notes Eric was unable to converse with her. He knew his name but not his date of birth. Apparently, Eric believed he was "young and did not know where he was, what year it was or his home address."[21] He provided no information and did not know his wife was dead. Dr. V noted Eric having severe memory loss, especially for recent events. He could not dress himself, attend to his own hygiene, eat, or process questions and follow instructions. Adding to the earlier diagnosis of VaD, she stressed that Eric had advanced AD. His prognosis was very poor and she expected further losses in functioning, including total dependence in the near future. In Dr. V's opinion, Eric was unfit to stand trial.

Dr. H, a psychiatrist, also saw Eric. He reported it was impossible to establish rapport with him. Eric's speech had become "incoherent and his thinking disorganized."[22] He could not provide any personal information about himself, follow instructions, or respond appropriately to simple questions. Significantly, he "made nonsensical statements sometimes accompanied by agitation and anger."[23] Like Dr. V, he opined Eric was unfit to stand trial and would never become fit for that purpose. He was eventually placed in a specialist, secure residential facility that cares for behaviorally disturbed dementia sufferers.

Because He Was Red

In a rare female-perpetrated overkill, Patricia Kees, age 68, shot her husband, Dean Kees, age 60, 14 times and then dragged his corpse to a ravine near their house. The rifle she used was bolt action and held a five-round magazine. She would therefore had to have reloaded the gun at least three times. The couple lived in El Paso, Wisconsin. With blood on her face and clothes she then went to Langer's Bar in Ellsworth, Wisconsin, just a few miles from their home. There she ordered a drink and told patrons her husband had died. The Pierce County Circuit Judge, Joe Boles, placed Patricia at the Mendota Mental Health Institute for a 15-day in-patient psychiatric evaluation. Investigators noted she first denied killing Dean then later admitted to doing so. She apparently told police she cleaned up "red" around the house and, using a rug, dragged his body out of the house "because he was red."[24] During their interview with Patricia they noticed she had a hard time recalling her age and the year. Her defense attorney, Mark Gherty, expressed "real concerns" about her mental health because when he met with her "Things weren't clicking."[25]

Doctors at the Mayo Clinic Health Systems in Eau Claire, Wisconsin, determined she had experienced an undiagnosed stroke two years prior to the killing. She was diagnosed with dementia and a softening of the brain, which they suspected to be AD. During her court hearing, she asked investigators if she could go home. In general, she appeared not to appreciate the seriousness of her predicament. When told by police that her husband was dead, she asked, "He is?"[26] The investigator confirmed Dean's death. She then said, "Oh, OK. Hmm . . . hmmm . . . Yeah, I shouldn't have done that."[27] When police apprehended Patricia at Langer's Bar, she had blood on her face and clothes and smelled of alcohol.

Patricia was deemed incompetent to stand trial and placed in a secure mental health facility. Her case reminds us that the psychotic behavior associated with AD might be exacerbated by alcohol use. We do not know if such exacerbation happened in Patricia's case. But in general, the research on psychotic behavior in combination with drug or alcohol abuse clearly points to greatly elevated risks of violence, particularly homicidal violence, especially among women. A systematic review of 20 studies involving 18,423 individuals with schizophrenia and other psychoses found a one- to seven-fold elevated risk among men and a four- to 29-fold increased risk among women compared with general population controls.[28]

Possible Misrecognition Cases

Henry Michaels ("Spiked Railings," Chapter 1) who was likely suffering from DLB, introduced the possibility that PWD who kill do so in a dissociative state or possibly as a result of misrecognition syndrome, sometimes referred to as Capgras syndrome. Such possibilities give us pause when considering other killings by PWD involving confusion as to their eventual victims' identities. For example, we learn from the *Columbus Dispatch* that 72-year-old Booker Moody fatally shot to death his granddaughter, 19-year-old Jordan C.V. Williams, after "mistaking her for an intruder."[29] Jordan returned home without her keys a little before 11:00 p.m. on the night of August 15, 2018. She knocked on her grandfather's first floor bedroom window in an attempt to get him to let her in the front door. Apparently fearing someone was breaking into the home, a possible persecutory delusion, Booker fired his shotgun through the window, killing Jordan. Booker was deemed incompetent to stand trial and was held in a secure nursing facility. In addition to his dementia, he also had heart problems. His daughter, Tracy Brown, noted her father's dementia and commented, "I know personally if he knew it was her, he wouldn't have killed her."[30] Speaking highly of her father, Tracy reported she would await her father's release so she could care for him.

In another case which involved failure to recognize family members and persecutory delusions, Bobby King, age 79, shot and killed his wife, Dorothy, age 84, and his caregiver daughter, Cynthia, age 55. According to his granddaughter, Karen Evans, Bobby would always be remembered as a "very good grandfather."[31] Karen noted Bobby suffered from depression and other mental illness as well as dementia. The killings occurred at their Spring Lake, North Carolina, home near Fort Bragg. King, a US Army veteran, had apparently been in declining mental health in the years before the killings. Police had previously attended the residence in response to calls that Bobby threatened Dorothy after accusing her and others of taking his property. As in *Moody*, the family stood by Bobby in spite of his double killing. At the hearing, we learn from press accounts that family members gasped and wept as King entered the proceedings using a walker. His daughter, Cheryl, remarked, "He has no idea what's going on. He says he does, but he doesn't." She said the family supports Bobby and that, "We do forgive him. We'll be with him to the end."[32] At another point, Cheryl commented that her father "didn't know who I was."[33]

Larry Dillon, age 65, had AD. He apparently thought his wife and granddaughter "were in trouble" and fired his gun through a wall several times, killing his wife, Sandra Dillon, age 63, but not shooting his 9-year-old granddaughter. The killing occurred inside their home at the White Oak Valley Mobile Home Park, Bluefield, West Virginia. Dillon, a disabled coal miner, had been using a wheelchair since a coal mining accident 43 years prior. According to Princeton police, there was no history of domestic violence in this case.

Readers will recall the case of Henry and Gloria Michaels. The couple had lived in the same quaint English village for their 50 years or so of marriage. A focal point was the old church, surrounded by a black iron fence with spiked railings. Henry contracted dementia in his later seventies, probably DLB. Like Bobby King, Henry had accused his wife of stealing his property. Similar to Larry Dillon, the disabled coalminer, Henry had a serious disability. In his forties, he had fallen off of a ladder, injuring his back. There is no record of an accompanying head or brain injury. The fall resulted in lifelong severe back pain which eventually led to early retirement at age 43. Henry received an invalidity pension. The couple adjusted their lifestyle, living within their means.

In a manner recalling the lead-up to the homicidal violence of Bobby King, Booker Moody, and Larry Dillon, Henry Michaels appears not to have recognized the wife he killed. All four men were found mentally unfit to stand trial and placed in long-term mental health care facilities.

In *Moody* and *Dillon*, it appears the culprits were fearful and confused and reacted violently, killing family members. Neither Booker Moody nor Larry Dillon came face to face with what they apparently perceived to be the intruder. It seems unlikely either man killed because they "knowingly" responded to an imposter. Put differently, neither *Moody* nor *Dillon* appears to be a Capgras or other type of misidentification case.

In the killing by Bobby King, the limited data make it more difficult to rule out a Capgras or other type of misidentification case. In addition to his dementia, Bobby, an army veteran, also suffered from depression and an unspecified form of mental illness. In other words, he was mentally ill, but the diagnosis was not publicly known.[34] Like Henry Michaels, Bobby had previously accused his wife of stealing from him. Like Henry, police had previously been called to the residence for at least one dementia-related disturbance. Like Henry, Bobby, at times, did not recognize family members. Bobby seems to have killed his wife and daughter in a face-to-face encounter. We have no information about whether he mistook one or both of them for someone else or an imposter. In cases of CS, the deluded believe that a familiar person has been replaced by an imposter. Sadock and colleagues note patients with DLB "often have CS."[35] Their observation may be relevant to *Michaels* since Henry's most likely diagnosis was DLB.

Other variations of CS, not necessarily relevant to the cases I have narrated, may be worth bearing in mind. These include Fregoli's phenomenon, a condition in which the delusion involves the sufferer believing that "persecutors or familiar persons can assume the guise of strangers."[36] A much rarer delusion known as intermetamorphosis entails sufferers believing "familiar persons can change themselves into other persons at will."[37] These forms of mental illness are associated with dementia, schizophrenia, and epilepsy.

According to Bourget and Whitehurst, CS occurs in 20–30 percent of Alzheimer's patients.[38] The research literature indicates a higher incidence of severe acts of violence in the delusional disorders compared with other psychiatric disorders.[39] This is especially true in CS cases. Bourget and Whitehurst's summary of four CS cases comports with earlier research which showed that people with CS "pose significant danger to others."[40] All four individuals had committed severe acts of interpersonal violence, including killing a family member. Each exhibited psychosis following the violent act. "All four held delusions of misidentification and directed their violent act(s) toward the misidentified person(s). For each individual, there was evidence of persistent and long-standing delusional ideas of persecution and (or) paranoid ideation."[41] The researchers note command auditory hallucinations in two cases. Three of the four displayed a blunted affect. Bourget and Whitehurst point to other research suggesting that family members are often the target of CS violence, violence that is "usually well-planned."[42]

In a letter to the editor of the *Nebraska Medical Journal*, physician Gary Blount concurred with earlier reports in the literature about the dangers posed by some CS patients. Dr. Blount followed a group of 50 chronic schizophrenic patients over a two-year period. Three of these patients exhibited CS symptoms. Of these, two killed people brutally. One "bludgeoned and then decapitated his 82-year-old stepfather after quarreling with him about the need for the patient's hospitalization."[43] One wonders if Gloria Michaels, as implied by the police officer present at the incident at the neighbor's house the day preceding the killing, mustered the emotional energy to seek outside help, a move Henry found objectionable, triggering the brutal homicide?

Notwithstanding these earlier case reports concerning the potential dangerousness of people with CS, later research, with much larger and perhaps less discerning data sets, suggests the extant research association between CS and violence is overblown, possibly resulting from publication bias in the medical/psychiatric literature. Currell and colleagues identified 34 CS cases in a large healthcare database from a major London provider of secondary and tertiary health services. They found no cases of CS delusion where violence was reported, and only 6 out of 34 reports involved verbal hostility toward the subject of delusional replacement.

Like Booker Moody (heart problems), Bobby King (limited mobility), and Larry Dillon (wheelchair-bound), Henry suffered serious health problems. These problems grew in the years before he violently killed Gloria. They included chronic obstructive pulmonary disease (COPD), rheumatism, osteoarthritis, an aortic aneurysm, sciatica, and in later years, incontinence. At this point it is important to note that what we call the mind and body, and the brain and body, cannot be separated. I return to this matter when I try to make sense of the gray mist killings in Chapter 9.

Caregiver-Killers With Abnormalities of Mind

The Ballroom Dancer's Promise

A case from the UK with rich documentary sources underlines the complex intersection of mercy/compassion and exhaustion. It involved Malcolm Carter who knifed to death his wife, Julia, a woman in the seemingly agonizing throes of AD. There is also overlap with the mental illness cases insofar as Malcolm developed an "abnormality of mental functioning"[44] fueled by depression and insomnia. His state of mind resulted in the court accepting his plea of guilty to manslaughter by diminished responsibility.

In the early hours of the morning, Malcolm stabbed Julia in the heart, killing her. He then called police to tell them he fully intended to kill her, that she had dementia, and that she had been asking him to kill her. Both spouses were in their late seventies. According to the judge who sentenced him, they had been happily married for nearly 60 years. The judge described the case as exceptionally sad and tragic. The DHR team reported the couple and their children "enjoyed a close and loving family atmosphere . . . with no previous history of domestic violence, or any other form of abuse."[45] Julia worked in government and also actively cared for her grandchild. The couple enjoyed ballroom dancing and volunteered for a local charity. Malcolm was an ex-serviceman. In later life, he worked in the motor industry.

Six years before Malcolm killed Julia, her health took a turn for the worse. She had a relatively minor and routine medical procedure in the hospital to remove hemorrhoids. It appeared to go well. However, about a week later, she went to the hospital complaining of abdominal pain, a UTI, and other symptoms. Julia was catheterized. She found this traumatizing. In his sentencing remarks, the judge noted Julia "complained of pains all down her legs and not being able to sit down and of her skin being 'on fire' and not wanting to wear clothes."[46] Medical professionals could not identify the cause of the problem. A letter summarizing the medical review of her case notes stated, "the symptoms described are virtually impossible to explain from a neurological point of view."[47] The medical review recommended an urgent referral to a psychiatrist for "pathological stress reaction to an uneventful surgical procedure."[48]

Julia's memory problems emerged roughly three years after the traumatic surgery. She soon became unable to remember how to use a light switch or how to wash herself. Her medication for generalized anxiety disorder was increased soon after her memory began to fail her. She continued to take antidepressants, pain medications, and sleep medications. Julia's deterioration intensified greatly after the death of her brother-in-law, Ronnie, ten weeks before her own demise. Her extreme reaction to Ronnie's death resulted in acute anxiety and hyperventilation. At one point, an ambulance came to the home. Julia was rocking back and forth, crying and wailing.[49] Malcolm endured Julia's prolonged bouts of wailing. He described these as "incessant and horrendous."[50] She was readmitted to the hospital just three weeks before Malcolm killed her.

The DHR team did not report the possibility that Julia's anxiety stemmed from any intimate terrorism or coercive control on Malcolm's part. Neither did the team consider Julia possibly had an intimate relationship with Ronnie and that such a relationship might have provided Malcolm a motive to murder her. A key informant and member of the review team told me there were two main interpretive camps: (1) psychologists and psychiatrists who thought Julia's mental health problems stemmed from her physical problems and (2) doctors who treated her physical problems who thought they were routine and that her mental health problems came from elsewhere. She stayed in the hospital for two weeks during which time she uttered phrases such as "I don't want to live like this" and "I don't want to live anymore."[51] The overall hospital assessment/working diagnoses included "dementia" and an "acute psychotic episode due to bereavement."[52] Five weeks before her death, Julia mentioned seeing Ronnie even though he had already passed away. She made these statements to Malcolm, their adult daughters and Malcolm's sister. Three days before her death, her General Practitioner (GP) made a referral to the old age psychiatry service for generalized anxiety disorder. The referral stressed "she is still declining mentally, more confined to her bedroom and expressing suicidal ideation."[53]

In the wake of the homicide, Malcolm shared Julia had repeatedly said to him, "You promised me."[54] Malcolm took this to mean he had promised he would not let her suffer. Apparently, he had to take her to the toilet repeatedly, as many as 20 times a day. On occasions, he said he comforted her there for several hours. Dementia symptoms tend to be worse at night, and Julia's situation was no exception. She woke frequently. Malcolm reported never sleeping more than two or three hours at a time. He found it increasingly difficult to cope. Malcolm appears to have kept these feelings to himself.

The judge acknowledged Malcolm's devotion to Julia, noting that Malcolm felt duty-bound to care for Julia himself. It was only in the last 72 hours of Julia's life that Malcolm asked for extra help from social services. Furthermore, the judge noted Malcolm had not slept for 24 hours in the lead-up to him killing his wife. In those fateful early morning hours when his tiny part of the world was dark, Malcolm called police to report, "I have just killed my wife. . . . She's in dementia; she's not slept for two days and she's very, very, distressed telling me to help her to go."[55] Once police arrived, he led them to the downstairs bedroom. They found Julia lying on her back with a kitchen knife sticking out of her upper abdomen, just below her ribcage. Malcolm informed police, "I gave her medication tonight, she has been struggling to go to the toilet, she was asking me to help her and said that I had promised."[56] He then explained to an officer, "I was in the Army. I was taught to do it properly."[57]

Interviewed by police, Malcolm explained the previous two days had been especially difficult. He told them, "She's never been as bad as this; she's never, never screamed, it was like a howl."[58] Julia apparently told Malcolm that she did not want to go to the hospital. She spat out her sleeping pills and was trying to remove the catheter again. Malcolm then explained that at that juncture he went to the kitchen. She was screaming, howling. "I walked straight in and stabbed her and that's it. Finished. I put some new underwear on her . . . and kissed her and said I love you."[59] Investigators found no evidence of defensive injuries or injuries indicative of forceful restraint or resistance on Julia's part.

In *Carter*, the judge, with helpful input from consultant psychiatrists for the defense and prosecution, issued a non-custodial disposition.[60] The defense psychiatrist was Dr. J and the prosecution's Dr. K. The two psychiatrists concurred that Malcolm killed Julia while suffering "from an abnormality of mental functioning brought about by a combination of a moderate depressive episode (or adjustment disorder) combined with enforced insomnia."[61] Dr. J referenced a "perfect storm of events"[62] which led to the killing. These included Julia's worsening health, Ronnie's death, Malcolm's exhausting care regimen, and Malcolm's stoical nature and pride that manifested as him feeling it was his duty to care for Julia. These case elements "affected his rational judgment at the material time and his ability to exercise self-control"[63] and provided an explanation for the killing. The judge was satisfied that Malcolm killed Julia on impulse rather than as part of a murder plan. Malcolm pleaded guilty to manslaughter by diminished responsibility committed under conditions of extraordinary stress.

In passing sentence, the judge referenced numerous testimonials that spoke glowingly about Malcolm, his love for Julia, his contributions to the community, and his impeccable character. The judge wrote, "An immediate custodial sentence for manslaughter is not required. . . . This seems to me to be a paradigm case for leniency and mercy."[64] Malcolm received a sentence of two years imprisonment, suspended for two years.

A Cremation at Home

In the early hours of the morning, a member of the public spotted smoke rising from the home of Ellen Ash, age 83, and her son, Jeffrey Ash, age 50 (real names).[65] Ellen had AD and various co-morbidities. Jeffrey was her primary carer. Firemen found Ellen's badly burned corpse on the living room floor. They located bottles of white spirit and turpentine substitute scattered around the detached house in Glasgow, Scotland. Jeffrey had smothered his mother, set the house on fire, and caught a bus to London, where he turned himself in to the police. Jeffrey told the police he had caused his mother to fall over. He then "covered her nose and mouth and leaned with as much pressure as he could for about four or five minutes until she died."[66] Jeffrey acknowledged his growing inability to cope and his concern for his mother. "I could not see her suffering any more," he told police. Notably, "I could not stay around there anymore—I had to get away."[67]

Jeffrey pled guilty to charges of culpable homicide and willful fire-raising and was jailed at the High Court in Edinburgh. He was eventually sentenced to 40 months in prison. The court heard he could no longer cope with his mother's terrifying hallucinations, her failure to recognize him, and the burden of caring for her. Psychiatrists examined Jeffrey after the killing and concluded he was suffering from an abnormality of mind when he killed his mother.

The significant case review into Ellen's killing laid out her worsening dementia and other co-morbidities, Jeffrey's difficulties attending to her many needs, and the failure of social and health services to coordinate her care and protect her properly. As one GP explained, *Ash*, among other cases, reflected the inherently unsafe nature of the Scottish social care system.[68]

My interest is not in the failure of various state systems. Rather it is to point out, as in *Carter*, the BPSD that confronted Jeffrey. In reading out Jeffrey's confession in court, Mr. Scullion, the prosecutor, acknowledged that the abnormality of mind "substantially impaired his ability" to control his actions.[69] Mr. Scullion reported that Ellen's GP had noted that in the period leading to her death she was "very difficult to treat" and "extremely un-cooperative" due to her illness.[70] Remarking on the fire-setting, the prosecutor reported Jeffrey's words to police that after determining his mother was dead "he then decided to set fire to the house to give his mother a cremation."[71] The significant case review enlightens us further.

Three years before her death, Ellen was admitted for the first of six extended stays. Her AD had been exacerbated by frequent UTIs. She stayed almost three months before being discharged to a community clinic associated with the Older People's Mental Health Service. Five months later, she was admitted again after being found bruised on the floor of her home. She was doubly incontinent. On her third visit, just two years before her death, she was refusing fluids and food and was incapable of making decisions concerning her treatment. Hospital case notes described her as "unkempt on admission, confused, constantly wandering and verbally aggressive."[72] She also had chronic confusion and extensive bruising, the result of banging into furniture at home.

Jeffrey reported numerous times that his mother refused to enter a nursing home or other care facility. He had no power of attorney over her. At times, Ellen would refuse to bathe, on some occasions going weeks without a bath. Throughout this period of three years prior to killing her, Jeffrey was her primary carer. He told authorities he worked away from home a lot. Questions were raised about Jeffrey being neglectful. The failure to coordinate Ellen's care or to proactively protect her resulted in her receiving just two carer visits per day, reduced to one per day in the last year of her life. Jeffrey continued as primary carer but increasingly began to tell authorities he could no longer cope.

Mrs. Ash scored just 10 out of 30 on a Mini-Mental State Exam (MMSE) test administered just four months before her death. At times she did not recognize Jeffrey. He told social workers that his approach to dealing with her repetitive behavior was to go into another room. Try as he did, Jeffrey could not persuade his mother to enter a care facility. Her intransigence regarding entering a care facility is common. It is a cause of frustration among carers who feel caught between a rock and a hard place. As the judge put it, Ellen Ash "had become virtually impossible to care for."[73]

The court decisions regarding abnormality of mind and diminished responsibility in *Carter* and *Ash* referred to temporary and unusual states of mind at the time of the killing. Such states of mind help explain the homicidal behavior of some caregiver-killers. These states of mind are very different from the chronic and usually worsening states of mind of the PWD that they kill.

Mental Illness Among Killers With Dementia and Caregiver-Killers

There are other differences in mental health between the two subgroups of perpetrators, PWD and caregivers, that transcend the summary judgments embedded in court decisions regarding gray mist killings. All perpetrators with dementia evidenced a range of mental health problems. Only a relatively small number of caregivers were deemed by courts to have been experiencing an abnormality of mind or mental disorder at the time they killed a family member with dementia.

Criminal courts use various experts (e.g., physicians, psychiatrists, psychologists, neurologists) to speak to matters of diminished responsibility, abnormalities of mind or mental disorders at the time of a killing. These determinations range considerably in their level of detail. Australian trial transcripts stood out in terms of the amount of publicly available mental health data. Given the range of these data and the difficulties in comparing them across jurisdictions, US states, and countries, Table 6 reports only the four lowest common denominators, or low-hanging fruit.[74] Three concern mental illness: (1) whether the perpetrator had mental illness in the form of dementia, (2) whether the perpetrator was mentally unfit to stand trial, and (3) whether the criminal court determined the perpetrator had diminished responsibility due to an abnormality of mind or mental disorder at the time of the killing. The fourth concerns whether the homicide qualified as an overkill (see Chapter 1), a possible proxy for the degree of rage of the offender and a crude indicator as to whether we classify the homicidal act as a form of impulsive and/or expressive violence as opposed to instrumental violence to achieve a specific goal.

Three out of 54 cases (6 percent) involving perpetrators with dementia ended in homicide-suicide.[75] With no one to prosecute, no criminal trial ensued, hence there was no determination of fitness to stand trial or a detailed court-generated mental health assessment that might have signified diminished responsibility. In another six of the 54 cases, I could not find legal assessments of mental health concerning either fitness to stand trial or diminished responsibility. Therefore 45 of the 54 perpetrators with dementia received mental health determinations from the criminal courts. In nearly three-quarters of these cases (33 out of 45; 73 percent) courts ruled perpetrators unfit to stand trial. Just over a quarter of the 45 cases (12 out of 45; 27 percent), that is, all of those that went to trial (12 out of 12; 100 percent), resulted in rulings that the perpetrator had diminished responsibility due to an abnormality of mind or other mental disorder at the time of the killing.

These outcomes contrast rather sharply with dispositions in cases involving caregiver-perpetrators. In just 11 percent of all caregiver-killer cases (5 out of 44), courts determined perpetrators had diminished responsibility due to an abnormality of mind or other mental disorder at the time of the killing. In only one out of 44 cases (2 percent), did the criminal courts determine the killer was unfit to stand trial? As we will see in the next chapter, the vast majority of the caregiver-killing cases involved various combinations of mercy, exhaustion, and related themes.

PWD committed 24 out of the 26 (92 percent) overkills among the 100 cases. Caregivers committed only two (8 percent). This contrast reflects the fact that PWD were more likely to engage in what criminologists refer to as impulsive or expressive, rageful violence, compared with the violence of caregivers, which was more measured, calculated, or instrumental, sufficient to get the job done. I return to these important differences in Chapter 9.

Closing Reflections

The dementing illness evident in the case narratives involved chronic and severe cognitive, emotional, and functional disturbances. We have little information about what such dementing illness meant to these dementia sufferers and other family members or whether any of these parties saw the BPSD as mental illness. We can only infer the state of mind and emotional condition of killers suffering from dementing illness around the time they killed. In several cases one might speculate the dementing illness reached a particularly acute state, a fever pitch, as if perpetrators crossed a threshold. In the aftermath of the killing, perpetrators exhibited considerable confusion, some apparently forgetting they had killed, others apparently forgetting their spouse was dead, others appearing not to be "present."

Alzheimer's sufferer Larry Dillon somehow thought his wife and granddaughter were in trouble and discharged his weapon, apparently in a confused attempt to respond to the situation. In so doing, he may have discharged some of his own fear and anxiety. Booker Moody perceived his home was under threat and fired similarly.

Bobby King killed his wife and daughter after accusing his wife of stealing from him. Depression and other unspecified mental illness accompanied King's dementia diagnosis. In *King*, we witness persecutory delusions and cannot rule out CS.

These delusions also surfaced in *Michaels*. The day before he killed his wife, Gloria, Henry Michaels accused her of stealing his money. On numerous occasions prior to the killing, he did not recognize Gloria. Again, we cannot rule out CS or imposter syndrome. In the opinion of the police officer who was at the incident the day before Henry killed, Gloria may have made a decision to seek outside help, a development that may have alarmed Henry and triggered the homicide.

Eric Moseley suffered from AD and VaD. At the time of the killing, it seems likely he feared Roberta was considering a vacation and contemplating an assisted living placement for him. Finally, Pearl Padgett, at one point in the court proceedings thought to suffer from bvFTD, knifed husband Jim to death after what appears to have been an irritating altercation that seemingly tapped into a habit of her giving in to him. All these cases suggest that the boundary between impulsive and instrumental violence is cloudy not clear, a fact I revisit when I attempt to make sense of these killings.

Pearl Padgett and Eric Moseley had different memories of killing. Pearl told detectives she snapped and felt like a different person as she stabbed Jim. It was almost as if she had something akin to an out-of-body experience or dissociative episode. Her recall of killing appeared clear, acute, and lasting. It likely contributed to her guilt and perhaps her suicide. In *Padgett* we apparently do not see intense perpetrator fear and anxiety associated with a misinterpreted external threat. Rather, if we are to believe Pearl's account, we see one concession too many that appears to have led to homicidal hostility. The build-up of homicidal hostility in *Padgett* appears gradual, perhaps involving many years of concessions or compromises along with possible accumulating resentments. It is difficult to tell whether Pearl somehow felt emotionally persecuted by Jim.

We must ask if her neurodegenerative disorder, whatever its final psychiatric label, potentiated her act of homicidal violence. How might such potentiation have occurred? Her sudden resort to violence may have had its roots in the chronic pattern of concessions and compromises she could no longer tolerate. Did Pearl's biochemistry somehow change and potentiate her act of homicide? Is there a molecular component to the explanation? Perhaps a sudden surge in the presence one chemical or another? Is it somehow possible to infer retroactively the existence of such a chemical surge from testing subsequent to the homicide? I return to these thorny questions. Suffice it to say at this point that no such conclusive testing emerged in *Padgett*. On the contrary, subsequent psychiatric testing did not confirm earlier and incomplete assessments that she had bvFTD.

According to his neighbor, Eric Moseley was confused at the crime scene, saying there was a little dead girl in the house. Eric made unsolicited statements to police, such as "I've killed her" and "I've done a terrible thing." However, Eric also seems to have forgotten that he killed his wife. In the early stages of post-arrest institutionalization, Eric was totally disoriented in time, place, and person, and he would ask when Roberta was coming to visit him.

In summarizing the dementing illness that the narratives illuminate, words like mysterious and puzzling come to mind. Any altered states of mind, soul, and self that appear to have informed the killings by those with dementing illness coexisted with various and often debilitating medical problems and, in some cases, adversarial relationship dynamics. These dynamics may have taken the form of what Tom Kitwood referred to as malignant social interactions.

As noted, our sources of data contain little information about perpetrator perspectives on their dementing illness and their overall plight. We learn little about how they felt about the course of their neurodegenerative disease. Articulate sufferers of psychoses such as Elyn Saks have emphasized their "utter terror and confusion" regarding what she has come to describe as the disorganization of the self that accompanies a psychotic break. Was it the same for our perpetrators? Did they experience "utter terror and confusion" before they killed? Did some of those with dementing illness experience psychotic breaks and enter a similar realm of chaos and incoherence, a loosening of their frames of reference, a distancing from the prohibitions and inhibitions of modern life? Do we see, in the neurodegeneration, an unknotting of the regulatory ties that Norbert Elias refers to as the civilizing process?[76] Or, to use Freudian language, an undoing of modern era repressions? Increasingly distanced from behavioral mores, a significant number of PWD exhibit behaviors others interpret as aggressive and adversarial, traits that may seem at odds with their declining physical strength. These transgressions may take the form of hitherto unheard lewd remarks, uncharacteristically contrary or hostile behavior, verbal abuse, and, at times, violence. Their growing incoherence and seeming contempt for taken-for-granted mores become increasingly problematic and at times frightening for those who live with and/or care for PWD. If they did suffer these adverse experiences, what may have further potentiated them to kill? The evidence points to most gray mist killers with dementing illness, possibly not Pearl Padgett, experiencing fear, perhaps even terror. Did any fear and terror drive or contribute to their homicidal acts?

We might frame perpetrators' apparent de-centering as involving the interplay of biological and psychosocial forces. Biological forces might include the biochemical imbalances, the adverse influence of various genes, and damage to the brain and nervous system. We must also include pharmaceutical interventions and their possible adverse side effects, or the failure to receive medications that may have prevented the violence (rivastigmine in the case of Henry Michaels). Psychosocial forces might include perpetrators' socioemotional biographies and their malignant social interactions including what they perceived as threatening, provocative, or seemingly taunting or provocative behavior of carers or others. But the mysteries remain and the haunting presence of the inexplicable looms large.

None of the 43 caregivers who killed a wife or mother with dementing illness suffered from mental illness sufficient to render them unfit to stand trial. As noted, this contrasts sharply with the almost three-quarters of PWD who killed subsequently deemed unfit to stand trial. The five caregivers determined to have had diminished responsibility for their acts of homicide exhibited temporary abnormalities-of-mind. These determinations reflected the input of expert testimony from professionals such as physicians, psychiatrists, psychologists, and neurologists. I have framed them as get-out-of-jail free mechanisms undergirded by a sense of compassion and understanding on the part of the courts. I do not make this observation out of a sense of cynicism but rather as a reminder of the growing pressure on the courts over the dementia-related killings present. The killings are just the tip of the iceberg. If we add cases of abuse of and by PWD, including financial offenses against them, it might be worth considering setting up specialist courts to deal with cases involving dementing illness. These courts would be homologous to other specialist courts dealing with transgressions related to domestic violence or drug addiction. At a minimum, it would be helpful to generate more research to learn about how different legal jurisdictions handle these matters. My convenience sample only scratches the surface in this regard.

Notes

1 See Appendix, Table 4: Overview Characteristics of the 54 Gray Mist Killings by Perpetrators with Dementia.
2 The DHR report uses the words "out of the blue."
3 Language from the DHR report.
4 Language from the DHR report.
5 Language from the DHR report.
6 Language from the DHR report.
7 Language from the DHR report.
8 Media source withheld to preserve anonymity.
9 Information from the DHR.
10 Quote from newspaper report of the coroner's inquest. Source withheld to preserve the anonymity of the parties.
11 Researchers note bvFTD is under-recognized and commonly misdiagnosed. See, for example, P. S. Pressman and B. L. Miller, "Diagnosis and Management of Behavioral Variant Frontotemporal Dementia," *Biological Psychiatry* 75, no. 7 (April 2014): 574–81, https://doi.org/10.1016/j.biopsych.2013.11.006. For a discussion of the difficulties distinguishing between bvFTD and primary psychiatric diagnoses and the problem of inaccurately diagnosing bvFTD, see P. S. Pressman, D. Matlock, and S. Ducharme, "Distinguishing Behavioral Variant Frontotemporal Dementia from Primary Psychiatric Disorders: A Review of Recently Published Consensus Recommendations from the Neuropsychiatric International Consortium for Frontotemporal Dementia," *Journal of Neuropsychiatry and Clinical Neuroscience* 33, no. 2 (Spring 2021): 152–56, https://doi.org/10.1176/appi.neuropsych.20090238.
12 J. Diehl et al., "Frontotemporale Demenz und delinquentes Verhalten" [Misdemeanor in frontotemporal dementia], *Fortschritte der Neurologie-Psychiatrie* 74, no. 4 (April 2006): 203–10, https://doi.org/10.1055/s-2005-870962 cited in M. Liljegren, M. L. Waldö, and E. Englund, "Physical Aggression Among Patients with Dementia, Neuropathologically Confirmed Post-Mortem," *International Journal of Geriatric Psychiatry* 33, no. 2 (February 2018): e245, https://doi.org/10.1002/gps.4777.
13 M. Liljegren et al., "Criminal Behavior in Frontotemporal Dementia and Alzheimer's Disease," *JAMA Neurology* 72, no. 3 (March 2015): 295–300, https://doi.org/10.1001/jamaneurol.2014.3781.
14 Liljegren, Waldö, and Englund, "Physical Aggression Among Patients," e245.
15 Liljegren, Waldö, and Englund, e245.

16 M. Zucca et al., “High Risk of Suicide in Behavioral Variant Frontotemporal Dementia,” *American Journal of Alzheimer’s Disease and Other Dementias* 34, no. 4 (June 2019): 265–71, https://doi.org/10.1177/1533317518817609. The authors also explore possible neurobiological correlates of suicidal behavior.

17 Quote from court transcript which if divulged would reveal the names of the parties.

18 Court transcript.

19 Court transcript.

20 Court transcript.

21 Quote from court transcript.

22 Quote from court transcript.

23 Quote from court transcript.

24 M. Longaecker, “Western Wisconsin Woman Charged with Shooting Husband, Hiding Corpse,” *Twin Cities Pioneer Press*, July 13, 2015, www.twincities.com/2015/07/13/western-wisconsin-woman-charged-with-shooting-husband-hiding-corpse/.

25 Longaecker, “Western Wisconsin Woman Charged.”

26 Longaecker.

27 Longaecker.

28 S. Fazel et al., “Schizophrenia and Violence: Systematic Review and Meta-Analysis,” *PLoS Medicine* 6, no. 8 (August 2009), https://doi.org/10.1371/journal.pmed.1000120.

29 J. Woods and J. Futty, “Man Who Fatally Shot Granddaughter He Mistook as Intruder Ruled Incompetent to Stand Trial,” *The Columbus Dispatch*, July 24, 2019, www.dispatch.com/story/news/crime/2019/07/24/man-who-fatally-shot-granddaughter/4615126007/.

30 Woods and Futty, “Man Who Fatally Shot Granddaughter.”

31 “Man With Dementia Charged in Shooting of Wife, Daughter,” *AP News*, September 16, 2016, https://apnews.com/article/45e222af634b49f883449f5bd9a3b3e1.

32 S. DeVane, “Family Wants Accused Killer Moved to Dementia Unit,” *The Fayetteville Observer*, September 16, 2016, www.fayobserver.com/story/news/2016/09/16/family-wants-accused-killer-moved/22380131007/.

33 P. Zarcone, “ ‘We Do Forgive Him,’ Says Family of Spring Lake Military Vet Charged With Murdering Wife, Daughter,” September 16, 2016, www.cbs17.com/news/we-do-forgive-him-says-family-of-spring-lake-military-vet-charged-with-murdering-wife-daughter/.

34 I requested the police files in *King* to no avail. A UK DHR might have explored the “unspecified mental illness” in greater depth than the review available through US data sources.

35 Sadock, Sadock, and Ruiz, *Synopsis of Psychiatry*, 710.

36 Sadock, Sadock, and Ruiz, 335.

37 Sadock, Sadock, and Ruiz, 335.

38 D. Bourget and L. Whitehurst, “Capgras Syndrome: A Review of Neurophysiological Correlates and Presenting Clinical Features in Cases Involving Physical Violence,” *Canadian Journal of Psychiatry* 49, no. 11 (November 2004): 720, https://doi.org/10.1177/070674370404901102.

39 Bourget and Whitehurst, “Capgras Syndrome,” 721.

40 Bourget and Whitehurst, 721. See also J. A. Silva et al., “Capgras Syndrome and Dangerousness,” *The Bulletin of the American Academy of Psychiatry and the Law* 17, no. 1 (1989): 5–14.

41 Bourget and Whitehurst, “Capgras Syndrome,” 721.

42 Silva et al., “Capgras Syndrome and Dangerousness,” 722.

43 G. Blount, “Dangerousness of Patients With Capgras Syndrome,” *The Nebraska Medical Journal* 71, no. 6 (June 1986): 207.

44 Language from the DHR report.

45 Language from the DHR report.

46 Court transcript. Source not disclosed to preserve anonymity.

47 Language from the DHR report.

48 Language from the DHR report.

49 The rocking back and forth comprises a primitive form of self-soothing. It is frequently a sign of extreme distress and may suggest anxiety, depression, or PTSD. See J. Navarro, "5 Ways That Body Language Can Signal Trouble," *Psychology Today*, January 1, 2014, www.psychologytoday.com/us/blog/spycatcher/201401/5-ways-body-language-can-signal-trouble.

50 Language from the DHR report.

51 Reported in Judicial Remarks from the court case documents, which, if cited would identify the case.

52 Language from the DHR report.

53 Language from the DHR report.

54 Language from the DHR report.

55 Sentencing remarks from court documents.

56 Sentencing remarks.

57 Sentencing remarks.

58 Sentencing remarks. Screaming and other disturbing vocalizations may be linked to pain. They may therefore be amenable to medical treatment. They might also be associated with atypical forms of depression, possibly amenable to antidepressant treatment, although the research literature on this matter remains unclear. See, for example, A. Bourbonnais and F. Ducharme, "Screaming in Elderly Persons with Dementia: A Critical Review of the Literature," *Dementia* 7, no. 2 (May 2008), https://doi.org/10.1177/1471301208091156. In nursing home settings, screaming among dementia patients is common and has been attributed to vulnerability, suffering, a sense of loss, loneliness, physical pain, clinical depression, and, some might say, calls for help or the need to fill a void with sound or emotion. These notes draw heavily from a report in "Screaming Among People with Dementia and the Nursing Home Setting," *Annals of Long-Term Care*, February 28, 2014, www.hmpgloballearningnetwork.com/site/altc/news/screaming-dementia-nursing-home. In particular, the news article cites A. Bourbonnais and F. Ducharme, "The Meanings of Screams in Older People Living with Dementia in a Nursing Home," *International Psychogeriatrics* 22, no. 7 (November 2010), https://doi.org/10.1017/S1041610209991670.

59 Sentencing remarks.

60 Meaning he was not sentenced to serve prison time.

61 Sentencing remarks.

62 Sentencing remarks.

63 Sentencing remarks.

64 Sentencing remarks.

65 I use real names in this case since there was no DHR process in Scotland at the time, the significant case review is a publicly available document, and most of the information derives from media and court sources, both publicly available.

66 B. Horne, "Glasgow Man Jailed for Smothering Demented Mother," *The Scotsman*, September 19, 2013, www.scotsman.com/news/glasgow-man-jailed-for-smothering-demented-mother-1560800.

67 "Jeffrey Ash Admits Smothering His Sick Mother Ellen," *BBC News*, August 19, 2013, www.bbc.com/news/uk-scotland-glasgow-west-23756865.

68 M. McCartney, "The Social Care System Has Become Inherently Unsafe," *British Medical Journal* 357, no. 8108 (June 3, 2017), https://doi.org/10.1136/bmj.j2329.

69 "Jeffrey Ash Admits Smothering."

70 Horne, "Glasgow Man Jailed."

71 Horne.

72 Cited in the Significant Case Review, Adult Protection Committee, Glasgow.

73 Significant Case Review, 4.

74 See Appendix, Table 6: Comparison of the Mental Health and Homicidal Behavior of Perpetrators With Dementia and Caregiver-Perpetrators.

75 See Appendix, Table 4: Overview Characteristics of the 54 Gray Mist Killings by Perpetrators With Dementia.

76 N. Elias, *The Civilizing Process* (Oxford: Blackwell, 1994).

4 Mercy and Exhaustion

Caregiver Burden

As we saw in the preceding two chapters, caring for PWD can prove difficult, if not impossible. The cases of Pearl Padgett and Eric Moseley remind us that PWD can use homicidal violence. Much more common is hostile, aggressive, suspicious, demanding, narcissistic, paranoid, and disinhibited behavior that subverts the norms of everyday civil discourse. Doubtless, these negative behaviors are a product of dementing illness and the social responses to it. The acute burdens felt by Malcolm Carter and Jeffrey Ash (Chapter 3) attest to the toll dementing illness takes on carers.

Those who care for PWD report many adverse behavioral and psychological symptoms including depression, anxiety, dysphoria, guilt, loneliness, distress, hostility, and aggression.[1] Early research among relatives who lived with someone with AD and served as a primary caregiver found 55 percent met the criteria for clinical depression.[2] In addition to feeling burdened by the totality of their situation, caregivers are motivated by many factors including "love, equity, morality, and greed."[3]

Interviews with the primary caregivers of 55 patients with dementia revealed feelings of anger, depression, and fatigue. Ninety-three percent of families reporting memory disturbances from PWD reported such behavior to be a problem. Other behaviors reported as problems included catastrophic reactions (89 percent), demanding/critical behavior (73 percent), hiding things (71 percent), communication difficulties (74 percent), suspiciousness (79 percent), making accusations (82 percent), daytime wandering (70 percent), delusions (83 percent), physical violence (94 percent), and incontinence (86 percent).[4] The behaviors that most frequently rose to the level of serious problems included physical violence, memory disturbance, incontinence, catastrophic reactions, making accusations, and suspiciousness.[5]

Research on caregiver homicidal ideations is difficult to conduct and therefore scarce.[6] However, there is sufficient information to show that caregivers occasionally admit to fantasizing or thinking about killing those for whom they care.[7] O'Dwyer and colleagues note that two of 21 participants in a qualitative study reported actively contemplating homicide while caring for a person with dementia.

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Their findings suggest, “homicidal thoughts in carers are a real phenomenon.”[8] Anderson and colleagues’ analysis of blogs written by family caregivers of people with AD and related dementias speculates that “thoughts of suicide and homicide may be more common than previous research suggests.”[9]

The caregiver-killing cases I narrate in Chapter 4 concern the complex interweaving of mercy and exhaustion. As noted in the preceding chapter, all 44 cases involved men caring for women with dementia. For organizational purposes, I focus on themes concerning mercy under a separate subheading than themes related to exhaustion. My separation is entirely arbitrary; clearly, the two co-occur. Seemingly genuine merciful sentiments appear prominent in some cases more than others. Similarly, exhaustion seems to play a more prominent role in some of the caregiver killings. In what follows, I use case studies to try to capture the range of involvement of mercy and exhaustion. My choice to emphasize these two themes among the caregiver killings derives in part from the evidence in the case documents and the language of the parties, including the courts, family members, neighbors, friends, and other important key informants.

Mercy

John Locke defined mercy as “the power to act according to discretion, for the public good, without the prescription of the Law, and sometimes even against it.”[10] The media use of the term “mercy killing” includes homicides committed by caregivers, nearly always older men, who kill their spouses/partners with dementing illnesses. Perpetrators do so supposedly as a means of releasing spouses/partners from the horror and suffering of dementing illness. Stated reasons often include their spouses/partners asking them to, not wanting their loved ones to go into a care facility, or because, perhaps paradoxically, it was the humane thing to do. There are many definitional problems concerning the use of the language of mercy killing.

Assigning the label “mercy killing” is highly subjective. It likely varies considerably across countries, communities, legal systems, review bodies, and media outlets. According to the CDC, for a killing to qualify as a mercy killing, the victim had to have been killed, at the victim’s request and out of compassion in order to end his or her pain or distress. Additionally, the suspect had to have acted to bring about the immediate death, allegedly in a painless way.[11]

The CDC definition raises many questions. How do we know the victim requested to die? Was such a request made once or consistently? Was the request recorded, perhaps notarized? Who recorded the request and might that person or persons have had a conflict of interest and possibly stand to benefit from the death? Was the person with dementia in a state of mind deemed capable of consenting to his or her own demise? In cases where PWD kill, their neurocognitive deficits sometimes render them unfit to stand trial and unfit to contribute to their own defense. We might therefore ask if such impairment undermines or negates such a person’s ability to freely request their own death.

How would we know if a mercy killer acted out of compassion? The killer or others might say he or she killed out of compassion, yet financial exigencies often loom large. Killers might stand to save a considerable amount of money by not paying for their spouse to enter an assisted living or nursing facility. These financial resources might be essential to the killer's own survival.

We might ask how adult children really know what caregiver-fathers were thinking and feeling when they killed wives with dementing illness? Is it not possible in some cases that adult children are ashamed by their father's act of killing and hence tend, if at all possible, to frame such an act in terms of compassion rather than murderous behavior?

The CDC qualifying criterion that the killing be painless raises obvious questions. Is a bullet in the back of the head, unseen and unanticipated, painless? Or did it hurt, perhaps agonizingly, only for the nanosecond from the time it was first felt until the moment of death? Can we dismiss nanoseconds of pain? Did the perpetrating spouse believe the bullet in the back of the head to be a painless way of effecting death? In the mind of the offender, was the bullet preferable to a likely long, slow death from dementia? A fate worse than death in a nursing facility that in the minds of husband and wife was tantamount to warehousing? The case studies encounter these issues.

Exhaustion

I employ the word "exhaustion" because it, or words like it, haunt the lives and case files of many of the 42 husband-caregivers. We also saw profound exhaustion in the life of Jeffrey Ash before he killed his mother, Ellen Ash. Caregiver-killers' exhausted physical and emotional condition was associated with a growing desperation and hopelessness.

It is not my intention to ignore the exhaustion, desperation, and hopelessness of PWD. Neither is it my intention to minimize the exhaustion a far greater number of female caregivers' experience looking after husbands/partners or other family members with dementing illnesses without killing them. The dearth of data in the case files about the exhaustion of PWD may reflect, at least in some cases, their inability to communicate extreme weariness. It might also reflect the fact that observers did not ask them about these matters, or if they did, such information did not enter the official record. Notwithstanding these important caveats, the record suggests the profound enervation of men who killed wives with dementing illness played an important part, alongside mercy and other considerations.

The disciplines of neurology and psychiatry have explored human exhaustion. In the aftermath of the American Civil War, Dr. George Beard, a neurologist, defined the condition of neurasthenia as the exhaustion of the nervous system, a weakness of the nerves.[12] For many clinicians, chronic fatigue syndrome is a modern-day version of neurasthenia.[13] Terms such as shell shock and combat fatigue also address the nervousness, anxiety, and exhaustion of those engaged in extreme and life-threatening situations for extended periods of time. The slow burn of dementia-related exhaustion exhibits a special kind of weariness and futility. It is associated with the gradual disappearance of husbands' love objects, the undoing of their decades-long marital bond, and, in particular with our cultural cohort, often a role reversal.

