BE SAFE BOLTON STRATEGIC PARTNERSHIP

And

BOLTON SAFEGUARDING ADULTS BOARD

DOMESTIC HOMICIDE REVIEW (DHR)

Incorporating

SAFEGUARDING ADULTS REVIEW (SAR)

Margaret

Died March 2019

OVERVIEW REPORT

23rd February 2022

Chair and Author Paul Cheeseman

Supported by Ged McManus

CONTENTS

1. INTRODUCTION

1.1 This report of a Domestic Homicide Review[1] [DHR] examines whether agencies could have identified if Margaret, a resident at address 1 in Bolton, was at risk from her husband Aaron who killed her in March 2019. This report also includes the results of a Safeguarding Adult Review [SAR] conducted in conjunction with the DHR. The SAR examines the care and support provided to Margaret and Aaron and considers whether partner agencies could have worked more effectively to protect them.

1.2 In February 2019 Aaron was admitted to hospital in Bolton after concerns he was becoming confused. He was diagnosed with acute kidney injury and was experiencing delirium. After treatment, his kidney injury was resolved. While Aaron was in hospital Margaret disclosed to a community nurse that Aaron had perpetrated domestic abuse on her, and she did not feel safe with him.

1.3 During the hospital discharge planning process a number of discussions took place between social workers, Margaret, and her daughter Mary Ellen. Aaron was then discharged from hospital to address 1 with a package of care. About 08.30hrs, a few days after his discharge from hospital, Aaron made a telephone call to North West Ambulance Service [NWAS]. He said he had stabbed Margaret after they had argued. Greater Manchester Police [GMP] were informed and paramedics and police officers visited address 1 and found Margaret deceased.

1.4 Aaron was arrested and while in custody his mental health was assessed. He was unfit to be detained in police custody and was removed to hospital under the provision of S2 of the Mental Health Act 1983 [See Appendix E]. He was later charged with the murder of Margaret. Psychiatric assessments of Aaron concluded that, because of dementia, he was unfit to enter a plea or stand trial before a court. Instead, in late 2019, a finding of fact hearing was held before a jury at a Crown Court. The jury found Aaron had committed the act he was accused of. The judge imposed a hospital order[2] on Aaron.

1.5 In addition to agency involvement the review will also examine the past history 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. By taking a holistic approach,

[1] Section 4 of this report sets out in more detail the purpose of both a DHR and SAR and the terms of reference the review panel adopted.
[2] Under S37 of the Mental Health Act 1983 is an alternative to a prison sentence and a court can make an order that a person is detained in hospital if it thinks this is the most appropriate way of dealing with them.

the review seeks to identify appropriate solutions to make the future safer for people at risk from Domestic Abuse and Violence[3].

1.6 The key purpose for undertaking domestic homicide reviews 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.

1.7 The DHR panel wish to extend their condolences to the family and friends of Margaret on their tragic loss. Having read the DHR report, Mary Ellen said;

'Margaret was a fighter and remained independent until her life was taken at the hand of Aaron. I would hope and pray that other families never have to go through the anguish of losing a loved one in this manner'

[3] Home Office Guidance Domestic Homicide Reviews December 2016.

2. CONFIDENTIALITY

2.1 This table shows the age and ethnicity of the victim, the perpetrator of the homicide and other key individuals. The pseudonyms were agreed with Margaret's family.

Name	Relationship	Age	Ethnicity
Margaret	Victim and wife of Aaron	80	White British
Aaron	Perpetrator and husband of Margaret	88	White British
Mary Ellen	Eldest daughter of Aaron and Margaret	Adult	n/a
Ron	Son of Aaron and Margaret	Adult	n/a
May	Youngest daughter of Aaron and Margaret	Adult	n/a
George	Grandson of Aaron and Margaret	Adult	n/a
Shirley	Granddaughter of Aaron and Margaret	Adult	n/a
Address 1	Home address of Aaron and Margaret and scene of the homicide.	n/a	n/a

3. TERMS OF REFERENCE

3.1 The Panel settled on the following terms of reference at its first meeting on 14 October 2019. They were shared with Margaret's family who were invited to comment on them.

3.2 The review covers the period from 1 November 2018 to a day in late March 2019 when the homicide occurred. Agencies held little information of relevance about either Margaret or Aaron and 1 November 2018 was felt to be reasonably proximate to the point when Aaron's mental well-being started to deteriorate.

The purpose of a Domestic Homicide Review [DHR][4]

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.

The purpose of a Safeguarding Adult Review [SAR]

The criteria for holding a SAR is set out in Appendix A. Bolton Safeguarding Adults Board[5] considers the purpose of a SAR is to:

[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

[5] https://www.bolton.gov.uk/downloads/file/1965/safeguarding-adult-review-practice-guide

- Establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk.
- Identify how lessons learned will be acted upon and what is expected to change as a result.
- Disseminate lessons learned, promoting effective practice and improvement action to minimise the risk of future deaths or serious harm occurring.

Safeguarding Adults Reviews are not to apportion blame, or to further investigate the death or injury.

Specific Terms

1. Did your agency identify that either Margaret and/or Aaron were adults needing care and support? How and when were their needs identified and what services did your agency provide to them both?

2. Did your agency have any information that indicated Margaret and/or Aaron might be at risk of either neglect or abuse including the risk of domestic abuse? What did your agency do in response to such information?

3. Did your agency consider conducting a Mental Capacity Act assessment on Aaron?. If so, what prompted this and what was the outcome?

4. Did your agency consider whether use of the Mental Health Act may be appropriate with reference to Aaron? If so, what prompted this and what was the outcome?

5. Did your agency have any information that Aaron might present a risk to anyone else other than Margaret? What did your agency do in response to such information?

6. Did your agency document an assessment of any risk Aaron might present to Margaret or any other person? If not, why not?

7. Did your agency share any of the information above with any other agency including making a referral to MARAC? If not, why not?

8. What involvement (if any) did your agency have in relation to the decision not to conduct a S42 safeguarding enquiry in respect of Margaret? Why was that decision made? Was that decision in compliance with the Care Act and/or your multi-agency Safeguarding policy?

9. What involvement (if any) did your agency have in relation to the decision to hold a multi-disciplinary meeting to discuss the concerns that had been raised in respect of Margaret and Aaron? Why did that multi-disciplinary meeting not take place? Did the decision not to hold a multi-disciplinary meeting have an impact upon the risk that Margaret faced?

10. What involvement (if any) did your agency have in relation to the decision to discharge Aaron from hospital on 20 March 2019? Who was involved in the discussions and decisions to discharge Aaron (including any family members)? What assessments were made in relation to that decision and how were they documented?

11. Did any assessments relating to Aaron's discharge from hospital identify that Margaret was at risk from Aaron? If any risk was identified what plans did your agency have to remove, reduce, or manage that risk?

12. Were the services your agency offered Margaret and Aaron accessible, appropriate, and sympathetic to their needs? Were there any barriers in your agency that might have stopped Margaret from seeking help for the domestic abuse?

13. What knowledge or concerns did Margaret's family or friends have about her relationship with Aaron? Did they have any information which might have indicated there was any domestic abuse in the relationship? If so, did they know what to do with such information?

14. Was there any evidence that Margaret and/or Aaron had issues with managing debt? If so, to what extent did that impact upon their relationship?

15. What were the circumstances of any housing application that Margaret and/or Aaron made? To what extent were the couple's living arrangements impacting upon their relationship?

16. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Margaret and Aaron?

17. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Margaret and Aaron, or on your agency's ability to work effectively with other agencies?

18. How effective was your agency's supervision and management of practitioners involved with the response to the needs of Margaret and Aaron and did managers have effective oversight and control of the case?

19. Were single and multi-agency policies and procedures, followed; are the procedures embedded in practice and were any gaps identified?

20. What learning has emerged for your agency?

21. Are there any examples of outstanding or innovative practice arising from this case?

22. Does the learning in this review appear in other domestic homicide reviews commissioned by Be Safe Bolton Strategic Partnership?

4. METHOD AND TIMESCALES

4.1 On 1 April 2019 GMP notified Be Safe Bolton Strategic Partnership of the death of Margaret. The following day letters were sent to agencies requesting they secure their files and provide chronologies of their contact with Margaret and Aaron.

4.2 On 7 May 2019 Be Safe Bolton Strategic Partnership [Core Screening Panel] met to consider information provided by twenty-two agencies following which they determined the death of Margaret met the criteria for a domestic homicide review [DHR]. The panel also agreed that a recommendation should be made to Bolton Safeguarding Adults Board to hold a SAR which should be run in parallel with the DHR.

4.3 Paul Cheeseman was appointed as the independent Chair and author and a scoping meeting was held with him on 24 June 2019. The first of 5 panel meetings were held on 14 October 2019. The review panel determined which agencies were required to submit written information and in what format.

4.4 Because of delays in the criminal justice processes involving Aaron, the Chair of Be Safe Bolton Strategic Partnership agreed to extend the completion date of the DHR until 31 March 2020 and the Home Office were notified in writing.

4.5 The DHR panel carefully considered the material provided by agencies and the contributions made by the family of Margaret [see section 5 post] to establish what it told them about her life and her relationship with Aaron. They identified a number of issues and learning points for agencies which are considered in detail within section 15 of this report.

4.6 Following consideration of the written material the panel invited key practitioners from each of the agencies to attend a workshop. Many of these practitioners had been involved in caring for either or both Margaret and Aaron. Practitioners studied the chronology of events and discussed key issues relevant to the case. They then identified key learning points for themselves and their agencies. Practitioners attending the event acted with openness and integrity and with a willingness to build on the lessons they identified in their future practice.

4.7 Following the DHR panels deliberations and the practitioner event a draft overview report was produced which was discussed and refined at further panel meetings. Unfortunately, before the panel could meet for the 4th time [scheduled for 11 March 2020], the COVID-19 19 pandemic precluded

further face to face work. Because of demands upon local agencies a decision was taken to suspend work on the review. The family were informed of this decision by the Chair who maintained contact with them and kept them updated.

4.8 Work resumed on the review in August 2020. The Chair of Be Safe Bolton approved revised completion dates of 31 December 2020 and then 31 March 2021 and the Home Office were informed of both. A virtual panel meeting [the 4th] was then held using the internet. A further version of the report was then circulated by e mail and refined until the panel were satisfied it could be shared with the family which took place in late November 2020.

4.9 Because of continuing travel restrictions associated with COVID-19, the chair was unable to travel and meet with the family. Instead, he maintained contact with them by telephone and e mail. The family provided written feedback on the report and on particular issues concerning the way in which professionals dealt with Margaret.

4.10 Following the receipt of feedback the panel met virtually with three members of the family on 10 February 2021. This meeting provided the family with the opportunity to explain to the panel how they had been affected by the homicide. Feedback provided by the family to clarify specific events has been included in the report where that event occurs. Feedback provided by the family about their opinions and feelings relating to the DHR are included within the conclusions to this report at section 15.2.

4.11 The Chair presented this report to Bolton Be Safe and Bolton Adult Safeguarding Board on 23 March 2021. They approved it and the report was then sent to the Home Office Quality Assurance Panel.

5. INVOLVEMENT OF FAMILY

5.1 The DHR Chair wrote to the family of Margaret through Ron and invited them to contribute to the review. The letter included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA) leaflet.

5.2 The family of Margaret is being supported by a member of Victim Support's Homicide Service and also by a member of Hundred Families[6]. On 8 November 2019, the DHR Chair met with the family of Margaret at the home of Mary Ellen. Also present at the meeting were Ron, Shirley, and George. Also in attendance was the Victim Support Officer and GMP Family Liaison Officer.

5.3 The author gave the family the panel's condolences on the tragic loss of Margaret and provided them with information about the DHR and SAR process. The family were keen to be involved and were able to provide useful background information about Margaret and Aaron which is included within the body of the report. The family were invited to provide a tribute to Margaret, select pseudonyms and were invited to meet with the DHR panel.

5.4 May lives in the South East and was not able to attend the meeting although she was keen to contribute to the review. The Chair of the DHR spoke to her by telephone on 15 November 2019: he also gave her the panel's condolences on her loss and information about the DHR and SAR process. In turn she provided useful information about her parents which is included within the body of this report. She agreed to maintain contact with the Chair by telephone and e mail because of her distance from Bolton.

5.5 When the panel had prepared and agreed a draft report it was shared with the family of Margaret and the Victim Support Officer working with them. The family also held a virtual meeting with the panel [see paragraph 4.8 et al].

5.6 Family members provided a comprehensive picture concerning the lives of Margaret and Aaron. Further useful information was unlikely to be gleaned by widening the scope of engagement to others beyond the victim's family. The homicide enquiry that preceded the DHR had already explored these avenues and found nothing further that would have advanced the work of

[6] Hundred Families is a charity that provides advocacy, accurate information and practical advice for families bereaved by people with mental health problems. www.hundredfamilies.org

the DHR. In addition, the impact of Covid 19 and the need to minimise face to face contact, particularly during periods of national lockdown, restricted personal contact with others outside the family.

6. CONTRIBUTORS TO THE REVIEW.

6.1 Twenty-two agencies responded to the initial request for information. Only a small number of agencies had records of contact with either Margaret or Aaron. This table show the agencies who provided information relevant to the review.

Agency	IMR[7]	Chronology	Report
Greater Manchester Police [GMP]			√
Greater Manchester Fire and Rescue Service [GMFRS]			√
Bolton Council Adult Services	√	√	
Bolton NHS Foundation Trust	√	√	
NHS Bolton CCG	√	√	
Greater Manchester Mental Health NHS Foundation Trust	√	√	
Bolton Housing Options			√

[7] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review which includes a chronology.

7. THE REVIEW PANEL MEMBERS

7.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Sharon Boardman	Deputy Adult Safeguarding Lead	Greater Manchester Mental Health NHS Foundation Trust
Paul Cheeseman	Chair and Author	Independent
Zylla Graham	Det. Inspector	GMP Serious Case Review Team
Suzanne Hilton	Chief Executive	Age UK
Tony Kenyon	DHR Lead	Be Safe Bolton
Martina Kingscott	Assistant Director of Nursing	Bolton NHS Foundation Trust
Paul Lee	Director of Operations	Integrated Care Partnership Bolton Council[8]
Ged McManus	Support to Chair	Independent
Mike Robinson	Associate Director of Governance and Safety	Bolton CCG
Gill Smallwood	Chief Executive	Fortalice [Providing front line services for women, families and children affected by domestic abuse and violence]
Rachel Tanner	Managing Director	Integrated Care Partnership Bolton Council
Charlotte Thaker	Manager	Bolton Adult Safeguarding Board
Michelle Tynan	Advisor on Adult Social Care	Co-optee

7.2 The Chair of Be Safe Bolton Strategic Partnership was satisfied the panel Chair was independent. In turn, the panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

[8] Paul Lee replaced Rachel Tanner as the Integrated Care Partnership panel member from January 2021.

7.3 The panel met 5 times and matters were freely and robustly considered. Outside of the meetings the Chair's queries were answered promptly and in full.

8. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

8.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and authors. In this case the Chair and author were the same person.

8.2 The Chair completed thirty-five years in public service [British policing and associated roles] retiring from full time work in 2014. He has undertaken the following types of reviews: Child Serious Case Reviews, Safeguarding Adult Reviews, Multi-Agency Public Protection Arrangements [MAPPA] Serious Case Reviews and Domestic Homicide Reviews. The Chair has not worked for any agency providing information to this review. He previously undertook a DHR review in Bolton in 2016.

8.3 The chair was supported by Ged McManus, an independent practitioner, who has chaired and written previous DHRs and Safeguarding Adult Reviews. He is currently Independent Chair of a Safeguarding Adult Board in the north of England and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England.

9. PARALLEL REVIEWS

9.1 Her Majesty's Coroner for Bolton opened and adjourned an inquest into Margaret's death. On 20 May 2019 the partnership notified HM Coroner by letter that a DHR/SAR would be undertaken.

9.2 GMP completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

9.3 The panel are not aware that any other agency is undertaking reviews connected with the death of Margaret.

10. EQUALITY AND DIVERSITY

10.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

10.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if—

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[9]

10.3 Margaret and Aaron were born in the United Kingdom and their ethnicity is White British. They both spoke and wrote English. There is no indication either of them required support when expressing a view orally. Margaret was literate and was able to use text services as well as conventional means of written communication. While able to read and write, Aaron was not as skilled in techniques for written communication.

10.4 Margaret's gender is considered to be a significant factor in her abuse. Domestic abuse is a gendered crime which is deeply rooted in the societal inequality between men and women. Women are overwhelmingly the victims of domestic abuse and men the perpetrators.

'Women are more likely than men to experience multiple incidents of abuse, different types of domestic abuse'[10]

10.5 Margaret had some physical health issues and was known to use a wheelchair for mobilising. Her disability is also considered to be a significant factor in her being a victim of domestic abuse.

[9] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[10] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/

'Studies have shown that disabled women are twice as likely to experience domestic abuse'[11]

A study published by Public Health England[12] also found that disabled women are significantly more likely to experience domestic abuse than disabled men.

10.6 Disabled victims of domestic abuse like Margaret also face additional barriers to reporting their experiences. The Public Health England Report found these barriers prevent disabled people from accessing domestic abuse services and health care services and the barriers are often related to disabled people's knowledge of domestic abuse services, to the needs and experiences of disabled people, and to the accessibility of domestic abuse services[13].

10.7 Nothing was revealed in the notes of her contact with agencies that indicated Margaret lacked mental capacity.

10.8 Aaron was more ambulant and used sticks and a scooter to mobilise. While there is no evidence that an agency undertook a Mental Capacity Act assessment[14] with him, in the weeks before the homicide there is evidence he suffered from delirium which may have resulted in him having a mental impairment as specified in Section 6 of the Equality Act 2010. Following his arrest for the murder of Margaret he was detained in hospital under S2 of the Mental Act 1983. He was later assessed as suffering from dementia and consequently was not well enough to enter a plea or stand trial at court.

[11] https://safelives.org.uk/knowledge-hub/spotlights/spotlight-2-disabled-people-and-domestic-abuse

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf

[13] Op Cit P17

[14] Mental Capacity Act 2005

11. DISSEMINATION

11.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Be Safe Bolton Strategic Partnership Board
- Bolton Safeguarding Adults Board
- Office of the Mayor for Greater Manchester
- All agencies contributing to the review

12. BACKGROUND INFORMATION

12.1 Most of the information in this section was drawn from the meeting the Chair held with the family and his telephone conversation with May.

Background of Margaret

12.2 Margaret was born in Farnworth [Bolton]. She was an only child. She received a secondary education and after leaving school became a nursing cadet. She remained in nursing and became a ward sister at a [now closed] hospital in Astley near Wigan. Latterly she worked for a short period nursing in the private sector before retiring.

12.3 Margaret suffered poor health. Mary Ellen said Margaret suffered from spinal stenosis and was also paraplegic, so she was not able to use any walking aids. She mobilized in an electric wheelchair. Margaret also suffered from bronchiectasis and aspirate pneumonia. She had previously suffered from 2 small strokes. Because she needed the use of a wheelchair she had adaptions in the house such as a lift. She also had a condition which meant she aspirated her food. She went into hospital for treatment and was fitted with a PEG tube[15]. This improved matters for her, and the family say that in the last two years of her life she was much better physically than she had been before: she put weight on and was coping well with her health.

Background of Aaron

12.4 Aaron was born in Tyledsley [Manchester] and had two sisters [both now deceased]. He left school when he was quite young. He was not a well-educated man although he could read and write. He worked in the building trade and was a scaffolder.

12.5 The family described Aaron as Margaret's carer. Although he had knee replacements, suffered from Osteomyelitis[16] and needed the use of sticks and a scooter, the family said he was physically fit. He went out 3 times a day to walk the dog.

[15] PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach.
[16] Osteomyelitis is an infection of the bone, a rare but serious condition.

Margaret and Aaron's Relationship

12.6 Margaret and Aaron had been married for 59 years and had lived together at address 1 for 47 years. This was a property they owned and on which there was no mortgage. Ron and Mary Ellen described a happy family upbringing. They had good memories of family holidays and as children said they wanted for nothing. They had no childhood memories of their parents fighting or arguing. They both left home and their younger sister May remained with her parents for some time before moving out. She had a different perspective of her parent's relationship which is described later on in this section.

