PRESTON COMMUNITY SAFETY PARTNERSHIP

CHESHIRE EAST COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

CASE B

OVERVIEW REPORT

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CONTENTS

Appendices

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

CASE B

REPORT OF A REVIEW OF CIRCUMSTANCES LEADING TO THE DEATH OF NI

Report produced by Preston Community Safety Partnership and Cheshire East Community Safety Partnership.
Date: 9th March 2015

1. Introduction and Context of the Review

This report of a domestic homicide review examines agency responses and support given to NI, a resident of Preston, prior to the incident which led to her death on 19 September 2013. The review considers agencies' contact/involvement with NI and her daughter BM from July 2009 up to and including 24 July 2013 when NI was found with serious injuries which led to her death in September 2013.

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

Preston City Council is a District Council, working alongside Lancashire County Council as part of a two-tier local government system. The Preston Community Safety Partnership cites violent crime, including domestic violence, amongst its six priorities in its 2011 – 2014 Strategic Plan.

Community Safety Partnership members are:

- Preston City Council (including Elected members)
- South Division of the Lancashire Constabulary
- Lancashire Fire & Rescue Service(Preston area)
- Lancashire County Council (including Elected members)
- Greater Preston Clinical Commissioning Group
- Registered Social Landlords (Community Gateway Association are represented on the Executive Group)
- Preston Community Network
- Cumbria and Lancashire Community Rehabilitation Company
- National Probation Service
- Lancashire Youth Offending Team (Preston area)

Preston has a population of 134,600 (mid 2009).Preston is the 45th most deprived (local authority) area in the country according to the Index of Multiple Deprivation 2010. In 2012, there were around 19,800 people aged 65 and over in Preston which represented 14.1% of the resident population; a relatively low proportion in

comparison to a number of other Lancashire authorities. The ethnic mix is similar to some other authorities in Lancashire. It is predominantly white. The largest minority ethnic groups are Indian and Pakistani.
NI's town of residence was an area of Preston which has low crime rates and low levels of unemployment. Most of the residents are home owners and are most commonly aged between 25 and 49 (38%). This number is higher than the national average. NI and her husband were in a minority group of retired residents (13%). NI had lived with her husband in a privately owned property.

Domestic violence remains a County wide problem and there have been a number of domestic related homicides across the county over the last three years. It disproportionately affects one sector of society with approximately 82% of domestic related crime victims being female. Alcohol is present in 38% of the domestic crimes recorded across Preston. Reported assaults (with and without injury) have reduced over the last two years although they still account for a substantial proportion of all violence against the person. Assaults are a County wide problem with the city centre remaining a key hotspot due to its concentrated links to the night-time economy. Alcohol continues to be a key causation factor in relation to violence.[1]

The perpetrator (BM) lived in a semi-rural town located in the unitary authority of Cheshire East. The town has a population of approximately 11,775. She is a fifty-four year old, white British woman of Roman Catholic faith. She is married and her husband is of similar age and ethnic origin.

Cheshire East has a population of 360,000. The age structure of Cheshire East is slightly older than that of England & Wales. The number of people aged 85+ will double between 2006 and 2026.[2]

The Safer Cheshire East Partnership members are:

- Cheshire Constabulary
- Cheshire Police and Crime Commissioner
- Cheshire East Council (2 members)
- Cheshire Fire and Rescue Service
- South and Eastern Cheshire Clinical Commissioning Groups
- Cheshire East Youth Engagement & Offending Team
- Registered Social Landlords (Housing Associations) representative
- Cheshire East Domestic Abuse Partnership
- Probation Trust
- Manchester and Cheshire Community Rehabilitation Company
- Cheshire East CVS - Voluntary Sector representation

The Community Safety Partnership cites domestic abuse and vulnerable people among its priorities in its Partnership Plan.

The Cheshire East Domestic Abuse Partnership says that women with children are its largest high risk group but also targets older and vulnerable adults and mental health and substance misuse amongst its priorities. The priorities for action are:

[1] Preston Community Safety Partnership data.
[2] Cheshire East Community Safety Partnership data.

- Developing a Commissioning Strategy
- Ensuring a 'whole family approach' to domestic abuse
- Focusing on prevention and early intervention
- Co-ordinating efforts to prevent Teenage Relationship Abuse
- Improving monitoring and evaluation of interventions
- Involving stakeholders - and particularly clients – in making decisions about the best way forward

The Partnership intends to take action jointly with the Adult Safeguarding Board and the Safeguarding Children Board. People with complex needs are a target group for better, co-ordinated intervention and the Partnership has developed a 'Toxic Trio' training event which aims to improve staff understanding of and response to such complex presentations.

In Cheshire East there were 1065 incidents of domestic abuse reported to police during 2012-13 involving 22% repeat victims. 387 high risk victims with 470 children were subject to Multi Agency Risk Assessment Conferencing (MARAC). These cases represent the top 10% of victims in terms of risk

2. Circumstances leading to the Review being undertaken.

The circumstances leading to a review being undertaken were as follows:

NI was born in July 1930 and lived with her husband in Preston. NI had suffered some memory loss since 2009 and was diagnosed as having dementia in March 2011. Her husband was her main carer. The couple were supported by home care workers from a local home care agency. The couple have six children some of whom were regular visitors and provided support to their parents.

NI had suffered from dementia for the past four years but had become progressively worse in the last six months. She was described as fairly mobile and not aggressive with care workers, but could be anxious when her husband was not present and had been seen to hit out at some family members.

On Tuesday 23rd July 2013, NI's husband left his home in company with his son in law (BM's husband) to visit his grandson and they were to stay away overnight. NI was left in the care of her daughter BM.

At 09:00 on Wednesday 24th July 2013, one of the home care workers went to the home of NI to provide her daily care. When the home care worker arrived at the property on a planned visit, she did not get a reply and could not gain entry to the property. She described this as being unusual. She contacted her office and was instructed to wait. At 09.15 that morning, BM opened the door and the home care worker immediately noticed that she smelt of alcohol. BM informed her NI had fallen during the night and requested her help to lift her from her position on the floor. The home care worker found NI in a distressed state lying on her bedroom floor with visible injuries to her face and body. She described how she could see NI had a large lump to the top right side of her head, that her hands were bruised and swollen and that she had two black eyes. The home care worker asked BM if an

ambulance had been requested. BM confirmed it hadn't. The home care worker contacted North West Ambulance (NWAS) and summoned an ambulance. NI said BM had caused her injuries.

At 09.35 another care worker, arrived at the home, as expected, to assist the first worker. She noticed the air smelt strongly of alcohol and she saw NI lying on the floor and describes her as having large painful injuries, which included finger bruising to the throat and upper arms. When she queried why BM had not called an ambulance, BM informed her that she presumed NI was being awkward and stubborn by lying on the floor.

An ambulance was summoned. BM informed the paramedics her mother had fallen over at 04.00 that morning but she had not sought medical treatment as she thought she was being awkward. The paramedics noticed bruises to NI's throat. NI was taken to hospital and the police were informed by a member of staff from North West Ambulance Service (NWAS).

The injuries sustained by NI were as follows:

- Fracture of the left femur (Operated on 25/07/13)
- Bruising to the scalp
- Bruising around both eyes
- Small bruises to the left side of her neck
- Small bruises to both upper arms
- Bruising all over the back of both hands.

BM was arrested that day. She was interviewed and denied causing any harm to her mother. She was charged on 26th July, with Attempted Murder and remanded in custody.

NI remained in hospital until Friday 13th September when she was transferred to a care home. On Sunday 15th September 2013, NI was re-admitted to hospital.
On 19th September 2013, NI died in Royal Preston Hospital.
On 20th September a Home Office Post Mortem was conducted, the cause of death was:
Bronchopneumonia following Blunt Impact Trauma and Fractured Neck of Left Femur (operated)
BM was charged with murder on 10 December 2013.
On 16th December 2013, BM appeared at Preston Crown Court where she pleaded guilty to Manslaughter and the proceedings for the Attempted Murder were 'stayed'.
On 24th January 2014, BM appeared at Liverpool Crown Court where she was sentenced to 16 months imprisonment. As she had already served a number of months on remand BM was released, subject to licence, in March 2014.

It is clear that the death has had a devastating effect on this close family. Some family members remain angry and confused about the loss of NI. Others have shown considerable understanding and concern for BM despite their feelings about the loss of NI.

3. Decision to undertake a review

NI, the subject of the Review, died on 19 September 2013. Because of the circumstances, in particular the time lapse between the incident in July and NI's death in September, and the need to ascertain the cause of death, the possible need for a Domestic Homicide Review was not notified to the Community Safety Partnership until 13 December when the Police Review Officer became aware of the charges against BM. This is evidence of the system working well to identify matters which would otherwise not be known to the Community Safety Partnership.

A Community Safety Partnership Meeting to discuss need for Domestic Homicide Review took place on 13 January 2014.

A Community Safety Partnership must undertake a Domestic Homicide Review in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by:
A person to whom he was related or with whom he was or had been in a personal relationship **or**
A member of the same household as himself
with a view to identifying the lessons to be learnt from the death.

The deceased was aged over 16 years and was a resident of Preston. Her death was as a result of injuries sustained. The alleged perpetrator of the injuries was the daughter of the deceased, who was subsequently convicted of manslaughter.

4. The scope of the review

The review covers the time from when NI first began to show signs of memory loss and therefore might have begun to be considered a "vulnerable adult" (now referred to as an "adult at risk"), to the day she was discovered at home with serious injuries and was admitted to hospital. No matters were identified which merited investigation during the period between NI's admission to hospital and her subsequent death. The period under review is therefore from July 2009 until 24 July 2013.

Organisations were asked to review any earlier information about both NI and BM and check if it had any bearing on understanding the circumstances of the death of NI, including any evidence of violent behaviour, mental ill health or substance misuse.

All information known to a service providing an IMR was reviewed. Any information regarding involvement prior to the period of the detailed chronology and analysis was summarised in the IMR.

5. Status and ownership of the overview report

The overview report is the property of the Preston Community Safety Partnership as the commissioning board.

The Cheshire East Community Safety Partnership was also invited to accept the Report jointly with the Preston CSP.

All overview reports provided to CSPs for DHRs in England have to be published in full. This overview report provides the detailed account of the key events and the analysis of professional involvement and decision making in relation to NI and BM.

The report has to balance maintaining the confidentiality of the family and other parties who are involved whilst providing sufficient information to support the best possible level of learning.

An executive summary was provided at the conclusion of the review. This provides a brief summary of events and the most significant points of learning identified as a result of the review.

The CSP will determine how and what further information is provided to the family at the conclusion of the review prior to the submission of the overview report and executive summary to the Home Office.

6. Previous domestic homicide reviews in Lancashire

This is the eighth domestic homicide review in Lancashire since the statutory implementation in April 2011 but only the second for the Preston area. As there are 14 community safety partnerships within Lancashire, a consistent approach to domestic homicide reviews has been developed with all relevant agencies based on the serious case review process.

A recent report in Lancashire has identified that since implementation there have been 11 qualifying domestic homicides in Lancashire:

- 8 female victims (73%); 3 male victims (27%).
- 2 female perpetrators (20%); 8 male perpetrators (80%) – one perpetrator committed 2 homicides
- Average age of the victim is 69 years old (7 homicide victims were over the age of 50)
- Average age of the offender is 45 years
- 6 cases meet the government definition of domestic violence i.e. intimate personal relationships
- 5 are homicides by family members (these qualify as DHRs)
- 1 homicide was a 'known' domestic abuse case.

Three key themes have been identified across the Lancashire cases, and the majority of cases have at least one of these identified commonalities:

Emerging common themes:	Perpetrator
Mental health issues	44%
Substance misuse	78%

Previous known violent behaviours	78%
Carer needs / responsibilities (*both victims and perpetrators)	50%*

Themes which have emerged nationally from adult multi agency adult serious case reviews have been collated by Hull Safeguarding Adults Partnership Board.[3] The analysis identifies the themes as follows:

Practice (26%)
Accountability (12%)
Joint Working (9%)
Training (9%)
Systems (7%)

Awareness raising and training for all staff features frequently. Recognition of the role of family members and the need for improvements to carers' assessments and the need for better care co-ordination and review and contract monitoring are also recurrent themes.

A similar analysis of adult serious case reviews in Lancashire identifies the following themes:

Practice (including record keeping and the recognition of the family and their needs).

Accountability including complex funding arrangements and recognition of the responsible agency, responsibility around continued review and assessment, multi-agency accountability and the needs of self-funding service users.

Joint working, training (in risk assessment and what constitutes abuse) and systems also feature in the Lancashire reviews.

7. The methodology of the Domestic Homicide Review

NI was a resident of Preston, Lancashire. BM was a resident of Cheshire East. Therefore the Preston CSP took the lead role in commissioning the DHR. The CSP in Cheshire East was contacted and asked to provide information and support to the DHR. Organisations in Cheshire which had provided services to BM were invited to take part in the DHR and to become members of the DHR Panel.

The Preston Community Safety Partnership has in place an information sharing protocol which all partner organisations have agreed. The Cheshire East CSP information sharing protocol was sent and agreed with Preston CSP.

The decision to conduct a DHR was notified to the Home Office on 13 January 2014. Terms of Reference were agreed by the Panel on 21 January 2014.

[3] Hull Safeguarding Adults Partnership Board Serious Case Review Analysis. 2013

The Review began on 21 January 2014 and was concluded on 3 November 2014.

A multi-agency combined chronology was compiled in order to assist the Panel to examine events during the period defined in the Terms of Reference.

Agencies that identified significant background histories on family members pre-dating the scope of the review provided a brief summary account of that significant history.

Reviews of all records and materials were considered including;
- Electronic records
- Paper records and files
- Patient or family held records.

Individual management reviews were completed using the template provided by the Preston Community Safety Partnership, and were quality assured and approved by a senior officer of the reviewing agency.

The following agencies have provided an individual management review that were completed in accordance with *Multi-agency statutory guidance for the conduct of domestic homicide reviews* 2013 and associated local guidance and relevant procedures.