Writing in the aftermath of World War I, Dr. Edward Lazell, a psychiatrist, explored the war neuroses of returning combat veterans. Many of these men had faced the threat of sudden death and/or dismemberment from bullet, bayonet, and/or blast. For Lazell, "all fear is reducible to the fear of death, which is always our own death."[14] Regarding World War I, he writes, "Streams have been choked with the dead and rivers have run red with the blood of the wounded, so that even the water of vast areas has been made unpotable."[15] These lasting images included not only the "death of trees and shrubs, even the grass" but also the "death of hope and everywhere the despair of death."[16]

Similarly, we appear to witness the death of hope and the despair of death among exhausted husbands who killed their wives. In their own ways they faced the "inexplicable riddle of death,"[17] often in graphic detail, up close and personal. The older, beleaguered men who inhabit these pages faced not only the pending death of their love objects but their own deaths too. The fog of fatigue that engulfed them differed from the direct, visceral, and immediate threats to life combat veterans endure in war. Caring for a spouse with dementia is a slow burn, a gradual recognition of pending loss. They did not kill an officially or socially accepted "enemy," rather they killed their love objects, some of whom, for perpetrators, may have looked increasingly like antagonists, aggressors, and ironically, paradoxically, enemies of sorts.

The following narratives include cases that reveal varying degrees of mercy and exhaustion. Some narratives draw on a greater range of source material than others. The American narratives are usually less detailed and draw more upon court, newspaper, and other media sources than the UK cases. The latter draw heavily upon detailed DHRs as well as media and court documents.

Some husbands take their own lives after killing wives with dementia. In general, these homicide-suicide cases contain less information because there is little or no investigation. The IPHs are a different matter, often producing rich documentary materials that allow us to explore the case in much greater detail.

Homicide-suicides are rare events. In the US, they comprise roughly four percent of all homicides and 1.5 percent of all suicides. However, in the field of violence against women, roughly a third of women killed by intimate partners lose their lives in homicide-suicides. The perpetrators are mostly current or former husbands/male partners.[18]

Salari studied 225 intimate partner homicide-suicides. Only 7.5 percent of the victims in her sample had dementia.[19] Half of the cases involved illness. Among those dyads with reported health problems, "34 percent had only a victim who was ill, 30 percent had only a perpetrator who was ill and in 36 percent of cases both had health problems."[20] Only four percent of the cases revealed evidence of a suicide pact. Usually these had joint or victim-authored suicide notes.

In 2000, Donna Cohen opined that homicide-suicides among the elderly "are not acts of love or altruism. They are acts of depression and desperation."[21] Our case studies allow us to explore her claim.

Cases With Prominent Themes of Mercy

On May 1, 2019, at about 3:30 p.m., John Thombleson, age 67, called the Sheriff's Department in Jacksonville, Florida, to tell them he had killed his wife, Gwendolyn Thombleson, age 66. John also told the operator he was about to take his own life. SWAT members surrounded the house. They attempted to make contact but to no avail. Eventually they entered to find John and Gwendolyn's dead bodies in a bedroom.

The couple were high school sweethearts. They had been married for 47 years. Gwendolyn worked as a data entry clerk for Southside Middle School in Jacksonville. John was retired. Her health took a precipitous turn for the worse after surgery in the autumn of 2018. She developed several health problems, including dementia. As Gwendolyn's health deteriorated quickly, the medical bills mounted. John told neighbors their health insurance was expiring and they faced the possibility of losing their house.

Gwendolyn's sister was quoted saying,

> I want everyone to know this incident was not a domestic dispute. Johnny Thombleson loved my sister Gwen with all his heart. Johnny became her 24/7 caretaker. Their lives were destroyed and he could no longer bear to see her suffering. He did this with a broken heart and knew he could not live without her. A tragic end to a true love story.[22]

With only media coverage of *Thombleson*, our knowledge remains limited. We do not know if authorities found evidence of a suicide pact, suicide notes, a statement by Gwendolyn that she wanted to die, and so on. Similar difficulties arise in other homicide-suicides where only media coverage is available.

Gary Bowers, age 75, and his wife, Mary Bowers, age 83, hail from DeBary, Florida, seven miles north of Orange City on the northern shore of the St. Johns River near Lake Monroe.[23] Orange City was originally named in 1882 in recognition of the thousands of acres of orange groves in and around the incorporated area. However, back-to-back freezes in 1894 and 1895 wiped out the entire citrus crop. Oranges, lemons, grapefruits, and limes all froze on the trees, their barks splitting. The river, the longest in Florida, runs 310 miles. Its alligator population is substantial.

Consistent with other elder homicide-suicides, there was no apparent suicide pact, illness was a prominent theme, and Gary Bowers used a gun to kill Mary and then himself. Unusually, the killing took place within a nursing facility and not their home. Mary had AD and other illnesses. Gary could no longer take care of her. Since February 2013 when Mary was hospitalized, she has needed around-the-clock care. On August 14, 2013, he checked her into the Savannah Court assisted living facility in Orange City. According to nursing home employees, Gary phoned the facility several times a day to check on his wife. He was apparently worried he had made the wrong decision by placing Mary there. To those who knew him, Gary also appeared depressed. He had his own medical problems. On Sunday, August 25, Gary turned up at the facility at 8:07 a.m. to join Mary for breakfast. At about 8:45 a.m., a staff member saw the couple returning to Mary's room. A nurse entered the room at 9:20 a.m. to administer medications, only to find Mary dead on her bed. She had been shot in the head. Gary lay on the floor beside her bed, dead from a self-inflicted gunshot wound to the head. The nurse told police dispatch, "It's a terrible sight. She is laying across the bed. He is laying on the floor."[24]

According to family, friends, and neighbors, Richard and Alma Shaver were soulmates and remained so until Richard killed her and then himself.[25] Gerry O'Connell had lived on the same block as the Shavers for 20 years. He emphasized the Shavers were "absolutely soul mates."[26] They had been spouses for 60 years. Richard had a successful career as an electrical engineer. He traveled often for his job. They raised three daughters. Alma ran the household and was principally responsible for childrearing and housework. We learn she was "strong-willed and warm, meticulous about her home and her appearance. She had meals on the table at 5 p.m., dressed up as Mrs. Claus, led a girl scout group, and delivered handmade gifts."[27]

Her AD came on slowly. Eventually, her confusion grew. She became anxious and fearful in social situations. Alma forgot the names of their children and forgot how to sew and cross-stitch. In the early stages, Richard sat with her, rubbed her hand, and "tried to calm her unease."[28] He left notes for her, explaining simple tasks. Richard chose her clothes for social occasions.

There is no available evidence that Alma and Richard entered into a suicide pact and that she consented to her own demise. The coroner's report disclosed Alma tested positive for oxymorphone, a potent painkiller with an abuse liability similar to morphine, and that she had been shot in the back of her neck. Information also surfaced that Richard had metastatic tumors on his liver and kidneys and that he suffered from emphysema. He shot himself in the mouth.

Izak Waide, age 92, shot his wife, Malka, age 92, in the head, and then himself. He perished. She succumbed to her injuries a week later.[29] Her AD and other health conditions had worsened. Immediately prior to the double shooting, Izak called his son to tell him what he intended to do and that he could not stand to see Malka suffer. The pair had been married for more than 60 years. Neighbors noticed during the last two months that the couple no longer took walks together. Previously, the Waides would walk the neighborhood twice a day, sometimes holding hands. Izak continued to walk on his own but would not venture far because he feared leaving Malka alone. Neighbors described Izak as a World War II veteran who was healthy and strong.

Tracy Pastor, a neighbor, described the pair as "a beautiful couple."[30] Her husband, Jay, said Izak and Malka would sit for hours on their backyard patio drinking coffee and chatting. The Pastors would sometimes walk beside the Waides as they took their walks. Another neighbor, Heather Noumeh, communicated that Izak was worried about Malka injuring herself on walks or getting lost, hence he wanted her to stay home. Noumeh added, "They lived like lovebirds. They were always together."[31]

It is clear from the aforementioned homicide-suicides that any mercy evident in the killing was likely accompanied by varying degrees of depression, hopelessness, and desperation. However, these themes comingle with strong elements of love, compassion, and caring, as family members, neighbors, and others observe. Are we to dismiss the reported observations of love, compassion, and other prosocial behaviors in *Thombleson, Bowers, Shaver, and Waide*? Are these media reports mere sanitized interpretations of what were really acts of desperate murder? The comingling makes for an uneasy, paradoxical, and some might say suspicious mix.

But what do we make of the caregiver-killer cases where the so-called mercy killer does not commit suicide? Do they differ from the homicide-suicides? A selection of cases helps explore these questions.

We learn that Jack Tindall (real name), age 96, strangled his wife, Ernestine, age 88, to death with a cord from her dressing gown. The spouses had apparently agreed that if one of them had to enter an assisted living facility the other would take his or her life. We learn from press accounts that Jack surrounded his "dead wife's beautiful face with lilies."[32] She had AD and had had a hemorrhagic stroke which paralyzed one side of her body. Family members on both sides said he killed her out of love. A granddaughter said Ernestine "continually asked"[33] Jack to help her die. She saw Jack as a "lovely, caring man."[34] He was initially charged with murder, but the charge was reduced to manslaughter. He received a 12-month prison term, suspended for two years. Yet, the judge was clear, "This was not a case of assisted suicide. This was a killing as a perceived act of mercy."[35]

Frank Mansfield of Elizabeth City, North Carolina, told police he had to kill his wife because he could no longer care for her at home. Apparently, officials at the Pasquotank Department of Social Services and other agencies had spoken with Frank about placing her in an assisted living facility, a possibility he resisted. Phyllis Mansfield had AD. Instead of the institutional placement, he shot her to death in their garage before calling police. Frank told them he saved her from a life "as a caged animal" in a nursing home.[36] Authorities originally charged Frank with second-degree murder. Eventually, he pleaded guilty to voluntary manslaughter. His grand jury was delayed for eight months due to his own health problems. The US grand jury, a reflection of public sentiment and ideally a community bulwark against unfounded or unreasonable prosecution, refused to indict him. Frank was set free.

Not an Eyebrow Out of Place

Roswell and Emily Gilbert lived in a ten-story condominium in Fort Lauderdale, Florida, overlooking the Atlantic Ocean. He was 75; she was 73. The couple married in 1934 and had been married for 51 years. Roswell enjoyed a successful and prosperous career as an engineer. Emily was a champion bridge player. They had one daughter, Martha. Eight years before her death, Emily developed osteoporosis of the spine, an incurable, degenerative bone disease. By the time she died, she had fractured three ribs and almost every bone in her lower spine. Emily was also in the later stages of AD.[37]

On March 4, 1985, Roswell used his 9 mm Luger pistol to shoot Emily in the head as she lay on the couch. He claimed he took her life to end her suffering because she asked to die. Put simply, he claimed his killing was an act of mercy. A Broward County grand jury indicted Roswell on first-degree murder charges. His daughter expressed shock at the decision to charge her father. "He's OK, but I'm worried about him. It's a tremendously emotional thing for him, and I don't know how he will make it through a trial."[38]

Detailed investigative journalism and appellate court transcripts shed light on *Gilbert*. The gray areas warrant careful consideration. The case drew national attention, in part because a grand jury in the same Florida county had declined to indict Hans Florian in another so-called "mercy killing" two years earlier. Both cases raise important legal and ethical questions. Both help us understand the continuum of issues involved in so-called mercy killings.

According to Roswell Gilbert's defense attorney, Harry Gulkin, Roswell could not summon the emotional energy to testify before the grand jury. Commenting in the wake of the grand jury decision, Mr. Gulkin explained, "There was no criminal intent. He did it with a weapon because he wanted it to be painless and instantaneous."[39] Esther Rothchild, president of the Broward County Alzheimer's Association, disagreed with the decision to indict, saying, "I feel that man has suffered more than most people have suffered in a lifetime. It took tremendous courage to do what he did. . . . He's not a killer. He's not a criminal. He did something out of an act of love," she opined.[40] Martha reaffirmed her father's love for her mother, saying, "He's a very quiet, private person, but he loved my mother very much. He stood by her every minute. He was the only one she wanted around."[41]

At trial, jurors learned Emily's physician, Dr. Eduardo Hidalgo, prescribed Percodan for the moderate pain associated with her osteoporosis.[42] Emily's friend, Lillian Irvin, testified for the defense. She stated that Emily was in a lot of pain. On one occasion, Lillian was in her condominium office when Emily came looking for Roswell. Emily was upset and crying. Lillian called Roswell out of a condominium meeting to attend to Emily. When he arrived Emily exclaimed, "I'm so sick, I want to die, I'm so sick. Ros, I want to die, I want to die." However, on cross examination, jurors learned that Emily would come down every day from her tenth-floor apartment to either look for Roswell or walk around the pool. Lillian's testimony about Emily wanting to die referenced one occasion only.

One of Emily's acquaintances, Jacqueline Rhodes, testified that Emily was in pain and forgetful. Jacqueline also observed that Roswell "had always been very kind and attentive to his wife."[43] On one occasion, Jacqueline visited Emily's condominium where she found Emily "on the sofa crying and looking very sick."[44]

Roswell described the events leading up to him killing Emily. On March 2, 1985, Emily had another bout of pain associated with her osteoporosis. The next day he took her to the hospital. Emily did not want to remain in the hospital and insisted on returning home. Roswell took her home. On March 4, Roswell took Emily out to lunch as usual. He returned her to their condominium, situated her on the sofa, and gave her four Percodan tablets. Roswell then went to a condominium meeting. She followed him a few minutes later. He left the meeting to take her back to the condominium. Roswell reported that while lying on the sofa, Emily said, "Please, somebody help me. Please, somebody help me."[45] According to his courtroom testimony, he reflected on his decision to take her life, saying,

> Who's that somebody, but me, and there she was in pain and all this confusion. . . . I thought to myself, I've got to do it. . . . I've got to end her suffering, this can't go on.[46]

When quizzed why he felt he had to take Emily's life, Roswell reasoned as follows: there was no cure for Alzheimer's disease or the osteoporosis, so the doctors could not help Emily; she did not want to go into care, especially given her recent reaction to being in the hospital; if he shared his intentions with her doctor, the doctor was duty bound to report those intentions and Roswell thought authorities "would pull me out of the picture."[47] He declared to the jury,

> I didn't consider what would happen to me at all. The only important thing was to terminate her suffering. . . . Sure, I know I was breaking the law but there seems to be things more important than the law, at least to me in my private tragedy. So, it's murder. So what?[48]

In the Circuit Court in Broward County, the jury found Roswell guilty of the premeditated murder of his wife. He received a 25-year prison sentence. Sylvia Firestone, age 67, the elected jury foreman, commented, "One doesn't go to lunch at 12 o'clock with her husband and then at 2 o'clock be ready to be terminated. . . . Terminated. That's his word. How telling."[49] Firestone, an attorney, and another juror, Wanda Lieberkoswki, a manicurist, both found significance in Emily's presentation of self. They both admired her jewelry and the careful application of her rouge and eye shadow. Lieberkowski remarked, "There's not an eyebrow out of place."[50] Emily's animated, careful, and meticulous presentation of self, ran counter to the defense claims that she wanted to die.

On hearing the verdict, his daughter, Martha, howled in grief, saying "They killed my father!"[51] Roswell did not expect the jury to convict him. As the bailiff took him away, he addressed reporters, "I thought I'd be acquitted. . . . I never expected to go to jail."[52] Reflecting on the case from his prison cell, Roswell shared more about his travails caring for Emily. We learn, "Her memory just folded up . . . she couldn't remember her daughter's name or if she was married or if she had grandchildren." He said,

> I'd spend half the day looking for her glasses or her cosmetics. She'd drop her clothes in oddball places . . . Oh, and the osteoporosis. It made for a hellish combination. I'd have to give her Percodan for the pain, and that made her constipated. So, I had to give her enemas. Then she'd lose control.[53]

Significantly, Roswell never asked for help. He kept his wife's deterioration to himself. He continued to socialize somewhat independently of his life with her. For example, he did serve on the condominium's board of directors. However, as her condition worsened, the couple became more isolated, and fewer friends came to their home.

Roswell's counsel appealed the decision but to no avail. As it moved toward affirming the decision of the Circuit Court and therefore upholding Roswell's sentence, the Florida Appellate Court pointed out a few pertinent facts: up until the time of her death, "Emily was always neat and well-dressed, wearing makeup, jewelry, and coordinated outfits. She also went to the hairdresser every two weeks up until the last week of her life."[54] Put simply, Emily had the wherewithal to take pride in her appearance. Additionally, her doctor testified she could have lived another 5–10 years. Tellingly, the appeals court stressed, "She was never bedridden or completely incapacitated."[55]

Additionally, Roswell's counsel provided no evidence that Emily left a "mercy will," a persuasive document that compellingly conveyed Emily's wishes and which others could have used as a moral compass upon which to base future decisions, for example, regarding the termination of extraordinary life support. The appeals court found it "ridiculous and dangerous" to suggest, as Roswell did, that "constructive mercy" resulted when Emily stated, "I'm so sick I want to die." The court warned, "Such a holding would judicially sanction open season on people who, although sick, are also chronic complainers."[56] Concurring with fellow appellate justices, Judge Glickstein added,

> Even if there had been a mercy will, and even if appellant could show good faith intentions, we cannot equate his pulling the trigger of a gun held at his wife's head with the removal . . . of extraordinary life support systems from a terminally ill patient. The object of the former is to end a life; the latter to let nature take its course.[57]

Roswell Gilbert served five years of his 25-year sentence. Florida Governor Bob Martinez and three members of his Cabinet granted him clemency in 1990. Reflecting on killing Emily, Roswell would later say that he was wrong, commenting "I shouldn't have killed my wife; now I know that. . . . I loved her dearly, I truly did." He commented that Emily's illness "created a complete state of desperation in my mind. . . . It's a lousy excuse, but that is what it was."[58] The passage of time in a prison cell gave rise to a new interpretation regarding the uneasy juxtaposition of Roswell's compassion and desperation. Roswell Gilbert died in his sleep at his daughter's house in Baltimore in September 1994.

A Woman on Fire

Johanna (Hannie) Florian, age 62, had advanced Alzheimer's disease. Her husband, Hans, age 79, a retired butcher and immigrant from Germany, could no longer care for her. He had to pry her mouth open to feed her. She was incontinent and resisted being washed. Apparently, Johanna did not recognize anyone. Neighbors could hear her cry out in pain, complaining that she felt she was on fire.[59]

Hans placed her in a nursing home. After eight months, nursing home authorities informed Hans that his wife had become "unmanageable" and as a result could not remain. Hans moved her to a hospital but was told she could not stay and would have to go home. It was at that critical juncture Hans wheeled her in her wheelchair into a hospital corridor and shot her in the head. Hans claimed he wanted to take his own life right after but hesitated because he was not sure she was dead. At his bond hearing he told the judge, "My greatest concern was my wife. . . . I was afraid I missed or something and only hurt her."[60]

Hans was not indicted. The grand jury foreman in *Florian*, John Morris, a banker, reflected on what the jury had heard and how jurors interpreted matters.

> He had lost all ways of connecting with her. . . . Sure we knew he pulled the trigger. But the question is, "Pull the trigger on what?" We decided it might not have been correct from a legal standpoint, but we made a judgment as a group of human beings. He hadn't done something we wouldn't do ourselves.[61]

Morris echoed a common sentiment among the general public: that after a certain point, AD sufferers are apparently no longer accessible.

Interviewed later, Hans commented on *Gilbert*. "I have nothing but sympathy for Mr. Gilbert. . . . But Mrs. Gilbert, she could come down from the 10th floor. She could eat lunch. There were nursing homes for Mrs. Gilbert."[62]

As Hans Florian observed, Johanna Florian's AD was more advanced than Emily Gilbert's. Using the typology developed by Donna Cohen and colleagues, one interpretation might be that Johanna had reached the last of six phases of change experienced by dementia patients, namely what some researchers refer to "separation from self."[63] Others take a different tack. Stephen Post contends that self-identity diminishes but absent a persistent vegetative state or brain death, "there is no justification for asserting that it is ever entirely gone."[64] I return to these controversial matters in Part 3. Nevertheless, the difference in the two women's cognitive and emotional condition seems to have informed the decision-making of grand jurors, summarized by John Morris' choice of words that Hannie Florian was no longer accessible.[65]

Neither Roswell Gilbert nor Hans Florian utilized the full range of social services available. Both men used guns to kill. Both men professed great love and affection for their spouses. Witnesses confirmed these feelings of affection. In neither case was there any hint of a prior history of IPV/A. According to both men, the AD rendered them desperate to the point they killed. Apparently, Hans Florian seriously contemplated killing himself after he killed Johanna. Roswell Gilbert appears to have had no such inclination. After his release from prison Gilbert remarked that he should not have killed Emily. Interviewed two years after killing Johanna, Hans Florian remarked, "I have no peace."[66]

Jurors were more willing to interpret Hans Florian's killing as a mercy killing than they were Roswell Gilbert's. *Gilbert* evidenced a mixture of explanations that included elements of mercy, panic, desperation, and self-interest. *Florian* also showed elements of exhaustion and desperation but is closer to what we might loosely refer to as a pure mercy killing.

Cases With Prominent Themes of Exhaustion

We do not know what causes neurocognitive decline, and we do not know how to reverse it. We do not know why an infinitesimally small number of exhausted husbands kill wives with dementia and the vast, vast majority do not. Since my convenience sample contains no control or comparison group of PWD and caregivers of PWD who do not kill, we do not learn about all those exhausted and merciful wives/female intimate partners who do not kill their husbands or male partners. In short, the narratives describe how events appear to have unfolded but do not explain why. In terms of our ways of understanding, the narratives appear to connect one unknown with another.

Writing at the end of World War I and during his own nervous breakdown, T. S. Eliot took time off from his job at Lloyd's Bank to convalesce in Margate, a seaside resort on the southeast coast of England. His famous poem, *The Wasteland*, references his time there.

> On Margate Sands.
> I can connect
> Nothing with nothing.[67]

Our first exhaustion case contains themes of the unknown set against the metaphoric backdrop of coastal holidays.

Seaside Magic and the Fog of Fatigue

For decades, Ian Hurst took his cohesive, loving family to a popular UK seaside resort each year. At the time of the killing, he had planned a trip to the coast with his adult children, communicating with them on the night before the homicide-suicide that he and Shelly, his wife, would follow them to the coastal resort. Both Ian and Shelly were in their mid-eighties.

The resort is a fine place to catch fish. Sea bass swim up and down the coast, in and out of the rocky coves. Night fishing is particularly good. The clear waters host razor clam, squid, and mackerel. Kelp beds abide. Dolphins, porpoises, and seals come and go. Shore fishermen fix their rods in the sand and wait. Families ride the tourist fishing boats out to sea, renting rods, waiting for tension in the line.

The Hurst family kept a boat and caravan there.[68] It was their tradition to drive there from their home. Ian and Shelly met while working in a laboratory. He was 20, she 19. World War II was over. After the war, the US and Soviet Union squared off for what would become roughly four decades of cold war. The Communists seized power in China in 1949. The world was changing, but the British still loved their seaside resorts. Many in our cohort grew up with the specter of communism and centralized state control. One wonders if and how the specter of communism and centralized state authority affected the responses of families to assistance from the welfare state.

It was in the wake of the Chinese Revolution that Ian first asked Shelly out. She declined, telling him she played cricket on Saturdays. Daughter Chelsea explains, "He was intrigued—but Mum played hockey and football too. She loved sport and wouldn't let anyone tell her she couldn't do something because she was a woman."[69]

Like my own father, Ian completed his national service in the Royal Norfolk Regiment of the British Army. The regiment, formally named in 1935, had a very long history and a tradition steeped in honor and discipline. Its soldiers fought the Nazis in World War II, particularly in France and Belgium. Members of the Second Battalion of the Royal Norfolk Regiment fought the Japanese in Burma, confronting their advance on India in 1944, helping push them back to Mandalay and then Rangoon. In 1952, out of apparent concerns about a Chinese attack on Hong Kong, members of its First Battalion took up defensive positions on the border between Hong Kong and China.

Ian and Shelly married in 1952. They raised six children. The DHR points out that Shelly brought up the children while Ian was a salesman for the textile industry and would fly all over the world in the course of his job. Once the children were old enough, Shelly returned to the paid workforce as a tax inspector. The gendered division of labor in the family was typical for the times, men being principal breadwinners, women being principal nurturers.

As adults, the children remained emotionally close. All six signed a tribute to Ian and Shelly which appears as the opening statement to the DHR. The report addresses the killing of Shelly by Ian, who then went on to attempt suicide, only to die later of the injuries he suffered during the attempt.

The adult children, all in their fifties and sixties, comment collectively,

> We loved and adored our parents. . . . For over 65 years they loved and adored each other. We will never know the thoughts that were in our father's mind during the final days of our parents' lives but we will seek comfort in our belief that in his mind he was, as always, only doing what he believed to be the best for our mother and for their six children.[70]

The night before the killing, five of the six adult children assembled at the family home. They ate a meal together, a last supper. The siblings reported the atmosphere as "pleasant."[71] However, they also observed their mother's AD had worsened. The entire family had planned a few days at their usual coastal resort. The next morning, they all had breakfast together. The adult children went their separate ways, two to their homes nearby, three to the coastal resort. Ian and Shelly were due to drive to the coast a few days later. They never made the journey.

At 12:30 p.m. that same day, a train pulled into a station. Ian slid down the platform as the train arrived. It crushed his leg. Ian told the train conductor, with near-palpable shame, he wanted the train to run over his head. Doctors later amputated the injured leg. He died seven weeks later of pneumonia, septicemia, and organ failure.

As paramedics and police attended to Ian, he told them he killed Shelly earlier that morning. From beneath the train, he told a police officer,

> I've killed my wife. She had Alzheimer's. I didn't want her to suffer any more. I just want to die. Let me die. My wife suffers dementia and incontinence. She told me if I ever put her in a home, she'd kill herself."[72]

Referencing apparent conversations with Shelly, he said he told her he would kill her quickly and "then I'd throw myself under a train."[73] He apparently told paramedics that his wife took a lot of killing, that he had just wanted to suffocate her but could not. However, there was a lot of blood. He told police that he killed Shelly that morning by smothering her, putting her out of her misery.

Police went to the family home. They found Shelly in an upstairs bedroom, a bloodstained bedside lamp nearby. She suffered eight blunt-force injuries to her head and face. It appeared as if Ian used a nearby bedside lamp to assault her. She had a severe brain injury. Notably, she also had injuries to her hands, suggesting she may have raised them instinctively to defend herself.

The adult children, through the youngest sibling, Kevin, had composed a letter to Ian. It expressed their concerns about his increasing inability to care effectively for Shelly. They thought Ian might benefit from a letter rather than trying to talk through the many difficulties he was facing. In the letter, Kevin noted how odd it was writing to his father. The letter acknowledged his father was a great carer but one who needed more help. Poignantly, he comments, "I had just finished writing the letter and had just folded it up when my sister called and said that mum was dead and dad had thrown himself under a train."[74]

We can only infer Ian Hurst's intentions at the time of killing Shelly. However, the circumstances suggest he reached his breaking point in terms of caring for her. What Kevin would refer to as his father's "fog of fatigue"[75] seems important. Ultimately, the haunting presence of the inexplicable remains.

The DHR interviewers met with Gerald, the fourth adult child, almost seven months after his mother's killing. He reported changes in Shelly's behavior from her late seventies, some six or seven years before her demise. Her short-term memory began to deteriorate. It was four years later Shelly went to a memory clinic where she disclosed that her memory was failing her. She was unable to articulate precisely how, but Ian provided more detail. She would leave toast to burn. Formerly a tax inspector, she would become confused and muddled when faced with family financial matters. Shelly loved to cook. She would do so for an array of friends and relatives. For years, they had a lively social life. Her memory changes meant she was increasingly less adept with recipes. She had more and more problems recalling words. With these baseline clinical observations on the record, clinical tracking commenced.

She returned to the memory clinic three months later. Staff noted a decline in her mobility. A month later, daughters Amy (eldest adult child) and Peg (third adult child) took Shelly to the memory clinic. They expressed concern about their mother's increasing dependency on their father and about the toll this was taking on Ian. At this time, clinicians diagnosed Shelly with mild dementia and probable AD. They notified her GP. A week later, a specialist nurse visited their home to advise the family about the support available. The family declined support at that time. The nurse also advised about lasting power of attorney. Such power enables the donor (e.g., Shelly) to appoint one or more people to help her make decisions or to make decisions on her behalf. These decisions might concern her health and welfare, property and financial affairs, or both. Ian apparently said he did not think the invocation of such legal powers necessary.

It was at this juncture, some three years before the homicide-suicide, that Ian would describe himself as "fit as a flea."[76] His self-diagnosis, in his mid-eighties, did not sit easily with his diabetes or his GP's concern about him being at risk of a stroke. Like many older people, Ian was a frequent visitor to his local GP surgery. The year after declaring himself as fit as a flea, he attended 19 times for a range of issues. The year after that, 28 times.

In the 18 months before her death, Shelly's physical health worsened. The adult children became more involved, helping with her needs during the day. We learn that Ian found managing her incontinence, particularly at night, increasingly difficult. Eleven months before she died, Shelly fell, suffering a compression fracture to her lower back. Ian often declined help from the Department of Social Services. He refused to have a carer, a stranger, come into his home. As the nights shortened and winter came on, Ian appeared stressed. He was losing weight.

Some six months out from the killing, the family contacted the Department of Social Services about a bathing assessment and the possibility of a walk-in shower for Shelly. An occupational therapist (OT) visited the home. During this visit, Ian mentioned he was having difficulties managing Shelly's behavior. The OT suggested a referral to Mental Health Services for Older People, but Ian declined the offer. Kevin contacted the Department of Social Services and said his mother was suffering from dementia and that his father was caring for her and was "totally exhausted."[77] Kevin also said his father was proud and reluctant to receive help. The department informed him Ian would need to consent to any home visit to assess whether they might provide services.

Just a couple of weeks later, Kevin again called the department. He requested services for his father but also informed them that his parents' situation was becoming more volatile. Kevin said Ian was losing his temper with Shelly, at times flying into a rage. Kevin told reviewers that on one occasion his father had banged his fist on the table in frustration. He also requested the department not report this information back to Ian as it would only worsen the situation. As a result of this report, the department conducted a needs assessment at the Hurst residence. From this point on, Shelly would attend a day center to give Ian a break. Shelly also received telecare sensors (press-button alarm).

Within two weeks, Ian removed the telecare equipment, saying it was invasive. Two weeks later Ian was offered a referral to Mental Health Services for Older People but he declined. At about this time Shelly commenced her visits to the day center. Life continued. Two months from the homicide-suicide, there was a routine six-week review between a social work assistant and Ian. We learn in the DHR report that Ian communicated "Shelly was enjoying her time at the day center."[78] No other issues surfaced. But Shelly's seeming contentment at the day center began to change. Her dependence on her family increased. Two weeks before her death, the day center told Adult Social Services that Shelly could not settle after lunch and expressed a desire to be with Ian.

For his part, it seems Ian was spiraling down. His frustration and exhaustion became increasingly acute. If he had thoughts of the coast and the sea fishing he loved, the morning gray mists and fogs, beaches of nothing, they may have seemed as increasingly poignant as they did distant. Most nights he had to attend to Shelly's toileting needs, a lightning rod for anger for some PWD. He had introduced some discipline into their lives, perhaps to protect himself, give himself room to breathe, and inject a sense of predictability into the growing uncertainties of life. The discipline may also have countered any disruptive effects of Shelly's failing memory, any tendency on her part to seemingly dismiss his care as something imposed.

In the DHR, Ian emerges as regimented in his approach to caring for Shelly. He began to put Shelly to bed in the early evening, regardless of whether she was ready to sleep. Daughter Peg noted he did this to give himself a break from caring for her. Ian also got Shelly up during the night for toileting, regardless of whether she expressed the need. His idea was apparently to prevent her soiling the bed. Perhaps from her perspective, she had had a rubber sheet fitted to her bed and wore pads to deal with bodily waste, thus obviating the need for such regimentation. Significantly, Ian might have been swayed by the fact Shelly had lost considerable weight because of a UTI. Nevertheless, as adult son Gerald indicated, these regimented toileting interventions seem to have increased Shelly's resentment and aggression toward Ian.

Kevin also described how once Shelly's dementia worsened, Ian began choosing her clothes for her. The DHR notes his observation that "the daily clothes for his mother were decided by his father and she had to do what he said." Both Shelly and Ian appear to have had problems with the installation of an alarm system. As noted, Ian found the telecare system "invasive." Daughter Amy describes how her mother removed an alarm fitted to her bedroom door to detect if she got out of bed during the night. We do not learn from the DHR whether Ian was in agreement with her removing the door alarm.

Daughter Peg observed Ian would get irritated with Shelly for refusing to wear her hearing aid. Her refusal meant the television would have to be turned up loud. It likely meant it was more difficult for him to hear her words and for her to hear him. His frustration and anxiety were heightened by her tendency to wander. Peg commented, "If he took his eyes off his wife, she would be gone."[79]

The struggles over these issues continued. Increasingly, Shelly appeared less and less like the woman he had spent over 60 years enjoying, appreciating, and admiring. Daughter Chelsea, quoted in the DHR, observes her father "found it hard that his vivacious, brilliant, active wife had become confused and disorientated and that shared history of 64 years was slowly being deleted from memory."[80] He had lost considerable zest too. He used to enjoy sea fishing. Ian was a proud gardener, working his allotment (community garden) with great enthusiasm. He enjoyed archeology and history. Both he and Shelly were good bridge players, she especially.

As the Alzheimer's worsened, Amy described how her mother found it increasingly difficult to take food and medication. She would reject these things, adding to Ian's frustration. Shelly started to fall and he found it increasingly difficult to pick her up. At one point, Ian told Amy he had "lost his wife a long time ago due to her dementia."[81] Amy reports she never witnessed her father assault her mother. But she told reviewers he would shout at her and become verbally aggressive when he was tired.

The Home Office Quality Assurance Panel apparently raised questions about whether Ian had been coercively controlling Shelly, recommending the DHR team explore this possibility more than it had in their draft report.[82] The panel apparently used the examples of him selecting her clothes and disconnecting the house telecare alarm system for further consideration. The DHR Chair responded robustly to the panel's suggestion. He argued the available evidence was that the couple

> had a long and loving marriage . . . with absolutely no suggestion ever of . . . domestic violence/abuse or coercion. To suggest otherwise would do a grave disservice to their memory. . . . The control elements in the latter stages of the marriage directly related to his management of her dementia.[83]

The chair's letter highlights a comment from Peg that suggested "how much he loved his wife and how desperate he was to have her cared for properly, because at the time of making the comment he was at the end of his tether." Referencing the Saturday prior to the homicide, Peg heard Ian tell Shelly, "I love you but I've got to put you in a home—it will be nice though."[84] The full context for Peg's words warrant mention. This was the first time, to her knowledge, that her father had mentioned putting her mother in a home. She stressed he was "tired and drained."[85] His intention was apparently to sell the family home, build an extension onto daughter Amy's house, and move in. Peg noted her mother refused to consider being placed in a home, at which point Ian replied, "I can't cope any more. I've had enough."[86] These references to Ian's mental state in the lead up to the killing comport with son Kevin's observation of his father's emotional state at the emergency department after the killing and his suicide attempt. Kevin considered his father to be "in a dark place emotionally."[87]

Road Closed

The policeman stood erect between two traffic signs at the entrance to the street, left hand folded over right just below his waist. His neon yellow anorak was zipped up to his neck. He looked cold. It had been raining steadily; the sky was gloomy. The thin silver-gray lateral and vertical stripes on his anorak matched his shiny gray constabulary badge. The ashen rain-soaked pavements ran gradually downhill behind him. To his right, the white-lettered sign on a red rectangular background messaged "ROAD CLOSED." To his left, the white lettering against a blue background said, “POLICE: ROAD CLOSED.” Authorities had just found two bodies inside one of the semi-detached Edwardian houses. They soon worked out that Peter Lampard, in his late seventies, had killed his wife, Vicki, in her eighties, before committing suicide.

Peter completed military service in the Royal Air Force and later became an aircraft engineer. She had worked as a legal secretary. Vicki was six years his senior. The couple had two adult children, Paul, a consultant medical doctor, and Emily, a teacher. Neighbors described the couple as happy in their own company and in private. The adult children both lived away from their parents but stayed in touch by phone, visiting occasionally. They also maintained contact with Peter and Vicki’s immediate next-door neighbors, a source of “wonderful support”[88] for Peter and Vicki. Both spoke fondly of their parents and asked that their father should not be judged by his final act.

Peter Lampard had been terminally ill and knew so. It was his impending death and his concern about what would happen to Vicki that apparently led to his decision to kill her, then himself. The coroner’s report described his decision as “terrible, terrible” and referred to his love for her as “warped.”[89] At the same time, the coroner said she felt Peter did what he thought was right under tragic circumstances. His exhaustion, desperation, and depression are entangled with both parties’ advancing medical problems.

Twenty-five years before killing his wife, Peter was involved in a car crash. He experienced multiple leg fractures and went into cardiac arrest. His treatment included electric shock therapy to restart his heart. In the decade before the killing, he suffered from hypertension for which he took medication. Peter complained the medication had adverse side effects and was ruining his life. The DHR report notes that at one point, about eight years before the killing, the GP notes report Peter saying, “I feel low and tired all the time, humorless and looking for domestic trouble . . . ask my wife.” Reviewers wondered if his disclosures about looking for domestic trouble hinted at prior domestic violence. Others wondered if they were a cry for help.

Within a year of Peter’s disclosures about feeling low, tired, and humorless, he was diagnosed with locally advanced intermediate high-risk prostate cancer. An MRI showed no spread. He opted not to have radical surgery and had radiotherapy only once. He also decided against receiving hormone treatment. He had a transurethral resection of the prostate, was prescribed medication to relieve symptoms, and reviewed every three months. Within three years, Peter wrote to his GP concerned at the rise in his prostate specific antigen (PSA) score and complaining of leg pain. Radiological testing traced the cause of his leg pain to the metal work he had after his road traffic accident 20 years previous. The orthopedic surgeon treating him noted his increasing PSA and alkaline phosphatase and suggested a referral back to a urologist because of the possibility the prostate cancer had metastasized.[90] Peter said he did not want to see the urologist again.

Peter’s urinary tract difficulties resurfaced through the official record in the form of an ambulance call two years before the killing. He was hospitalized due to urinary retention and fitted with a catheter. His PSA started to rise significantly, a possible sign of progressing disease. The urologist commenced hormone therapy and ordered a pelvic and whole-body MRI. Peter was also referred for palliative radiotherapy for his hip pain. Palliative radiotherapy is used to shrink cancerous growth, slow it down, or control symptoms associated with it. It is not a cure for cancer.[91]

About a month after being fitted with the urinary catheter and returning home with pain medications, Peter received abnormal blood test results. He returned to the urology department. At the appointment, Vicki raised concerns about his reduced mobility and increased sleeping. His catheter was successfully removed yet his urinary tract problems and recurrent infections persisted. In spite of his hormone therapy, Peter's PSA continued to rise. Doctors described him as quite sick. He complained about the side effects of his medications which he felt "ruined his quality of life."[92]

Vicki's dementia emerged in tandem with Peter's marked physical decline. Up to that point, a little less than two years before the homicide-suicide, she had had limited contact with doctors. In her mid-sixties doctors diagnosed Vicki with ovarian and endometrial cancer for which she had surgery. In the weeks after Peter received abnormal blood test results, Vicki attended a memory clinic for testing. Peter, Paul, and Emily all noted that she was "struggling to remember everyday events."[93] They had observed her cognitive decline over the preceding 18 months. She was writing lists to keep track of her daily activities. Vicki scored 23 out of 30 on her first MMSE test with "the recall of words being completely beyond her."[94] A score of 23 out of 30 indicates MCI and invites further assessment. A consultant psychiatrist came to the Lampard home to conduct additional testing. This time Vicki scored 26 on the MMSE and 80 out of 100 on the Addenbrookes Cognitive Exam (ACE-R).[95] The psychiatrist reported she was calm and cooperative. She had normal speech and mood and showed no signs of psychosis. Her main deficits were in the domain of memory. He diagnosed her with MCI and reported no risks. According to the DHR report, Peter, Vicki, and their GP received no advice other than the need to re-refer her for assessment in the event her mental state deteriorated. No other members of her family were consulted about her symptoms and apparently no care plan was considered. Paul, Emily, and others who knew Vicki, reported her being "significantly more impaired."[96]

Nine months or so before the homicide-suicide, Peter was admitted to the hospital. A tumor on his pelvis was obstructing his bowels. His bowels had not opened for three weeks. He had bowel surgery soon thereafter. A colostomy bag was fitted. His physical mobility had decreased significantly. At home, he suffered a number of falls. Three months before the killing, doctors ordered another scan due to Peter suffering severe pain in his right arm.

Reviewers perceived that in the weeks before the tragedy, given his terminal prognosis, Peter sensed that when he next went into the hospital, he would not come out. All those who knew Peter Lampard said he was a proud man who wanted to handle his own problems. He was suffering intense and constant pain, barely mobile, but would apparently not take morphine. His bed had moved to their lounge. Vicki slept on the living room couch to be nearer to him. The family felt that she did not really recognize Peter's pain and distress, or if she did, because of her advancing dementia, saw it afresh each time. Vicki was always clear that she did not want to go into a care or nursing facility or even have carers come into their home. Peter knew she would need help. He tried to persuade her to have carers, but she refused. Reviewers thought he supported her decision to decline help out of loyalty to her. He continued to voice his concerns about what would happen to Vicki when he was in the hospital.

Peter left two notes at the scene of the homicide. The paperboy found his note on the front door. It advised the reader not to come into the house because inside, he and Vicki were dead. It asked the reader to call the police, which the paperboy did. Officers found Peter hanging in the hallway. He had apparently used a white rope to suspend himself from the banister at the top of the stairs, his feet resting just a few inches off the ground. They found Vicki on the living room sofa covered in a blanket. Peter had apparently rendered her unconscious by hitting her head with a small sledgehammer. Police found the hammer, wrapped in a black sock, beside her body. He then used a scarf to strangle her to death.

Undetected Caregiver Killings

The rarity of the caregiver killings belies the possibility of a number of them remaining undiscovered. It would be naïve to think we might identify and track all gray mist killings through information gleaned from the newspapers, police, prosecutors, courts, medical examiners, and coroners. It is likely there are many more killings than end up in the official record. A decade or so ago, US National Public Radio ran a segment on cutbacks in conducting autopsies.[97] Listeners learned that many underfunded and understaffed medical examiner and coroner offices ceased performing autopsies for some deaths. Numerous jurisdictions had stopped doing autopsies on people over 60, unless there was a violent, not just suspicious, death. The curtailing of autopsies for many elderly decedents raised concerns among law enforcement and health care professionals of a "quiet epidemic" of "gray homicides" that go undetected and unpunished.[98] Part of the problem involved stereotypes about the elderly, such as they always have bruising and they fall a lot. Hence, noticing a violent death among elders was more difficult than with someone younger.

Take the hypothetical case of police officers attending the residence of a 90-year-old deceased mother with advanced Alzheimer's disease and a number of other health problems. They may look for signs of foul play, forced entry, obvious defensive injuries on the body, and suspicious statements by family members, friends, neighbors, or others. Some astute officers might log medications in plain view or even discretely check for medications not in plain view. They may do so to see if the death possibly involved an overdose. The officers may conclude the ailing mother died of natural or disease-related causes at a ripe old age. An inquisitive officer may have wanted to obtain the name of the prescribing physician. The physician, once notified of the death and the circumstances, might sign a death certificate reporting a death, for example, from unspecified natural causes.

Assuming the police department had the policy and resources to send a detective to the scene, the investigation might be more thorough. Detectives differ in their degree of investigative skill and willingness. Some, perhaps sensing something was awry at our hypothetical scene, might push for further investigation, including possibly a full autopsy. Police administrators, cognizant of budgetary constraints, might not approve the detective's request to investigate further. Such disapproval might reflect ageism and/or ableism, with the police administrator adding, "She's 90. She had dementia and other health problems. You've got better things to do. Move on."[99]

Whether a dementia-related family killing becomes part of the official record involves complex social processes. Few cases involving the 90-year-old woman would result in an autopsy. Researchers would not even know of these cases, let alone be able to dig for principal reasons or motives, unless police identified a suspect and prosecutors filed a charge. Therefore, it is possible that some family killings of PWD are hidden. Moreover, we ought to ask if it is more likely that women might kill in ways less likely to be discovered than men, less brutally perhaps? Without a handgun, but through some means more discrete, such as withholding medication? Poisoning?

My reasoning echoes critiques of official statistics regarding other social problems. Jack Douglas' classic critique of Durkheim's study of suicide warrants mention.[100] Using official statistics, Durkheim argued that suicide rates varied in inverse proportion to the degree of integration of the social groups to which people belong. For example, Catholics were less likely to commit suicide than Protestants, the latter belonging to a more "individualistic" religion where adherents are alone before their God. Douglas criticized Durkheim's reliance on official statistics because they failed to address the complex social processes involved in a death qualifying as a suicide. For example, Douglas notes the way coroners infer intent to commit suicide in a variety of ways. Hangings are more likely to qualify as a suicide than road deaths. Coroners differ in their willingness and the informal criteria they use to designate a drug overdose a suicide as opposed to a mistake.

Relatedly, if people who commit suicide were well integrated into social groups, members of such groups (families, friends) might be less likely to recognize or acknowledge to coroners the possibility the death constituted a suicide. Hence, higher levels of social integration may appear to predict lower suicide rates when, in fact, they signify lower disclosure rates. Put simply, the designation of a death as a suicide reflects a social process, a social construction, not a self-evident fact amenable to easy scientific analysis.

Suicides also have various social meanings that differ by society and historical epoch. Douglas notes the social meaning of the suicide of a businessman who takes his own life because his business failed differs greatly from that of the Inuit who commits suicide out of a concern for the social group during a time of food scarcity. Rather than simply counting these disparate incidents as suicides, case studies enable researchers to explore the motives, intent, and social context within which the death took place. Two very different forms of taking one's own life can be labeled a suicide. These observations caution us about the difficulties of comparing gray mist mercy killings across countries and cultures.

Even if authorities determined the death of our hypothetical 90-year-old was unlawful, determining the principal reason or explanation for the killing would still be difficult. Was the hypothetical perpetrator, for example, a desperate and exhausted caregiving adult daughter following her mother's stated wishes to take her life by using an undetectable method? Did the daughter act out of greed because she knew her mother could no longer cope at home and that placing her in an assisted living facility or nursing home would eat into the daughter's inheritance? Did the daughter act out of malice after enduring what she saw as years of her mother's hostility, disdain, insensitivity, manipulation, hallucinations, delusions, accusations, aggression, violence, and growing cognitive impairment? Or in the panic and weariness of her mother's fast approaching death, did the daughter read the mist in her eyes, and out of a sense of responsibility and/or great compassion, decide, that in spite of the law, it was time to end what she perceived as her mother's suffering? If she would do the same for her pet dog, why not for her mother? Alternatively, did the daughter, in the face of the mother's seemingly sinister glares and evil glances, exorcise the devil?

Closing Reflections

Forty-two of the 44 caregiver killings were perpetrated by older husbands. Most appeared loving, caring, and devoted to their wives. These feelings, to the best of our knowledge, were reciprocated. These dynamics were reflected in the deployment of largely instrumental rather than impulsive/expressive/rageful violence to kill. Only two cases took the form of overkills. There is nothing to suggest prior IPV/A took place in any of these relationships. That does not mean prior IPV/A was absent. Two cases involved sons killing mothers with dementing illness. In nearly all cases, the couple was cohabiting and the killing took place at home. Nearly half the cases took the form of homicide-suicides.

