Safer Cornwall CIOS Safeguarding Adults Board

# Joint Domestic Homicide/Safeguarding Adult review Overview Report

## DHR/SAR 7 - Regarding the death of Margaret – died February 2017

**Prepared by:**

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**Independent Chair and Author**

**Revised November 2019**

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## Message to the family from the DHR Panel

The DHR panel wishes to express its condolences to the family of Margaret and recognises the distress that the incident and this subsequent review brings.

We hope this report will provide assurance that the circumstances of the involvement of local agencies has been properly and thoroughly reviewed.

# Section One
# Introduction and background

## 1.1 Introduction

This combined Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) was commissioned jointly by Cornwall Community Safety Partnership and Cornwall and Isles of Scilly Safeguarding Adults Board in response to the death of Margaret. (The names of the victim and perpetrators have been changed.)

This murder meets the criteria for a DHR to be conducted in that the death of a person aged 16 or over has resulted from violence by a person with whom she had been in an intimate personal relationship. As a result, Cornwall Community Safety Partnership decided to commission a DHR.

In view of the vulnerability of the victim Margaret, the services being provided to her, and the relative vulnerability of the perpetrator Donald, Cornwall Safeguarding Adults Board decided that the criteria for conducting a SAR were also met, in that an adult in its area had died as a result of abuse and there was concern that partner agencies could have worked more effectively to protect that adult.

A decision was taken to run the two reviews as a combined process. Whilst it was anticipated that the DHR process would provide a thorough and challenging review of this case and identify learning with which to improve practice, it was felt that there could well be additional learning for partner agencies by adding the health and social care perspective which the SAR would bring.

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Margaret in Cornwall in February 2017. The DHR was commissioned by Cornwall Council on behalf of Safer Cornwall (Cornwall's Community Safety Partnership). In August 2017 an open tendering process was completed to appoint an independent chair and author and the formal contract was agreed in October 2017.

## 1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —*

- *a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'*

The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

This DHR was also conducted as a joint Safeguarding Adults Review and as such has conformed to the requirements of such. A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

In addition to agency involvement the review also examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. The review seeks to identify the lessons that may be learned from this case and through its recommendations, assist in making victims and those affected by domestic abuse safer in the future.

**1.3 Subjects of the review**

The Overview Report uses the pseudonyms for the victim and the perpetrator.

**Margaret– victim**
White British Female aged 88 years at time of death
Date of Death: February 2017

**Donald - perpetrator**
White British Male aged 89 at the time of the incident

### 1.4 Process of the review

The DHR has been conducted in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews updated in December 2016. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

The review has considered agencies contact/involvement with Margaret and Donald from February 2015 to the date of the homicide. The panel discussed and agreed this timescale and felt that looking back over a two year period was a proportionate timescale given the previous lack of statutory organisational contact.

Prior to the events subject to any information that emerges that prompts a review of any earlier incidents or events that are relevant.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The DHR began in January 2018 and was completed in September 2018. Three panel meetings were held during this period. The report was approved by the DHR panel prior to its submission to the Home Office.

### 1.5 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Safer Cornwall accepts the Overview Report, Executive Summary and Action Plan.

The first version of this Overview Report used initials to represent the subjects of the DHR. Following advice from the Home Office, pseudonyms have now replaced initials. The victim is represented by the name Margaret; and the perpetrator by the name Donald. Their son, who contributed to the review, is represented by the name David.

### 1.6 Terms of Reference

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.

- Identify what the lessons are, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter-agency responses were appropriate leading up to and at the time of the incident, suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend and changes as a result of the review process.

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

- Highlight good practice.

### 1.7 Methodology

An initial scoping process was undertaken in March 2017 to establish the agencies and organisations that had contact with Margaret and Donald. As part of this process a list of agencies and relevant contacts was developed and a timeline was created. This process enabled the gathering of information about types and level of contact and informed the decisions about which agencies and organisations to approach to request Independent Management Reviews.

Independent Management Reviews (IMR) were requested from a range of agencies to establish if there had been contact with either Margaret or Donald and if so the nature of that contact and any services or interventions provided to them either individually or as a couple.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs were also to assess the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

IMRs were reviewed by the panel and then discussed at a panel meeting. IMRs were presented. Questions were asked and clarifications sought by the panel regarding specific elements of each of the IMRs. Some IMRs were amended and resubmitted as a result of those discussions.

The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the DHR panel. All were written by individuals who were independent and had no prior contact with the subjects of the DHR or knowledge of the case.

This Overview Report is based on IMRs commissioned from local agencies as well as summary reports and scoping information. It has also been informed by information provided by Margaret and Donald's son and other members of the family.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review.

### 1.8 Involvement with the family

The panel has sought throughout the review to ensure that the wishes of the surviving family members have informed the DHR Terms of Reference and are reflected in the DHR report.

The family were provided with the Home Office leaflets and were provided with information about specialist advocacy through AAFDA, but chose not to take up this offer.

The Chair of the panel wrote to Margaret and Donald's son, David, to advise him of the process of the DHR and to invite him to contribute to the process if he wished to do so. He has already been made aware of the process by Safer Cornwall and had corresponded with them. In that correspondence he outlined some of the key areas that he felt needed to be explored and that he would wish to see addressed as part of the review.

Following an exchange of emails the Chair met with David and his wife. This meeting was comprised of two elements. The first being a further explanation of the process and the timeframe and the second being the gathering of relevant information from David and his wife in relation to his parents history and the incident, as well as his father's current care and treatment.