- Age Concern Central Lancashire (Withy Trees Day Centre)
- Cheshire and Wirral Partnership NHS Foundation Trust (Cheshire Psychological Therapies)
- Home Care Mellor (Home Care agency provider)
- Lady Elsie Finney House (Home for Older People)
- Lancashire Care NHS Foundation Trust
- Lancashire County Council (Adult Social Care service)
- Mid Cheshire Hospital NHS Foundation Trust
- NHS England Lancashire Area Team
- NHS England Cheshire Warrington and Wirral Area Team/South and Eastern Cheshire Clinical Commissioning Group
- The Priory Hospital Altrincham (private provider)

The following organisations provided information:
- Alzheimers Society (Dementia Advisor)
- Banksfield Nursing Home
- Lancashire Constabulary

Information that was sought from other services at the outset of the review is described in Appendix 1.
Information was also sought from members of the family and is described in section 13.

The national guidance in regard to DHRs provides advice on issues that the review should consider. This also includes a requirement for the panel to establish terms of

reference for the review and the provision of reports from agencies with significant contact or involvement. This was done in the early stages of the Review in January 2014.

The Chair and the Police representative on the Panel met the Senior Investigating Officer from the Police in order to share information and ensure that the review did not create any difficulties for the prosecution. In this case, the alleged perpetrator had been arrested and remanded in custody very quickly, charged with attempted murder. NI died in September and on 16th December 2013, BM appeared at Preston Crown Court where she pleaded guilty to Manslaughter where the proceedings for Attempted Murder were 'stayed'.

On 24th January 2014, BM appeared at Liverpool Crown Court where she was sentenced to 16 months imprisonment. She was released on 25th March 2014.
The completion of the criminal proceedings meant that the Police had no concerns about witnesses, (professional staff or family members) being approached to take part in the Review. The SIO asked that time be allowed for him to offer feedback to family members following the trial. Family members were approached in April 2014 and asked if they wished to contribute to the Review.

A briefing session was held for authors of Individual Management Reviews in February 2014 to ensure that authors understood what was expected of them and to offer guidance about the process of preparing an IMR. Authors were provided with templates for chronologies and for IMRs.

All contributors were asked to provide a chronology of their organisation's involvement which was used to create a combined chronology.

A session was held in early March 2014 for practitioners, managers and IMR authors to review the combined chronology and begin to identify any key practice episodes and lines of enquiry for the review.

Three organisations which were not part of the Review were notified in July 2014 and again in September 2014 that the Overview Report was likely to contain some negative comments about them, and were invited to respond. Their responses are included in Section 16.5 of the Overview Report.

On 17 September 2014 a response was received from the National Offender Management Service/National Probation Service and it was incorporated into the Overview Report.

On 15 October 2014 a response was received on behalf of both of the courts and it was incorporated into the Overview report.

The panel had access to legal advice from a solicitor in the council's legal service.

Written minutes of the panel meeting discussions and decisions were recorded by a member of the CSP staff team in Preston.

Advice was sought for the Panel from an alcohol specialist, the Services Manager for Criminal Justice and Integrated Drug Treatment System in the Central Lancashire Drug and Alcohol Recovery Services, in relation to the services offered to BM and about alcohol misuse and its treatment. The advice was taken into consideration during the Panel's deliberations.

A representative of the Domestic Violence Service in Preston (who had not been involved in offering services to NI or BM) was invited to provide expert advice to the Panel about domestic violence and responses to it.

8. Timescale for completing the Review

The Review commenced on 21 January 2014 and was scheduled to complete by 13 July. As the Review progressed and agency records were examined, it became apparent that a number of organisations which may have had substantial contact with NI had not been identified in the early stage of the Review. The main reason for this is that although enquiries were made at the outset to establish the extent of the involvement of organisations with the victim and the perpetrator, NI and her family had made use of the self-directed care approach, including the use of vouchers to enable respite care to take place.

As the Review progressed and organisations produced their chronologies, references to more organisations emerged. As a result, other care providers engaged by the family were discovered later in the Review and were therefore asked to provide information and in some cases IMRs due to the extent of their involvement with the victim.

In order to ensure that those organisations were allowed sufficient time to examine their records and, if necessary, complete IMRs, the Independent Chair sought agreement from the Community Safety Partnership to extend the timescale by four months, until 13th November 2014.

The Home Office was asked on 21 May 2014 to agree to the extension of the timescale by 4 months (See Appendix 2) and agreement was given on 16 June 2014. A new timeline was created with a completion date of 13 November 2014.

A further period was required to prepare and agree the multi-agency plan. The Home Office were advised that there were some aspects of the plan which did not receive immediate agreement and the Community Safety Partnership would be required to extend the period until this could be achieved. The timeline was therefore extended until 9th March 2015, to ensure that that there was agreement on the actions in the combined plan.

9. Particular issues identified by the panel for further investigation by the individual management reviews:

It was decided by the Panel that the timeframe for the Review should be from 1 July 2009 (the approximate date when NI began to be identified as a vulnerable adult) to 24 July 2013 (the date on which NI was discovered at her home suffering from the

serious injuries which ultimately led to her death). Those writing IMRs were asked to include any relevant information before or since this timeframe in summary form. No matters were identified which merited investigation during the period between NI's admission to hospital on 24 July 2013 and her subsequent death on 19 September 2013 and therefore there was no detailed examination of agency actions during this period.

Detailed questions were formulated by the Panel to assist particularly those organisations which had not previously undertaken an IMR.

The Key Lines of Enquiry were as follows:

What knowledge or information did agencies have that indicated NI might be a victim of domestic abuse or that BM might present a risk to others?
Consider in particular the circumstances in which BM and others provided care for NI up to and including 24th July 2013.
Consider in particular the circumstances leading up to NI being found with injuries to her person on the morning of 24th July 2013.
Consider whether NI or BM was or should have been identified as a vulnerable adult. Was action timely and in line with local and national protocols?
Include any historical information about NI or BM in relation to any offending history, mental health, alcohol or substance misuse and any history as a victim or perpetrator of domestic violence.
Examine whether information sharing and communication systems in relation to concerns about domestic violence or mental health problems, within and between agencies were effective. How, when and why was information shared or not shared?
Consider whether there are any cross boundary issues arising from the geographical location of NI and BM. Consider any implications for partnership working.
What policies and procedures for risk assessment including screening/disclosure/identification for domestic abuse does your agency have and were there any occasions when these were applicable?
How did your agency respond to any information provided by others and did this include any risk assessments in regard to emotional, social or physical vulnerability. Were those assessments sufficiently robust and effective?
Was your agency's response to the information and/or risk assessments shared in accordance with your agency's policies and procedures including multi-agency protocols? Include any involvement by the MARAC, MAPPA and/or any victim organisation or helpline.

What services were offered to NI and BM and were they accessible and sympathetic?
Were practitioners sensitive to the needs of NI and BM and were they knowledgeable about vulnerable adults and potential indicators of domestic violence?
Include consideration of the measures implemented to provide care for NI following the onset of her dementia, approximately four years before her death.
Include consideration of the effectiveness of safeguards implemented to protect NI in the circumstances of care being provided for her.

Did services consider the needs of BM in relation to possible mental health, drug or alcohol issues and make appropriate referrals?

What information did family and friends have that might have indicated that NI might be at risk or that BM presented a risk to her?
In consideration of this think about how your agency would respond and if there is a process for family members and/or friends to approach the service with any concerns. How would your agency deal with issues of confidentiality and any specific requests that the victim or others might have made in relation to the need for confidentiality and who and when information can be shared.
Did your service have any information about friends, family, work colleagues or employers of NI or BM which might enable the panel to determine those people who should be invited to contribute to the DHR?
Was there any relevant information about other family members which might have had a bearing on the care of NI or BM?
What arrangements were in place within the family to ensure that NI's interests were safeguarded (eg power of attorney/ court of protection) and did these have a bearing on how organisations responded to NI's needs?
Were there any financial issues which may have impacted on the care of NI (eg availability of benefits, allowances or other financial support available to the family)?

What knowledge did agencies have that BM might be a perpetrator of abuse or pose a risk of significant harm to NI?
Establish whether BM had previously experienced any mental health or substance misuse problems and whether appropriate and timely services were offered to her.
Did BM have any experience of being abused including experience of domestic abuse? In consideration of your response did your agency offer any services/referring to the alleged perpetrator of domestic violence?

Were there any risks in relation to resources or capacity that had an impact on how services were provided to the victim or to the alleged perpetrator, or that impacted on agencies' ability to work effectively with other services?
Consider whether your agency had the necessary resources and capacity for this case. Consider whether professionals working with the family were suitably skilled and adequately supervised and whether there is evidence of management accountability and support.
The effects of any organisational change during the period under review should also be considered. Information should be included about what has changed, in relation to organisation or practice, since the period under review, which would have impacted on the care of NI or BM.
Do any of your agency's policies or procedures require amending or do new ones need establishing as a result of this DHR, including those covering risk assessment or identifying any specific vulnerability relating to individuals?
What lessons has your agency learned from this DHR? Think of areas where work may have been done over and above the required standards, this would be good practice. It should also be considered whether or not the agency feels there are any gaps in their current provision, including skills, knowledge and/or ability to respond effectively to the needs of the victims or the alleged perpetrator.

Examine whether all agencies and professionals gave due and proper consideration to all diversity issues, including ethnicity, religion, language, disability, gender, culture, age, social background and integration.
Are there any specific considerations in relation to age and disability?

Throughout the Review, consideration should be given to previous Domestic Homicide Reviews (by this Community Safety Partnership or elsewhere) and any other relevant reviews. Information should be included about what has changed, in relation to organisation or practice, since the period under review, which would have impacted on the care of NI or BM.

10. Membership of the case review panel and access to expert advice

A Review Panel was created, which met on 8 occasions to support the contributing organisations, review the IMRs and identify key themes and learning from the Review.

The Review Panel was:

Position	**Organisation**
Annie Dodd	Independent Reviewer (Chair and Author)
Assistant Director of Nursing, Safeguarding Adults	Lancashire Care NHS Foundation Trust
Lead Nurse for Safeguarding Adults and Mental Capacity Act	Greater Preston Clinical Commissioning Group also representing NHS England Lancashire Area Team
Review Officer	Public Protection Unit, Lancashire Constabulary
Designated Nurse, Adult Safeguarding	NHS England/South and Eastern Cheshire NHS Clinical Commissioning Group
Community Safety and Justice Co-ordinator	Lancashire County Council
Senior Social Worker	Lancashire County Council
Panel Support and Observers	
Chair of Preston Community Safety Partnership	Preston City Council
Community Safety Manager	Preston City Council
Community Safety Manager	Preston City Council
Chief Executive	Preston Domestic Violence Services
Strategic Lead, Prisons & Criminal Justice	Discover Central Lancashire Drug and Alcohol Recovery Services

Representatives of the Lancashire and Cheshire Safeguarding Adults Boards were invited to join the Panel when recommendations were being discussed as there was a possible recommendation for the LSABs.

None of the Panel Members had any previous direct involvement with NI, BM or their family members. None of the Panel Members was responsible for the direct line management of any of the staff involved in the care of NI or BM.

11. Independence and experience of the lead reviewer

Annie Dodd is a qualified and HCPC registered Social Worker and has 40 years' experience in Children's Social Care services. She holds the qualifications of BA Hons., CQSW and MA (Econ.) She has managed assessment, child protection and looked after children services and for 10 years was Assistant Director in a local authority. She has never been employed by any of the organisations involved in the Review. Ms Dodd now works as an independent social work consultant. Her work includes chairing Serious Case Reviews for Local Safeguarding Children Boards, Domestic Homicide Reviews, undertaking audits and reviews for LSCBs and local authorities and acting as Child Protection Advisor to a national children's charity. She has previously chaired Serious Case Reviews and a joint SCR/DHR in the Lancashire area.

12. Cultural, ethnic, linguistic and religious identity of the family

NI was of white British origins as is her immediate and extended family. They are a large family with strong local connections. NI was of the Roman Catholic faith as are most family members. They are a working family, most of whom are in employment. The older family members are retired. The house in which NI lived was, clean, well-furnished and privately owned. It is situated in a non-deprived semi-rural area. NI and her family, other than BM, were not known to the Police prior to this incident. A number of family members are deaf.

13. Family contribution to the review

A number of family members and others were identified who might wish to contribute to the Review. These included:
The husband of the victim
A brother and two sisters of the victim
The six children of the victim, including the perpetrator (BM)
The husband of BM
The neighbours of NI

A meeting was arranged on 30 January 2014, between the Chair of the Review Panel, the Police representative on the Review Panel and the Senior Investigating Officer to discuss contact with the family. The criminal proceedings had been completed so there was no concern that the Review might create any difficulty for the Police or the witnesses. However, the SIO had agreed to hold a further meeting with the family, so contact with the family was delayed so that this could take place.

Letters were sent to all family members for whom the Review had contact details, informing them of the DHR, enclosing the appropriate Home Office leaflets and inviting their contributions to the Review.

It was made clear again to those family members who made contact with the Review that the method and timing of their involvement was for them to decide.

A sister of NI provided contact details for another sister and a brother of NI. Letters were also sent to them and they responded agreeing to a meeting with the Chair. Meetings were held with all three.

QI met the lead reviewer accompanied by representatives from Victim Support and Advocacy After Fatal Domestic Abuse.

A daughter of NI spoke to the lead reviewer with her husband in attendance.

A son of NI responded and agreed to a meeting with the Chair which his wife also attended.

A son of NI provided details of other children who might wish to contribute to the review. Those adults were also asked if they wished to contribute to the review.

A letter was sent to BM while she was still in prison informing her of the Review and inviting her contribution. A further letter was sent in April and on 6 May BM responded and agreed to a telephone discussion with the lead reviewer.