12.7 Ron and Mary Ellen said their parents had been heavy drinkers. They suggested they were possibly at the level of being functioning alcoholics. They stopped drinking [and smoking] completely several years ago after their GP had to have a liver transplant which shocked them both. Ron and Mary Ellen felt the absence of drink was a turning point for the relationship between their parents.

12.8 Margaret was the person who managed the money in the household. The family said that Aaron was a saver and Margaret was a spender. Aaron was said to be obsessed with saving and in one conversation Ron recalled asking his father why he was hording money. In contrast Margaret was very generous although the family say she was also someone who spent money on what they described as rubbish.

12.9 Because she could not manage money well, she got herself into a lot of debt. May told the panel she loaned her mum the sum of £5,000 to pay off debts which Margaret repaid in instalments over 12 months. The day Aaron went into hospital Margaret tried to get into his shed looking for his money. She later lost the shed keys and told him this during a conversation on the telephone while he was in hospital. Shirley felt this could have angered Aaron as he was very protective over his shed.

12.10 The family say Aaron never contributed to the running of the house. One of the issues the family noticed was that Margaret bought him lots of fancy foods out of the money she had for managing the house. However, he never contributed towards this. The family asked Margaret why she did this, if he did not give her any money. After that Margaret stopped buying Aaron food and also cancelled the Sky TV contract. He started to self-neglect and the family say he was eating poor quality meals.

12.11 The family say Margaret and Aaron used to swear at each other and could be verbally abusive. Neither would give way to the other. An example of the

tension between the couple was that, for several winters, Aaron said someone was turning the boiler controls up in the house. Margaret denied that it was her and there were even discussions about having the controls sealed to stop this happening again. The family say it got to the stage where neither Margaret nor Aaron wanted to live together anymore: although they could not actually live apart from each other either. They slept in separate bedrooms. Both Mary Ellen and May said their mother 'mithered' their father [i.e., a colloquial expression for making a fuss and moaning].

12.12 When May spoke to the Chair by telephone she described her childhood and adolescent experiences. She said these were not great. She felt she had gone through the worse of it because she was the youngest and had stayed with her parents after her siblings left home [May left home when aged 25].

12.13 May said her Nana [her mother's mum] had brought her up a lot of the time as her parents both worked. She was aware from an early age that her parent's relationship was volatile and remembered her father as being more aggressive than her siblings did. She felt that, because she was the youngest and remained at home for much longer than them, she witnessed much more of her father's bad behaviour.

12.14 She said her father would come home from work drunk. He would lift the whole dining table up and everything would go flying and he would shout 'where is my tea'. May said he was a cruel man and was cruel to animals too. She said her Mum also drank and she learned from an early age never to argue with her father when he had consumed drink. May said that, even when Aaron stopped drinking, he was still 'massively volatile'. When he was drinking she felt it just compounded his behaviour. May described how he ruined both her 21st birthday and her first wedding because of his behaviour.

12.15 May recalled that, as a teenager, her parents argued an awful lot. While Ron and Mary Ellen did not witness any physically aggressive behaviour by Aaron, May remembers her father getting ready to 'go for' her mother. May slapped him to stop him, pinned him against the wall and said she would call the police if he continued. He then calmed down and disappeared to his room [or his shed]. May said these sorts of events happened 4 or 5 times that she could remember. She did not know whether Aaron ever hit her mother, as she did not see this happen, although she considered it likely he had.

12.16 May spoke on the telephone to the Chair of an event in which her father assaulted her and put marks around her neck. This event was also witnessed by Shirley who independently described the same event when she met with the Chair. The event happened about 2009. On this occasion May was acting

as carer for her mother. She was at address one with her partner doing some cleaning with Shirley.

12.17 Aaron confronted May and said something like 'Are you going to get your [sic] ffing work done'. There was an argument and Aaron got May by the neck and pushed her up against the bathroom wall. Margaret was present and was screaming at him. Aaron then attacked May putting his hands around her throat and leaving marks on her neck. May felt she should have rung the police. However, she did not, and instead took her mother to her partner's house. May told the panel her mother blamed her for the argument even though Shirley had witnessed it.

12.18 May said she tried to persuade her mum to leave her father, but she would not and that they had been together for so long they just could not separate. May said that, on the occasions she got between Aaron when he was arguing with Margaret, she feared Aaron would have hurt Margaret had she not been there to stop him. As a result of the incident in the bathroom May stopped talking to her mum and dad for about 4 or 5 years.

12.19 About one year before her mum was murdered May said she made up with her, and 'sort of' made up with her dad. Although she said their father/daughter relationship was never the same again as he 'could be a bit vindictive'. By the time she resumed contact with her parents, May said her father was starting to get forgetful and her mother told her he had developed glaucoma.

12.20 When the Chair met the family they spoke about the decline in Aaron's health. They said he started to become forgetful and found it hard to get words out. For example, he could not remember the PIN for his pension. The family say Margaret started to become concerned about his condition.

12.21 The tipping point was when the hairdresser visited Margaret and noticed something was not right with Aaron. He went to get a drink of water and just kept pouring water into a bottle. The hairdresser persuaded Margaret to ring the doctor following which Aaron was admitted to Bolton Hospital on 22 February 2019 [to preserve the chronology the events while Aaron was in hospital and the family's recollections of discussions with professionals are described in detail within section 13].

12.22 While Aaron was in hospital Margaret arranged for the family dog to be rehomed as both she, and the family, felt Aaron would not return home. The family felt Margaret did not want Aaron to return home and they said to her that, if she felt it was not right for him to return home, she should say so. The family felt she was holding something back and asked her what she was

frightened of. She did not say whether she was frightened of anything. The family have no knowledge of physical abuse perpetrated by Aaron on her, however, their view is that Margaret would only tell the family what she thought they wanted to hear.

12.23 The family were aware that, while Aaron was in hospital, Margaret had completed a housing application online to be rehoused as a sole tenant in the Bolton area. They said Aaron knew that Margaret wanted to move out and he was not really bothered: they felt he would not come home again.

12.24 Aaron was discharged from hospital to address one on 20 March 2019 with a care package[17] three times each day. Once he had returned home Mary Ellen recalls taking him to the post office to sort out his pension. She described him as still being confused and 'doddery'.

12.25 The night before Aaron killed Margaret, Ron described how he had received two missed calls from his mother. He sent her a text message asking if she was OK. In response Margaret sent a text message to Ron in which she said.

'if he raises his sticks to me it is 999'.

The family felt that indicated, if Aaron was violent towards Margaret, she would have rung 999. That was the last contact any member of the family had with Margaret.

12.26 The family are shocked and saddened by the homicide of Margaret. When seen in November 2019 by the Chair, the criminal justice process in respect of Aaron was still underway. The family said they would all struggle to cope this coming Christmas which they did not feel like celebrating. The family are concerned about the sequence of events that led to the homicide and in particular the discharge from hospital process when it was clear that Margaret did not want Aaron to return home. The family say they would like to know why, if he had assaulted two nurses, did agencies not consider that Aaron was a risk to others?

Involvement of Aaron in the DHR/SAR

12.27 The Chair of the DHR wrote to the clinician responsible for Aaron's care in the hospital where he is now detained and requested an opinion as to

[17] A care package is a combination of services put together to meet a person's assessed needs as part of the care plan arising from an assessment or a review. It defines exactly what that person needs in the way of care, services or equipment to live their life in a dignified and comfortable manner.

whether Aaron was capable of contributing to this review. The clinician advised that Aaron did not have mental capacity to consent to an interview and that it would not be in Aaron's best interests to do so.

12.28 The panel understand Aaron made some disclosure to Mary Ellen about what happened before the finding of fact hearing in October 2019. The panel feel these are important to help it, and readers of this report, to fully understand what happened. However, the panel recognises the accuracy of this information has to be treated with caution given it has been provided by someone who, at the time of the finding of fact hearing, was suffering from advancing dementia.

12.29 Aaron said that on the night before the homicide he planned/decided to kill Margaret as he believed she was about to, or trying, to kill him. He believed she may be poisoning him, so he wanted to act first. He has not given any indication as to why he thought his wife was going to kill him. He is described as having a 'superficial' personality and does not give much away. He has some problems with finding words so conversations with him can be difficult. Mentally he has remained in a similar condition ever since his initial admission.

12.30 Aaron believed the background of Margaret's perceived ill intentions towards him was the history of their poor and deteriorating relationship. Aaron indicated she needed money from him, and she used to go searching for access to his money. The rehoming of the family dog was a significant event to him and a further indication of what he felt was Margaret's intentions towards him.

12.31 Aaron has never given any specific examples of anything that Margaret did or said to him which could support his belief that she was attempting to kill him. However, he has said that Margaret used to continually run over his feet with her wheelchair and he was very preoccupied with this when he was first admitted to hospital. Aaron is convinced she was doing it deliberately in order to harm him [Shirley said she felt her mother running over Aaron's feet would have been an accident and not a deliberate act]. Aaron also complained that Margaret was quite verbally abusive towards him. He has never disclosed having thought about telling anybody else about this behaviour towards him.

13. CHRONOLOGY OF EVENTS AND FACTS

13.1 Introduction

13.1.1 This section of the report sets out a detailed chronology of the events that took place leading up to the homicide of Margaret. Rather than presenting information individually by agency a chronological approach has been adopted to aid the reading and understanding of these events. This section contains the information that was known to agencies and supplied to the DHR in their IMRs, chronologies and reports as well as information gathered by GMP during their homicide enquiry.

13.1.2 It includes information provided by the family, particularly about their recollections of conversations and contact with professionals during the hospital discharge process. Margaret made significant use of text messages to keep in touch with her family and particularly her daughter Mary Ellen: sometimes sending several messages a day. The family kindly made all of these available to the DHR panel.

13.1.3 The panel Chair has analysed these. While many of them are of a personal nature and reflect every day conversation between a mother and daughter, some of them relate directly to events relevant to the DHR. The text messages are dated and timed and it has therefore been possible to insert them chronologically within the sequence of events.

13.1.4 The review panel felt this helped illustrate what was happening from the family's perspective and in particular it helped give a voice to Margaret. By including the exchanges between Margaret and her family the review panel also felt it avoided creating a hierarchy of testimony and allowed some balance to be given to Margaret and her family's voice.

13.2 Information prior to 1 November 2018

13.2.1 Because of Margaret's health conditions she had extensive contact with medical and agency professionals before the start of the review period. None of the information within that period relates directly to Margaret being a victim of domestic abuse. However, the review panel felt there were two events that were noteworthy.

13.2.2 On 18 February 2008 Margaret was seen within the service then provided by Greater Manchester West (GMW) NHS Foundation Trust[18] for an assessment

[18] Prior to 01 January 2017 mental health services were provided by Greater Manchester West (GMW) NHS FT. Through a formal acquisition process GMW acquired Manchester Mental and Social Care Trust (MMHSCT) and on 01 January 2017 Greater Manchester Mental Health (GMMH) NHS FT was founded. GMMH provides inpatient and community-based mental health care for people living in Bolton, Salford, Trafford, and Manchester

by a psychological therapist. She disclosed a number of issues relating to family dynamics. The nature of which are not recorded. During the assessment she became upset. Aaron came into the session and shouted at her. He also became verbally aggressive to the practitioner.

13.2.3 It was considered to be an unsafe environment to explore any domestic abuse matters. It was thought this would have placed her at more risk. After the session the psychologist contacted Margaret to arrange a further appointment. She did not make an appointment and said she was fine. She told the practitioner, as a result of increased levels of care being put in place, there was less work for her husband and therefore, tensions between them had dissipated. She told the practitioner she no longer required input from a psychological therapist. The practitioner offered her direct contact in the future if she wanted it. A letter was sent by GMW to Margaret's GP in which information about this event was shared.

13.2.4 On 12 November 2015 Margaret was admitted to hospital with breathing issues. She was treated there during which a PEG was fitted. On 18 November 2015 a referral was made to the Rapid Assessment Interface and Discharge Team [RAID] team as Margaret reported low mood: she was not sleeping well or concentrating and had decreased motivation over the last 6 months. She said she was lonely at home and wanted more social interaction, although she had good family support. After the assessment by RAID the ward staff nurse made a referral to Age UK and to Margaret's GP for her mood to be reviewed in 2-4 weeks. This referral is documented in the patient notes.

13.2.5 The panel asked the member from Age UK to check and establish if a referral was received by Age UK. The member said there was no record of one having been received.

13.3 Information after 1 November 2018

13.3.1 Both Margaret and Aaron were registered at the same GP practice in Bolton. Between 1 November and 9 November 2018, the practice recorded 12 telephone contacts concerning Margaret. In the same period there were 4 telephone contacts in respect of Aaron. All of these related to routine medical issues that have no bearing on this case nor could have been considered indicators of domestic abuse.

13.3.2 On 12 November 2018 the cleaner from address one contacted the GP surgery as they were concerned Margaret was confused. It was reported that over the last 5 weeks she had been speaking to people who weren't there or speaking on the phone to people when it had not rung. Aaron was aware, and concerned, and had asked the cleaner to book an appointment for

Margaret with the GP. The panel heard the cleaner had a background in, and was skilled at, caring for the elderly. They felt their action, recognising Margaret was confused and contacting the GP, was a good example of using their skills and demonstrated initiative.

13.3.3 Later on 12 November 2018 a GP visited address 1 and spoke with both Margaret and Aaron. They both denied any problems with memory or confusion. The GP carried out a Six Item Cognitive Impairment Test [6CIT][19] on Margaret which was low [Zero] and therefore normal. No confusion or memory issues were identified.

13.3.4 Between 13 November 2018 and 14 February 2019 there are 19 entries in the GP records relating to contacts, visits or the results of tests relating to Margaret and Aaron. All relate to routine medical issues that have no bearing upon this DHR. In the period between 10 December and 21 February community nursing services made 15 visits to address one to see Margaret in respect of routine clinical care. No concerns or issues related to domestic abuse were recorded.

13.3.5 On 21 February 2019 Margaret spoke to the duty GP by telephone. She said Aaron had become more vacant, needed prompting with eating and drinking and did not seem to want to eat. She said he was unable to remember anything, was lying on his bed fully dressed all night and was confused.

13.3.6 Later that day a GP visited address one. Margaret told the GP she thought Aaron had dementia. The GP carried out an examination and noted that Aaron was 'pleasantly confused' although showing no signs of agitation. The GP carried out a 6CIT test which was abnormal and returned a high score [28]. A blood sample was taken, and arrangements made for a telephone consultation the following day.

13.3.7 During the evening of 21 February 2019 the out of hours GP service received a call from the Pathology Lab with blood result of raised Potassium for Aaron[20]. The GP service spoke to Margaret by telephone, discussed the results with her and she said she would call the ambulance service and take him to A&E for repeat blood tests.

13.3.8 Later that evening Aaron was admitted to hospital in Bolton with acute kidney injury. On 22 February 2019 an Occupational Therapist made an unannounced visit to address one and spoke to Margaret. She told the

[19] The Six Item Cognitive Impairment Test (6CIT) is a brief cognitive function test which takes less than five minutes and is widely used in primary care settings. It involves three orientation items – counting backwards from 20, stating the months of the year in reverse and learning an address.

[20] Such results require urgent medical assessment and treatment to prevent permanent kidney damage and address the cause of the acute kidney injury.

therapist Aaron was in hospital with kidney failure and he also had dementia. The visit concerned Margaret's mobility and the loan of a walker to assist her. Margaret did not raise any concerns about Aaron's behaviour towards her.

13.3.9 After a period of assessment Aaron was transferred to a medical ward on 23 February 2019. On 25 February he was reviewed by a consultant who noted Aaron was experiencing delirium and was pleasantly confused. A scan of his head was conducted that disclosed small vessel disease[21] with no acute pathology.

13.3.10 On the same day an occupational therapist from Bolton hospital conducted an assessment for Aaron as part of which they spoke to Margaret. Amongst issues they discussed was that Margaret would not be able to cope with Aaron if he was discharged unless a package of care was in place. Margaret did not raise any concerns with the therapist about Aaron's behaviour.

13.3.11 Aaron received visits from family members while he was in hospital. May recalled on one occasion when she was at the hospital Aaron asked for his shoes and said, 'the railway line is just up there, I'll do myself in, it be done then'. May appears to have taken this as an indication Aaron wanted to end his life and he repeated this statement a few times. Although Aaron's comment to May indicates possible suicidal ideation, the DHR panel did not find any evidence from within agency IMRs that the comments Aaron made that day were reported to staff, nor that Aaron repeated these comments or taken any steps towards carrying out such an act.

13.3.12 At 12.27hrs on 25 February Margaret sent the following text message to Mary Ellen[22].

'[sic] Dad staying in untill more tests are done I have told them that I cannot take him home like he is xxx'.

[21] Small vessel disease, or SVD, is a major cause of dementia and can also worsen the symptoms of Alzheimer's disease. It is responsible for almost half of all dementia cases in the UK and is a major cause of stroke, accounting for around one in five cases. Patients with SVD are diagnosed from brain scans, which detect damage to white matter -- a key component of the brain's wiring.
https://www.sciencedaily.com/releases/2018/07/180704161504.htm

[22] The panel have included these text messages as they feel it provides the victim with a voice in this report. However, in doing so, the panel also recognise that the content of the text messages was not shared with agencies until after the homicide took place and therefore there may have been information within these texts that was not known to agencies when they made assessments and decisions concerning Aaron.

13.3.13 On 26 February the following text messages were exchanged between Margaret and Mary Ellen.

11.59hrs from Margaret.

'[sic] Dad no different I havwe told them again I cannot have him at home the way he is social worker will come to see me when they have seen dad if you go on weds ask for further information'.

20.03hrs from Margaret.

'[sic] Don't forget to speak to the nurses I have spoken to a lady today and told her my problems asked about stair lifts and toilets and was eager to but in 24hr care for dad but I told no okxxx'.

20.06hrs from Margaret.

'[sic] Social worker will contact me when she has seen dad xxx

20.07hrs from Margaret.

'[sic] Do you think I should ring my Dr and ask for my own social worker or leave it to the hospital'.

20.07hrs from Mary Ellen.

'[sic] When they visit I want to be there. Ask them to come to the house. They can see what you are dealing with then. Can show her the bed x'.

20.08hrs from Margaret.

'[sic] I told her about the bedxx'.

20.08hrs from Mary Ellen.

'[sic] You need an assessment. Yes. X'.

20.12 from Mary Ellen.

'[sic] Just give them the truth and that you've been trying to manage and not managing cos you didn't want to be split up and move. X'.

20.14 from Mary Ellen

'[sic] Plus you have both hidden the fact that things weren't going too well. If he has been abusive you need to tell them that too x'.

13.3.14 The same day a notice requesting an assessment was received by the Integrated Discharge team at the hospital. Another Occupational Therapist visited Margaret at address 1 to provide her with the walking aid. She was upset as she had made the decision to rehome her dog. She said she was struggling to care for the animal since her husband had been in hospital and

she doubted her husband would be coming home as he needed full time care.

13.3.15 The following day the same Occupational Therapist, who had visited the day before, returned to address one to complete risk assessment paperwork in relation to her mobility. During the visit the therapist provided Margaret with advice on how to register for housing. Margaret expressed concern that she had not been unable to access Aaron's pension for three weeks as he forgot his PIN number prior to going into hospital.

13.3.16 On 28 February Aaron was reviewed by a consultant who noted the kidney injury had resolved, however he remained confused. In view of Aaron's history of deteriorating memory and cognition, the ongoing delirium was assumed to be related to undiagnosed dementia. Aaron was assessed as medically fit for discharge while requiring social and therapy assessment. The notes show the ward had already made a referral to Adult Services for assessment in readiness for discharge planning.

13.3.17 On 1 March 2019 the duty social worker [SW1] attended the ward at the request of Margaret's family. She was present along with Aaron and their daughter Mary Ellen. SW 1 noted there were some tensions between Margaret and Aaron and they argued throughout the discussions, mainly about finances[23]. It was disclosed that Aaron did not contribute to the household bills and had refused care in the past due to the financial implications.