David has two sisters, who had expressed their wish that he represent their views and provide them with updates about the DHR. They did not wish to take part in the review process itself.

The Chair has kept David and his wife updated on the progress of the review by email or telephone. A draft copy of this Overview Report was shared with them. They had the opportunity to read and comment upon it, before a meeting with the Chair in August 2018 to respond to their comments and to make any necessary amendments.

### 1.9 Contributors to the review

A number of agencies contributed to the review through the submission of IMRs and the provision of initial scoping information. Those agencies were:

- NHS England – Primary Care
- Cornwall Council – Adult Services Department
- Cornwall Partnership NHS Foundation Trust

Devon and Cornwall Police provided scoping information and information relevant to the criminal proceedings that were completed before the commencement of the DHR process.

### 1.10 Panel Membership.

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| Steve Appleton | Independent chair and author |
| Ben Beckerleg | Inspector - Devon & Cornwall Police |
| Nicholas Rudling | Deputy Safeguarding Lead - NHS England South West |
| Ann Smith | Head of Safeguarding - Cornwall Council |
| Tina Sanford | Service Manager - Cornwall Council |
| Karen Howard | Adult Safeguarding Lead - Cornwall Partnership NHS Foundation Trust |

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| JulieAnn Carter | Head of Nursing, NHS Kernow Clinical Commissioning Group |
| Tom Dingwall | Chief Executive - First Light – Domestic Abuse Charity |

The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case.
Since the original report was written, some panel members have left the roles and organisations detailed above.

### 1.11 The Overview Report author

The independent author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority community safety partnerships across the country, including two previous reviews for this CSP. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation

Steve has had no previous involvement with the subjects of the review or the case.

### 1.12 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, if the cultural background of Margaret and Donald and if this played any part in how services responded to their needs.

"The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and materinty, race, religion or belief, sex and sexual orientation."[1] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

The nine protected characteristics in the Equality Act were considered by the panel and two were found to have direct relevance to the review. These were age and disability.

The victim was an older person who was living with dementia. The panel ensured that the review always considered these issues in their thinking about the engagement and involvement of organisations and professionals and where identified, the impact of them on decision making and whether these presented a barrier to accessing support and assistance.

### 1.13 Dissemination

The Overview Report will be sent to all the organisations that contributed to the DHR. In addition an appropriately anonymised electronic version of the Overview Report will be posted on the Safer Cornwall website. A copy will be provided to the Police and Crime Commissioner. It will also be available on the Safeguarding Adults Board website.

Members of the family have been provided with copies of the Overview Report.

### 1.14 Chronology

A full combined chronology of agencies contact with both the victim and perpetrator has been compiled as part of the DHR. That chronology is not appended to this report in accordance with Home Office advice but has been submitted separately.

[1] Paragraph taken from Home Office Domestic Homicide Review Training; InforMargarettion Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhuMargaretnrights.com/.../1_overview_of_the_gender_duty

# Section Two

## 2.1 Introduction

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Margaret and Donald. The report examines agency responses and support given to them in the two years prior to the incident in February 2017. The DHR panel agreed this timescale and believe it to be proportionate in this case.

### 2.1.1 Summary of the incident

Margaret and Donald had been married since 1948. They have three adult children, one son and two daughters. All three children live in Buckinghamshire. Both Margaret and Donald were living with the impact of memory impairment. It is reported by their son that between November 2016 and February 2017 there were changes in the pattern of his father's behaviour.

On the morning of the day of the incident the couple's regular carer attempted to carry out a home visit, but received no answer. Later that morning their newspaper was delivered and again there was no response following knocks on the door. The same lady that delivered the newspaper returned an hour later and still got no response.

Just after lunchtime on the day of the incident, the GP and the case coordinator from Adult Social Care attended the couple's house to conduct a home visit. Donald did answer the door to them and led them into the property. When they entered the bedroom in the property they found Margaret lying on the floor between the bed and the wall. She was badly bruised around the face and neck and had other injuries to her arms including open cuts.

The care coordinator went outside to get a mobile phone signal and called an ambulance and the Police. The GP came outside while the care coordinator was on the phone and confirmed that Margaret was deceased. When the police arrived (about an hour after the commencement of the GP/care coordinator home visit) Donald was arrested and was subsequently charged with murder.

Donald was later diagnosed with Alzheimer's Disease. He was found unfit to stand trial. The case was heard at Crown Court and he was convicted of murder. The judge imposed a hospital order and Donald is now detained at an independent medium secure mental health hospital.

## 2.2 Overview

### 2.2.1 NHS – General Practice

Margaret and Donald were both registered with the same General Practice but had different named GPs. Margaret saw a number of different GPs, but the majority of her consultations were with the same few doctors, all of whom were familiar to her and who knew her. This overview concentrates on the contact between Margaret and Donald and the GPs at the practice in the two month period prior to the incident.

In January 2017 the GPs at the practice were first alerted to potential concerns about Margaret and Donald. The practice Manager was concerned that neither of them had attended surgery or collected their medication for a period of three months, this was unusual and represented an especially lengthy period. Margaret and Donald's son had also contacted the surgery on the same day. He reported that he had had no contact with his parents since a visit to them in November 2016. Although this was not unusual, he stated he was now concerned about his parents and in particular he felt that his mother was experiencing significant memory impairment and he believed she had dementia. He was concerned that he was not receiving any response to phone messages or to cards and letters that he had sent.

The GP undertook to contact adult social care and to conduct a home visit the following day. This visit took place.