In total 9 family members have made a contribution to the Review. None has identified any clear example of action which the organisations could have taken which would have prevented the incident which caused the death of NI. All have provided valuable reflection on the services provided. Some have commented on services which are outside the remit of the DHR but, because of their importance to victims' families, those comments are included in this report.

Family members have talked about many aspects of their experience and this has given the Panel valuable insight into the circumstances of NI's illness and death. Because this is personal information it is not reproduced here.

It is clear that members of the family hold differing views about a number of aspects of the events described in this report. Whilst it would not be appropriate to go into detail about those differences in the report, every effort has been made not to exacerbate the family's differences.

All family members who made a contribution were offered the opportunity to receive feedback about the draft Overview Report in September and October 2014. All of them accepted the offer and some further comments were added to the Report.

All the family members who made a contribution were offered the opportunity to read the draft report before submission.

The Panel are grateful to the family members who have made a contribution to the Review and wish them well in their recovery from this traumatic incident.

The views of Sister (1) of NI

Sister (1) was seen at her home by the Overview author and another Panel member. She told us that NI had vascular dementia, not Alzheimer's, so her memory lapses came and went. She would get very agitated, angry, was terrified of what was

happening to her. NI frequently didn't know her husband. If someone else was looking after her she would be agitated until he came back.

Before her illness NI was very outgoing, played bridge, was very competent, a lovely cook, was full of life.

Sister (1) was a regular visitor to NI and sat with her once a week, while her husband went out. The main helper was BM, because other family members were working. BM went 2 or 3 times a week, went to appointments with NI. BM bought her mother's clothes and bought nice things, took care over it.

In relation to services, Sister (1) was familiar with the services provided. NI went for day care and respite care even though she did not like it in order to give her husband a break. After the incident, Royal Preston Hospital were really good and caring.

Sister (1) did not think services to NI could have done things differently, though there could have been more liaison, but there was family backup. She wonders whether there might have been more help for BM.

The Police investigation, court proceedings and prison were a shock to her, she had never experienced this sort of thing before.

The staff at Styal Prison were very good with the family.

Since the incident there are two things Sister (1) wants to comment on:

1) There was no hearing loop available in the public gallery at Preston Magistrates Court or at Preston Crown Court. In the Magistrates Court, BM could not hear what was being said. Sister (1) complained about it (and she thinks, so did both the defence and prosecuting counsel). At Liverpool Crown Court, all 5 members of the family who needed it were provided with assistance.

2) The Police FLO worked with NI's husband and children but not with NI's siblings. She wonders how the "family" is defined.

The views of Sister (2) of NI

NI's sister was seen at home by the Overview author and another Panel member.

Sister (2) felt that it had taken took a long time to get an assessment for NI because the Memory Assessment Service was overloaded with referrals.

She had been involved in the aftermath of the incident on 24 July

Family members had not realised how bad BM's alcohol problem was until a few weeks before the incident.

NI's treatment in Preston Royal Infirmary was superb, the family were allowed unlimited visiting. There was a very good doctor when NI was readmitted shorty before she died.

Sister (2) was also very pleased with Styal Prison's treatment of the family.

As with other family members, Sister (2) found out about some of BM's history through the court proceedings.

Some family members have commented that they wish BM could have stayed longer in prison so that she could have had longer to deal with her alcohol misuse.

Sister (2) commented that the lack of an induction loop at Preston Magistrates Court and Preston Crown Court was not helpful. Liverpool Crown Court was different, the usher was really good. How the ushers treat people makes a big difference.

The views of Brother of NI

NI's brother was seen at home by the Overview author and another Panel member.

NI's brother felt that BM's side of the story had not been heard because of her guilty plea.

He felt that Styal Prison could not have been better. BM had responded well in prison.

NI had been violent and difficult because of her dementia.
NI's brother had also seen her every week. He felt that Social Services couldn't have done more. They changed the bathroom, she had a carer every day. They did all they could for her husband.

Family members were aware that BM had a problem with alcohol but didn't know how bad and that there had been problems at her home.
Some people had suggested that NI shouldn't have been left with BM, but it was done to give her husband a break. Of all the family BM had the time and the opportunity to help NI most. There had not been any sign of friction but NI was strong. NI would have been difficult to look after even if BM had not had an alcohol problem.

From his point of view there is no criticism of services. BM didn't give the impression of having an alcohol problem, she is pleasant.

At Preston Magistrates Court we couldn't hear. Sister (1) complained. At Liverpool the usher went and got the aids and tested them.

Views of NI's Daughter (1)

NI's daughter was seen at home with her husband.

NI's daughter reflected on her mother being a very loving person with whom she had a good relationship as an adult. She felt that because of the dementia they had already lost their mum. NI was incredibly unhappy, said she wanted to die.

BM knew the most about services for NI. Most services were in place. NI's husband could have had more support but he was not necessarily comfortable with it.

Some aspects of services were good. Home care was really good. I was impressed with the carer and the organisation. NI's husband didn't really want people in the house.

Before the incident NI's daughter was aware of more than one occasion when BM had been aggressive with her immediate family. BM cared and loved her mum so much and had never done anything violent to her.

NI's daughter did not think any organisation could have prevented what happened. NI's daughter felt that there should be a better system for victims to know what support is available and that the family should have had a FLO at the time of the incident. "The Police were lovely, dealt with us very nicely, that's very important. It was difficult for them to deal with family members with different views. There were difficulties in the hospital, and the Police dealt with it sensitively.

The hospital were really good, let us visit any time of day for months. They were not perfect but the hospital staff were doing a good job and were so nice.

I also felt that the senior staff at Mellor Care were very sensitive and helpful with me in our dealings after the incident up to and including Mum's funeral."

The views of NI's Daughter (2) (BM)

BM did not initially want to be seen in person but spoke to the lead reviewer on the telephone.

BM feels that nothing could have been done differently to make a difference. Her mum was difficult to deal with and BM had been drinking and she was at the end of her tether. If she had not been drinking she would have been able to ring for an ambulance. BM does not think the services need to do anything different. "No-one could have done anything differently, only myself."

BM said there had been no other episodes of violence. Care services were doing everything they could. Mum was ready to go into a home, but Dad was reluctant to let her. As soon as she was in hospital she started to succumb.

BM had been battling with a drink problem for 15 years. Her family had been through hell. She had tried different things including controlled drinking. The absolute shock of what has happened has had an effect. "I believe now that I will never drink again." BM had tried counsellors and other alcohol services, because she thinks different things work for different people. Her problem was very bad.

Asked if anything had been missed, BM said some of her siblings had asked why she put herself in that position. She had stayed before at her Mum and Dad's and had usually had a drink. Usually she would just go to sleep and then carry on. This time was a one off.

Later, BM did agree to meet the Overview author at home with her husband. After the meeting, she added:

- I was not being uncooperative in not meeting, rather felt undeserving.
- My overwhelming feeling is one of remorse; sorrow and horror at what happened that night.
- I had no feelings of malice towards my Mum, only sheer frustration. The majority of the day, and night, we were ok; I had looked after and cared for Mum hundreds of times, always smiling, always willing. After her fall, I believed I was doing my best, apart from the brief, nasty assault. It was the alcohol which twisted my views, poisoned my mind, sapped my resolve.

The views of NI's Son (1)

NI's son was seen at a neutral location, with his wife, by the Overview author and another Panel member.

NI's son reflected on how difficult it had become to care for his mother as her dementia progressed and she could be aggressive.

There had been family discussions about residential care for NI from time to time but then the situation would ease. Family members were leaving it to NI's husband to decide. Some thought it was too soon to decide.NI hated being in residential care when she went for respite.

Asked whether there was anything the services should have done differently:

BM and her husband gave a lot of help. Other relatives were visiting. Overnight was hard because NI had to be taken to the toilet.

"There were discussions with Dad when it was really bad. Then it would get better so he could cope again. Some family members thought it was too soon to talk about residential care."

NI's son added further comments at a later stage:
NI's son felt that the memory assessments did not lead to any difference in services or medication so he wondered what was the purpose of them?

Family members say that NI was not offered treatment for her constipation, they believe because of the difficulties in obtaining informed consent from her. Eventually the family arranged a private consultation for her to deal with this problem.

NI's son felt that the Social Worker was very good at asking questions "Is it too much? What do you need?"

BM's problems were contained within her immediate family. NI's son had never seen her drunk or aggressive.

NI's son felt that there should have been a stronger package of care to support BM and get her help earlier, the agencies were not joined up. Organisations involved with BM should have asked if she was caring for anyone.

NI's son wanted to make the following points about support to the victim's family:

- The FLO did not make contact until after NI had died. NI's son understood this to be a matter of resources. The family were given a booklet about Victim Support but it had taken a long time to get support for some family members.
- The family were not contacted about parole conditions. NI's son understood that it was the responsibility of the FLO to give details of the family to the Probation Service. We don't know what the parole conditions are. We should know, is she banned from doing certain things? The victim's family should know whether BM has conditions for her parole.

The views of NI's Son (2)

- NI's son (2) wished to make a contribution to the Review after the report had been agreed by the CSPs and the Home Office.

- He had not understood the extent of BM's difficulties when she was in a position of having sole responsibility for their mother. He thought that other family members had tried to deal with services on behalf of their mother but had been turned away by services because BM was seen as the main contact. He wondered whether services were aware of the extent of BM's difficulties, but they, as well as family members, may have assumed she was capable of caring for NI. Family members had relied on the help that BM had been able to give to their parents.

- He thought that the difficulties for NI's husband had not been fully appreciated by services. Growing up as a deaf person, especially many years ago, could mean on going limitations on communication, understanding and social and emotional wellbeing.

- Family members had not understood and needed some reassurance about the post release conditions for BM. They would have liked to have known she was receiving support, especially as she continued to care for and support NI's husband. NI's son wondered whether services had assured themselves that BQ was not being put in the same situation again.

- NI's son also commented on the confusion family members had felt about the court proceedings. He felt they would have benefitted from some factual information about how things worked, even written information. It should not have been left to one or two people to inform the whole family about how things would happen.

The views of NI's Daughter in Law (2)

- One of NI's daughters in law thought that not enough attention had been paid by professionals to the vulnerability of NI's husband and how his deafness from childhood had impacted on his ability to understand what was happening in

relation to the issues for NI. His need for support may have been underestimated.

The views of QI

QI was seen at home by the Overview author and another Panel member, supported by Victim Support and Advocacy After Fatal Domestic Abuse.

QI talked about her childhood and said her mother was very loving. She described the progression of her mother's dementia and "I didn't see her aggressive or violent". She felt that there should be more support for family members when there is a diagnosis of dementia.

QI felt that the home carers had provided a good service. "They were lovely people, one in particular was having a nice time with Mum. So Dad felt good too. They helped Dad and provided a good service."

QI visited NI at LEF and felt that they gave her a good service. NI did not like staying there but they did look after her. The rooms were clean and they were feeding her and taking her to the toilet.

"One residential respite placement was awful. The family took her out early. NI was sitting in a tiny room and was frightened. The family were alarmed that NI had packed her bags and left, got as far as the car park." QI asked to see the manager and did not find her reassuring.

At Withy Trees day care, NI had found it hard going but it was good.

QI did not know whether BM had been offered alternative services and whether that would have helped her. She wonders whether services asked if BM was caring for anyone and whether BM's husband had been consulted.

QI felt that not enough had been done to support the family after the incident:

- She felt there should have been a Family liaison Officer from July rather than from September when NI died.
- She felt that Victim Support should have been involved from July while her mother was in hospital the family had questions.

QI later added:

- Victim Support were referred to me from SAMM much later, in the early part of this year. The police did not refer us to Victim Support. It would have been beneficial if we had Victim Support as with their insight knowledge and support this would have helped us greatly. My VSO thereafter struggled to collate information from the FLO to find out about what had happened.

- The FLO met the family after NI died and gave written and verbal information, but after one or two months she was moved to another role. The Victim Support worker had struggled to get information from the new FLO. QI wanted help about the court proceedings.

  QI later added:
  - "The written information was only the A5 folder which comprised of what looks a comprehensive detailed book of information. After a short while the FLO was moved to another role so someone else stepped in and contacted my brother. I feel this did not provide consistent help and support for the family."

The Probation Service did not make contact with the family when BM was due for release. "I wanted conditions on BM's licence and needed to know what the conditions were, so to reassure my family that BM was being monitored and was engaging in some sort of a programme to deal with her severe addiction. To know such conditions are in place which may reduce the likelihood of BM's reoffending during her probation would help me and my family to pick up the pieces and to somehow get on with our lives.

It is important that the case does not lose sight of the effect and impact of the horrific crime has had on me and the rest of my family, the victim's family, throughout the ordeal. Therefore it is crucial we are reassured thereby made aware of BM's conditions of her licence. We have a right to know as we are victims too."

The hospital staff looked after the family when NI went back into hospital and family members were allowed to stay overnight.

14. Summary of agency involvement

This narrative summary of professional contact with NI and BM provides an account of the most significant events and decisions from the different services involved with them during the timeframe established for the review.

This summary, and indeed the whole overview report, has to strike a balance between protecting the confidentiality of the victim, their family and the various people who were in contact with them whilst providing a sufficiently detailed account of events in order to draw out the points for learning and development in the later chapters. Therefore, the summary does not contain every contact with the family.

Prior to July 2009 organisations were asked to include only information which was of significance to the key lines of enquiry.

Between 1993 and 2009 there were visits by BM to the GP and A&E for minor medical matters. In June 1996 BM was fined for driving under the influence of alcohol. In November 2004, BM was assessed for the Addiction Treatment Programme at the Priory Hospital Altrincham but did not pursue treatment. This is the first record of BM seeking help for her alcohol problem though she told the review that she had had an alcohol problem for 15 years and her drink driving conviction in 1996 suggests that there may have been a problem for longer than that.

In December 2007 BM referred herself to the Central Cheshire Alcohol Service but did not engage with the service.
In January 2009 BM told a medical practitioner that she only drank alcohol occasionally. However, in October 2009 BM was referred by her GP to a specialist alcohol service. In addition there were two visits to A&E by BM for minor medical matters.