13.3.18 The notes record that Margaret and Mary Ellen explained Aaron had been self-neglecting at home. He did not tend to his personal hygiene needs, did not cook and when he did, he left the oven on. They also said he left address one and become disorientated. While in discussions with Aaron, the social worker felt there was some cognitive deficit with him. For example, he could not retain information the social worker gave him five minutes before about equipment and support on discharge.

13.3.19 The social worker recalls Aaron took comfort in knowing that he had a dog at home. He asked his family about this and they broke the news to him that they had rehomed the animal to a family friend. On hearing this Aaron became tearful. However, throughout the meeting he did not retain this information, continued to ask about the dog and continued to become upset.

[23] During Aaron's hospital stay May recalled travelling to Bolton to see him. She said he was very confused and talking 'funny'. Both May and her partner, who was also there, noticed Margaret and Aaron were glaring at each other and just looked as though they wanted to 'kill each other'. It is not clear on what date that visit took place.

13.3.20 Margaret told SW1 that she did not want Aaron to return home. The social worker explained to Margaret that, because they jointly owned their house, Aaron had a right to return there if he wished to do so. Margaret and Aaron also expressed a wish to separate and said they did not want to live together at address one. The social worker explained that was a long-term goal and could not be facilitated from hospital: hence they would both have to live at address one as an interim measure.

13.3.21 The social worker felt a mental capacity assessment should be undertaken because Aaron was declining care and support. SW1 was to complete this on 4 March 2019. They spoke to their deputy manager and it was agreed the case should be allocated to a qualified social worker for complex discharge planning rather than to a community assessment officer. The following actions were agreed.

(i) Both Margaret and Aaron were to be referred separately for extra care housing.

(ii) Mental capacity assessment to be undertaken with regard to Aaron declining all offers of care and support when planning discharge.

(iii) Allocation of a Social Worker for complex discharge planning [subsequently SW2].

The family's recollections of this meeting are similar to what is recorded in the Adult Services notes. Mary Ellen recalls around this time Aaron tried to leave the ward and there was an incident when he assaulted two nurses. She said this frightened Margaret.

13.3.22 The Adult Services notes record that on 6 March 2019 Margaret contacted SW2 by telephone for advice about Aaron's benefits whilst in hospital. During the conversation she told SW2 she wanted to apply for rehousing for herself and her husband in a two-bed bungalow. SW2 gave her telephone and online information for Homes for Bolton. They explained to Margaret that she would be contacted during discharge planning however the ward was currently closed due to hospital infection.

13.3.23 That evening Aaron became wander some and aggressive and assaulted a nurse and a health care assistant on the ward. He was confused and needed treatment to deal with raised serum potassium. The health care assistant involved attended accident and emergency and did not complete their shift. Neither they nor the nurse suffered a significant injury. The matter was not reported to the police.

13.3.24 By 12 March, Aaron was reported as being settled and 'oriented to place and person'[24]. On 13 March notes record SW2 went to see Aaron on his hospital ward. While SW2 was there Mary Ellen came to visit [Margaret was not present]. SW2 noted that Aaron lived at home with Margaret who was wheelchair bound and there were no previous care packages as they were managing independently. However, Aaron had been neglecting his personal care as well as having problems with cognition. Doctors had suggested that he had delirium. His family requested a mental health assessment/diagnosis. Aaron was mobile and transferred independently on the ward. SW2 noted Aaron was mildly confused but had good insight. He told the social worker he did not need support and that he could manage at home. However, SW2 says that Mary Ellen felt he needed care so it was agreed that a package of care [3 times each day] was needed to help with personal care and meals. Mary Ellen said her mother supported Aaron with medication from blister packs. She also confirmed the family would support with shopping.

13.3.25 The following outcomes and actions from the meeting were recorded.

(i) Referral to the memory clinic post discharge by Doctor on ward.

(ii) Aaron suitable for reablement team on discharge a package of care to be arranged. Three times daily to support personal care and meal preparation. SW2 to complete independence plan as referral for service.

(iii) Medication was to be administered by Margaret, she had previously been doing this prior to his hospital admission and family to do their shopping.

(iv) Careline referral to be made.

13.3.26 On 14 March 2019 a community nurse visited Margaret at address one. During the visit Margaret disclosed that Aaron was volatile and aggressive when carers were not present and that she felt unsafe. She also requested that his discharge from hospital should be postponed as she felt a discharge planning meeting was required so she could highlight her concerns. The community nurse passed this information to SW3 the duty social worker in Bolton Council who agreed to notify the allocated social worker [SW2]. Later

[24] Orientation is a function of the mind involving awareness of three dimensions: time, place and person. Problems with orientation lead to disorientation, and can be due to various conditions, from delirium to intoxication. Typically, disorientation is first in time, then in place and finally in person.

the same day Margaret contacted the hospital ward by telephone and said that she did not want Aaron home.

13.2.27 The following exchange of text messages took place that day between Margaret and Mary Ellen.

O9.35hrs from Margaret.

'[sic] District nurses[25] puttin in a safeguarding alert against dad's name to show that it is not safe for him to come home on this environment also goig to speak to the social worker 're his discharge ward told dn not fit yo come home yet !!!!!do they know what they are doig ???xxxlol'.

09.37hrs from Mary Ellen

'[sic] Idiots. Need a proper story off someone x'.

09.53hrs From Margaret

'[sic] I have to request an m d t meeti'.

13.3.28 The following day a social worker [SG SW] from the Adult Safeguarding Team returned the community nurses telephone call. The community nurse explained Margaret's diagnosis and said she was visited by District Nursing once weekly. The community nurse informed SG SW that Aaron had presented as violent towards Margaret and to nursing staff on the ward. The community nurse said that Margaret had indicated she did not want him to return home even with a care package: she could not cope.

13.3.29 SG SW then spoke to SW2 who explained they had spoken with Aaron to arrange the package of care for him to return home. SG SW explained to SW2 that Margaret had stated she could not cope if he was to return home due to his violent episodes which were thought to be brought on due to his health. SW2 explained to SG SW that Aaron had delirium and since he had been in the ward he had not been violent. SG SW agreed for SW2 to arrange a multi-disciplinary meeting [MDT] to address the issues in more detail so that SW2 could confirm the most appropriate discharge destination for Aaron.

13.3.30 SG SW noted this concern did not require progression to a s42 safeguarding enquiry under the Care Act 2014[26] due to the following rationale.

[25] Margaret used the expression district nurses to refer to the community nurses.

[26]The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

(i) Is independent with all her support needs except for her catheter care.

(ii) Has experienced aggression and violence by Aaron. It would appear he is not fully aware of his actions and aggressive outburst due to his health needs of dementia and delirium. He is currently in hospital and requires a needs assessment with consultation with Margaret to identify the appropriate discharge destination.

(iii) Is able to protect herself as she has voiced her wishes and views about Aaron not returning home.

13.3.31 SG SW then spoke with Margaret and she repeated what she had told the community nurse: that she could not cope with Aaron returning home from hospital and would like alternative care arrangements for him. The same day SG SW spoke with the Deputy Safeguarding Team Manager who confirmed the episode did not require progression to a section 42 enquiry and agreed with the actions and advice that had been given. The Safeguarding Team manager then closed the contact document for Margaret as 'signposted to other services'.

13.3.32 On 15 March a request was made from the ward at Bolton hospital for a dementia/mental health assessment. A consultant psychiatrist advised that it was not appropriate at that time to assess for dementia on a background of a resolving delirium as it would be difficult to assess the severity.

13.3.33 The same day the following text messages were exchanged between Margaret and Mary Ellen.

10:46hrs from Mary Ellen.

'[sic] Can you ring [SW2] the social worker. He's trying to contact you. No luck with the house phone. Give him your mobile'.

11:13hrs from Margaret

'[sic] [SW2] is going to contact you with regards to a meeting next week xxx I have told him that I cannot look after dad and it is an unsafe situation xxxlol'.

13.3.34 When the Chair spoke with the family they recalled a number of visits to hospital and conversations with social workers in person and by telephone. Understandably, because of the distressing circumstances they are in following the death of Margaret, they struggled to place precise dates and times upon these events. Mary Ellen recalled SW2, and conversations she had with them. Shirley says she also spoke to SW2 by telephone and recalls her grandma [Margaret] also speaking to them.

13.3.35 Shirley says she was told that a capacity test would be completed when her grandad [Aaron] returned home. She says she told SW2 it was not safe for him to go home. She says SW2 told her Aaron had to go home as he owned the house. Shirley also recalled another telephone conversation when a professional rang her grandma to enquire as to whether she could cope. Shirley says the person who spoke to Margaret told her that Aaron had to come home. In response Margaret said.

'I will do 2 weeks[27]'.

Bolton Adult Services advised the panel that the social worker involved has no recollection of these conversations with Shirley. There is no record of them on the Adult Services system [Liquidlogic]. The DHR panel has not been able to reconcile these differences.

13.3.36 The same day, the Adult Services records show[28] SW2 spoke to Margaret by telephone. She explained she was wheelchair bound and vulnerable and said Aaron had tried to hit her previously and displayed aggressive behaviour towards her. Margaret said Aaron was not safe at home, left the gas on, went shopping in the night, did not contribute to household bills, had all his money in the bank, forgot his bank code number and managed his money by himself. Margaret said Aaron came into her bedroom despite living in separate rooms. She said she did not feel safe living with him. Margaret had previously worked in care services and had good knowledge of what was available. She requested Aaron should go into Wilfred Geere House[29] for further assessment. Alternatively, she wanted a planning meeting before Aaron was discharged from hospital. The notes from Adult Services record that Mary Ellen was aware of the service and that a referral was being completed by a discharge nurse for Wilfred Geere House.

13.3.37 The same day, records show SW2 spoke to Aaron on the ward. The social worker recorded Aaron was lucid today and could follow the conversation, he showed good cognition and his presentation had improved from 2 days ago. He said he did not try to hit Margaret and would not do that. He did not remember leaving the gas on but said that he went out late evening to do shopping, while sleeping during the day. He said he wanted to go home. He advised the social worker to speak to his daughter Mary Ellen and said Margaret could have behaviour issues herself.

[27] Having read the DHR report Mary Ellen believes the comment from Margaret meant Margaret was willing to try and see if she could manage for 2 weeks.
[28] The time and date of the events on this day are taken from Bolton Council Adult Services system Liquidlogic.
[29] Wilfred Geere House offers accommodation for persons who require nursing or personal care, Dementia, Caring for adults over 65 years.

13.3.38 SW2 noted that Aaron had good insight and seemed to have capacity about his discharge destination. Therefore, SW2 did not carry out a formal mental capacity assessment. SW2 also noted that Aaron was mobile with walking sticks independently on the ward and was not on any supervision[30]. He transferred independently and dressed himself with occasional prompts for personal care. He ate and drank well, was alert and lucid. He was mainly independent on the ward and that was why reablement was being requested: to help him maintain a daily routine at home.

13.3.39 SW2 then spoke to Mary Ellen and recorded that Mary Ellen was of the view that Aaron should return home with a care package for a few weeks to see how he managed at home. She felt it would be unfair for Aaron not to come home without giving him a chance of staying at home. SW2 recalls [although they did not record it in notes] telling Mary Ellen he would cancel the package of care for Aaron. SW2 says Mary Ellen requested they did not do that until she had spoken to her mother. The following possible options were open at that time;

i. Go home with a package of care.

ii. Referral to Wilfred Geere for further assessment and/or.

iii. Discharge planning meeting.

It was agreed Mary Ellen would speak to her mother and then contact SW2 to inform them of what they agreed. SW2 says Mary Ellen did not raise any concerns about Aaron going home.

13.3.40 Mary Ellen says she did not have any further conversations with the social worker. She does not know whether Margaret had any conversations that she did not disclose to Mary Ellen. Mary Ellen says she has no knowledge of any conversations that social workers had with Margaret or Aaron about referring him for a bed at Wilfred Geere. The next thing that Mary Ellen recalled was that Aaron was to be discharged from the hospital with a package of care. Mary Ellen says she had no discussions with any social workers in relation to that issue.

13.3.41 At 15:37hrs on 15 March 2019 Margaret sent the following text message to Mary Ellen.

'[sic] Not been referred to the memory clinic yet so I have asked them to chase it up xxlol'.

[30] Mary Ellen disagrees with SW2's assessment and believes Aaron was being observed at all times by members of staff on the ward.

13.4.42 At 15.42 hrs that day the Adult Services notes record that, following discussion with Mary Ellen, Margaret had agreed for Aaron to be discharged home with a care package of support by the reablement team. They would provide visits three times per day to support Aaron with his personal care and meal preparation. Margaret would support medication administration. Margaret was reported to have said she wanted to give Aaron a chance to see if he could manage at home with support. It was noted that SW2 telephoned Margaret who confirmed that Aaron could return home and was asked if she still wanted the discharge planning meeting. She declined and felt that Aaron should be discharged home to see if they could manage. The same day SW2 notified the reablement team and advised them to keep looking for a start date for a package of care.

13.4.43 On 18 March 2019 Margaret registered on-line with Homes for Bolton[31] Choice Based Letting Scheme as a couple. Aaron was a joint applicant from Address 1. There is reference in the application to disability / wheelchair living for her and that he was awaiting a memory clinic assessment for dementia. The application indicates that a daughter or son [Mary Ellen or Ron] were able to assist with their application if necessary. The applicant also indicated in relation to 'support services you or any person in your household are currently involved' with as being: Adult Services and Mental Health Services. There was no direct contact with Homes for Bolton and on-line applications do not require any direct customer contact to allow them to go live. No further progress was made with the application. After reading the DHR report Mary Ellen and Shirley said that as far as they were aware the application was solely in Margaret's name.

13.4.44 The same day SW2 recorded in notes that a package of care was in place and would commence on 20 March 2019. The following day [19 March] Margaret left a message with an administrator in Adult Services with queries about Aaron returning home. She wanted to know what times the reablement visits would take place and whether someone would be coming to assess Aaron at home. The duty worker advised Margaret that the first Home Support Reablement would be a teatime call on 20 March 2019 and they would sign-up Aaron before the first visit. Later the same day SW2 completed a needs assessment for Aaron.

[31] Bolton Council and Bolton Community Homes (BCH) partners operate the Homes for Bolton choice-based lettings service. It is a partnership of eight landlords, including Bolton at Home, representing approximately 95% of social rented houses and providing access to over 24,000 homes for rent in the Bolton area.

13.4.45 On 20 March 2019 Aaron was discharged from Bolton hospital to address one. The hospital sent a discharge summary to the GP practice in respect of Aaron as follows.

'admission date: 22/02/2019, discharge date: 20/03/2019. Diagnosis of AKI / Acute kidney injury – likely medication related, causing delirium secondary to above. Investigations included – CT head (showed small vessel disease), ECG, Chest X-ray. IV fluids treatment and medication changes led to improvement in bloods / renal function, reviewed by MDT and discharged home once home support in place. During hospital admission the 6CIT was re-assessed, score 28/28, patients wife stated GP recently completed assessment and Aaron is waiting for appointment with the memory clinic, MDT in agreement that Aaron required to be reviewed by the Memory assessment service. Lisinopril stopped due to high potassium. BP stable during admission. Amlodpine reduced. No suggested GP actions'

There was no further recorded telephone or face to face contact between the GP practice and either Margaret or Aaron before the homicide.

13.4.46 Later on the day of the discharge Aaron was visited by the Home Support Reablement Team and was signed up for their service. He reportedly did not appear to know the worker was visiting for this purpose and asked them to speak to Margaret. Aaron was 'a bit defensive' when the worker explained why they were there. Margaret told him why the team needed to attend. He was very abrupt with her, telling her not to say things about what he did when he was ill. Margaret disclosed quietly that he had hit staff on the ward with his walking stick and that she would call the police if he did that to her.

13.4.47 After reading the DHR report Mary Ellen provided more details about this event. She said the care worker visited about 5pm and at that point Aaron had not been signed up to the service. She recalls the care worker rang their line manager and was told it would only be completed the following day. The care worker told Mary Ellen he could not perform any caring duties without Aaron being signed up. The care worker left and Mary Ellen made Aaron a sandwich.

13.4.48 The Reablement Service completed a service risk assessment which stated the following.

i. The doctor suggested delirium and a referral to the memory clinic is to be made.

ii. Aaron has shown aggression at one time on the ward towards staff, carers to be mindful of this.

iii. Margaret has stated that she would telephone the police if Aaron presents with any signs of aggression towards her.

iv. Staff should report any concerns to the office (reablement).

13.4.49 On 21 March SW 2 completed a case transfer summary which included the following.

i. Aaron was discharged 20/03/2019 with care package 3x daily by Reablement. Lives at home with Margaret. Carers to also monitor safety and wellbeing of Aaron & Margaret and alert any concerns to relevant professionals.

ii. Case transfer to Home Support Reablement for 2 weeks review. Main contacts are his wife Margaret and Mary Ellen.

iii. SW2 noted Aaron may benefit from day care post discharge.

13.4.50 Over the following days the Reablement Service continued to visit address 1 and provide care and support to Aaron. No concerns were reported and it appeared that limited support was required by Aaron. On the morning of the homicide [sometime before 08:12] Aaron answered the door with the reablement folder and passed it to the worker. He said he no longer required the visits then closed the door. The reablement worker informed their office.

13.4.51 At 08:12 hours that day North West Ambulance Service [NWAS] reported to GMP they had received a call from address 1. Aaron told NWAS he had argued with Margaret and stabbed her in the stomach. Police officers and paramedics attended and at 08:19 hours found Margaret deceased at address 1 with stab wounds.

13.4.52 Aaron was arrested. A kitchen knife with blood on it was found in the kitchen. On arrival at the custody office Aaron, when asked if he required a solicitor, replied.

" I don't need one, I've just murdered someone".

He was later released from police custody and then compulsorily detained in hospital under S2 of the Mental Health Act 1983. The result of the criminal justice process that followed have already been described at paragraph 1.4.

14. ANALYSIS USING THE TERMS OF REFERENCE

Introduction

This section of the report looks at each of the terms requiring analysis as listed in Section 3. The individual terms appear below in bold followed by the analysis. Some of the material and events that are analysed may be relevant to more than one term and where this occurs a best fit approach has been adopted to avoid unnecessary repetition.

14.1 Term 1

Did your agency identify that either Margaret and/or Aaron were adults needing care and support? How and when were their needs identified and what services did your agency provide to them both?

14.1.1 Care and Support Statutory Guidance [issued 2018 and henceforth referred to as 'The Guidance'][32] sets out how Local Authorities and other agencies should fulfil their obligations to The Care Act 2014. In short, Local Authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person. This may sometimes be referred to as 'the wellbeing principle' because it is a guiding principle that puts wellbeing at the heart of care and support. The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision, in relation to a person.

14.1.2 'Wellbeing' is a broad concept, and it is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect).
- Physical and mental health and emotional wellbeing.
- Protection from abuse and neglect.
- Control by the individual over day-to-day life (including over care and support provided and the way it is provided).
- Participation in work, education, training or recreation.
- Social and economic wellbeing.
- Domestic, family, and personal.
- Suitability of living accommodation.
- The individual's contribution to society.

14.1.3 The responsibility for formally assessing wellbeing rests with the Local Authority [in this case Bolton Council] in their role as providers of care and support under the Care Act 2014. Bolton Council Adult Services told the

[32] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

review that Margaret had limited involvement with them as a service user within the timeframe of this report. She was receiving care and support from NHS Bolton Community Nursing Team in relation to pre-existing medical conditions. She had been assessed by Occupational therapists from Bolton Council for a thru floor lift in January 2019 to enable her to access the upstairs of the property. She was independent in all but one area of that assessment and needed assistance with cleaning. This was met as she employed a cleaner weekly. No other intervention was required.

14.1.4 From reviewing the information provided the review panel are satisfied that, until the point at which Bolton Council received safeguarding information from the community nurse [24 March 2019], there was no requirement for them to conduct a Care Act Assessment of Margaret's wellbeing. The circumstances of that disclosure, the way in which it was handled and the services provided to Margaret by Bolton Council are considered in section 14.8 [post].