The GP noted that Donald was reluctant to let him into the property but did consent after some discussion. The IMR records that the GP heard Donald being 'verbally aggressive' to Margaret, and he would not let the GP see her in the bedroom but brought her to see him. The GP noted that Margaret appeared wearing a dirty dressing gown, dirty nightgown, and with her hair unkempt. The GP noted a number of bruises and healing lacerations on her hands. The GP asked about her eating and cooking, she stated that she did not cook much anymore which was in contradiction to what Donald had told the GP when questioned. Donald tended to answer for Margaret when the GP put questions to her and this, according to the GP made it harder to make an assessment. The GP did secure agreement for him to talk to their son about their situation and the outcome of his home visit.

The GP also asked Donald some questions about his own health. Donald responded that he did not know he was supposed to be taking medication to manage his blood pressure or a thyroid condition. GP felt that Donald had capacity and he secured Donald's agreement to attend surgery for blood tests and blood pressure check.

Two days later the practice Manager sent a letter with an appointment for the blood tests and blood pressure check, having received no response to phone messages.

The GP did provide information to adult social care following this home visit and made a safeguarding referral. It appears that this referral was returned by the Safeguarding Team as it was 'incorrect' – it was not on the correct form. This was rectified immediately.

Communication between adult social care and the GP practice took place over the ensuing fortnight and a joint planning meeting took place at the surgery between adult social care and the GP at the start of February 2017. This was followed on the same day by a joint home visit between the GP and a social worker from the Safeguarding Team.

Again Margaret was dressed in a dirty night gown which appeared to be stained with dried blood. The bed was similarly stained. The impression was that Margaret may be experiencing symptoms of dementia. The social worker did manage to speak to Margaret alone and agreed to visit again the following week. The GP and social worker did discuss the provision of support for Margaret in relation to bathing but Donald was not willing to accept this help – he said he did not need it so neither did his wife.

The social worker asked Donald if she could visit the following week to assess for support. Donald was reluctant but she offered to bring the repeat prescription the following day and Donald agreed to this.

A couple of days later the social worker visited again. After some discussion Donald agreed to let her into the house. Margaret appeared to be in the same night dress and it was clear that the sheets had not been changed. Margaret was willing to accept some support but told the social worker she should ask Donald about this. When asked he apparently turned to Margaret and said 'you don't want this help do you, you don't need it do you?' The social worker fed this back to the GP surgery.

A further joint home visit took place between the GP and a social worker. GP attempted to take blood from Margaret and after some difficulty did achieve this. GP noted bruising to her face and arms. Donald said this was due to a fall. He was reluctant to accept that Margaret was not coping and needed extra support. It was noted that he appeared to have little patience with her and could be brusque when talking to her. The social worker did manage to change Margaret's night dress for a clean one. She also confirmed that she would be arranging for carers to visit.

The GP recorded in the notes that he was 'concerned about her poor care and there is not a reasonable explanation for the injuries.'

The GP practice was advised that carers had been arranged for the couple the following day. The GP made a referral to the memory clinic.

Further communication took place between the social worker and the GPs during February in relation to carer visits and blood tests and the declining of the memory clinic appointment.

The GP undertook a home visit. During that visit he advised Donald that if, as had been happening, carer visits continued to be refused then it might be necessary to take Margaret away from the home environment. The nature of that removal was not clear from the IMR.

Plans for a joint visit between the GP and the case coordinator from adult social care were made. It was during this visit that Margaret was found deceased.

### 2.2.2 Adult Social Care

Adult Social Care (ASC) first had contact with Margaret and Donald in 2009, this was in relation to the provision of handrail in their property.

There was further contact in December 2015. This followed concerns being expressed to ASC by Margaret and Donald's son, David. He had not seen them for two years but often spoke with them on the telephone. His concerns centred on Margaret becoming more confused about her surroundings and having memory problems. He was also concerned that Donald had lost weight. The ASC Access Assessor advised David to contact his parents GP surgery but he advised that he did not know their surgery.

The Access assessor advised David that an assessment of need could be undertaken but that this would require his parents' consent. It was agreed that the Access Assessor would contact Donald to discuss David's concerns and to establish if Donald felt that he and his wife needed any support. The Access Assessor made contact by phone. Donald advised that he and his wife were coping well, he was unsure why his son had concerns. He felt his wife's memory problems were aged related. He told the Access Assessor that he knew how to ask for help if needed and it was agreed that the Access Assessor would send Donald a letter with the contact details of the Access Team should he ever feel support was needed. The Access Assessor updated David on this contact.

There was no further contact until late January 2017, when David again contacted the Access team. He advised that following a recent visit, he had concerns that his parents were becoming more socially isolated, that they no longer answered the door or telephone and did not respond to letters. While they appeared clean and well

kempt he was concerned about their eating. He had made them an appointment with their GP but they failed to attend. When he raised this with the GP surgery, he said they had told him that their situation was a social care issue. The Access Assessor reported the advice from 2015 about the need to obtain consent or an assessment.

The Access Assessor also suggested that the GP could raise a Safeguarding alert if they were concerned about issues of self-neglect. David said he would go back to discuss this with the GP and the Access Assessor said that they would await further contact.

At the end of January the ASC Adult Safeguarding Team received a letter outlining safeguarding concerns from the GP. This was triaged and then followed up with contact with David, a call to the GP and arrangements made for a joint home visit. The joint visit took place in February 2017. As outlined in the GP IMR, Donald was initially reluctant to admit the social worker and GP into the house but did so after some persuasion. He was suspicious of the need for the visit, citing his son's interference, as he saw it.