Advice and support was given with a follow up appointment with the GP attended by BM on 05 November 2009 and 15 December 2009. At these appointments BM was under the care of Cheshire Alcohol Services (Cheshire and Wirral Partnership).

The first referral for NI to Adult Social Care was by her GP on 6 January 2009. A Social Worker visited NI on 20 January 2009. Information and advice only was given as NI did not meet the criteria for a service. This was based on discussion with NI who indicated that family members were assisting with shopping laundry and cooking.

On 17 May 2010 BM was seen by her GP with anxiety/depression (not for the first time) and advised that her alcohol intake was under control and was approximately drinking 1-2 times per week. At this appointment the GP undertook an assessment including recording of anxiety and depression scores. Medication was prescribed and BM was also referred to a counsellor.

On 16 July 2010 NI was referred by her GP to the Community Mental Health Team for assessment with a one year history of deteriorating cognitive function. She was also prescribed fluoxetine for depression.

On 11 August 2010 the GP was notified that BM had not contacted the counselling service.

On 13 August 2010 the GP discussed counselling with BM and encouraged her to make contact. BM was reviewed on 31 August 2010 with regard her medication and alcohol problem by a GP. BM disclosed that her drinking has increased and she is worried she will lose her husband/family. At this appointment the GP discussed the options available to BM.

On 2 September 2010 BM was admitted on an informal basis to The Priory Altrincham for treatment of alcohol dependency. BM completed the inpatient Alcohol Treatment Programme and was discharged on 30 September 2010. Thereafter she attended aftercare which is run on a weekly basis and her last attendance was 1 December 2011.

During the course of her treatment BM indicated that she could become aggressive and nasty under the influence of alcohol. BM reported suffering from depression as a young adult. She discussed her relationship with her husband and its influence on her drinking. BM also told staff that her mother had dementia. NI visited BM in hospital on two occasions.

A discharge summary letter was received by the GP from The Priory on 1 October 2010 relating to BM's admission and stated that she has successfully completed a

28 day detoxification programme, will attend AA meetings post-discharge and will be reviewed by the Priory. The Priory report BM's risk assessment on discharge to be low.

During out-patient follow up between October 2010 and July 2011, BM indicated that she had relapsed from abstinence on a number of occasions. Her relationship with her husband appeared to play a role in her drinking alcohol.

On 7 October 2010 a telephone contact was received by the Community Mental Health Team from NI, worried about her memory, having to be on the waiting list for memory assessment and how long it will take before she is seen. NI said that she has no history of anxiety or depression, but noticed short term memory problems for the last year, she has been more worried.

On 11 October 2010 BM was reviewed by a GP following her discharge from The Priory. At this appointment BM stated she was 10 days abstinent.

On 17 October 2010 NI was referred by her son to Adult Social Care. NI was allocated for OT assessment which was completed on 26 November 2010. Respite vouchers were issued. The assessment indicated that NI's extensive needs were met by her husband and other family members who wished to continue to care for her themselves.

On 30 November 2010 BM requested contact from ASC and on 21 December 2010 BM asked ASC for a financial assessment following OT assessment.

On 10 January 2011 a CPN in the Memory Service undertook an initial assessment. NI was seen at home with her husband present. NI was in considerable discomfort on arrival crying out in pain due to her bowels. General Practitioner appointment arranged for today at 17.10. The CPN was unable to get any information from NI due to her distress so the appointment was rearranged for 21 January 2011. Family members have commented on the extent of the distress caused to NI by constipation.

On 12 January 2011 NI's son requested help with respite care for NI and on 17 January 2011 with personal care

On 14 January 2011 a home care worker noticed bruising on NI's left side.

On 19 January 2011 a home care worker noticed "quite bad bruising" on the right side of NI's stomach.

On 20 January 2011 an assessment was undertaken by Adult Social Care plus a carer's assessment. This concluded that there should be a Care Package managed by self-directed support "care managed route". NI was described as at risk of further deterioration due to extensive health problems. NI needs to use the toilet 6 times a night. NI's husband was said to be happy caring for his wife, although NI was described as fearful in accepting help with her care. The family was seen as supportive. Application was made for attendance allowance. On 21 January 2011 the team manager issued vouchers to purchase care or residential respite. The record

reports that the family have now agreed to personal care for NI and 4 hours of a sitting service were offered. The record states "NI would be in residential care if she did not have such a good family". The outcome of the assessment was for the local authority to continue to oversee the management of NI's Care Package which was to be reviewed in 12 months.

BM was reviewed by her GP on 24 January 2011 regarding her depression and alcohol problem. BM remained abstinent from alcohol and advice was given regarding medication.

On 25 January 2011 NI's son telephoned the ASC service advising of NI's further deterioration. The family were reported as struggling to cope and he was requesting a call back about the possibility of permanent residential care.

At an appointment on 31 January 2011 BM advised the GP that NI has Alzheimer's disease and it is stressful providing care. There was no follow up by GP regarding level of care being provided to NI by BM.

On 3 February 2011 two CPNs from the MAS visited NI at home. Present were NI's husband, NI's sister and NI's son, all of whom were able to assist in the assessment.

On 9 February 2011 a home care worker noticed bruising to right arm which was reported to her husband.

On 11 February 2011 according to ASC records personal care for NI started.

On 23 February 2011 a CPN who was duty clinician in the Memory Assessment Service received a telephone call from NI's GP who advised he had undertaken domiciliary visit today. NI, NI's Husband and BM were present. NI had been wandering, climbing the garden fence, being verbally aggressive towards her husband. The GP had ruled out any underlying infection and that he was requesting a review for NI. The CPN was to contact NI at home to obtain further information from BM or NI's husband then would decide what further action is required. BM told the CPN she visits regularly and stays over. BM said NI had been more confused over last 6/7 weeks. An urgent referral was made to CMHT.

NI attended respite care at LEFH, a care home run by LCC, on 5 occasions since 26/02/2011, and she also attended the integrated day care unit regularly on a Thursday from 29 September 2011. During NI's respite stays at LEFH, she had at least one assisted bath or shower. However the home was unable to locate records for the early part of 2011.

On 8 March 2011 a formal diagnosis of NI was made of dementia of mixed aetiology by a locum consultant psychiatrist.

On 15 March 2011 NI's son telephoned the ASC SW to say that his father was not coping and that a psychiatrist due to assess NI. Reference was made to a family meeting to discuss and after of a follow up visit to complete a self-rating questionnaire which would allocate a level of funding to support NI at home.

On 16 March 2011 ASC reviewed NI's care package and NI was moved to self-directed care (care managed). Multi vouchers were to be used and day care one day per week.

On 16 March 2011 BM was reviewed by her GP regarding her anxiety/depression and advised she had been abstinent from alcohol for 7 months.

On 25 March 2011 a home care worker showered NI and noticed a bruise on NI's right arm with the middle of it being slightly open and weepy. The care worker rang the District Nurses and left a message for them to ring NI's husband.

On 5 April 2011 NI was seen in the memory clinic with her husband and sister-in-law. Both NI and her husband report an improvement in her sleep since starting the Donepezil. Dose increased and prescription given. Review in 6 weeks.

On 8 April 2011 a home care worker noted that "NI has a black eye, left eye NI had said she woke up with it yesterday". There is no recorded questioning of how NI received the injury. This is the fifth injury to be recorded since January but there is no apparent consideration of whether there is a pattern of injuries.

On 12 April 2011 BM was seen by her GP following a skiing accident which resulted in her sustaining a closed fracture of her clavicle. BM was referred to a fracture clinic at hospital where she attended on 19 April 2011.

19 April 2011 A Dementia Advisor visited NI and gave information about services. This is the only visit from this service.

On 17 May 2011 NI was reviewed in the MAS clinic by a CPN She attended clinic with her husband and BM. NI remains well with no side effects from the Donepezil. Sleep and appetite patterns are good. Both NI and her family report a generalised improvement with her no longer having suicidal thoughts.

BM was reviewed on 20 May 2011 by her GP regarding her anxiety/depression and advice was given.

On 28 July 2011, BM attended the aftercare service at the Priory and informed them that she had had several relapses from sobriety.

On 1 September 2011 BM contacted Adult Social Care and requested a review of care for NI because her husband was not coping.

On 5 September 2011 there was a further telephone call from BM to the Social Worker. BM said NI's incontinence had returned, and so had NI's levels of depression and distress. Her husband is her main carer, but he is now struggling and BM says things are beginning to get on top of him and he does not really know how to cope. NI has started to get up in the night and he has to get up and help her.

On 13 September 2011 the Occupational Therapist took a telephone call from BM who was enquiring about activities at Charnley Fold and other day care. Discussed activities at Charnley Fold and Withy Trees Day Care organised by Age

Concern. BM stated that NI feels less stimulated at Lady Elsie Finney House, where she currently attends day care twice a week.

On 21 September 2011 there was a Review and Carers Assessment which resulted in no change in service, needs assessed as the same. NI's husband reported as having regular breaks as well as a skiing holiday each year.

On 22 September 2011 BM attended an out-patient appointment at the Priory and discussed her difficulties in maintaining sobriety. She was referred to an independent psychologist for one to one treatment but did not attend appointments.

29 September 2011 Telephone call from BM to NI's allocated Social Worker from BM's home. BM reports NI's condition had deteriorated, medication had been prescribed by GP. Worker advised she would close the case if no contact within 1 week.

A letter was received by the GP Practice on 30 September 2011 from the Priory regarding BM and requests she is referred to a Psychologist. BM's GP made a referral to Primary Care Mental Health Team on the same day requesting a self-esteem course for BM.

On 11 October 2011 BM was reviewed by her GP regarding her anxiety/depression, and she disclosed that she was drinking occasionally. The GP encouraged BM to attend a self-esteem programme. The GP referral did not meet the criteria of severe and enduring mental ill health for secondary mental health care and it was considered that BM's needs could best be met within primary care mental health services (Improving Access to Psychological Therapies). BM was referred to the IAPT service for a women's self-esteem group.

On 1 December 2011, the day of her last attendance at the aftercare service at the Priory, BM was demanding to see a member of the therapy team who was unavailable at the time, as a consequence it appears that she threw a plant pot at the door before leaving the building. This is the only incident recorded. The Consultant Psychiatrist wrote to her twice to say that she would need to have a discussion with him and the hospital manager before returning for further sessions. BM did not respond.

A letter was received by BM's GP from the Consultant Psychiatrist at the Priory on 08 December 2011 which stated that BM lacks support from her family to achieve sobriety and that she had failed to engage with an Independent Psychologist. In addition the letter states that at a 1 to 1 session BM became abusive and confrontational, there are worries regarding BM's mental health and that they considered this to not be normal behaviour for BM and believe she is drinking again. Dr Haslam advises that BM will not be encouraged to attend any further sessions.

When BM was reviewed by her GP on 21 December 2011 regarding her anxiety/depression she was encouraged to remain teetotal and attend self-esteem programme.

A further letter dated 02 February 2012 was received by BM's GP from the Consultant Psychiatrist at the Priory which states that BM's husband strongly influences her. BM advises that he encourages her to drink socially and does not like AA meetings. BM has said that her GPs have been a good support and put in place all she needs. The Consultant Psychiatrist advises BM's GP that she would benefit from residential support but her family will not support and thanks BM's GPs for providing support they have to her.

Between 23/02/12 to 31/05/12 twelve sessions of the women's self-esteem group in IAPT ran. BM attended ten of the twelve sessions over this period. In May 2012 the counsellor recorded in a discharge letter to the GP that BM had engaged well with the women's self-esteem and assertiveness group and BM reported gaining benefit from the group experience.

16 April 2012 Request from BM from her own home for further assessment by ASC for NI. NI was described as more anxious and the home situation increasingly strained. BM requested to be present during assessment. A list of residential homes sent out. On 17 April 2012 there was a further telephone call from BM to the SW. NI was said to be deteriorating and her husband was described as struggling to cope. The case was not yet allocated.

On 26 April 2012 and 8 May 2012 there were further telephone calls from BM to the Social Worker about NI.

On 16 May 2012 there was a home visit for further assessment by Adult Social Care. Some additional services were commissioned; additional day's day care to enable NI's husband and BM to have a break. There was no review of the carer's assessment.
28 May 2012 NI's son discussed with the Social Worker short term care and the possibility of a care home.

NI was admitted to an independent residential care home and on 30 May 2012 ASC recorded she had had got out unsupervised. One family member has reported they were not happy with the care there and they took her out early after this incident. The Social Worker visited the home. NI was described as anxious and confused. NI reported that she had been accused of murdering someone and she needed to try to escape and get to her family. The Social Worker spoke to the home manager advising that the GP should have been called. Additional staff were to be put in place to support NI. The Social Worker wrote out a reminder for NI to inform her where she was and why she was there. Staff were briefed to reorientate NI.

On 31 May 2012 BM requested reassessment for additional support at home for personal care for NI. BM said the family are ready to consider residential care.

A letter was received by BM's GP on 01 June 2012 from the IAPT Counselling Service advising that BM has completed 10 out of 12 self-esteem sessions and is now discharged.

On 11 June 2012 a risk assessment was completed with NI and the Deputy Manager on NI's first day at Withy Trees Day Support Centre. NI stated she required

someone to assist and reassure when mobilising out of her home environment, due to sometimes becoming disorientated. Support was required with personal care, e.g. using the toilet and dressing as NI stated she could become anxious.

In June 2012 NI began to attend Withy Trees Day Centre one day a week. This service did not conduct any home visits. The only family member with whom they had contact was NI's husband (though BM says she did have initial contact with the Centre). NI was recorded as being anxious at times. She enjoyed quiet activities. There were some periods of absence, notably 18 February 2013 to 18 March 2013 and 25 March 2013 to 15 April 2013. Her attendance continued up to 22 July 2013 which is the last date on which she attended.

When BM was seen by her GP on 13 June 2012 for a throat infection, BM advised she had a normal relationship with alcohol and that NI has diverticulitis.