14.1.5 In respect of Aaron the review panel is satisfied that, prior to his admission to hospital in March 2019, there was no evidence that he had unmet needs for care and support. Consequently, there was no requirement for Bolton Council to a conduct a Care Act assessment before 4 March 2019. On that date a referral was made by Bolton Hospital indicating Aaron was medically optimised and fit for discharge. The circumstances surrounding the discharge from hospital process and the completion of the assessment is considered in section 14.10 [post].

14.2 Term 2

Did your agency have any information that indicated Margaret and/or Aaron might be at risk of either neglect or abuse including the risk of domestic abuse? What did your agency do in response to such information?

14.2.1 The review panel is satisfied there was no evidence that either Margaret or Aaron was at risk of neglect within the meaning of the Care Act 2014. As set out in section 14.1 any needs for care and support were being met.

14.2.2 Having reviewed the material supplied in the IMRs and chronologies the panel are satisfied there was no direct information held by agencies to indicate Margaret was a victim of domestic abuse before she made a disclosure to the community nurse on 14 March 2019.

14.2.3 The review panel felt the incident on 18 February 2008 was noteworthy [see paragraph 13.2.2]. Unfortunately, the nature of the family dynamics that Margaret disclosed are unknown because they were not recorded. Given Aaron's verbally aggressive behaviour, there is a possibility they may have

involved him. The practitioner involved in Margaret's care appears to have correctly identified the need to consider domestic abuse. They felt it unsafe to ask questions at that time. It seems that was an appropriate decision. As was the decision to make a follow up telephone call to Margaret.

14.2.4 The explanation over the telephone from Margaret, that tensions between her and Aaron had dissipated, may have been plausible. However, the possibility exists that Margaret could have been put under pressure to make excuses by Aaron who may have realised his abusive behaviour had been exposed to others outside their relationship. For example, in other cases of domestic abuse, victims have reported their perpetrator standing next to them when they have been in conversation hence ensuring they say 'the right thing' when talking to professionals or even their own family.

14.2.5 The GMMH IMR author felt that, if Aaron was experiencing carer fatigue, he could have been referred for a carer's assessment or a check made to see when the last carers assessment took place. If carer fatigue had manifested into domestic abuse the practitioner, in their letter to the GP, could have been more explicit and asked the GP to explore this further with Margaret at her next clinic appointment. A safeguarding alert could have been raised and information sought from adult social care in relation to care and support needs.

14.2.6 The review panel concurred with the views of the IMR author and felt this incident was potentially an indicator that Margaret may have been the victim of domestic abuse. The panel felt an opportunity was lost here to further explore those issues with Margaret.

14.2.7 The incident on 12 November 2015 [see paragraph 13.2.4] contained less direct information to indicate the potential for domestic abuse than the previous event. However, the review panel felt the links between domestic abuse mental health and isolation are noteworthy.

14.2.8 For example, in 2016 the Home Office conducted research[33] into domestic homicides and reviewed 33 cases involving intimate partner homicide. In 10 of those cases the victim suffered mental health issues, 9 of which involved depression. All of those cases were known to health services.

14.2.9 Isolation is something that many victims of domestic abuse can experience and is something that perpetrators will engineer as a pattern of coercive and controlling behaviour.

[33] Domestic homicide reviews: Key findings from analysis of domestic homicide reviews: Home Office December 2016

'Noticing abuse can be made more difficult by the perpetrator. Through controlling or threatening behaviours, perpetrators can cut a victim's social network and restrict their interactions with others. Social isolation can be a key tactic and deliberate form of abuse and control'[34].

14.2.10 On this occasion, staff from GMMH caring for Margaret were not aware of any domestic abuse concerns. Consequently, the panel felt it was reasonable that they did not make a connection between Margaret's presenting condition and the potential for domestic abuse.

14.2.11 Since both of these events GMMH have made changes in relation to their policies and training which reflect contemporary good practice in relation to domestic abuse. This includes asking direct questions of patients about domestic abuse when it is safe to do so.

14.2.12 The panel looked closely for any further evidence that might have allowed agencies to identify any indicators of domestic abuse between November 2015 and the period of this review. The panel are satisfied there were no opportunities.

14.2.13 The panel felt the actions of the cleaner in contacting the GP were good practice. The actions of the GP, in attending the same day, were also timely and an example of good service. The first direct disclosure of domestic abuse took place when Margaret spoke to the community nurse on 14 March 2019 and said Aaron had been volatile and aggressive when carers were not present and she felt unsafe.

14.2.14 The community nurse made a safeguarding referral the same day to Bolton Adult Services Safeguarding Team. The panel felt the actions of the community nurse were appropriate and in accordance with multi-agency policies on safeguarding [the actions of other agencies following receipt of this referral are considered in more detail later within this report].

14.2.15 The community nurse also acted correctly by making both the duty social worker at the hospital, and the ward that Aaron was detained, aware of the disclosure made by Margaret. While the information the community nurse gained from Margaret was sufficient to make a referral, there was little detail as to the nature of the abuse that Margaret suffered. The lack of detail meant it was difficult for those receiving the referral to then make any sort of assessment of risk.

14.2.16 The community nurse may have thought [quite reasonably], that having made a safeguarding referral, other agencies would then be responsible for

[34] A link in the chain. The role of friends and family in tackling domestic abuse: Imogen Parker August 2015

investigating the substance of the disclosure. As it will later transpire, the absence of detail within the initial disclosure was one of the factors behind the decision not to proceed to a S42 Safeguarding Enquiry. The panel feel there is a learning point here about the process for receiving and referring domestic abuse disclosures including the level of detail that is recorded [see lessons in section 16].

14.2.17 Margaret later made a disclosure to SW2 that she had been a victim of abuse by Aaron. The circumstances of that disclosure and the actions of SW2 are covered in detail later within sections 14.7 and 14.10 of this report.

14.3 Term 3

Did your agency consider conducting a Mental Capacity Act assessment on Aaron? If so, what prompted this and what was the outcome?

14.3.1 Appendix D sets out the principles of the Mental Capacity Act 2005 (MCA 2005). Mental capacity is time and decision specific. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make decisions may also fluctuate over time.

14.3.2 When Aaron was admitted to hospital he was seen by a consultant and his ongoing delirium was assumed to be related to undiagnosed dementia [paragraph 13.3.16]. When SW1 saw Aaron with his family the following day they noted he could not retain information. It was SW1 who felt a mental capacity assessment should be carried out as Aaron declined offers of care and support. That was an appropriate decision and in line with the principles of MCA 2005. The plan was for SW1 to complete this assessment on 4 March 2019.

14.3.3 SW1 did not subsequently complete the mental capacity assessment as the case was reallocated to SW2. One of the actions that was agreed was the need for the mental capacity assessment to be completed [see paragraph 13.3.21]. The responsibility for action passed to SW2.

14.3.4 On 13 March SW2 met with Aaron and his family. They noted he was mildly confused and that his family were requesting a mental health act assessment/diagnosis. One of the actions arising from that meeting was that a referral should be made [post discharge] to the memory clinic.

14.3.5 On 15 March SW2 had conversations with Aaron and with his family in connection with the discharge from hospital process [see paragraph 13.3.37]. At that time SW2 says they had no concerns Aaron lacked mental

capacity and for this reason they did not undertake a mental capacity assessment.

14.3.6 The author of the Adult Social Care IMR believes there were missed opportunities to assess Aaron's capacity regarding his care and support arrangements, including where they should be delivered. The concerns raised should have resulted in an assessment being carried out and this was clearly stated as one of the actions that needed to be completed before Aaron was discharged. It is the IMR author's view that a capacity assessment should have been undertaken, prior to discharge, given that it had been determined Aaron required a referral to the memory service.

14.3.7 The reasons why an assessment was not undertaken was considered by the IMR author. They concluded the language used by SW 2 [in their case notes] could be interpreted that they were not clear if Aaron had capacity. They noted he seemed to have capacity and there had been improvements in his presentation. SW2 confirmed to the author they believed Aaron to have capacity to decide the discharge destination and his own care needs and wished to go home.

14.3.8 The review panel recognise that assessing capacity is a subjective judgment. However, on this occasion SW2 did not undertake an assessment despite a clear action having been agreed with SW1 for this to happen. The review panel believe that, on the facts as presented to them within the Adult Services IMR, that was an inappropriate decision.

14.3.9 The review panel recognise that SW2 was not the only professional who could conduct a mental capacity act assessment of Aaron. The assessment of mental capacity is decision and time specific and therefore the person who is involved with the particular decision which needs to be made is the one who would assess mental capacity[35]. As Aaron was a patient in hospital for a number of days there may have been other decisions that had to be made in respect of Aaron's treatment and therefore other occasions when his mental capacity required assessment. The review panel have not found any other references within the records provided to them to indicate any other professional undertook, or considered undertaking, a mental capacity assessment of Aaron.

14.3.10 Had an assessment been made, and had that found Aaron lacked capacity, then professionals would have been required legally to move to a 'best interests decision' in respect to the discharge planning process. This should have led to a meeting between professionals, Margaret, and her family to

[35] https://www.carersuk.org/help-and-advice/practical-support/managing-someone-s-affairs/mental-capacity-in-england-and-wales

consider the safe discharge of Aaron and a protection plan for her. Consequently, not undertaking a mental capacity assessment meant a further opportunity was lost to safeguard Margaret.

14.4 Term 4

Did your agency consider whether use of the Mental Health Act may be appropriate with reference to Aaron? If so, what prompted this and what was the outcome?

14.4.1 Once Aaron was admitted to hospital he was treated as a voluntary patient. The Bolton NHS Foundation Trust IMR author states there was well documented evidence from numerous professionals that Aaron had experienced recurrent episodes of confusion during his admission and had been violent and aggressive assaulting two members of staff [see paragraph 13.3.23].

14.4.2 Staff informed the IMR author that a Deprivation of Liberty Safeguard[36] [DOLS] was not considered as the violent episode was isolated. Although no ongoing restrictions were necessary, Aaron was placed on the Trusts enhanced care planning approach so that his behaviour could be monitored.

14.4.3 When considering the use of powers within the Mental Capacity Act a key issue for professionals is whether the response is proportionate. This means considering what is the least intrusive type, and minimum amount of restraining.

14.4.4 It appears to the panel that the decision to place Aaron on the enhanced care planning approach [rather than depriving him of his liberty using DOLS] was appropriate.

14.4.5 It is clear from having spoken to the family that they, and Margaret, all had concerns Aaron was suffering from some sort of mental illness. At various times there had been conversations within the family and with professionals about these concerns. For example, on 1 March 2019 the family held a meeting with SW1 during which concerns about Aaron's mental health was discussed [see paragraph 13.13.17]. This may be the same occasion Shirley says she asked a social worker about Aaron's mental state and whether he had been assessed. Shirley also recalls conversations she had with SW2 in

[36] The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards set out a process hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person them of their liberty, in order to provide a particular care plan.

which he told her a 'capacity test' would be completed when Aaron returned home.

14.4.6 On 15 March Bolton hospital asked a consultant psychiatrist for a dementia/mental health assessment [see paragraph 13.3.32]. The notes from the hospital make it clear this request was made because the family had asked for it. The panel discussed whether the family understood what sort of assessment they were asking for. There are differences between mental capacity act assessments [see section 14.3] and mental health act assessments and families may not always understand these differences.

14.4.7 The panel do not know the content of the conversations that took place between the family and the hospital as the detail is not recorded. The panel recognise the important thing is that the family were looking for answers to help them understand what was wrong with their father/grandfather. The fact the hospital made a request to the consultant psychiatrist [on behalf of the family] was therefore appropriate.

14.4.8 The panel discussed the role of families and whether they can lawfully be provided with a relative's medical information. The panel were told by the representative of Bolton NHS Foundation Trust that data protection legislation[37] means care has to be taken about the information that is provided to them. In general, patients need to consent for this information to be released to relatives. If for some reason they cannot consent then other issues need to be considered [a discussion on the circumstances of each of these is beyond the scope of this report].

14.4.9 The panel recognise that data protection considerations mean that information could not automatically be provided to the family. However, there is nothing within the chronology from the hospital to indicate that consideration was given to seeking consent from Aaron to disclose this information to the family. While recognising the hospital had many factors to consider, the panel feel it is disappointing the family were not given a sufficient level of feedback to help them fully understand what was happening in respect of Aaron's mental health.

14.4.10 There are a number of references within agency records of the need to refer Aaron to the memory clinic after his discharge from hospital [for example see paragraph 13.3.25]; the discharge notes to the GP [paragraph 13.3.45] includes the fact that Aaron was awaiting an appointment with the memory clinic. It was not clear to the panel whether an appointment was ever made

[37] The General Data Protection Regulation 2016/679 is a regulation in EU law on data protection and privacy in the European Union and the European Economic Area. It also addresses the transfer of personal data outside the EU and EEA areas

for the memory clinic and whose responsibility it was to action that appointment.

14.4.11 The panel therefore asked for the records of the memory clinic to be checked to establish whether a referral had been received, and if so which agency had made it and when Aaron would have been seen. The panel representative for GMMH [which is the agency responsible for the memory clinic] advised the panel there was no record that a referral for Aaron had been made.

14.4.12 The family of Aaron had made representations about his mental health and had been given assurances that he would be seen in the memory clinic. The text message sent by Margaret on 15 March 2019 [see paragraph 13.3.41] indicates she felt frustrated by the fact a referral had not been made and she would have to chase it up.

14.4.13 Given the concerns of the family, it is very disappointing that despite there being a number of references within agency notes concerning the need for Aaron to be seen in the memory clinic, a referral had not been made. If it had been, it had not been recorded and an appointment made for Aaron to attend. All of the agencies that had a part to play in Aaron's care could have made a referral to the memory clinic or, when the family raised concerns, could have checked to establish if a referral had been made. There is learning here for all of those agencies.

14.5 Term 5

Did your agency have any information that Aaron might present a risk to anyone else other than Margaret? What did your agency do in response to such information?

14.5.1 The panel did not find agencies held any information to indicate Aaron might present a risk to anyone other than Margaret until the occasion on 6 March 2019 when he assaulted two members of staff on the hospital ward [see paragraph 13.2.23]. The hospital felt this incident was related to Aaron's delirium and staff viewed this as a 'one-off incident'. Following the incident, a risk assessment was carried out and this was subject to ongoing daily reviews until staff were satisfied that incidents had abated.

14.5.2 The matter was not reported to the police. Bolton Foundation Trust told the review panel staff are encouraged to report incidents to the police. However, staff do not always view such incidents, which are committed during an illness, as a crime so many are not reported. The review panel recognise this incident occurred before Margaret made a direct disclosure of domestic abuse. Without other information, it was therefore reasonable for staff to assume the assaults by Aaron were caused by his delirium. The actions of

Bolton Foundation Trust were therefore an appropriate response to that incident.

14.6. Term 6

Did your agency document an assessment of any risk Aaron might present to Margaret or any other person? If not, why not?

14.6.1 Term 2 of this report [section 14.2] has already considered whether Aaron presented a risk of domestic abuse to Margaret. Term 5 [section 14.5] considers the risks Aaron presented to others. Consequently, that information is not repeated here.

14.7 Term 7

Did your agency share any of the information above with any other agency including making a referral to MARAC[38]? If not, why not?

14.7.1 The risk of domestic abuse that Margaret faced from Aaron was not referred to MARAC. Before a referral to MARAC could have been made then an assessment of the risk that Margaret faced would need to have been made. This would have necessitated a professional from one of the agencies completing a DASH [39]risk assessment form. [NOTE: The panel representative from Bolton NHS Foundation Trust told the panel that Community Nurses were not in a position to complete a DASH risk assessment-consequently any further references to missed opportunities to complete a risk assessment does not refer to the actions of the Community Nurse].

14.7.2 Opportunities to complete a DASH risk assessment were missed. On 14 March 2019 the community nurse correctly made a referral to Bolton Adult Services Safeguarding Team. For the reasons set out in Term 8 [see section 14.8] that matter was not progressed to a S42 enquiry and neither was a DASH risk assessment completed by the Safeguarding Team.

14.7.3 Another opportunity to complete a DASH risk assessment occurred when SW2 spoke to Margaret by telephone [see paragraph 13.3.6]. During that conversation Margaret provided information about both potential physical harm she faced from Aaron as well as coercive and controlling behaviour and possible economic abuse. SW2 did not complete a DASH risk assessment.

14.7.4 Neither SW SG [who received the disclosure from the community nurse] nor SW2 appeared to have recognised the behaviour that was described to them

[38] A Multi-Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed.

[39] The Dash risk checklist is a tool used by practitioners to identify victims who are at high risk of harm from Domestic Abuse and whose cases should be referred to a MARAC meeting.

as domestic abuse. It was for that reason they did not complete DASH risk assessments. Had they recognised what they were being told about was domestic abuse then they should have followed the guidance issued to Local Authorities[40] which sets out the importance of risk assessment when dealing with domestic abuse.

'An assessment of risk should take place in all situations where an adult with care and support needs is experiencing domestic abuse. This assessment should be personalised and along the same principles of Making Safeguarding Personal. Comprehensive, accurate and well-informed risk assessments are fundamental to good practice and good outcomes for people who need both adult safeguarding and domestic abuse services'.

14.7.5 Neither is it clear why SW2 discussed the allegations Margaret made with Aaron who provided an explanation that he did not try and hit Margaret, nor would he do that. There is no evidence SW2 ever discussed with Margaret, or gained her consent, for the information she supplied to be shared with Aaron. The first key principle when working with victims of domestic abuse is to enquire safely about violence and abuse[41];

'Safe enquiry means ensuring the potential perpetrator is not and will not easily become aware of the enquiry. It is a cornerstone of best practice in domestic abuse. Safe enquiry has been developed following circumstances in which women and their children have been placed at risk of serious harm (and homicide) due to perpetrators becoming aware that professionals knew about their behaviour. Research has shown that incidences of violence and levels of harm increase when a perpetrator's control is being challenged. It is very important that the perpetrator does not learn about any disclosure or plans being made by the person at risk by accident or without the knowledge of the person at risk, unless there are very exceptional circumstances'.

14.7.6 The guidance issued by LGA and ADASS sets out examples of when the limits of confidentiality might be breached, for example if a child was in danger, if another adult was in serious danger or if a crime may have been committed. There is no evidence those limits had been reached in this case and there appears to be no justification for sharing the information Margaret provided with Aaron.

[40] Adult safeguarding and domestic abuse A guide to support practitioners and managers. Second Edition 2015 P40. Local Government Association [LGA] and the Association of Directors of Adult Social Services [ADASS]
[41] Op cit P38

14.7.7 One of the common barriers to effective risk assessment and management is what the LGA/DASS guidance refers to as 'Unintended collusion with the perpetrator'[42].

'this can take many forms but common examples include…the victim is not seen as credible and their account of their circumstances is seen as inaccurate or embellished….the perpetrator presents as rational and appears to cooperate with professionals….the perpetrator makes counter allegations of abuse'

14.7.8 When SW2 spoke to Aaron, he told the social worker he did not try to hit Margaret [and would not do] and said Margaret could have behaviour issues herself. The fact SW2 did not challenge what Aaron said, and instead appeared to accept his explanation [noting he had good insight and seemed to have capacity] may be indicative of such unintended collusion.

14.7.9 As highlighted earlier, one of the dangers of disclosing information to perpetrators is that it may increase the risk to the victim. It can be seen by the perpetrator as a challenge to their control. Evidence of Aaron's potential to react adversely, when information about his behaviour was disclosed, can be seen from the incident on 20 March 2019 [see paragraph 13.4.45] when the Home Support Reablement Team visited and Margaret disclosed what Aaron had done when ill and in hospital.

14.7.10 While a number of professionals knew of the safeguarding concerns in relation to domestic abuse, it appears this information was not shared with all professionals involved in the care of Aaron and Margaret. This was an issue identified within the IMR completed by Bolton NHS Foundation Trust.

14.7.11 Finally, when discussing this section of report the panel acknowledged that, even if a risk assessment had been completed, it did not follow that this case would automatically have been referred to MARAC. Within the Greater Manchester area, risk in domestic abuse cases is assessed as meeting one of three levels, high, medium, or standard. Cases that are assessed as high-level cases are automatically referred to MARAC. Cases at the other two levels may be referred to MARAC on the recommendation or professional judgment of the officer completing or reviewing the DASH risk assessment. As a DASH was never completed in this case the panel are not in a position to say what level it would have reached.