Although there was nothing medically wrong with Margaret, it was noted that her night dress was dirty and she had clearly not bathed, despite Donald's assurances that she had. Bruising and scabs were noted on her face and arms and there were signs of dried blood. Donald said this was due to a fall. The social worker discussed the option of support with bathing etc. but Donald said his wife did not need this help. The social worker managed to secure Donald's agreement to her returning the following day, partly to bring them medication.

When the social worker returned for the follow up visit she found Margaret to be wearing the same night dress as before. Donald again refused offers of help, answering for his wife when questions were put to her, saying, 'you don't need this help do you?' The social worker noted that she had left the house with concerns, in particular about what she felt was neglect in relation to Margaret. She articulated these concerns during her communication with colleagues and with the GP surgery.

At the start of February 2017, a different social worker undertook a home visit with the GP. Again bruising was present on her knees, thigh, chest and arm and her finger appeared to be injured. She appeared frail and thin. Donald was again insistent that they did not require any help with personal care. Again Margaret's night dress was soiled. The social worker observed Donald to be brusque in his exchanges with his wife, and that he pushed her along when she walked. The social worker advised Donald that if no support was provided then it might be necessary to admit his wife to hospital. The social worker did manage to get Margaret into a clean night dress. Donald reluctantly agreed to accept some support. Following this visit an interim care and support plan was drafted and plans put in place for support provision.

Care support visits were started in February 2017. A referral was also made to mental health services. Donald refused the carers entry on the first visit that day.

In mid-February a series of conversations and meetings took place between the ASC team, the GP surgery and the mental health services.

A Community Psychiatric Nurse was able to visit the couple. Donald complained about people coming into his house, he did not feel it was necessary. Margaret was not dressed, despite the visit taking place in the afternoon.

In mid-February the carers were only able to gain access once and Donald would not let them conduct any actual care. There is no evidence that they raised concerns about this.

A further joint visit between the social worker and the GP was arranged. Concern was escalating, in part due to the fact that the care support was not being utilised by Donald.

It was during the joint visit that Margaret was found deceased in the bedroom of the property

### 2.2.3 Cornwall Partnership NHS Foundation Trust (CFT)

Prior to referral in early February 2017, neither Margaret or Donald were known to CFT. It was on this date that a referral was received from the GP surgery for memory assessment of Margaret. The receiving team was the North and East Locality Complex Care and Dementia Team (CC&D). The referral was triaged and allocated to a community psychiatric nurse (CPN).

On 8 February 2017 the Early Intervention Service (EIS), now called Home First, received a triage enquiry from adult social care about an assessment for a walking frame for Margaret. Although there was no health need identified, given the safeguarding issues identified in the electronic notes system to which EIS workers have access, the request was discussed with the EIS Manager. It was agreed that the EIS physiotherapist would conduct an assessment.

Their ability to do an assessment soon was limited and so the referrer was advised to contact the community rehabilitation team for a quicker and more local response. The referrer didn’t contact the local team.

In mid-February 2017 a CPN undertook a planned visit to Margaret and Donald. This was in response to two referrals, one for each of them. Originally this was to be a joint visit with a social worker, but in the end it was just the CPN. Entry to the house was refused, but the CPN returned in the afternoon.

Donald was reluctant to engage with the CPN. Entry was gained and the CPN managed to stay for about 10 minutes. The CPN was briefly able to speak to Margaret. Donald asked her to leave the house.

The CPN fed back to adult social care and no further CPN appointments were scheduled. This was agreed with the social worker who suggested the GP was best placed to engage with the couple.

The memory assessment in mid-February appointment for Donald was cancelled at the request of the CPN, citing Donald's refusal to let anyone into the house. An assumption was made by the CPN that Donald would not agree to assessment until they had engaged the couple over time.

In February a letter was sent to the GP advising that the referral for Donald had now been closed and that he was discharged. Margaret was to remain open to with a plan for longer-term engagement.

### 2.2.4 Views of the family

Margaret and Donald's son David has been the principal contact during the DHR process. Safer Cornwall and the independent chair made contact with them by email advising him and his wife of the commencement of the review. Following an initial phone call at the end of January 2018, a meeting at their home was arranged and took place on 8 March 2018.

During that meeting the chair outlined the DHR process in more detail, confirmed the specific concerns that David had in relation to his parents situation and the things he felt the review should consider. These were known to the chair from David's earlier email to Safer Cornwall and had been incorporated in the terms of reference which were shared with David and his wife during the meeting. They were content with the terms of reference.

The rest of the meeting provided an opportunity for David and his wife to offer further background information and views about Margaret and Donald. What follows is a summary of that discussion, supplemented by information that was gathered from them by CFT in the development of their IMR.

David is a retired Thames Valley police officer. He has two sisters who, like him, live in Buckinghamshire. He confirmed that his sisters did not wish to contribute to the DHR but were happy for him to represent their views.

Margaret and Donald moved to Cornwall 28 years ago. Donald is a retired Police Officer who served in the Thames Valley force. When they first moved to Cornwall the three adult children and their families would visit for holidays and there were frequent phone calls, but over time this level of contact had dwindled and almost completely ceased. David and his wife did visit his parents in November 2016 and it was then that concerns were raised following that visit that led to the increased engagement of primary care and adult social care.

David described his parent's marriage as being 'traditional' with his father and that as he looked back, it was possible to conclude that his father had been quite controlling of his mother and indeed of him and his siblings. He reported that all three children were keen to leave home; indeed he did so at the age of 15 to join the Army.