On 26 June 2012 BM was reported to the police as driving her vehicle whilst under the influence of alcohol, she was circulated for observations but not located and no arrest was made.

On 06 July 2012 at 7pm BM attended Terminal One Manchester Airport along with her husband and 2 daughters to see off her son who was leaving the UK for Australia. There was a family disagreement which resulted in the Police being called (possibly because the family feared self-harm). All family members returned home together. The Police reported that there were no issues regarding self-harm.

On 7 July 2012, BM's husband contacted the police in Cheshire reporting his wife was out of control and she had locked herself inside the family home. There had been an incident the previous day at a wedding when BM had become very drunk and embarrassed the family. It was noted at the time that BM had issues with alcohol and suffered from depression. No offences were recorded.

On 8 August 2012 BM was seen by her GP following a fall that morning with injuries to her fingers. The GP referred BM to A&E Department.

On 8 August 2012 BM attended A&E Department after sustaining a trauma injury to the left hand. BM reported that she had fallen downstairs. The presentation of injury was consistent with the explanation offered by BM. The A&E triage and clinical assessment process provides opportunity for disclosure of domestic violence and none was subsequently made by BM. No safeguarding concerns were identified by A&E staff regarding this attendance. Staff routinely check for any risk markers on the information system at point of admission to indicate additional vulnerability. Any additional vulnerability for any patient can be indicated on a patient's electronic record. In this case, there were no safeguarding concerns and there were no risk markers (alerts) present on the patient's ICS (Information Soft-care System) to indicate any additional need or vulnerability. It has been suggested that this attendance was in relation to an incident when BM allegedly threw herself over a bannister.

On 3 September 2012 a thyroid function test was arranged for BM.

BM was reviewed on 4 September 2012 by her GP regarding her alcohol intake and advised she was drinking again. The GP discussed areas for support.

BM was reviewed regarding her alcohol problem on 15 October 2012 by her GP. BM stated her husband attempts to control her drinking and she appeared reluctant to accept that she has a problem with alcohol.

On 17 October 2012 NI attended clinic for a follow up appointment with the memory service. She was accompanied by her husband, BM, her son, and son in-law. Sleep and appetite were satisfactory. NI's husband also reported that he can't do anything in the house she was following him everywhere and if she can't see him she is shouting out where are you and then she will become anxious.

On 03 January 2013 BM was reviewed by her GP and advised that she had been getting on well with husband, only drinking alcohol socially and had a number of holidays planned. GP does record that she believes BM does not give whole story.

From November 2012 to 16 July 2013 BM was seen on a number of occasions for other medical conditions all of which were clinically managed.

On 6 February 2013 the Community Mental Health Team duty officer made a telephone call to BM who said NI was tearful, negative and aggressive to husband. CPN records that the family is supportive and NI's daughter stayed overnight.

On 28 March 2013 BM spoke to a CPN in the Community Mental Health Team to explain that NI has gone into a week's respite as her father has hurt his back trying to get NI out of bed. BM said NI's mood is no better she feels she is getting worse.

On 2 April 2013 NI's GP contacted the CMHT saying he would like NI seen in the next few days, concerned because NI is agitated and her mood is labile with fleeting thoughts of suicide. NI has family around her and he is confident that she wouldn't harm herself. GP is now aware that a care coordinator from Preston Older Person Community Mental Health Team has been allocated. The agreed plan was a short course of PRN Lorazepam. The GP will contact the Community Mental Health Team tomorrow to express concerns and request a review as soon as possible and will give the Crisis Team number to the family to call for advice in an emergency.

On 11 April 2013 BM changed an appointment for NI with the MAS and said NI's mood was lower. NI has been on CPN waiting list for some time now and it seems NI's situation is deteriorating. Telephone contact to BM who confirmed her mother's mood has lowered further and whilst family are supporting, NI does need other help.

On 12 April 2013 NI was seen in clinic by the CPN who recorded no immediate risk.
On 15 April 2013 NI was seen in outpatient by a CPN accompanied by husband, daughter and son-in-law. Gets agitated and angry mainly with husband. It is believed that NI would not self-harm because of her religion and family.

On 19 April 2013 NI's GP wrote to Community Mental Health Team as single point of entry raising concerns that patient appears to be lost to follow up. The letter outlines how the patient has expressed thinking about death and had expressed feeling a

burden to her family. Letter was received by Community Mental Health Team on 22 April 2013.

On 24 April 2013 there was a telephone call to the GP from her son about NI's aggressive behaviour.

On 25 April 2013 there was a telephone call from NI's GP to Memory Services duty officer. Challenging behaviour and aggression toward husband reported to the Community Mental Health Nurse

1 May 2013 Home visit by MAS Nurse Advised NI will have "good days and bad days" and to "use the coping strategies and distraction" that they had discussed.

On 14 May 2013 BM requested an unscheduled review for NI by ASC.

On 31 May 2013 BM requested reassessment for additional support at home for personal care. BM said family are ready to consider residential care.

Assessment completed on 19 June 2013. Assessment identified NI is part of a warm and caring family. NI reported as getting up 4-5 times during the night and this had an impact on NI's husband. Additional support declined by him. No carers' assessment undertaken or evidence this was offered.

24 July 2013 ASC recorded a safeguarding alert raised by care coordinator, Home Care Mellor. Passed to Active Intervention and Safeguarding team.

15. The Individual Management Reviews

1. Age Concern Central Lancashire (Withy Trees Day Centre)

The author of the IMR identifies herself as a senior manager who had had no direct involvement in the care of NI and is at least two levels removed from practice at the day centre.

The centre supports individuals who have a diagnosis of dementia, through individual/group therapeutic activity. Age Concern was asked to provide an additional day per week of day care for NI from June 2012 until July 2013. NI attended weekly, with some notable gaps in attendance. The only family member known to the staff was NI's husband (though BM says that she did visit the centre with NI's husband).

According to daily/personal records NI was quite anxious when first attending the centre. NI's key worker spent time building on trust and offering reassurance, allowing NI to have the support required to help her settle into a new environment amongst other people. For individuals with dementia, routine and a familiar face is paramount in establishing trust and reassurance within any unfamiliar setting. Individuals with dementia often need to visit a new setting for a period of time before recognition becomes apparent and in some cases, if at all.

NI was always brought in a morning to the centre by her husband and again he would take NI home late afternoon. This consistent pattern appeared to work well for both individuals. The centre does offer a daily minibus service. NI's husband and NI declined this choice of service, as do other carer's and this is respected by the organisation. Due to this decline of service no visits where made by staff to the family home and no other personal, face to face contact with other members of the family was ever established. (BM has said that NI did use the minibus service.)

The author asserts that staff at the centre would note and report any safeguarding concerns had there been any. No further evidence is offered to support this assertion.

The author rightly identifies that as the day centre did not receive a copy of an assessment, the staff should have pursued this as it is their responsibility to ensure that they have the information they require to provide a good service.

The author also identifies that reasons for absences from day care should be recorded for safeguarding purposes as they may be significant in relation to safeguarding.

Two relevant recommendations are made to address these gaps in service.

2. Cheshire and Wirral Partnership NHS Foundation Trust (Cheshire Psychological Therapies)

The IMR is written by a Specialist Nurse for Adult Safeguarding who has had no involvement with the services offered.

The Trust (CWP) service provision for the population within Cheshire East Local Authority includes, primary and secondary mental health care, through Community Mental Health Teams (CMHT) and Improving Access to Psychological Therapies (IAPT), Drug and Alcohol services, Learning Disability service and Child and Adolescent Mental Health Services (CAMHS).

The services of CWP that were specifically involved include Community Mental Health Team (2011) and Improving Access to Psychological Therapies (2011 – 2012). Two of the three episodes did not result in any face to face contact with services, one of which was outside of the date range, but these are included in the summary of agency involvement and were reviewed alongside the terms of reference.

On 03/10/2011, the CMHT received a fax referral from the GP, requesting a self-esteem course for BM. The GP referral did not meet the criteria of severe and enduring mental health for secondary mental health care and BM's needs could best be met within primary care mental health services (IAPT).

The national standard assessments used in IAPT to monitor outcome measures were used; they are completed at the start and end of treatment.

Between 23/02/12 to 31/05/12 BM attended ten of the twelve group sessions over this period. The group was small with seven members. The notes for this type of group are written as a group record, with brief comment on each member. BM engaged well and did disclose her drink problem to the group but was never seen under the influence of alcohol. The author says that there was never any indication that other services were required.

On 31/05/12 a discharge letter was sent to the GP, this indicated BM's feedback that she had found the group beneficial. A patient experience questionnaire was completed by BM in which she stated overall she was satisfied with the course.

The IMR provides a thoughtful analysis of the interventions provided and identifies three areas where useful learning has been obtained. These are in relation to risk assessments, training in relation to domestic abuse and improvements to recording.

The service was not aware of any risks posed by BM to any other person, though there could have been more consideration of possible risks from BM's alcohol misuse towards other family members.

Three appropriate recommendations are made to address the learning from the IMR.

3. Home Care Mellor (Home Care agency provider for NI)

The author of the IMR is a manager in the home care agency who had had some contact with NI and her family. Providing an author with sufficient seniority and independence to write an IMR presents a challenge to many small organisations. In order to counteract this and provide a sufficient degree of independent scrutiny, the author was joined by two panel members, one from the CSP and one from a health background, who assisted in the preparation of the report.

Homecare Mellor commenced a package of care for NI on 10 December 2010. Originally the package of care was put in place via respite vouchers – these are vouchers issued by LCC in the name of NI to provide support for her full time carer (her husband) and can be used for domiciliary or respite/residential care. Soon after (26/01/2011) the package of care was directly commissioned by LCC for three mornings per week on a Monday, Wednesday and Friday for 50 minutes each day (one hour commissioned which is inclusive of 10 minutes travelling time). A brief assessment was given by LCC Social Services and the package of care that was put in place was requesting support for NI with personal care needs. There was concern in respect of NI's husband and carer breakdown as he was the main carer for NI. NI's husband was providing extensive support to NI with all care needs and was unable to go out unless family called to sit with NI as it was felt that she couldn't be left alone due to her health problems.

The visits in place were normally carried out on the three mornings between 8.30am and 9.00am. The IMR author identified that for the most part there were two regular carers who attended the visits whilst other carers attended occasionally for sickness and holiday cover.
The report is limited by the fact that, although NI was provided with consistent carers throughout the involvement of the organisation (generally, inconsistency of carers is

a frequent source of complaints from service users) the carers have since left the organisation and have therefore not been available for interview.

The package of care was commissioned by Adult Social Care but appears to have been reviewed only by Home Care Mellor. Reviews by the Social Worker do not appear to have included Home Care Mellor. This raises some questions about the care co-ordination of packages of care.

There were five occasions when home care workers noted bruising to NI:
14 January 2011 Bruising to left side
19 January 2011 Bruising to right side of stomach
9 February 11 Bruising to right arm
25 March 11 Bruise to right arm, open and weeping
8 April 2011 Black eye. NI says she woke up with it

The injuries to NI were recorded during the first four or five months of the HCM involvement. There are no injuries recorded after April 2011.

Scrutiny of records by the Overview author during this period has identified only one possible opportunity for another service to observe any of these injuries.

There is no suggestion that these injuries were inflicted. However, there are no recorded attempts by the home care workers to enquire about the causes of the injuries. If these injuries *had* been caused by abuse or mishandling, the home care workers would have been in a good position to identify that concern.

It has not been possible to ask the workers the reasons for their not enquiring further about these injuries. The Panel has speculated that this was influenced by the workers assuming that this was a “nice” family and that therefore there was nothing untoward.
There is no recorded attempt to report the injuries to anyone other than NI’s husband. As the main carer, he should have been asked how the injuries were caused. Any discrepancy between the injuries and the accounts given would be a cause for concern. The home care workers should have been alert to the possibility that injuries might be caused by a carer. There is no evidence that they were aware of that possibility.

The Pan Lancashire Adult Safeguarding Procedures contain the following:
Signs and Symptoms of Physical Abuse
The signs of Physical Abuse are often evident but can also be hidden by the abuser or the victim. Any unexplained injuries should always be fully investigated. Evidence to look out for includes:

- *Any injury not fully explained by the history given;*
- *Injuries inconsistent with the lifestyle of the Adult at Risk;*
- *Bruises and/or welts on face, lips, mouth, torso, arms, back, buttocks, thighs;*
- *Clusters of injuries forming regular patterns or reflecting the shape of an article;*
- *Burns, especially on soles, palms or back; from immersion in hot water, friction burns, rope or electric appliance burns;*
- *Multiple fractures;*
- *Lacerations or abrasions to mouth, lips, gums, eyes, external genitalia;*

- *Marks on body, including slap marks, finger marks;*
- *Injuries at different stages of healing.*

There is no evidence that the home care workers considered the possibility of these injuries being deliberately inflicted or the result of poor handling techniques.

There is no suggestion that the home care workers were aware of BM's alcohol misuse prior to 24 July 2013 when NI was found by them with serious injuries. The Pan Lancashire Adult Safeguarding Procedures also include guidance about some carer factors which might raise concern:

- *Substance misuse;*
- *Mental illness;*
- *Stress;*
- *Chronic fatigue;*
- *Conflicting demands of other family members;*
- *Individual unmet needs;*
- *Bereavement;*
- *Financial difficulties, or dependent on the Adult at Risk for assistance;*
- *Victim of abuse;*
- *Poor or inadequate living conditions;*
- *Isolated or unsupported.*

There is no suggestion that they were aware of her alcohol misuse or had seen her under the influence of alcohol.

The Lancashire Adult Safeguarding Board procedures detail the action which should be taken if abuse is suspected:
An 'alert' is a response to a concern, where an individual believes that a vulnerable adult may be at risk of harm or abuse.
A worker, who is either directly or indirectly involved, volunteer or agency worker who first becomes of concerns of abuse must report those concerns as soon as possible and in any case within the same working day to the relevant manager (or responsible person) identified in their internal agency procedures.
As a general rule, alerts should be raised as soon as abuse or neglect is witnessed or suspected. This should always be the case if the adult remains in or is about to return to the place where the suspected/alleged abuse occurred and the alleged abuser is likely to have access to the adult or others who might be at risk.
On receiving an alert, the person responsible must decide whether to make a referral to the Local Authority Safeguarding Adults Team.
If the responsible person is not contactable, concerns should be reported directly to the Local Authority Safeguarding Adults Team.