One's personal perspectives on the sanctity of life and euthanasia likely influence how one makes sense of the caregiver killings. For some, it is never acceptable to kill a spouse who has dementia. Others find it easier to interpret the action as merciful and/or a product primarily of extraordinary exhaustion and stress. It is impossible to know for sure what emotions preceded or drove their acts of homicide. The limited input of the eventual decedents remains largely opaque. The case narratives reflect varying degrees of mercy and exhaustion. Grand jury decisions, judicial remarks, so-called expert opinions, and plea agreements capture the complexity of public sentiments.

We cannot shy away from the obvious. In our convenience sample of gray mist killings that meet my inclusion criteria, it is men who kill women. I have cautioned that these killings may not be the whole story and that women may use more discrete means such as poison or withholding medication, in order to kill. These discrete killings may be substantial in number, a revelation that might alter the highly gendered ratio of killing. Notwithstanding my caveat, a number of writers have focused on the gendered nature of mercy killings.

Silvia Canetto has questioned whether the mercy killings of older women comprise acts of compassion.[101] She suggests that when framed against the pervasive social devaluing of older women, these killings look more sinister. She suggests the husband-caregiver who kills appears to operate from a position of power and authority vis-à-vis his wife with dementing illness. I have noted that depression, suicidality, desperation, sadness, rage, and anxiety form part of these power and authority relations. Even though the behaviors and actions of the wife with dementia may be difficult and disturbing to deal with for husband-caregivers, wives are in an extremely vulnerable and dependent position.

Consonant with differences in power and authority is the gendered nature of caring, particularly for this cohort of men and women. As some of the case narratives indicate, men did much less of the childcare than women and were in general much less accustomed to provide emotional and personal one-on-one care for others than women. Their caring took the form of making financial provision for family members. Their threshold of merciful behavior was likely much lower than that of women, and hence, in a few rare cases, easier to exceed. We must ask: does the label "mercy killing" sanitize the killing?

The vast majority of caregivers, men or women, do not kill their spouses/partners or other family members as dementia worsens. Most struggle, get help, feel frustrated, angry, tired, seek solace in the memories of better times, take drugs, and, perhaps in darker moments, fantasize about killing.

These observations about the very low absolute risk of a person with dementia losing his or her life in a gray mist killing reminds us of the hazards of searching for explanations of mercy killings amidst broader social and historical patterns of gender relations. Even if we are willing to distill from the historical and sociological evidence that older men exercised considerable power over older women, especially those with dementia, we ought not interpret such power as simple, unidirectional, unfettered, and uncontested. The history of patriarchy is not simply reducible to the rights, privileges, and power of the patriarch, in spite of what the faddish language of gender-based violence might imply.[102]

As Susan Amussen points out in relation to early modern America and England, "The legitimacy of patriarchal power depended on restraint and wisdom in its use."[103] The role of "patriarch," however outmoded this term might seem today, does not accrue to male heads of household without accompanying responsibilities and duties. Doubtless, these responsibilities and duties have changed significantly in the last half century in advanced democracies in lockstep with the transformation of intimacy. Yet for our cohort, we cannot rule out that it is these responsibilities and duties, perhaps more than any limited power, authority, and at times, raw domination, that informed the taking of a life. Indeed, it is in areas of security and protection, such as making decisions about possibly taking life, for example, that of an intruder that the old patriarchal responsibilities persist.

It is also important to consider the possibility that there is a gendered reaction to exhaustion at work in the caregiver killings. We must ask whether men, when pushed to exhaustion, are more likely than women to resort to violence as a solution to perceived problems. Part of any such inquiry involves considering whether the gendering involves a simple lack of experience with or tolerance of caring for others up close and personal, or whether it reflects genetic predispositions. These are controversial matters and represent a different spin on men's greater responsibility for safety and security within families.

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5 Prior Intimate Partner Violence and Abuse

Violent Abusive Men With Dementing Illness Who Kill Wives

Learning to Agree

Liam and Colleen Murphy lived in a picturesque, small town of outstanding natural beauty in the UK. They had been married for over 40 years. He was in his late seventies and she was in her early seventies. The little community dates back to the establishment of a nearby Benedictine priory. Its architectural remnants still speak to the Catholicism its first monks extolled in the twelfth century. Indeed, the first Benedictine monastery in England, St. Augustine's dates back to the sixth century. It was St. Augustine, sent by Pope Gregory from Rome in 595, who would preach Christianity to the pagan Anglo-Saxons. Liam Murphy's Roman Catholicism formed a tiny part of a long religious tradition.

Colleen loved to see the daffodils and crocuses bloom in the spring. Her three adult children, a son and two daughters, described her as a proud grandmother, a devoted mother, and a loving wife. Barry Riles, a neighbor, described Liam and Colleen as a very loving, happy couple. Another neighbor opined that Colleen was a lovely lady who had a good relationship with Liam. Therefore, when Liam brutally killed Colleen, inflicting numerous injuries to her head and body, including breaking her ribs and a tooth, the community was shocked. We learn from the media that Liam, who had dementia, could not remember killing Colleen. On a daily basis, after killing her, he apparently asked where she was, as if she were still alive. At the Crown Court hearing into the killing, we learned Liam had had dementia for a number of years and that it was getting progressively worse.

The night of the killing, Liam had wandered over to Barry Riles' house. It was a little before midnight. Barry and his wife were sleeping. Liam rang the doorbell. It woke them. Standing on their doorstep, Liam asked them, "How do you get 999?" Media reports note Barry saying Liam was bewildered and confused. Liam asked Barry to call the police, which he did. Neighbors went to the Murphy residence. They found Colleen dead in the hallway at the bottom of the stairs. According to Barry, Liam was oblivious to the fact that he had apparently killed Colleen. Rather, Liam was worried about the location of his house keys. Police arrived. Liam had an injury to the knuckle on his right hand. The knuckle continued to swell as people

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worked out what had transpired. According to Liam's sketchy account, he had left Colleen watching television. He later saw her asleep and shook her to try to wake her. The forensic pathologist testified that some of Colleen's injuries might reflect accidental wounding from, for example, a fall down the stairs. However, other injuries suggested blows from a fist or defensive wounds as she tried to protect herself.

Liam was arrested at the scene on suspicion of murder but later released without charge to a mental health facility. Within six months Liam appeared in court, charged with her murder. Several months later, a jury determined he had killed Colleen but that he should, because of his mental health problems, be confined indefinitely to a mental health facility. One of the investigating police officers described the case as "tragic" but expressed satisfaction at the jury's decision.

Victim impact statements, reported in the media, provided further insights. The eldest daughter, Ciara, said she had spoken to her mother just hours before the brutal killing. She lamented she had not properly said goodbye. Ciara also expressed worry her father would one day be released. Her mother's death had disturbed Ciara deeply. She no longer attended the Roman Catholic Church and had removed her children from Catholic school. Her statement referenced her father's religiosity and said his actions made a mockery of religion. Ciara's younger sister, Clodagh, told the court she was still angry and now had a low tolerance for humanity. Unable to concentrate anymore, Clodagh was troubled by memories of her mother and had not even been able to work in a voluntary capacity.

In his summation, the judge expressed his sympathy for family members. He noted the killing occurred with "great violence" and that Colleen was attacked at the top of the stairs and ended up at the bottom. He also noted Liam had been behaving bizarrely earlier that fateful day but there was nothing in the record to predict such a violent, brutal outcome. Invoking the powers of the state under Section 37 of the Mental Health Act 1983, he ordered Liam to remain in the hospital. Under Section 41 of the same act, he imposed restrictions which meant Liam would not be released without the express permission of the British Home Secretary. This, the judge deemed, was necessary for the public protection.

The sentencing thus provided a bookend for the public phase of this overkill case. A man, an elderly husband, apparently lost control because of his dementia. Indeed, he had seemingly forgotten what he had done. His neighbors saw the couple as happily married. Liam was apparently a good Roman Catholic husband. End of story. However, the DHR would reframe the atrocity tale. In so doing, it would provide a cautionary note about how to interpret gray mist killings seemingly attributable to dementing illness.

Liam had had a career in the Merchant Navy, the fleet that protects British commercial shipping. It dates from the "halcyon days" of the British Empire and the trade in commodities such as sugar, opium, tea, and spices. At the opening of World War II, the British Merchant Navy was the largest in the world. At the close of his naval career, Liam found employment in an engineering firm, rising to the rank of manager. However, he was made redundant in his late fifties and never worked again. According to family members, the redundancy dispirited him. He felt rejected and his mental health deteriorated.

David Stonecypher, writing in the *New York Times Magazine* around the time Liam Murphy entered the Merchant Navy, noted how forced retirement stressed older people, particularly older men. Using the prose of his day, he notes the blow to a man's self-esteem, especially in the eyes of his wife and family. The man suffers the "implication that he is too feeble to carry on."[1] For Stonecypher, "A woman is not deprived of her activities as much as a man, primarily because she maintains her housekeeping responsibilities. Then, too, the woman's interests as she becomes a grandmother are similar to those she had as a mother."[2] For men, these life transitions gave rise to new, unconscious fears. According to Stonecypher, some of the forgetfulness that accompanied men's retirement stemmed from their attempts to wall off treasured memories of more successful times. He comments,

> Doctors used to marvel that a man who could not find his way home from the grocery store could still repeat accurately the plays of a football game forty years earlier. The explanation is simple. The man enjoys remembering the times he was victorious. But the same man, retired from foreman at the plant to become errand boy for his wife, unconsciously finds it so painful to come home that he cannot remember his way.[3]

Stonecypher's interpretation reflects the gendered division of labor and societal views of many men and women in the 1950s. It is important to remember, though, that Liam and Colleen, like most of the couples that appear in these pages, came of age in the 1950s or thereabouts. For men, the potential emasculation of forced retirement, of being thrown on the scrapheap of post-World War II capitalism, may well have undermined their sense of self, their pride. These views also echoed the then-prominent psychodynamic models of aging. The dementias, then, according to writers like Stonecypher, were at least in part socially created. Biological forces, the deterioration of the brain and nervous tissue, were mediated by social and psychological forces of considerable importance. In short, if you don't use it, you lose it. Was loss of manly pride part of Liam Murphy's decline in retirement?

Within four years of his retirement, police responded to a domestic violence disturbance at the Murphy residence. Colleen had run from their house to a neighbor's house. The neighbor, hearing a heated argument in the Murphy's garden, had summoned police. Liam had apparently laid hands on Colleen. She yelled "no" at him several times. The neighbor expressed concern for Colleen's safety. The call, nestled away in police records, was coded as "emotional domestic abuse." Police apparently sent the couple a list of community resources.

Daughter Ciara recalled an attempted assault by her father seven years after the first police visit to their home. It took place at a stressful juncture. Colleen had just been discharged from the hospital after having a mastectomy. She would remain under the care of a specialist breast care nurse for the rest of her days. Ciara was pregnant. Clodagh was recovering from a surgery. Amidst this turmoil, Liam apparently claimed he was not receiving enough attention from his family.

Some might infer from this information that Liam's fear of rejection was considerable, that he suffered from abandonment anxiety, that he was narcissistic and acted out a sense of profound entitlement, and that he was oblivious to the plight of his wife and daughters. One might conclude that he was incapable of an intimate relationship. Ciara recalled one occasion during this difficult juncture when Liam lost his temper and attempted to strike Colleen. Clodagh intervened. She stood between the spouses and prevented the assault. Colleen moved out to live with Clodagh. Ciara remembers her mother taking photographs with her, as if making a permanent break from her husband. Colleen stayed with Clodagh for two weeks, eventually returning to live with Liam.

About two years before the killing, Liam's GP referred him to the Early Intervention Dementia Services (EIDS) because of concerns about his failing short-term memory over the preceding two years. An EIDS nurse conducted a follow up visit at the Murphy residence a few weeks later. The nurse noted Liam repeatedly asked the same questions and was disoriented with respect to time, having difficulty recalling the year. Within a month of the EIDS nurse visit, Liam saw a lead consultant at the Older Adult Mental Health Services. Colleen accompanied him. She had complained about his deteriorating memory and him becoming more aggressive verbally and physically. The consultant arranged for him to have a CT scan to learn more about his condition. Liam questioned why he needed the assessment. He could not remember the EIDS nurse's visit to his residence a month earlier. Liam scored 75 out of 100 on the ACE-R, a well-established diagnostic test for dementia. This score was below the cut off of 82 out of 100 and suggestive of mild dementia. Relatedly, he had scored only 9 out of 28 on the memory test and had no recollection of being asked to remember test items.

The CT scan revealed disease of the small blood vessels. Three months after visiting the consultant, Liam was diagnosed with mixed AD and vascular disease. Doctors explained that his dementia was very mild and would have a limited impact on his daily life. The overall assessment did identify his overactive, aggressive, disruptive, or agitated behavior, but the report did not raise any concerns about these. Colleen became his sole carer.

Within a month or so of his official diagnosis, an EIDS nurse and the dementia advisor came to the Murphy home. Apparently, Colleen was not present when they came. Liam explained to the health care professionals that Colleen had forgotten about their visit. They visited again six weeks later. This time Colleen was present. She informed them she had recently stayed overnight at her daughter's house. During her stay over, Liam had repeatedly forgotten where she was, expressing, perhaps deceptively, he was concerned for her safety. At that same visit, the EIDS nurse explained to Liam and Colleen that unless they had further needs, the plan was to discharge Liam from the EIDS.

A little over four months later, Colleen called the police. The operator could hear shouting in the background but Colleen did not say anything. Eventually, the call was disconnected. It was traced to the Murphy residence. Police tried to reach the residence using the phone but could not get through. Liam had smashed the phone. Police went to the residence. They found both Liam and Colleen drunk after consuming three bottles of wine between them. Police surmised that a verbal argument had taken place between the couple, brought on by the worry associated with

Liam's dementia diagnosis. Liam had apparently been verbally abusive to Colleen. Although police tried to arrange an overnight hotel stay for Colleen, she declined. Instead, she stayed over at a neighbor's house so that she could remain close to Liam. The police recorded the visit as an "emotional domestic abuse incident." Colleen refused to acknowledge the incident constituted domestic abuse. Police made no referral to Health or Adult Social Services.

Six weeks or so later, Colleen presented at the emergency department of the local hospital. Doctors found an un-displaced fracture to the distal radius. In a follow-up visit with her GP, Colleen reported she broke her wrist in a fall. It seems no suspicions were raised at the hospital or by her GP about the possibility her broken lower arm bone might have stemmed from a domestic assault. This may have been because such injuries, if stemming from IPV, usually involve the ulna (the bone on the pinkie or little finger side of the forearm),[4] or hands and fingers,[5] often caused by holding the arm up to protect the face/head from a blow.

By this point, Liam's dementia had worsened. His GP sent a letter to the locum (substitute) consultant in Older Age Psychiatry requesting a review of his case. Colleen had reported that Liam's memory was significantly worse and that he was becoming increasingly disoriented and agitated. A community psychiatric nurse (CPN) responded to the GP's letter by arranging a blood test for Liam. The CPN also telephoned Colleen. It was during this call Colleen shared Liam had been the cause of her broken wrist six months earlier. Colleen also said Liam was becoming physically aggressive at times. She told the CPN about her most recent call to the police. Significantly, Colleen reported she had "learned to agree with him as this helps him remain calm."[6] In later conversations with the DHR team, the CPN said she interpreted Colleen's placatory stance vis-à-vis Liam as a sign she was learning to manage his dementia. The CPN did share this information with the admiral nurse, but that was as far as it went. It did not enter the broader social services network, and no risk assessment for domestic abuse occurred, even after Colleen's disclosure that it was Liam who broke her wrist. One wonders in how many other cases involving dementia the violence and abuse of PWD is not situated amidst the complex dynamics of pre-existing IPV/A?

Liam's case quickly became a point of discussion at a team referral meeting. The minutes of the meeting do not reference Colleen's disclosure that Liam was becoming physically aggressive or that he was responsible for breaking her wrist. This was a point the DHR team examined, as per the UK Home Office statutory guidance.[7] Agencies involved in domestic homicides produce written individual management reviews (IMRs) as part of the DHR process. In *Murphy*, the IMR authors received a briefing from an expert on dementia to "enlighten the panel regarding the effects of dementia on individuals and families as well as the developing problems carers face as dementia progresses."[8] One key concern was how the Older Adult Psychiatry team interpreted Colleen's statement; she had learned to agree with Liam. The IMR author noted her statement was taken as evidence she was coping with Liam's behavior. It was not taken to mean she was possibly subject to his coercive control[9] or situational couple violence.[10] The IMR author noted the team had no other evidence to support an interpretation of IPV/A. Significantly, staff felt that Colleen was "in charge," that she was a "forthright character" who had carefully negotiated the level of services she needed.

A day after the team referral meeting, the admiral nurse called Colleen. During that call Colleen communicated Liam had deteriorated since his contact with the EIDS. She reported she was finding it difficult to adjust. Two days later, an admiral nurse visited the Murphy home. Liam and Colleen were both present. The admiral nurse documented Colleen was finding it difficult to adjust to the fact that dementia involved progressive deterioration. She felt Colleen was looking for a treatment intervention to arrest his decline. The DHR reports no mention in the admiral nurse's documentation of the wrist injury Colleen sustained six months earlier. However, the admiral nurse did document there was no evidence of abuse. One specific exchange caught the DHR team's attention: "Is there any evidence that the PWD is at risk of harming others?" The recorded answer was "no."[11] The admiral nurse did report that Liam's skills had deteriorated of late and that his irritability had increased. Notably, Liam "shouts at Colleen and has limited patience for his grandchildren." The nurse was critical of Colleen's "limited understanding of dementia," noting Colleen found it hard to discuss the future and how it might look. The admiral nurse reported Colleen did accept an invitation to attend a Psycho Educational Group.

In between the admiral nurse's visit and the Psycho Educational Group, a doctor and a GP trainee doctor visited the Murphy home. They noted Liam was "less given to frustrations or episodes of increased irritability and agitation on his current dose of medication, and that Colleen had confirmed that he had been calmer."[12] These medical observations do not mean that Liam had ceased to be irritable or agitated. Rather, they suggest the doctor's written interpretation was that Liam's medication was keeping his dementia symptoms at bay at that particular juncture.

Colleen attended three Psycho Educational Group meetings in the space of a month. She had less than three months to live. There is no record of her disclosing Liam's IPV/A in those groups. Ciara would later tell the DHR team her mother would not have disclosed abuse within the group because a friend was also a member of the group, and Colleen would have been embarrassed to share such details. In a conversation with the admiral nurse a month before her death, Colleen apparently reported finding the Psycho Educational Groups useful. She also shared her home situation had settled. As a result of this conversation, the admiral nurse apparently concluded her services were no longer needed. Colleen was discharged from the service and given the option to re-contact them, if needed.

During those last three months of Colleen's life, Liam saw his GP and a consultant psychiatrist. Six days before the killing, the consultant in Old Age Psychiatry wrote the following: "Other than the occasional increased irritability and being a bit more short-tempered, there has been no significant aggression or behavioral disturbance. His wife reports no management difficulties and maintains feeling extremely well supported by the team."[13]

The day of the killing a gas fitter saw both Liam and Colleen at their house.[14] The fitter reported "All appeared well between them."[15] Apart from Liam, the fitter was probably the last person to see Colleen alive. Colleen was due to go to her part-time volunteer job that day, but she did not attend. In a conversation with a co-worker, Colleen apparently explained she had trouble with her car. The DHR team thought this to be an excuse and not the reason she failed to attend work.

Interviews with the Murphy daughters add to our understanding of the complex micro-dynamics in this case and give us a glimpse of the seemingly counterintuitive behavior of victims of IPV/A, especially when they are caring for a spouse/partner with dementia. Both daughters saw their mother as a private person who would not share details of her marital problems. Ciara described Liam as a very strict disciplinarian. To illustrate her point, she referenced the tension at Sunday lunches. After a Roman Catholic Church service, Liam would retreat to the pub, eventually arriving home for lunch. The reviewers note, "Any minor infringement such as talking or dropping food would result in physical chastisement." Ciara shared how her brother "was hit and bruised" by her father. Her mother told Ciara and Clodagh to "tell his school he had fallen off a slide." According to Ciara, Colleen also meted out physical chastisement. Ciara reported Liam was "often physically violent towards the children and Colleen."

One of Ciara's observations about Liam warrants note. She comments that during the church service, when the congregation shook hands during the sign of peace,[16] her father would squeeze the hands of other congregants so tightly "to hurt them." The sign of peace has deep symbolic meaning in the Catholic Church; it is much more than a sign of respect to those in nearby pews. Scholars and theologians trace it back to St. Augustine's writings and particularly his emphasis on making peace in the consciences of the faithful as much as among the faithful.[17]

Regarding the relationship between Liam's dementia and his domestic tyranny, Ciara remarks, "He was not a man who became violent due to dementia. He was a violent man who got dementia." Ciara describes an 18-month period in her earlier life when her father moved away from home in order to work in a different county, only returning on weekends, as "the best 18 months of her childhood."

Ciara tried to persuade her mother to see a different GP. She complained to Colleen's male GP that he did not take Liam's increasing aggressiveness toward Colleen seriously enough. Colleen reported feeling depressed at that time, and Ciara felt the GP dismissed her mother's feelings of depression. Additionally, Ciara felt there was a conflict since the male GP was a congregant at the same church where her father "liked to give the impression that he was a devout Roman Catholic and busied himself in church during mass to be popular." Finally, Ciara explained that her mother and Colleen's three siblings were all beaten by Colleen's mother, opining her demeanor as a "victim" was learned. Around that time, Ciara also spoke with her mother about placing Liam into a care home but Colleen replied she would not do that.

Clodagh also felt Colleen's male GP lacked empathy, particularly regarding Liam's aggressiveness. She wanted her mother to use a female GP, the one she had worked well with in relation to her breast cancer. Importantly, Clodagh felt her mother was ready to divulge her abuse at Liam's hands to the female doctor. Like Ciara, Clodagh felt her mother drank too much alcohol. Indeed, Clodagh reached the point where she only telephoned her mother in the morning when she knew she was more likely to be sober. Like her sister, Clodagh also recognized her father's destructive use of alcohol.[18] Nevertheless, she was emphatic that Liam was a violent bully "who did not need alcohol to fuel his aggression or violence."[19]

The pathology report revealed Colleen's injuries, extensive as they were, had been inflicted over a long period of time. This injury history comports with Ciara and Clodagh's accounts of their family life. The case leaves us with many questions. Was Colleen more reluctant to leave Liam because she had been married to him for over 40 years? Because of her religious beliefs? Her embarrassment? Her love for him? Her guilt? Her fear of the unknown? Her hope for an improved relationship, however misplaced? Did these concerns and others contribute to her reluctance to put him under care?

Given the importance of studying the social determinants of health, we might also ask if it is possible that Colleen's long-term subjection to Liam's IPV/A contributed to her breast cancer.[20] Did his alcohol consumption and smoking contribute to his dementia? Worsen it? Create a state of delirium rendering him more prone to homicidal violence? Or was his dementia a bit of a red herring, an excuse, a distraction from the inevitable trajectory of an angry man in decline who was a domestic tyrant at his very core?

We must also interrogate Liam's social history, something neither the media coverage nor the DHR did to any significant degree. We might ask what went into his emotional biography that contributed to his violent and aggressive proclivities. As James Garbarino points out, many killers are untreated traumatized children inhabiting the bodies of adult men.[21] Does this hold true for gray mist killers with dementia? At the same time, the vast majority of untreated traumatized children do not kill. Finally, we must ask whether Liam's act of seemingly frenzied overkill[22] contributed to his inability to recall events and the intensification of his dementia, particularly his seeming repression of memories of his wife's death. Put simply, in the aftermath of the overkill, did Liam experience what is known as perpetrator trauma?[23] Alternatively, was Liam malingering or confabulating?

Angry All the Time

As if to emphasize the global commonalities among gray mist killings like *Murphy*, a similar case occurred in an urban area of New South Wales, Australia. Again, we see a woman who had been subjected to long term coercive control finally meeting her end in a frenzied stabbing attack. Abdel Khalil, in his early seventies, stabbed wife, Injila, in her late sixties, 19 times after she told him she was thinking of leaving him. They had been married for 50 years and hailed from the Middle East. Abdel retrieved a hunting knife from his bedroom and returned to the kitchen where the couple had been arguing. After killing Injila, Abdel exited the home and yelled, "I killed her, I killed her, I killed the bitch, call the police, call the police." He told arriving police, "I think she's dead. I want her dead. I wanted to kill her." Later he told police, "I don't [sic] want to do it, she made me. I want to die." On the way to a police station he said, "I don't [sic] want to do it. She made me do it.

I swear to God I didn't want to do it. I pray to my God but I had to do it, she made me. Please don't tell my daughter it will kill her too. We have trouble for long time. She hit me. I say please don't do it. She always out. She have [sic] lots of sisters. Always out. I have nobody. I want to die." Malingering? Confabulation? Word salad? Something else?

The judge referenced materials submitted to the court to indicate that Abdel had been verbally and physically abusive to Injila. He commented that Abdel, "Appears to have been very domineering toward her and attempted to control her life to his benefit. . . . It was a frenzied stabbing in the context of a history of abusive conduct towards the victim." From the court's perspective, Injila had apparently communicated to Abdel that she was thinking of leaving him. This was likely the trigger for the frenzied violence.

According to court transcripts, the dementia, probably Alzheimer's disease, was operative at the time of the stabbing and had been progressing for at least a year. About a year after the killing, Dr. C diagnosed Abdel in the "early to mid-part of stage I of the dementia."[24] Psychiatrist A proffered the opinion that at the time he killed Injila, Abdel was "probably manifesting signs and symptoms of dementia of 'some degree of severity.'" For A, this meant that Abdel had a "reduced capacity" to rein in his impulses. Psychiatrist B opined that Abdel suffered MCI that would have affected his ability to reason.[25] She also pointed to problems with Abdel's memory, judgment, and attention that raised questions about his fitness to be tried.

Crown prosecution, defense counsel, and the court all agreed that the most appropriate legal course was for Abdel, through counsel, to plead guilty to manslaughter. His diminished mental capacity and his prognosis ruled out proceeding against him for murder. The Supreme Court duly sentenced Abdel to a minimum of 2.5 years in prison with a maximum term of four years and 10 months. The judge remarked that the low sentence would not have been appropriate in "normal" cases where a husband killed his wife in this way. But he noted the case was "very unusual" because of Abdel's mental condition. Specifically, the judge remarked, "Having regard to the present mental condition of the offender and the prognosis of a continued decline in his mental state the denunciation of that conduct should be substantially moderated. The situation is that there is little prospect of the offender having any real enjoyment of life after his release from custody."

The judge added that the sentence may seem unfair to family members. Indeed, Abdel and Injila's only living child, Iffaa, articulated the depth of her grief and said she wanted nothing to do with her father. In her victim impact statement to the court, Iffaa stressed her mother had been a "pure innocent person," as opposed to her father, who "was angry all the time and didn't like people." Iffaa's perspective on her father recalls that of Ciara and Clodagh Murphy about Liam.

Victim-Precipitated Homicides

I now narrate three gray mist killings where perpetrators, one man and two women, had dementia and where they appear to have been the long-term victims of IPV/A that predated the signs and symptoms of their dementia. These killings take the form of what Wolfgang once referred to as victim-precipitated homicide, namely,

> criminal homicides in which the victim is a direct, positive precipitator of the crime. The role of the victim is characterized by *his* having been the first in the homicide drama to use physical force directed against his subsequent slayer.[26]

Other researchers saw criminal homicides arising out of a process of social interaction. In a classic article, Luckenbill rejected the idea that criminal homicide was a "one-sided event with an unwitting victim assuming a passive, non-contributory role. Rather, murder is the outcome of a dynamic interchange between an offender, victim, and in many cases, bystanders."[27] Luckenbill emphasized the importance of "saving or maintaining face and reputation and demonstrating character,"[28] themes which "characterized all cases irrespective of such variables as age, sex, race, time and place, use of alcohol, and proffered motive."[29]

We might ask to what extent the gray mist killings involve these increasingly intense spirals of negative interactions to save face, to restore a semblance of pride, a modicum of control. To what extent does the increasing neuropathology of the PWD inform these negative spirals? As James Gilligan notes, unrecognized, bypassed, hidden, or secretly held emotions of shame and humiliation often drive acts of violence.[30] Explosions of violence, however temporarily, act to restore pride and a sense of control. How does the development of dementia affect the experience of shame and its potential transformation into hostility, violence, and gray mist killing? Are some PWD more susceptible to entering potentially dangerous spirals of social interaction? The victim-precipitated cases that follow help make sense of this matter.

The Gentle Giant

In an outlier case of gray mist killing with only scant information, retired newsagent, David McLeish (real name), age 74, strangled his wife, Dorothy McLeish, age 72, in their flat on September 7, 1994, in Glasgow, Scotland. He had been in the early throes of dementia at the time he killed. According to the judge at the High Court in Edinburgh, David's diminished mental state justified three years of probation as opposed to a custodial sentence.[31] Psychiatric reports and brain scan data confirmed David's dementia. We learn the dementia could have resulted in David losing his normal inhibitions and killing his wife in a fit of rage. Even her relatives supported David, noting he coped with an intolerable situation. His lawyer said David was also subject to "sporadic violence at the hands of his wife."[32] In addition, he had gout and could not walk properly.

We learn Dorothy had been an alcoholic since the time David retired and had been "abusive and very difficult throughout that period."[33] On the day of the killing, Dorothy had been drinking. She apparently ordered him out of their two-bedroom flat. To avoid her, he apparently retreated to a bedroom. She followed him. At that point, he reported he grabbed her throat and told her he was going to kill her. Dorothy returned to her chair in the living room. David eventually entered the living room with a length of rope, approached Dorothy and strangled her. He then called police and told them what he had done. They arrived to find Dorothy in the same chair in the living room, the rope on her chest, and blood coming out of her ears.

The fact Dorothy's relatives supported David implies he was indeed the victim of abuse from Dorothy. There is no available official record of any violence on her part, so we are left with the statement of his lawyer that David was subject to sporadic acts of violence. As with all these cases, there is so much we do not know. We cannot rule out that David was violent or abusive to his wife. However, neighbor Margaret observed, "To us, Mr. McLeish was a gentle giant and all the neighbors just hope he can come home and live the little time he's got left in peace."[34]

Our next two cases involve female perpetrators: one African American, one Aboriginal Australian. From the available evidence drawn from documents such as police reports, prosecution files, defense counsel statements, court transcripts, publicly available psychiatric reports, and media reports, both women appear to have been subjected to long-term IPV/A at the hands of their intimate partners. The confluence of these legacies of abuse and the biological, emotional, and cognitive damage of their dementias provide context and meaning for their acts of gray mist killing. The first of these two cases hails from New Jersey.

A Red Car and a Red Tracksuit

On July 19, 2012, Fredricka Rosa (real name), diagnosed with dementia in 2009, shot and killed her husband of 54 years, Valpa Rosa Sr., age 79, with his .357 Magnum. Upon her arrest, a news camera filmed 77-year-old bespectacled Fredricka limping with a cane beside a burly Pemberton Township, New Jersey police officer. Her red tracksuit catches the eye. It matches the color of her small red car as she shuffles past it on her way to a police cruiser. Her salt and pepper hair blends well with the silver branches of the summer shrubbery. The temperature is in the nineties. Scattered cloud drifts. At roughly 50 percent humidity, the air is not as moist as that in Charleston, South Carolina, Fredricka's place of birth. She had lived in Pemberton Township since 1973. Valpa Sr., a retired postal worker, had previously served in the Army and Air Force.

The news segment pans to her two adult children, Rosetta and Valpa Jr. The siblings came from their homes out-of-state to be with their mother after she called them to tell them she had shot their father, killing him. Rosetta, age 51, enlightened viewers, "He drove her insane. He drove her to the point where she picked up a gun and shot him. . . . He tells my momma he don't want her no more. She can't cook no more. I don't want you."[35] The local NBC affiliate shows a family photo of the married couple, smiling. Valpa Jr. describes the photo as misleading because it masks years of violence by their father. He tells viewers, "I understand why my momma did it." Other witnesses concurred that Fredricka, in ailing condition, waited hand and foot on Valpa Sr.

A number of conflicting reports characterize *Rosa*. We learn in one that Fredricka claimed she shot Valpa Sr. because she heard him sexually assaulting their granddaughter. However, as Rosetta pointed out, the granddaughter was not near the house prior to Valpa's death. The granddaughter denied sexual contact with Valpa Sr. at any time. Fredricka made similar claims about her son's girlfriend, who, for a time, also lived in the family home. As noted, Rosetta and Valpa Jr.'s interpretation was their mother killed their father because of years of domestic abuse, particularly emotional abuse. Family members remarked he was consistently verbally abusive to Fredricka. Indeed, one wonders if any such domestic abuse contributed to the onset of her AD.

In the year before the killing, Fredricka's AD worsened. During that year, a number of domestic disturbances occurred. On November 22, 2011, Pemberton Township police were called to the family home. Valpa Sr. called because two of his adult children turned up at the house accusing him of harming their mother. He told police their mother was in the hospital because of medical problems the preceding day. Police asked the adult children to leave. They did. Police asked Valpa Sr. if he wanted to take out a restraining order against the two adult children. He declined. A week later, Fredricka called police. She accused Valpa Sr. of taking her car keys. The police report notes her dementia, leaving open the possibility her claim reflected dementia-related paranoia.

On April 17, 2012, Fredricka called police to report her husband harassing her. She claimed he had yelled at her and told her, "to get the fuck out of the house." She filed a formal complaint and requested an order of protection. Valpa Sr. surrendered his weapons: two pistols, one shotgun, and one pellet gun. Police arrested him. He was released on his own recognizance.

As 2012 unfolded, Fredricka's dementia worsened. Her son worried because after cooking she would leave the flame burning on the stove. Fredricka's persecutory delusions of Valpa Sr.'s sexual relationships with younger women in the family continued. On June 21, 2012, Fredricka again summoned police. She complained that Valpa Sr. had told her to get out of the house by the time he returned from a doctor's appointment. When police arrived, she appeared to be disoriented, unable to give a consistent story, and did not know the day or date. Police contacted Valpa Sr. He showed police written confirmation of her Alzheimer's diagnosis. The next day police returned for an abandoned 911 call. Again, Valpa Sr. explained the role of her dementia in calling police. Fredricka expressed concerns about Valpa Sr.'s alleged removal of their son and his girlfriend from the residence. Valpa Sr. apparently wanted his guns back since he was not subject to an order of protection. Due to previous infractions, his son could not be around firearms. Within three weeks or so, in spite of Fredricka's protestations, Valpa Jr. left the residence. The guns came back to the house. Fredricka used one of them to kill her husband.

In the early summer of 2012, those treating Fredricka's AD recommended she wear an ID and that discussions begin about placing her in an assisted living facility. Valpa Sr. was making plans for such a placement. Some family members objected. Others were more supportive of the proposed move. Available records do not reveal Fredricka's position on any such move.

On July 19, 2012, Revello Rosa, the youngest adult son, apparently received a call from Fredricka asking that he come to the family home. At first, he claimed she would not tell him why. He called his older sister, Rosetta. She recommended finding out more information. Revello called his mother back. He reports her saying she had shot dead Valpa Sr. Revello informed Rosetta of their mother's claim. Fredricka reportedly said she could not endure Valpa Sr.'s abusiveness. Neither sibling seemed able to discern what had happened. They told police later they wondered whether their mother was telling the truth. Navigating through a gray mist of strange facts, they apparently decided to leave their respective out-of-state residences to travel to the family home in New Jersey. They arrived, Revello first, on July 19, Rosetta a day later. They delayed reporting the killing to police until the morning of July 21, 2012.

The circumstances of the killing and the delay in reporting it rendered the case confusing for law enforcement. Regarding the delay in reporting the death to police, the adult children said they wanted time with their mother to calm things down, time often denied them by their abusive father. Why might Fredricka have killed her husband? Did she kill him as an act of revenge for all the years of verbal and occasional physical abuse? In self-defense? Because she perceived he forced their eldest son from the home? Because she believed he was having sex with younger females living in the house? Because he was about to place her in an assisted living facility? Out of some combination of these grievances? As a result of neurodegeneration?

Importantly, we might ask what was the state of her mind at the time of the killing. Was she in a lucid phase of the AD, however fleetingly, where she knew right from wrong? Did a lucid mind form the intent to pull the trigger three times, killing Valpa Sr.?

Her now retired public defender, Cedric Edwards, confirmed that several psychiatric reports determined Fredricka suffers from dementia. Significantly, at the time those reports were produced, Fredricka apparently no longer realized she had killed Valpa Sr. Edwards said at her court appearance, Fredricka "was asking if her husband was in the courthouse."[36] The reports led to a conclusion the prosecutor, defense counsel, and the court agreed upon: that Fredricka was unfit to proceed with trial and that her condition was progressive and irreversible. This meant she would have been unable to understand the court proceedings, know the roles of the lawyers, judge, and other court personnel, and not be able to participate meaningfully with Edwards in her own defense.[37] We might ask, as in other cases, whether any perpetrator trauma stemming from the killing accelerated Fredricka's AD beyond the point she was no longer fit to stand trial. If such acceleration did occur, we might rightly wonder what her state of mind was at the time she pulled the trigger.

Amyloid plaques and tau neurofibrillary tangles often characterize the deteriorating nervous systems of PWD from all backgrounds across the globe. Some groups, as noted, have a higher likelihood of developing these neurocognitive disorders than others. Disadvantaged groups are more adversely affected. Are these observations relevant to Fredricka's situation as a Black elderly woman?

Stolen Generations

Our final case in Chapter 5 takes us to south Australia, a part of the world the infamous British seafarer, navigator, and cartographer James Cook first mapped in 1770. Excerpts from his remarkably detailed journals warrant mention. For example, on April 22, 1770, Cook noted a gentle breeze and smoke from several fires near a beach on the coast of southeast Australia. At 5:00 p.m. he observed the perpendicular cliffs that he named Point Upright. As they approached the shore the following morning, they observed several people on the beach. Cook noted the dark color of their skin or clothing. During the afternoon of April 30, 1770, Cook recorded the presence of 16–18 natives within a hundred yards of Mr. Hicks and other members of Cook's contingent. Mr. Hicks, we learn, made every effort to entice them closer with gifts. His efforts were to no avail. Cook writes that all the natives seemed to want was for Mr. Hicks and his group to be gone.

These early contacts between the English explorers and native peoples prefaced a long period of colonization running through to the present. Themes of colonization permeate the killing by an Aboriginal woman, Debbie Colthurst, of her long-term abusive partner, George Mindham (pseudonym). Debbie was an illiterate woman in her mid-sixties with an IQ of 63. She had a mild intellectual disability, worsened by multiple head injuries and acts of non-fatal strangulation. Debbie was born in a sheep-rearing town in the Southern Tablelands of New South Wales, roughly the same distance from Sydney as Point Upright. Europeans apparently first saw the settlement two centuries ago.

As a member of the so-called Stolen Generations, Debbie was forcibly removed from her Aboriginal parents' care and placed in a girl's home in Goulburn.[38] There, she was assaulted. The domestic violence fatality review team report attributed her removal to a racist welfare policy. She was then fostered on a sheep station before finally being placed in an orphanage in Sydney. From childhood, Debbie experienced extreme physical and sexual abuse. Her sexual abuse between ages 5 and 14 resulted in her experiencing gynecological problems in her 20s. When depressed in her 20s and 30s she attempted suicide. Relatedly, she was plagued by chronic substance misuse. She abused both alcohol and cannabis from age 20. In her 30s, Debbie received counseling and support from a Christian organization. She lived in social housing for three decades. Debbie received a disability support pension but it was not until the aftermath of killing George that she received psychiatric services.

She developed early-onset VaD. In the aftermath of the killing, neurophysiological testing resulted in a diagnosis of mild intellectual incapacity and small vessel ischemia, an infarct hemorrhage, and multiple small subcortical infarcts. In addition to her VaD, diabetes, and heart condition, Debbie also had anxiety, PTSD, and depression. The PTSD was associated with George's abuse. Various experts working on behalf of the Crown and Debbie concurred that she was not fit to be tried and that her mental impairment adversely affected her ability to control herself.

The documented IPV/A in *Colthurst* spans at least the five years prior to her killing him. George was no stranger to meting out violence. In previous intimate relationships it appears he had been the primary aggressor. Emma Pettit, an earlier girlfriend, reported not only verbal abuse at George's hands but also considerable violence. That violence included knocking her to the ground, throwing a frozen chicken at her, throwing a saucepan of boiling water at her, and choking her. Emma took out an order of protection against George. He breached the order on several occasions. During one such episode, police used pepper spray to subdue him and drag him away. Emma noted he became blind drunk after consuming 6–7 glasses of wine and then resorted to violence. When sober, she described him as a "really good bloke." Over the years his alcoholism severely undermined his health, rendering him extremely vulnerable.

His relationship with Debbie commenced at least five years before she killed him. During those five years Debbie reported George strangled her, destroyed her property, and assaulted her many times, such as cutting her with glass or smothering her with a pillow. In one year alone, there were four police reports including one where George punched her and put a pillow over her head. The fatality review team report notes a number of occasions where she or others did call police. However, these episodes were apparently coded as "domestic violence-no offence." Police reports highlight officers questioning her credibility due to her alcohol consumption and cognitive impairment.[39]

Numerous witnesses reported seeing injuries to Debbie over the years, many of which apparently were not reported to authorities. About a year before the killing, Debbie suffered a heart attack and later underwent triple bypass surgery. She thought she had the heart attack because George was in the habit of suffocating her with a pillow, putting his hands around her throat and strangling her, and forcing her head into a mattress so that she could not breathe.

According to Debbie, on the evening she killed George he had become violent. She told authorities she warned him "don't put your hands on me," a warning she said he ignored. As a consequence, she hit him "on the legs and bones" with a metal pole. She then poured boiling water over him as he continued to argue with her. He coughed and vomited up blood. The court heard evidence that after the assault, George, with Debbie's help, reportedly laid down on a dry mattress and fell asleep. Debbie apparently curled up beside him, "cuddled him and went to sleep with him." When he failed to awaken the next morning, Debbie called an ambulance. Debbie's other accounts differed and the court concluded it was impossible to tell for sure whether Debbie assaulted George with the metal pole before she poured boiling water over him. Her conflicting accounts may signify transitory delirium in the aftermath of the killing as opposed to the effects of dementia.[40]

Police at the scene noted Debbie had bruises on her neck and an injury to her hand. She said George caused the injuries. It soon became clear during the police interview that Debbie had problems with her short-term memory. She could not remember clearly what happened the preceding day, giving conflicting accounts. Debbie did tell officers that she had given up alcohol after her heart attack, although it is not clear from the records this was accurate. During the course of their relationship over many years, it is clear they drank together to excess and had reputations as street alcoholics. They would drink in bus shelters, alleyways and elsewhere in the streets.

Autopsy results revealed George had approximately 65 blunt force injuries over his body, some seemingly defensive injuries. Not all of these blunt force injuries were of recent origin, and some may have been caused by the rough and tumble of his life as a street alcoholic. Indeed, there was clear evidence that a number of people, other than Debbie, had assaulted George in the past. He had also experienced a number of alcohol-related falls. Additionally, at the time of autopsy, he had burns over 20 percent of his body.

The court also heard evidence from George's family members. They claimed they had not seen George be violent toward Debbie. According to them, on the few occasions they saw the couple together, Debbie was "always the aggressor." Weighing the available evidence, the judge commented,

> I am satisfied that the evidence establishes not only that during their relationship Ms Colthurst and Mr Mindham had repeatedly been both verbally aggressive and violent towards each other, but also that Mr Mindham had a tendency to act violently, particularly towards Ms Colthurst.

Weighing the different accounts of what might have happened that fateful night, the judge concluded,

> Mr Mindham is likely to have been seriously injured before 11pm, because neighbors heard no more arguing, after that time. By the way that she burnt him, Ms Colthurst plainly succeeded in bringing the altercation which neighbors heard that night to a halt. Had Mr Mindham still then been capable of retaliating, it is likely that he would have done so and that Ms Colthurst would likely have suffered more serious injuries than she in fact did suffer.

The judge considered Debbie's VaD when weighing up whether she believed she had to pour more boiling water over George while he was apparently immobilized and laying on the ground. Considering expert psychiatric testimony regarding the impact of lifelong trauma on her cognitive functioning, he commented,

> But for the consequences of her mental impairments, I would also have been satisfied beyond reasonable doubt that when Ms Colthurst poured more boiling water over Mr Mindham, after he had fallen to the ground, she was not acting in self-defense. Given the consequences of her mental impairments, however, I am not satisfied, beyond reasonable doubt that Ms Colthurst did not then believe that her actions were necessary, in order to defend herself.

Consultant forensic psychiatrist, Dr. P opined Debbie's mental impairments not only affected her ability to control herself but could also have resulted in disinhibited and aggressive behavior and in her being less willing to tolerate what she perceived as provocation. These observations appeared relevant not only to the events on the night of the homicide but also to any violence Debbie may have used in the relationship that was not a direct response to violence from George.

Uncertainties remained. Dr. F, a forensic psychiatrist, could not rule out the possibility that Debbie had exaggerated the accounts she had given of George's behavior in the hours immediately preceding the killing. It was only "on balance" that he considered how the combined effects of her low IQ and intellectual functioning, PTSD, and VaD comported with her conduct and her narration of events.

Drs P and F's most recent examinations of Debbie prior to trial revealed she was

> suffering a range of psychotic symptoms, including various auditory phenomena and unusual ideas and beliefs. They included that Mr Mindham's spirit is in her house; that she is being followed; that pedophiles are intent on killing her; and that it was not Mr Mindham but another person, who had died.

The two forensic psychiatrists agreed that Debbie's symptoms were not feigned but that it was possible they would respond to treatment. Significantly, the experts opined that any prospect of recovery hinged "on a range of complex matters, including the basis of her psychotic symptoms, including whether or not they are psychotic memories." The court recognized that at time of trial, it was not possible to know the basis of her psychotic symptoms.

After several years of court proceedings and tribunals Debbie received a limiting term sentence of 2.5 years for manslaughter. Under section 24 of the Mental Health (Forensic Provisions) Act of 1990 a tribunal determined whether Debbie (a) was suffering from mental illness, or (b) was suffering from a mental condition for which treatment is available in a mental health facility and, when the person is not already in a mental health facility, whether or not the person objects to being detained in a mental health facility. "Mental condition" refers to "a condition of disability of mind not including either mental illness or developmental disability of mind." In its amended determination, the tribunal accepted the views of two psychiatrists that "the main component of Ms Colthurst's presentation was the mental condition of her vascular dementia rather than the mental illness which is at present in remission because it is unprovoked." The mental illness referenced referred to the psychoses which had apparently abated, presumably because the social forces that precipitated such reactions no longer pressured her and/or because of various treatment interventions. Consequently, the tribunal deemed a mental health facility to be an inappropriate placement, recommending instead treatment in the community by a suitably secure aged care facility.

Closing Reflections

IPHs are rare events, especially compared to the total number of IPV/A cases.[41] As subsets of total IPHs, those committed by spouses/partners with dementia are *extremely rare*. It is important to keep the extreme rarity in mind. That being said, the violence, aggression, hostility, and disturbed affect that might accompany acts of homicide committed by spouses/partners with dementia are not rare.