[42] Op cit P43

14.8 Term 8

What involvement (if any) did your agency have in relation to the decision not to conduct a S42 safeguarding enquiry in respect of Margaret? Why was that decision made? Was that decision in compliance with the Care Act and/or your multi-agency Safeguarding policy?

14.8.1 The decision in relation to a S42 safeguarding enquiry was made by the Adult Services Safeguarding Team in Bolton Council after they received information from the community nurse about the disclosure from Margaret. The circumstances of this are set out in detail in paragraphs 13.3.26-13.3.31.

14.8.2 Bolton Council Adult Services spoke to staff involved in this decision as part of the preparation of their IMR. Given the time that has passed since their involvement with this case, the deputy safeguarding team manager [SG M] was unable to recall fully the conversation with SG SW.

14.8.3 After reading the case records, SG M says they had a conversation on 15th March 2019 with SG SW and agreed there was no requirement at the time to progress the case to a Section 42 safeguarding enquiry. From the information provided by SG SW verbally, Aaron was not returning home. Advice was being given to the hospital Social Worker [SW 2] that a discharge planning meeting was needed to discuss an appropriate discharge destination.

14.8.4 It is SG M's understanding, that Margaret had stated she did not wish Aaron to return home because she could not cope with him at home. Therefore, any further risk to Margaret would be removed by Aaron not returning home. No consideration was given to completion of a DASH risk assessment and progression to MARAC for the reason given. SG M also noted that the Team Manager [who has since left post] authorised Margaret's case closed and therefore, the assumption of SG M and the IMR author is that the Team Manager was also satisfied with the action being taken at the time.

14.8.5 SG M does not recall if they recognised at the time if Margaret's case amounted to a disclosure of domestic abuse. However, during the meeting SG M did recognise that Margaret had care and support needs, despite not receiving services, and remained independent. Margaret had made a disclosure and from reading the case notes there was a lack of professional curiosity and therefore, any opportunity to ask further information and clarity about what Margaret had disclosed was missed.

14.8.6 SG M does not recall if they gave advice or if they had more than one conversation with SG SW about any advice the hospital social worker should be giving if Aaron returned home. Because the assumption was this would

not be happening. SG M has received training and, on reflection, they would have followed up that the discharge planning meeting went ahead. They would have considered SG SW attending to offer support to the meeting and ensure that, should Aaron return home, then a protection plan and risk assessment was put in place.

14.8.7 SG M told the IMR author that, since March 2019, there have been changes made within the safeguarding process. Further training has been delivered to Adult Services staff and SG M would expect that workers, in the first instance, would now recognise the need to progress to a Section 42 enquiry before discussion with a manager. Should this not occur, SG M feels they would offer further oversight. SG M suggests the learning from this DHR report is shared and discussed across the service.

14.8.8 The Adult Services IMR author believes several factors and assumptions appear to have influenced the decision SG SW made, in consultation with their deputy manager, not to undertake a S42 enquiry.

1. SG SW [who spoke to the community nurse] interpreted the information being given as related to Aaron's current period of ill health and assumed he would not return home.
2. Margaret had told the community nurse she did not want Aaron to return home.
3. During the telephone conversation with the community nurse, SG SW was told Aaron had a diagnosis of Dementia. This was not the case at that time[43], however it led SG SW to believe the concern about Aaron was in relation to his current presentation, as he was not fully aware of his actions.
4. SG SW spoke with Margaret by telephone and felt satisfied she did not disclose any other abuse had occurred previously. SG SW says Margaret said she would telephone the police if necessary and therefore SG SW felt Margaret was able to protect herself.
5. There would be a discharge planning meeting, whereby an appropriate discharge destination would be found. Therefore, any risk that Aaron presented to Margaret would be reduced.

14.8.9 The criteria for a Section 42 enquiry under the Care Act 2014 is;

- The person has care and support needs and;
- They may be experiencing or at risk of abuse or neglect and;

[43] Aaron did not receive a diagnosis of dementia at any time before he killed Margaret. This diagnosis was only given after he had been arrested for the offence.

- They are unable to protect themselves from that abuse and neglect because of those care and support needs.

14.8.10 When the decision was made not to undertake a S42 enquiry the referring agency [i.e. Bolton Foundation NHS Trust the employers of the community nurse] should have been informed. That did not happen. It does not appear the multi-disciplinary team were made aware that a safeguarding referral had been made and the outcome was not to progress to a Section 42 enquiry. Neither was the ward at Bolton hospital provided with any feedback on what happened to the safeguarding referral.

14.8.11 The IMR author for Bolton Council Adult Services believes, based on information known at the time the decision was made, that the criteria were met for a S42 enquiry. There was evidence Margaret had care needs; there was information suggesting she was at risk or experiencing abuse; at the time of the referral staff were unable to establish she was able to protect herself. As such, this referral should have progressed to an enquiry and followed Bolton's Multi Agency Safeguarding process [the issue of MARAC has already been considered within Section 14.7 of this report]. That meant there was no formal investigation to establish the extent of the disclosure and the outcomes and support that could be offered to Margaret, through making Safeguarding Personal principles[44].

14.8.12 The review panel have considered all the reasons above given by the IMR author and agree with their findings that a S42 enquiry should have been undertaken. The panel were told it is not unusual for professionals, including both clinical staff and social workers, to be presented with a patient with challenging behaviours during a period of delirium. The fact that patients may have assaulted staff or engaged in other disruptive conduct during a period of delirium does not mean they will then be compulsorily detained under the Mental Health Act and never allowed home. Very often delirium subsides and it is then considered that a patient is suitable to return home. The focus of professionals is upon 'thinking home' first.

14.8.13 The important difference in this case is that Margaret was a victim of domestic abuse before Aaron entered hospital. This information was

[44] Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. The work is supported by the LGA with the Association of Directors of Adult Social Care (ADASS) and other national partners and seeks to promote this approach and share good practice. A series of tools to support MSP, measure effectiveness and improve safeguarding practice is also available. https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

available to be discovered if agencies asked appropriate questions. In this case inappropriate assumptions were made on the basis of incomplete information. Consequently, the panel feels there is a lesson to be learned here about the importance of asking questions and seeking as much information as possible about domestic abuse from the victim. That ensures risk can be formulated and appropriate measures and plans put in place to protect the victim [see lesson 3 section 16].

14.9 Term 9

What involvement (if any) did your agency have in relation to the decision to hold a planning meeting to discuss the concerns that had been raised in respect of Margaret and Aaron? Why did that meeting not take place? Did the decision not to hold a meeting have an impact upon the risk that Margaret faced?

14.9.1 Following the safeguarding referral made by the community nurse the social worker in the safeguarding team [SG SW] had a conversation with SW2 [see paragraph 13.3.36]. During this conversation it was agreed that SW2 would arrange a multi-disciplinary meeting [MDT] to address the issues in more detail. One of the factors that may well have influenced the decision not to progress the safeguarding referral to a S42 enquiry was that the safeguarding team knew an MDT was going to be held.

14.9.2 SW2 knew from the conversation with SG SW, and with the conversation they had with Margaret, that allegations had been made that Aaron had been aggressive to his wife and had tried to hit her [see paragraph 13.3.36]. They had agreed with SW SG that an MDT should be held. SW2 did not arrange that meeting. The review panel do not know why they made that decision. It was a missed opportunity to share information and assess risk.

14.9.3 Margaret also made at least two requests to hold a discharge planning meeting. The first of these was on 14 March 2019 [see paragraph 13.3.26] and the second occasion was on 15 March 2019 [see paragraph 13.3.36]. A discharge planning meeting was not held either. The hospital ward was told by the integrated discharge team [through routine MDTs] that a decision had been agreed with Aaron to return him home with a package of care.

14.9.4 No members of staff from the ward had been involved in the discharge planning discussions as they had principally involved SW2 and the family. While some members of staff from the ward were aware of the allegations made by Margaret [and that a safeguarding referral had been made] they were never told that a decision had been made not to progress that referral to a S42 enquiry. At least six members of the integrated team had been

involved in this case and it is also unclear if all of them were aware of the safeguarding concerns.

14.9.5 Because information was not shared and discussions were not held with other professionals and Margaret [through either an MDT or discharge planning meeting], opportunities were lost to challenge the decisions that were being made and to fully consider the risks that Aaron posed to Margaret and the plans for her safety.

14.9.6 The decision not to hold an MDT [when it had been agreed with SG SW that one should have been held] was inappropriate. While Margaret eventually agreed she did not want a discharge planning meeting she consented to that decision over the telephone after it had been agreed that Aaron would return home. Again, it is felt that the decision not to have a discharge planning meeting with Margaret, was not appropriate and meant opportunities were lost to fully involve her in safety planning. However, the panel also recognise that, even if a discharge planning meeting had been held, the outcome may still have been that Aaron was discharged home.

14.9.7 SW2 has reflected on this case and identified their own learning which they shared with the panel. This includes.

i. That they should have insisted on a discharge planning meeting to bring everyone together.
ii. They should have sought advice from a manager in respect of the concerns raised by the community nurse.
iii. Having discussed the case with their manager they would continue to update on the case.

14.10 Term 10

What involvement (if any) did your agency have in relation to the decision to discharge Aaron from hospital on 20 March 2019? Who was involved in the discussions and decisions to discharge Aaron (including any family members)? What assessments were made in relation to that decision and how were they documented?

14.10.1 The hospital discharge process was initiated on 26 February 2019 when Adult Services first received a referral from the hospital ward where Aaron was receiving treatment. The referral stated there were problems with his self-care and mobility and that Margaret was not able to cope. The discharge process was undertaken by members of staff from the Integrated Discharge Team [IDT] based at Bolton Hospital.

14.10.2 There were a number of discussions between staff members, Margaret, Mary Ellen, and other members of the family. While they were not seen by staff

from the IDT, the exchange of text messages between mother and daughter clearly demonstrate Margaret was no longer able to cope with Aaron. They also indicate that Mary Ellen had concerns her father had been abusive to her mother [see paragraph 13.3.12].

14.10.3 The first face to face meeting between IDT staff and the family happened on 1 March 2019. The notes of this meeting, which was attended by SW1 [see paragraph 13.3.17 et al], clearly identify there were tensions between Aaron and Margaret. She made it clear she did not want him to come home and could not cope with him.

14.10.4 The arguments she described with Aaron, about finances and her disclosure about his refusal to contribute to household bills, were potential indicators of financial/economic abuse. A professional trained in domestic abuse [such as an Independent Domestic Violence Advocate [IDVA]] might have identified those issues and probed further. Had domestic abuse been suspected and disclosed, then a trained professional would have been extremely cautious about giving the advice that SW1 did about Aaron having a right to return home.

14.10.5 While Margaret made a clear statement she no longer wanted to live with Aaron, this seems to be contradicted by her conversation with SW2 on 6 March in which she expressed a desire to be rehoused with Aaron in a two-bed bungalow. The review cannot reconcile the different intentions expressed by Margaret. While unable to reconcile these different intentions, the panel feel it should be made clear that at no point within the patient notes for Aaron does it say that he would not be going home either.

14.10.6 Neither can this review reconcile the different recollections of Mary Ellen and SW2 over the conversation that took place on 12 March 2019. SW2 says that Mary Ellen agreed to her father having a package of care. Mary Ellen does not recall that conversation and neither does she recall there ever being any mention of a referral to Wilfred Geere House.

14.10.7 Whatever agreement that might have been made between SW2 and Mary Ellen, Margaret [as Aaron's wife] was in the position of being both his next of kin and his carer. Her views should have had primacy. The conversation between her and the community nurse on 14 March 2019, in which she disclosed domestic abuse [see paragraph 13.3.26] was therefore significant and should have placed a completely different perspective on the discharge planning process.

14.10.8 The text messages [paragraph 13.2.27] that passed between Mary Ellen and Margaret are helpful and allow the victim's voice to be heard. It is very clear

Margaret did not feel safe with Aaron returning home and seemed to be expressing a high degree of frustration with the discharge planning process.

14.10.9 Margaret's voice continues to be heard in text messages she exchanged the following day with her daughter [see paragraph 13.3.33] in which Mary Ellen asked her mother to ring SW2. Margaret's response to Mary Ellen indicates she had spoken to SW2 regarding a meeting and that she still continued to feel returning Aaron home was unsafe. Margaret also expressed frustration to her granddaughter Shirley [see paragraph 13.3.35].

14.10.10 The review has not been able to establish what happened later that day, during conversations between Margaret and SW2, that led to her apparently changing her mind so significantly and consenting to allowing Aaron to return home with a package of care. The review cannot reconcile the differences between the notes produced by SW2 and Mary Ellen's recollections.

14.10.11 Irrespective of the differences in the accounts as outlined in section 14.9, SW2 now acknowledges they should have insisted on a discharge planning meeting taking place. The review panel agrees.

14.10.12 While this review recognises the pressures that are upon professionals to free hospital beds this was not a routine hospital discharge case. Margaret had made clear and unambiguous statements to a number of professionals that she had been the victim of domestic abuse. Those concerns were never properly addressed, because a decision was made not to hold a S42 enquiry. They should still have been recognised as significant issues that had a bearing upon the discharge planning decision. They were not, and that was a missed opportunity to assess the risk to Margaret. A discharge planning meeting, rather than a series of telephone calls between SW2 and the family, would have been a much more appropriate and effective way of fully exploring those issues.

14.11 Term 11

Did any assessments relating to Aaron's discharge from hospital identify that Margaret was at risk from Aaron? If any risk was identified what plans did your agency have to remove, reduce, or manage that risk?

14.11.1 On 19 March 2019, when Aaron was ready for discharge from hospital, SW2 recorded information in a need's assessment. SW2 shared this with the Home Support Reablement team. The IMR author for Bolton Council states the needs assessment is brief, it does reflect Aaron's recent circumstances and that he was physically aggressive towards ward staff and for carers to be mindful of this. The Assessment records Aaron was eligible in three domains with clear instruction as to what carers needed to do to meet his needs.

- Eating and drinking
- Personal care
- Being safe around my home

14.11.2 The review panel have been supplied with a document completed on 20 March 2019 in respect of Aaron. The title of the document is Bolton Council Social Care 'Service User Risk Assessment'. Page 1 of the document contains a risk assessment. In the risk box is a section with the title 'Behaviour of the Service User Family or Others i.e. to others'. The following is extracted from that box;

'[sic] Doctors have suggested that [Aaron] had delirium.

Memory Clinic referral to be made.

[Aaron] has shown aggression at one time on the ward towards staff carers to be mindful of this'.

14.11.3 Opposite that risk in the box entitled 'Control measures/precautions already in place' is the following entry.

'[sic] Support staff to give regular feedback and report any concerns back to the office.

Support workers to monitor [Aaron's] behaviour and report any concerns back to the office.

Staff to adapt a low arousal approach.

[Margaret] has stated that she would telephone the police if [Aaron] presents with any signs of aggression towards her'.

The letter D appears in a column titled 'Risk Level'

In the final column titled 'Further action required to manage risk' is the following entry.

'To be reviewed in line with departmental policies.

14.11.4 Within the 'Falls screening tool and management plan' [page 8 of the same document] within a box headed risk assessment' is the following entry.

'Can become aggressive at times Support workers to be aware'.

14.11.5 There is no direct reference within this document that Aaron presents any risk to Margaret and no reference to the disclosure that she made concerning domestic abuse at his hands. There is an inference that she may be at risk, from the reference in the control measures box to Margaret ringing the police if Aaron became aggressive towards her.

14.11.6 The review panel accepts the document would have been appropriate had this been a case of a discharge from hospital with an underlying health condition. However, the review panel concludes the document does not adequately identify and formulate the risk of domestic abuse that Margaret faced from Aaron. Neither is the plan to protect Margaret appropriately robust, relying almost entirely upon her contacting the police if she felt threatened. While Margaret understood this was an option [separately she told Ron and a reablement worker she would ring the police if necessary] other measures could have been considered[45].

14.12 Term 12

Were the services your agency offered Margaret and Aaron accessible, appropriate and sympathetic to their needs? Were there any barriers in your agency that might have stopped Margaret from seeking help for the domestic abuse?

14.12.1 The review felt that, overall, the clinical services offered to Margaret and Aaron were appropriate and sympathetic to their needs. Margaret had regular contact with her GP and with community nurses with whom she seemed to have formed an excellent relationship. When either Margaret or Aaron had health needs there appeared to be a very efficient response to these. For example [paragraph 13.3.3] the response of the GP to concerns about Margaret being confused. Another example was the speed with which the GP responded to concerns about Aaron's behaviour [see paragraph 13.3.6]. This led to blood samples being taken and his immediate admission to hospital the same day.

14.12.2 As already set out in this report, the review finds there were weaknesses in aspects of the social care that was provided to the couple. These weaknesses relate to the way in which the disclosure of domestic abuse by Margaret was handled, the lack of a mental capacity assessment and the hospital discharge processes. As they have been considered in detail elsewhere in this report they are not repeated here.

[45] For example: ensuring staff specifically asked Margaret questions each day as to whether she had received any aggression from Aaron in the last 24 hours, involving the family of Margaret in the development of the safety plan, a physical review of address 1 to identify a safe room that Margaret could go to and lock the door in the event she felt threatened, checking Margaret had emergency numbers programmed in that she could speed dial, ensuring Margaret kept her telephone charged each day and carried it with her, Adult Services contacting the police to report a 3rd party disclosure of Domestic Abuse which could have led to a DASH submission to the MASH. Consideration could have been given to adding a marker to the address to denote the vulnerability of F1 and/or the risk of domestic abuse.

14.12.3 In relation to domestic abuse, the review did not find there were any barriers within agencies in Bolton that prevented Margaret making disclosures. All agencies involved in this review have policies in place in relation to domestic abuse that set out pathways for receiving reports. Margaret had a good relationship with community nursing and this may well have been why she chose to make a disclosure to the nurse. The nurse in turn ensured the disclosure was reported into the Safeguarding Team in Adult Services. Margaret also repeated that disclosure to other professionals including SW2. Rather than barriers, the weaknesses in this case appear to be the way in which those disclosures were handled.

14.12.4 While the panel did not find barriers to Margaret making a disclosure of domestic abuse they do feel it is important to recognise that, as a group, elderly females within the UK may be faced with a number of generic barriers. Some of these barriers are explored in more detail within section 14.15 of this report.

14.13 Term 13

What knowledge or concerns did Margaret's family or friends have about her relationship with Aaron? Did they have any information which might have indicated there was any domestic abuse in the relationship? If so, did they know what to do with such information?

14.13.1 The family each had different experiences of Aaron's behaviour. The information they held is set out in detail within section 12 and is therefore not repeated here.

14.13.2 May's experiences were the most recent as she is the youngest of the three siblings and was the last to remain at home. When she spoke to the Chair of the DHR by telephone he asked her about her understanding of domestic abuse. She said that, when she was young, she did not recognise what she was witnessing was domestic abuse. However, as she grew older she realised what was happening was actually domestic abuse.

14.13.3 While her siblings had witnessed abusive behaviour by Aaron, they had not directly witnessed physical abuse by their father. May had, and she had also been the victim of it as well. For example, she had witnessed her father's extreme volatility when returning from work and demanding his tea. She also described him as being a cruel man and cruel to animals as well.

14.13.4 Her remark about cruelty to animals is significant as there is a documented correlation between this and domestic abuse. This is a fact that was very unlikely to be recognised by the family of Aaron [nor until recently by many professionals] unless they had specialised knowledge of domestic abuse.

'It is easy to overlook the fact that…animal abuse and domestic violence are directly related as different manifestations of the common denominator of family violence[46]'

14.13.5 That is starting to change in the UK and there is now an increasing recognition of this issue. For example, the NSPCC have produced a booklet in conjunction with animal charities that helps professionals better understand those links[47]. In this case the panel has seen no evidence to indicate that professionals knew Aaron was cruel to animals.