The IMR author assumes that the home care workers did not report concerns because they were not concerned, but is unable to evidence that the possibility of abuse being considered.

Consistency of workers is a positive aspect of the home care provided in this case. However, the fact that the workers had built a good rapport with NI and her husband might have led them to be less alert to the possibility of abuse.

The IMR details the training which is delivered to home care workers during the first 13 weeks of employment. This however does not include the basic LASB training which would be applicable to all practitioners.

In relation to safeguarding training the LASB procedures state:
Each partner organisation has a Training Strategy which will ensure that staff and volunteers at all levels have appropriate knowledge and competencies in relation to:

- *Potential for the occurrence of abuse and neglect;*
- *Identification of abuse and neglect;*
- *Safeguarding Adults Policy and Procedures;*
- *The requirement to report any concerns of abuse or neglect;*
- *Internal reporting structure for such concerns.*

Employers are responsible for ensuring their employees are confident and competent in carrying out their responsibilities and for ensuring employees are aware of how to recognise and respond to safeguarding concerns. They should also identify adequate resources and support for inter-agency training. This would include providing staff who have the relevant expertise to contribute to the planning, resourcing, delivering and evaluation of training; and releasing staff to attend the appropriate inter-agency training courses.

The LASB provides basic training (available as e learning on the website) as follows:
This training raises awareness of abuse and equips individuals to understand what constitutes abuse, how to recognise abuse and what to do if you find or suspect abuse.
It examines values and attitudes in working with adult abuse and helps develop skills in responding to disclosure and what to do if abuse is suspected. It clarifies reporting procedures, roles and responsibilities across the Lancashire multi-agency partnership.

The IMR author suggests that a new procedure should be put in place for reporting *all* injuries to more senior staff in the organisation. This is likely to produce a large number of reports of injuries which are of no concern. Instead it would be preferable to institute routine enquiries by home care workers about the mechanism of injuries so that what is reported is 1) injuries which in themselves cause concern because they are in an unusual position, are of an unusual shape 2) injuries which are not consistent with the explanation given 3) repeated injuries.

If, in addition to this, if workers were routinely offered the opportunity to reflect on their practice and the organisation had a means of monitoring practice, this might raise workers' confidence in their ability to recognise and report concerns appropriately.
Commissioners of services for adults at risk should monitor the quality of services. This would include the training of workers. A further recommendation is made by the Review in relation to commissioning.

The IMR identifies four recommendations for improving practice.
In addition to the recommendations in the IMR, the Review recommends that
1) All home care workers are required to undertake basic training in recognition and referral of concerns.
2) All home care workers are offered regular opportunities for reflective supervision

3) The home care agency institutes a means of monitoring the effectiveness of training and supervision
4) That the LASB be asked to assure itself that all organisations in Lancashire providing personal care to adults at risk have in place arrangements for training and supervision of workers.
5) That commissioners of health and home care services are asked to ensure that their contract monitoring arrangements include the monitoring of training, supervision and compliance with safeguarding procedures.

The IMR author received feedback from the Panel about the initial IMR and made appropriate changes to the IMR and recommendations in response to the feedback. Subsequently the Training Officer provided details of the training which had been provided to the care workers. It included the procedure to follow on noticing a bruise or mark. She advised that this had been place prior to the incident and included training on measuring, describing marks and use of body maps, monitoring the mark on follow up visits, enquiries about how it had occurred and recording information, notification to the office and following up if they felt that issues weren't being addressed. The training has now been supplemented and the refresher will be given drawing on the lessons learned. This information further emphasises the need for monitoring of the effectiveness of training.

4. Lady Elsie Finney House (Home for Older People)

The IMR is written by the Registered Manager of the home, who had no involvement with NI during her stays and details the procedures used in providing respite care for NI.

Lady Elsie Finney House is a purpose built care home (built in 2007) which cares for individuals with advanced dementia. It is owned and run by Lancashire County Council. It has 45 permanent beds for residential live-in, divided amongst 3 units in the same building. There is no difference between the units, but residents prefer small-group living with the same staff on the unit for continuity and familiarity, which promotes person-centred care. There were 3 respite rooms available at the start of this review, but this has since been reduced to one respite care room.

LEFH care home also has a limited number of places for day care attendees. These are usually allocated to individuals who are in the more advanced stages of dementia and are unable to attend the day care unit. A register of attendees for the day care is kept, and also noted is if anything untoward has happened or was seen.

NI attended for residential respite care on 5 occasions since 26/02/2011, and she also attended the integrated day care unit regularly on a Thursday from 29/09/2011.

The IMR addresses the key lines of enquiry for the Review. However records for the early part of 2011, when injuries to NI were seen by home care workers, are no longer available. No other matters of concern were recorded by staff at the home.

Records show that during NI's respite stays, she had at least one assisted bath or shower. For health & safety reasons, the staff assist in the process. The author states that any bruising or marks would be reported immediately to the duty officer

and a body map completed. The duty officer would act according to safeguarding procedures and concerns would be reported to Adult Social Care.

During NI's time at LEFH, there were no incidents or evidence of anything untoward occurring in relation to her or her family. All records indicate a normal residency or attendance. However, records for the early part of 2011 could not be retrieved and this is significant in relation to the concerns about injures to NI during this period.

Care home records are listed in Schedules 3 and 4 of the Care Homes Regulations 2001. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 require only that records are kept for “an appropriate period of time”.

The IMR therefore makes one recommendation in order to address the issue of recording and storing information.

5. Lancashire Care NHS Foundation Trust

The author is a senior manager who had no contact with NI or her family.

The LCFT IMR describes the organisation’s involvement with NI. It provides a good level of analysis of the services offered and identifies a number of areas where the service could be improved.

NI, an 83 year old lady was known to Lancashire Care NHS Foundation Trust (LCFT) from the 16 July 2010 until her death in September 2013. During this time frame NI had involvement with LCFT’s Mental Health and Community Services covering the Preston area including, The Memory Assessment Service (MAS) the Community Mental Health Team, the Intermediate Support Team (IST), and the Royal Preston Hospital Liaison Team. Additionally NI had received assessment, care and treatment from LCFT’s Central Lancashire, Continence Service between January and June 2011, District Nursing Services from the 30 September 2011 to the 5 October 2011, and Podiatry Service in the new patient clinic on the 26 April 2013.

From July 2010 until January 2011 NI was on the waiting list for MAS services, having been referred by her GP. This is a waiting time of 6 months, which is acknowledged by LCFT and commissioners to be too long.

Practice has changed since 2011 and the current MAS clinic is now situated in a ‘one stop shop’, this allows the patient to be assessed by both nurse and consultant psychiatrist on the same day as far as is possible. This is an improved practice standard and would therefore reduce the likelihood of such a delay happening again. During the period that MAS was completing assessment NI’s husband reported a deterioration in presentation, agitation and behaviour (Feb-Mar 2011) and the CMHT was asked to triage the case for assessment. The CMHT did not follow the LCFT operational protocol for older adult community mental health teams, which states a referral should be rated ‘immediate, urgent or routine response’. This should have happened, however as NI was to go for respite care, this did not impact on her well-being and safety.

On 23 February 2011 it is documented that the Duty Clinician Memory Assessment Service, telephoned NI's home and had spoken with BM. BM advised she visited NI and her father regularly and stayed over quite often. BM said that her mother had been getting more and more confused over the past 6 to 7 weeks. The MAS Manager has identified that with hindsight this was a missed opportunity to clarify the impact NI's deteriorating cognitive state was having on BM as a carer. Carer's needs had been considered in relation to NI's husband, and there is evidence that a review of the husband's carer's needs had been completed by social services in February 2011.

BM was not offered a carer's assessment as it is normal to offer only to the main carer, so it would not be expected that BM would be referred to Lancashire County Council for a carer's assessment within current practice. LCFT older adult mental health services should now consider if this standard practice be reviewed to apply to all carers.

There are multiple contacts with NI and BM (on behalf of NI) and a number of assessments were conducted over a period from July 2010 to September 2013 involving the CMHT, the MAS and the Immediate Support Team None of the assessments identified any safeguarding concerns.

There were no documented safeguarding concerns in the Mental Health service electronic record, nor the Continence, Podiatry and District Nursing paper records, prior to the incident in which NI sustained a fractured neck of left femur.

The MAS locum consultant saw NI in March 2011 and gave a formal diagnosis of 'probable moderate dementia of mixed origins (Alzheimer's and vascular)'. A clear plan of care was given at this time including the prescription of anti-dementia medication and follow up in the nurse led memory clinic.

Throughout 2011-2012 NI was seen for review in clinic by an assistant practitioner. This was normal and expected practice. Throughout this time NI showed a steady decline in cognitive functioning and assessments completed evidenced the steady progression of NI's dementia. The assistant practitioner received clinical supervision of her caseload and discussed this case. The service would expect to see a record in the notes of when any practitioner discusses a case in supervision that this is recorded. The assistant practitioner did not make this record.

This steady deterioration in cognitive function and increase in agitated behaviours, along with the lack of a completed safety profile were missed opportunities to recognise any indication that NI could have been at risk as a vulnerable adult from her family or carers. It also was a missed opportunity to recognise if NI may have been a risk to her family or carers.

On 6th February 2013, NI was referred by her GP to the community mental health team duty desk. She was triaged over the phone. The CPN spoke first to NI's husband and then to her daughter BM, as NI's husband could not hear well on the phone. This is normal and expected practice. The outcome of the Triage was to allocate the case to a team nurse for assessment. That nurse held NI as a waiting case on her caseload and did not assess.

The assessment was not rated by the triaging nurse as 'immediate, urgent or routine', therefore the CMHT operational protocol was not followed and should have been. The CMHT nurse allocated NI for assessment should have assessed NI and this did not happen. On the 11th April the CPN allocated the case realised NI had not been assessed and discussed with the team. The case was allocated to another nurse and the assessment then happened on the 12th April 2013. When the assessment did occur it is noted that it was thorough and included the safety profile, and no indication of any risk to NI was apparent, indicating that the delay to assessment did not contribute to the final outcome of the assault to NI.

A safety profile (risk screening assessment tool) should have been completed by the Memory assessment team. Throughout the 3 year period of care this was not completed. It should have been completed, and is an important part of the safeguards in the assessment process to protect all service users. No clinician has been able to explain why it was not completed. It is an omission that should not have occurred. The implication of not completing the safety profile is that any risk to NI is less likely to have been found.

Further analysis of the daily record of the meeting in which the safety profile was completed indicates that any risk from NI towards her husband was not fully explored. This should have happened and did not. Not assessing thoroughly the needs and risk to NI's carer (husband) and then considering how best to meet the needs of NI and her carer (husband) meant that any opportunity to support, advise and manage better the situation at home was missed by services.

Whilst further trained in a skill set to carry out review assessments, the assistant practitioner should have continued to work under the guidance and clinical supervision of a qualified practitioner. There is no indication in the record that this occurred. The team manager has confirmed that supervision took place but this is not recorded in NI's record as would be expected.

The author concludes that there was no point at which different action by the Trust would have resulted in a different outcome for NI.

The IMR identifies 9 learning points and the Action Plan proposes action to remedy or improve those areas of service.

6. Lancashire County Council Adult Social Care

The Individual Management Review is written by a senior operational manager, who had no direct involvement with the case.

Lancashire County Council is the upper tier authority covering 12 district local authority areas, with a total of approximately 1.2million residents. As such, Lancashire County Council (LCC) is one of the largest local authority areas nationally. Providing social care services is part of LCC's remit. These services in Britain are facing an enormous challenge. The population is growing in size and age and people are more likely to suffer from long term illnesses that require ongoing care. In adult social care situations, individuals have the right to make their own

decisions and have privacy in how they manage their lives and care needs. This is in line with national governmental policy for local authorities to change the way systems work and includes helping people to help themselves. Supporting self-management means providing information and encouragement to help people maintain greater control by understanding their condition and being able to monitor and take appropriate action.

The first referral to ASC was in January 2009. The Adult Social Care service was contacted again by NI's son in November 2010 and remained involved until NI's death.
The analysis of involvement provided gives some suggestions about why there was little enquiry, not only by ASC, but by any of the organisations involved with NI about the ability of the family to cope with NI's needs. ASC, along with other organisations providing services to NI did not have any information which indicated possible risk to NI from BM. However, none of the organisations appears to have made any attempt to enquire about the possible vulnerability of the family as carers.

It was identified in a specialist social care assessment completed that NI was supported by "a very warm and caring family who all offer support to both NI and (her husband)".

The risks that were identified were those of possible carer breakdown, in relation to NI's husband but he declined support on several occasions. Multi vouchers which could be used to provide respite care were provided.

Adult Social Care completed a carer's assessment in respect of NI's husband, which identified that NI had a family that provided extensive support. No carer's assessment was completed for BM, or any of NI's children, as this was considered to be a shared responsibility. At no stage during ASC's involvement did BM indicate she was a primary carer for NI. BM was not identified as providing more care and support than the rest of the family.

Adult Social Care did not have any recorded information that identified BM might present a direct risk to NI.

There was no evidence regarding domestic violence or other mental health problems for either NI or BM. There was a shift to self-directed support during the Adult Social Care involvement with this case. This saw NI and her family having more direct control in terms of how assessed need was met. Whilst this approach has many advantages, it may reduce the extent to which possible abuse of adults at risk can be identified. The ASC IMR nevertheless recognizes that the service needs to consider other carers involved in supporting adults at risk, in order to give them an appropriate level of assessment and support in addition to the primary carer.