He described them as not being a close family. He said that his parents never celebrated their wedding anniversary. David described his father's personality as being 'black and white' and that it was 'his way' was to be followed. He said there were no grey areas and that if Donald liked you this would be fine, but if he didn't he would have no tolerance for you.

David said that his mother had never been allowed to learn to drive and that as a consequence she and Donald always had to travel together and she was reliant on him.

David felt that the root of Margaret's difficulties followed a fall some four years previously when she broke her hip. He felt she had never really properly recovered from this. He felt it had affected her confidence and made her more dependent on his father.

David first contacted adult social care in mid 2016 asking for an assessment of his parents, he was concerned that they were not coping as well as they had been. He reports that he had no feedback about this from adult social care, although the IMR reports that he had been advised that an assessment would require his parents consent. He did make contact with the National Association for Retired Police Officers (NARPO) as he felt his father might be more receptive to them. A NARPO officer did visit but was not able to enter the house. The NARPO officer observed Donald to be well dressed and did not identify anything that concerned them. The NARPO officer did not see Margaret during the course of this visit.

David and his wife visited his parents in November 2016. His father was initially reluctant for them do so, saying there was no need. David said that his mother was not engaging in conversation in the way she had in the past and seemed muddled about where she was. He also felt his father was more confused and was also not hearing as well as he had done. He observed that both his parents had lost weight. He urged them to seek an appointment with their GP. He was concerned about their

memory impairment and their ability to cope with daily task such as cooking and bathing.

During a visit after the incident, in March 2017, David also spoke to neighbours who reported a decline in Margaret and Donald and that they had become more socially withdrawn over previous months. There was also a report of Donald's car breaking down and being recovered to a garage away from their home town. A couple of days later Donald walked past his local garage and enquired where his car was, he could not recall it having broken down and being recovered. The local garage were able to locate the vehicle and had it brought back.

It was following this visit in November 2016 that David again contacted adult social care.

David reported that his father is now at a medium secure mental health unit. He and his wife have visited. Donald had experienced heart problems recently but was receiving treatment. David stated that his father had no recollection of the incident.

David and his wife described their shock and disbelief that Donald could harm Margaret as there was no evidence of domestic abuse or violence that they were aware of.

David had outlined five questions/issues that he felt the DHR needed to consider. These are set out below and addressed in the conclusions of this report.

- Once we had ascertained to which GP practice my parents were registered with, following a phone call we were informed that the GP was about to visit as they were classed as being a "cause for concern" due to missed and cancelled appointments and failing to respond to letters or telephone calls from the surgery. We are concerned that the length of time this took to come to light was already impacting on their health and welfare and following this visit a safeguarding alert was made.

- Between the January and February visits were made to my parents by the GP and Social Workers and as per statements read out during the trial, my mother was found to be wearing the same soiled night wear on subsequent visits, which again did not appear to have raised concerns regarding her welfare or any attempt made to change her out of these clothes.

- On several occasions during these visits new bruises were noticed but my father gave the same explanation to the GP and Social workers. Did this also not register concern?

- When the carers were obstructed by my father from entering the house and grounds (we have been informed that he padlocked the gates) following the safeguarding alert, was this not considered serious enough to call the police to gain entry?

- Was the risk of abuse (neglect, physical and/or emotional) and the prevention of this by keeping my mother in her home, considered by the GP and Social Worker?

### 2.3 Analysis from the review of the IMRs

This section of the report provides an analysis of the information received by the panel. Any issues or concerns identified are a reflection of the evidence made available. In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible.

The GP practice with which Margaret and Donald were registered is spread over four sites. It has no domestic abuse policy in place. Other policies are stored electronically and no hard copies are available. There is no process in place to ensure that staff have read and understood those policies. The panels view was that the managerial governance in relation to policies and procedures meant that there was the potential for gaps in knowledge and for inconsistent application of those policies. The lack of a domestic abuse policy represents a significant gap.

The GPs who had most contact with Margaret and Donald had a good knowledge of their health needs and had sought to develop good relationships with them. They sought in particular to respond sensitively and in a timely way.

Although the GPs did not identify any safeguarding concerns prior to the initial home visit in January 2017, they responded appropriately in making a safeguarding alert but their knowledge of the process meant the initial alert was rejected as a result of the incorrect forms being used which caused some delay.

There was no evidence of risk in relation to domestic abuse, although risks were identified in relation to neglect. It was only towards the latter period of engagement prior to the incident that it appears that this possibility was considered as a reason for the bruises and cuts that Margaret had sustained, but even then it does not appear that it was sufficiently considered, although the GP did refer to this possibility in the records.

Communication between the GP surgery and adult social care overall was good. The undertaking of joint visits is an example of good joint working and liaison. Decisions relating to actions appear to have taken jointly.

Although clinical assessment of Margaret was difficult, if a fuller assessment had been made the option of hospital or nursing home admission might have been given greater prominence as an intervention option, at least to alleviate the presenting concerns about neglect.

As might be expected, the approach of the GPs was to focus on the health needs of Margaret and Donald and to view their situation through a clinical lens. This rather narrow focus was ameliorated to some extent by the joint visits with social workers,

but it is the panel's analysis that the GPs looked to the social workers for expert knowledge that they felt they did not possess in relation to social circumstances.

The panel can find no evidence of a formal risk assessment process being in place or used by primary care. While it is clear the GPs had concerns this does not appear to have led to a more formal risk assessment process being used.