14.13.6 The incident when Aaron physically abused May and put his hands around her throat was also witnessed by Shirley. This incident was noteworthy as it marked an escalation in the behaviour of Aaron. The placing of hands around victim's throats is recognised as something that escalates the risks faced by victims and has been a precursor in many cases to much more harmful behaviour including homicide.

14.13.7 For example, Reducing the Risk[48] identifies 15 high risk factors of serious harm or homicide in domestic abuse cases these include.

'Strangulation (choking/suffocation/drowning): escalating violence, including the use of weapons and attempts at strangulation must be recorded when identifying and assessing risk. This includes all attempts at blocking someone's airway'.

Animal and pet abuse are also included within this list.

14.13.8 May felt she should have rung the police. However, she did not, and instead took her mother to her partner's house. Shirley, who was present and witnessed this incident, said she recognised what Aaron had done was domestic abuse. She and her aunt had considered whether it should be reported to the police. However, they had decided it should be sorted within the family.

14.13.9 May recognised that Aaron's behaviour was domestic abuse and had tried, without success, to persuade her mother to leave her father. May felt that, even if she had tried to get her parents some help for the domestic abuse, she didn't feel that they would have accepted any sort of support. Her mother would never have left her father she said.

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[46] Child Abuse, Domestic Violence and Animal Abuse: Linking the Circles of Compassion for Prevention and Intervention: Frank R. Ascoine and Phil Arkow Purdue University Press 1999.
[47] Understanding the links. Child abuse, animal abuse and domestic violence. Information for professionals. https://bswccg.nhs.uk/for-clinicians/safeguarding/child-safeguarding/287-understanding-the-links-child-abuse-animal-abuse-and-domestic-violence/file
[48] Reducing the Risk of Domestic Abuse is a charity that develops and delivers services for those affected by domestic abuse. www.reducingtherisk.org.uk

14.13.10 May was asked by the Chair what advice she would give other families in the position her family was in. She said they should call the police or find someone or some agency that can help. May felt the family doctor might be someone that can help in these situations. The Chair asked the other members of the family the same question when he met them. They said the advice they would give would be 'if you think something is going on ring professionals'.

14.13.11 The panel recognises the Family of Margaret were in a difficult position in relation to the information they held and they acted in the way that many families would also have done. The panel recognise that, what they tried to do, should not be viewed through the telescope of hindsight. However, the panel believe the experiences of this family reinforces the vital role of other families in the future identification of domestic abuse: it is an important piece of learning to emerge from this review. It is learning that appears in many other domestic abuse cases and is therefore worth revisiting.

14.13.12 In this case the family [notably May and Shirley] recognised that some of the behaviours they witnessed from Aaron were domestic abuse. While May had not witnessed Aaron abusing her mother, she considered it possible this had occurred.

14.13.13 Other members of the family had different experiences. While they had not witnessed physical abuse by Aaron some of the incidents they were aware of could, unbeknown to them, have been part of a pattern of coercive and controlling behaviour by Aaron [See Appendix C]. For example, not contributing to the family budget and mysteriously turning the heating down. One of the barriers to providing effective support to victims is that family and friends struggle to recognise acts such as these as domestic abuse.

14.13.14 In a survey and report conducted by Citizens Advice[49], only in the case of physical abuse, did more than half of the respondents feel confident they could recognise what was happening to someone they knew. Respondents were also unclear about whether certain behaviour counts as abuse and also about who abuse can happen to. Even if domestic abuse is recognised, then family and friends may not engage because of its perceived sensitive and private nature.

'As victims may struggle to begin the conversation, its important friends are encouraged to overcome their anxieties and reticence and be equipped to ask about abuse if they have concerns'[50].

[49] A link in the chain. The role of friends and family in tackling domestic abuse: Imogen Parker August 2015
[50] Op Cit P35

14.13.15 The key finding from this research is the need to 'support the supporters'.

> 'Encouraging friends and family to engage with abuse is not as simple as telling people they should: the majority of the public believe they would engage, but there is a gap between intention and interaction'[51]
>
> The report calls for the equivalent of a 'green cross code' for domestic abuse that directly addresses the barriers for family and friends to intervene and which[52];
>
> - Details [early] signs of abuse, dispels myths and moves beyond stereotypes.
> - Offers strategies for asking safely.
> - Shifts some responsibility onto informal networks to 'lean in' and engage.
> - Encourages a positive first response disclosure.
> - Signposts to information and support, both for victims and supporters.

14.13.16 The review panel have therefore identified learning and recommendations that embodies the spirit of this 'green cross code' and seeks to strengthen the support Be Safe Bolton provides to the families of victims of domestic abuse.

14.14 Term 14

Was there any evidence that Margaret and/or Aaron had issues with managing debt? If so, to what extent did that impact upon their relationship?

14.14.1 The family identified finance was a significant issue in the lives of their parents and is described in detail with section 12 of this report. In summary it appears Aaron was someone who hoarded money while conversely Margaret was very generous, although she could not manage money well and consequently got herself into debt. Aaron never contributed to the running of the house and this responsibility was left to Margaret.

14.14.2 There were other indicators that suggest finance was an issue within the couple's relationship. For example, Aaron's complaint that the heating controls were being turned up. With only Margaret and Aaron occupying the house, the only logical conclusion is that she was turning the heating up. The fact that she denied this may well have been because she was fearful of admitting to Aaron that she was cold. Whether his motive for complaining

[51] Op Cit P39
[52] Ibid

and keeping the heating controls low was to save money, or instead as some sort of coercive act will never be clear.

14.14.3 While much of the detail of what happened in the relationship between Margaret and Aaron is not known, it is important to recognise how financial and economic abuse can form part of a wider pattern of coercive control within the context of domestic abuse [see Appendix B]. The links are well documented.

'It's important to understand that financial abuse seldom happens in isolation: in most cases perpetrators use other abusive behaviours to threaten and reinforce the financial abuse[53]'

14.14.4 Economic abuse is wider in its definition than 'financial abuse', as it can also include restricting access to essential resources such as food, clothing, or transport, and denying the means to improve a person's economic status (for example, through employment, education, or training)[54]. The charity Surviving Economic Abuse describes it in the following way:

"Economic abuse is designed to reinforce or create economic instability. In this way it limits women's choices and ability to access safety. Lack of access to economic resources can result in women staying with abusive men for longer and experiencing more harm as a result."

14.4.5 May spoke about Margaret not being able to leave Aaron. The family said neither Margaret nor Aaron wanted to live together anymore yet they could not actually live apart. As Margaret's voice can no longer be heard, the panel cannot reach a view on why they could not separate.

14.4.6 One possibility may have been that Margaret relied significantly upon Aaron for financial support. Without him she would have found it difficult or impossible to survive. As part of a pattern of coercive and controlling behaviour, some perpetrators will deliberately manipulate family finances so that the victim is entirely dependent upon them. Without any means of financial support this makes it impossible, or extremely difficult, for the victim to leave an abusive relationship.

14.4.7 Without more information the panel cannot reach a view as to whether Aaron did manipulate the finances deliberately and in such a way as to exert financial and/or economic abuse upon Margaret. It may be that Margaret simply did not recognise that she was the victim of such abuse. For example,

[53] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/financial-abuse/
[54] Op cit

Aaron did not contribute to the running of the house and yet she bought him fancy foods out of the money she had for managing the house.

'Many people assume abuse has to be physical, so would not see themselves as a victim even if they experienced other types of abuse'[55].

14.15 Term 15

What were the circumstances of any housing application that Margaret and/or Aaron made? To what extent were the couple's living arrangements impacting upon their relationship?

14.15.1 Margaret considered moving from address one as she had spoken to both family and some professionals about it. When the Chair met with the family they told him they knew Margaret had completed a housing application although they believed it was in her name only as a sole tenant. This reflected their belief that Aaron would not return home because of his condition.

14.15.2 On 28 February 2019, when Margaret was seen by an occupational therapist, she was given advice on how to register for housing. On 6 March 2019 Margaret told SW2 she wanted to apply for rehousing for herself and her husband in a two-bed bungalow and was given telephone and online information for Homes for Bolton.

14.15.3 Records provided to the DHR show Margaret submitted an on-line application with Homes for Bolton on 18 March 2019. The application was made for a couple by Margaret with Aaron shown as a joint applicant. There is no indication Aaron took any part in completing the application [on that date he was detained in hospital awaiting discharge home] and it was unlikely he had the means or capability to complete a computer-based application.

14.15.4 Homes for Bolton told the panel there was no direct customer contact or any detailed case work or assessment in relation to the application. In most circumstances [as with this one] the on-line application process does not require any direct customer contact to allow it to go live. Homes for Bolton housing register currently stands at approximately 23,000 household applications with approximately 4 to 5000 new applications annually.

14.15.5 Housing providers often hold detailed information both in applications and in day-to-day contact with tenants that can be of value in identifying domestic abuse. There is a significant body of research to support this view. For example, Safelives[56] were commissioned by a social housing provider in the

[55] Struggling for support? Citizens Advice: Parker I 2015

[56] Safelives is a national charity dedicated to ending domestic abuse for good: www.safelives.org.uk

North-East to examine their role in identifying abuse and how early intervention can help protect victims and their families. The research[57] found that 13% of all repair jobs and 21% of all repair costs were potentially related to domestic abuse.

14.15.6 The research made a number of recommendations for housing providers, amongst which was the early identification of victims by asking them about domestic abuse routinely and sensitively. The panel recognised the application made by Margaret was online and had not reached the stage of face-to-face customer contact. However, the DHR panel sought assurance from Bolton Homes as to whether direct questions about domestic abuse are asked during their housing application process.

14.15.7 Bolton Homes told the panel that if, there had been any concerns, this application would have been screened and considered for a referral to be MARAC screened. Bolton Homes are adopting a new application system that will be implemented in May 2020 which contains specific questions about the reasons for the application and whether domestic abuse is a factor. The system in operation at the time of Margaret's application did not have that facility.

14.15.8 It is clear from what the family have told the review that Margaret and Aaron found it increasingly difficult to live together. The design and suitability of address one may have had an impact upon their relationship because of their physical conditions. For example, Margaret had difficulty mobilising and used a frame and wheelchair. She had the use of a lift to gain access to her first-floor bedroom. Aaron's mobility was better although he still needed to use sticks and a scooter.

14.15.9 Physical disability can be a factor in domestic abuse. The Crime Survey for England and Wales[58] found that 12.6% of women and 4.% of men with a disability experienced abuse in the previous year compared to 4.9% of women and 2.5% of men without. The design and suitability of address one may have compounded the issues of physical disability and could have increased tensions between the couple. For example, the family spoke of Margaret riding her wheelchair over Aaron's feet. She also felt unsafe because Aaron came into her bedroom.

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57 http://www.safelives.org.uk/sites/default/files/resources/Safe%20at%20Home%20Report.pdf

58 Crime Survey of England and Wales 2013/14

14.15.10 Family members spoke of Margaret and Aaron not being able to live together and of attempts to try and persuade Margaret to leave. For example, May tried to persuade her some years before the events under review in this report. May felt her parents had been living together for so long they just could not separate. This may be one explanation as to why Margaret did not leave Aaron some years ago. There may be others that the family were not aware of.

14.15.11 As Margaret no longer has a voice, this review cannot say with any certainty what her reasoning might have been. Research provides some illumination as to why many victims of domestic abuse do not leave abusive relationships. For example, Women's Aid[59] cite danger and fear, isolation, shame, embarrassment, denial, trauma, and low confidence as amongst the reasons. There are also a host of practical reasons that will vary depending upon the circumstances of each case. For example, where the victim is going to live?

14.15.12 The fact Aaron appeared unlikely to leave hospital may have presented Margaret with the first practical opportunity to take control of her future, and hence make a housing application. [She had already received support from occupational therapy to ensure address 1 was suitably adapted to deal with her and Aaron's needs see paragraph 13.3.11]. Initially the family felt this application was for her to live alone. The choice of a bungalow would certainly have addressed Margaret's mobility difficulties and made life more comfortable for her. However, when Margaret later spoke to professionals, she talked of living with Aaron and when she made the application it was in joint names.

14.15.13 Again, because Margaret does not have a voice it is not clear why she appeared to have changed her position; from wanting to live alone to moving to new accommodation with Aaron. In many conversations with professionals, she had spoken of feeling unsafe and not wanting Aaron to return home. However, because Margaret made an application in joint names, should not be a reason for believing she no longer felt at risk from Aaron.

14.15.14 There can be many reasons why older people remain in an abusive relationship rather than leaving. Research[60] shows that older victims of abuse are likely to have lived with abuse for prolonged periods of time before seeking help. Hence they may feel anxious about leaving behind a life time

[59] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

[60] Safe Later Lives: Older people and domestic abuse: Safelives Ending Domestic Abuse #Oct 2016
http://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

of contributions such as homes and treasured possessions. For older people there may also be much more emotion attached in leaving an abusive partner and increased fear about the change in family dynamics.

14.15.15 Physical health and dependency for others to care for them as well as isolation can all be factors in the decision made by older victims of abuse to remain[61]. It is noteworthy that Margaret had previously sought help for feelings of loneliness in 2015 [see paragraph 13.2.4]. In cases when the perpetrator starts to suffer illness research has also identified this can change a victim's view.

'The caring dynamic can also present difficulties when the individual being cared for becomes the perpetrator, perhaps due to medical issues that can exacerbate aggression such as dementia. In these situations, the victim may feel a lot of guilt….'[62]

14.15.16 While these are factors that might have influenced Margaret's decision to apply for a joint tenancy, this review can never be certain as to precisely what it was that made Margaret completed the application in joint names.

14.16 Term 16

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Margaret and Aaron?

14.16.1 Both Margaret and Aaron were white British born and raised in the United Kingdom. English was their first and only language and there is no evidence that either of them had difficulty expressing their views verbally. There is no indication that either of them had any cultural, faith or diversity issues that needed to be considered when assessments were completed.

14.16.2 Margaret was a qualified nurse and retired as a sister. She understood the care system better than many others in her position would have done. Other than the incident referred to earlier [see paragraph 13.3.3,] when the cleaner felt she was confused, there is no indication she suffered from memory loss nor lacked mental capacity to make decisions. Margaret was a significant user of SMS, exchanging many text messages with Mary Ellen. She also appeared capable of using computer-based systems, for example, completing an on-line housing application. Consequently, it would appear that Margaret had the capability of understanding assessments that she was asked to contribute to.

[61] ibid P14
[62] Ibid p14-15

14.16.3 Aaron may not have had the same capability as Margaret in terms of written media. There is no evidence he used SMS or computer systems. However, until his illness and admission to hospital, there is no indication he lacked capability to understand and contribute to assessments. That picture changed following his admission to hospital and there is clear evidence he suffered from conditions that impaired his cognition and hence his ability to contribute to assessments. This issue has been discussed earlier in this section and is therefore not repeated here.

14.17 Term 17

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Margaret and Aaron, or on your agency's ability to work effectively with other agencies?

14.17.1 The review panel did not find a lack of capacity or resources was the root cause behind any of the issues within this review. Rather, the focus of learning within this review is upon the ability of professionals to recognise and assess the risk of domestic abuse and safeguard the victim in a relationship involving two elderly people.

14.17.2 However, the panel did recognise discharging people from hospital is done within a system that faces many pressures. The review panel heard the demand for beds within hospitals such as Bolton are significant. For example;[63];

'the National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. Occupancy rates for acute beds have increased from 87.7% in 2010/11 to 89.5% in 2014/15. High levels of bed occupancy may affect patient care as directing patients to the bed most suitable for their care is less likely to be possible'.

14.17.3 When practitioners met as part of the review process [see paragraph 4.6] they spoke about their experiences in relation to bed occupancy levels and how unmet demand for beds regularly created pressure within the hospital discharge planning process. The panel recognise the experiences of staff working within IDTs are not isolated to just Bolton hospital but across Trusts nationally at times e.g. winter pressures. Consequently, as suggested within the Adult Social Care IMR, this may have had an impact on SW2 and their focus at the time Aaron was in hospital.

[63] https://www.nice.org.uk/guidance/ng94/documents/draft-guideline-39

14.18 Term 18

How effective was your agency's supervision and management of practitioners involved with the response to the needs of Margaret and Aaron and did managers have effective oversight and control of the case?

14.18.1 With the two exceptions considered below, the panel is satisfied the supervision of individual professionals involved in this case was effective.

14.18.2 The first exception relates to the Section 42 Safeguarding enquiry discussed in section 14.8. There is evidence the Safeguarding Social Worker spoke with a manger within Adult Services and agreed a Section 42 enquiry should not progress. The review panel identified earlier in this report this was not an appropriate decision.

14.18.3 The second issue relates to the information SW2 received directly from Margaret that she was concerned about Aaron. She told SW2 Aaron had tried to hit her and displayed aggressive behaviour towards her. She said she was not safe at home [see paragraph 13.3.6]. The same day SW2 received that information they had a conversation with Aaron who said Margaret could have behavioural issues as well.

14.18.4 The IMR submitted by Adult Services found SW2 did not seek advice from managers on the Integrated Discharge Team in relation to that information. It is expected staff, when made aware of any safeguarding concerns, discuss this with their own management team and not just the Safeguarding Team.

14.18.5 Staff and managers within IDT meet daily to discuss complex cases. The case of Aaron was not raised in any of those daily meetings. Not raising the issue with management meant there was no opportunity to discuss the appropriateness of the discharge plan or whether a discharge planning meeting should have been held.

14.18.6 The IMR submitted by Adult Services provided this review with information about improvements being made which will address some of the issues in this case. The review panel were told IDT management team have identified further discussion is required when any discharge to assess bed is identified. This is to discuss the suitability for those being referred and agreement to progress any vacancies. This also allows for further case discussion about appropriateness of discharge plans.

14.18.7 Any safeguarding concerns and/or complex cases are now discussed at the daily huddle meeting and weekly managers meeting to ensure management oversight and support to IDT staff in making decisions. Bolton Council commenced a business improvement review of Adult Safeguarding before

the death of Margaret. Learning from this DHR/SAR will now be fed into that review.

14.19 Term 19

Were single and multi-agency policies and procedures, followed; are the procedures embedded in practice and were any gaps identified?

14.19.1 The review panel has already identified within section 14.8 of this report that Adult Services did not deal appropriately with the information it received from the community nurse concerning the disclosure of domestic abuse by Margaret in accordance with the Care Act 2014 and Bolton Council's Safeguarding Policy. In addition, having received information that indicated Margaret was a victim of domestic abuse and at risk from Aaron, Adult Services did not then follow the multi-agency policy for dealing with domestic abuse. This issue has already been considered within section 14.7 of this report.

14.19.2 The review panel did not identify there were any other occasions when single or multi-agency policy was not followed.

14.20 Term 20

What learning has emerged for your agency?

14.20.1 Individual agency learning is set out at section 16.1 post.

14.21 Term 21

Are there any examples of outstanding or innovative practice arising from this case?

14.21.1 While there were some examples of good practice the review panel did not identify any practice that was either outstanding or innovative.

14.22 Term 22

Does the learning in this review appear in other domestic homicide reviews commissioned by Be Safe Bolton Strategic Partnership?

14.22.1 Bolton Community Services panel representative analysed the domestic homicide reviews undertaken in the partnership area over the last seven years. None of the homicides matched the victim and perpetrator profile of Margaret and Aaron and there was no learning that was felt to be closely aligned between this case and historic cases in the partnership area.

14.22.2 However, there have been cases in other parts of the North West that have matched the profile in this case were similar learning has been identified. For

example, the case of Joan in 2016 who was killed by her husband Albert. He was admitted to hospital with confusion. Following his discharge home, he hid a knife under a chair and made a threat to kill Joan which he carried out. It was only after the homicide that he was diagnosed with an age-related dementing condition.

14.22.3 In that case there were a number of similar themes such as.

- Understanding adult safeguarding alert procedures and when to apply them.
- When to undertake carer's assessments.
- How to assess risk of serious harm.
- How to produce good risk management plans.
- Reviewing domestic abuse policies to ensure they address the need to refer older people with mental health problems to appropriate services.
- Training on domestic abuse specifically including abuse between elderly people that involves coercive and controlling behaviour.