The same ASC social worker was involved with NI for a considerable length of time, and this is seen as appropriate practice as it builds up a positive working relationship with the family, and prevents them needing to repeat their information more than once. This approach was replicated in the move to a formal commissioned service to meet NI's needs (same agency for day care services).

The IMR identifies that a new structure is planned in ASC that will ensure a greater degree of consistency in terms of allocated worker by moving from a function focus to a consistent contact focus. This will remove the risk associated with the two month delay in NI's reassessment request in April 2013, when the allocated worker was on extended leave.The IMR author reflects on one of the key themes of the review overall which is that most adults, whether needing support themselves or as carers, have the capacity and capability to make decisions for themselves.
In the case of NI and her carer, her husband, additional options of support were discussed on many occasions at assessment or review, which were declined. The author comments that Adult Social Care cannot intervene above an adult's decision to make choices for themselves.

A summary of the learning from a series of adult Serious Case Reviews in Lancashire included the following:
Accountability including complex funding arrangements and recognition of the responsible agency, responsibility around continued review and assessment, multi-agency accountability and the needs of self-funding service users.

Reviews conducted by Adult Social Care do not appear to have included the home care agency. The home care package which was provided for NI appears to have been monitored and reviewed by the home care agency. There was no evidence seen by the Review of independent monitoring of the home care service by Adult Social Care. This appears to expose individuals to considerable potential risk. In addition, it did not appear to be clear to some people who the commissioner of the service to NI *was,* where NI and her family were choosing the type of provision she would receive. This compounded the lack of clarity about where to report injuries or incidents. This meant that an opportunity to discuss the injuries to NI in early 2011 and the need for workers to understand the need for reporting was lost. Whilst the Review does not draw any conclusions from the injuries in 2011, a further recommendation from the Review is made about care co-ordination.

The author makes three recommendations for service improvement.

7. Mid Cheshire Hospital NHS Foundation Trust

The IMR was written by the named Nurse for Safeguarding in the Trust, who had had no contact with BM or her family.

Mid Cheshire Hospitals NHS Foundation Trust is an acute provider organisation which manages Leighton Hospital, Crewe; the Victoria Infirmary, Northwich and Elmhurst Intermediate care Centre, Winsford. The Trust was originally established as an NHS trust in April 1991 and then became a Foundation Trust in April 2008. It employs approximately 3,200 members of staff and has around 540 hospital beds. A range of services, including A&E, maternity, outpatients, therapies and children's health, are provided for people predominantly from the Crewe, Nantwich, Congleton, Middlewich and Northwich areas, although patients from other areas are also cared for. In October 2005 the Trust also opened a purpose-built NHS Treatment Centre, specialising in day surgery and diagnostics for a range of conditions.

There was a number of referrals for BM made by her GP for straightforward clinical interventions and on three occasions BM attended her local A&E. This is not considered by the author to be excessive.

At no stage during her own clinical interventions did BM indicate that she was a carer for anyone.

The IMR author could not identify any evidence of offending behaviour, substance misuse or significant mental health issues related to BM. However, there was relevant historical information relevant to alcohol consumption. On 22.06.09, BM attended a consultation within Gastroenterology and was asked about her alcohol consumption; BM stated she had a bottle of wine per week. Given that the average bottle of wine contains nine units of alcohol and a women is safely able to consume up to fourteen units of alcohol per week, this would not have been assessed as a potential to BM's health status by MCHFT and would not have led to further challenge or action.

An attendance on 17.12.09 at the Accident and Emergency Department for a back injury provided both the practitioners at the time and the IMR author a picture of a potential domestic abuse incident and associated alcohol reliance. However, despite being challenged upon the history of events and being provided with opportunity for disclosure BM maintained there was no cause for concern in either area. The IMR author acknowledged that in 2009, services in MCHFT were very different in relation to recognition and responses to adult vulnerability. MCHFT now has an amalgamated Safeguarding Children & Vulnerable Adult Safeguarding Service. This provides practitioners with consistent levels of advice and support and a comprehensive training programme. MCHFT have also recently employed an Independent Domestic Violence Advocate (IDVA) whose remit is to advise on cases of domestic abuse presenting to the organisation.

The author had discussed with the IDVA whether the specialist knowledge and support might have made a difference for BM if she had presented today.

The IMR Author also discussed with the Lead practitioner of the Alcohol Liaison Service the clinical response to BM's presentation. It was felt that a proactive response would have been difficult to progress in 2009 because of the nature of the alcohol services that had existed at that time. Given that BM was denying any regular consumption it would have been hard for practitioners to do any more than what was done. Presentations of alcohol reliance that were not requiring an active clinical response such as detoxification, would have been referred to their GP or the Community Alcohol Services (which would have required BM's consent to activate support). The Lead practitioner of the Alcohol Liaison Service was not convinced that BM would have provided consent; based upon the information provided by the IMR Author. However, the IMR Author was able to establish that support pathways have been dramatically improved since 2009. Since 2011, there is now an Alcohol Liaison Service based within Accident and Emergency, offering twenty-four hour advice, assessment and support pathways. As with the issue of domestic abuse, the IMR Author considers whether the specialist knowledge and support could have made the difference for BM if she had presented today.

The IMR author was able to establish that there was limited policy, procedure and formal process linked to the screening, disclosure and identification of Domestic abuse at the time of a key Accident and Emergency presentation in 2009. Whilst MCHFT did participate in the DAFSU and MARAC process, there was limited practitioner involvement and superficial dissemination of case discussions. Domestic abuse was not included in the Mandatory training programme and was conducted on an ad-hoc / as requested basis. However, the IMR Author could evidence that since 2009, there has been concerted commitment, effort and resource allocation to this area from MCHFT. There is reference to Domestic Abuse both within the Vulnerable Adults and Safeguarding Children Policies. There is a Safeguarding Children, Domestic Abuse and Vulnerable Adult trigger flowchart – providing action steps for frontline practitioners. There has been increased participation within the Domestic Abuse Family Safety Unit (DAFSU) and Multi Agency Risk Assessment Conference (MARAC) process with MCHFT representatives being provided from the Safeguarding Committee, ensuring consistent approaches to MCHFT and partner agencies. Frontline practitioners utilize the Risk Indicator Checklist (RIC) documentation and conduct referrals to DAFSU and / or Children's Social Care as appropriate. Since 2013, domestic abuse has been included in the Mandatory Training programme ensuring staff maintain a basic knowledge of recognition and responses. However, the IMR Author recognized this could still be improved and this is addressed through the DHR single agency action plan.

In a referral letter from the GP to General Surgery on 18.06.10, the IMR Author observed GP information which indicated that in 1999 BM had experienced low self-esteem and that as a coping mechanism BM has increased her alcohol consumption to approximately fifty units per week. This is three and a half times the recommended safe level for women and should trigger frank discussion and support pathways available. However, this did not occur within MCHFT, as the GP had also documented that BM was aware of this reliance and was happy to receive assistance from her GP; along with counselling sessions. Therefore, the IMR author was able to conclude there would not have been any additional role for MCHFT with this historical information and there would have been continued concentration purely on the clinical issue.
The IMR provides some good evidence of learning in relation to

- Recognition and response to the needs of vulnerable adults when accessing care at an acute health provider.
- Recognition, response and providing advice / support within a safe environment in relation to domestic abuse.
- Trigger factors within healthcare presentations that can be assessed / supported within a safeguarding context; such as alcohol consumption, history of mental health difficulties or risk taking behaviours.

And there is some good reflection by the members of staff interviewed:
The IMR Author was able to clarify that historically in 2009, key frontline practitioners; such as in the Accident and Emergency Department did have some basic awareness of domestic abuse – however it was rare for the Safeguarding professionals to receive any notifications or referrals for domestic abuse issues other than regarding direct patient disclosures. As one member of staff recalled "*I think we knew the basics… but it was having the confidence to put it into practice. It's not like*

today. We know who to contact for advice… even it's just a gut feeling; we know we can do something."

The author makes two recommendations with appropriate actions specified.

8. NHS Chorley and South Ribble Clinical Commissioning Group/NHS England Lancashire Area Team (Lancashire GP)

The author of the IMR is the lead GP for safeguarding and has had no contact with any member of the family

The IMR provides some useful reflection on the part of the author and the GPs who were interviewed by the author.

The records show that even before her diagnosis of dementia NI was a frequent attender at the GP surgery. She had a range of physical problems including bronchiectasis (a chronic lung condition leading to a tendency to chest infections), urinary frequency (very common in ladies of this age), dermatitis/eczema and glaucoma.

NI was seen on many occasions by the GPs at the practice, both in the surgery and at home. On one occasion she was seen at the nursing home where she was in respite care ie away from any family members. There is evidence within many of these consultation records that the doctors spent time talking directly to NI and listening to her concerns. At no point did she say anything to alert the doctors that abuse was happening or had happened in the past.

There are several comments in the records suggesting that her husband was struggling to cope though he does not appear to have sought help from the GP in his own right. It was the wider family who frequently asked for help with NI's physical and psychological symptoms. Two daughters are mentioned in the GP records, BM and DI. BM was the one who made most calls to the GP and was the daughter authorised on the records to share information with. There is also mention of a son and a brother. The GP practice did not know if anyone other than NI's husband lived in the house with them or how much care the family actually provided.

In retrospect, according to this agency's information, NI met the criteria of a vulnerable adult from around October 2010 when she became dependent on others for care (there is specific mention that her husband would remind her to take her medication). The practice had not considered this and even when the diagnosis of dementia was eventually made, the link between this diagnosis and vulnerability was not specifically considered.

The question of when exactly a person meets the definition of a vulnerable adult is somewhat subjective and the author could not identify any specific guidance for GPs on when to add this code to the records. However the Review was told that there is a nationally recognised toolkit for practitioners (GP's). If NI's records were to have been coded as "vulnerable adult", this may have increased future vigilance for those dealing with the family at a later date. However, coding everyone with mild dementia

or other chronic illness as “vulnerable” would render the code so common that it would no longer catch people’s attention.

The practice has undertaken vulnerable adults training and the GPs spoken to are both aware that a vulnerable adult is more likely to be abused than one who has no such vulnerability, but had not specifically identified NI as being such.

There was no information shared between the GPs and agencies other than health – eg social care. Given the complexity of NI’s problems (bowel problems, incontinence, chest condition, low mood and rapidly progressing dementia) and the frequency of GP input over a prolonged time, multiagency meetings/discussions would have been extremely helpful. An integrated approach may have reduced workload for the GPs, resulted in more effective joined up care for NI and more support for her family. Concerns regarding BM from other agencies may have been flagged up in which case cross boundary information sharing could have been appropriate

There are several instances of what the author considers to be good practice evident from the records. For example on 5/12/10 the family phoned the out of hours GP service to discuss their worries. This information was sent over to the GP practice and a home visit arranged the very next day on 6/12/10. Bearing in mind the amount of mail a practice receives the author views it as excellent that this was spotted and acted on so quickly.

The GP surgery in Lancashire had no knowledge that BM might present a risk to others. She was registered at another practice in another county and they therefore had no access to any of her health records. In their dealings with BM she always appeared to have her mother’s best interests at heart and to be appropriately worried about her wellbeing. Again the appearance of a good caring family may have meant that practitioners did not enquire further about the impact of NI’s care needs.

The family called on many occasions about worries and problems with NI. The practice responded with either advice over the phone or a home visit as appropriate. On two occasions (14/1/11 and 24/4/13) a member of staff realised the seriousness of what the family were saying and documented the content of the phone calls as well before passing the concerns onto the doctor immediately. It is very rare for practice staff to need to write in the records but it is excellent that the risks involved here were appreciated and the member of staff acted on her own initiative

Assessing risk (physical, psychological and social) is an integral part of every consultation in general practice and at times the records document this in detail eg the home visit by a GP on 23/2/11. At other times the written notes are less detailed but it is still clear, in the view of the author, that some element of risk assessment has taken place.

If the link between dementia and vulnerability to abuse had been considered and NI had been specifically identified as a vulnerable adult the doctors may have been more inquisitive eg why was she agitated at times? – in addition to dementia and physical problems, a behaviour change secondary to abuse should have been considered.

The author reflects on the level of time and energy spent on responding to the family and making attempts to obtain support from other services and wonders whether a different approach such as calling a multi-agency meeting to agree a long term plan for NI might have been more productive.

The author expresses the view that there is a general lack of clarity amongst many GPs as to how the mental health services for the elderly work.

The concept of NI's vulnerability and the possibility of abuse was not really considered by the practice and it may be that further training would help raise awareness for the future. This does not imply that the author considers that there were any missed opportunities or signs that were not recognised.

The author says that all practice staff have received training in equality and diversity and GMC guidance is clear that discrimination is against the "duties of a doctor". Ethnicity is routinely recorded at the practice. GP training stresses the importance of a holistic approach, taking into account diversity issues, and there is good evidence from the notes that NI's age and disability have been properly considered. For example she was actively offered a flu vaccine due to her age and long term medical conditions. Her inclusion on the dementia register meant that she was actively invited to reviews by the practice. Her disability was also taken into account when arranging care and she was frequently seen at home by the GPs.

9. NHS England, Cheshire, Warrington and Wirral Area Team (CWW)/ Eastern Cheshire Clinical Commissioning Group (Cheshire GP)

The IMR is written by the Assistant Director of Nursing, Quality & Safety from NHS England (CWW Area Team) who has had no operational involvement in the GP practice.

The IMR author could not identify any evidence of offending behaviour, substance misuse or significant mental health issues related to BM. However, there was relevant historical information relevant to alcohol consumption and depression recorded within BM's GP records. It is evidenced from the chronology that BM initially raised alcohol dependency with her GP on 26 October 2009 and this features throughout her attendances at the Medical Centre. BM received appropriate clinical care from the Medical Centre regarding these attendances and was also an inpatient in a private alcohol treatment facility.