The panel agrees with the IMR analysis that speedier escalation of consideration about a possible move out of the home for Margaret would have been beneficial. It does not appear that this was discussed or contemplated in sufficient detail.

Donald was persistently reluctant to allow the GP (and others) into the home. This would render traditional approaches to care provision more difficult as was evidenced by the rejection of the carer's who attempted to provide support. It is not clear that there was ever a 'plan B' to overcome this reluctance to admit professionals to the home or to address the unwillingness to engage despite the presentation of issues that were causing concern both the GP and the social worker.

The two GPs involved in the case took care to brief each other and to ensure each had an up to date knowledge of the situation as it was at the time.

The panel noted that concerns were raised by the practice Manager about Margaret and Donald not collecting medication and prescriptions. A previous SAB (Safeguarding Adults Board) serious case review conducted in 2013 in Cornwall identified a pattern in GP practices in Cornwall whereby no one notices if vulnerable patients with serious health concerns do not request repeat prescriptions for their long term health conditions; meaning some patient's health is not followed up or reviewed by the GP. Recommendations for changes to systems and processes were made. Although in this case the practice manager did pick up the non-collection, there remains no formal process in place.

ASC did not consider domestic abuse to be a risk. They attributed Donald's behaviour to him holding strong views about his role in the household. This meant that domestic abuse was not adequately considered as a potential factor.

There were issues in gaining the trust of Donald and working with him to accept that help and support would be beneficial to him and to Margaret. His reluctance to engage was long standing and he had a history of not allowing others to enter the home. He had also resisted his son's attempts to gain support for him.

The panel agrees that professionals involved from ASC showed an over optimistic view of their ability to intervene and in relation to the actual situation as it was presented. Given the history that was known and the presentation, it is the panels analysis that an acceptance of Donald's reluctance to engage and his explanations for his wife's condition and ability to cope were too readily accepted and wider consideration of abuse was not given by all agencies involved.

The request for an earlier assessment of social care needs from David was not undertaken due to lack of consent from either Margaret or Donald. At first view this seems problematic, given the clear concerns.

Where repeated referrals for assessment are made and consent is not obtained, the case must be discussed with a Team Manager who would then make a decision to override the need for consent. The requirement for consent may be overridden if a risk of neglect or abuse is suspected. The panel's analysis is that this did not happen in this case.

Although there were no overt or definitive signs of domestic abuse, ASC staff did not adequately record the rationale for their assessment of risk and why the range of indicators led them to believe that domestic abuse was not present.

The interventions put in place did not achieve their aim, this was due to Donald's refusal to allow carer's entry to the house. The panel's analysis is that there was no back up plan to mitigate this and that consideration of alternatives was not sufficiently advanced.

The use of the Mental Capacity Act does not appear to have been considered to have been appropriate in this case. However, the panel's analysis is that staff used the presumption of capacity (in line with the principles of the MCA) and did not seek to respectfully challenge given the presentation of Margaret, Donald, their circumstances and the concerns raised which meant that the use of the Mental Capacity Act was not fully thought through.

There were delays in the receipt of the safeguarding alert from the GP, this was due to it being on the wrong form and this resulted in a delay in it being processed and considered.

An assumption was made by the CPN that Donald would not agree to assessment until they had engaged the couple over time. The offer of assessment should have been made.

There were several examples of professionals recording in their notes that Margaret was wearing soiled or dirty night clothes. Although this was regularly noted, it is clear from the IMRs, that other than on one occasion when a social worker helped Margaret to change her clothing, this did not result in any specific action.

The panel's analysis is that although this was recorded, it did not appear to result in any direct escalation in relation to review of risk in relation to neglect or to any other form of response to address this.

The Early Intervention Service did not record the advice that they gave to adult social care, which includes an observation that the situation was similar to a case presented on the domestic abuse training, and were overly reliant on ASC to document their discussions and decisions about assessment.

There was an imbalanced focus on health issues, rather than social circumstances and the challenges in the relationship between Margaret and Donald. This meant that other factors were not adequately considered.

# Section Three
# Conclusions

## 3.1 Conclusions

The conclusions presented in this section are based on the evidence and information contained in the IMRs and the panel's analysis.

Margaret and Donald were an older couple who were experiencing difficulties in coping with the onset of memory loss and other physical health issues. They were a private couple, but in the two months prior to the incident they had become increasingly socially isolated and withdrawn.

The relationship between Margaret and Donald is characterised by his dominance within it. In part this has been ascribed to what are sometimes described as traditional roles within a marriage. The panel's conclusion is that some of Donald's behaviour could, in current terms, be viewed as controlling. In particular his habit of speaking on behalf of his wife when she was questioned by professionals, his reluctance to allow professionals into the house and his manner when talking to his wife are examples of this. It is the panel's judgment that it is hard to ascribe current terms and norms in such situations, given that different social and cultural norms were accepted in the past. Nonetheless it is the panel's conclusion that professionals were too willing to rationalise Donald's controlling behaviour and to accept his assurances.

However, the panel concluded that there was an element of controlling behaviour that in current legislation might well fall within the description of domestic abuse. Having said that, the panel has not found any evidence of prior domestic violence or abuse relating to Margaret in this review, either from the IMRs received or the wider work of the panel.

Donald was consistently reluctant to allow professionals to visit him and his wife at home, or to allow carers to provide support. He appears to have had a strong desire to be seen to coping. It is not clear whether this was due to the notion of pride, which often precludes older people from actively seeking or accepting help, or whether there was another reason.