The effects of violence, abuse, and neglect over time matter greatly when considering gray mist killings. Does the fact that couples have been married for perhaps five, six, or seven decades have special significance? Does IPV/A over longer periods of time render dementia more likely among those elderly women? Are those perpetrators, largely men, who mete out such coercive control more likely to develop dementia than non-offenders? Relatedly, does the form of violence matter for the development of the dementias? Are head injuries more significant than broken arm bones, punches in the stomach, serial strangulation, or rape? For example, some research suggests a correlation between a history of head injuries and the risk of developing Alzheimer's disease.[42] Other research suggests the PTSD caused by trauma associated with violence and abuse in general is a strong risk factor for all-cause dementia.[43]

Among the 100 gray mist killings, 13 revealed *known* histories of prior IPV/A between the perpetrator and homicide victim.[44] According to the observations of family, friends, neighbors, and community stakeholders, IPV/A predated the symptoms of dementia in 10 out the 13 cases (77 percent). In seven of these 10 the abuse histories appeared to take the form of coercive control and in the remaining three, situational couple violence. Uncertainty looms large regarding the relationship between prior IPV/A and dementia symptoms. It can take several years to recognize dementia symptoms and even longer for an official diagnosis. In three cases, the IPV/A surfaced after the onset of dementia. In these three cases, there is insufficient information to identify the form of the IPV/A—that is, whether it evidences the emotional abuses that would enable us to subjectively identify coercive control. In three cases involving prior IPV/A, women with dementia killed men (Pearl Padgett, Debbie Colthurst, Fredricka Rosa).[45] Significantly, all three had been victims of IPV/A at the hands of their husbands/male partners. In the case of Debbie Colthurst there is evidence of her suffering strangulation/suffocation at the hands of George Mindham, so one is inclined to identify this case as more severe IPV. However, without knowing more about the context of such acts, I remain guarded in my interpretation. In keeping with the killings by PWD, almost half of the 13 cases (46 percent or 6 out of 13) took the form of an overkill.

We must note the low proportion of gray mist killings evidencing *known* IPV/A prior to or concurrent with the development of the dementias. Even though the number of cases is small, men predominate as perpetrators. I explored two of them in detail. The balance of the evidence suggests that Liam Murphy and Abdel Khalil had coercively controlled or personally terrorized their wives for a long time. In *Murphy*, Liam's mental capacity meant he was unfit to stand trial for murder. He had behaved bizarrely the day of the killing. At the scene, he appeared worried about his house keys and seemed oblivious to the fact he had just killed his wife, Colleen. It was almost as if he had not been present at the brutal killing. Was his dementia a red herring or did his neurodegeneration and the social responses to it somehow intensify his chronically violent and abusive tendencies to the point he committed overkill?

We might make similar points regarding *Khalil*. According to the courts, Abdel Khalil's dementia was very influential at the moment of overkill, producing a "reduced capacity to rein in his impulses." In sentencing, the judge noted the case was "very unusual." Daughter Iffaa's testimony, like that of Ciara and Clodagh Murphy, pointed to the chronicity of her father's IPV/A. As with Liam Murphy, the question remains: to what extent did Abdel's neurodegeneration and the social milieu within which it manifested further potentiate his violence in the direction of homicidal overkill? In both cases, the courts seemed to attach great significance to dementia.

The three victim-precipitated gray mist killings, one each from the US, UK, and Australia, all resulted in the killers being deemed unfit to stand trial. Had these perpetrators not had dementia, the legal consequences for the killings likely would have been very different. David McLeish, Fredricka Rosa, and Debbie Colthurst had all been subject to prior IPV/A. In *McLeish* and *Rosa*, the eventual decedents appear as primary IPV aggressors of long-standing. *Colthurst* is more complicated, steeped, "sadly,"[46] in interwoven legacies of historic and life course trauma of the most profound and disturbing kind. Thus, in all three of these cases, we must explore the mutually potentiating effects of the prior IPV/A and the dementia as contextual frames to help us make sense of what happened.

We cannot neatly separate the hostility, aggression, and violence expressed by some PWD from that evident in classic IPV/A cases without dementia. A number of possibilities emerge from the case studies. One is that dementing illness and the social milieu within which it unfolds intensify and worsen pre-existing and/or co-occurring IPV/A. Another possibility is that dementia-driven homicidal behavior, however generated, whether through biological, psychological, or social forces, is of such power that it does much more than potentiate pre-existing violent and abusive proclivities. Rather, it takes over as the *principal or primary driver* of gray mist killings that have pre-existing or co-occurring IPV/A.

Knowing about IPV/A among elderly couples is difficult. The social networks of the elderly tend to shrink. Older victims may experience shame over being victimized for so long. They are often resistant to or fearful of interventions that involve others entering their homes. Interveners are not necessarily attuned to the nuances of IPV/A, assume such abuse is beyond the physical capabilities of older people, rationalize injuries and/or deteriorating physical and mental health as products of aging, perhaps linked to falls, medication side effects, or poor nutrition, or simply infantilize the old and assume they will whine and complain excessively, like an attention-seeking child. Put simply, agism and ableism come into play.

Notes

1 D. Stonecypher, "Old Age Need Not Be 'Old,'" *New York Times*, August 18, 1957, 27.

2 Stonecypher, "Old Age," 27, 67.

3 Stonecypher, 67.

4 B. Khurana et al., "Recognizing Isolated Ulnar Fractures as Potential Markers for Intimate Partner Violence," *Journal of the American College of Radiology* 18, no. 8 (August 2021): 1108–17, https://doi.org/10.1016/j.jacr.2021.03.006. The authors found that up to one-third of adult women sustaining isolated ulnar fractures may be victims of IPV.

5 R. Thomas et al., "Upper Extremity Injuries in the Victims of Intimate Partner Violence," *European Radiology* 31, no. 8 (August 2021): 5713–20, https://doi.org/10.1007/s00330-020-07672-1. The authors conclude that hand and finger injuries are the most common upper extremity injuries in patients with IPV histories.

6 Language from the DHR report.

7 UK Home Office, Multi-Agency Statutory Guidance.

8 Language from the DHR report.

9 Coercive control refers to a pattern of assaults, threats, humiliation, intimidation, or other abuse used to harm, punish, or frighten those subjected to it. Evan Stark sees coercive control as a "malevolent course of conduct" that is "ongoing rather than episodic," where the outcomes are "cumulative rather than incident-specific," and where the resultant harms are "more readily explained by these factors than by its severity." See E. Stark, *Coercive Control: How Men Entrap Women in Personal Life* (Oxford: Oxford University Press, 2007), 12.

10 Michael Johnson refers to IPV/A that involves incident-based transgressions such as a slap, shove, or even an extreme act of violence, as "situational couple violence." He contends that men and women commit such incident-based violence at similar rates, although female victims report more extensive injuries. For Johnson, with situational couple violence, "the perpetrator is violent (and their partner may be as well); however, neither of them uses the violence to attempt to exert general control." See M. Johnson, *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence* (Boston: Northeastern University Press, 2008), 5.

11 Language from the DHR report.

12 Language from the DHR report.

13 Language from the DHR report.

14 A gas fitter installs and services natural gas appliances and systems.

15 Language from the DHR report.

16 At Sunday Mass after the last words of the Lord's Prayer are said, mass goers engage in what appears as a ritual greeting (shaking hands or hugging) with those around them.

17 See particularly, St. Augustine's sermon 227 in which he references the kiss of peace.

18 The DHR reports Liam stating he drank "socially" up to five times a week, consuming 18 pints of lager a week, as well as wine while at home. He also smoked 14–15 cigarettes a day, a habit he traced back to his days in the Merchant Navy. For research on the relationship between smoking and the development of dementia see G. Zhong et al., "Smoking Is Associated with an Increased Risk of Dementia: A Meta-Analysis of Prospective Cohort Studies with Investigation of Potential Effect Modifiers," *PLOS One* 10, no. 3 (March 2015): e0118333, https://doi.org/10.1371/journal.pone.0118333.

19 Language from the DHR report.

20 For a discussion of the exposure of breast cancer patients to IPV, see D. Aygin and H. Bozdemir, "Exposure to Violence in Breast Cancer Patients: Systematic Review," *Breast Cancer* 26, no. 1 (January 2019): 29–38, https://doi.org/10.1007/s12282-018-0900-6. See also F. Diogini et al., "Commentary: 'My Husband Affects Me More Than My Cancer': Reflections on Simultaneous Intimate Partner Violence and Breast Cancer Experience in a 48-Year-Old Woman," *Journal of Cancer Treatment and Diagnosis* 4, no. 2 (2020): 36–38, https://doi.org/10.29245/2578-2967/2020/2.1181; M. C. Black, "Intimate Partner Violence and Adverse Health Consequences: Implications for Clinicians," *American Journal of Lifestyle Medicine* 5, no. 5 (September–October 2011): 428–39, https://doi.org/10.1177/1559827611410265.

21 J. Garbarino, *Listening to Killers: Lessons Learned From My Twenty Years as a Psychological Expert Witness in Murder Cases* (Berkeley: University of California Press, 2015).

22 The forensic pathologist counted at least 65 injuries to Colleen's body.

23 S. Mohamed, "Of Monsters and Men: Perpetrator Trauma and Mass Atrocity," *Columbia Law Review* 115, no. 5 (June 2015): 1157–216, www.jstor.org/stable/43582425. Mohammed argues we ignore the suffering and trauma of perpetrators at our peril. Usually, we seek the trauma in a perpetrator's past that might have informed, influenced or caused their monstrous act. Rarely do social scientists, victim advocates, and criminal justice professionals acknowledge the importance of perpetrator trauma from the instant offence he/she perpetrated. Victims deserve to have their trauma acknowledged and

healed. Perpetrators are much less deserving of such consideration. Mohammed cites Kati Blom, "The glass cage conveniently separates us from the person inside it, but it also reflects our own gaze. If we look long enough, we might just see-against our urges, but productively, nonetheless-ourselves." K. Blom, "Transparency and Catatonia," in *Constructing Place: Mind and Matter of Place-Making*, ed. S. Menin (London: Routledge, 2003), 189.

24 The three stages of dementia are early, middle, and late, sometimes called mild, moderate, and severe.

25 Personalities can change, becoming more aggressive or agitated prior to the onset of dementia and certainly before a formal diagnosis. When depression accompanies MCI, the likelihood of contracting Alzheimer's disease increases. Not all cases of MCI morph into dementia, but all cases of dementia exhibit prior MCI.

26 M. E. Wolfgang, *Patterns in Criminal Homicide* (Philadelphia: University of Pennsylvania Press, 1958), 252 (italics in the original).

27 D. F. Luckenbill, "Criminal Homicide as a Situated Transaction," *Social Problems* 25, no. 2 (December 1977): 185, https://doi.org/10.2307/800293.

28 Luckenbill, "Criminal Homicide as a Situated Transaction," 186.

29 Luckenbill, 186.

30 J. Gilligan, *Violence: Reflections of a National Epidemic* (New York: Vintage Books, 1997).

31 It is not clear from the available evidence whether David's conditions of probation included mental health treatment.

32 "Mercy for Man, 75 Who Killed Wife," *The Herald*, January 26, 1995, www.heraldscotland.com/news/12668197.mercy-for-man-75-who-killed-his-wife/.

33 "Mercy for Man, 75 Who Killed Wife." We have no information about why the onset of Dorothy's alcoholism appears to coincide with David's retirement. My experience tells me not to rule out the possibility that David's behavior played a part in Dorothy's developing alcoholism. For example, we must ask, was he abusive? Readers might discern from these facts that the descriptor "coercive control" on Dorothy's part is more apt than situational couple violence. Unfortunately, we have no sense of what Dorothy's apparent abuse meant to David.

34 "Mercy for Man, 75 Who Killed Wife."

35 "Wife Shoots, Kills Husband in Pemberton Township Home," *NBC Philadelphia*, video, www.nbcphiladelphia.com/news/local/wife_shoots__kills_husband_in_pemberton_township_home__family_philadelphia/1934788/.

36 J. Hefler, "Woman With Alzheimer's Won't Be Tried in Husband's Killing," *Philadelphia Inquirer*, August 19, 2013, www.inquirer.com/philly/news/new_jersey/20130820_Woman_with_Alzheimer_s_won_t_be_tried_in_killing_of_husband.html.

37 See A. J. Vincent, "Defending the Elderly," *Criminal Justice* 27, no. 1 (Spring 2012): 55–56, 63 for a discussion of the legal issues regarding defending elderly clients.

38 See "Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From Their Families," Commonwealth of Australia, ISBN 0 642 26954 8, April 1997, https://humanrights.gov.au/sites/default/files/content/pdf/social_justice/bringing_them_home_report.pdf. These forced removals took place from 1910 well into the 1970s.

39 For a discussion of police impunity to indigenous Australian victims of IPH, see K. Cripps, "Indigenous Women and Intimate Partner Homicide in Australia: Confronting the Impunity of Policing Failures," *Current Issues in Criminal Justice* (2023), https://doi.org/10.1080/10345329.2023.2205625.

40 I am grateful to Dr. Virgil Hancock for this observation regarding transitory delirium.

41 For example, in the US, the CDC reported that for the period 2010–2012, the annual prevalence of contact sexual violence, physical violence, or stalking by an intimate partner was 7,919,000 for women and 7,260,000 for men, or a combined annual prevalence of 15,179,000. Compared with these 15 million or so cases, only approximately 2,000 (0.013%) IPHs have occurred annually over the past decade. The US population

in 2010, according to the Census Bureau, was 309.3 million. See S. G. Smith et al., *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010–2012 State Report* (Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017).

42 S. Fleminger et al., "Head Injury as a Risk Factor for Alzheimer's Disease: The Evidence 10 Years on; a Partial Replication," *Journal of Neurology, Neurosurgery, and Psychiatry* 74, no. 7 (July 2003): 857–62, https://doi: 10.1136/jnnp.74.7.857; Y. Li et al., "Head Injury as a Risk Factor for Dementia and Alzheimer's Disease: A Systematic Review and Meta-Analysis of 32 Observational Studies," *PLOS One* 12, no. 1 (January 2017), https://doi.org/10.1371/journal.pone.0169650.

43 M. Günak et al., "Post-Traumatic Stress Disorder as a Risk Factor for Dementia: Systematic Review and Meta-Analysis," *The British Journal of Psychiatry* 217, no. 5 (November 2020): 600–8, https://doi.org/10.1192/bjp.2020.150.

44 See Appendix, Table 7: Overview Characteristics of the 13 IPHs Committed by Perpetrators with Dementia.

45 Two other women with dementing illnesses killed men, Patricia Dees and Gloria Villa. The files do not contain information about prior IPV/A in either case.

46 My use of the word "sadly" derives from the use of the word "sad" by a key informant on the New South Wales review team to describe *Colthurst*.

6 Thieves and Fraudsters

In the afternoon of November 18, 2005, probationary police officer Sharon Beshenivsky and her colleague, Officer Teresa Millburn, confronted three armed men who had stolen £5,405 from Universal Travel on Morley Street, Bradford, UK. One of the men fired at the officers, killing Sharon, and seriously injuring Teresa. Officer Beshenivsky had only been a West Yorkshire Police constable for nine months. She had three children and two stepchildren.

Apparently, within minutes of the shooting, police used footage from the closed-circuit television (CCTV) cameras in Bradford city center to identify a getaway car involved in the robbery. The CCTV network was linked to a database of vehicle registration numbers. The linkage between CCTV and the automatic number plate recognition (ANPR) system had only been in place for six months. The British Home Office and the police hailed the new technology as revolutionary. Crime prevention specialists noted its powerful potential to deter crime. A spokesman for West Yorkshire police told the BBC,

> Most forces in the UK use ANPR system as a patrol car-based method of checking vehicle identities. In Bradford we have taken it a step further by linking this technology to the local authority's network of CCTV cameras which are monitored from a central control room.[1]

The Beshenivsky murder was solved primarily by combining ANPR data with CCTV footage.[2] Chief Superintendent Geoff Dodd of West Yorkshire Police referred to ANPR as "the best investigative tool we have had since the introduction of DNA analysis."[3] Civil libertarians cautioned that it was the thin end of the wedge toward mass surveillance and Orwellian totalitarianism.[4]

Unlike the robbery described, the theft of money from PWD often happens without direct physical violence. Elderly family members with dementia often have savings, pensions, and/or social security benefits. They are vulnerable to fraud, embezzlement, and extortion. Fraud is a form of theft. It involves obtaining something of monetary value by using deception. Embezzlement is another form of theft. It involves the illegal diversion of funds. In relation to the gray mist killings, embezzlement can take the form of misusing funds that are entrusted to someone for the express or implicit purpose of caring for a PWD. Extortion involves the

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actual or threatened use of force, violence, or intimidation to acquire money or property from an individual or entity.

Those who would misappropriate the funds of PWD may be family members knowledgeable about their worth and who, in some cases, enjoy power of attorney over them. As dementia advances, skill with numbers often declines making it more difficult to detect and remember any exploitation. The decline in numeracy often occurs early in the development of dementia, even before family and others observe any deterioration in other cognitive abilities.[5] In some cases, as we have seen, paranoid delusions regarding money being stolen add to the complexity. The personalities of PWD may change. They may become increasingly hostile at times, less easy to be around, more difficult/expensive to care for and more forgetful. Their changing personality may make it easier to justify, rationalize, or excuse fraud, embezzlement or extortion, or, as in one of the two studies in this chapter, murder.

Our first case involves a granddaughter who brutally killed her grandmother, who had AD; the second is a husband who killed his wife after she confronted him about stealing money from her father with dementia. These two "outlier" cases exhibit themes present in a significant number of well-documented cases where people, mostly family, friends, neighbors, and acquaintances, defraud PWD. This is to say nothing of the mountain of cases that, for whatever reasons, do not end up as part of the official record.[6]

The Apple of Her Grandmother's Eye

A combination of ANPR and CCTV evidence brought Beverly Richmond to justice, uncovering a web of lies, deception, fraud, extortion, and malicious violence. Julia Piven was Beverly Richmond's grandmother. She was 77 years old when she was brutally murdered with a blunt object as she lay in her bed. Beverly was questioned concerning her grandmother's death. She told investigators that at the time of the killing, she was home sleeping and, at other times that night, had been watching named television shows. However, the ANPR and CCTV footage contradicted her accounts. Significantly, the surveillance evidence captured her traveling between her home and Julia's cottage three times on the night of the killing.

Three days after the killing, police also covertly recorded Beverly talking with her mother, Laurie Richmond, age 56. On the tape, Laurie was heard saying she was worried about getting in trouble for the money she had taken from Julia's account, many thousands of pounds, in a series of withdrawals over the preceding months. She was also heard telling Beverly not to worry about what she had done, that her grandmother, Laurie's own mother, was a "horrible, horrible" person who had caused much trouble.

Investigators soon learned that Julia's AD had advanced to the point that social services had recommended she move to an assisted living facility. Among other things, this would have necessitated documenting Julia's financial standing and recent monetary transactions. Investigators also learned that Beverly feared Julia's considerable savings and home equity would be drained to pay for her care, leaving little if any for her. These facts provided a motive for murder. They comported with Beverly's previous financial exploitation of Julia. Notably, investigators had learned that Beverly, who appeared to be the apple of her grandmother's eye, punished Julia by not visiting her if Julia declined to give her money.

Beverly's story to police changed, creating suspicion. On becoming a prime suspect, she eventually told police it was frightening what one could do without realizing it, saying she heard voices, one of them sounding like that of her granddad, telling her to kill her grandmother. It was as if Beverly was feigning mental illness. Recalling the crime scene through a seeming gray mist of uncertainty, Beverly told police her grandmother had been sleeping at the time of the killing. She reassured investigators that she loved her grandmother, who acted like a mother toward her.

Forensic evidence added weight to the state's case against Beverly. Police learned she went to considerable lengths to clean her car, the murder weapon, Julia's clothing, and the crime scene.[7] Trial testimony revealed how Beverly had asked her brother and a close family friend to lie for her by telling police she heard voices. Strangely, a week or so before the killing, Beverly sent a text to a male coworker, Brian, with whom she had been in a relationship. It said, "Got to Grandma's early and found her dead. Police have been and she has been taken away, head totally done in. In need of a friend."[8] Was she envisioning what she might do? Perhaps rehearsing her lines? On another occasion, she had told co-workers she had financial problems and had said that "it would be best if the deceased just fell down some steps."

Tempting as it might be, *Richmond* cannot be reduced to psychiatric diagnoses, greed, evil, pathological deceit, and extraordinary violence. All of these case themes feature prominently in media accounts. However, it is only when we socially situate them within the context of her life history that a fuller and richer version of the case unfolds.

Beverly Richmond last saw her father when she was six years old. He had reportedly been violent toward her mother. Rumor had it that by age nine, Beverly had been admitted to a mental health facility for treatment for depression. Publicly available documentation cannot confirm this admission. By the time Beverly was 13, Julia had become a widow and sole owner of her cottage.[9] That same year, Beverly gave birth to her first and only child, Brittany. Within a year of Brittany's birth, Beverly began to receive mental health services as a result of taking an overdose of paracetamol.[10] The overdose was apparently a reaction to an argument with her partner, Michael Gates, nine years her senior. Michael had reportedly threatened to leave her. According to Michael, Beverly frequently threatened to take her own life. The argument, he reported, stemmed from her having an affair. Around this time, Beverly left school and began work at a post office, sorting the mail. It was also around this time her daughter was assessed, age 13 months, for developmental delay.

Beverly learned that Brittany had a serious developmental delay. Separated from Michael Gates, Beverly and Brittany were living in the home of her mother, Laurie. Beverly's health visitor, a specialist community public health nurse, expressed concerns about Beverly's ability to bond with Brittany or to cope with childrearing without substantial help from Laurie. Her occupational therapist (OT) indicated Beverly's desire to move back in with Michael. The estranged couple continued their volatile relationship. As Brittany's second birthday approached, Beverly was convicted of assaulting Michael. She had thrown a cup at him. At the scene of the assault, she told police she suffered from postnatal depression, a fact the police apparently logged. However, her medical file did not substantiate her claim.

As Brittany approached her fourth birthday, Beverly's GP referred Beverly to a consultant psychiatrist. The GP had noted she suffered from depression over the preceding year. Her moods varied. She was short-tempered and not sleeping well. In particular, she found the separation from Michael difficult. The GP prescribed Beverly antidepressants. Beverly did not attend the appointment with the consultant psychiatrist. She failed to attend other psychiatric appointments over the course of the next year before being discharged from the mental health service in her area.

Two years before murdering Julia, Beverly received a police caution for stabbing Michael Gates.[11] The assault appears to have happened in the workplace. She was suspended from work. Her GP referred her to a consultant psychiatrist again and she began to receive treatment from the mental health services team. Brittany was eight.

Within a year or so of the stabbing, Laurie was granted power of attorney over Julia whose AD had worsened. In Julia's final year, Laurie began to siphon money out of her mother's saving's account. She stole an estimated £20,000, mostly in amounts ranging from £750 to £1,200 with the largest amount being £4,000. These withdrawals were only discovered during the police investigation of Julia's murder. The prosecution contended the murder occurred at a point when Laurie's fraudulent withdrawals from her mother's account were about to be discovered. It was at this point that Julia's worsening AD led to social services recommending she enter a full-time care facility, a change that would have required an assessment of her financial standing.

During that same year, Beverly became increasingly depressed. Her GP began treating her with sertraline, an antidepressant, and became increasingly concerned about her harming herself or committing suicide. The GP referred her to a consultant psychiatrist once more. It was significant that none of the mental health professionals, nor Beverly's GP, appear to have known about her police caution for the stabbing. Eventually, the GP made an urgent referral to specialist mental health services. Apparently, Beverly was seriously considering suicide and was only held back, according to the GP, by the thought of how suicide might adversely affect her family. Specifically, the GP wrote he was "now quite concerned about her risk of self-harm." Later that same day, Beverly was seen by a senior house officer (SHO).[12]

The SHO noted Beverly's ten-year history of recurrent depression and anxiety, including her paracetamol overdose. In four of the preceding seven years, the GP noted Beverly's "neurotic (reactive) depression." In psychiatric parlance, reactive depression is sometimes referred to as situational depression—that is, depression stemming from life stressors (e.g., loss of a loved one, unemployment, relationship breakup) rather than from more chronic biological or neurochemical causes. If the reactive depression proceeds beyond the duration of the life stressor, then major depressive disorder might be present. Beverly's stressors included the breakup of her relationship with Michael and the possibility of her losing her job because of her disciplinary infractions.

One research study on the validity of neurotic-reactive depression reviewed histories of 1,450 females admitted to psychiatric hospitals for depression.[13] Its author, physician George Winokur, observed among the ranks of those suffering from neurotic-reactive depression the disproportionate presence of family histories of alcoholism, "stormy lifestyles," certain life events, specific symptoms such as self-pity and hostility, and personality traits such as immaturity. It is easy to see how Beverly's depression fit with some of these criteria. Indeed, some four years after the murder, when interviewed, one of her consultant psychiatrists, Dr. W, noted that after seeing the court report he realized there were times when Beverly drank heavily. He opined, "In retrospect, I think that alcohol may have been a rather bigger issue than I believed at the time."

Yet the diagnosis of neurotic-reactive depression, like many diagnoses, was not a neat fit. One of her major life stressors, Brittany's severe developmental disability, was permanently part of her emotional life. It seems, too, that her on-again, off-again relationship with Michael continued to cause her grief. Indeed, the SHO notes her "relationship difficulties." She had apparently split up with Michael eight months prior, but the relationship has remained "on and off since then."

Two days after her relationship difficulties entered the medical record, a staff grade (permanently appointed) doctor assessed Beverly.[14] She was "tearful, had reduced energy, lacked enjoyment, had poor appetite, had lost six pounds over the past few weeks, had initial insomnia [difficulty falling asleep], disturbed sleep and early morning wakening, poor concentration and confidence." At one point, Beverly told the doctor, "I can't see myself ever being happy, I don't want to be here but I've got my child to care for."

We learn more about her relationship with Michael from the notes of her conversation with the staff grade doctor (Dr. Y). She reported that she and Michael had had relationship difficulties since Brittany's birth. Both found Brittany's disability stressful. They also argued a lot about Michael's mother, who, according to Beverly, never thought she was good enough for Michael. The notes read, "I came from a council estate [the US equivalent of public housing]; his family are very wealthy. I feel very insecure." Beverly also shared that there had been violence between her and Michael. Beverly reported that five weeks previous she had been suspended from her place of work and moved temporarily to another work base for assaulting Michael at work. Beverly said she and Michael had attended Relate, a UK relationship support organization, but Michael would not continue to go because he did not want to reconcile with her. Michael paid Beverly child support but she told Dr. Y she had trouble paying her bills. About a week prior to meeting with Dr. Y, Beverly had reportedly purchased several boxes of paracetamol but had refrained from taking them. She also told Dr. Y she had self-harmed in the past by cutting her wrists, pulling her hair, and banging her head. Additionally, she reported a history of being bullied at school because she was overweight. In response to Beverly's information, Dr. Y increased her dosage of antidepressants and referred her to the acute community day service (day unit or outpatient facility).

Dr. P, an SHO at the day unit, wrote Beverly reported that Michael "had hit her and verbally abused her." This is the first time the files reveal Beverly reporting Michael's violence toward her. Dr. P's notes rehash Beverly's other problems. Dr. P then prescribed zopiclone, a sleeping tablet.[15] In her first meeting with Dr. W, Beverly reported that Michael said she had a Jekyll and Hyde personality. Normally, she was quiet. On some occasions, she talked manically for an hour or two. These episodes occurred once every few weeks. Dr. W noted she may have type II bipolar disorder. In psychiatric parlance, bipolar disorder can be confused with depression because those with it have episodes of depression. Depression is unipolar, referring to the fact that there are no "up" periods, whereas the term "bipolar" refers to ups (manic episodes such as those Beverly reported) and downs. Bipolar I disorder sufferers have more severe manic episodes than those with Bipolar II disorder, where the manic episodes are hypomanic (not a fully blown manic episode). Dr. W arranged for blood tests and gathered more information from her treatment history. He also expressed an interest in interviewing Michael.

Dr. W's specialist registrar, Dr. S, interviewed Michael.[16] Michael reported Beverly "totally loses it, pulling hair out, eyes popping." She reached these states after arguments with Michael. He said these states could last for up to an hour. Dr. S concluded Beverly had bipolar disorder II with obsessional/compulsive symptoms. After blood tests, Beverly was prescribed lithium to augment her antidepressant medication and to stabilize her mood. Her GP was apparently not informed about the prescription for lithium, an oversight Dr. W acknowledged.

Beverly's first case coordinator at the day unit reported a vague recollection of feeling uneasy about working with her. He felt it would be better if she had a female case coordinator. Her second case coordinator (CC2) was female. CC2 reached out several times to Beverly over the ensuing months. About three months before the murder, CC2 completed a risk profile. At this point, the multidisciplinary team knew of Beverly's aggression toward Michael. They also learned that Beverly damaged Michael's car and the door to his house. She had also been charged with assaulting his girlfriend.

Significantly, there was no evidence of social care having any involvement with Beverly until after the murder. There seems to have been little interest in Brittany's disability and general needs. In the months leading up to the homicide, the mental health services team seemed to accept Beverly's statement that Laurie did most of the caring for Brittany and that they did not need help from state services. In short, Brittany appears to have been vulnerable but little was done to explore her vulnerability, especially in the light of her mother's compromised mental health.

As part of a pattern of no-shows at important appointments, Beverly failed to attend her outpatient appointment with Dr. W three months prior to Julia's death. Laurie wrote to Dr. W three days later, explaining they had gotten stuck in traffic. In the apology letter, Laurie dated Beverly's troubles to the period after Brittany's birth. She wrote Beverly had twice tried to commit suicide and that Beverly had assaulted her various times, although not in the last few years. Laurie attributed

Beverly's violence toward Michael and his new partner as a reaction to Michael's mental cruelty toward Beverly. Laurie stressed the importance of Beverly returning to work so that she could earn money. She mentioned she would like to meet with him before he wrote his report for the court concerning her assault of Michael's girlfriend. Dr. W did not respond to Laurie's letter, an "oversight" for which he later apologized.[17]

A little over a month after Julia's murder, Dr. W met with Beverly to prepare his court report related to Beverly's assault of Michael's girlfriend. Dr. W noted her diagnosis as bipolar disorder II. At the time of the alleged assault on Michael's girlfriend, he described Beverly's mood as being in the elevated phase of the illness. Dr. W argued it was beyond reasonable doubt in his mind that her symptoms substantially affected her behavior on that day, leading to the assault. He noted Beverly did pose a risk of violence to others in the future, "but only when mentally ill." Dr. W opined, "I think the severity of this risk is relatively low and can be reduced further by appropriate treatment of her mental illness."

About a week before the murder, Beverly saw Dr. W one last time. She informed him that over the last month she felt "entirely well." She had ceased taking lithium and sleeping tablets, although it is not clear whether she communicated her self-withdrawal from her medications to Dr. W. He noted the court had been very sympathetic regarding her assault of Michael's girlfriend. He felt Beverly could return to work gradually. Dr. W told the mental health services team that he increasingly felt that Beverly suffered from major depression and not bipolar disorder II. He questioned whether she was ever really manic, rather just that she had episodes of mood elevation.

Julia was found dead in her cottage. Beverly had used a blunt object to strike her numerous times in the head. She shattered Julia's skull. Her breastbone and ribs were broken. Beverly had let herself in with a key during the night. After murdering Julia, she drove home, had a bath, and tried to clean the murder weapon. She disposed of her bloody clothes and shoes. Only later did she return to Julia's house to raise the alarm. Investigators found traces of Julia's blood on the murder weapon and in Beverly's bath.

Dr. W. was interviewed four years after the killing. He reported being surprised when he learned that Beverly had been arrested for murder. Questioned if he felt Beverly had been mentally ill at the time she killed her grandmother, he replied he did not think so. His observation was at odds with his earlier statement that she would likely only pose a threat to others if she was mentally ill. Dr. W opined that Beverly's act of murder had been carefully planned and potentially committed at a time when she was "well."

When interviewed almost four years after the murder, Beverly opined that she should not have been released from the day hospital. She also thought not enough was done to follow up with her. Beverly told interviewers that she had stopped taking her lithium and other medications about a month before she murdered her grandmother. Her position was that she felt better and therefore did not need them anymore. Regarding her last meeting with Dr. W, she said she was not feeling very good at that time. Her employer was trying to relieve her of her duties on grounds of ill health and she needed a green light to return to work. Specifically, she said, "So I made out I was better than I was. I wanted him to write to work to say I was better."

When Dr. W learned of Beverly's comments to the case review interviewers, he retorted that he learned about patients' mental states from what they communicated to him, their appearance and their behavior. He did not feel Beverly was trying to con him during their last session. Rather, he thought she felt better because the medication was working. But Dr. W did comment, "I don't really know."

In his summation, the judge said he accepted that mental illness, falling short of diminished responsibility, was a factor in the killing. He sentenced her to life imprisonment with a reduced number of years because of the mitigating effects of her mental illness. He acknowledged her life was difficult and stressful because of the demands posed by Brittany's severe developmental disabilities and because Beverly's illness made it difficult for her to make and keep friends.

For her part, Laurie pleaded guilty to stealing her own mother's money. The judge required her to pay for both sets of lawyer's fees and court costs, commenting he did not see why the taxpayer should pay these expenses. Laurie was the rightful heir to her mother's estate and now had the resources to pay court costs. The judge also decided not to imprison Laurie beyond the time she had already served. He contended that Brittany's life would be much the worse if Laurie could not use her inheritance to support her. Hence, he directed Laurie to care for Brittany, in full knowledge Beverly was subject to life imprisonment.

In *Richmond*, greed emerged as a central motive in the accounts offered by police, prosecution, and the media. Yet narrating the tale provides a more complex picture, and words like "greed" appear inadequate. Laurie's assessment of her mother as a "horrible, horrible" person may be unbelievable, yet these are not uncommon sentiments. *Richmond* raises important questions about the extreme violence meted out to PWD. Where does it come from?

Profligacy

Richmond involved working-class people trying to survive. Our next case, *Weir*, involved middle-class folk who were struggling to maintain an unsustainable lifestyle. John Weir was an IT consultant who advised banks in the City of London. John and his wife, Jean, a supply (substitute) teacher in local schools, had been married a little over 30 years at the time of her murder. They had four children and lived in the Weald, formerly a heavily forested area of southeast England originally known for its production of iron.

After roughly a decade of marriage, John began to get into debt. Within three years of these economic troubles, they had to sell their family home. The forced sale caused great tension between John and Jean, with Jean blaming John's profligacy for their growing economic problems. Details remain sketchy but it appears they moved within the Weald and bought another home. Their children continued to receive private education. Slowly, over the course of another decade, their economic woes increased. Five or six years before the killing, they were once again forced to sell their home. This time, the family moved into rented accommodation and took their children out of private education.

Within two years or so of the Weir family moving into rented accommodation, doctors diagnosed Jean's father, Kevin Charlton, age 90, with VaD. His mental and physical health worsened steadily and within two years of the diagnosis Jean and John acquired power of attorney over Kevin's finances, health, and welfare. It was John and not Jean who dealt with Kevin's finances. Within the next year or so, Kevin had a fall, was taken to A&E (Accident and Emergency) and admitted to the hospital. In the ward, an OT advised that Kevin living alone in his home put him at risk. Knowing Kevin did not want to go into a nursing home, Jean suggested a care package (plan) at the Weir home. Within a month of being admitted to the hospital, Kevin was transferred to a rehabilitation ward. He remained there for a month.

Fifteen months before Jean's killing, Kevin returned to his own home with a care package. It was the week before Christmas. Unfortunately, he neglected to take the antibiotics prescribed as part of his rehabilitation package. He was apparently unaware he had to take them.[18] Consequently, within a week, he was readmitted to the hospital. He stayed there another three weeks, then returned home, only to fall again and be readmitted to the hospital a couple of weeks later. It was after this hospital stay that Kevin moved into a room of his own at the Weirs' rented home. The GP's notes give the reason for the move into the Weirs' home as Kevin's increasing number of falls.

In the meantime, Jean arranged for a needs assessment at her home in anticipation of Kevin's arrival. The assessment recommendations included adding therapeutic equipment. From the point of Kevin moving in, Jean reported experiencing major difficulties meeting his complex needs.

The proceeds from the sale of Kevin's home far exceeded the threshold for publicly funded social care support. Except for the last three months before the killing, Kevin's savings paid for most of his social care services while he was living at the Weirs' home. A private care team attended the home four times a day, seven days a week. Jean's GP noted just how jarring Kevin's arrival had been. He had difficulties settling in and was disturbing the family at night by wandering around the house. Kevin refused to attend a social care day center. His doctor requested Jean meet with the CPN. A memory assessment pegged his dementia as severe. He also evinced nighttime disturbance, agitation, and severe confusion. A new care plan called for changes in Kevin's medication. The plan also recommended requesting the support of the Alzheimer's Society.[19] His dementia-related problems continued after the medication changes. A couple of months later, Kevin was taken to A&E after pulling out his catheter.

Representatives from the Alzheimer's Society, private carers, members of Jean's church, and people from other voluntary groups came to sit with Kevin at various times during the day. Nevertheless, nine months before Jean's murder, the Alzheimer's Society raised a safeguarding concern with the local National Health Service (NHS) and Social Care Partnership Trust, stating that Kevin was left alone for significant portions of the day. When quizzed, the private care agency reported they never saw any family members during their visits. Significantly, the private care agency did not know of the safeguarding concern raised by the Alzheimer's Society. Indeed, when questioned by the DHR team, the private carers said older PWD are often left alone for many hours between carer visits, a fact they saw as the reality of the situation rather than a safeguarding concern. Given John worked in the City of London, Jean was a supply teacher, the children attended their educational establishments, and Kevin stated he did not want to attend a care center, was there any realistic alternative? A live-in carer?

One of the older sons challenged the observations of the Alzheimer's Society representative, stating people were home more often than the safeguarding report suggested. Based on the evidence available, the reviewers did not concur with the older son's interpretation. From the perspective of Kevin Charlton, there may have been a significant difference between a member of the Weir family being home as opposed to being *present* with him. It is part of the seemingly counterintuitive behavior of some people with Alzheimer's disease that they will guard their solitary living arrangements against what they perceive as the sterile, standardized, impersonal atmospheres in care institutions at the same time as lamenting it, stating they feel unheard and lonely.

Weir concerned much more than an elderly man with severe dementia changing his living arrangements and moving in with family. Those new living arrangements were not what they might have appeared to be to the various volunteer visitors. John Weir's life was spiraling out of control. In the same month that Kevin moved into the Weir home, John visited his GP complaining of suicidal thoughts. He told his GP he had previously tried to commit suicide, although the details of when and how this might have happened do not surface in the case files. After reporting his problems, John underwent treatment for depression and anxiety. During that treatment, he revealed he had been drinking excessive amounts of alcohol, some 40 units per week, roughly three times more than the UK government-recommended weekly limit.[20]

Around the time of Kevin entering their home, John and Jean attended the GP's surgery together. John reported he was suffering from "stress-related problems." In particular, he highlighted his depression and financial problems, although he noted he still had a good income from his job. At the same time, he described his work as "all-consuming," and noted he had few outlets from it. John sought treatment through his private medical insurance from work. A report from the treatment provider, sent to his GP, noted he presented with symptoms of mild depression and anxiety. He also had negative thoughts about himself. The communication also states that since he had shared these feelings with his wife they had lessened. Significantly, John reported having had these feelings of suicide for the previous six years and at one point, six years earlier, had actively planned to take his own life. Within a couple of months his treatment provider discharged him, noting he reported reducing his alcohol intake to two glasses of wine three days a week. Using cognitive behavioral therapy, he had apparently made some improvements in his life, including improving his quality of sleep.

John called the CPN to get more information about caring for Kevin. He received contact information for charities and care providers. The CPN also had a conversation with Jean about the provision of care for Kevin in a manner that did not result in him being left alone. Jean reported "feeling very upset and unsupported" by being told her father could not be left on his own. She felt "criticized." Again, she emphasized her father should remain in the family home and that he would be "very unhappy" in residential care. Both Jean and John reported neighbors and friends from church had been very supportive in helping to care for Kevin.

At the same time as John appeared to be addressing some of his own problems, for example, his excessive consumption of alcohol, depression, anxiety, and negative self-image, he still had sufficient wherewithal to siphon money from his father-in-law's account into his own furtive financial ventures. Indeed, it is hard to know whether his thievery was a result of his problems or a partial cause of them. Reviewers learned that eight months before he killed Jean, John tried to borrow £20,000 to set up an escort business with a woman he had been meeting. In another instance, he asked a co-worker for £90,000 to purchase a flat for the woman.

As noted, John handled the financial side of the couple's power of attorney over Kevin's affairs. He was also the sole point of contact with the private care provider. Apparently, Jean never dealt with the financial matters concerning her father. When Kevin's house was sold, the proceeds were paid into Kevin's account. By the time of Jean's murder, John had stolen the proceeds from the house to pay for escorts, prostitutes, and gambling.

After absorbing what she perceived as criticism for leaving her ailing father on his own, Jean made a few changes. She took up running and began to eat more healthy food. As summer unfolded in the year before her death, friends and work colleagues noticed she had lost a "significant amount of weight." Eventually, she saw the nurse at her GP's surgery about the extent of her weight loss. Their eldest son told reviewers his mother was pleased with her weight loss. He did not see the weight loss as a serious concern. However, Jean's friend of 42 years, Valerie Paston, told Jean she was worried she was developing anorexia. Valerie had also become concerned about Jean's ability to look after Kevin.

Kevin's health continued to deteriorate. The same month Valerie gave Jean feedback about her significant weight loss, Jean called her GP worried that Kevin was having a stroke. On subsequent occasions, he was admitted to the hospital for chest infections. Four months before her death, the care package for Kevin changed. Now, two carers would be present on each visit to the home. He needed new equipment, a full hoist, a hospital bed, and an increased care package. Four months before her death, Jean was invited to a face-to-face meeting with her GP to discuss her ability to cope with Kevin.

In the last three months of Jean's life, John was no longer able to pay for private care. The private care continued in spite of John's inability to pay. Their landlord gave the Weirs three months' notice to leave their home, perhaps because of rent arrears. Six weeks before the killing, law enforcement received a suspicious activity report in relation to John's financial dealings.[21] It noted large sums of money had been transferred from Kevin's account to John's account over the preceding year.

Less than a month before the killing, police visited the old home address for Kevin prior to him moving into the Weir home. They learned he had since moved in with his daughter and son-in-law because of the advance of his VaD. Police also reached out to the Office of the Public Guardian to learn John and Jean shared joint power of attorney over Kevin's finances and welfare. They also learned that Jean's sister, Jane, was aware of the power of attorney. According to reviewers, police believed that Jane's knowledge of the power of attorney reduced the risk to Kevin. Apparently, police felt that talking with John would have divulged the identity of the confidential filer of the suspicious activity report. Thus, they took no further investigative action. Reviewers concluded, with the benefit of hindsight, that had police proceeded against John for illegally diverting Kevin's assets, he could have been subject to arrest before he killed Jean.

Two weeks before the killing, John called his employer, a financial advising company, and said he was sick. He never returned to work. He continued to give his family the impression that he was still going to work in London.

On Wednesday, the day before Jean's murder, John traveled to London by train. There, he visited a hotel with an escort. Later that day, he returned home. On the way home, he exchanged text messages with Jean. She communicated she could no longer trust him. It is not clear that she told him she discovered he had been taking Kevin's money. He arrived home at around 9:00 p.m. Neighbors heard raised voices later that evening at the Weir home. The argument continued into the next morning, at which time he punched her in the throat and then strangled her to death.

That fateful Thursday morning, John told their youngest daughter her mother was unwell, still sleeping, and not to be disturbed. He drove the youngest daughter to the station on her way to school then returned home, parking his car out of sight. Then he called the school at which Jean was due to work and reported her ill. He later drove his oldest daughter to the station. In his car, he left a suicide note to his children saying that he'd killed Jean, that he had failed to manage the family money properly, and that losing the house was his fault. He added their mother was a "beautiful, kind, and caring person who loved you all." He then explained, "I can't carry on living."

Father and eldest daughter took the train to London before going their separate ways. The daughter went to university. John checked in to a hotel with the woman with whom he was planning to set up the escort agency. He ordered a martini and apparently fell asleep. At some point, he left the hotel to purchase a knife and more alcohol. Later that Thursday, he sent a text message to Valerie Paston, telling her he had "accidentally killed" Jean and that "in a second, I will have killed myself too." He told Valerie that Jean's body was in the bedroom. He asked her to "do what you can to comfort the children." Valerie called the police.

A neighbor, Boris Wylie, described the Weirs as normal, very pleasant people. Boris said he left his home that Thursday at around 4:00 p.m. to pick up fish and chips from the shop nearby. He passed the Weir bungalow and all was quiet. However, by 4:30 p.m. the police arrived. Boris witnessed the accumulation of police vehicles and the crime scene cordon around the bungalow. The residence, on a private estate opposite the village green, was very near an exclusive private school. Jean taught at this private school in her capacity as a supply teacher and the Weirs were "well known at the school," according to the head teacher. The frenetic police activity must have comprised a startling juxtaposition to life on the private estate opposite the village green. One neighbor described the episode as "very sad" for the village. The police forced entry into the bungalow and found Jean, dressed in her bed clothes, dead on the bedroom floor. Kevin had been in the house the whole time but had apparently not discovered his daughter's body.

A massive 24-hour manhunt ensued with armed police boarding area trains. At around 3:00 p.m. on Friday, John called the reception desk from his hotel room. He asked for an ambulance. Hotel managers found him in his room covered in blood, apparently the result of self-inflicted knife wounds. John told arriving paramedics he had killed his wife.

Tensions about money permeated John and Jean Weir's marriage for the best part of two decades. There was no known history of domestic violence in the family. Indeed, the children described the relationship between their parents as loving, with occasional arguments. The review team concluded that Jean's discovery of John stealing from her father's estate led to the altercation that resulted in her murder.[22] The team highlighted the failure to share information between private care agencies and publicly funded organizations and the failure to carefully scrutinize the power of attorney over Kevin's assets as significant missed opportunities to intervene. Aside from these observations, there was little the team could suggest that might have prevented Jean's death.

John wrote to his sister-in-law to explain he and Jean had been fighting so much and that Jean attacked him and had been goading him prior to him killing her. In the hospital, he apparently told a psychiatric nurse that his wife had accused him of being a failure. He told the nurse she had hit him. In response, he "snapped" and punched her in an attempt to stop her from screaming. He then grabbed her by the throat, eventually asphyxiating her.

In his summation, the judge addressed John's "snapping." He noted John did indeed "snap" but that his snapping moment became something more prolonged, a "sustained attack on her." The judge's remarks stressed that asphyxiation involves more than a second or two of pressure but rather something more "persistent" and "of a deliberate kind." He sentenced John to life imprisonment with a minimum sentence of 15 years.

We can see in *Weir* many of the case characteristics that I have described elsewhere for the civil reputable perpetrator of familicide.[23] The Weir family was slowly losing its place among the ranks of the respectable middle class. Their descent from grace took a couple of decades. Kevin Charlton's entry to the family home may have been the straw that broke the camel's back. From John's perspective, it may have provided an "opportunity" to reverse the decline. It was certainly a major disruption at the same time as it offered John a novel, albeit illegal, economic option. The temptation proved too great. He was attracted to the glitz of the high life, escorts, drugs, booze, and renewed opportunities for what he might have seen as a bit of glamor in his life.

From the albeit speculative perspective of psychoanalytic theory, John's relationship with his "shadow" was complex and riven with guilt. His suicidality predated Kevin's arrival in the home by a number of years. His shame about his compromised status as a father and a provider had deep roots in early financial failures, to say nothing of any unknown childhood problems. John's narcissism in the face of the final ignominies, being removed from the private road on which his family lived in rental housing, and facing destitution, all likely contributed to the humiliated fury that informed his murderous behavior.

Closing Reflections

I have organized the chapters in Part 2 around the principal reasons or motives for killing. As noted, my taxonomy is subjective. Theft lies at the center of *Richmond* and *Weir*. *Richmond* exhibits a prior history of IPV/A although not between the perpetrator of the gray mist killing and her victim. *Weir* does not. Both cases evince desperation. Both cases contained elements of mental illness in the form of depression and suicidality. Both killings evinced colossal rage from perpetrators humiliated by their life circumstances and their own poor choices.