14.22.4 While occurring in the North West, none of the learning in the case of Albert or Joan was directed at any agencies involved in providing services in the case of Margaret and Aaron. Neither were any agencies involved in both cases.

15. CONCLUSIONS

Panel conclusions

15.1 Both Margaret and Aaron had mobility issues, these were not exceptional for people of their age. Margaret received support from community nurses and adaptations had been made to assist her in mobilising. The panel found no evidence that either of them were at risk of neglect nor had unmet needs for care and support before Aaron was admitted to hospital. Prior to that event he had acted as carer for Margaret. When he was discharged from hospital those roles were then reversed.

15.2 Before Margaret made a disclosure to a community nurse on 14 March 2019, the review panel found no evidence that agencies had any direct knowledge she was at risk of domestic abuse from Aaron. As a result of the work undertaken reviewing information in this case, the panel has identified there were two historic occasions which were potentially indicators Margaret may have been at risk of domestic abuse.

15.3 The first of these was in February 2008 when Aaron was verbally aggressive to her in the presence of a professional. The professional involved correctly identified the potential for domestic abuse and consequently made a follow up telephone call to Margaret. Although Margaret gave assurances that tensions had dissipated, the panel felt there was a lost opportunity here to consider whether carer fatigue had manifested into domestic abuse and to ask Margaret's GP to explore this at her next appointment.

15.4 The second historic occasion when domestic abuse might have been an issue was in 2015 when Margaret was referred to RAID with low mood and made a disclosure that she was lonely at home. Because there were no other indicators, the review panel felt it was reasonable on this occasion that professionals did not consider domestic abuse. However, while they found no evidence this was the case here, the panel feel it is important to recognise that isolation is something that many victims of domestic abuse can experience and may be deliberately engineered by perpetrators.

15.5 Although Margaret's family have been deeply affected by her death and the criminal justice process, they have been eager to cooperate with this review and recognise how their contribution might help other families in the future. They were able to describe in some detail the day to day lives of their parents. Members of the family had different recollections. While there were undoubtedly some happy times, it is clear there were also some aspects of Aaron's behaviour going back some years that would now be recognised by professionals as indicators of domestic abuse.

15.6 Because she was the youngest, and remained at home the longest with her parents, May was able to provide some significant context around her father's behaviour. This included Aaron being ready to 'have a go' at Margaret and May suffering physical abuse from him when he put his hands around her throat following an argument. May summed him up as a person who was 'massively volatile'. Although May did not recognise the connection [as many lay people and professionals would not], the information she provided that her father was also cruel to animals was significant because of the well-established connections between such behaviour and domestic abuse.

15.7 Although the family had different individual experiences of Aaron's historic behaviour, they all recognised that, in their senior years, there were significant tensions between the couple. There were many examples given. For example, the situation in relation to the central heating and complaints by Aaron that Margaret ran over his feet with her wheelchair. The family summed the situation up as one in which Margaret and Aaron did not want to live together yet could not live apart.

15.8 The panel's professional backgrounds and access to material for this review mean they recognise Aaron's behaviour amounted to domestic abuse. The family did not and could not reasonably have been expected to have reached such a conclusion before these events. A significant lesson from many other reviews of domestic homicides is that families often hold pieces of information which, if known to professionals, might help them identify a pattern of domestic abuse.

15.9 Although Aaron had been in better physical health than Margaret, and had acted as her carer, the family evidenced a rapid decline in his health from early 2019. When he was admitted to hospital in late February 2019, both Margaret and other members of the family were reasonably confident he would not come home. For example, Margaret re-homed his dog.

15.10 The series of text messages between Margaret and Mary Ellen provide a voice for her as the victim. They illustrate that Margaret did not feel able to cope if Aaron returned home. She repeated this position when she spoke to SW1 and also gave that social worker information about his disorientated behaviour. SW1 felt there might be some cognitive defect and hence a mental capacity assessment should be undertaken.

15.11 The responsibility for that assessment rested with SW2 who took over the case from SW1. SW2 did not undertake a mental capacity assessment despite a clear action having been agreed with SW1 for this to happen. The review panel believe that was an inappropriate decision. However, they also recognised other professionals could have assessed Aaron's mental capacity while he was in hospital. There is no record to indicate whether that

happened. If Aaron had been assessed as lacking capacity, then a 'best-interests decision' might have led to a meeting between professionals, Margaret, and her family to consider the safe discharge of Aaron.

15.12 Margaret and her family had concerns about Aaron's mental health which they repeated to professionals. For example, Shirley says she asked a social worker about Aaron's mental state and whether he had been assessed. She says SW2 told her a 'capacity test' would be completed when Aaron returned home. It seems the family were looking for answers to help them understand what was wrong with their father/grandfather.

15.13 Although a consultant psychiatrist gave advice about Aaron's mental health following a request from the hospital, it is clear from what the family says that it was not passed on to them. While the panel recognise there are data protection considerations, they feel it is disappointing the family were not given a sufficient level of feedback to help them fully understand what was happening in respect of Aaron's mental health.

15.14 There are a number of references within agency records of the need to refer Aaron to the memory clinic after his discharge from hospital. From text messages exchanged between Margaret and Mary Ellen it seems Margaret raised this issue with professionals, felt frustrated with their responses and had been given assurances a referral had been made. It was only when this review panel specifically asked for the facts to be checked that it was found no referral for Aaron had ever been recorded. The panel feel it is very disappointing for the family that did not happen. All the agencies that had a part to play in Aaron's care could have made a referral to the memory clinic or checked to establish if a referral had been made.

15.15 There were missed opportunities after he was admitted to hospital in February 2019 for agencies to identify, document and assess the risk of domestic abuse to Margaret from Aaron. While the review panel feel the community nurse who received the first direct report from Margaret on 14 March 2019 acted correctly in referring that disclosure to SW SG, an opportunity was missed to record more information from Margaret about the nature of her abuse.

15.16 Margaret made a further disclosure of domestic abuse when she spoke to SW2 by telephone. Unlike the community nurse, SW2 did not appear to recognise what Margaret was describing was actually domestic abuse. Neither SW SG nor SW2 completed a DASH risk assessment. They should have followed guidance and done so. The fact they did not meant an opportunity was missed to record, assess, and formulate the risk that Margaret faced from Aaron.

15.17 The review panel also found SW2 had no justification nor consent from Margaret for sharing with Aaron the information she had given about the

domestic abuse she suffered. Disclosing information without justification about domestic abuse to perpetrators can increase the risk victims face. Aaron denied to SW2 that he had tried to hit Margaret. Having disclosed what Margaret told them, SW2 did not then challenge Aaron's explanation. Such action may be indicative of unintended collusion which in itself can be a barrier to effective risk assessment and management.

15.18 Domestic abuse is often mistakenly believed to be something that does not involve nor impact upon the elderly, both as victims and perpetrators. That is a perception or belief that is wrong as illustrated by this and an increasing number of other cases nationally. However, that was not the reason the domestic abuse was missed in this case. The panel are clear, that the core lesson here is that professionals simply did not recognise that what they were being told about was domestic abuse. It appears that professionals may have mistakenly treated Aaron's abusive behaviour as connected to, and a manifestation of, his underlying medical condition.

15.19 Although the information provided by the community nurse to SW SG amounted to domestic abuse and should have been recognised and recorded as such, it also met the criteria for a S42 safeguarding enquiry. The decision not to progress in this direction was inappropriate and meant there was no formal investigation to establish the extent of the disclosure and the outcomes and support that could be offered to Margaret. Several assumptions, some incorrect or inappropriate, appear to have then led to the decision not to progress to a S42 enquiry.

15.20 There is variance between the accounts the family have given and the recollections and notes of SW2 concerning the hospital discharge planning process. SW2 recalls that Margaret, in a telephone call consented to the discharge of Aaron and did not want a discharge planning meeting. The series of text messages between Margaret and Mary Ellen appear to show Margaret continued to feel that returning Aaron home was unsafe. The review has not been able to establish what happened later that day, during conversations between Margaret and SW2, that led to her apparently changing her mind so significantly.

15.21 The review panel recognises the pressures upon professionals in respect of hospital beds and hence discharges. They also recognise that, even if a discharge planning meeting had been held, it may not have led to another outcome and Aaron may still have been discharged home with a package of care.

15.22 However, this was not a routine hospital discharge. It was complex and involved statements from Margaret that she was a victim of domestic abuse. Those concerns were never properly addressed, because a decision was made

not to hold a S42 enquiry. They should still have been recognised as significant issues that had a bearing upon the discharge planning decision. They were not, and that was a missed opportunity to assess the risk to Margaret. A discharge planning meeting, rather than a series of telephone calls between SW2 and the family, would have been a much more appropriate and effective way of fully exploring those issues.

15.23 When he was discharged from hospital, the review panel concludes that the Bolton Council Social Care Service User Risk Assessment [while it may have been appropriate for a simple discharge from hospital with an underlying health condition] did not adequately identify and formulate the risk of domestic abuse that Margaret faced from Aaron. Neither was the plan to protect Margaret appropriately robust relying almost entirely upon Margaret using her own initiative to contact the police.

15.24 It is not clear what happened in the final few hours before Aaron killed Margaret. Her final text message to Ron ['It is 999 if he raises his sticks to me'] suggests she may have again felt threatened by Aaron. The use of '999' suggests Margaret did recognise she could call the police if she felt threatened. Whether she had the opportunity to do so before Aaron killed her, or whether she was attacked so suddenly she had no opportunity to do so, will never be known.

15.25 The panel conclude this review by once again expressing their condolences to the family of Margaret on their tragic loss. They thank the family for their valuable contribution to this review and their patience and understanding because of the delays brought about by the COVID-19 pandemic. Without their help and cooperation, the panel would not have been able to identify important lessons for the future.

Family comments

15.26 Having seen the DHR covering report, members of Margaret's family made a number of comments in writing and repeated some of these views when they met with the panel.

15.27 Mary Ellen said that she felt 'let down by professionals'. Mary Ellen and other members of the family have spoken about the need for agency and individual accountability. The Chair has provided the family with information about the DHR/SAR processes and explained to them neither the DHR nor SAR can hold any agency or individual to account. The DHR panel understands members of Margaret's family are now engaging with agencies in relation to concerns that do not sit within the remit of the DHR/SAR process.

15.28 May said she was 'shocked that, having assaulted two nurses, those in charge of Aaron felt he was fit to allow home and did not present a risk to others'.

15.29 May felt that, while her father was in hospital, her mother had made the decision to leave Aaron. She said agencies 'should have done more to protect Margaret'.

15.30 Shirley says Margaret asked several times for a discharge planning meeting. Shirley said she thought it very unlikely that Margaret would simply decide she no longer wanted to have such a meeting. Shirley said she felt Margaret had been 'backed into a corner' to accept Aaron home.

15.31 Both Mary Ellen and Shirley referred to some events as being 'red flags' that in their opinions should have alerted agencies. Shirley says one of these occasions was when Aaron returned home and he seemed to fluctuate between understanding the care and support package at one point, and then later on that day not understanding it. Mary Ellen says one of these occasions was when Margaret made the comment that she would call the police if Aaron 'raised his sticks' to her.

15.32 Mary Ellen and Shirley commented that they had not received some pieces of information relating to the care of Aaron while he was in hospital. These include the scan of Aaron's head, the involvement and advice of the consultant psychiatrist and consideration of a discharge to Wilfred Geere House. The panel member from Bolton NHS Foundation Trust told the panel there were conversations in hospital with the patient [Aaron] and next of kin [Margaret]. The panel member said it has to be made clear that the level of engagement with wider family is not within policy or legal requirements and is dependent on the patient's wishes.

15.33 Shirley said she felt there had been too much focus upon 'thinking home' in order to free beds. She believes this approach led to Aaron being in a position in which he could kill Margaret. The DHR panel have found no evidence that the decision to discharge Aaron was connected to a need to free beds. The panel has concluded [paragraph 15.21] that even if a discharge planning meeting had been held, it may not have led to another outcome and Aaron may still have been discharged home with a package of care.

15.34 Mary Ellen asked the panel to consider making a further recommendation. That is, when agencies have contact with family members concerning care plans, consideration should be given to backing up advice or conversations in writing [for example using text messages, e mails or letters]. Given the technology now available she feels this is achievable. This would provide an audit trail as well as recipients having a clear understanding of the plan of care. Mary Ellen says in this case it could have helped her in making an informed decision if she had all the facts. The DHR panel thank Mary Ellen for her suggestion. The panel do not feel able to make a detailed recommendation in precisely the terms suggested by Mary Ellen because of

the potentially significant implications concerning technology. The panel have therefore translated Mary Ellen's request into a broader recommendation that preserves the sentiment of what she suggests [see recommendation 6 section 17.2 post].

16. LESSONS IDENTIFIED

16.1 Agencies Lessons

16.1.1 Bolton NHS Foundation Trust

- Exploration as to who is responsible for initiating MARAC/Domestic Abuse assessments.
- The need to make more detailed explorations of domestic abuse disclosures particularly as to the degree of violence used.
- The need for further training on 'making safeguarding personal'.
- The need to complete mental capacity assessments.
- The need for professionals to feel confident about challenging decisions.

Bolton Council Adult Services

- The use of language in notes can be interpreted in different ways.
- The safeguarding referral was managed within the set timescales.
- A number of assumptions were made about the time the alleged abuse occurred and that this was directly related to M1's period of ill health. A section 42 enquiry should have been undertaken to formally investigate and establish the extent of alleged aggression from M1.
- The MARAC process was not considered and there needs to be further clarity about the referral process and who is responsible for referring once a concern for domestic abuse has identified.
- A Mental Capacity Act assessment should have been carried out.
- An MDT meeting could have been established and subsequently recorded as to whether an assessment was appropriate prior to discharge and if not a clear rationale.
- Further discussion is required when any discharge to assess bed is identified.

Bolton Clinical Commissioning Group

- This case demonstrates that domestic abuse or violence can and does occur with all age groups throughout life and specifically to older people.
- Vulnerability and frailty can be more than physical and clinical, and consideration needs to be taken from a safeguarding adult point of view if a person is vulnerable, who is an adult at risk, with care and support needs and agencies need to establish if a person has capacity or not to protect him or herself from harm or exploitation.

16.2 The Domestic Homicide Review Panel's Lessons

16.2.1 The DHR panel identified the following lessons. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson One-Panel Recommendation Two Applies
Narrative Margaret disclosed to a community nurse that Aaron was violent and aggressive. She said she did not feel safe. Margaret also told a social worker she was vulnerable, and that Aaron had tried to hit her and displayed aggressive behaviour towards her. The behaviour Margaret described fits the government definition of domestic abuse. Professionals did not record nor deal with Margaret's disclosures as domestic abuse and did not follow multi-agency policies and procedures for handling disclosures of domestic abuse. Instead, they appeared to treat Aaron's abusive behaviour as a manifestation of his medical condition.
Professionals should be able to recognise when information they receive is a disclosure of domestic abuse. They should understand how to handle and record this information in accordance with multi-agency policy and procedures on domestic abuse.

Lesson Two-Panel Recommendation One Applies
Narrative Margaret and Aaron were elderly residents of Bolton [aged 80 and 88 respectively]. The way in which Margaret's disclosures of domestic abuse were handled was not appropriate [as set out in lesson 1]. While age is not the reason domestic abuse was missed in this case, professionals might not always recognise that elderly people can be both victims and perpetrators of domestic abuse.
Lesson Professionals need to recognise the false assumption that domestic abuse ends after a certain age. Policies and procedures need to acknowledge that the experiences of older victims of domestic abuse may be markedly different from those in other age groups.

Lesson Three-Panel Recommendation Two Applies
Narrative

When the disclosure of domestic abuse was made by Margaret insufficient detail was obtained. This meant assumptions were made about when and how the abuse occurred. Those assumptions led to opportunities being missed to formulate and assess risk and hence protect the victim.

Lesson

When receiving disclosures of domestic abuse it is important professionals obtain sufficient information from the victim and do not make assumptions so the opportunity to formulate risk is not missed.

Lesson Four-Panel Recommendation Two Applies

Narrative

Although a safeguarding alert was submitted it was decided not to proceed to a S42 enquiry. That decision was inappropriate and was based upon incomplete information and assumptions that were incorrect. Margaret met the criteria for a S42 enquiry and not proceeding with one meant there was no formal investigation to establish the extent of the disclosure by Margaret and hence the opportunity to protect Margaret from further harm. The decision not to proceed with a S42 enquiry was not shared with all agencies and professionals concerned with the care of Aaron.

Lesson

In order to make appropriate decisions and prepare plans to ensure victims are protected, professionals should have a thorough understanding of relevant legislation and policy and as much accurate information as is available.

Lesson Five-Panel Recommendation Two and Three apply

Narrative

Margaret made an initial disclosure of domestic abuse and then shared the same information with other professionals involved in the discharge from hospital process. Margaret told professionals she did not want Aaron to come home and did not feel safe. She requested a planning meeting before he was discharged. The risk to Margaret was not documented and assumptions were made about the nature of the abuse, and it was assumed his behaviour was linked to Aaron's temporary confusion.

Lesson

It is important that, when victims of domestic abuse make disclosures, risk is documented and assessed. It is important that decisions are not made about the protection of victims solely on the assumption they are no longer at risk or are able to protect themselves from such risk.

Lesson Six-Panel Recommendation Three and Six apply

Narrative

The professional responsible for discharge planning spoke to Margaret by telephone who [they said] then agreed Aaron could be discharged home and she no longer needed the discharge planning meeting. The family have provided a different perspective. The review panel have not been able to reconcile the different accounts.

Lesson

The failure to hold a discharge planning meeting was the result of inappropriate decision making. The discharge policy was not followed in this case. Better communication is needed in the future so that the views of patients, carers and families are understood and considered, and they understand what is happening.

Lesson Seven-Panel Recommendation Two Applies

Narrative

When Aaron was discharged, needs assessment documentation was completed. This contained a reference that Aaron had been physically aggressive to staff but did not contain any information about the disclosure of domestic abuse he had perpetrated upon Margaret. That information was then repeated within a service user risk assessment document that also did not record the risk of domestic abuse [although it did refer to Margaret telephoning the police if he presented with any signs of aggression towards her]. This meant the plan to protect Margaret when Aaron returned home was weak and relied solely upon the reablement workers feeding any concerns back and Margaret protecting herself by making a telephone call to the police if she felt threatened.

Lesson

Professionals should ensure the risk of domestic abuse is recorded, that risk is formulated and shared with other professionals who may have a role in protecting the victim and robust plans developed to protect the victim. This will ensure all professionals fully understand the risk, the plan to protect the victim and their roles in it.

Lesson Eight-Panel Recommendation Two applies
Narrative Margaret disclosed to a professional that she had been abused by Aaron. The same professional revealed that disclosure to Aaron. The professional did not seek the consent of Margaret and it did not appear the circumstances were such that a disclosure was necessary without first seeking consent.
Lesson Professionals should ensure they follow the principles of making safeguarding personal and do not reveal to perpetrators disclosures by victims except in very exceptional circumstances. Failure to follow these principles can increase the risk to victims.

Lesson Nine-Panel Recommendation Four applies
Narrative The family of Margaret had different historic experiences concerning Aaron and his behaviour. While there were happy times in childhood, some aspects of Aaron's behaviour were either direct instances of domestic abuse or indicators that might have led to further enquiry if disclosed to a professional [For example, May's recollections of his behaviour towards her mother, placing hands around May's throat and Aaron's cruelty towards animals].
Lesson In many cases of domestic homicide, reviews find that families hold information, like pieces of a jigsaw, that if disclosed or reported to professionals might have allowed them to identify and assess the risk of domestic abuse. As in this case, families very often do not recognise the significance of the information they hold or if they do, for many reasons they do not consider sharing it with professionals or feel uncomfortable or disloyal for doing so.

17. RECOMMENDATIONS

17.1 Agencies Recommendations

17.1.1 The agencies recommendations are set out within tables at Appendix F. As this is a Domestic Homicide Review and a Safeguarding Adults Review jointly commissioned by Bolton Safeguarding Adults Board and Bolton Be Safe Strategic Partnership (Community Safety Partnership) all single agency and multi-agency action plans will be monitored by both Be Safe and Bolton Safeguarding Adults Board.