When home visits from professionals took place, Donald was reluctant to allow them to speak with Margaret alone. This meant that there was no opportunity to conduct an individual assessment of her needs or to ask her any questions that she might have responded to differently if she had been speaking in private. This has been a theme of other DHRs concerning older people. Opportunities for individual

assessment and discussions are crucial to gaining a true picture of a persons' situation.

Despite the engagement of social work professionals, the overwhelming focus was upon the health needs of the couple. This narrow lens meant that the social circumstances, although considered, did not, in the panel's view, have sufficient prominence in professionals thinking.

The panel has concluded that there were clear signs of neglect in relation to Margaret. There are a number of examples when she was found to be wearing soiled nightwear. On only one occasion did a professional help her to change her garments. There were also examples of the bed being soiled and of Margaret having bruising and cuts on various parts of her body. Although these were noted and formed part of the rationale for raising a safeguarding alert, the panel has concluded that this did not result in any immediate escalation of concerns or immediate action to mitigate the neglect that was clearly evident. The panel regards this as a significant missed opportunity.

Professionals seemed, to the panel, to be too willing to adopt an optimistic view about how the couple were coping and to accept the assurances of Donald that he could manage and that he and his wife did not require assistance. There was a lack of deeper questioning about their circumstances.

The practice manager at the GP surgery identified the non-collection of prescriptions and medication. Adults who are more vulnerable due to care and support needs and, or, older age and poor physical health are less likely to be using primary care health services to meet their health needs. The current prescribing systems do not take account of this, leaving vulnerable individuals to go 'unnoticed' when they don't engage. Perversely the current system works for adults who can meet their own needs with minimal support and who actively engage with health care services. The current systems do not support adults who often have the most need and potentially this is a form of discrimination. That non-collection was identified by the practice manager was fortuitous but it was not part of an established process or system, despite previous reports highlighting the need for such a process.

The safeguarding process does not appear to have been fully understood. The panel's conclusion is that the completion of the appropriate form did not take place in the first instance and this resulted in a delay in the safeguarding team actioning the alert. This is a matter of process, but one that needs to be resolved to ensure that professionals can make such alerts swiftly and appropriately.

It was the GP that managed the safeguarding alert. While the panel concludes that this was appropriate, it would have been possible to advise the couple's son that he

could make such an alert. This could have been done when he first contacted adult social care in 2016.

Margaret and Donald were not known to CFT Adult Community Services, so CFT was not aware of Council led Adult safeguarding processes until after the referral to the Complex Care and Dementia Service in February 2017. CFT adult safeguarding team was not aware of the Council's involvement with the Adult Safeguarding processes until after the incident.

Donald did not have a definable mental health problem or mental illness. His cognitive impairment was not fully diagnosed until after his arrest, when it was determined he was experiencing Alzheimer's Disease.

Recording of decisions and updating of notes, in particular by ASC and CFT staff was variable in quality with some examples of non-recording. This issue arises in almost every DHR or other form of serious incident review. The panel concludes that accurate and timely recording of actions and decisions is a fundamental practice standard for all professionals that in this case fell below what should be expected.

The issue of consent to social care assessment featured in the panel's discussions. In this case it is the panel's conclusion that the use of provisions in the Care Act 2014 were not considered and that as a result, the provisions in relation to intervention when a risk of neglect is thought to be present were not used to enable an assessment. This was a missed opportunity to intervene.

The panel concludes that there were opportunities to act earlier. There was insufficient consideration of removal of Margaret from the home environment, either to hospital or to residential or nursing home care, even if for a short time. Such an action would have reduced risk and allowed for a more thorough assessment of need and risk. The panel concludes that there were missed opportunities to take such pro-active action.

The panel concludes that there is evidence of good joint working and communication between adult social care workers and the GPs. This is evidenced by the number of joint meetings and joint home visits that took place. Regular updates were provided between the adult social care and the GPs; this meant those involved were well informed about each other's views and engagement in the case. However, the roles and responsibilities of each do not appear to have always been well understood.

The panel concludes that insufficient consideration was given to the use of the Mental Capacity Act in relation to both Margaret and Donald. The Act provides a well-established framework for assessing the capacity of individuals to make decisions. The use of the Act to conduct an assessment of capacity would have

provided clear evidence of capacity and enabled other forms of intervention.

The lack of a domestic abuse policy within the GP practice is a cause of concern. Significant work has been done in Cornwall to promote the development and provision of such policies, clearly there is more to be done. Other DHRs have drawn attention to this and the panel concludes that this should no longer be seen as simply a local issue and that national agencies such as NHS England should be encouraged to take a lead on this. Previous DHRs including at least two conducted by the Independent Chair of this DHR have made recommendations on this matter.

The lack of hard copies of policies and gaps in the governance systems within the GP practice remain problematic. The panel concludes that there is no adequate system for ensuring GP Practice staff have read, understood and are applying policies.

The use of routine enquiry in relation to domestic abuse appears to remain variable. This is not a position that is unique to Cornwall, but nonetheless, the panel concludes that this did not take place in this case.

Taking a broad view of these issues, it is clear that this was an example of an older couple, clearly experiencing memory impairment and physical health problems that led to them being unable to cope without support.

The DHR panel was clear that there is a need for increased awareness of domestic abuse amongst older people, and better understanding of the potential interrelationship with economic abuse, coercive control and dementia.