Having noted the idiosyncrasies of these two theft-related gray mist killings, we must note their rarity. They are the only two theft-related killings among our convenience sample of 100 cases. They are extraordinarily rare as forms of homicide in general. *Richmond* and *Weir* emerge as rarer still if we situate them against the backdrop of cases of theft involving the elderly with dementia. I have already discussed how more discreet, less obviously violent killings of PWD may fly under the radar of police and authorities. The extreme rarity of cases like *Richmond* and *Weir* has implications for those who assess risk in cases involving theft from the elderly with dementia. In short, we would not be looking for the needle in the haystack. Rather, we would be looking for the needle among many haystacks.

As populations gray the world over, the opportunities to steal from those with dementia will likely increase. The tendency for family members to steal will depend, as always, on their life circumstances, their life chances, their personalities, and their moral compasses. But it will also depend on broader resource patterns and societies being less and less able to pay for the care and support of the increasing number of older PWD. The relative wealth of some older people and their physical, emotional, and cognitive deterioration only add to the temptation. The pressure to care for them, even partially, insincerely, or cynically, provides justifications, excuses, and rationalizations for all kinds of transgressions, including gray mist killing.

Notes

1 "CCTV Network Tracks 'Getaway' Car," *BBC News*, November 21, 2005, http://news.bbc.co.uk/2/hi/uk_news/england/bradford/4455918.stm.

2 A. Haines, "The Role of Automatic Number Plate Recognition Surveillance Within Policing and Public Reassurance" (doctoral thesis, University of Huddersfield, 2009), https://eprints.hud.ac.uk/id/eprint/8760/.

3 "CCTV Network Tracks."

4 See for example, S. Connor, "Surveillance UK: Why This Revolution Is Only the Start," *The Independent*, December 22, 2005.

5 E. Widera et al., "Finances in the Older Patient With Cognitive Impairment: 'He Didn't Want Me to Take Over'," *JAMA* 305, no. 7 (February 16, 2011): 698, 705, https://doi.org/10.1001/jama.2011.164.

6 S. Deane, *Elder Financial Exploitation*: *Why It Is a Concern, What Regulators Are Doing About It, and Looking Ahead* (U.S. Securities and Exchange Commission, Office of the Investor Advocate, June 2018), i, www.sec.gov/files/elder-financial-exploitation.pdf. Stephen Deane cites a New York state study that found that the overwhelming majority of incidents of elder financial exploitation go unreported to authorities. Indeed, for every documented case, 44 went unreported.

7 To preserve Beverly's anonymity, I do not include information about the murder weapon.

8 Language from the Significant Case Review.

9 Living with a spouse apparently lowers the risk of financial exploitation from other family members. See J. Peterson et al., "Financial Exploitation of Older Adults: A Population-Based Prevalence Study," *Journal of General Internal Medicine* 29, no. 12 (December 2014): 1615, https://doi.org/10.1007/s11606-014-2946-2.

10 There is no information about whether an abortion or adoption was considered. Neither is there any information about a possible sexual assault against Beverly.

11 A police caution in the UK is a formal warning given to a person who has admitted an offense. If the person refuses the caution, then they will normally be prosecuted for said offense.

12 The term senior house officer is now outdated in the UK. It used to refer to a junior doctor under the tutelage of a more experienced doctor. Nowadays, the more common term is junior clinical fellow.

13 G. Winokur, "The Validity of Neurotic-Reactive Depression: New Data and Reappraisal," *Archives of General Psychiatry* 42, no. 11 (1985): 1116–22, https://doi.org/10.1001/archpsyc.1985.01790340100014.

14 At the time Beverly was seen, in order to be appointed as a staff-grade doctor, the physician must have had at least six years of experience. Nowadays, the title staff-grade doctor is used less often.

15 Zopiclone is used for short-term treatment of insomnia, especially in cases where sleep initiation is problematic, as in Beverly's case.

16 At the time of *Richmond*, the Specialist Registrar typically had 4–6 years of specialty training and worked under the guidance of the consultant psychiatrist, Dr. W.

17 "Oversight" was the word used in the official case review of the killing.

18 As PWD age, many who live alone in their own homes fail to take antibiotics. This may be due to forgetfulness, recalcitrance, or concern about side effects. In rare cases with elderly PWD, the side effects of antibiotics include disturbing hallucinations. The decision to initiate or withhold antibiotic treatment from PWD who have developed a life-threatening infection comprises a hot topic in medical ethics. As they age and their susceptibility to infection increases, many dementia patients take antibiotics. For a discussion, see G. Bravo, "Attitudes Toward Withholding Antibiotics from People with Dementia Lacking Decisional Capacity: Findings from a Survey of Canadian Stakeholders," *BMC Medical Ethics* 22, no. 119 (2021), https://doi.org/10.1186/s12910-021-00689-1.

19 Founded in 1979, the Alzheimer's Society in the UK is a charity that offers care for PWD and their carers and conducts research into the dementias.

20 The concept of counting units of alcohol was introduced in the UK in 1987. One unit is equivalent to 10 mg or 8 grams of pure alcohol, approximately the amount the average adult body can process each hour. One unit is about half a pint of average strength beer. Early in 2016, the UK's chief medical officer set the weekly recommended alcohol limit for men in the UK at 14 units, the equivalent of seven pints of beer. "Health Survey

for England, 2014," Joint Health Surveys Unit of National Center Social Research and Research Department of Epidemiology and Public Health at UCL, 2015, https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2014; H. Siddique, "Weekly Alcohol Limit Cut to 14 Units in UK for Men," *The Guardian*, January 8, 2016, www.theguardian.com/society/2016/jan/08/mens-recommended-maximum-weekly-alcohol-units-cut-14.

21 Proceeds of Crime Act, 2002, c. 29 (UK). The UK Proceeds of Crime Act identifies prosecutable money laundering offenses. Various reporters, for example, financial institutions, lawyers, and accountants, can file suspicious activity reports with the UK National Crime Agency. The filings are not reports of criminal activity but rather information reports that warrant investigation. The filing entity remains strictly confidential.

22 One must wonder whether the argument had anything to do with John's relationship with the escort.

23 N. Websdale, *Familicidal Hearts: The Emotional Styles of 211 Killers* (New York: Oxford University Press, 2010), chapter 5.

Part 3

Contemporary Interventions

7 Problematic Contemporary Responses

Using some of the gray mist cases as touchstones, I explore themes in the social responses to PWD. A few words of caution are in order. These themes form part of the much broader array of social responses to the elderly in the UK, US, and Australia. These high-income, advanced, representative democracies exhibit considerable individualism and have well-developed state apparatuses, a rule of law, and relatively high life expectancies. Hence, we must frame responses to elderly populations within these social and historical formations. The four chapters in Part 2 focused on what the files suggested were the most likely motives/principal reasons for the killing. Chapter 7 broadens the analysis and examines the contexts within which interventions with PWD and their caregivers developed.

These themes also emerge within intimate relationships, among families, and within communities. We have very limited information about the responses of spouses/partners, family members, and community agencies and organizations to managing care for PWD. The data in the 100 cases do not allow any systematic assessment of, for example, whether there was a coordinated community response to PWD, whether PWD took their medications, whether professional caregivers did what the files said they were contracted to do, whether there were consistent patterns of malignant social interactions or malignant practices, what precise form spousal/intimate relationships took in the lead-up to the killings, and what support caregivers received, if any. Even contemporary talk of coordinated community responses suggests an absence of community. Traditional or so-called primitive societies with a more collective or communitarian ethos than modern, more individualistic societies were likely better able to absorb any burdens the senile, decrepit, and potentially problematic elderly posed. This is not to romanticize the treatment of the elderly in traditional societies nor to suggest that the treatment of elderly men and women or those of higher and lower social standing was the same.

The gray mist files provide snapshots, glimpses of incidents and interventions, and anecdotal observations concerning interactions, conflict, and possibly malignant social psychology. We learn from the impressions of caregivers, family members, and others about the behavior and emotional condition of PWD. Rarely do the files address the perceptions of the PWD. Hence, my approach is exploratory and designed to open up lines of inquiry and raise questions rather than offer a definitive account of problematic responses in cases that ended tragically.

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Malignant Practices and Malignant Social Psychology

Drawing from the work of Martin Buber and Carl Rogers on personhood,[1] Dr. Tom Kitwood applied the concept of person-centered care (PCC) to the treatment of PWD.[2] He argued that the dementias involve much more than just deteriorating nervous systems. Rather, the human interactions between PWD and others exert powerful influences on the dementing illness. For Kitwood, personhood stresses the ultimate value of people and calls for recognizing and respecting them as human beings, regardless of their dementia.

Positive person work recognizes that the way others respond to PWD influences how PWD will behave. According to Kitwood, PWD need comfort, a viable identity in the face of the potentially profound erosion of selfhood, social inclusion, attachment to others, and to be occupied by the normal processes of life. He identified 17 malignant practices that undermine, block, detract from, or prevent the realization of these needs, contribute to depersonalization, and worsen the plight of PWD. These practices often occur in under-resourced, routinized, and impersonal nursing and care homes. Although not Kitwood's and others' primary focus, the malignant practices can also manifest within family homes between spouses, partners, and other family members.

Malignant practices also inflame and render more conflictual the relationship between caregivers and PWD, thus contributing to adverse outcomes for caregivers too. Such emotional inflammation might be especially problematic in the home between spouses and partners. Might such malignant practices contribute to homicide?

As PWD age, many face much discomfort. Many are acutely sensitive to pain. Malignant practices such as intimidation, withholding, and outpacing, all undermine comfort. *Intimidation* induces fear and involves the use of threats or physical power over the PWD. *Withholding* entails the refusal to give attention when sought or requested or the failure to meet an evident need, such as affection. PWD commonly complain that people are rushing them, moving at a speed that is beyond their capabilities, *outpacing* them. This may involve providing information and options too fast for the PWD to grasp or being perceived as doing things too quickly or hastening them along. In short, to avoid undermining comfort, it is ideal to treat PWD with warmth and at a relaxed pace. At times, this might be easier said than done.

As PWD become more and more forgetful, especially in the short term, the threat to their self-identity builds. Caregivers bolster that sense of compromised identity by engaging PWD with exploring their identities, lives, activities, hopes, dreams, and travails. This requires caregivers being "present," not in a contrived or deliberate way like a social worker that prescriptively and hyper-caringly latches on to a person's "strengths," but rather being still, open, and genuinely available, curious, and engaging. As Simone Weil puts it, "the capacity to give one's attention to a sufferer is a very rare and difficult thing; it is almost a miracle; it is a miracle."[3] For Weil, "Attention is the rarest and purest form of generosity."[4]

Kitwood argued that infantilization, labeling, and disparagement of PWD further undermine their eroding sense of identity. *Infantilization* involves treating PWD very patronizingly, perhaps as an insensitive or insecure parent might treat a young child. *Labeling* comprises treating PWD primarily in accordance with their master or governing status as someone with a neurocognitive disorder. *Disparagement* refers to making remarks that PWD are incompetent, useless, or worthless, thus further feeding their own growing belief that they may indeed be of ever-diminishing value.

In bureaucratized, under-funded institutional care settings, the malignant practices of stigmatization, ignoring, banishment, and mockery all work against the PWD feeling included. Related to labeling, *stigmatization* involves treating PWD as outcasts. *Ignoring* happens by talking or acting as if PWD are not present. Ignoring happens in the privacy of the home as well, for example, when paid caregivers talk with caregiving spouses as if the spouse with dementia is absent. Related to ignoring is *banishment*, where PWD are excluded, physically or psychologically. *Mockery* involves making fun of PWD's "strange" or incomprehensible comments or actions. Such ridiculing includes teasing, humiliating, or making jokes about them. Again, there is a fine line here between engaging PWD with humor and crossing over to ridiculing. It is often difficult to read the shifting sensibilities of PWD, hence Kitwood's point about many of the malignant practices being inadvertent rather than malicious.

PWD often complain of feeling unattached, regardless of their actual or perceived/remembered contact and engagement with others. Kitwood identifies the malignant practices of accusation, treachery, and invalidation as undermining PWD's attachment to others. *Accusation* involves blaming PWD for action/inaction that stems from their inability to complete tasks or to comprehend situations. *Treachery* refers to the use of deception to distract or manipulate a PWD in a manner that is contrary to their best interests. *Invalidation* entails a failure to acknowledge the reality of the PWD's experience, for example, by perhaps, for reasons of personal discomfort or guilt, failing to acknowledge the PWD's feelings of loneliness. Kitwood suggests that genuine acknowledgement and validation of PWD counters their sense of disconnection.

Disempowerment, imposition, disruption, and objectification all detract from PWD being occupied with some or many of the processes of normal life. *Disempowerment* refers to the failure to permit PWD to utilize their abilities and talents. *Imposition* entails forcing PWD to do something against their best interests. PWD experience *disruption* when someone abruptly interrupts their activities or thoughts or otherwise suddenly disturbs them. *Objectification* occurs when someone treats a PWD as an object, perhaps to be cleaned, lifted, pushed, wheeled, or redirected in a manner that denies their sentience.

Kitwood's work emerged alongside the proliferation of the nursing/care home and hospital industries for PWD and all their bureaucratic, depersonalizing, and routinizing tendencies. Concepts such as PCC and relationship-centered care emerged as ways of improving impersonal climates in nursing/care homes for PWD and the old-old in general. Doubtless, these humanistic responses influenced professional caregivers who worked in the homes of PWD. It is possible that caregiving spouses/partners and family members internalized some of these principles as they cared for loved ones with dementia.

Kitwood and the PCC movement have their critics. Some argue that these humanistic approaches are time-consuming, idealistic, unrealistic, unachievable, enervating, depression-inducing, and rage-inducing for caregivers. Innes argues that PCC places "huge demands on family carers and paid care workers."[5] As a UK residential care worker once put it,

> The only way someone with dementia gets one-to-one care is if they are at home, and looking after someone with dementia 24 hours a day is a killer. I know many cases in which the care caused the deaths of the partners.[6]

The inevitable failure to deliver such care ends up creating conditions that undermine the personhood of the PWD and the caregiver. Brendan McCormack suggests it is more realistic to talk about person-centered moments that are metaphorically powerful, as opposed to PCC.[7]

Other critics have argued the focus on the micro-dynamics of caregiving and the individual experiences of PWD detracts from the broader socio-political context within which people, particularly the poor and the female marginalized old-old, age in Western societies. Put crudely, the decrepit elderly with dementia comprise what Steven Spitzer once referred to as "social junk," dependent people jettisoned onto the scrapheap of capitalist welfare states.[8]

Kitwood's observations regarding malignant interactions pertain to nursing/care home settings, although they might equally apply within homes between family members. It is impossible to know much about the malignant interactions in our 100 cases. However, it is possible that such interactions triggered or provided important proximal or distal contexts for the killing of or by PWD. A few excerpts from the cases warrant mention.

Readers will remember the Australian case of Eric and Roberta Mosely reported in Chapter 3 in *A Little Dead Girl*. A neighbor found Eric, who was in his late 80s, wandering around his front garden. He muttered to the neighbor that there was a "little dead girl" in the house. Eric, in an advanced state of AD, had apparently killed Roberta, although he told police he could not remember having done so. He presented at the scene as "incongruently cheerful" but could offer no information about himself or an account of recent events. Eric was disoriented as to time, place, and person.

Roberta, with the help of her two sons, had apparently been providing 24-hour care for him. It was apparently an exacting regimen of caring. She managed his entire daily routine, from feeding him to administering medications to keeping his appointments. Less than a month after the killing, we learn from a psychiatric report that Eric had lost the ability to dress himself and attend independently to his own hygiene. He also required supervision with meals and was unable to process questions and instructions.

Earlier that fateful day of the homicide, Roberta called her son, Brad, to tell him she had to drop her car off at the repair shop. She asked Brad to "babysit" Eric. Might this communication betray a broader pattern of malignant interactions that included what Kitwood called *infantilization* and *mockery*? Upon entering the residence, police found literature concerning respite care on an office desk in the study where they found Roberta's body. Had Eric read that literature, perhaps feeling he had not been told about Roberta considering placing him in respite care? Was she moving too fast for him, *outpacing*? Was she about to *banish* him to a nursing facility? Was she about to *disrupt* his routines? Did he perhaps perceive she was deceiving him, engaging in *treachery*? Did he perceive her considering information about holidays as treachery? As noted in Chapter 3, her interest in respite care and holidays had previously led to a violent incident.

There is an obvious danger here that we end up implying Roberta is to blame for precipitating Eric's act of homicide. Had she engaged in malignant practices that precipitated the homicide? There is further complexity here and more "ifs." Roberta may have broached respite care and holidays with Eric, perhaps on a number of occasions. We do not know if she was considering a holiday for herself for a much-needed break or a holiday with Eric. She may have told him clearly about respite care and holidays. However, in his advanced state of AD and VaD, he may have been deeply forgetful and just not remembered such humane communications. The short answer is we just do not know. However, the possibility of malignant interactions precipitating homicide warrants mention.

In the case of Ian and Shelly Hurst discussed in Chapter 4 in *Seaside Magic and the Fog of Fatigue*, we see a different dynamic. Here, the eventual perpetrator of the homicide, Ian, understandably due to his acute exhaustion, engaged in malignant practices. Indeed, his youngest son, Kevin, noted he was in a dark place emotionally just before the killing.

Readers will remember son Kevin describing how Ian lost his temper with Shelly and, at times, flew into a rage. On one occasion, he banged his fist on the table. Daughter Amy told reviewers that he would shout at her and become verbally aggressive when he was tired. Were these behaviors examples of the malignant practice Kitwood called *intimidation*? He put Shelly to bed early, apparently regardless of whether she was ready to sleep. Was this *infantilization, stigmatization*, or merely giving himself a space to breathe, survive in the face of exhaustive caregiving, and therefore live to care another day? He got her up during the night to use the toilet, apparently regardless of whether she needed to use it. Was such treatment *objectification*? *Invalidation* of her feelings and needs? An *imposition* of his needs over hers? Did he further objectify, invalidate, and impose on her when he chose her clothes?

We have no way of knowing whether Ian's possibly malignant practices were intentional. His adult children opined he was just doing what he thought was best for the family. The DHR chair wrote Ian's behavior was not a form of coercive control we might witness in a case involving IPV/A but rather behavior directed at managing Shelly's dementia in a manner that allowed them both to survive.

Our ways of knowing about what happened in *Hurst* are limited and problematic. Were his outbursts and malignant practices rare, embedded in an overall milieu of positive person work? Were episodic malignant practices part of an overall malignant attitude? Was his overall emotional orientation toward her a positive one, a caring one, interspersed with understandable frustrations and inadvertent malignant practices? As Mitchell and Agnelli point out, "It is erroneous to suggest that people with dementia should be in a constant state of wellbeing because this is not a maintainable state for any person, well or unwell."[9] Nevertheless, people's attitudes and emotional demeanor matter profoundly to PWD. Indeed, in an impressive qualitative study of the narrative accounts of PWD, van Wijngaarden et al. found that "the attitude of others is what has most impact on daily life."[10]

The Specter of the Nursing Home

In the US, the Social Security Act of 1935, including the Old Age Assistance (OOA) program, provided financial support to poor, elderly people unable to live with family members. Such provisions helped facilitate the rise of old-age homes because federal OOA funds could be used to fund residents' stays. The use of OOA funds paved the way for government oversight of old-age homes and the industrialization of the modern nursing home. The nursing home business blossomed after the 1965 Medicare and Medicaid amendments to the Social Security Act. By the mid-1970s, the number of nursing homes had increased by 140 percent, and their revenues had swollen by 2000 percent.[11]

The proliferation of nursing homes occurred mostly in the private sector and was well underway by 1970. In that year, the *New York Review* published W.H. Auden's poem, "Old People's Home." In it, Auden talked of old people being "stowed out of conscience as unpopular luggage."[12] He notes, "their generation is the first to fade like this, not at home." By that time, the nursing home industry in the US had taken off in earnest. That same year, 1970, also saw the publication of an article in *The New Republic* by US Congressman David Pryor describing nursing homes as half way houses between society and the cemetery.[13] The criticisms of the burgeoning nursing home industry were many. Words like "warehousing" and "junkyards" presaged much-needed scrutiny and regulation that followed in the 1980s.

These cultural sentiments matched similar language from Western Europe. Simone De Beauvoir's classic book, La Viellesse (Old Age), was first published in Paris in 1970. It is a scathing indictment of modern attitudes toward the elderly. In the first American edition she writes, "As far as old people are concerned this society is not only guilty but downright criminal. . . . It treats old people as outcasts. . . . They are condemned to poverty, decrepitude, wretchedness and despair."[14] If the elderly express similar desires to the young, "the world looks upon them with disgust: in them love and jealousy seem revolting or absurd, sexuality repulsive and violence ludicrous."[15]

The Nursing Home Reform Act of 1985 introduced mandatory quality of life standards and a Residents' Bill of Rights for every nursing home certified to accept payment from Medicare or Medicaid.[16] Breaches of these regulations can result in a loss of federal funding, yet, as Pipal indicates, "many nursing homes consciously disregard state and federal regulations by unlawfully discharging nursing home residents."[17] Dementia patients exhibit aggressive and disruptive behavior that prove expensive for nursing homes to manage because they need more and better trained care staff. Many nursing homes inappropriately or illegally discharge patients with dementia, citing bogus reasons for doing so.[18]

Abuses have also been documented in care homes and nursing facilities where PWD reside. These abuses include care staff's physical and emotional maltreatment of residents and profiteering at the apparent expense of residents' well-being.[19] They also include inappropriate sedation through the use of antipsychotic drugs. One report notes nursing facilities in the US inappropriately administering antipsychotic drugs to over 179,000 people who do not have diagnoses for which the drugs are approved. Most of these are PWD who are not in a position to consent to such usage.[20] These drugs are administered to control and manage symptoms of dementia that manifest in understaffed facilities with inadequately trained direct care staff.

Problems providing nursing care for PWD are also found across Europe.[21] Systemic gaps include fragmented impersonal care systems, failures to respect the preferences, values and needs of PWD, limited knowledge and skill of care providers, poor communication and information sharing about the cases/treatment of PWD, and ineffective health care policies at national, regional, and local levels. Much also remains to be done in customizing treatment to the needs of PWD to provide PCC or something approximating it. Dewing and Dijk also note the difficulties for PWD who enter hospitals because of other health problems. These acute care settings appear ill-equipped to provide PCC.[22]

Similar compromises exist in Australia. The extensive Australian Royal Commission Reports on caring for the elderly highlight "many examples of inexpert dementia care that caused unnecessary distress and left pain untreated."[23] The authors note the most common areas of substandard complex care involve dementia and associated "challenging" behaviors. Dementia care ought to be more of a focus since at least half and perhaps up to 70 percent of the residents in aged care facilities in Australia have dementia. Nevertheless, "substandard dementia care was a persistent theme in our inquiry. We are deeply concerned that so many aged care providers do not seem to have the skills and capacity required to care adequately for people living with dementia."[24]

Most of the 100 gray mist killings involved PWD who did not want to enter nursing homes. In most cases, family members did not want to place loved ones with dementing illness in those settings. In some cases, the reluctance to use nursing homes appears to have played a role in the homicide. A few examples help illustrate ways in which the nursing home social response option did not sit well with spouses, partners, and families.

As reported in Chapter 4, Frank Mansfield killed his wife, Phyllis, rather than place her in an assisted living facility for PWD. He told Elizabeth City, North Carolina, police he could no longer care for her at home and that by killing her, he saved her from institutional life "as a caged animal." He was originally charged with second-degree murder. Frank eventually pleaded guilty to voluntary manslaughter. However, Frank had health problems of his own, and his grand jury was delayed for eight months. When it convened, grand jurors refused to indict him and he was set free. The decision of the grand jury may signify at least some sympathy for the view that a nursing home placement would have resulted in an undesirable outcome for Phyllis.

Chapter 4 describes how Peter Lampard killed wife, Vicki, in full knowledge she adamantly refused to be placed in a nursing facility and would not allow caregivers into their home. Like Frank Mansfield, the inability to place her in the home seems to have played a significant part in his decision to kill her. Unlike Frank, he then took his own life as well.

As reported in Chapter 4, Gary Bowers hesitantly placed wife, Mary, in a nursing facility in Orange City, Florida. Previously, she had been hospitalized and needed around-the-clock care. We learn of no dissatisfaction on Gary's part about the performance of the nursing facility. Rather, he was so pained about the placement that he called the facility several times a day. Within a week or so of the placement, he killed her there and then took his own life.

As we saw in Chapter 4, Social Services recommendation that Julia Piven needed assisted living care lay at the root of Beverly Richmond's decision to kill her. Beverly's mother, Laurie Richmond, had already been stealing from Julia, and her theft would have been exposed by the audit required for the care placement. Notably, the money needed to pay for Julia's care would have come from the existing equity in her home, equity Laurie stood to inherit.

Financial temptation of a different kind resulted from 90-year-old Kevin Charlton's unwillingness to enter a nursing home and the decision of his daughter, Jean Weir, to look after him in her family home. Jean's husband, John, seized upon Kevin's presence in their home to steal from him. When confronted by Jean, John killed her.

Finally, the killing by Lawrence Franks, age 86, of his wife of 60 years, Patricia, age 84, in Stockport, UK, provides segue to our next section on problematic diagnostic and treatment interventions. Patricia had insider-knowledge of nursing home care and pharmaceutical responses in dementia cases. She worked as a pharmacy assistant at the NHS Altrincham General Hospital for 30 years and knew of the negative experiences of elderly people in the care system. In his ruling, Judge David Stockdale stated that Patricia "was particularly anxious not to be placed in a care home and said so repeatedly, particularly as her health deteriorated."[25] Lawrence was convicted of manslaughter due to diminished responsibility. He received a sentence of two years in prison, suspended for two years.

Of Lawrence, Judge Stockdale commented, "You showed your wife nothing but love and affection and for the last 10 years tended to her every need. Your devotion was quite exceptional. . . . But the burden of looking after her became impossible for you."[26] His defense lawyer, Vanessa Thomson, stressed Lawrence and Patricia's concerns about the specter of the nursing home. She observed, "He knew he could no longer give her the adequate care she needed, but he also knew he could not put her in a care home where he felt she would be left to rot."[27]

Tricky Diagnoses and Treatments

A wide range of systemic and neurological disorders can mimic the signs and symptoms of dementia.[28] In summary, these disorders include degenerative conditions such as Parkinson's disease, metabolic problems such as liver or kidney failure, neoplastic developments such as carcinomatous meningitis,[29] traumatic brain injury, immunologic difficulties such as multiple sclerosis or lupus, infections (bacterial, fungal, viral, prion) such as Creutzfeldt-Jakob disease (CJD), endocrine conditions such as hypothyroidism, nutritional conditions such as vitamin B-12 deficiency, and cerebrovascular diseases.

In addition to these systemic and neurological disorders, it is also important to rule out other medical conditions such as delirium or encephalopathy, and brain diseases that affect brain function and structure, such as an infection, tumor, or stroke. Similarly, it is important to exclude psychosis and drug abuse, both of which can produce behavior and personality changes that mimic those found in cases of dementia.

In the sheer complexity of the *Paine* case study that follows, we witness some of the possible problems with the diagnoses and treatments involving PWD.[30] We must ask, how and to what extent might these problems have contributed to homicide.

A Dog in the House, People Upstairs, Peering Into Drains

A UK couple, Martin and Cindy Paine (pseudonyms), had been married roughly half a century. He was in his early seventies, she her mid-sixties. One day, and in a manner resembling the two overkill cases discussed in Chapter 5, *Murphy* and *Khalil*, Martin brutally attacked Cindy in a violent frenzy, kicking and knifing her many times. She died several days later in the hospital. His dementia had rapidly worsened in the preceding months. Cindy's sister, Mavis Mirren, was at the Paine house at the time of the killing. Mavis helped Cindy in her role as the principal carer for Martin. Mavis was upstairs when she heard what she described in court as a horrendous piercing scream. She ran downstairs thinking Cindy might have fallen. Cindy suffered from heart disease. When Mavis got to the kitchen, she saw Martin stamping on Cindy's head. He would not stop kicking her head. Mavis jumped on him and tried to pull him away from her sister. He shrugged her off. She tried to put her fingers in his eyes. He pushed her away. Mavis looked at Martin and realized he was carrying a knife. She sensed he was about to attack her with it. Cindy yelled to her to run. Mavis ran to a neighbor's house to summon help. She returned to find Martin standing over Cindy's body. He was holding the knife. It was dripping blood. In court, she described Martin's demeanor as "lucid." Mavis said he told her to call the police and the ambulance.

It was five years or so before the killing, and Martin had recently retired. Martin suffered lapses in short-term memory, forgetting significant portions of conversations he had earlier the same day. His GP, GP R, referred him to a memory clinic. Martin and Cindy indicated Martin's personality had begun to change. He lost his temper more easily and was increasingly frustrated about his memory problems. During this first episode of care which lasted about a year, the community mental health nurse (CMHN) conducted an MMSE test at the Paine's home and Martin scored 29/30, a normal score. Martin was assessed to be a low-risk to himself and others. Psychiatrist D assessed him and concluded he had MCI. Martin was discharged at the end of his first episode of treatment without a risk assessment, something reviewers observed should have been administered.

Martin presented with symptoms of memory loss but a normal MMSE score of 29 out of 30. His case was "comparatively unusual." He had become "snappy" and "short-tempered" as well as "frustrated at his apparent memory problems." There had been a "possible lowering of mood." Four months later the CMHT raised the possibility that Martin, as a former bomb disposal engineer, was suffering from PTSD.

Bomb disposal experts are regularly exposed to blasts. Recent research points to the damage detonations of military explosives cause to neuro-circuitries of the hippocampus which research suggests is involved in episodic memory encoding and social behavior.[31] These neurological problems from blast exposures can arise in the absence of detectable brain damage. As Almeida and colleagues indicate, researchers have linked moderate to severe traumatic brain injury (TBI) with elevated risk of dementia. They cite research which demonstrates that even mild TBI, with no loss of consciousness, results in more than a doubling of the relative risk of receiving a dementia diagnosis.[32] It may follow that military blast shock-waves produce a degree of synaptic pathology more subtle than mild TBI, inducing "Alzheimer-type neuronal compromise."[33]

In relation to this first episode of care, reviewers commented, "The clinical notes contain nothing to demonstrate that differential diagnosis was considered. In addition, no further relevant investigations were undertaken at this stage, such as a CT or an MRI scan, or seeking psychopharmacological advice."[34] Additionally, they comment the medical record contains no reference to the CMHT contacting Cindy to see how she was coping and whether she needed support services.

The second episode of care commenced roughly two-and-a-half years later. GP R referred Martin back to the memory clinic because his memory had deteriorated. He had trouble remembering the names of his grandchildren, got lost in conversations, and could not find the right words. The CMHT administered another MMSE. Martin again scored 29 out of 30. A CT brain scan showed generalized changes in the cerebral cortex that can be consistent with both normal aging or early dementia. It was at this juncture Martin received a prescription for 20 mg of citalopram to treat his depression.

Six weeks later, he scored 30 out of 30 on the MMSE test. His emotional demeanor apparently had not changed. The citalopram did not appear effective, so consultant psychiatrist A substituted 20 mg of mirtazapine. His new doctor at the memory clinic, consultant psychiatrist A, also arranged for Martin to have an MRI scan and return for another consultation in four months.

Four months later and 10 months before the homicide, the couple discussed the MRI results with consultant psychiatrist A, the lead medical professional handling the case. Cindy confirmed Martin's continuing memory problems, his difficulties recalling names, and his tendency to get lost in conversations. Notably, Martin was also having problems working out finances and was increasingly unable to cope with change. He reported his thinking was slowing down and that he had a tremor in his right hand which did not swing when he was walking. Cindy added that Martin had difficulty getting out of his chair, shuffled when he walked, and that his writing was decreasing in size. Martin also had lower back pain for which he was prescribed 600 mg of gabapentin three times a day. He was having nightmares, which medical professionals and Martin thought were perhaps due to his switch to mirtazapine for his depression.[35] Consultant psychiatrist A recommended he return to using citalopram.

The scan revealed mild to moderate symmetrical brain atrophy. The brain tissue loss was most marked in the frontal and parietal lobes. Martin had also suffered widespread mild cortical white matter ischemia (compromised blood flow). Additionally, the scan showed diminished blood flow to pathways connecting different sections of the brain.

At that same appointment, consultant psychiatrist A noted tension between the spouses and referred Martin to social services to be assessed for day care services. Unfortunately, as reviewers note, the files contain no record that consultant psychiatrist A followed up on his social services referral. Reviewers concluded this apparent omission resulted in a missed opportunity to explore whether authorities ought to introduce safeguarding measures or systematic risk assessment. They comment, “The lack of a systematic risk assessment . . . is serious and clinically significant.”

Dementia followed by the Parkinsonian-like symptoms Martin displayed, such as the tremor in his right hand, his gait abnormality (he shuffled as he walked), and mood fluctuation, could signify AD with Lewy bodies or DLB. There is a difference. AD, the more common form of dementia, primarily affects memory, language and behavior. DLB is a form of dementia that exhibits Parkinsonian-like symptoms that affect problem-solving, speed of thought, memory, movement and mood.

A month after the Paines’ meeting with consultant psychiatrist A, a staff member from the social services access team called Cindy to see how she was doing.[36] Cindy reported that she was Martin’s principal carer although she received support from her sister, Mavis. Cindy said she helped Martin with his personal care and was generally managing well in spite of the fact she suffered from chronic obstructive pulmonary disease. The staff member raised the possibility of day care for Martin. Cindy said she did not know whether he would consider it.

Reviewers later opined that Cindy and her family received insufficient support, advice, and information regarding their entitlements to social care. They interviewed the sons of Martin and Cindy who provided useful insights about the economic compromises Cindy faced. As noted in other cases concerning the specter of the nursing home, Cindy was worried about being means-tested and about having to sell her house if Martin had to go into full-time care.

A month after the access team’s telephonic outreach to Cindy, a consultant (specialist) physician diagnosed Martin with Parkinson’s disease *and* dementia. He was prescribed 125 mg of co-careldopa three times a day, a medication typically prescribed to help with tremors and stiffness and that raises brain levels of dopamine.

At the next meeting with consultant psychiatrist A, some six months before the homicide, Cindy shared she declined a care package offered through social services. Tellingly, at this meeting, Cindy said Martin had been seen by consultant physician E and diagnosed with Parkinson’s disease. Apparently, she did not communicate consultant physician E's diagnosis that Martin was suffering from Parkinson's disease *and* some sort of dementia. Cindy reported that he was still having memory problems. Consultant psychiatrist A apparently opined these memory problems were "most likely to be related to his Parkinson's disease but they were mild, and so, under NICE guidelines for treatment of mild to moderate dementia, acetyl cholinesterase inhibitors were not recommended."[37] Consultant psychiatrist A wrote to GP R advising a follow-up appointment had not been made but that he would be happy to see Martin again "if his presentation changed."[38] The communication marked the end of the second episode of care.

The UK National Institute for Health and Care Excellence (NICE) guidelines advise that in cases like Martin's, a variety of possible diagnoses (e.g., frontal lobe syndrome including Lewy body dementia, dementia related to alcohol abuse, and the side effects of medication) warrant consideration.[39] Instead of considering a variety of possible diagnoses, reviewers opined consultant psychiatrist A relied on information given by Cindy and Martin and did not seek out consultant physician E's report. That report contained information "not wholly compatible" with his own conclusion that the memory problems were likely to be related to Parkinson's disease.

GP R received a letter from the consultant physician E stressing a different interpretation to that of consultant psychiatrist A. The physician wrote that Martin "does not have any significant history of hallucination and it is difficult to pinpoint whether he is having Alzheimer's type dementia or Lewy Body dementia."

Reviewers opined that as the lead medical specialist in *Paine*, consultant psychiatrist A discharged Martin from his second episode of treatment "based on the untested assumption that a physician had reached a similar diagnostic conclusion to his on the cause of Martin's dementia, and was competent and willing to manage Martin's dementia in future."[40] There was no communication between the two doctors regarding this matter of whether Martin's dementia was linked to his Parkinson's disease as apparently consultant psychiatrist A thought, or, whether it took another form, possibly AD, DLB, or some combination of these, and possibly other problems as consultant physician E apparently believed. In the words of reviewers, the decision to discharge "was neither wise nor reliable. An opportunity to clarify a complex diagnosis with a possible impact on treatment and management was missed."[41] Additionally, reviewers noted that consultant psychiatrist A apparently did not consider recommending home visits by a CMHN to provide support to Cindy and monitor progress.

Ten weeks after being discharged by consultant psychiatrist A, consultant physician E saw Martin and Cindy at a follow-up appointment about Martin's potential Parkinson's disease. Consultant physician E noted Martin's condition as "stable" but recorded a score of 7 out of 10 on an abbreviated mental test score. The score suggested "significant deterioration of memory." The assessment comported with Cindy's own interpretation of Martin's ongoing problems with memory. Therefore, consultant physician E re-referred Martin back to the memory clinic.

Six weeks later, Martin and Cindy saw GP U not GP R, Martin's regular GP. The couple told GP U they had taken a vacation at a seaside resort. Cindy informed

GP U that while on vacation Martin became agitated. He had demanded his tablets. Cindy felt Martin was going to hit her with an iron. Reviewers found no evidence in the written record that GP U attempted to talk with Cindy alone or set up various safeguarding measures on her behalf. GP U did phone the CMHT to request an urgent appointment. He spoke with the team secretary. Reviewers comment that

> there is no record in the clinical notes showing that the team secretary referred the case to the team manager or duty worker so that they could gather any risk factors and all other necessary information as outlined in trust policy.[42]

The team secretary made an appointment for Martin to see Dr. S, a specialty doctor in psychiatry. Significantly, consultant psychiatrist A supervised the work of Dr. S. The face-to-face appointment was for nine days later, not, as per NHS trust policy, within the 48-hour window for "urgent" requests.

GP U started Martin on 25 mg of quetiapine twice a day, a low dose. Quetiapine treats mental/mood conditions. It can decrease hallucinations associated with conditions such as schizophrenia and bipolar disorder and flatten severe mood swings or decrease their frequency. Quetiapine comes with a black box warning for older patients with dementia since it is associated with death, particularly at higher dosages.[43]

Nine days later, Cindy and Martin saw Dr. S. Cindy complained about the rapid deterioration of Martin's mental state, cognitive functioning, and behavior. She also reported his aggression toward her on vacation. She did report an improvement in his behavior since commencing the quetiapine, but she stressed he was still abusive toward her. Tellingly, the medical records show that Martin had experienced visual hallucinations, including seeing a dog in the house and people upstairs. Dr. S recorded Martin's cognitive impairment as severe. Dr. S said she was unable to complete an MMSE because Martin was suspicious and irritable. She described his comprehension as impaired and his mood as dysphoric. However, Martin apparently denied to Dr. S any suicidal thoughts or thoughts about harming others. During her assessment, Dr. S was unable to detect any delusions or hallucinations. At the time of this appointment, Martin was taking 300 mg of gabapentin 3 times a day, 125 mg of co-careldopa three times a day, 20 mg of citalopram daily, and 25 mg of quetiapine twice daily.

The DHR report comments on Martin's drug cocktail. It notes that Dr. S knew he was taking gabapentin, co-careldopa, citalopram and quetiapine. It also observes that visual hallucinations are fairly common with co-careldopa, particularly when given simultaneously with other medications. They expressly comment Martin's medications had changed many times and the "possibility that this was the cause of some or all of the recent deterioration and hallucinations would have been important."[44]

At this juncture, a little over three months before her death, Cindy's concerns entered the medical record. She communicated that she was struggling to cope. Tellingly, she "requested urgent respite." The next day, Dr. S requested an assessment by social services. Reviewers noted there was a concern regarding "carer breakdown." An urgent CT scan was ordered but the hospital refused to carry out the scan because one had been done in the preceding year in response to similar symptoms.

A week after her request, a social worker and a social care assessor visited Martin at home. Cindy and their son were also present for the visit. The social worker met with Cindy, the care assessor with Martin and the son. The social worker denied to reviewers that Cindy, when asked, had reported any such abuse. Apparently, Cindy described Martin's behavior as "nowty," regional vernacular meaning bad-tempered, possibly used euphemistically. Martin and Cindy declined the use of a telecare pendant (an alarm). Cindy declined respite care, a break of a weekend or longer while someone else cared for Martin. Nevertheless, arrangements were made for Martin to attend day care on Mondays.

As reviewers pointed out, social services did not report the outcome of their home visit to Dr. S. Neither did Dr. S pursue feedback from them. Ten days later, the Paines saw GP R. The GP wrote that Cindy reported noticing an initial improvement in Martin's agitation but a "marked deterioration in his hallucinations and paranoid ideation since he had started taking quetiapine." The GP told Cindy of previous experiences he had had with anti-Parkinsonian medication causing hallucinations. In consultation with Cindy, he stopped the quetiapine and co-careldopa, doing so through downward titration over a few days. He asked Cindy to provide feedback on how the withdrawal was going. Reviewers later commented that at this particular juncture, Martin's symptomology "should have led to a systematic assessment of risk but this did not take place."

In a discussion with GP R two weeks later, Cindy noted an improvement in Martin's general functioning and his ability to hold a conversation. However, she noted his obsessiveness continued. Cindy apparently told the GP she was keen to stop other medications that might be affecting Martin's behavior. The GP advised weaning Martin off the citalopram and gabapentin.

Just two weeks before Martin's ultimately fatal attack, the couple returned to the surgery to see GP R. Records reveal Martin complained of lower back pain. His memory was poor and he became frustrated when he could not find his words. GP R restored the gabapentin at the dosage of 600 mg three times a day, his earlier dosage. He also issued a prescription for slow-release tramadol, an opiate painkiller.

Later that same day, the couple went to see consultant psychiatrist A. Cindy apparently reported that Martin was attending the day care center and that his mental state had improved. Consultant psychiatrist A was aware that GP R had discontinued the use of co-careldopa, citalopram, and quetiapine. The notes show Martin's language was significantly impaired. His mood was reactive. He was also disoriented by time, had poor recall, and was inattentive. He only scored 15 out of 30 on the MMSE. Martin's memory had deteriorated, and his overall performance had declined significantly.

On the morning of the attack, Cindy called GP R, concerned about Martin's behavior. In the preceding two weeks, he had become more confused, was experiencing visual hallucinations, was reluctant to dress, and felt his clothes no longer fit. Many of his senses were deteriorating. Martin had begun peering into drains in the street. He was verbally aggressive and agitated. It was Thursday, and Cindy expressed fear that he might strike at her if she had to cope with him over the weekend. Apparently, the GP could not see Martin immediately because their son came over to the house and took Martin out for the day. The GP advised Cindy to collect a urine sample from Martin and spoke to the CMHT secretary. She arranged an urgent outpatient appointment with consultant psychiatrist A the next day. The next day Martin attacked Cindy. She died of her injuries three days later. Martin, unfit to stand trial, entered a secure mental health facility.

Perhaps significantly, Cindy and Martin's two sons supported Martin even after his brutal attack on their mother. Their support may suggest they knew of no prior history of IPV/A that predated the onset of his dementia. Readers will recall from Chapter 5 the different responses of Ciara and Clodagh's adult children in *Murphy* and Iffaa's in *Khalil*. Notwithstanding the possible absence of prior IPV/A, we must ask what fear Cindy experienced in the run-up to her demise. We might also ask to what extent carers, particularly older, frail women, fear spouses/partners with dementing illness.

Siege Mentalities

Many couples in our cohort were born in the Great Depression or soon thereafter, lived through World War II, and experienced the rise of the modern welfare state. The cultural values and norms of our cohort, including their gendered spousal roles influenced how they experienced old age and the dementias. In the face of dementia, we see amongst many couples a regrouping, an adaptation to growing adversity, and a near-reversion to older psychic routines of self-sufficient survival reminiscent of Great Depression and World War II coping styles.

Many couples appear to have developed siege mentalities. These orientations were suspicious of the intrusive offerings of the welfare state. In many cases, these mentalities eschew the supposed expertise, knowledge, and well-intentioned but often perceived as condescending/paternalistic interventions frequently accompanied by compromising means-tests. The cohort retained many of its steely, isolationist qualities, whether located in the US, UK, or Australia. Siege mentalities seemed to also persist regardless of the degree of any actual, suspected, or perceived coercive control in the relationship. A case example helps illustrate the siege mentality theme.

Padlocked Gates: Withey

The British couple's carer rolled up to the house in the sleepy English coastal village. Joe Withey (pseudonym) had a habit of denying carers entry. On occasions, Joe, almost age 90, had padlocked shut the gates leading to their home. He had not done so this morning. The carer knocked but received no response. A little later that morning, the local woman who delivered newspapers knocked. She, too, received no answer. She delivered the newspaper and returned an hour later to knock once more. Again, she received no response.

Our newspaper woman's unanswered second knock was followed an hour later by a visit from the GP and the Witheys' case coordinator from Adult Social Care (ASC). Joe answered the door. He apparently told the visitors Lorraine was on the floor, unable to get up. He led them into the house. Upon entering a bedroom, they found Lorraine, also in her late 80s, lying dead on the floor between the bed and the wall. Police arrived an hour later. Lorraine had bruises on her face and neck, open cuts on her arms, and a dislocated shoulder. A postmortem found multiple bruises on her body. Joe had suffocated her.

Joe and Lorraine Withey had been married for nearly 70 years. They had three adult children who did not live nearby. The couple moved to the coastal area of England upon his retirement, after roughly 40 years of marriage. Lorraine had dementia. In the aftermath of Lorraine's death, Joe was eventually diagnosed with AD. The couple had married in 1948 in the aftermath of World War II, a year before Mao and the communists seized control in China, two years before the Korean War commenced, and a year after the Taft-Hartley Act of 1947 dealt a severe blow to American labor unions. Joe had spent his career as a policeman.

Joe and Lorraine's first contact with ASC came eight years before the killing. ASC provided a handrail to assist with mobility at the property. Nevertheless, five years later when Lorraine was in her mid-eighties she apparently fell and broke her hip. Their son, Ralph, opined the hip breakage diminished his mother's confidence and made her more dependent on Joe. Within a year of the hip injury, Ralph reported his mother's confusion over her whereabouts and her memory problems to ASC. He also reported being concerned about his father's weight loss. An access assessor, the first point of contact from ASC, reached out to Joe to see what he and Lorraine might need. The assessor shared Ralph's concerns with Joe. In a manner akin to that of other gray mist killers, Joe said he and Lorraine were coping well, that he knew how to reach out for help, and that he would reach out for help if needed.

Another year passed. Ralph and his wife, Norma, visited his parents just three months before the killing. During that visit, Ralph contacted the GP surgery to express concern about his parents. Lorraine's memory problems had worsened. Ralph reported he believed his mother had dementia. Joe initially resisted Ralph and Norma's visit, saying there was "no need." Ralph told reviewers that during this visit, his mother seemed more withdrawn, more reluctant to engage in conversation than previously, and muddled about her whereabouts. He also said his father seemed more confused. Ralph told reviewers that Joe's hearing had deteriorated. Both parents had lost weight. Ralph told the GP he was worried about his parents' ability to cope with everyday life, especially cooking and bathing. He reported these concerns to the ASC team but was told that his parents had to give their consent before an assessor could visit their home.

Roughly two months before the killing, the practice manager at the GP surgery expressed concern because neither Joe nor Lorraine had visited the surgery or collected their medication in the preceding three months. A neighbor, Janice, raised further concerns with the GP. She had visited Joe and Lorraine and found Lorraine unable to take herself to the toilet. Janice reported Lorraine to be in a state of neglect.