17.2 The Panel's Recommendations

17.2.1 The DHR panel has avoided repeating recommendations already identified within the single agencies plans at Appendix F. The panel identified the following recommendations.

Number	Recommendation
1	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board will seek assurances from the relevant partner agencies that they have reviewed current policy and practice to ensure that it recognises older people can be victims and perpetrators of domestic abuse and there are appropriate pathways in place for handling disclosures of domestic abuse from older people.
2	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board to review multi-agency training for Domestic Abuse and Safeguarding Adults to ensure that it addresses the learning from this review, particularly relating to domestic abuse in older people, including; how to receive disclosures about domestic abuse, how to complete DASH risk assessments and the levels of detail professionals should seek, identifying when an enquiry under section 42 of the Care Act 2014 might be triggered and understanding the principles of Making Safeguarding Personal.
3	Bolton Safeguarding Adults Board will seek assurances from Bolton NHS Foundation Trust and Bolton Council that a review of hospital discharges procedures will be undertaken to ensure where appropriate, voices of the next of kin and carers are included in discharge planning giving consideration to complexity and/or safeguarding issues.
4	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board reviews the information it produces and distributes to the community about domestic abuse and

	ensures it informs families about the need to report concerns about domestic abuse and the pathways a family can take when they hold such information.
5	Be Safe Bolton Strategic Partnership to provide periodic briefings to Bolton Safeguarding Adults Board as to the progress and delivery of recommendations arising from this review.
6	Bolton Safeguarding Adults Board to be given assurances by partner agencies that they have reviewed their processes regarding information sharing when they have contact with individuals, family members, significant others. This should include reviewing how and when advice or conversations concerning care and support plans is given, to who and when.

APPENDIX A

SAFEGUARDING ADULT REVIEW CRITERIA

1. Section 44 Care Act 2014

Safeguarding adults' reviews

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Appendix B

Domestic Abuse Act 2021

Definition of "domestic abuse"

Definition of "domestic abuse"

(1)This section defines "domestic abuse" for the purposes of this Act.

(2)Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a)A and B are each aged 16 or over and are personally connected to each other, and

(b)the behaviour is abusive.

(3)Behaviour is "abusive" if it consists of any of the following—

(a)physical or sexual abuse;

(b)violent or threatening behaviour;

(c)controlling or coercive behaviour;

(d)economic abuse (see subsection (4));

(e)psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4)"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b)obtain goods or services.

(5)For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

(6)References in this Act to being abusive towards another person are to be read in accordance with this section.

(7)For the meaning of "personally connected", see section 2.

Definition of "personally connected"

(1)For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a)they are, or have been, married to each other;

(b)they are, or have been, civil partners of each other;

(c)they have agreed to marry one another (whether or not the agreement has been terminated);

(d)they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e)they are, or have been, in an intimate personal relationship with each other;

(f)they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g)they are relatives.

(2)For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if—

(a)the person is a parent of the child, or

(b)the person has parental responsibility for the child.

(3)In this section—

"child" means a person under the age of 18 years;

"civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004;

"parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act);

"relative" has the meaning given by section 63(1) of the Family Law Act 1996.

Appendix C

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[64]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family.
- depriving them of their basic needs.
- monitoring their time.
- monitoring a person via online communication tools or using spyware.

[64] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep.
- depriving them of access to support services, such as specialist support or medical services.
- repeatedly putting them down such as telling them they are worthless.
- enforcing rules and activity which humiliate, degrade or dehumanise the victim.
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities.
- financial abuse including control of finances, such as only allowing a person a punitive allowance.
- threats to hurt or kill.
- threats to a child.
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault.
- criminal damage [such as destruction of household goods].
- rape.
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix D

Mental Capacity[65]

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery. Examples of people who may lack capacity include those with:

- dementia
- a severe learning disability
- a brain injury
- a mental health illness
- a stroke
- unconsciousness caused by an anaesthetic or sudden accident

But just because a person has one of these health conditions doesn't necessarily mean they lack the capacity to make a specific decision. Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, to decide what items to buy at the local shop). The MCA says:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise.
- wherever possible, help people to make their own decisions.
- don't treat a person as lacking the capacity to make a decision just because they make an unwise decision.
- if you make a decision for someone who doesn't have capacity, it must be in their best interests.
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.

People should also be provided with an independent advocate, who will support them to make decisions in certain situations, such as serious treatment or where the

[65] https://www.nhs.uk/conditions/social-care-and-support/mental-capacity/

individual might have significant restrictions placed on their freedom and rights in their best interests.

Appendix E

Mental Health Act[66]

In most cases when people are treated in hospital or another mental health facility, they have agreed or volunteered to be there. You may be referred to as a voluntary patient.

But there are cases when a person can be detained, also known as sectioned, under the Mental Health Act (1983) and treated without their agreement.

The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Find out how to deal with a mental health crisis or emergency

Advice for carers and families

If your loved one has been detained, he or she will have to stay in hospital until the doctors or a mental health tribunal decide otherwise.

You still have the right to visit. Visiting arrangements depend on the hospital, so check visiting hours with staff or on the hospital website.

In some cases the patient may refuse visitors, and hospital staff will respect the patient's wishes. If you're unable to see your relative, staff should explain why.

With permission from your relative, doctors may discuss the treatment plan with you.

You can also raise concerns or worries with the doctors and nurses on the ward.

Hospital accommodation should be age- and gender-appropriate.

Not all hospitals will be able to offer a ward dedicated to each gender, but all should at least offer same-sex toilets and wash facilities.

For more information:

- browse Rethink's guide What sort of ward will my relative be on?
- read or download easy read factsheets, which explain in simple terms your rights and choices when you're detained under the Mental Health Act

Who decides that someone should be detained?

In emergencies

[66] https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-act/

An emergency is when someone seems to be at serious risk of harming themselves or others.

Police have powers to enter your home, if need be by force, under a Section 135 warrant.

You may then be taken to a place of safety for an assessment by an approved mental health professional and a doctor.

You can be kept there until the assessment is completed, for up to 24 hours.

Find out more about the Section 135 warrant

If the police find you in a public place and you appear to have a mental disorder and are in need of immediate care or control, they can take you to a place of safety (usually a hospital or sometimes the police station) and detain you there under Section 136.

You'll then be assessed by an approved mental health professional and a doctor.

You can be kept there until the assessment is completed, for up to 24 hours.

Find out more about the Section 136 warrant

If you're already in hospital, certain nurses can stop you leaving under Section 5(4) until the doctor in charge of your care or treatment, or their nominated deputy, can make a decision about whether to detain you there under Section 5(2).

Section 5(4) gives nurses the ability to detain someone in hospital for up to 6 hours.

Section 5(2) gives doctors the ability to detain someone in hospital for up to 72 hours, during which time you should receive an assessment that decides if further detention under the Mental Health Act is necessary.

Non-emergencies

In most non-emergency cases, family members, a GP, carer or other professionals may voice concerns about your mental health.

They should discuss this with you, and together you should make a decision about what help you may need, such as making an appointment with your GP to discuss further options.

Find out more about accessing mental health services

But there may be times when there are sufficient concerns about your mental health and your ability to make use of the help offered.

In these circumstances your relatives or the professionals involved in your care can ask for a formal assessment of your mental health through the Mental Health Act process.

Your nearest relative has the right to ask the local approved mental health professional service, which may be run by local social care services, for an assessment under the Mental Health Act.

It's also possible for a court to consider using the Mental Health Act in some circumstances, or for a transfer to a hospital to take place from prison.

As part of this formal process, you'll be assessed by doctors and an approved mental health professional.

One of the doctors must be specially certified as having particular experience in the assessment or treatment of mental illness.

Find out more about getting a mental health assessment

The length of time you could be detained for depends on the type of mental health condition you have and your personal circumstances at the time.

You could be detained for:

- up to 28 days under Section 2 of the Mental Health Act
- up to 6 months under Section 3 of the Mental Health Act, with further renewals

During these periods, assessments will be regularly carried out by the doctor in charge of your care to determine whether it's safe for you to be discharged and what further treatment is required, if any.

You should always be given information about your rights under the Mental Health Act.

Read the Royal College of Psychiatrists' Q&A about being sectioned in England and Wales.

What does the term 'being sectioned' mean?

The Mental Health Act is structured in many sections.

If someone says, "You're being sectioned under the Mental Health Act", they mean you're detained according to a particular section of the Mental Health Act.

In most cases, you'll be told which section of the Mental Health Act applied in your case. For example, "You're detained under Section 2 of the Mental Health Act".

How can I appeal against being detained?

Any person who's compulsorily detained has the right to appeal against the decision to a mental health tribunal (MHT) or to the hospital's managers.

An MHT is an independent body that decides whether you should be discharged from hospital.

You may be eligible for legal aid to pay for a solicitor to help you do this.

Visit GOV.UK if you want to apply to the mental health tribunal

You also have the right to see an independent mental health advocate if you're detained.

Ask the nurses on your ward or the hospital manager how you can get to see one.

An independent mental health advocate can help you understand your rights and could also help if you're not happy with your situation.

You can also make a complaint to the Care Quality Commission (CQC) if you're unhappy with the way the Mental Health Act has been used.

Consent to treatment

If you're held under the Mental Health Act, you can be treated against your will.

This is because it's felt you do not have sufficient capacity to make an informed decision about your treatment at the time.

This is also the case if you refuse treatment but the team treating you believe you should have it.

The CQC provides detailed guidance about your rights in terms of consenting to medication and electroconvulsive therapy if you're detained in hospital or placed on a Community Treatment Order (CTO).

Appendix F

Agency Action Plans

Review Panel

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board will seek assurances from the relevant partner agencies that they have reviewed current policy and practice to ensure that it recognises older people can be victims and perpetrators of domestic abuse and there are appropriate pathways in place for handling disclosures of domestic abuse from older people.	1.1 Focussed monitoring of the relevant recommendations within the Bolton Council Adult Social Care, Bolton NHS Foundation Trust and Bolton CCG single agency action plans which already address this learning. 1.2 Chairs of Bolton Strategic Partnership and Bolton Safeguarding Adults Board to write to relevant agencies and request responses to provide the relevant assurances and responses will be monitored. 1.3 Create a learning summary addressing this aspect of learning and	• Monitoring reports for single agency action plans • Reports and responses from agencies. • Learning Summary • Report on Safeguarding Adults Week	Professionals always recognise that elderly people can be both victims and perpetrators of domestic abuse. Policies and procedures acknowledge that experiences of older victims of domestic abuse may be markedly different from those in other age groups.	Bolton Council Head of Service for Adults Bolton Council Head of Community Safety LOCAL SCOPE REGIONAL SCOPE

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
		circulate to agencies being asked to respond. 1.4 Safeguarding Adults week focussing on domestic abuse targeted at staff across the partnership to access training, pod casts, 'Eyes Wide Open Campaign' and Evergreen Training which covers DA provision for over 55's.			
2.	Be Safe Strategic Partnership and Bolton Safeguarding Adults Board to review multi-agency training for Domestic Abuse and Safeguarding Adults to ensure that it addresses the learning from this review, particularly relating to domestic abuse in older people, including; how to receive disclosures about	2.1 Be Safe and BASB to review the training offer to the workforce, ensuring that the training includes all the learning themes set out in the recommendation and that professionals have clarity regarding how adult safeguarding, domestic abuse and health policies and procedure are interrelated. 2.2 A learning summary will be prepared covering	• Reports on review of training offer to the workforce. • Changes to learning objectives. • Amended DAV handbook	When following policies, protocols and procedures, professionals will be able to make the connections between adult safeguarding and domestic abuse, how they are interrelated and how they can be operated separately and in parallel.	Bolton Council Head of Service for Adults Bolton Council Head of Community Safety LOCAL SCOPE

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	domestic abuse, how to complete DASH risk assessments and the levels of detail professionals should seek, identifying when an enquiry under section 42 of the Care Act 2014 might be triggered and understanding the principles of Making Safeguarding Personal.	the events of the case and how they relate to training. 2.3 To review the DAV handbook to ensure that the information is assessable and comprehensive and reflects any changes process made following this review.		Professionals will have a thorough understanding of relevant legislation and policy and as much accurate information as is available.	REGIONAL SCOPE
3.	Bolton Safeguarding Adults Board will seek assurances from Bolton NHS Foundation Trust and Bolton Council that a review of hospital discharges procedures will be undertaken to ensure where appropriate, voices of the next of kin and carers are included in discharge planning giving consideration to	3.1 Multi- agency task and finish group to explore learning from recommendation and review relevant Hospital Discharge procedures 3.2 Findings of the review and any changes to procedures to be reported back to Bolton Adult Safeguarding Board and shared with Be Safe Bolton Strategic Partnership (CSP)	Report of findings and recommendations of Task & Finish Group	Policies ensure that the views of next of kin and carers are considered and that the risks they may face as a consequence of someone being discharged from hospital are always recognised, formulated and managed.	Bolton Council Head of Service for Adults

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	complexity and/or safeguarding issues.				
4.	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board reviews the information it produces and distributes to the community about domestic abuse and ensures it informs families about the need to report concerns about domestic abuse and the pathways a family can take when they hold such information.	4.1 As part of the review of the DAV strategy and DAV business plan we will ensure that information which is shared with the public is pitched at the appropriate level for the different community groups in Bolton. Taking account of older people, BME groups and people who may have a learning disability. 4.2 Where appropriate revise content of existing public awareness materials to amalgamate learning from this review.	• DAV strategy and business plan • Revised public awareness materials. • Evidence of campaigns to promote awareness	Enhanced awareness amongst families and friends' networks in respect of older people, BAMER and marginalised communities about recognising domestic abuse and violence and how to access the appropriate support services.	Bolton Council Head of Service for Adults Bolton Council Head of Community Safety LOCAL SCOPE
5.	Be Safe Bolton Strategic Partnership to provide periodic briefings to Bolton Safeguarding Adults	5.1 Be Safe to monitor action plans through progress reports.	• Monitoring reports	Both partnerships will be able to exercise joint monitoring of the	Bolton Council Head of Community Safety

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	Board as to the progress and delivery of recommendations arising from this review.	5.2 Briefings to be provided to quarterly Board meetings.		progress of all single agency action plans	LOCAL SCOPE
6	Bolton Safeguarding Adults Board to be given assurances by partner agencies that they have reviewed their processes regarding information sharing when they have contact with individuals, family members, significant others. This should include reviewing how and when advice or conversations concerning care and support plans is given, to who and when.	6.1 Partner agencies to review their current processes.	• Report findings, any recommendations and actions.	Staff to have a clear understanding of when and how information is shared with individuals, family members, significant others.	Bolton Council Head of Service for Adults. LOCAL SCOPE

Bolton Council

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	Review of application of Safeguarding Adult Section 42 enquiry criteria.	Review safeguarding training offered to adult social work staff.	Evidence of training sessions.	Increase in number of Section 42 enquires from contact to enquiry. Specifically, in relation to DAV.	Head of Safeguarding
2.	Review of what training is offered to adult social care staff in identifying signs of domestic abuse and violence and how to ask direct questions to gain further information to develop an appropriate risk management plan with a particular focus on Older Adults.	Embed the Bolton MARAC Domestic Abuse and Assessment and referral in practice by ensuring that staff attend briefings and training events.	Increased awareness across adult social work teams and multi agencies.	Quicker access to appropriate services. Increased awareness of the Bolton Domestic and Abuse Strategy across all Social Work Teams, not solely the Safeguarding Adults Team and across the Safeguarding Board Partnership.	Bolton Safeguarding Adults Board Partners
		Identity key staff and then roll out an ongoing programme for Social Work and Social Care staff.			Head of Safeguarding

3.	Identify staff who have not had refresher or undertaken Mental Capacity training across Adult Social Work Teams.	Mandatory Mental Capacity training.	Ensure that staff continue to be legally illiterate and apply the MCA principles.	High quality and proportionate assessments and outcomes, support plans for people who lack capacity.	Principle Social Worker / Head of Services – Social Work Teams.
4.	Reinforce the offer to complete Carers Assessments to highlight any risks of carer fatigue, stress and offer of advice, information, and services.	Ongoing Care Act assessment training, case discussion with managers.	Numbers of Carers Assessment remain stable and/or increase.	Carers feel supported in continue in their caring role.	Head of Service – Social Work Teams. Commissioning Team.

Bolton CCG

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	The IMR Authors felt that domestic abuse does not just apply to adults with children or of working age adults but domestic abuse does and can occur in older adults / or across all age groups. There is	**Specific:** CCG Domestic Abuse Lead to meet with IRIS Project and review and re-evaluate the training delivered to General Practice staff.	• PowerPoint slides • Agenda • Pictures of the event • Staff evaluation forms	To increase the awareness of domestic abuse in older adults across General Practice and for General Practice staff to know which services to signpost people too locally.	CCG Head of Safeguarding Adults will have oversight of the action plan.

	a need to raise awareness of older people (elder abuse) domestic abuse in General Practice.	**Measurable:** This would be done by training evaluation forms, General Practice staff, Feedback from General Practice Staff, at the GP event in February 2020. **Achievable:** CCG Domestic Abuse Lead will work with the head of Safeguarding Adults to raise this awareness across General Practice. **Realistic:** The CCG Safeguarding Team run regular training sessions for GP Practices. Therefore this recommendation is realistic. Timed: December 2020			GP Lead for Safeguarding Adults, Bolton CCG. Deputy Designated Nurse for Safeguarding Children and Looked after Children, Bolton CCG (Who is also the lead for domestic abuse)
2.	The Named GP for Safeguarding Adults felt there is a need to update GP's in General Practice for people who	**Specific:** With current GP education for safeguarding adults, delirium and older people is not a stand-alone training subject for GP	• GP education • PowerPoint slides • Agenda	To increase the awareness of delirium in older people and the impact on carers and	CCG Head of Safeguarding Adults will have oversight of

	are at risk of delirium exacerbating harm to carers or self.	safeguarding leads. It's an opportunity to build this into the existing safeguarding training that the CCG safeguarding team deliver. **Measurable:** This would be done by training evaluation forms, Feedback from GP safeguarding leads at the annual GP safeguarding adult. **Achievable:** The Named GP will work prepare and design the training slides for this specific issue and deliver as core business with existing GP training programmes. **Realistic:** December 2020	• Pictures of the event • Staff evaluation forms • GP safeguarding newsletter	self for GP safeguarding leads in general practice.	the action plan. GP Lead for Safeguarding Adults, Bolton CCG.

Bolton NHS Foundation Trust

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	To continue to ensure comprehensive assessment of mental capacity following	1. Identify cohorts of learners requiring additional training via BOSCA accreditation.	1. New protocol with associated flow chart now developed which prompts action to be	1. Ability to identify patients with potential for violence and	Lead Nurse Safeguarding Adults

	episodes/incidents of violence and aggression or where capacity is in doubt when significant decisions have to be made e.g. discharge planning.	2. (audit) 3. Continue rolling programme of training provision. 4. Reinforce Violence and Aggression policy and requirement to complete mental capacity assessments. 5. Review of Enhanced Care assessment tools.	taken following episodes of violence and aggression. 2. All wards assessed in respect of completion of MCA training. All wards/Trust achieving >95% of designated cohorts. 3. All staff within Integrated Discharge Team have received training from Trust's MCA lead.	aggression to aid improved risk management. 2. Completion of mental capacity assessments by the appropriate professionals.	Enhanced Care Coordinator Manager Integrated Discharge Team
2.	Ensure all agencies aware of how to respond to/escalate disclosure of Domestic Abuse and Violence (DVA)	1. Review information available for all staff on variety of platforms. 2. Provide multi-agency training for all senior staff. 3. Implement Trust wide new Bolton DAV Protocol devised by DAV partnership.	1. Bolton FT DAV training included in L1/L2 and Level 3 training packages. 2. Police now delivering DAV training to senior staff on a monthly basis as part of Level 3 training package provided by Bolton NHS Foundation Trust. Managers/Team Leaders from Safeguarding Board	To raise awareness and improve response to DAV and the fact that it can affect any age group including older people. Training to improve multi-agency working.	Trust Safeguarding Leads- Adults/Children Safeguarding Adults Board Children's Community Partnership

			partners invited to access.		