It is the DHR panel's overarching conclusion that opportunities to intervene were missed. There was clear evidence of neglect. Although the bruises and cuts that were present on Margaret's body could have resulted from falls, they may also have been the result of domestic abuse. The panel has concluded that this possibility was not given sufficient prominence in professionals' thinking.

The impact of deteriorating mental and physical health on older people can be significant. The desire of older people to maintain their independence, the notion of pride and not wishing to accept help are particularly relevant. They are factors that are increasing in prominence as the population ages, people live longer and have to cope and adapt to changes in their physical and mental health. This can undoubtedly lead to them experiencing pressures and stresses that if not addressed can contribute to the occurrence of domestic abuse and violence. This is an issue that goes much further than just this case and is a matter that all public services will need to consider and address in relation to the way in which they attempt to support vulnerable people.

# Section Four
# Recommendations

## 4.1 Recommendations

This section of the Overview Report sets out the recommendations of the DHR panel.

### 4.1.1 DHR recommendations

The DHR panel therefore offers four recommendations for action:

1. We recommend that professionals across Cornwall be updated in their training in relation to domestic abuse and violence to ensure a thorough and up to date knowledge. Moreover, they should be encouraged in the use of routine and direct enquiry about domestic abuse.

2. We recommend that the provision of a domestic abuse policy should be a requirement for all GP practices. At local level this should involve an initial audit of practices led by either NHS Kernow or NHS England SW. In addition we recommend that NHS England SW raise the wider issue of domestic abuse policy provision with NHS England nationally so that steps can be taken to ensure such policies exist and to assist in a consistent approach across the country.

3. We recommend that adult social care write to GP practices and other agencies across Cornwall to provide clarity about safeguarding processes, in particular to provide clear guidance about the use of forms or templates to avoid mis-communication and incorrect processes that could cause delay.

4. We recommend that adult social care review its internal processes and guidance in relation to the application of the Care Act 2014, in relation to the provision of assessments of vulnerable people who are or are suspected of being at risk of neglect, and where necessary make changes to this guidance to ensure practitioners are clear about when issues of consent may or may not be overridden.

### 4.1.2 IMR Recommendations

**NHS England – Primary Care IMR recommendations**

- All staff should be required to sign that they have read and understood policies
- A Domestic Violence Policy should be in place in the GP surgery
- Clear threshold for the completion of a written risk assessment for inclusion in the GP notes, should be identified
- Development of a mechanism that would highlight patients receiving regular medication, where it had not been picked up for several months
- Minuting of all meetings where patient care of safeguarding issues discussed and information shared with clinical staff not at the meeting.
- All letters received to be date stamped on receipt from other organisations, including those where it reads ”date as postmark”
- The date and time of telephone calls from relatives should be recorded.
- The Re-instigation of regular multi agency meetings at the GP practice, to enable pro-active case discussion that informs future planning to promote positive outcomes and to minimise risk.
- The development of a shared risk assessment for Margaret
- That District Nursing services have clearly defined criteria for their role with the frail and elderly population where there is a known medical condition ie. Diabetes or that the person is inactive and requires pressure area assessments

**Cornwall Council IMR recommendations**

- Questionnaire needed to understand the current level of knowledge in Adult Social Services in relation to domestic abuse amongst the elderly and in light of results produce bespoke training to address learning needs.
- Recommend a researcher to undertake literature review of domestic abuse amongst the elderly and use this to provide discussion at peer and team leaning events.
- Propose learning from review to be shared widely and County Wide Annual Social Work Conference
- Undertake caseload analysis across comparative Councils
- Implement a mechanism that makes it a requirement to review any initial risk assessment within Safeguarding Strategies
- Joint Risk and Decision Making training across Health and Social care services
- Knowing who how and when to refer a decision to the Court of Protection. Joint training awareness workshop for Health and Social Care professionals with legal partners

**CFT IMR recommendations**

- The Early Intervention Service (now called Home First) Standard Operating Policy to be reviewed and updated to include clear criteria and referral process for:
    - Assessment
    - Intervention
    - Functions

  To be disseminated to all relevant external agencies by 30.6.18 so all agencies have guidance regarding the role and remit of Home First

- Record Keeping; risk assessments and decision making rationale – The Complex Care and Dementia Team Manager will explore with their team the practice of completing risk assessment and core assessment as per policy, to understand wider team culture. The Team Manager will through supervision undertake random audit of completion of risk assessments. Evidence of written rationale of decision making in progress notes. Dependent on findings, compliance audits might be necessary across the team, to ensure record keeping meets standards as required in Clinical Record Keeping Policy (Dec 2017). This should be disseminated across all teams in CFT.

- Adult Safeguarding supervision – Adult Safeguarding Lead in conjunction with Locality Managers to evaluate the adult safeguarding supervision provision available in and to the Complex Care and Dementia teams, and assess what additional provision is needed to ensure adequate expert challenge is embedded in clinical practice, to be relayed to Chief Operating Officer for consideration by 01.06.18

- MDT minutes – All services must record a brief summary of any clinical discussions held in MDT by 01.05.18 using the SBAR Tool: Situation-Background-Assessment-Recommendation. This to be recorded as a minimum in the patient's clinical record. The MDT template to be amended to record this information. The Nurse Consultants for each area to measure compliance and quality of information summarised.

- Routine Enquiry - Following the expansion of CFT to include Adult Community Services CFT to re-visit the roll out of Routine Enquiry into Domestic Abuse across all service areas. To be discussed in Education Delivery Group CFT to use Quality Improvement Model for review and implementation. Action plan and progress monitoring to be agreed.