GP B visited the Witheys at their home. Joe was reluctant to let him enter. When asked about Lorraine's welfare, GP B reported Joe as defensive. He also noted that Joe was aggressive toward Lorraine. The GP observed bruises on Lorraine's body, particularly "a number of bruises and healing lacerations on her hands," and was concerned she was "subject to abuse or neglect."[45] Furthermore, the GP noted that when he questioned Lorraine, Joe would answer for her. Joe's interjections made it difficult for GP B to assess Lorraine's condition.

Two weeks later, the GP returned with a social worker. The social worker noticed fresh bruises on Lorraine's knees, thigh, chest, arm, and finger. Joe told them she had fallen in the shower. Frail and thin, Lorraine was walking around in soiled nightclothes which appeared stained with dried blood. Her bed was similarly stained. Joe told them he would change the clothes. The social worker observed Joe was brusque in his dealings with Lorraine. He pushed her along as she walked. Both the GP and social worker discussed the provision of support, especially help with bathing, but Joe said they did not need it. At this point, the social worker informed him it might be necessary to admit Lorraine to the hospital. A key informant on the DHR panel opined Joe was perhaps rather frightened at the prospect of separating from Lorraine. Although Joe claimed the couple were coping, the house had fallen into disrepair. It was dirty, and there was evidence of hoarding.

Within a couple of days, the social worker returned. Joe reluctantly let her into the house. She observed Lorraine still in the same soiled nightclothes and the bed linen unchanged. Lorraine said she would accept help, but the social worker would need to consult Joe. Upon consulting Joe, he said, "You don't want this help, do you? You don't need it, do you?"[46] The social worker reported her findings to the GP surgery. In his medical notes, the GP wrote he was "concerned about her poor care and there is not a reasonable explanation for the injuries."[47]

Questions arise regarding Joe's responses to these interventions. Had his yet-to-be-diagnosed AD set in and he had forgotten his earlier commitment to change Lorraine's soiled clothes and bed linen? My informant thought Joe was cognitively unable to comprehend her condition or cope with it. He suggested Joe saw himself as her husband, not her carer. We might therefore ask whether his AD, albeit undiagnosed, rendered him dismissive of Lorraine in a way different from that seen in non-dementia-related coercively controlling relationships. Was he resisting unnecessary state intrusions, perhaps intrusions he had seen before as a police officer? Or, was he consciously excluding professional "helpers" because he wanted to isolate Lorraine? Keep her to himself? The possibilities seem endless, and this is to say nothing of the various permutations and combinations among them. Gray mist.

The GP revisited the home. He advised Joe that if he continued to refuse care visits, it might be necessary to remove Lorraine from their home. There is nothing written about how Joe received this information, whether he was distraught or aggressive. We do learn that a week later, a CPN attended the residence. At first Joe refused her entry. Eventually, he relented. She talked briefly with Lorraine. Joe was reluctant to talk with the CPN. After ten minutes, he asked her to leave the house. Around the same time, Joe also refused entry to carers, letting them in on only one occasion. Notably, on the day before the killing, he refused carers entry.

In spite of Joe's behavior and the fact professionals suspected Lorraine was living at minimum in a state of neglect, authorities administered no formal risk assessment. The DHR team was unable to find any domestic violence policy at the GP practice, itself spread over a number of locations. The team noted this as a "significant gap." My informant told me the team did not want to be too critical, hence the term "significant gap." Asked for a more candid personal position, the informant described the lack of a formal risk assessment as a "direct contributing factor to the killing." I return to these matters in Chapter 9.

The DHR interview with Ralph was instructive. Ralph's sisters declined to participate in the DHR and were happy for Ralph to speak on their behalf. Like so many of the adult children interviewed in the gray mist killing cases, Ralph described his parents' marriage as traditional. In retrospect, Ralph felt it was "possible to conclude that his father had been quite controlling of his mother and indeed of him and his siblings."[48] We learn from Ralph that all three children were keen to leave home. He left at age 15 to join the Army. According to Ralph, the family was not close. His parents apparently never celebrated their wedding anniversary. He described Joe as being "black and white." It was Joe's way or no way. There were "no grey areas" with Joe. If Joe liked you, more to the good. If he did not, "he would have no tolerance for you." Significantly, Ralph said his mother "had never been allowed to learn to drive and that as a consequence she and Joe always had to travel together and she was reliant on him."[49]

In post-World War II England, compared with the US, a far lower proportion of women had licenses to drive vehicles. There were likely many reasons for this, not least of which was the fact people in the UK had better access to public transportation, taxes on petrol were comparably much higher, hence its relative cost was greater, and driving was more of a necessity in the US given the greater distances over which social and economic life unfolded. The fact Lorraine had never been "allowed" to drive comprises one piece of the coercive control jigsaw puzzle. Such restrictions might have been part of the broader structure of a coercively controlling relationship or indeed a society in which women played out subordinate, dependent roles. However, there are other possibilities, such as health concerns, that the available data do not allow us to explore.

For the record, there was no actual determination of IPV in *Withey*, only conjecture. If readers infer coercive control was at work during parts or most of the 70 years of the Witheys' marriage, other important questions arise. Was it the coercive control and any broader social patterns of "patriarchy" or an unfair or tyrannical gender order that informed Joe's unwillingness to entertain the "caring," "supporting" overtures of the welfare state? Put differently, was Joe's little kingdom at home a throwback to those times when patriarchs ruled within families because the state was not sufficiently authoritative?

Missed Opportunities

The case studies speak to what appear to be failures in communication, coordination, and collaboration among those involved in caring for PWD. For instance, readers will remember Henry and Gloria Michaels from "*Spiked Railings*." They lived in a quaint English village for their entire 50 years of marriage. He liked to hunt game birds but had to give up his hobby because of a disabling back injury. He later developed what was most likely DLB with Parkinsonian features. The consultant in the case suggested a trial on rivastigmine. The university hospital reported to the DHR panel that a letter was sent to the community psychiatry team at a local mental health hospital recommending rivastigmine use. The letter was never received. A follow-up fax was sent nearly two months later. It arrived just six days before Henry killed Gloria.

The DHR team concluded, "It is unfortunate that Henry Michaels did not get the opportunity to benefit from this medication prior to the fatal stabbing."[50] Given the results of a randomized, double-blind, placebo-controlled, international study found rivastigmine appeared to reduce apathy, anxiety, delusions, and hallucinations and that Henry's hallucinations had become increasingly problematic just days before the killing, the team's concern is understandable.

The *Michaels* breakdown in communications may have contributed to the homicide. We will never know. In what follows, I document one glaring failure to share information that seems to have triggered a homicide-suicide.

A Finger Across the Throat

Greg and Mandy Summers (pseudonyms), both former academics in their early eighties, lived in a tiny village in England bordered on one side by a river and the other by mountainous terrain. They had been married for nearly 60 years and had two adult sons, one of whom, Tom, contributed to the DHR. He had visited his parents from his home overseas in the last year of their lives. Tom told reviewers that his father was a very private person who neither sought nor wanted advice. His mother had been more gregarious. According to Tom, Greg "ran the show." Six years before Greg killed Mandy, and then, a few months later, himself, Mandy was diagnosed with AD.

During his final visit, Tom noticed Mandy's memory had deteriorated. She forgot names and places. At times, she could not remember where she was. But he described her spirits as "good." She was still physically fit. Indeed, she liked to take long walks with Greg. On a couple of occasions in the last year of her life, she climbed out of a window and "wandered" off into the nearby mountains. She was located later after a helicopter search. When asked about their marriage, Tom said his parents were "very fond of each other." Greg could be volatile with other people, touchy about sharing personal matters, and very much "in control." Greg always told Tom there was nothing Tom or his family could do to help.

Mandy's brother, who also lived overseas, described the couple as "very private people." They were "happily married" but "isolationist." Greg was not good at asking for help. The Summers' next-door neighbor, Jean Wildman, described the couple as "close." They "enjoyed spending time together," and "going on long walks." They were "not sociable people." As Mandy's AD worsened, Jean often observed her in the garden "just staring." Jean described Greg as a "good carer" who did all the cooking, including catering to Mandy's vegetarian diet. Jean told reviewers that Mandy felt as if Greg was imprisoning her by trying to prevent her from going out. None of the parties in the case even hinted at IPV/A. Significantly, Jean had no idea if social services were involved with Greg and Mandy. She and her husband imagined Greg "would not have wanted that." Indeed, the record shows that from the point of Mandy receiving her diagnosis of AD six years prior to her demise, the couple did not want home visits from carers.

Seventeen months before her death, Mandy was found wandering. She was taken to A & E. Her GP, Dr. L, learned of her wandering when she received a letter from A & E. No further action was taken because it was not considered unusual for someone with dementia to wander. Since the police were involved, Dr. L assumed appropriate action had been taken. Reviewers found fault with Dr. L's inaction, and she herself stated that with additional safeguarding experience and training, she would do things differently. Specifically, she would consider reaching out to the family, requesting more information from A & E, and informing the elderly psychiatric team and ASC.

A month later the social worker visited Greg and Mandy. In the aftermath of Mandy's "wandering" incident, she discussed the possible use of mobile phones, GPS tracking devices, and other assistive technology. During the visit, Greg mentioned he would be undergoing medical treatment and would need to make provision for Mandy while he was in the hospital and therefore unable to care for her. Reviewers were critical of the social worker for not completing a support plan at that time. The record also shows no carer's assessment. Apparently, the social worker intended to firm up support plans once Greg's hospital date had been fixed, a strategy the reviewers deemed insufficient. She did recommend that Greg contact the NCC (pseudonym) to conduct the carer's assessment.

Roughly eight months passed before the social worker reached an agreement with Greg to contact NCC. At the time of that agreement, the social worker obtained consent to refer Mandy to local Dementia Support Services. The case was closed for the social worker at this point, an outcome that resulted in no contact for another four months—that is, until just three months before Greg killed Mandy.

Records reveal that it was a month or so later that the social worker made the referral to NCC.[51] Notes show no conversation between the social worker and NCC nor what case information was shared. Reviewers noted, "The referral to NCC was not timely."[52] Worse still, the social worker failed to follow up with NCC to find out whether the carer's assessment took place. Tellingly, the DHR opines, "The social worker overlooked an opportunity to ensure that Greg's needs as a carer were being addressed."[53]

Ten days later, Dementia Support Services contacted the social worker. They noted they had had contact with Greg just a few days earlier and that he had turned down receiving support. Again, reviewers were critical that the social worker missed the opportunity to proactively help Greg develop a support network, address why he declined support from Dementia Social Services, and ensure that his needs as a carer were being addressed.

An incident at the GP's surgery some three weeks later provided clues as to Greg's emotional condition. Someone at the surgery mistakenly made an appointment for

Mandy on a day when it was closed. Greg filed a complaint on his wife's behalf. He became "rude and unpleasant" and "shouted at the practice manager for about 15 minutes." Dr L only became aware of this episode as she later combed through practice records in preparation to contribute to the DHR. At around the same time, the CPN noted Greg was "not under strain." His demeanor toward the practice manager suggested otherwise.

It was during these months that Greg first visited the Greenacres Care Home (pseudonym). He was becoming increasingly vulnerable. Mandy had another episode of wandering. A police officer visited Greg at his home during Mandy's disappearance. He reminisced about better times, talking about Mandy's successful career as a teacher. He said he missed her and felt overwhelmed by the cruelty of the disease. Greg became tearful when the officer made him a cup of tea, saying it was a long time since anyone had made him tea. He said that Mandy had made it clear to him that she did not want to go into a care home. However, she was becoming increasingly difficult to deal with. The officer noted that upon Mandy's return, Greg was "immediately attentive and checked her for injuries." The next day, Greg placed Mandy on a waiting list for a Greenacres room.

The police contacted ASC, who in turn took over a week to reallocate the case to the original social worker. Reviewers commented that the reallocation of a case of this seriousness took too long. They also observed the social worker and her line manager failed to consider the possibility that Mandy was climbing out of windows at her home because of "unnecessary restraint" by Greg.

As Greg's date for gallbladder surgery approached, he became increasingly concerned about what would happen to Mandy while he was in the hospital. He had become quite ill himself, was debilitated and in considerable pain. A month before the killing, the hospital reassured Greg he had gallstones and not the cancer he suspected. At that time a CT scan of Mandy's brain confirmed general atrophy and that her brain function had declined. ASC became increasingly involved in the case.

The social worker contacted Greg with a list of care homes for Mandy. The list did not include Greenacres, the care home near to Greg which would have been relatively easy for him to visit. Greg confirmed that in light of recent developments, presumably the most recent episode of wandering, his ill health, her CT scan results, and his increasing difficulty managing her behavior, that he was now considering moving Mandy into a long-term care home. In the meantime, he said he would benefit from help with bathing her and that he intended to follow up with a care agency. He had also spoken with a day care provider who was able to help. The social worker gave him contact numbers for ASC and her mobile phone number but explained that she only worked two days a week. Greg told the social worker he required no further support.

The DHR argues the social worker missed an opportunity to provide support for Greg in making suitable care arrangements for Mandy. Since they had savings in excess of the threshold below which they would have qualified for state aid, the Summers would pay for Mandy's care. It is appropriate for a social worker to withdraw their support in self-pay cases if the person does not want or need assistance. Reviewers felt, given recent developments, the social worker should have arranged a subsequent home visit to check that Mandy was receiving appropriate care.

A little less than two weeks before the homicide, Greg received a call saying a bed had become available for Mandy at Greenacres. The home's owner and manager, Lynn Ransome (pseudonym), a trained nurse, explained the room needed to be prepared and that she would need to assess Mandy before admitting her. At that time, Lynn was taking a holiday and would return to assess Mandy and supervise her "settling in." Dr. L expressed concern Greenacres was not an appropriate choice because of Mandy's dementia and her history of wandering. She reportedly spoke with Lynn while visiting another patient there. Dr. L reports telling Lynn that Mandy was "fit and prone to wandering." At the coroner's inquest into Mandy's death, Lynn denied receiving this information from Dr. L.

In the meantime, Greg brought in some clothes for Mandy and they were placed in the vacant room. He was described as "insistent and a little odd." When Lynn returned from holiday, she found a letter from Greg saying that he was bringing Mandy in that very day. This was apparently not what Lynn had planned since she had yet to assess Mandy. However, Greenacres staff agreed Greg could bring Mandy in on a trial basis. Concerned, Lynn apparently told Greg the home was not a secure unit. He reportedly responded by telling staff that if his wife had company "she would be content and he did not feel she would try to leave."

Greg brought Mandy to the home at 10:00 a.m. Lynn had apparently agreed to meet the Summers there at 1:45 p.m. A short risk assessment was completed but it was handwritten and did not mention Mandy's tendency to wander. Meagre Greenacre records show Greg leaving Mandy sometime after noon. Mandy was apparently tearful. Staff reassured her she was staying with them while he prepared for his hospital treatment. Lynn left the facility at 5:00 p.m. only to be called later by staff to learn Mandy was missing. She had apparently wandered off while staff were not looking. Staff located her quickly. Lynn later wrote that she was unaware of Mandy's history of wandering or that she had previously been located by Mountain Rescue after one episode of wandering months earlier. She felt Mandy would not be safe at Greenacres and called Greg to ask him to pick her up. He said he could not as he had had some alcohol. Lynn and her husband, the care home director, took Mandy home to Greg. They dropped her neatly folded clothes on the doorstep in bin liners. She had been bathed and made ready for bed.

Mandy apparently arrived home at around 9:00 p.m. According to the DHR, Greg tried to make a joke of Mandy's reappearance at home. Reportedly, he said, "you've done it again," and "drew his finger across his throat," a gesture which Lynn suggested was a jokey way to say he could "do himself in."[54] He also apparently remarked, "You'll be the death of me yet." Reviewers noted from the contents of Greg's calls to other care homes that he was "at the end of his tether." Apparently, from the time Greg knew Lynn was bringing Mandy home to the time she arrived, Greg tried to make alternative arrangements. He called seven other care facilities to no avail.

At 7:06 p.m., he called the social worker on her mobile phone. Greg said he knew the social worker was off-duty but that she might check her messages. He explained Mandy's pending return home after the temporary placement at Greenacres had fallen through. He mentioned his gallbladder surgery was just three days away, and he was desperate to find an appropriate placement for Mandy. Twenty-four hours elapsed before the social worker checked her messages. By that time, Mandy was dead, and Greg had been arrested for her murder.

At the coroner's inquest into her death, an attending police officer wept as she spoke of Greg, describing his desperation that drove him to kill Mandy. The officer commented Greg told her "She'd been returned like a farm animal."[55] Mandy's brother told the inquest that Greg told him it was at the moment of Mandy's return to the doorstep from Greenacres he decided to end her life. He laced her cocoa with crushed sleeping pills, placed a plastic bag over her head, and then suffocated her with a pillow. He then went into the garage, and unsuccessfully attempted to pipe exhaust fumes into his car to asphyxiate himself.

In the aftermath of his unsuccessful attempt, he summoned emergency services. They responded and he immediately admitted to killing Mandy, adding that he did not regret his decision. Poignantly, a paramedic who talked with Greg before police arrested him told the coroner's inquest, "I asked if he had called the out-of-hours doctor. He said he hadn't because she wasn't ill."[56] She said she explained to Greg he could have asked the doctor to have his wife admitted to the hospital as a place of safety. Greg apparently said, "So I need not have done all this?"[57] The paramedic sensed Greg was saying that he need not have killed Mandy or attempted to take his own life.

In a note left by Greg for the coroner and his brother-in-law, he wrote,

> We have both promised that we would not allow ourselves to go into care with dementia. We have had a long life together, and despite what has happened I am pleased that I had the courage to keep our promise.[58]

We need not dwell on the plethora of recommendations regarding missed opportunities to intervene in *Summers*. A couple will suffice since they provide segue into Chapter 8. At the inquest, the deputy coroner asked Lynn why she did not call the emergency social services team and keep Mandy overnight until another place was located. She replied, "Yeah, absolutely, I wouldn't do the same again—I've reflected on it again and again."[59] The coroner issued a Regulation 28 Report (a report to prevent future deaths) recommending that "the Local Authority provide a general guidance to residential homes when considering discharging a resident. They should seek advice from Social Services so that ASC can be satisfied that there are appropriate arrangements in place for the safety and wellbeing of the resident after discharge, and the appropriate time for that discharge."[60] This guidance applied regardless of whether social services had placed the resident within the home or if they had been placed privately, as in *Summers*.

The Chair of the Community Safety Partnership in the county where the deaths occurred summarized the deaths. She noted the depth of the DHR analysis and that it concluded the deaths were not predictable. Lessons learned included better information sharing, assessing risk, and assessing levels of support for carers such as Greg Summers. For his part, Greg talked with the CPN after Mandy's death.[61] He described his wife's condition as "stroppy Alzheimer's." The point at which Lynn returned Mandy to their home and left her clothes in bin bags was "the tipping point."[62] Reviewers observed that at this critical juncture he appeared to be a broken man who was also proud but who had little faith in services. They stressed the role of Greg's stubborn character in affecting how agencies and people worked with him. Indeed, according to reviewers, his emotional demeanor might have cautioned social service professionals about the risk he posed. Overall, the review panel emphasized the importance of taking a "broader and contextual picture" rather than dwelling on the triggering effects of Greg reaching a particular tipping point. I return to talk of risk and danger in Chapter 8.

Closing Reflections

The problematic responses highlighted in the chapter are products of their time and place. As Auden's poem "Old People's Home" points out, the problem of caring for the infirm elderly on a rapidly increasing scale is of recent origin. In 1970, he wrote that their generation was the first to fade like this, not at home. But "fade" is the wrong word when we talk about managing PWD. Some might fade passively. Others present difficulties to caregivers in private and public arenas and to the growing army of related professionals. As one key informant put it to me in the course of my work, PWD can "scramble your brain." At the same time as these difficulties, PWD precipitate immense love, sadness, and the panic of pending loss.

The gray mist killings occurred mostly at home within contexts where the spouses or partners lived at home. The problematic responses may have contributed to the killings. We will never really know. Many reflect a desperation on the part of families and social responders of all kinds. If only we could identify cases where these killings might take place, we might stem their tide. It is in that direction and what I refer to as the "fiction of prediction" that I turn.

Notes

1 See M. Buber, *I and Thou*, trans. R. G. Smith (Edinburgh: Continuum, 1937); C. Rogers, *On Becoming a Person: A Therapist's View of Psychotherapy* (Boston: Houghton Mifflin, 1961).

2 D. Brooker and I. Latham, *Person-Centred Dementia Care: Making Services Better with the VIPs Framework*, 2nd ed. (London: Jessica Kingsley, 2016); G. Mitchell and J. Agnelli, "Person-Centred Care for People with Dementia: Kitwood Reconsidered," *Nursing Standard* 30, no. 7 (October 2015): 46–50, table 1, https://doi.org/10.7748/ns.30.7.46.s47. These provide useful summaries of Kitwood's important contribution.

3 S. Weil cited in R. Zaretsky, "Simone Weil's Radical Conception of Attention," *Literary Hub*, March 9, 2021, https://lithub.com/simone-weils-radical-conception-of-attention/.

4 S. Weil to J. Bousquet, April 13, 1942, in S. Pétrement, *Simone Weil: A Life*, trans. R. Rosenthal (New York: Pantheon, 1976).

5 A. Innes, *Dementia Studies: A Social Science Perspective* (Thousand Oaks: Sage, 2009), 49.

6 M. McFadyean, "Losing Our Minds," *The Guardian*, August 19, 2005, www.theguardian.com/theguardian/2005/aug/20/weekend7.weekend5, quoted in A. Balfour, "Facts, Phenomenology, and Psychoanalytic Contributions to Dementia Care," in *Looking into Later Life: A Psychoanalytic Approach to Depression and Dementia in Old Age*, ed. R. Davenhill (London: Karnac Books, 2014), 242.

7 B. McCormack, "In Search of (My) Personhood," January 20, 2014, video, https://blogs.bmj.com/ebn/2015/11/16/person-centred-care/.

8 S. Spitzer, "Toward a Marxian Theory of Deviance," *Social Problems* 22, no. 5 (June 1975): 638–51, https://doi.org/10.2307/799696. He contrasted social junk with social dynamite, citing labor radicals who threatened social systems as an example.

9 Mitchell and Agnelli, "Person Centered Care," 47.

10 E. van Wijngaarden, M. Alma, and A. M. The, "'The Eyes of Others' Are What Really Matters: The Experience of Living with Dementia from an Insider Perspective," *PLOS One* 14, no. 4 (2019): e0214724, 7, https://doi.org/10.1371/journal.pone.0214724.

11 W. Pipal, "You Don't Have to Go Home but You Can't Stay Here: The Current State of Federal Nursing Home Involuntary Discharge Laws," *Elder Law Journal* 20, no. 1 (2012): 235–68. See also M. R. Gillick, *Old and Sick in America: The Journey Through the Health Care System* (Chapel Hill: University of North Carolina Press, 2017).

12 W. H. Auden, "Old People's Home," *New York Review*, July 23, 1970, www.google.com/search?q=W.H.+Auden%2C+1970%2C+Old+People%E2%80%99s+Home%2C+New+York+Review&rlz=1C1GCEA_enUS984US984&oq=W.H.+Auden%2C+1970%2C+Old+People%E2%80%99s+Home%2C+New+York+Review&aqs=chrome.69i57j33i160l2.426j0j7&sourceid=chrome&ie=UTF-8.

13 D. Pryor, "Somewhere Between Society and the Cemetery: Where We Put the Aged," *The New Republic*, April 15, 1970, 15.

14 S. De Beauvoir, *The Coming of Age*, trans. P. O'Brien (New York: W. W. Norton, 1972), 2.

15 De Beauvoir, *The Coming of Age*, 3.

16 Pipal, "You Don't Have to Go Home," 246–47. As Pipal points out, over 97 percent of nursing homes have this certification, so these regulations apply to nearly all of them.

17 Pipal, 248.

18 Pipal, 254–56.

19 For example, see R. Booth, "Owner of UK Care Home Group Paid Himself £21m Despite Safety Concerns," *The Guardian*, January 17, 2023, www.theguardian.com/society/2023/jan/17/owner-of-uk-care-home-group-paid-himself-21m-despite-safety-concerns.

20 For additional information see "They Want Docile: How Nursing Homes in the United States Overmedicate People with Dementia," *Human Rights Watch*, February 5, 2018, www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia.

21 A. Martin, S. O'Connor, and C. Jackson, "A Scoping Review of Gaps and Priorities in Dementia Care in Europe," *Dementia* 19, no. 7 (October 2020): 2135–51, https://doi.org/10.1177/1471301218816250.

22 J. Dewing and S. Dijk, "What Is the Current State of Care for Older People With Dementia in General Hospitals? A Literature Review," *Dementia* 15, no. 1 (January 2016): 106–24, https://doi.org/10.1177/1471301213520172.

23 Royal Commission Into Aged Care Quality and Safety, "Summary and Recommendations," *Final Report: Care, Dignity, and Respect*, 2021, 37, https://agedcare.royalcommission.gov.au/publications/final-report.

24 Royal Commission into Aged Care Quality and Safety, "Summary and Recommendations," 69.

25 D. Wilkinson, "A Husband's Determination to Keep His Promise to His Wife and Never Put Her in a Home Ended in Tragedy," *Manchester Evening News*, November 22, 2018, www.manchestereveningnews.co.uk/news/greater-manchester-news/husbands-determination-keep-promise-wife-15451778.

26 Wilkinson, "A Husband's Determination."

27 Wilkinson.

28 See for example, M. D. Geschwind, A. Haman, and B. L. Miller, "Rapidly Progressive Dementia," *Neurologic Clinics* 25, no. 3 (August 2007): 783–807, 783, https://doi.org/10.1016/j.ncl.2007.04.001, PMID: 17659190; PMCID: PMC2706263.

29 A neoplasm is an abnormal growth of tissue stemming from excessive cell growth and division. They can be benign or malignant. In carcinomatous meningitis, cancer cells spread to the meninges, the layers of tissue that protect the brain and spinal cord. See A. Anwar, A. Gudlavalleti, and P. Ramadas, "Carcinomatous Meningitis," in *StatPearls* (Treasure Island: StatPearls Publishing, 2023), www.ncbi.nlm.nih.gov/books/NBK560816/.

30 My reporting of *Paine* draws heavily on the language of the investigative report into Martin Paine's act of homicide. The report was made to the NHS in the county where the killing occurred. To preserve the anonymity of the parties, I do not reference the report. I use pseudonyms to de-identify the parties.

31 M. F. Almeida et al., "Distinct and Dementia-Related Synaptopathy in the Hippocampus After Military Blast Exposures," *Brain Pathology* 31, no. 3 (May 2021): e12936, https://doi.org/10.1111/bpa.12936.

32 D. E. Barnes et al., "Association of Mild Traumatic Brain Injury With and Without Loss of Consciousness with Dementia in US Military Veterans," *JAMA Neurology* 75, no. 9 (September 2018): 1055–61, https://doi.org/10.1001/jamaneurol.2018.0815 cited in Almeida et al., "Distinct and Dementia-Related Synaptopathy," 9.

33 Almeida et al., 9. For coverage of synaptic dysfunction associated with Alzheimer's disease see S. K. Jha et al., "Stress-Induced Synaptic Dysfunction and Neurotransmitter Release in Alzheimer's Disease: Can Neurotransmitters and Neuromodulators Be Potential Therapeutic Targets?" *Journal of Alzheimer's Disease* 57, no. 4 (2017): 1017–39, https://doi.org/10.3233/JAD-160623.

34 The reviewers in this case drew upon the expertise of an honorary (retired but highly experienced) consultant in old-age psychiatry.

35 M. Matthews et al., "Mirtazapine-Induced Nightmares," *Primary Care Companion to the Journal of Clinical Psychiatry* 8, no. 5 (2006): 311, https://doi.org/10.4088/pcc.v08n0510b. The authors note that vivid dreams and nightmares have been reported with other antidepressants that increase REM sleep. This article was published at least three years before Martin reported his nightmares.

36 Adult social services can provide carers help with aspects of daily living such as washing and dressing, laundry services, meals, equipment and adaptations for continued living at home, and access to day care centers.

37 Language from the DHR report.

38 Language from the DHR report.

39 "NICE Guidelines," UK National Institute for Health and Care Excellence, updated July 4, 2023, www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines#:~:text=NICE%20guidelines%20are%20evidence%2Dbased,prevent%20ill%20health.

40 Language from the DHR report.

41 Language from the DHR report.

42 Language from the DHR report.

43 D. E. Curry and B. L. Richards, "A Brief Review of Quetiapine," *The American Journal of Psychiatry: Residents' Journal* 18, no. 2 (December 2022): 20–22, https//doi.org/10.1176/appi-rj.2022.180207.

44 For a good introduction to the literature on the pros and cons of pharmaceutical interventions in psychiatric cases including neurocognitive disorders, see A. Scull, *Desperate Remedies: Psychiatry and the Mysteries of Mental Illness* (London: Penguin, 2022); D. Healy, *Pharmageddon* (Berkeley: University of California Press, 2012). It lies well beyond my scope to fully explore the possibility that various permutations and combinations of pharmaceuticals triggered killings. Relatedly see S. Shah et al., "Quality of Prescribing in Care Homes and the Community in England and Wales," *British Journal of General Practice* 62, no. 598 (May 2012): e329–36, https//doi.org/10.3399/bjgp12X641447. See also F. La Frenais et al., "Psychotropic Prescribing for English Care Home Residents with Dementia Compared with National Guidance: Findings from the MARQUE National Longitudinal Study," *British Journal of Psychiatry Open* 7, no. 5 (September 2021): e169, 1–7, https//doi.org/10.1192/bjo.2021.21.

45 Language from the DHR report.
46 Language from the DHR report.
47 Language from the DHR report.
48 Language from the DHR report.
49 Language from the DHR report.
50 Language from the DHR report.
51 One assumes that the social worker made the referral a month after she obtained consent to do so. If so, then strictly speaking, the case was officially closed for the social worker.
52 Language from the DHR report.
53 Language from the DHR report.
54 Language from the DHR report.
55 Media source withheld to preserve anonymity.
56 Language from the DHR report.
57 Language from the DHR report.
58 Language from the DHR report.
59 Newspaper source withheld to preserve anonymity.
60 The Coroners and Justice Act 2009 allows a coroner in the UK to issue a Regulation 28 Report to an individual, organizations, local authorities, or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths. See www.legislation.gov.uk/ukpga/2009/25/contents for additional details.
61 At that time, some six weeks after the homicide, he had been released on bail due to his age and allowed to live in a hostel rather than prison.
62 Language from the DHR report.

8 The Fiction of Prediction

Risk and Danger

During the last three months of Colleen Murphy's life, Liam Murphy saw his GP and a consultant psychiatrist. Six days before Liam frenziedly killed her, the consultant in old age psychiatry wrote the following: "Other than the occasional increased irritability and being a bit more short-tempered, there has been no significant aggression or behavioral disturbance. His wife reports no management difficulties and maintains feeling extremely well supported by the team."[1]

This statement may appall some readers, who, like the safeguarding service manager of the Integrated Safeguarding Team at the NHS Trust, felt information about the earlier known "risks" to Colleen should have circulated more widely among attending professionals. Readers might remember from Chapter 5 that these so-called risks included a prior history of IPV/A, verbal and physical aggression linked to his deteriorating mental state, the smashing of Colleen's phone, his alcoholism, controlling and tyrannical behavior, abandonment anxiety after being made redundant, depression, narcissism, and a traditional husbandly sense of entitlement. Indeed, the safeguarding service manager pointed out, "the learning for us as an organization is that risk must be *recognized* and information recorded and *shared effectively* in order that the *right care* can be *delivered* to *support and protect those at risk*."[2]

The language of risk also pervaded the court handling of *Murphy*. In his summation, the judge commented on the "great violence" involved. He reiterated that Liam had been behaving "bizarrely" earlier that fateful day. The judge also noted "there was nothing in the record to predict such a violent, brutal outcome." Indeed, Liam posed such a threat the judge ruled he would not be released without the express permission of the British Home Secretary.

We might ask what the safeguarding service manager meant by "recognizing" risk, "sharing it," "the right care and its delivery," and the feasibility of "supporting and protecting" those "at risk," ostensibly, those "in danger." What is this pervasive language of risk all about? What do the terms such as risk, threat, hazard, safeguarding, threshold, perfect storm of events, and trigger that pepper the case files speak to? My questioning of the risk discourse on dementing illness echoes the concerns of anthropologist Mary Douglas. She suggested, "Instead of isolating risk as a technical problem we should formulate it so as to include, however crudely, its moral and political implications."[3]

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The moral and political implications of exploring the relationship between dementing illness and gray mist homicide go far beyond the narrow focus of the extant research literature. That literature dwells myopically on the characteristics of the parties, cases, and situations. It produces a tiresome language of correlates or factors that might matter. It is a discourse of lists rather than a narrative of human relationships and their waxing and waning. We might describe these as micro-considerations.

What Douglas is suggesting is that we explore what we might call macro-considerations. These might include the long-term aging of populations, the apparent growing prevalence of dementing illness, cultural attitudes toward the elderly and especially the elderly with dementia, the political decision to dramatically reduce institutional support (e.g., asylum care) for PWD and replace it with less than satisfactory (some might say shameful) care in the community, warehousing PWD, the rise of pharmaceutical interventions and the chemical pacification of the elderly, the prioritizing of biomedical explanations of dementing illness at the expense of downplaying or undervaluing social and historical forces, the bigger-picture political decisions about what percentage of gross domestic product to use toward caring for PWD, and so on. All of these "macro-considerations" create social structural frameworks within which the micro-considerations play out. Focusing on both micro- and macro-considerations helps us understand these moral and political matters and provides a more comprehensive lens through which to view the problem of dementing illness and gray mist killings.

Risk: A Brief Introduction

It is likely that people have always had their fears and uncertainties. The Neanderthals likely feared the saber-toothed tiger. Cave dwellers may have wondered if the sky would fall. Pre-modern seafarers may have feared falling off the edge of a flat world. These seem like big fears, fears related to death.

The gray mist cases contain reference to many risks, risks that if left unattended or unmanaged could conceivably end in death or a serious threat to life. The risks appear to form a series of touchstones that guide and facilitate the development of detailed intervention policies, protocols, and practices. Growing knowledge about the dementias and the seemingly promising or best responses to PWD further inform this proliferation. We might add that these developments in our interventions appear to be only loosely aligned with scientific evidence regarding their effectiveness. As Douglas once opined, "The language of danger, now turned into the language of risk, often makes a spurious claim to be scientific."[4]

Sociologists sometimes refer to modern societies like the US, UK, and Australia as "risk societies."[5] Increasingly shorn of many of the alleged sureties of pre-modern tradition, religion, community, ritual, ceremony, and custom, these societies value scientific inquiry and are increasingly more rational, secular, capitalist, and individualistic. As sociologist Anthony Giddens points out, these risk societies increasingly use specialized scientific knowledge in an attempt to minimize negative outcomes, manage behavior and populations, and maximize human health, safety, happiness, longevity, and productivity.[6]

Others highlight the irony in some of these developments regarding risk. Some people's concerns and anxieties, for example, with their cholesterol counts or the number of steps they take each day, belie the fact that many modern people live longer, generally better lives than their ancestors. Canadian journalist Dan Gardner wryly notes, "It seems the less we have to fear, the more we fear."[7] Alternatively, one might argue that some modern people, in full recognition of how good they have it, want to ensure that things continue that way, that they maximize their benefits, extend their privileges, and minimize adverse outcomes.

What were the origins of this more systematic, "modern" thinking about risk? Historians trace its rise to the emergence of modern marine insurance policies to protect the Italian merchant traders of the thirteenth century in cities like Florence and Genoa. Standing at the gateway to Africa and Asia, their trading adventures involved long and often dangerous journeys, including hazards such as adverse weather systems, warships, pirates, structural problems with vessels, disease, and the insurrections of enslaved people that some ships carried. Marine insurance enabled them to spread the risk among investors, simultaneously expanding the sharing of profits.

The Italian traders and businesspeople also began to develop double entry bookkeeping, an accounting system that permitted the careful logging of debits and credits. Such novel practices enabled businesses to calculate the balances in their accounts. They also enabled the assessment of future profits. Combined, marine merchant insurance and double entry bookkeeping began to haul the future into the present, reducing market uncertainty and thus slowly enabling the calculation of likely trading and business outcomes. These two developments greatly influenced the rise of modern capitalism.

Dating from the 1420s, the Italian traders working in London were the first to write marine merchant insurance policies to protect their own trading activities.[8] The practice proliferated, stimulating trade out of the growing port of London. In the 1660s, the famous English diarist Samuel Pepys (1633–1703) wrote of the detailed knowledge he acquired about the hazards of merchant trade by frequenting the fast-proliferating coffee houses in the vicinity of London's docklands. Ship captains, seamen, traders, insurers, and underwriters would frequent these coffee houses and share hazards. Their cargoes included sugar, coffee, ivory, precious metals, woods, hides, spices, tobacco, and enslaved people. Pepys learned more about threats to profits through coffee house gossip than he did in his job at the Admiralty.[9] One of these, Lloyd's Coffee House, would eventually evolve into the world-famous Lloyds of London Insurance Company. Both Lloyd's and the nearby Jamaica Coffee House, were intimately connected with the growth of the transatlantic slave trade. Pepys reportedly frequented the Jamaica Coffee House, an establishment dating to 1652 wherein "sugar plantation owners would meet with slave ship captains to broker deals over the fate of hundreds of enslaved Africans, thousands of miles away."[10]

Risk assessment was therefore at the fulcrum of the rise of modern capitalism and the modern slave trade. It concerned reducing the threats to profit by attempting to predict future outcomes. The more information learned about threats to merchant trade, the better the predictive power. Over the centuries, the rise of advanced statistical techniques added to this predictive power. For sure, assessing the risk of the loss of marine cargoes, material and human, was an inexact form of predictive analytics. But as shipbuilding improved and knowledge about hazards increased, so did the predictive power of the insurers and underwriters. Over time, the insurance and underwriting business thrived.

Samuel Pepys was a great reader and admirer of the work of natural scientist Robert Boyle (1627–1691). Like most of the early scientists, Boyle was deeply devout. As George Makari puts it, Boyle and his colleagues desacralized the entire world except for souls.[11] Boyle discovered one of the basic laws of chemistry. His law states that given a constant temperature, the volume of a gas is inversely proportional to its pressure. This relationship is captured in the equation $P \times V = K$, where P = pressure, V = volume, and K = a constant number. Put simply, if you increase the pressure on a gas, its volume decreases proportionately. Crudely speaking, the atoms or molecules of the gas bombard the walls of a container more frequently if the space is compressed. Boyle's law explains the behavior of gases.

The so-called social scientific approach to understanding human behavior differs considerably. Human behavior reflects the will or intent of human beings and the socially situated meanings they attach to their behavior. Human intent and meaning add inexorable complexity that militates against the establishment of causal laws. Predicting human behavior is therefore unreliable.

For our purposes, trying to predict which PWD or which caregivers will kill their spouse/partner is especially unreliable since it relies on information about behavior behind the closed doors of family homes, behavior about which people might often feel shame. The two types of perpetrator groups are different, although there is a little overlap between them since three caregivers also had dementia and one PWD also acted as a caregiver. Additionally, perpetrators with dementia are, by definition, deeply forgetful, rendering learning about their motives for killing and the case dynamics particularly difficult. Given the exploratory state of the research into these two distinctive case types, I therefore use the language of correlates rather than risk factors. With more research, the language of correlates may morph into a body of research amenable to risk analysis. My caution ought not detract from the potential value of noting correlates in killings by and of PWD.

Correlates When PWD Kill Spouses/Partners

To properly assess risk, we need to know both the relative and absolute risk of an outcome within a specified time period. An example from everyday life helps explain. Consider the supposed dangers of eating processed meats such as bacon and sausage. Some news media made a great deal about the dangers of the consumption of processed meat causing bowel cancer.[12] As a lover of bacon, I have a personal interest in this story. Professor Spiegelhalter, an expert in understanding risk, explains that research shows that eating 50 extra grams of processed meat a day, for example, "a great greasy three-rasher sandwich," is linked to an 18 percent increase in the risk of getting bowel cancer over the life course. We cannot make sense of this relative risk, or risk relative to those who eat a normal amount of bacon, without knowing 18 percent of what? The "what" is the absolute risk of getting bowel cancer in a group of people who eat the normal, as opposed to the "extra," amount of bacon. Cancer Research UK estimates normal bacon eaters' risk at about 6 percent—that is, out of 100 people eating the normal amount of bacon, six will develop bowel cancer during their lifetime.[13]

If we take 100 people who eat an extra bacon sandwich every day, research suggests seven of them will develop bowel cancer. We are now in a position to calculate the increase in risk from eating the extra bacon. It is 18 percent of the six in 100, one additional percentage point, meaning seven in the 100 who eat the extra bacon contract bowel cancer. Put simply, it is a one percent increase in the absolute risk of getting bowel cancer, a much less threatening amount than the 18 percent increase in relative risk touted by the media.[14]

Notwithstanding my concerns, I examine what the case studies and the extant research suggest are correlates (not necessarily causes) of PWD killing their spouses/partners. Regarding the extant literature, the range of optimism about predicting fatal outcomes varies. For example, Cipriani and colleagues argue that research is "critical to identify and clarify factors that increase vulnerability to homicidal behavior in persons with AD and related dementias, as well as to predict and prevent homicides."[15] More cautiously, Sundakov-Krumins et al. opine, "Rare outcomes such as homicide by people with dementia cannot be reliably predicted."[16] Nevertheless, they contend, "Knowledge of the characteristics of people with dementia who commit homicide could help guide clinical practice."[17] In what follows, I note some of the important correlates that emerge from the case studies and extant research.[18]

Home Setting: Almost 90 percent of the 54 PWD who committed homicide killed at home. This rather obvious correlate invites discussion of the timing of possibly relocating PWD to non-home settings as a precautionary measure.

Length of Intimate Relationship: For those couples where information about the length of their relationship was available, 22 out of 28 (79 percent) had been together for 40 or more years. The significance of this correlate remains unclear but warrants further exploration.

Race of the Victim: In all but one of the 54 cases, I knew the race of the victim. In 46 of these 53 cases the victim was Caucasian. The significance of this correlate remains unclear but warrants further exploration.

Men: The relative risk of a man with dementia killing his wife/female partner is much greater than a woman killing her husband/male partner who has dementia. As we have seen, men comprise 95 percent or so of our gray mist perpetrators. Sundakov-Krumins et al. note the limited number of descriptive studies but point out that "victims were overwhelmingly a current female domestic partner."[19] The fact remains that the overwhelming majority of PWD, let alone men with dementia, do not kill others. Hence while being a man raises the relative odds ratios of dementia-related homicide, the absolute risk rate of men with dementia killing spouses/partners remains miniscule. We might apply the same caution to all the correlates when referring to them as risk factors.

Prior Family Violence: A well-known axiom in criminology is that past violence is one of the best predictors of future violence. Therefore, we ought to consider the possible importance of prior IPV/A. However, as we have seen, only a low proportion of the 100 cases evidenced known IPV/A prior to or concurrent with the development of the dementias.

Neurodegeneration: Obviously, all cases of dementia evidence some form of neurodegeneration, hence it is an omnipresent correlate of our homicides. However, we must ask whether there is something about the type of dementia, its stage of development, or the specific social circumstances within which it manifests that somehow potentiates violence. Several cases I have referenced, for example, the gruesome case of Karlan Denio, involved perpetrators in the throes of FTD. However, I have also noted how difficult it is to diagnose FTD and, furthermore, discern and then attribute increased hostility, aggression, and violence to neurological changes. The case of Pearl Padgett in "The Light Blue Cardigan" serves as a reminder of these difficulties in attribution and their socially situated nature.

Importantly, we must also note the correlation between neurodegeneration and suicidality. Not that we need a perennial reminder, but neurodegeneration can be incredibly depressing, sad, and debilitating for those living with it. Many cases involved suicidality, regardless of whether the perpetrator completed suicide.

Delirium: Delirium, or acute confusional state, is an under-recognized problem characterized by inattention, cognitive dysfunction, and altered consciousness.[20] As we have seen, a number of the gray mist cases (e.g., *Colthurst, Michaels, Paine*) evidenced concerns by GPs to rule out delirium as a possible cause of hostile, aggressive, and threatening behavior. Compared with the general population, PWD are at higher risk of contracting delirium. It is usually reversible if the underlying medical problem is resolved. UTIs are a common cause of delirium, but there are others including thyroid dysfunction, heart problems, stroke, electrolyte imbalance, and renal failure. Medications can also cause delirium, such as anticholinergic and pain medications.

Since co-morbidities pepper the gray mist files and many PWD were taking multiple medications, the presence of delirium complicates the identification of correlates with homicide. For example, Sundakov-Krumins and colleagues point to the disinhibiting effects of dysexecutive syndrome (frontal lobe impairment), alcohol use, and delirium, suggesting a possible role for these three factors in violence and homicide.[21] The complexities increase when we include recent research suggesting a role for delirium as a possible precipitant or accelerator of a full-blown clinically recognized dementing illness.[22]

Delusions, Hallucinations, and Psychosis: Many PWD have delusions, hallucinations, and psychotic episodes, suggesting a much more important role for these factors than the sociological literature is wont to acknowledge. Readers will recall from the case involving Martin and Cindy Paine, Martin's delusions concerning a dog in the house and people upstairs, his paranoia and need to check the drains in the street. Persecutory delusions feature prominently in the gray mist killings and comport with findings from the extant literature. Henry Michaels claim that his wife, Gloria, was stealing from him is one example.

Among elderly patients admitted to psychiatric hospitals, delusions and particularly sexual jealousy feature prominently in attempted and completed male perpetrated IPH. One study found that among 14 elderly psychiatric patients who attempted or committed homicide, the most common precipitant "was a belief about the victim that was not based in reality."[23] Six of these 14 patients had dementing illness. Of these six, three experienced delusional sexual jealousy.

It is likely that a significant number of the gray mist killings occurred in the throes of psychoses or breaks with what most observers see as social reality. We might note the incoherent talk of Liam Murphy, who wandered over to his neighbor's house after brutally killing his wife, Colleen. According to neighbor Barry Riles, Liam seemed unconcerned about her death or indeed the injuries to his own knuckles but was instead distracted by a concern with the whereabouts of his house keys. We might speculate endlessly about what his concern might have represented metaphorically. To add further complexity, we cannot exclude the possibility of malingering and/or confabulation.

Head Injuries: Martin Paine, the former bomb disposal engineer, likely suffered head injuries from his professional exposure to bomb blasts. According to Zilkens and colleagues, head injuries increase the relative risk of developing dementia by a factor of 1.8.[24] Research also shows that victims of IPV subjected to head injuries are more prone to developing AD. If such victims with dementia go on to kill their abusers, the head injury ought to be investigated as a potential correlate. Leung and colleagues note that at the microscopic level "repeated head trauma leads to neurofibrillary tangles, diffuse Alzheimer amyloid and other neuropathological abnormalities."[25]

Misrecognition/Imposter Syndrome/Capgras Syndrome: Research points to the relatively higher threat of violence posed by people with these syndromes. The presence of this syndrome among PWD ought to be considered a possible correlate of serious violence and homicide. Much of the initial research into this phenomenon points to the overlap between misrecognition and persecutory delusions and/or paranoid ideas.

Victim Vulnerability: From the previous chapter, readers will remember Joe Withey. At times, he padlocked his gates to keep would-be helpers out. His wife, Lorraine, had been physically vulnerable and socially and geographically isolated for many years. Eight years before her demise at Joe's hands, ASC provided a handrail to assist with her mobility. Five years after its installation, she fell and broke her hip, a fall, which according to her son, greatly increased her dependence on Joe. Her own confusion and memory problems increased, as did Joe's. Lorraine's frailty greatly increased her vulnerability to Joe's eventual homicidal violence, itself linked to his initially undiagnosed AD.

Wives, usually of very long-standing, were the principal gray mist victims of homicide. Their physical proximity to perpetrators rendered them more vulnerable still. Like Lorraine Withey, many were physically frail, some dealing with medical problems of their own. Most were socially isolated and subject to the traditional gender role expectations that may have further limited their navigation of perpetrators' aggression, agitation, violence, and homicide. The social isolation of the couples and the mental incapacity of some perpetrators to summon emergency assistance rendered victims of attack more vulnerable to death, even if the husband-perpetrator did not have homicidal intent. Finally, we must note the dearth of facilities for violent PWD, a fact perhaps well-known by some of the decedents.[26]

Disinhibition and/or Aggression: Cindy and Martin Paine took a holiday in the months leading up to her death. Cindy reported that at one point during their seaside vacation, Martin became agitated. He had demanded his tablets. Cindy perceived that he was about to hit her with an iron. Later, she sought "urgent respite" and described Martin's behavior to a social worker as "nowty," the regional vernacular for bad-tempered. Dr. S could not complete an MMSE because Martin was "suspicious and irritable." On the Thursday morning before the ultimately fatal attack, Cindy reported Martin's behavior as aggressive and agitated. She expressed fear that he might strike at her if she had to cope with him over the coming weekend.

In social service circles the word "disinhibition" is often preferred to "aggression" in part because it has fewer negative connotations. Such language comports better with the strengths-perspective in social work. However, to the caregiving spouse/partner subject to unpleasant and fear-inducing aggression, disinhibition may appear euphemistic, a way of soft-soaping the daily hostilities—in short, a form of denial.

Regardless of word choice, disinhibition, aggression, and hostility feature prominently as an antecedent in many cases. It is likely the fine details and extent of such difficult behavior is vastly underreported, in part because caregivers become accustomed to it. But aggression, especially sudden-onset, intense aggression, remains an important correlate. As with the other correlates, aggression is common among PWD, yet the homicides are extremely rare. Hence while the relative risk of aggression is likely significant compared with cases where it is not present, absolute risk rates for this correlate remain very low.

Alcohol: Alcohol-related dementia comprises a specific form of dementing illness brought on by excessive alcohol consumption over long periods of time. Researchers note such consumption is implicated in aggression, violence, and homicide. However, acute alcohol intoxication, alcohol-related brain damage, and chronic alcohol dependence feature sparingly in the research literature regarding dementia-related homicides. As Sundakov-Krumins and colleagues indicate, many studies of dementia-related homicide do not explore alcohol use.[27]

Among the gray mist cases, chronic alcohol abuse surfaced in several cases. Liam Murphy and Debbie Colthurst abused alcohol chronically. The evidence from the cases is complex. Clodagh, Liam's daughter, opined to reviewers that Liam was a violent bully "who did not need alcohol to fuel his aggression or violence." Debbie, a known street alcoholic for many years, had reportedly given up alcohol after a heart attack, although this is not clear from the case archive.

Malignant Practices/Conflicts: Specific malignant practices or growing conflicts between spouses/partners might trigger or potentiate homicide. This possible correlation comports with the observation that some homicides are victim-precipitated or arise out of situated transactions.[28] Many of the 17 malignant practices described by Kitwood could set up intensely negative spirals of interaction that might shame and enrage PWD, especially men, to the point it further potentiates their aggression and hostility toward homicidal violence. Malignant spirals of interaction warrant consideration as potentially significant correlates of PWD killing caregiving spouses/partners.

Readers will recall the Australian case of Eric and Roberta Mosely. I raised the possibility that Roberta's approach to Eric might have been interpreted by Eric as her infantilizing or mocking him and that her interest in holiday brochures or information about nursing homes may have led him to believe she was about to abandon him, banish him to a nursing home. Might he have perceived, regardless of her actual intentions, that she was engaging in treachery? All of these possible malignant practices, whether engaged in between gang members on the street or between spouses/intimate partners without dementia, might precipitate hostility, aggression, violence, or, much less likely, homicide. In short, conceivably malignant practices directed at PWD might be shame-inducing and run the risk of triggering humiliated fury. Albeit difficult to research, such practices warrant the attention of would-be risk assessors in cases involving PWD.

Pain: A number of studies acknowledge that wounded animals, especially those in pain, are more dangerous than unwounded animals.[29] Given pain, sometimes severe and chronic, is common among PWD, we must ask whether forms of pain ought to attract more scrutiny as a possible correlate of PWD killing spouses/partners? A couple of case excerpts illustrate:

In *Paine*, discussed in Chapter 7, Martin Paine was taking gabapentin for his lower back pain. Two weeks before he killed Cindy, he complained to his GP about the pain. The GP increased the gabapentin dosage to 600 mg three times a day and issued a prescription for slow-release tramadol, an opiate pain killer. Was there any connection between his pain, his visual hallucinations, and looking into drains in the street, all reported to the GP the day before the killing, and his act of homicide?

Henry Michaels, who frenziedly killed his wife, Gloria, suffered severe back pain all his adult life due to a fall in his early twenties. It became so painful that he was unable to walk over rough terrain and had to give up his much-loved bird hunting. Two years before the homicide, he also developed severe knee pain. Did his pain, in combination with worsening neurodegeneration, feed his homicidal violence?

The research literature points to a strong association between pain and aggression among PWD and a correlation between the increasing severity of pain and the increasing frequency of aggressive behavior.[30] It is also the case that PWD may not be able understand or verbalize that they are in pain.

Firearms: In 2021, the UK Home Office further tightened gun laws by introducing more safety checks for people applying for a firearms license.[31] The statutory guidance, revised in February 2023, lists a range of medical conditions that doctors should consider which may affect the safe possession of firearms or shotguns.[32] These conditions include dementia. Applicants for a firearms license must provide a letter from a registered medical doctor stating the applicant has none of the qualifying conditions that might threaten the safety of the public. That letter informs the police force which ultimately issues the license. Commenting on these developments, Dr. Mark Sanford-Wood, deputy chair of the British Medical

Association GP committee, said, “As doctors we support the government’s overall message—that gun ownership is a privilege and not a right—and that firearms must be in the hands of only those who are deemed safe and responsible.”[33]

Similar checks and balances prevail in Australia. Each Australian state has specific firearms laws that enable, and sometimes compel, doctors to disclose information about situations involving firearms. In general, the Australian Privacy Principle (6.34) states, “personal information can be disclosed when it is reasonably believed that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety.”[34] A Queensland Civil and Administrative Tribunal ruled that a doctor “should have undertaken a more comprehensive medical assessment” before signing a medical certificate in support of a person’s request to overturn a police suspension of his gun license. The patient brought the letter of notification of suspension of gun rights. The letter referenced police suspicions about the patient’s dementia and delusional behavior. According to the tribunal, the doctor failed to give it due consideration. The doctor was reprimanded following a finding of unprofessional conduct.

In the US, there is considerable variation by state regarding access to firearms among PWD. Practically, restricting the ownership of or access to firearms for PWD is more difficult in the US than in the UK or Australia. US federal law prohibits those not mentally competent to make their own decisions, including those with advanced dementia, from buying or owning firearms. However, as we have seen, dementia develops over time and an initial diagnosis of dementia does not necessarily rule out owning a gun. Concerned families have to petition US courts to legally remove firearms from a PWD. The decision would turn upon the outcome of a competency evaluation.

Citing credible public health data, one report notes roughly nine percent of people 65 and older in the US have dementia.[35] Of these, a third own guns and another 12 percent live in a household with someone who owns a gun. Given roughly one third of PWD exhibit combative behavior over the course of their dementing illness, the report expresses surprise at how many Americans appear unconcerned about PWD having access to firearms. In a Kaiser Family Foundation poll, nearly half of respondents acknowledged they have relatives over age 65 who have guns. Of these, more than 80 percent said they were “not at all worried” about gun-related accidents.

Among our albeit small sample of gray mist killings, 17 PWD used a firearm to kill spouses/partners and other family members. One of these 17 cases hailed from the UK and one from Australia. The rest were from the US. Given the dearth of data on the relationship between gun ownership and dementia-related violence and homicide, more research appears warranted. This is especially the case given the projected increases in PWD.

Correlates When Caregivers Kill Spouses/Partners With Dementia

As I have noted, caring for PWD can be enormously burdensome.[36] Caregivers frequently report adverse physical and psychological symptoms. Older caregivers who co-reside with PWD, perform more demanding and unpleasant tasks, and who lack support fare worse than younger, non-resident caregivers. The caregivers in our cohort often had other problems, particularly medical ones. Many faced the dilemma over what to do about ailing spouses/partners who had clearly and perhaps consistently expressed a desire to die. In what follows, I note some of the correlates/antecedents of the 44 cases where male caregivers killed wives.[37]

Home Setting: Forty-one out of 44 PWD (93 percent) were killed at home. This rather obvious correlate invites discussion of the timing of possibly relocating some vulnerable PWD to non-home settings as a precautionary measure.

Length of Spousal Relationship: For those couples where information about the length of their spousal relationship was available, 28 out of 31 (90 percent) had been together for 40 or more years.

Race of the Victim: In all but three of the 44 cases, I knew the race of the victim. In 41 of these cases the victim was Caucasian/white. The significance of this correlate remains unclear but warrants further exploration.

Men: The most dramatic differences in patterns of killing between men and women occur among the 44 caregiver cases. No female caregiver killed the husband for whom she cared. However, I raised the possibility of a hidden number of more discrete caregiver killings, at least some of which women may commit.

Financial Pressures: Only two cases in 100 involved financial impropriety. However, financial considerations, particularly the threat to the inheritance of adult children and the threat to the future livelihood of the caregiver by the placement of the spouse/partner with dementia in a care facility, likely weighed heavily in some cases.

Mercy: Whether a death was labeled a mercy killing depended on the stage of the dementing illness, the willingness and ability of caregivers to cope, the expressed desire to die by the eventual decedent, and a number of other reasons including financial and moral concerns about placing wives in long-term care.

Exhaustion: Using the language of the case files, I employed the word "exhaustion" to capture the despair and depression of some male caregivers. As I emphasized, their exhaustion was likely matched or more than matched by the exhaustion of the wives they killed. The literature uses the term "caregiver burden" to describe the more general challenges facing those who care for PWD. Exhaustion to the point of near-total depletion among stoic, often highly disciplined men of the gray mist cohort is an important correlate.

Pain: Pain featured prominently in some caregiver killings but for precisely how many it is difficult to know. The pain of the eventual decedents seemed particularly important. An example helps.

According to his lawyer, Jerry Canfield killed his wife of 37 years, Joann, because she could not bear the pain associated with her dementing illness. He had apparently promised her he would do so and she had apparently concurred. Not only had she had a series of falls but she was also "seeing little demons."[38] In a letter read out in court by a victim-witness advocate, Joann's daughter and Jerry's stepdaughter, Lisa Reed, said, "I have no ill feeling toward the defendant because I knew in my heart that he loved her and didn't want her to suffer anymore."[39]

Misrecognition: We know very little about the impact their wives' inability to recognize them had on their supposed acts of mercy killing. Future research might explore the context and meaning regarding this correlate.

Firearms: Twenty-seven of the 44 caregiver-killers used firearms. Restricting the access of caregivers as opposed to PWD to firearms involves very different considerations. In the US it invites a political firestorm.

Prevention and the Fiction of Prediction

Scientific studies suggest the global prevalence of the dementias will continue to rise, largely due to population aging. In North America and Europe, the age-specific incidence (rate of new cases) of the dementias appears to have fallen in recent years. A recent public health report suggests the declines are linked to increases in educational attainment and better management of the risk factors associated with cardiovascular disease.[40] The Lancet Commission identified a number of modifiable risk factors for the dementias. These include low formal education, hypertension, hearing impairment, smoking, midlife obesity, depression, physical inactivity, diabetes, social isolation, excessive alcohol consumption, head injury, and air pollution.[41] Another scientific report suggests a history of mental disorders, not just specifically depression, elevates the relative risk of developing neurodegenerative disease and developing it earlier in life.[42]

It is not my intent to delve into the research linking the aforementioned risk markers to the onset of dementia. At this point, I want to emphasize the rather obvious point that these so-called risk factors are associated with multiple and intersecting disciplines, including biology, medical science, psychology, psychiatry, sociology, neurology, and public health. Their trans-disciplinary nature highlights the folly of separating the mind from the body, the physical from the mental, the self from society, and society from history. These may be convenient binaries, but they gloss over the socio-historical complexity of the dementias and the human condition. Put simply, these scientifically proposed risk markers, as important as they undoubtedly are, invite moral and political questions that segue into the final section of the book.

Closing Reflections: Assuaging Fears and Anxieties

The uncertainties about the dementias produce considerable fear and anxiety. The causes of dementing illness continue to elude us. At the moment, there is no cure. We worry about the financial, physical, and social costs of care. As fewer people have children and those people live longer, the question of how to pay for the care of PWD becomes increasingly acute. The ironies of dementing illness also warrant mention. It is almost as if dementing illness represents an undoing of the growing cult of the individual, a winding down of the speeded-up hypercognitive self, a forced slowing in times of social acceleration, and ultimately a profound reminder of death.

The risk markers allow us to bring the future into the present. Knowing the markers gives us some control. If only I don't smoke or consume excessive alcohol, maintain a heart-healthy diet, breathe clean air, exercise aerobically, and so on, I'll likely lessen my chances of neurodegeneration. The words from a recent scientific study in the *Lancet* provide succinct guidance, "We recommend keeping cognitively, physically, and socially active in mid-life and later life."[43] Among other things, these are cultural urgings embedded in a highly technical risk framework. The urgings address individual behavior over the entire life course. The possibility of blaming individuals for not following these scientifically validated urgings looms large.

I do not mean to suggest that these preventive recommendations are without merit. On the contrary, the odds of developing dementia if you do not follow the Lancet Commission guidelines are compellingly higher than if you do. However, to know comprehensively about one's own risk, as noted, requires knowledge of one's absolute risks as well. Here, the uncertainties loom much larger. The drift from the alleged sureties of tradition, custom, community, and religious beliefs may render such uncertainties increasingly difficult to bear. The elaboration of modern selves, now often flashily presented through various social media, may render modern uncertainties such as climate change, pandemics, nuclear war, and the threat of dementing illness harder to accept.

The word "risk" was first associated with probability and mathematical calculations about outcomes of various kinds. Nowadays, it almost exclusively spells danger. The politics of dementia are awash with talk of threats to the individual and hazards to society. Indeed, the gray mist killings remind us of some of the darkest aspects of dementing illness. They raise much more than technical questions about prevention, cure, cost, care, and so on. Rather, they comprise one manifestation of the politics of danger. Dementing illness defiles one of the sacred cows of modern life: the increasingly individuated and autonomous self. It also raises profoundly important questions about social organization, social cohesion, and regulation. Who among us might resist the call to prevent the annihilation of selves through dementing illness? Oppose the callous warehousing of PWD into ill-equipped nursing homes? Seriously question the highly profitable pharmacological management of hapless PWD? It is toward some of these and other political and moral questions that Part 4 turns.

Notes

1 Language from the DHR report.
2 Language from the DHR report. The italics are mine.
3 M. Douglas, *Risk and Blame: Essays in Cultural Theory* (London: Routledge, 1992), 51.
4 Douglas, *Risk and Blame*, 14.
5 German sociologist Ulrich Beck coined this phrase in 1986. See U. Beck, *Risikogesellschaft. Auf dem Weg in eine andere Moderne* (Frankfurt am Main: Suhrkamp, 1986).
6 A. Giddens, *Modernity and Self-Identity: Self and Society in the Late Modern Age* (Stanford: Stanford University Press, 1991).
7 D. Gardner, *Risk: The Science and Politics of Fear* (London: Virgin Books, 2008).
8 A. Leonard, "Gresham and Defoe (Underwriters): The Origins of London Marine Insurance," April 24, 2014, video, www.youtube.com/watch?v=SSH4nJs1dEI.

9 P. Bernstein, *Against the Gods: The Remarkable Story of Risk* (New York: John Wiley, 1998), 89. Bernstein notes that in 1675, Charles II was so threatened by the detailed knowledge in circulation through the coffee houses that he shut them down, only to reopen them 16 days later in the face of public uproar.

10 O. Wainwright, "A Slavery Tour of London: The Guided Walk Laying Bare Atrocities of the Past," *The Guardian*, September 17, 2020, www.theguardian.com/artanddesign/2020/sep/17/slavery-tour-london-guided-walk-atrocities-open-house. The walls of the coffee house contained notices about the latest mutinies and shipwrecks in the Caribbean. At times, people posted rewards for the return of runaway enslaved people.

11 G. Makari, "How What It Means to Be Human Has Changed Over Time," *Time Magazine*, November 16, 2015, https://time.com/collection-post/4115070/george-makari-soul-machine/.

12 *The Sun* newspaper warned, "Careless Pork Costs Lives" discussed in D. Spiegelhalter, "Choose the Yum and Risk the Yuk?" *BBC News*, May 6, 2009, viewpoint, http://news.bbc.co.uk/2/hi/health/8019357.stm. See discussion in D. Spiegelhalter, "Relative vs Absolute Risks: Why Relative Risks Are Misleading, and How to Communicate Absolute Risks," November 25, 2020, www.youtube.com/watch?v=ELNt0XZYsAQ.

13 Spiegelhalter, "Relative vs Absolute Risks."

14 See also M. Noordzij et al., "Relative Risk Versus Absolute Risk: One Cannot Be Interpreted Without the Other," in "Clinical Epidemiology in Nephrology," ed. C. Zoccali et al., supplement, *Nephrology, Dialysis, Transplantation* 32, no. S2 (April 2017): 1113–18, https://doi/10.1093/ndt/gfw465.

15 G. Cipriani et al., "Violent and Criminal Manifestations in Dementia Patients," *Geriatrics and Gerontology International* 16, no. 5 (May 2016): 546, https://doi.org/10.1111/ggi.12608.

16 T. E. Sundakov-Krumins, S. Lubbe, and A. P. F. Wand, "Homicide and Dementia: A Systematic Review," *Dementia and Geriatric Cognitive Disorders* 51, no. 1 (April 2022): 15, https://doi.org/10.1159/000521878.

17 Sundakov-Krumins, Lubbe, and Wand, "Homicide and Dementia," 15.

18 See Table 4, "Overview Characteristics of the 54 Gray Mist Killings by Perpetrators With Dementia," for details.

19 Sundakov-Krumins, Lubbe, and Wand, "Homicide and Dementia," 14.

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Part 4

Toward a Global Understanding

9 Making Sense of Gray Mist Killings

Awkward Questions

Many questions arise out of the case narratives and related research. For example, *how* does physical or material pathology manifest as the BPSD? There is, to use Joseph Levine's language, an explanatory gap between these phenomena.[1] A related question is, *If and how* does neurodegeneration among PWD manifest as homicidal behavior and/or behavior that somehow precipitates homicide? Why do specific PWD or their caregivers kill and the overwhelming majority of others in seemingly similar predicaments not kill?

We usually do not have autopsy data concerning the level, form, and degree of neurodegeneration that might have contributed to gray mist killing. Even if we did have these data, problems would remain. The data would only speak to biological conditions at the time of autopsy, not the moment of killing. Also, given the rightful concern of modern science and biomedicine for random controlled trials or at least quasi-experimental designs, we would still need control, comparison, or referent groups against which to isolate the effects of neurodegeneration and its relationship to homicide. The epistemological and methodological challenges here are immense.

Part of the problem with making biomedical sense of these killings derives from the sheer complexity and neuroplasticity of the human brain and nervous system. At the cellular and molecular level, the nervous system, and the neurotransmitters that flow through it, and the glymphatic system that cleans it, appear infinitesimally labyrinthine. Might morphological changes or neurochemical imbalances in the brain somehow drive or partially drive a very small number of PWD or their caregivers to homicide? Might the failure of the glymphatic system to remove toxins be implicated in homicide? Also, how might we "control for" sociohistorical considerations and/or heredity, or much more specifically, the perturbed expression of the protein-coding gene AQP4 (Aquaporin 4) mentioned in Chapter 2?

We might also note problems making sociological sense of these cases. There are many complicating themes. For example, some perpetrators with dementing illnesses had also committed prior acts of violence against wives (e.g., Liam Murphy, Abdel Khalil). In these cases, we must weigh the potentiating role in the homicide of the prior violence and abuse alongside that of the dementing illness. Of course,

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the prior IPV/A and the dementing illness co-occur and overlap, further complicating any attempt to make sense of the precise root of the killing.

In some cases, the prior IPV/A was directed at those with dementing illness who then turned on their aggressors, killing them. Examples here included David McLeish, Fredricka Rosa, and Debbie Colthurst. Here we must weigh different considerations. To what extent did the violence directed at these PWD somehow rebound against those meting it out, partially or fully precipitating their own demise? To what extent did their dementing illness potentiate the homicide? Again, we must note the possible overlap in these cases between violence and abuse experienced by PWD and the dementing illness. In both case types, we must ask to what extent did the overlapping prior IPV/A and dementing illness synergistically potentiate the act of killing. We must also inquire about other considerations, antecedents, or relative risks.

I pose these questions and raise these concerns rhetorically because we really do not have answers. However, the case narratives do allow us to make limited sense of these perplexing cases. In what follows, I discuss some of the things the narratives tell us.

Perpetrators With Dementing Illness

The dementias are general terms for the impaired ability to remember, think, or make decisions. The impairment increasingly interferes with everyday life. The interference involves profound forgetfulness, especially in the short term. It often involves aggression, hostility, hallucinations, delusions, which are often persecutory, paranoia, and other unsettling or disturbing symptoms. The world of PWD shrinks. They often turn in on themselves, focusing on their bodies, needs, medications, pain, the next physical step, the next life step, safety and security, in short, their survival. In some cases, they become assaultive. In some, understandably narcissistic. Their predicament is often not a cocktail for easy sociality.

Fifty-four of our perpetrators killed in the throes of their dementing illness. Some were more floridly mentally ill than others. Often these disturbing symptoms accompanied other illnesses. Some perpetrators could not recall killing. A number exhibited mysterious altered states of being and cognition, especially in the overkill cases. In several cases persecutory delusions peppered the hours or days prior to killing. Perpetrators with dementing illness were much more likely than caregiver-killers to use rageful and frenzied homicidal violence. Such furious violence was likely committed in dissociative mental states, whereas the homicidal violence of caregivers appeared more calculated and measured.

Such strong emotions may reflect on the part of some gray mist killers' deep feelings of injustice and/or threat, regardless of whether they are able to articulate such feelings or whether onlookers understood and/or validated them. They recall psychoanalyst Gregory Zilboorg's observation regarding the ambulatory schizophrenic, that "they are literally suffused with hatred"[2] and "their anger gives the impression of a quiescent but inwardly a fuming volcano."[3]

Similarly, we might draw on Eric Fromm's discussion of the relationship between fright and aggression.[4] Is it just possible that in at least some of the killings by PWD, we witness the discharging of their fear and fright through aggression, violence, and homicide? After all, are not malignant practices or slights directed at PWD's bodies, thoughts, needs, feelings, and property especially threatening?

Family members comprise the immediate and available targets of such rage and hatred. However, we might also wonder whether such frenzied killings represent a more ethereal expression of what Jungian psychoanalysts might call the collective unconscious among PWD and what some sociologists might see as violent resistance to a perceived pattern of oppression and injustice. In the furious homicides do we witness the discharging of inchoate hatred? Might that target consist of the complex of social arrangements that precipitate or accommodate the stigmatization of PWD, their warehousing, their pacification with drug therapies, the condescending professional approaches that endlessly highlight their strengths in spite of their mounting weakness, and the commercializing of them as substrates for economic entrepreneurialism? If such unconscious targeting exists, then it would be consistent with the calls of some researchers to explore more carefully the social causes of psychoses.[5]

The literature consistently reports that PWD experience a profound erosion of their identities, personhood, and social roles. Many feel lonely and distanced from those they know and love. They experience fear, terror, sadness, and a sense of loss. For men, these experiences may be galling, humiliating, and shameful, especially if they adhered to more traditional gender roles where they felt they were the more active, dominant, and "protective" spouse or partner.

The case studies attest to the many and varied BPSD. In assessing the possible role these symptoms played in the homicides, it is important to remember that they may appear to be the "property" of individuals. However, these symptoms are socially and historically situated. Selfhood and personhood erode in relation to others, not in a vacuum and certainly not just from neurodegeneration. For the parties in our cases, the mind, soul, body, and consciousness are all adversely affected by dementing illness. We have little idea for example, how dementing illness affects the unconscious and instinctual drives. It is in the domain of the unconscious that the bulk of information processing occurs.[6] Is it possible that the neurodegeneration and the sociohistorical milieu within which it plays out have consequences for the unconscious? Might one of those consequences involve the disinhibition of violence and homicidal behavior?

In *Civilization and Its Discontents* Freud referenced the importance of innate or instinctual aggression, essentially in males, and the part played by civilizing forces in taming or repressing such tendencies.[7] The sociologist Nobert Elias put Freud's ideas about the taming of human aggression into historical context.[8] He argued that attitudinal changes, first among the monarchy and aristocracy, spread slowly to the masses. For Elias, the formation of the modern state and the rise of capitalism intensified these tendencies. With its emphasis on calculation and prudence, the emerging capitalist marketplace increasingly valued reserved behavior and the downplaying of violent, unpredictable emotions. To work, trade had to be regular and reliable.

The English historian James Sharpe has criticized Elias's scheme of the history of growing pacification as too simplistic, as failing to adequately account for the role of pressures within English communities for people to live peacefully.[9] Put simply, people did not just accept the pacifying cultural attitudes of their "betters" but rather saw the intrinsic value of more measured and cautious social intercourse. Sharpe also suspects that Elias relied too much on histories of England and western Europe that overemphasized the untamed passions of people in the Middle Ages, particularly in regard to violence.

The important insights of Freud on aggression and Elias on the pacification of modern societies would not apply in the same way to Australia and the US. There the role of a centralized state was much more fractured and regional differences in violent expression much more pronounced. Yet pacification occurred in the US and Australia as well. My intent is not to try to identify the precise historical unfolding of tamed aggression and violent expression in these different modern capitalist societies with modern state apparatuses. Rather it is to point out that what appear as innate drives, are in fact long-term emotional tendencies shaped in the white heat of socio-historical change.

We are now in a position to see the lifting of psychical restraints in the gray mist killings PWD commit as historically situated. These killings cannot therefore just be framed as the product of contemporary malignant social interactions or neurodegenerative forces. I also suggest that we situate the rise of professional pacifying ideologies amidst these broader historical tendencies toward measured, calculated, and controlled human interaction. One example here might be the "strengths perspective" in social work, so often implicit in the "best practices" of practitioners plying their caring-for-pay trade in the growing gerontology industry. We might ask whether dementing illness somehow taps into or unleashes deeply repressed innate or instinctual forms of aggression especially among men. Another possibility is that dementing illness alters the balance between the processing and evaluation of conscious and non-conscious bits of information. Does dementing illness remove some of the historically accrued socioemotional filters that regulate behavior at an unconscious level? To even attempt an answer to these questions we must transcend biomedical approaches and recognize that social, historical, political and cultural forces matter. They may even matter at the molecular level, thus clouding the distinctions between biomedical and sociohistorical world views.

A century ago, medical science did not have an array of pharmaceutical interventions for the dementias. Regardless of whether the side effects of such pharmaceuticals contribute to gray mist killing, the mere fact that they are of recent origin and their rise accompanied the decline of asylum care matters greatly. Had humane asylum placements been available for many of the struggling families that grace the case studies, homicide may not have been the outcome. Had appropriate, affordable, and accessible community care been available in some cases, homicide may not have been the outcome. In different times, with a different cultural cohort, siege mentalities may not have played such a significant part in resisting available care and resisting nursing home placements.

Relatedly, the aging of populations in the US, UK, and Australia means that the prevalence of PWD has increased. This increases the pool of cases from which gray mist killings emerge. Pending more refined statistical research, it remains to be seen whether the prevalence of gray mist killings has increased relative to the prevalence of PWD. History matters.

So, too, do social patterns or what sociologists refer to as social structures. The gendering of the gray mist killing is a consistent theme and it comports with the gendering of IPH in general. Men comprise over 90 percent of the PWD who kill. As noted in Chapter 5, of the five women with dementia who killed, three (Fredricka Rosa, Debbie Colthurst, Pearl Padgett) had been victims of prior IPV/A.[10] Their experiences of prior IPV/A may have been the principal or a contributing motive force behind their acts of homicide. Even through the fog of their dementing illness they may have clung to an instinct of self-preservation that drove them to defend themselves.

If neurodegeneration is the principal motive force behind the gray mist killings, we must ask why these homicides appear strongly linked with sex and/or gender? Put differently, why are these killings so compelling clustered around the biological phenomenon of sex and the socially constructed phenomenon of gender? Is there something biological about being a male or an older male that provides the clue to understanding gray mist killing? Does neurodegeneration in males have a different biological impact than it does in women? If it does, why don't we see more older males committing gray mist killings? Leaving aside biological sex, is there something about being an older man among our cultural cohorts that increases the risk of IPH compared with being an older woman? Again, why don't more older men commit gray mist killings? Conundrums such as these need to be addressed. The sex and gender of the offender are the elephants in the room when it comes to understanding gray mist killings by PWD.

The dementia research does indicate men are more likely than women to engage in disruptive behaviors such as aggressiveness, wandering, abusiveness, and social impropriety. However, researchers acknowledge that the "mechanism behind the sex differences remains unknown."[11] To make matters more complex still, in Alzheimer's cases men are more likely than women to receive psychoactive medications to treat their dementing illness. Is it possible that this differential psychopharmacological intervention contributes to the gendering of the gray mist killings?

If these caveats were not enough, we must also mention the correlates noted in Chapter 8. At first glance, home settings, long cohabitation histories, delirium, psychosis, hallucinations, delusions, head injuries, misrecognition syndrome, and pain may appear as unproblematic biomedical factors or variables. Yet all of these so-called factors or variables are socially mediated. The likelihood that they will come to the attention of authorities or enter the public record depends on many things.

Take, for example, the case of delirium. If a husband with dementia refuses to allow trained caregivers into the household, the likelihood of any delirium receiving medical recognition might be much lower than if caregivers were permitted entry. If the same husband lives in an English community where NHS services are severely compromised, his caregiving wife may not be able to get through to the GP's surgery, let alone make an appointment for her ailing husband to be seen by a doctor.

Take, as another example, the case of a husband with dementia who has a long history of trying to coercively control his wife. Part of his controlling behavior involves accusing her of infidelity. His delusional accusations limit her movements, who she associates with, and how she associates with people. As part of the husband's siege mentality, he expects his wife to care for him and will not allow caregivers into the home. His delusions are dismissed by his wife as part of his overall unpleasant behavior. They may not be attributed to his dementia and may not enter the biomedical record.

Compare this situation with a loving husband with early-stage dementia who still demonstrably cares for his wife, and she reciprocates, especially in regard to his dementia. He and she have caregivers who enter the home three times a day to assist with his dementia care. She has talked with an admiral nurse and become educated about dementia. The husband takes medication X for his dementing illness. After commencing X, he begins to accuse his wife of infidelity. In this scenario, his delusional behavior is much more likely to surface as dementia-linked and form part of the official biomedical record. His dementia-savvy wife, perhaps in conjunction with the caregivers, may suspect his accusations are a possible side effect of the taking of X or a development associated with dementing illness.

The socially situated nature of some of these factors or variables may be more obvious in cases of victim vulnerability, malignant social practices, or access to firearms. Caregiving spouses or partners living near to and in regular contact with other family members may be much less vulnerable to IPH by husbands/partners with dementing illnesses than more isolated spousal/partner caregivers. Access to firearms for PWD will also vary considerably depending upon country of residence and its laws regarding firearm ownership and access for PWD.

All of the perpetrators with dementia evidenced a range of mental health problems. A significant number of these cases, particularly those taking the form of overkills, resemble what Richard Taylor calls psychotic homicides.[12] I narrated a number of cases where perpetrators seem to have lost contact with reality, had hallucinations and/or delusions, and whose thinking was disordered and/or confused. Readers might remember Henry Michaels, his knife, and the police rubber bullet fired to subdue him. They might recall Liam Murphy's damaged knuckles and the autopsy showing Colleen Murphy's 65 injuries. Readers might recollect the way Patricia Kees reloaded her rifle at least three times, her seeing "red," and then going for a beer at Langer's Bar. To add complexity, in a number of the overkill cases, perpetrators were taking medication cocktails, some of which may have contributed to drug-induced psychoses. The associations between severe mental illness and homicide warrant further consideration, especially in regard to IPH. The crusading domestic violence movement with its endless dogma has downplayed this association for too long, seeking instead to lay everything at the feet of a tyrannical, often historically-unchanging patriarchy.

The vast majority of insane people do not commit murder. One study concludes that homicides by patients with schizophrenia without substance misuse and in receipt of planned care are "extremely rare."[13] Indeed, they are much more likely than sane people to be the targets of violence and stigma. The likelihood of any insane person committing murder is extremely low, meaning the absolute risk is extremely low. Advocates and activists for the mentally ill emphasize this low absolute risk.

Nevertheless, the likelihood of an insane versus a sane person killing, that is the relative risk, is significantly higher and warrants consideration. The higher relative risk is often ignored or downplayed by advocates/activists for the mentally ill but emphasized by those, for example, who have lost a loved one to the homicidal violence of a mentally ill person.[14] These selective political emphases comprise the bookends of a highly charged discourse on the relationship between violence and mental illness.

Research into all known homicide incidents in Iceland from 1900–1979 identified 47 offenders and 62 victims.[15] The authors found that one-third of perpetrators were psychotic, mentally subnormal, or committed suicide. Another one-third were diagnosed as personality disordered, alcoholic, drug dependent, or neurotic. Like the gray mist killers with dementia, a substantial number of the Icelandic offenders, particularly those who were mentally ill, had fairly marked physical disabilities.

Taylor and Gunn surveyed the records of 1,241 male prisoners in Greater London.[16] Five times more homicide offenders suffered schizophrenia than expected given their presence in the Greater London population. Moreover, the researchers suggest this level of overrepresentation may be an underestimate. Relatedly, court-ordered psychiatric examinations of 251 homicide defendants in Copenhagen from 1959–1983 found 23 percent to be psychotic at the time of their offenses.[17]

Swanson and colleagues point to a series of population studies from Nordic countries and Australia that reveal "a modest but significant link between mental disorders and violence in the community."[18] They note at least 20 studies have examined violence in patients with schizophrenia spectrum disorders and point out that "meta analyses of this literature reported that the risk of violence was on average three to five times higher for men with schizophrenia, and four to 13 times higher for women with schizophrenia, compared with their counterparts without schizophrenia in the general population."[19] Similarly, a meta-analysis of 204 studies of psychosis involving 166 independent data sets found that psychosis was significantly associated with a 49–68 percent increase in the odds of violence.[20]

Forensic psychiatrist Richard Taylor opines, "Most homicides involve extremes of 'normal'—or at least understandable—mental states such as anger, rage, impulsivity, fear or jealousy, but there can be a fine line between these states and mental disorder at the time of killing."[21] Taylor maps broad correlations between mental states and homicide. For example, he observes that while 0.5 percent of the world's population have diagnoses of schizophrenia, schizophrenics commit from 6 to 11 percent of homicides.[22] In relation to matricide, he notes "those who kill their mothers are around six times more likely to be found to have a psychotic illness compared to other homicide perpetrators."[23]

But correlation is not proof of causation, and as I have cautioned, the vast majority of mentally ill people do not commit violence, let alone homicide. Picking which person with dementia and psychotic tendencies might harm, let alone kill, remains hazardous. One is much better off on the roulette wheels in Las Vegas, at least for now. In commenting on the desire to prevent homicides, Taylor concludes, "risk prediction is notoriously inaccurate."[24]

The case of Patricia Kees who smelled of alcohol and was covered in blood, reminds us of the links between psychosis, possible alcohol abuse, and homicidal behavior. Diagnosed with a stroke and AD two years prior to killing her husband, Dean Kees, Patricia told police she cleaned up "red."[25] She had dragged his body on a rug and dumped it into a ditch at the back of their house "because he was red."[26] Her likely psychotic homicide is rare, especially for a woman. We do not know if she had been a victim of prior IPV/A, a fact that may have contributed to her homicidal behavior or indeed her dementing illness. Neither do we know if she had a problem with alcohol or drugs. Yet the possibility of either of these antecedents reminds us of the complexity of interpreting the role of dementing illness in homicide. To further complicate matters, the influence of these social forces works differently with regard to gender. Men are more likely than women to use offensive, injurious, controlling, chronic violence and abuse. Yet, as I noted in Chapter 3, women who use alcohol in excess and are prone to psychotic breaks are much more likely than men to deploy homicidal violence.

Our knowledge of the relationship between aggression, violence, homicide, and dementing illness points only to broad correlations. As with the aforementioned research into the relationship between mental illness, violence, and homicide, the relative but not absolute risks posed by psychoses loom large.

Some research suggests an important role for brain atrophy, a phenomenon which may be a necessary but not sufficient prerequisite. For example, researchers have traced progressive changes in behavior and aggression to prefrontal cortical atrophy. Other brain areas significantly associated with aggression and dementia include the dorsomedial prefrontal and orbitofrontal cortices and the amygdala. These correlations warrant note, but short of detailed brain scan and autopsy data in each of our cases, it is difficult to explore their potential significance. We do know that the aggression associated with brain atrophy comprises a principal reason for hospitalization of dementia patients, some studies noting it as the major cause in over a third of cases.[27] Yet these studies are not able to identify the relationships and interactions between caregivers and dementia patients that may have triggered or fueled the aggression, perhaps independently of any brain atrophy. Put simply, we must ask to what degree social factors trigger or potentiate the homicides PWD commit.

Some of the classic studies on the supposed effects of brain injuries on behavior have been used as evidence for biological causes of aggression, violence, and homicide. One such study, that involving Phineas Gage, provides an object lesson in the dangers of "stretching evidence" in one direction (toward biological causes) or another (social causes), or about the hazards of talking binarily about these different causal roots as if they are mutually exclusive.

Stephan Schleim recommends exercising caution in interpreting the infamous case of Phineas Gage.[28] On September 13, 1848, Gage, a 25-year-old railroad construction foreman, was using a tamping iron to pack explosive charge into a borehole in a large rock. The friction of iron on rock created a spark which led to an explosion. It shot the spear-like tamping iron up through Gage's left cheek and out of the top of his skull, damaging his frontal lobe. He survived and recovered, living another 12 years. According to some commentators, in the aftermath of the accident and frontal lobe injury, Gage's personality changed for the worse. Malcolm Macmillan summarized the inconsistent and largely unsubstantiated claims made by various writers about these adverse changes. "The composite of modern writers has the accident transforming this Phineas into a restless, moody, unpredictable, untrustworthy, depraved, slovenly, violently quarrelsome, aggressive and boastful dissipated drunken bully, displaying fits of temper, and with impaired sexuality."[29]

Contrary to these claims, Schleim argues the evidence about Gage's personality change is "scarce, circumstantial, and controversial."[30] Any significant changes appear to have been temporary, complicated by transitory psychological trauma, physical disfigurement, and also the severe infections, fever, and coma he experienced in the days and weeks after the accident. Gage also suffered progressive brain damage that caused epileptic fits, the official cause of his premature death in 1860.

Schleim's analysis of the discourse on Phineas Gage's brain damage cautions us about how we interpret the deterioration of brain tissue in dementia cases. If neuro-rehabilitation is a possibility, it invites exploration of the social contexts/environments that encourage such rehabilitation and those social, psychological, and biological forces that enhance neuroplasticity.

Caregiver-Perpetrators

There were 44 caregiver killings. Forty-two involved caregiving husbands who killed their wives. Two sons killed mothers with dementing illnesses. The caregiver-perpetrators comprise a distinct group of offenders. Like the PWD that killed, the caregiver-perpetrators in intimate relationships were all married. They committed homicide in the family home. Of the 31 out of 44 cases for which information was available, 28 out of 31 or 90 percent had been together for 40 or more years. Of the 41 out of 44 cases for which information was available, all 41 victims were Caucasian/white. Unlike PWD who killed, caregiver-perpetrators mostly killed out of a mixture of mercy and exhaustion that accompanied caring for people who had dementing illnesses. In some cases, there may have been heavy doses of caregiver rage, although such occurrences are frequently difficult to discern from the available and, at times, conflicting evidence.

Notably, almost half the caregiver-perpetrator killings took the form of homicide-suicides compared with only six percent of the PWD who killed. Many caregiver-perpetrators who killed themselves after killing their wives apparently felt they did not want to live without their loved ones. They also committed far fewer "overkills" than the PWD with only five percent using violence above and beyond that needed to get the job done compared with 44 percent of the PWD.[31]

We might revisit briefly the case of Richard Shaver who shot his wife, Alma, in the back of the neck before committing suicide. The coroner's report noted she tested positive for oxymorphone, a potent painkiller. He then shot himself in the mouth. Readers will also remember 96-year-old Jack Tindall, who after taking wife Ernestine's life, surrounded her face with lilies. Family members on both sides commented that he killed her out of love and that she had continually asked him to help her die.

We must ask whether gray mist killings and the much more extensive range of violence and abuse concerning PWD warrant the introduction of specialist dementia courts, akin to domestic violence or drug courts. Given the intricacies and convolutions in assessing matters concerning intent, motive, and responsibility for homicide by PWD and caregivers the courts and lawyers referenced in these pages emerge favorably. Courts and juries often recognize the acute plight of perpetrators and decedents. Readers will remember the decisions in the below cases, all of which invite discussion of the feasibility of specialist dementia-related courts.

In *Tindall*, a caregiver-killing, the judge remarked, "This was not a case of assisted suicide. This was a killing as a perceived act of mercy." Nevertheless, Jack Tindall, an ex-soldier, pled guilty to a charge of manslaughter. The judge sentenced him to 12 months in prison, suspended for two years. The judge remarked,

> It is central to this case that Mrs. Tindall had repeatedly asked her husband to ensure that she did not suffer; to kill her rather than let her endure pain and indignity. In a sense, Mr. Tindall's actions were coolly and calmly rationally-fulfilling his promise to his beloved wife.[32]

The two Broward County, Florida, cases *Gilbert* and *Florian*, reveal the courts discerning treatment of two superficially similar mercy-type killings. The extenuating circumstances in *Florian*, Hannie's resistance to being washed, her screaming for hours that she was on fire, her apparent inability to recognize other human beings or to eat of her own accord, her incontinence, and the resultant decision of hospital authorities that she had become "unmanageable," contrast sharply with Emily Gilbert's still-careful presentation of self and only-occasional statements of wanting to die. These vital differences were reflected in the verdicts. In contrast to Ros Gilbert, the grand jury refused to indict Hans Florian. The jury found Ros Gilbert guilty of the premeditated murder of his wife. He received a 25-year sentence.

The criminal courts held that only one of the 44 caregiver-perpetrators was unfit to stand trial. Only five had diminished responsibility due to an abnormality of mind or other mental disorder at the time of the killing. This contrasts with the roughly three quarters of perpetrators with dementia deemed unfit to stand trial and the other quarter determined by the court to have had diminished responsibility.

I presented the caregiver-perpetrator case studies around the principal reasons or motives for killing, mostly mercy and exhaustion. My organizational scheme has its limitations. The broad and leaky categories of "mercy" and "exhaustion" are generalizations or abstractions, but there is considerable overlap between them.

Another way of looking at the caregiver killings is to explore continuities in patterns of socially situated emotion and mood among the parties. Notably, many caregiver-killers, like PWD who killed, experienced depression and desperation.

Caregivers' emotional plight might reflect feelings about the loss of their spouses, or in two cases, mothers. Many evinced sadness. Where evidence exists in the IPH cases, family and community members attest to the perpetrators love and devotion to their wives. Given the cultural cohort, we might add that many caregiver killers likely felt it their duty to care until the end, whether that end be a nursing home, hospital, or death at home.

Some professionals involved in the cases, physicians, mental health nurses, social workers, occupational therapists, and care workers, might have offered advice and help about how to cope with the BPSD. For example, the professional social work perspective might have recommended husbands deflect any conflicts and focus on the albeit fading strengths of their ailing wives, earlier memories, and so on. However, we must also ask whether the pressure to care from a strengths-perspective or by meeting PWD where they stand sometimes repressed the understandable anger and rage of caregivers, thus contributing to depression.

Among the so-called mercy killings, such interventions complicate our interpretation of the role of compassion in the homicide. For example, given the thrust of strengths perspectives we might ask if caregivers behaved one way around helping professionals and even family members and another way in private, behind closed doors with someone who is deeply forgetful. Put simply, how sincere was their public caring and how reliable are our reports of compassion? Witness observations about the compassion of loving husbands and the public display of caring likely do not tell the whole story, whatever that might be.

Cognitively accepting that some PWD's aggression, hostility, narcissism, disdain, and demands stem largely from their dementing illness is difficult enough. In some cases, the constant demands for care and attention require the patience of a saint. Readers will remember, for example, the exasperation of Ros Gilbert at the medical conundrum of giving his wife Emily painkilling Percodan to deal with her osteoporosis and, as a result, having to give her enemas because of her constipation, only for her to lose control of her bowel.

Dealing with the BPSD at an emotional rather than a cognitive level is another matter entirely. The male caregiver subject to these behaviors may be ill-equipped to handle them regardless of his knowledge of dementing illness and how "best" to respond. The behavior of ailing wives in the gray mist cases likely infuriated, humiliated, shamed, and enraged at least some of the caregiver-husbands. Put simply, the depression, desperation, and suicidality evident in the mercy and exhaustion cases likely reflects the repression/suppression of anger developed over years of "caring" or trying to care.

There are further methodological or epistemological problems we must consider. When rage erupts and observers see it, the record tends to capture it since it is often a taboo emotion in modern times. We saw how Ian Hurst would sometimes fly into a rage with his wife, Shelly. One of their daughters told of how he would shout at her and become verbally aggressive when he was tired. We heard how he bludgeoned her to death with eight blows, likely from a bedside lamp. Her hand injuries suggested she instinctively resisted his violence. But we ought not extrapolate from these recorded outbursts of anger and the final violence of the homicide to the relationship as a whole. It is important to remember that their six children attested to Ian and Shelly's loving relationship over many years. Put differently, we should be somewhat skeptical about public evaluations of degrees of compassion shown by caring husbands. At the same time, we should exercise skepticism about degrees of rage, not inferring chronic patterns of angry behavior based on isolated outbursts that make it into the official record.

Bearing these cautions in mind, it is inappropriate to conclude that anger was the sole or principal emotional force that drove the killings. Rather, we glimpse a mélange of emotions, some simpler, some more complex, through the small windows into marriage our sources permit. Anger, for sure, whether expressed or repressed, matters. Given the number of men who attended to their wives' personal care, we must add the guttural emotion of disgust, which likely surfaced from time to time. Deep down some men may have hated their wives for what they had become. Again, given the circumstances, the fusion of anger, fear, and disgust in the form of the complex emotion of hate makes sense, albeit rather poignant sense for marriages formerly steeped in love, mutual affection, and respect. But episodes of hatred, however transitory in the caregiver cases, form a bridge between the psychotic homicides of the PWD and some caregiver-killings. The difference lies in the fact that psychotic killings by PWD may have reflected more consistent or more frequent episodes of hatred as opposed to more limited patterns among caregivers. Clearly, we need more research on this matter.

Sadness runs alongside the anger, perhaps in equal measure. Relatedly, the caregivers exhibited much grief at the loss of their love objects, particularly where wives failed to recognize them and other family members. Such feelings came laden with hopelessness, disappointment, and low mood. We will recall Hans Florian whose wife Hannie apparently recognized no one. Readers will remember the grand jury foreman asking the big question in relation to Hans's mercy killing: What did Hans pulled the trigger on? The jury foreman voiced the sentiment that PWD, especially those with late-stage dementia like Hannie, were empty shells or human husks. People differ in their interpretations regarding these matters. However, given the exhaustion of caring for someone with late-stage dementia, one must ask if empty-shell/human husk interpretations of the sentience of PWD, of their presence of mind, are not tempting rationalizations, excuses, or justifications that enhance the survival chances of some caregiver-husbands or sons who killed.

Doubtless, men had much fear. Fear for their wives, fear of their wives at times bizarre behavior, aggression, hostility, and perhaps seeming manipulation and narcissism. Perhaps some of these husbands thought they witnessed evil. They likely had fear for their own futures, financial fears, and perhaps even fear about committing homicide. Doubtless, there was also joy at times but joyful episodes appear to have become increasingly scarce as the dementing illness wore on, at least according to available evidence. What is important to stress is that before the dementing illness took hold, these were mostly happy couples, at times joyful couples.

Yet the question still remains, given these common emotional and circumstantial predicaments involving older husbands caring for wives with dementing illnesses, why homicide? Why the extraordinarily low prevalence rates? Why male perpetrators? In short, why these 44 men?

Available evidence does not support the inference or argument that because many of these spousal relationships appeared "traditional" that the killings either reflected and/or perpetuated patriarchal patterns of power, control, and/or domination. If this were the case and given the prevalence of dementia, we would expect vastly more gray mist killings by caregiver-husbands. Indeed, my point in using the language of gray mist is to problematize a complex phenomenon rather than reduce it to political sound bites.

Swiss psychiatrist and psychoanalyst Carl Jung provides a metaphorical, some might say speculative, means for exploring these questions. Borrowing from the insights of Frederick Nietzsche, Jung introduced the concept of the "shadow," the unconscious, as an alternative to religious ideas about evil. For Jung, the shadow is "that hidden, repressed, for the most part inferior and guilt-laden personality whose ultimate ramifications reach back into the realm of our animal ancestors and so comprise the whole historical aspect of the unconscious."[33] These are mainly the sexual and aggressive instincts. Jung distinguishes between personal, hidden feelings (e.g., sexual lust, selfishness, envy, rage) and archetypal (universal) shadows (e.g., Nazism, the devil). He stresses the danger and destructiveness inherent in the unconscious, especially if its potential to inform conscious thought and action is unrecognized or repressed. Elements of the shadow are often unacceptable to the conscious ego. As such, they are more comfortably projected onto other people. Hence the observation that we are often most uncomfortable with others when we see in them negative traits that we have repressed in ourselves. Stephen Diamond describes the shadow as "a primordial part of our human inheritance, which, try as we might, can never be eluded."[34] The darker forces of the unconscious can temporarily control conscious will, especially when people wrestle with acute stress. But not all contents of the shadow are morally reprehensible. Diamond notes the good qualities, too, "normal instincts, appropriate reactions, realistic insights, creative impulses."[35]

Jungian psychoanalytic perspectives raise interesting questions about the killing of PWD. In at least some of the caregiver killings, is it possible that the caregiver reacts to the psychological projection of his own personality in the behavior of the PWD in their care? Put differently, do the conflicts, struggles, and antagonisms between caregiver and PWD diminish the ego strength of the caregiver to reveal his shadow, which in turn baits the shadow of the person with dementing illness? Does the seeming aggressiveness, argumentativeness, megalomania, selfishness, hurtfulness, and manipulation of some PWD uncannily mirror similar psychological characteristics in the restive shadow of the perpetrator, thus acting as an unconscious, unrecognized, and inadvertent trigger? Does such an interpretation come dangerously close to blaming the decedent for her own demise?

We might take a different tack. Is it just possible that one of the effects of dementing illness is to expose the shadows of the person with dementing illness, rendering them increasingly vulnerable to impulsive/expressive violence, like that seen in some of the overkill cases?

Closing Reflections

The greater frequencies of overkilling among gray mist killers with dementia compared with caregivers reflect the broader tendency of these killings toward impulsivity and expressiveness. Put simply, we generally see more anger and rage as these aggressive instincts or drives find expression within highly charged social dynamics and slow but sure neurodegeneration. That men comprise the vast majority of these perpetrators comes as no surprise. Their impulsive or expressive homicidal violence might reflect any permutation or combination of biological, social, and historical forces. We simply cannot make sense of these killings solely in terms of neurodegeneration.

The argument that a disturbed mind, independent of a degenerating brain and nervous system somehow engineers these impulsive-expressive killings fails to convince. Mind and body are one. The mind is some of what the brain and neurons do. It may be more than that, indeed much more, but our minds cannot fathom what might comprise any extras. We must also avoid falling into the trap of seeing neurodegeneration as located in brain parts and neurons and being distinct from bodily decay. As Costandi reminds us in his pioneering neuroscientific writing, to see the brain and body as separate entities is to once again feed a false dichotomy akin to that of mind and body.[36] Furthermore, as the case studies reveal, the killings by PWD involve not only the deterioration of the brain and nervous system but also other morbidities, all socially and historically situated.

Notes

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4 E. Fromm, *The Anatomy of Human Destructiveness* (New York: Holt, 1973), 223–24.

5 See for example G. E. Jarvis, “Rethinking Social Causes of Psychosis,” *The Canadian Journal of Psychiatry* 52, no. 5 (May 2007): 275–76, guest editorial, https://doi.org/10.1177/070674370705200501; L. Varchmin et al., “Traumatic Events, Social Adversity and Discrimination as Risk Factors for Psychosis: An Umbrella Review,” *Frontiers in Psychiatry* 12 (October 2021), https://doi.org/10.3389/fpsyt.2021.665957.

6 See for example M. Zimmerman, “The Nervous System in the Context of Information Theory,” in *Human Physiology*, ed. R. F. Schmidt and G. Thews (Berlin: Springer, 1989), 166–73. Zimmerman notes that just in regard to the eyes, we are conscious of 40 bits of information out of 10 million bits relayed every second. It is not the case that the brain ignores subliminal information and only processes that which is consciously available. For PWD, the question becomes: to what extent does the balance between the use of conscious and unconscious information change? Is, for example, the seemingly enhanced perceptual ability of PWD to sense the anger of caregivers a result of a recalibration of the evaluative bits of information processed from the conscious and unconscious domains? See also D. Wiliam, “The Half-Second Delay: What Follows?” *Pedagogy, Culture & Society* 14, no. 1 (2006): 71–81, https://doi.org/10.1080/14681360500487470. Importantly, Dehaene and colleagues note that “meaning and value can clearly be assigned non-consciously.” They note that people can deploy their attention and enhance

processing even if the target of such attention remains non-conscious. See S. Dehaene et al., "Toward a Computational Theory of Conscious Processing," *Current Opinion in Neurobiology* 25 (2014): 76–84, https://doi.org/10.1016/j.conb.2013.12.005. I am grateful to Andrew Wright for researching these references.

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10 Global Implications

Gray Bus Rides and the Purification of Populations

In October 1939, using his personal stationary, Adolph Hitler penned a brief that he backdated to the start of World War II, September 1, 1939. It read:

Reich leader Bouhler and Dr. Brandt M.D. are charged with the responsibility of extending the authority of specially designated physicians so that patients who, after a very thorough review of their condition, are judged incurable can be granted a mercy killing.[1]

Hitler's brief ushered in bureaucratic and medical procedures that led to the mass killing of mental patients in asylums, nursing homes, and institutions for epilepsy and mental handicap.[2] The phrase, a "life unworthy of life" (lebensunwertes Leben) came from a 1920 German book whose translated title reads, *Allowing the Destruction of Life Unworthy of Life: Its Measure and Form*.[3] It was written by Karl Binding, a jurist (legal expert) and retired university professor, and Alfred Hoche, a psychiatrist and professor. Hoche opined that some among the brain damaged, the intellectually disabled, and the mentally ill qualified for euthanasia. Hoche framed such taking of life as compassionate and consistent with medical ethics. He wrote that "putting such people to death . . . is not to be equated with other types of killing."[4] Rather, it is "an allowable, useful act."[5] For Hoche, brain damage and retardation signaled the patient was "mentally dead."[6] He described them as "empty shells,"[7] a description readers will remember from the gray mist case files.

The intellectual roots of their argument lay in the Social Darwinism of the nineteenth century, advocated by people such as the British philosopher and scientist, Herbert Spencer and the American sociologist and economist, William Graham Sumner. Briefly, the theory, now largely discredited, contended that human populations evolved through the "survival of the fittest," a process that governed plant and animal evolution. Hence social inequalities were the outcome of natural selection rather than the social perpetuation of pre-existing inequalities. Social Darwinism justified class inequalities, the competitive ethos of laissez-faire capitalism, and the imperialism of the societies that conjured up the philosophy.

It lies beyond my scope to delve into the various nuances of Binding and Hoche's writings. Suffice it to say that the Nazis applied it in a manner consistent with their own eugenic thinking, especially their belief in the superiority of the Aryan race

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and the sacredness of the social organism.[8] Nazi eugenicists nefariously blurred the boundaries between voluntary and involuntary euthanasia. Voluntary euthanasia takes the life of a competent but hopelessly ill and suffering person with his or her informed consent in a relatively quick and painless way for reasons of mercy. Involuntary euthanasia involves the taking of life without the informed consent of the eventual decedent.[9]

The German Medical Society marginalized Jewish physicians, a bias according to some authors that reflected its own compromised status and limited power.[10] German physicians were early joiners of the Nazi party. Their party membership surpassed that of all other professions in the Third Reich. Historians have struggled to reconcile the oath to "first do no harm" with Nazi involuntary euthanasia. One perspective contends that the Nazi doctrine that championed biomedical solutions to social problems appealed to the pride of German doctors at the same time as furthering their economic standing, in part by marginalizing Jewish physicians.[11] In the Weimar Republic of post-World War I Germany, large numbers of German physicians were unemployed or underemployed. The Nazi Party appealed to many doctors as a way of elevating their honor and income.[12]

Robert Jay Lifton explains the steps the Nazis took in operationalizing Social Darwinism.[13] They began soon after Hitler assumed power in 1933 with the passage of a sterilization law. It targeted those deemed "hereditarily sick." Lifton estimates the Nazis sterilized between 200,000 and 350,000 people. The killing of "impaired" children and then "impaired" adults, mostly from mental hospitals, quickly followed. The killing centers used in these earlier stages also served for the killing of "impaired" inmates in concentration camps, followed by the final step, the mass killing, mostly of Jews, in extermination camps.

The Nazi Euthanasia Office, Aktion T4, began its work in 1939. People targeted included those not employable in institutional work beyond doing purely mechanical tasks and those who suffered from specific illnesses including schizophrenia, senile diseases, feeblemindedness from every cause, and other neurologically incurable states.[14] In addition to Binding and Hoche's ideas about the biological legitimacy of certain forms of mercy killing of the mentally defective, the Nazis also emphasized the economic drain on German society of caring for the impaired and non-productive. Lifton cites the example of a German mathematics textbook that asks students to calculate how many government loans could be made to young married couples from the money the state spent caring for the "crippled, the criminal, and the insane."[15] We must set this observation against the economic struggles of the German state to pay the reparations due as part of the Treaty of Versailles in 1919 that blamed Germany for the damage caused in World War I. These payments caused widespread poverty among German people and Germans saw them as a national disgrace.

There are examples in the historical record of the Aktion T4 program euthanizing PWD.[16] Alois Zahringer met his end this way. He was born on September 20, 1921, and diagnosed as a child with epilepsy and profound dementia.[17] Alois became a patient at St. Joseph Catholic Institute, in Herten, Germany, on

August 9, 1929. He remained there until August 20, 1940, at which point he was transferred to the Emmendingen psychiatric center, a facility from which the T4 program selected patients for euthanasia. On September 6, 1940, he was taken to the Grafeneck euthanasia center, where he was euthanized upon arrival.

The euthanasia center at Grafeneck was formerly a Samaritan care home. It was the first of six euthanasia centers involved in the T4 program. During the less than a year of its operation, the Grafeneck center killed an estimated 10,000 people, including the seriously mentally ill and people with neurological disorders such as Parkinson's disease.

From the spring of 1940, Aktion T4 bureaucrats identified prospective victims from nearby regional mental institutions. They were collected in infamous gray buses. Upon arrival at Grafeneck, those with gold teeth received a special sign on their back. They were ordered to strip naked and enter a "shower room," which in reality was a gas chamber disguised with fake shower heads. The chamber was sealed and the authorized medical doctor would open the carbon monoxide gas valve. Typically, the gassing took 20–30 minutes. Upon completion, the gold teeth were extracted and sent away to be melted down. The crematorium next door incinerated the corpses. Indeed, new arrivals were apparently able to see and smell the smoke from the previous group of incinerated people.[18]

There are some thematic similarities between the Nazi extermination of "impaired people" and the contemporary management of PWD. Most PWD in the gray mist cases were beyond employment age. Some were clearly seen as "empty shells," regardless of the appropriateness of such a view. The PWD and some of their family members might have preferred a specially designated physician to humanely and mercifully take their life. Such forms of voluntary assisted dying, dispatched with the pre-existing, widely validated, carefully-crafted, and potentially revokable informed consent of the person with dementing illness, appeal to some and not others. However, should prior consent continue to apply when PWD can no longer apparently communicate, let alone object or change their mind? Is any prior consent to participate in voluntary assisted dying negated at that point? Does irrevocable consent on the part of PWD, perhaps in conjunction with family members, mean a doctor can then terminate life if certain medical eventualities emerge, despite the fact that those same PWD are no longer lucid and apparently unable to consent to die? This is a slippery slope, to which I return a little later.

How do we rule out a possible conflict of interest for family members because of "inheritance impatience?" As we saw with Beverly Richmond, her impatience to inherit provided a motive for her brutal killing of her grandmother, Julia Piven. Inheritance impatience is a serious practical concern and ethical conundrum in many cases where adult children stand to inherit.

As I have argued throughout, we cannot see dementing illness and our response to it solely in terms of the science of neurodegeneration. Social, psychological, and historical phenomena are of profound importance. They are not merely contextual frames against which to flesh out speculative biological arguments about the causes and potential cures of dementing illness. Rather, they are integral to any understanding.

Bearing this point in mind, it is worth re-emphasizing the acute vulnerability of the mentally ill in Germany during the Great Depression. Smarting from the loss of World War I and the disgrace of reparations, the economic plight of German society was profound. We must also remember the rising importance of Social Darwinism at the time and its seemingly logical appeal to many professionals including psychiatrists, doctors, lawyers, and university professors. Put simply, Germany was primed for the emergence of scapegoats who could be framed biologically, socially, economically, and historically as a scourge on society and the body politic. Clearly, the seeds of these eugenic sensibilities were found in many countries, not least the three from which our cases hail. Yet the acute vulnerability of the mentally ill in Germany stands out. Might PWD today be similarly vulnerable? A consideration of global increases in life expectancy, the lowering of global birthrates, and the so-called dementia time bomb provide at least a framework for exploring this possibility.

Increases in Life Expectancy

Life expectancy provides an objective measure that tells us only about the average length of life. Demographic research suggests that in 1800, no country in the world had a life expectancy longer than 40 years.[19] It has increased dramatically since, first in the rapidly industrializing countries and later in those slower to develop. Since 1900, the global average life expectancy has more than doubled. It is now over 70 years. The reasons for the increased longevity include improvements in sanitation, increased medical knowledge, declines in child and maternal mortality, the reduction or elimination of infectious diseases, improved prosperity and dramatic declines in extreme poverty, improvements in agriculture and hence nourishment, lowering of homicide rates and the rise of more peaceful societies, and improvements in education, increased knowledge, and literacy. In many ways, human progress on Earth is quite remarkable and is reflected in our increased life expectancy. We ought not forget this remarkable progress in spite of the fact that we are constantly reminded in the media of "things negative," a pessimistic tendency Steven Pinker refers to as "progressophobia."[20] Some examples help flesh out the increases in life expectancy.

Life expectancy at birth in England and Wales almost doubled between 1841 and 2011, with men's life expectancy increasing from 40 to 79 and women's from 42 to 83.[21] Similar increases occurred in the US. In Australia, life expectancy at birth increased from 69 years in 1950 to 84 years in 2022.[22] China has roughly one-fifth of the world population age over 65 years. The rate of increase of this over-65 age group has been quicker than that of developed Western countries. The dean of Fudan University's Institute on Aging, Peng Xizhe, notes "China's elderly population has reached 260 million, and in another 15 years or so, it will exceed 400 million."[23]

He estimates that it took Western developed nations about one hundred years to get to the same proportion of the elderly in the population that it took China 30 years to reach. Although Chinese authorities are investing in more elderly care centers, they cannot cope with the scale of the rapid demographic change. Peng Xizhe warns, “The investment of social resources into caring for this group will be huge—it will be like an abyss. The issue will get increasingly serious.”[24]

Declining Total Fertility Rates

Total fertility rates (TFRs) refer to the overall number of children that would be born to each woman if she were to live to the end of her childbearing years and bear children in accordance with age-specific fertility rates of the specified year.[25] Until 1870, the global TFR was steady at around 5.7 children per woman. Over the last half century rates have fallen precipitously. In 2000, the rate was 2.7 births per woman, well above the so-called replacement rate of 2.1, the rate that maintains a stable population absent net increases from migration. However, today it is around 2.3 and falling. In 91 countries and territories that hold roughly 45 percent of the world’s population, TFRs are below replacement level.[26] Researchers forecast that before the end of this century, 183 out of 195 countries will have TFRs below replacement levels.[27]

Declining fertility rates in East Asian countries such as Japan, South Korea, Taiwan, and Singapore where Confucian family values remain strong have raised major concerns.[28] In these countries gendered divisions of labor prevail in which men perform wage work and women housework and childcare. Although traditional Confucian family forms are diversifying, governments have tried to revive or shore up more traditional models and have not encouraged single parent or same-sex households. More and more people in these societies are marrying later or not at all. Many find it too expensive to raise children, with the costs of housing and private education often cited as reasons. Birthrates in East Asia, therefore, continue to decline. An antipathy to immigration further diminishes the proportion of tax-paying workers able to support the growing population of the elderly, especially those with dementing illnesses. Quoting United Nations estimates, the report notes the combined populations of Japan, South Korea, Taiwan, and Singapore will shrink by 28 percent between 2020 and 2075.

We have also witnessed declining rates in Latin America and Africa. TFRs in Latin America declined from roughly 5.8 children per woman to 2.2 children per woman over the period from 1950 to 2015. Over the same period, rates in Africa fell from roughly 6.6 to 4.7. Today Africa has the highest birthrates but these rates are still declining, in some places quite quickly. According to one report, the most spectacular decreases have been in North Africa, where from 1980 to 2017 the rate fell from six children per woman to three.[29] Child mortality rates have also declined in Africa from 183 deaths of children under the age of one for every 1,000 live births in 1955 to 47 in 2020.[30]

The Dementia Time Bomb

In *Gray Dawn*, published in 1999, financier and co-founder of the investment management company The Blackstone Group, Peter George Peterson, warned of the challenges of global aging, which threaten to bankrupt even the most affluent societies.[31] He contends that global aging will become the transcendent political and economic issue of the twenty-first century. Peterson argues that by the 2030s, over half of the population of today's developed countries and perhaps two-thirds of their voters will be near or beyond today's eligibility age for publicly financed retirement.

Like others, Peterson notes that

> because of stunning progress in public health and medical technology . . . global life expectancy has risen from around age 45 to age 65 since World War II. This is a greater gain in 50 years than civilization had achieved over the previous five thousand years.[32]

He informs readers that British Prime Minister Margaret Thatcher told him that she repeatedly tried to put the problem of the aging of populations on the agendas of the G7 summits.[33] She was apparently told that the problem would not emerge until years later and was therefore not relevant to those political leaders at that particular historical juncture. Politicians think in the short term and telling voters they have to work more years before they qualify for retirement benefits, that they will have fewer retirement benefits, and that their public health and social services will likely be less comprehensive is a recipe for being voted out of office.

For Peterson, "as the number of elderly explodes, global aging will place an unprecedented economic burden on working age people."[34] He points out that over the period from 2000 to 2050 in the US the number of people age 65–84 will triple and the number of people age over 85 will grow sixfold. These old-old, not necessarily decrepit old, consume twice as much hospital care per capita and more than 20 times as much nursing care as those age 65–84 years. Peterson estimates that governments in the developed world will have to increase their expenditures on the elderly (pensions, social services, nursing home care, and medical services) by at least an extra nine to 16 percent of annual GDP just to meet their benefit promises.[35]

The prevalence of dementing illness increases significantly as the elderly age. The cost of caring for those with dementing illness is much higher than caring for the infirm elderly in general. Peterson's projections suggest those suffering from dementing illness will become an increasingly needy and expensive proposition for governments.

In the aftermath of Peterson's book, some critics pointed to the dangers of stigmatizing the elderly. Charles Longino saw apocalyptic demography as "ageist, because it objectifies people who are aging and treats them as though they are all alike. They are not people anymore; they are 'the burden.'"[36] However, Peterson was clear about his position. He saw many positive things about aging populations and saw aging in general as a result of the triumph of modern science. Peterson recognized that a "great number of today's elders are energetic and talented, with serious contributions to make."[37]

That proportion of the elderly population who contract dementia began to attract significant attention by the 1980s and not just because of their burden on future resources. The dementias struck at the heart of the Western cult of the supposedly autonomous individual that had emerged during the post-Enlightenment period. Recalling the empty shell metaphors, cultural historian Jesse Ballenger contends the social anxiety and dread of dementia in the US is tied up with the "loss of the ability to independently sustain a coherent self-narrative."[38] Ballenger suggests that by the 1980s, "people with dementia were at the outer limits of stigma-characteristically represented as no longer 'really there,' as having somehow already died despite the troubling persistence of an animate body."[39] The need to provide for the still animate body would strain public services. The continued need to engage with still sentient human beings with economic, political, and cultural rights and entitlements raised other questions. The medical community understandably focused on what became known as the dementia time bomb.

A 2006 article titled "Defusing the Dementia Time Bomb," appeared in the influential journal *Lancet Neurology*. It warned readers that "Alzheimer's disease threatens to overload future healthcare systems as the number of cases worldwide will likely exceed 80 million by 2040."[40] Previewing the possibility of identifying future sufferers, the journal emphasized it was essential for neurologists to address the clinical risk factors in order to "control the explosion of dementia."[41]

Several themes emerge globally that warrant emphasizing. The aging of populations is a global phenomenon. In 2012, people over 60 comprised roughly 11 percent of the global population. By 2050, their share of the population will double to roughly 22 percent.[42] The aging phenomenon is clearly gendered. For every 100 women 60 or over in 2012, there were 84 men. For every 100 women 80 or over, there were just 61 men.[43]

The aging of global populations and the increasing prevalence of the dementias are related. Dementia is not a natural outcome of aging but aging is the strongest correlate of dementing illness. A special report in *The Economist* notes a 2015 estimate by the Organization for Economic Cooperation and Development (OECD) that "by 2030 the number of dementia cases would increase by 50 percent in rich countries and 80 percent in poorer ones."[44]

A report in *Lancet Public Health* estimates a 117 percent increase in all-age dementia prevalence between 2019 and 2050 due to population ageing, and a 166 percent increase due to a combination of population aging and population growth.[45] The report estimates that globally in 2019, 57.4 million individuals were living with dementia. By 2050 that number would be 152.8 million. The female-to-male ratio was expected to remain stable, with 1.69 to 1.0 in 2019 and estimated to be 1.67 to 1.0 in 2050.

The so-called dementia time bomb may present particularly acute problems in the world's two most populous countries, China and India, which together have more than one-third of the global population.[46] Both countries have relatively poor records on women's rights, particularly in regard to violence against women. They also have relatively high numbers of so-called missing women and surplus men resulting from the continued use of nowadays illegal sex selective technologies. Such technologies militate against the birth of females. Cultural mores that favor boys over girls result in the failure to provide the same medical care for young girls that is provided to young boys.[47]

Amartya Sen described the "terrible phenomenon" of missing women as resulting from unusually higher age-specific mortality rates of females in some societies, particularly in South Asia, West Asia, North Africa, and China.[48] Given symmetrical care, women should outnumber men by a ratio of at least 1.05:1.0. Such ratios are seen in countries like the US and UK. In the developing world the ratios of women to men are often below 1:1.[49] One recent report suggests a combined "excess" of 70 million men in India and China. These numbers are similar to Sen's original range of 60–100 million missing women in India and China combined.[50]

The gray mist killings happen at the other end of the life course. If there is a sex-selective bias against raising young girls in India and China, might we expect to see a similar bias at the other end of the life course? In both countries, women suffer disproportionately from dementing illnesses.[51] Might caregiver killings of women in these patriarchal cultural climates emerge in tandem with the fast-emerging dementias? What role might such bias play in potentiating the disproportionate killing of elderly women with dementia? Clearly, we need more research on this matter since gender power relations differ in these countries.

Gray mist killings differ by society and historical period. Attitudes towards violence against women will likely play a part in the identification, reporting, investigation, and research into such killings. Rates of dementia, the care of those with dementing illness within family and kinship networks, the provision of state care services for PWD, and numerous other factors all come into play for killings by and of PWD in countries like India, China, and elsewhere. In China, for example, the fast-changing situation regarding domestic violence, the dementias, and population aging will present many challenges to state authorities. We might briefly ponder how attitudes toward the elderly, growing knowledge about the dementias, a communist state that allows hybrid capitalist market activity, and patterns of patriarchy will affect rates of gray mist killing.

Mainland China currently has an estimated 10 million people with AD. Projections suggest there will be more than 40 million by 2050. One meta-analysis notes the paucity of recent epidemiological studies of the prevalence rates of AD in China.[52] The authors note that crude prevalence estimates range widely from seven to 66 per 1,000 people. Given that China has roughly one-fifth of the world's population over 65 years old, the paucity of studies strikes the writers as surprising.

In February 2023, authorities in Mainland China blocked internet users from accessing *Sixth Tone*, an alternative news outlet published since 2016 by the Shanghai United Media Group. Upon forming, its editor, Wei Xing, noted that Mandarin Chinese has five tones. He commented, "We want to be the sixth one. We want to be fresh and different."[53] The Shanghai committee of the Chinese

Communist Party oversees the Shanghai United Media Group. In its early days the *Sixth Tone* tackled some thorny issues. Its pre-debut home page lead story was "Waking Up to the Threat of Domestic Violence."[54] The story was published one month after the passage on March 1, 2016, of China's first national law against family violence.

Three months before the blocking of internet users' access to *Sixth Tone*, the news outlet carried a story that concerned the growing scourge of dementia in China.[55] We learn of Qian, age 45, who looks after his aging parents in an apartment complex in central Shanghai. Qian makes a point of greeting the security personnel who stand guard at the gates to the complex. His mother was diagnosed with AD five years ago. She now needs around-the-clock care. His father tries to look after her during the day when Qian goes to work. However, the father is frail and also in his seventies. The mother no longer recognizes their apartment as home. She becomes distressed and tries to leave. On one occasion, police found her wandering the streets 50 kilometers away. She had apparently boarded the wrong bus. The adult son reports he is "often on the verge of collapse."[56]

Qian observes authorities designed the centers for the elderly with physical disabilities or terminal illnesses, not dementia. Only in the last two years have these centers begun to admit PWD and their services are not equipped to address dementing illness.

The *Sixth Tone* article provides a case illustration of the inadequacy of current provisions for Chinese people with AD. One of the few Chinese AD patients to qualify for the government's long-term care scheme is Wang (pseudonym), a 62-year-old woman. She lives in the eastern Shanghai suburbs. The scheme pays for a maid to come to her house for an hour a day, five days a week, to clean, prepare meals, and bathe her. Her husband serves as her full-time caregiver. He reports that arranging for the albeit limited maid service "has been exhausting."[57] But he notes that four maids had quit because they could not handle Wang's behavior. A friend of the family, Chen Huili, observed that Wang yelled at the maids, "Because she was so scared of strangers. But they didn't understand. They described her as a monster and warned other maids about the danger of taking this job."[58]

Chinese authorities have long been aware of these massive demographic shifts and their implications. The shrinkage in the proportion of working-age people whose labor and taxes will help pay for the care of PWD raises daunting questions. In 2016, the Chinese government increased its one child per couple prescription to two. Recently, Chinese authorities approved couples to have up to three children.[59] Yet the decline in birthrates continues. In 2020, the birthrate per woman was 1.3. Two years later, it had fallen to 1.2. These rates are among the lowest in the world and well below the replacement rate of 2.1 births per woman.[60]

As we might expect in a society that has historically placed many restrictions on the flow of information, in China public knowledge about the dementias appears extremely limited. This seems to have changed since 2018 when China began to experience a dramatic increase in dementia-related posts on social media. A recent study of nearly one million original dementia-related social media posts in China from 2010 to 2021 notes the need for a national campaign to combat disparaging language and stereotypes.[61] The authors note the general public is more prone than other user groups (i.e., government, journalists/news media, and scientists/experts) toward expressing negative sentiments about PWD. Results indicate common usage of a derogatory term commonly used by the general public to describe those with dementing illness. The term (in Chinese "老年痴呆,") roughly translates to "old and stupid." It has remained the "most frequently used term for dementia on social media over the past decade."[62]

Public campaigns to combat negative stereotyping of those suffering dementing illness have also occurred in other East Asian nations (e.g., Japan, Hong Kong, and Singapore). In these settings campaigns seek to replace negative local terms with more neutral biomedical ones such as cognitive disorder and brain degeneration syndrome in Hong Kong or memory disorder in Singapore and Taiwan. Kong and colleagues report the rapidity of these attitudinal campaigns in China and East Asia. They remain optimistic that "the future looks bright, as advocacy and policy related discussions gain momentum."[63] Indeed, given the rapidity of demographic change in Asia and the potentially more intensive proliferation of dementia cases, we might expect a faster rate of cultural change in parts of Asia than witnessed in the US, UK, and Australia.

Unpopular Luggage

W. H. Auden apparently wrote the poem "Old People's Home," referenced in Chapter 7, after his visits to see his aging friend, Elizabeth Mayer. She was in a nursing home after suffering a stroke. V. S. Yanovsky, who met Auden at the home on one occasion, wrote that Auden "could not stand the place. . . . He suffered visibly and after half an hour or so rushed out."[64] In the poem, Auden raises similar issues to those arising in our gray mist cases. It closes with the question, "Am I cold to wish for a speedy painless dormition, pray, as I know she prays, that God or Nature will abrupt her earthly function?"[65] In this closing line, Auden captures the angst and pain of the elderly resident and her visitor. The angst and pain comport with language from the elderly in general about their plight and PWD in particular.

Widespread ageism and ableism toward the old-old or the decrepit elderly is a worldwide phenomenon. In 2014, 115 civil society organizations reported ways the elderly felt they were mistreated, why they thought this was happening, and the effects it had on their lives.[66] Excerpts include:

> "Old people are of no use, cost money and might have a lot of problems that can be frustrating if it is difficult to solve them," said a Swedish woman, aged 60–69.
>
> "There is a general ageism in our culture that devalues old age relative to youth, that expects older adults to be decrepit and demented," said an American woman of 70–79 years.
>
> "We feel isolated and alienated as if we are animals," said a Ugandan woman, over 60.

The limited research on the perspectives of PWD illustrates some of their specific difficulties. Excerpts from four voices of PWD speak to anger, stigma, hopelessness, and human withdrawal:

> "Because of this illness, I sometimes have a short fuse. People just don't understand."
>
> (V48)[67]

> "Well, you're going one step down in society. You're no longer considered a full member of society. . . . Someone who is now avoided by everyone."
>
> (DEM37)[68]

> "We are happy with the support we have from all sides now. . . . But I still feel hopeless. Presumably, you can hear it in the tone of my voice, both helpless and hopeless."
>
> (V242)[69]

> "The daily communication with my partner is becoming a problem. . . . I tend to withdraw. . . . More than before, I hesitate to ask or discuss things with her. That's a rotten side-effect of dementia."
>
> (V177)[70]

These observations, combined with the urgency of emerging public health campaigns, especially in Asia, herald the need for more research on the social milieu within which dementing illness unfolds. It is not enough to substitute allegedly "neutral biomedical" terms for derogatory cultural stereotypes, as noted in Kong and colleagues' aforementioned study. Such linguistic substitutions, improvements as they may be do not go far enough because they feed the sense that dementing illness is mostly or even merely a problem of biology, of neurodegeneration, of the brain, rather than a socially and historically situated phenomenon of great cultural as well as scientific complexity.

Canaries in the Coalmine: The Social Meaning of Gray Mist Killing

In some ways, the countries from which the gray mist cases hail are victims of their own progress. That progress emerged out of the Age of Enlightenment or Age of Reason, a period in the seventeenth and eighteenth centuries that saw the rise of constitutional government, the pursuit of knowledge based on reason and evidence, and the growing prominence of liberal values that emphasized the desirability of tolerance, democracy, individual rights, political equality, equality before the law, and property rights. These ideals are a work in progress. A more onerous aspect of these post-Enlightenment developments included histories of colonization and imperialism and long-term greenhouse gas emissions that attended the industrial revolution, and the burning of fossil fuels.

Compared with their Asian peers, the US, UK, and Australia are more individualistic and have elevated the cult of the individual to, at times, quite remarkable levels. On average, citizens in high income Western democracies are living longer, more productive, happier, and healthier lives than they were two or three centuries previous. Over the last 50 years or so one byproduct of this so-called progress has been an increasing prevalence and awareness of dementing illness. As we have seen, Western democracies do not have a monopoly on the dementias. These socially and historically situated neurodegenerative diseases are alive and well across the globe, as is the stigmatization of PWD. Yet it is in the more transparent democracies that detailed reviews of gray mist killings have developed.

The killings are extremely rare. Killers with dementing illnesses were largely unfit to stand trial. Their homicidal acts arose out of a complex mélange of biological, social, cultural, and historical forces. Their killing appears to have involved mostly impulsive-expressive violence. In the poetic language of Yeats, their emotional/affective centers could not hold, and in very rare instances, a handful of de-centered human beings committed homicide. The courts recognized this fact and its implications for their criminal culpability. Usually, those offenders were subject to an indefinite civil commitment. The gray mist killings by PWD warn us of the potential inadequacy of our handling of these cases. This is not to say that they were preventable. Rather, it is to say that we need more information about the circumstances within which these killings unfold and customize our responses in a manner informed by that knowledge.

Given the difficulties of caring for PWD, it strikes me as remarkable that there are not more caregiver killings. This fact alone speaks to how far modern societies have come since pre-modern times when some PWD in some countries and cultures were ostracized, chained, imprisoned, caged, whipped, otherwise tortured, or killed. Whether caregivers killed because of mercy, exhaustion, a temporary abnormality of mind, stress, or theft, they clearly contravened social and legal norms and undermined the processes of deliberative democratic practice which, mirroring contemporary public opinion, outlaw such killings. In a very real sense, the caregiver-killers engaged in either voluntary or involuntary euthanasia that was unavailable through the state. They therefore made decisions that were akin to those taken by some of the Nazi physicians involved in the Aktion T4 program. The main difference is that caregiver-killers, like those with dementing illness who killed, did so in intimate personal relationships in private settings and not as part of organized, bureaucratized, state-sanctioned euthanasia.

The caregiver killings form an extraordinarily small but profoundly important part of the social responses to dementing illness. As we have seen, the routine daily responses involve drug therapies, nursing homes, and in-home care by family members or professional caregivers. Caregiver killings caution us about the need to learn more about caregiver burden and its relationship to the panoply of responses to PWD who live in family settings.

Other responses to PWD such as the appropriateness of voluntary assisted dying have received increasing attention. Assisted dying has arrived in some countries for a variety of terminal health conditions (mostly cancers) but also for some mental health conditions. Assisted dying is an umbrella term that includes euthanasia and physician-assisted suicide (PAS). PAS or physician assisted dying (PAD) involves a physician providing the means of taking the life of a patient who has legally consented to die. The patient and/or caregiver kills, not the physician.

Proponents of voluntary euthanasia in countries like Belgium and the Netherlands, where it is legal, see it as a dignified, compassionate exit from life in a manner consistent with human autonomy. Opponents see it as contrary to the sanctity of human life and a contravention of a physician's duty to preserve life. Some worry that PAS might sully the reputation of physicians who are supposed to save lives, not take them. Others worry about the slippery slope and abuses of power that might end up scapegoating specific groups, as in the Aktion T4 program.

Still others point to examples of euthanasia in Belgium and the Netherlands involving patients that were not suffering from a terminal illness. As Frédéric Soumois points out, "performing euthanasia for mental suffering that cannot be alleviated is still considered an extraordinary measure."[71] Such mental suffering might include cases of dementing illness. Sousmois cites the example of Shanti De Corte, a 23-year-old Belgian woman euthanized on May 7, 2022, surrounded by her family. Six years earlier on March 22, 2016, Shanti had been at Brussels Airport when terrorists exploded bombs. She was only a few meters from the blasts. Previous to the explosions she had suffered depression and received inpatient treatment at a psychiatric hospital in Antwerp. She returned there after experiencing the blasts. Doctors treated her with antidepressants. At one point she was taking up to 11 antidepressants a day. She commented, "I feel like a ghost who doesn't feel anything anymore." Shanti had tried to commit suicide in 2020. A debate ensued as to the appropriateness of the decision to euthanize Shanti. It continues.

PAS, PAD, and euthanasia present complex problems in cases involving PWD. One research team notes the difficulty in determining whether the request is voluntary and well considered. There are concerns about whether the patient is competent to make the decision to die. Questions arise too about the patient's awareness of memory deficits and their cognitive difficulties, which might undermine the efficacy of a euthanasia directive.

Almost all cases of PAD in the Netherlands related to dementing illness have involved patients in the early stages of AD.[72] The same was true of the first Briton with dementia to undergo assisted suicide at the Dignitas assisted suicide center in Zurich, Switzerland.[73] A psychiatrist found the 83-year-old man, who was in the early stages of dementia, mentally competent to decide his fate, a Dignitas requirement. Dr. Michael Irwin, a retired general practitioner and an advocate for the legalization of PAS in the UK, told the BMJ that the man "knew very well all the implications of what dementia would mean for him and his family."[74]

The debate about the legal and ethical resort to euthanasia and PAS as responses to dementing illness continues. There is an important distinction between voluntary and involuntary euthanasia. The mostly men in the gray mist cases who killed PWD did so for many and often mixed reasons. They contravened the rule of law, although not necessarily the wishes of those they killed. That rule of law, through democratic deliberation, may render PAS legal for PWD under narrowly defined circumstances and conditions.

One wonders how these developments in the fields of law, ethics, democratic practice, and civic engagement will unfold. In Western capitalist economies the sale of care services and pharmaceuticals for PWD will likely militate against more sinister authoritarian interventions akin to Aktion T4. The aging of populations presents commercial opportunities and dementia services form a part of that enterprise.

Less transparent, more autocratic nations like China might deal with its emerging dementia time bomb differently. Harnessing their sense of communitarianism may prove helpful, especially if it can counter harmful stereotypes of PWD. On the other hand, centralized, autocratic regimes that do not permit thorough in-depth reviews of gray mist killings may forego the kind of knowledge that might improve responses.

From the late nineteenth century through much of the twentieth century, many rescue crews in coal mines carried caged canaries. The birds acted as early warning systems to detect the presence of carbon monoxide, which was released after an explosion in the mine. The explosions resulted from detonations, sparks from equipment, or the open flames in miners' carbide lamps. The canaries were small, breathed rapidly, and had a high metabolism. These characteristics rendered them highly sensitive to carbon monoxide, which is colorless, odorless, tasteless, lighter than air, and highly flammable. When it burns, it does so with a bright blue flame. Carbon monoxide is the gas of exhaust-fume-suicides, and as noted, the gas used to kill Alois Zahringer and many others in the Aktion T4 euthanasia centers. Mine workers were unable to detect its presence. Ailing canaries therefore warned miners and rescue crews of the presence of carbon monoxide, thus giving them time to don respirators and/or escape.

Those that descended into the mines were often discolored or had some other blemish or imperfection that rendered them less sellable to the general public. Female canaries did not sing as well as the males, and as a result, they often shared the same fate of serving as early warning systems in mines.

The stories of the gray mist killings speak to human discoloration, blemishes, and imperfections. Like the canaries in the coalmine, the case narratives and what we make of them serve as early warnings, sentinel phenomena. Like the canaries in the coalmine, most gray mist decedents were female. Whether as caregivers or PWD, men committed the vast majority of the killings. This observation alone, often glossed over or unexplored in the dominant biomedical paradigm on dementing illness, tells us much. Yet, more than observations about case patterns, the narration itself requires attention to lives, biographies, and human exchanges of the most profound and profane kind. It is here, in the white heat of everyday life, that we begin to understand how people react when the center can no longer hold.

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Appendix

Tables

Table 1 Overview Characteristics of the 100 Gray Mist Killings

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Heterosexual IPH (N = 100)	95	95/100
Family killings (N = 100)	5	5/100
Male perpetrated (N = 100)	94	94/100
Female perpetrated (N = 100)	6	6/100
Perpetrator and victim married (N = 100)	88	88/100
Perpetrator and victim cohabiting (N = 100)	90	90/100
Killing took place within the victim's home (N = 100)	86	86/100
Homicide-suicide case (N = 100)	24	24/100
Perpetrator had dementia (N = 100)	54	54/100
Perpetrator was caregiver (N = 100)	44	44/100
Neither perpetrator nor caregiver had dementia	2	2/100
Victim age 60–89 (N = 96)*	93	89/96
Spouse/partner relationship 40+ years (N = 61)**	82	50/61

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Victim Caucasian/white (N = 94)***	95	89/94
Overkill case (N = 100)	28	28/100

* Four cases did not identify the age of the victim.
** Thirty-four cases did not specify the length of the marriage/intimate relationship.
*** Six cases did not note the race of the victim.

Table 2 Overview Characteristics of the 94 Gray Mist Killings Involving IPH in Which Either or Both Spouses/Partners Had Dementia

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Male perpetrated (N = 94)	95	89/94
Female victim (N = 94)	95	89/94
Perpetrator and victim married (N = 94)	94	88/94
Perpetrator and victim cohabiting (N = 94)	95	89/94
Killing took place within the home (N = 94)	89	84/94
Homicide-suicide case (N = 94)	26	24/94
Perpetrator had dementia (N = 94)	55	52/94
Perpetrator was caregiver (N = 94)	45	42/94
Victim age 60–89 (N = 90)*	96	86/90
Spouse/partner relationship 40+ years (N = 60)**	83	50/60
Victim Caucasian/white (N = 89)***	97	86/89
Overkill case (N = 94)	28	26/94

* Four cases did not specify the age of the victim.
** Thirty-four cases did not specify the length of relationship.
*** Five cases did not specify the victims' race.

Table 3 Method of Homicide in the 94 Gray Mist Killings Involving IPH in Which Either or Both Spouses/Partners Had Dementia

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Shooting (N = 94)	44	41/94
Stabbing (N = 94)	22	21/94
Strangulation (N = 94)	17	16/94
Blunt force trauma (N = 94)	16	15/94
Lethal push (N = 94)	1	1/94

Table 4 Overview Characteristics of the 54 Gray Mist Killings by Perpetrators With Dementia

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Male perpetrated (N = 54)	91	49/54
Female victim (N = 54)	91	49/54
Perpetrator and victim married (N = 54)	85	46/54
Perpetrator and victim in intimate relationship but unmarried (N = 54)	11	6/54
Perpetrator and victim father and daughter (N = 54)	2	1/54
Perpetrator and victim grandfather and granddaughter (N = 54)	2	1/54
Perpetrator and victim cohabiting (N = 54)	91	49/54
Killing took place within the home (N = 54)	89	48/54
Homicide-suicide case (N = 54)	6	3/54
Victim age 60–89 (N = 51)*	92	47/51
Perpetrator age 60–89 (N = 54)	93	50/54
Spouse/partner relationship 40+ years (N = 28)**	79	22/28
Victim Caucasian/white (N = 53)***	87	46/53
Overkill case with perpetrator with dementia (N = 54)	44	24/54

* Three cases did not reference the age of the victim.

** Twenty-six cases did not specify the length of relationship.

*** One case did not identify the race of the victim.

Table 5 Overview Characteristics of the 44 Gray Mist Killings by Caregivers

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Male perpetrated (N = 44)	100	44/44
Female victim (N = 44)	100	44/44
Perpetrator and victim married (N = 44)	95	42/44
Perpetrator and victim in intimate relationship but unmarried (N = 42)	0	0/42
Adult son killed mother (N = 44)	5	2/44
Perpetrator and victim cohabiting (N = 44)	93	41/44
Killing took place within the home (N = 44)	93	41/44
Homicide-suicide case (N = 44)	45	20/44
Victim age 60–89 (N = 43)*	95	41/43
Perpetrator age 60–89 (N = 44)	86	38/44

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
Spouse/partner relationship 40+ years (N = 31)**	90	28/31
Victim Caucasian/white (N = 41)***	100	41/41
Overkill case (N = 44)	5	2/44

* One case did not reference the age of the victim.

** Thirteen cases did not specify the length of relationship.

*** Three cases did not identify the race of the victim.

Table 6 Comparison of the Mental Health and Overkills of Perpetrators With Dementia and Caregiver-Perpetrators

Case characteristic	*Percentage of perpetrators with dementia*	*Percentage of caregiver-perpetrators*
Mental illness in form of dementia (Ns = 54, 44))	100 (N = 54; 54/54)	2 (N = 44; 1/44*)
Criminal court determined that perp mentally unfit to stand trial (Ns = 45,** 44)	73 (N = 45; 33/45)	2 (N = 44; 1/44)
Criminal court determined the perpetrator had diminished responsibility due to an abnormality of mind or other mental disorder at time of killing (Ns = 45, 44)	27 (N = 45; 12/45)	11 (N = 44; 5/44)
Overkills (N = 26)	92 (N = 26; 24/26)	8 (N = 26; 2/26)

* One caregiver-perpetrator, Kenneth Burton, killed his wife, Sally, who did not have dementia but who was bedbound from a terminal illness. In the aftermath of the homicide, Kenneth was diagnosed with early-stage dementia. *Burton* therefore fits best, although not neatly, in the caregiver category.

** Forty-five of the 54 perpetrators with dementia received mental health determinations from the criminal courts. Three out of these 54 cases ended in homicide-suicide. With no one to prosecute, no criminal trial ensued; hence, there was no determination of fitness to stand trial or a detailed court-generated mental health assessment. In another six of the 54 cases, no legal assessments of mental health concerning either fitness to stand trial or diminished responsibility were available.

Table 7 Overview Characteristics of the 13 IPHs Committed by Perpetrators With Dementia

Case characteristic	*Percentage of N*	*Number with case characteristic/total cases with known information about the characteristic*
IPV/A predated the symptoms of dementia (N = 13)	77	10/13
IPV/A post-dated the symptoms of dementia (N = 13)	23	3/13
Male perpetrated (N = 13)	77	10/13
Female victim (N = 13)	77	10/13
Perpetrator of IPH had dementia (N = 13)	100	13/13
Perpetrator and victim married (N = 13)	92	12/13
Killing took place within the home (N = 13)	85	11/13
Perpetrator and victim cohabiting (N = 13)	100	13/13
Homicide-suicide case (N = 13)	0	0/13
Victim age 60–89 (N = 13)	85	11/13
Perpetrator age 60–89 (N = 13)	85	11/13
Spouse/partner relationship 40+ years (N = 9)*	78	7/9
Victim Caucasian/white (N = 13)	85	11/13
Overkill case (N = 13)	46	6/13

* Four cases did not specify the length of relationship.

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