There appears to be a lack of documentation within the records reviewed relating to BM's caring responsibilities in relation to NI, which if explored by the GPs may have led to relevant assessments and support being provided. However, the author's view is that if BM did not disclose this responsibility and its associated burdens to them, then it would be difficult for them to have acted on this and provided support.
There is no evidence in the records that BM disclosed any domestic abuse within her family relationships and it is unclear if the GPs considered this to be a factor in her alcohol abuse. There is reference to BM stating her husband encouraged her to drink socially and therefore it may have been appropriate for the GPs to consider and discuss the possibility of domestic abuse and if required make necessary referrals for support.

There is no evidence from the information available that BM was either a victim or perpetrator of domestic abuse.

There is one occasion which the author identifies as a possible missed opportunity. On 31 January 2011 BM was given dietary advice in relation to blood results received. At this appointment BM advised the GP that NI has Alzheimer's disease and it is stressful providing care. There is no follow up by the GP to this question in relation to the level of care being provided to NI by BM which whilst in the view of the author would be normal practice, may have been a missed opportunity to fully understand BM's caring role in relation to NI.

The Medical Centre has in place relevant safeguarding policies and procedures however there is no evidence from the chronology that BM was considered a vulnerable adult and therefore no evidence that these policies were used. The IMR Author was unable to establish from the records and subsequent chronology if BM should have been considered a vulnerable adult.

The author makes a number of recommendations for NHS England Cheshire and Wirral Area Team and for the GP practice.

10. The Priory Hospital Altrincham

The IMR was written by the Hospital Director/Regional Manager who is also the safeguarding lead for the region. He had had no operational involvement with BM's care at any point.

Priory Hospital Altrincham is a 47 bedded independent mental health hospital, part of Priory Healthcare Ltd. In addition to the inpatient services the hospital provides treatments on a day patient and outpatient basis.

The Addiction Treatment Programme (ATP) is one of three main service lines provided. Patients admitted to the hospital are funded privately through medical insurance & self payment or by the public sector.

The Addiction Treatment Programme (ATP) advocates abstinence and is based on the 12 step "Minnesota model". Service Users are assessed by a qualified ATP Therapist &/or Consultant Psychiatrist for their suitability before embarking on a 28 day inpatient admission; successful outcomes are dependent on the motivation of the service user for sustainable recovery.

Discharge planning commences upon admission. Families and carers are engaged wherever possible in the programme.

To support long term abstinence, Service Users are encouraged to engage with Alcoholics Anonymous (AA), attending meetings throughout their stay.

Following discharge from hospital, service users usually engage in a weekly aftercare group as well as continuing attendance at Alcoholics Anonymous (AA), a process they commence whilst an inpatient.

In September 2011, BM was referred to an independent psychologist for one to one sessions, but did not attend. (BM has commented that she did attend twice but did not feel comfortable and told the Priory that she would make other arrangements via her GP.)

There is an account of the last attendance by BM at the outpatient group at the Priory, including her throwing a plant pot at a door. (BM's view is that this is not an accurate account of the incident and that she subsequently made a complaint to the hospital.)

The IMR critically reviews the service provided to BM as an in-patient and in out-patient follow up. It is noted that, the hospital now considers psychological abuse as part of its risk assessment in relation to domestic abuse.

Eight appropriate recommendations are made for improvements to the service.

Immediate Actions before completion of the Review

Organisations were asked to identify any immediate actions which had been taken as a result of the Review. None was identified as necessitating immediate action.

16. Significant themes for learning which emerge from examination of the Individual Management Reviews

16.1. Predictability and preventability

It is not possible to say that the death of NI was either predictable or preventable.

Dementia is a progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function. Although many people with dementia retain positive personality traits and personal attributes, as their condition progresses they can experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, difficulties with activities of daily living, self-neglect, psychiatric symptoms (for example, apathy, depression or psychosis) and out-of-character behaviour (for example, aggression, sleep disturbance).

The National Institute for Clinical Excellence says that:
Dementia is associated with complex needs and, especially in the later stages, high levels of dependency and morbidity. These care needs often challenge the skills and capacity of carers and services. As the condition progresses, people with dementia can present carers and social care staff with complex problems including aggressive behaviour, restlessness and wandering, eating problems, incontinence, delusions and hallucinations, and mobility difficulties that can lead to falls and fractures. The impact of dementia on an individual may be compounded by personal circumstances such as changes in financial status and accommodation, or bereavement.[4]

[4] NICE CG42 Dementia: Supporting people with dementia and their carers in health and social care Nov 2006

NI became more difficult to deal with at some stages of the progression of her dementia. There were times when she was depressed and her behaviour could be aggressive at times. She required increasing levels of support with basic tasks including toileting. This is not to suggest that NI was in any way responsible for what happened to her, merely that the risk to her from any adult who was not in complete control of their responses must have increased with her dependency. The organisations supporting NI undertook carer's assessments in relation to NI's husband, but BM was not identified as providing a significant amount of care for NI. Even if BM had been offered a carer's assessment, it is unlikely that she would have disclosed that she had a significant alcohol problem.

There is no evidence that a "best interests" form was completed, although there is a suggestion from a family member that medical practitioners were reluctant to treat NI on some occasions because of the difficulty in obtaining her consent. A "best interests" meeting could have been arranged to include the Social Worker, GP and family members to consider this.

Several family members, notably NI's husband and children, were involved in aspects of caring for her. It is acknowledged that BM and her husband provided significant amounts of support, because they, more than other family members, were in a position to do so. BM's difficulties with alcohol were longstanding. She had made attempts to deal with them, but preferred, as is her choice, to keep some information to herself. BM's husband is said to have been supportive of her attempts to deal with her alcohol problem, but only in so far as this was in keeping with his own views. Although family members were aware of her alcohol problem, they were either not aware of the extent of it or did not believe that these difficulties made her a risk to NI. A number of family members have reflected on BM's driving between Lancashire and Cheshire and wondered whether there had been an element of risk to other road users.

None of the family members who contributed to the Review thought that there was much that organisations could have done to prevent the death of NI. However, all have questioned whether more could have been done to assist BM to control her drinking.

The extent to which any of the organisations involved with NI were aware either of BM's role in caring for NI or of BM's alcohol problem was very limited and therefore it would have been difficult for a link to be made between the two. The involvement of the Police in 2012 was in relation to relatively minor domestic disputes which, though they involved some damage to property, did not involve any harm to the person. When BM saw her GP, who was aware of her problem with alcohol, she mentioned only once her mother's dementia.

The Panel had some discussion of the extent to which services and society in general can or should intervene in the life of an adult who abuses alcohol or drugs, in relation to risk to others. It would be difficult to recommend actions which would have

a significant impact, without imposing huge burdens on the public purse and restricting the liberty of a large number of adults.

The Panel reflected at length about the challenges presented by this case and about how organisations might respond better to what is sadly, a growing problem in our society, which is how to care for vulnerable adults.

NI was clearly viewed by the organisations supporting her as a vulnerable adult, although there were times, particularly at the start of the involvement when she did not lack capacity to make decisions or express a view about her care.

There is no evidence that BM was a victim of domestic violence. There was one occasion when she was injured during an argument at home, but this seems to have been as a result of her own actions. She did not disclose any abuse by any other person. There is a number of occasions when BM makes statements about her husband's role in controlling her behaviour. The Panel had some concern about the extent to which she had been allowed to make her own decisions about her treatment for her alcohol problem. Awareness has grown since 2010 of the issue of coercion within relationships and the extent to which this might be considered abusive. How far this may have been an issue in this case remains a matter of conjecture.

The picture of a caring supportive family may have led practitioners to assume that NI was safe in their care. No enquiry was made about the extent of the support provided by members of the family other than NI's husband.

No enquiry was made about the possible vulnerability of family members and the impact of the stress of caring for NI on them. NI's husband refused additional support for some time. Whilst his wishes were respected, at least one family member has pointed out that there was likely to be an impact for others from this decision.

It is highly likely that further enquiries about the extent of care provided by BM and others would not have highlighted the vulnerability of BM as a carer and therefore the risk to NI. BM is unlikely to have disclosed the extent of her alcohol problem. She had stayed overnight before and had simply gone to sleep if she had had a drink and other family members, whilst they were aware of it (though not necessarily the extent of it) are unlikely to have raised it as an issue. Some family members reflected on whether they would have raised an objection if they had known that BM was to stay alone with NI overnight and felt that they would not.

The Panel considered whether the actions of the organisations might have been different had NI and BM lived in the same locality and concluded that this was unlikely. Notifications to other services would only have been made if there had been an identified link between the difficulties of BM and risk to NI.

Some of the organisations dealing with NI had some knowledge of the arrangements for her care. Adult Social Care and the CMHT knew of some of the respite arrangements and that family members were taking some responsibility for supporting NI and her husband. There is no routine means of enquiring about the suitability of family members to care for a vulnerable adult so unless services were

alerted to a risk from a specific family member, which in this case they were not, there would be no reason for them to make further enquiries.

However, there was very little communication between the home care agency, whose workers were seeing NI very frequently, and any of the other organisations who were involved with her. There was very little communication between the Adult Social Care service and other services involved with NI. The planning and review arrangements did not allow for the organisations to come together. The reviews of the home care provision were undertaken by a manager from that organisation and the Adult Social Care reviews did not include other services.

The organisations dealing with BM were largely unaware of her role in caring for NI BM told her GP on one occasion, in January 2011, that she was helping to care for her mother who had dementia and that it was stressful. There does not appear to have been any other time when BM's role as a carer was known to the organisations which were supporting her or offering services to her. Had there been at this point a detailed exploration of her role as a carer, it is unlikely that this would have led to the Lancashire agencies being notified of a risk to NI. BM appears to have played down both her role as a carer and the extent of her alcohol misuse in most of her contacts with organisations.

It is useful to note from the detailed chronology that BM was taking some responsibility for supporting her mother at times when her own health required attention and was causing her some anxiety and distress. This is not only in relation to her alcohol misuse but in relation to her physical health as well.

Family members have reflected on what might have been done (by them or by organisations) which might have led to different interventions. One issue that has been raised is that BM regularly drove between Cheshire and Lancashire and that by doing so she may have put other road users at risk by being under the influence of alcohol. There is no evidence that any of the organisations dealing with BM raised this as an issue. The DVLA expects to be informed *by licence holders* of dependence on or misuse of alcohol, illicit drugs or chemical substances.[5]

Not all of the risk was to NI. Some family members have commented on how NI could be aggressive as her dementia progressed. Some of their concern was for her husband and, on some occasions, for BM.

There was limited information about BM which might have predicted violent behaviour. Such information as there was about the extent of BM's problem with alcohol and the potential for violence was held by different organisations (Cheshire Police, Lancashire Police, her GP, Priory Hospital in Altrincham). There is no routine means by which such information can be brought together. The Review does not recommend that such a mechanism be created. It would be unwieldy, time consuming and probably counter-productive to suggest that organisations should communicate relatively low level information on a regular basis. It would lead to large

[5] For medical practitioners. At a glance guide to the current medical standards of fitness to drive. DVLA May 2014.

amounts of information being transmitted, most of which would not contribute to the safety of adults at risk, unless there were some means of determining its significance.

A more effective way of protecting adults at risk is to encourage well trained professionals to think more widely about the information which presents itself to them so that they make appropriate enquiries about arrangements for their care.

It has been suggested that drug and alcohol services should routinely ask individuals whether they have caring responsibilities.

The Panel has considered in detail the extent to which services can intervene in the lives of adults who are able to make their own decisions.

Should/could BM have been made to undertake treatment for her alcohol problem? Should/could the form of that treatment eg complete abstinence have been dictated to her? And her husband (who may have had other views)? When an adult is convicted of a drink driving offence, should alcohol treatment be automatically part of the sentence? What should be done about a person who tries to give up alcohol and does not succeed? When an adult is asked about the possibility of domestic violence and denies it, how far should s/he be pressed about it?

Similarly, in relation to NI and her husband:
NI did not like going to day care or residential respite, but chose to go so that her husband could have a break for caring for her. Should she have had to do that? What alternatives were there for her and her husband?

NI's husband was reluctant to accept services even when he was struggling to care for her. Family members had different views about the level and type of care NI should have. For how long should a carer be allowed to resist accepting services, when both the adult at risk and the carer may be at risk from the stresses of dealing with dementia? When NI's husband, as the main carer, refused services, some of the impact of his decisions fell on other family members, including BM. What support should families receive in negotiating those differences of view?

The Panel reflected on how practitioners caring for NI could have known of any risk from any family member. There was no information available to them which would have raised alarm. NI did not complain of any mistreatment by family members. There were many times when NI was seen in the company of BM both at clinics and at home. BM told practitioners on several occasions that she stayed overnight to care for NI. Contact with BM did not cause any concern because she was never seen under the influence of alcohol or behaving in an unusual way. BM appears to have successfully concealed the extent of her difficulties from most of the family for many years. Any routine enquiry about safeguarding was therefore not likely to have elicited any concern.

One of the themes of the review has been the definition of who is a family member or carer and who is considered to be a victim. This is a large family, with many members who have wanted to be involved in the care of NI and in the aftermath of her death. It may be difficult for services to include a large extended family in their

considerations, but there must be key points at which services consider the wider family context rather than just the needs of the main carer.
The NICE guidance says:
Good communication between care providers and people with dementia and their families and carers is essential, so that people with dementia receive the information and support they require. Evidence-based information should be offered in a form that is tailored to the needs of the individual. The treatment, care and information provided should be culturally appropriate and in a form that is accessible to people who have additional needs, such as physical, cognitive or sensory disabilities, or who do not speak or read English.
Carers and relatives should also be provided with the information and support they need, and carers should be offered an assessment of their own needs.

- *Health and social care managers should ensure that the rights of carers to receive an assessment of needs, as set out in the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004, are upheld.*
- *Carers of people with dementia who experience psychological distress and negative psychological impact should be offered psychological therapy, including cognitive behavioural therapy, conducted by a specialist practitioner.* [6]

but does not offer any assistance in defining who should be considered as a carer.

In drawing together the combined chronology the Panel found it difficult to identify a co-ordinating function for NI's care. There was no point at which those involved in the care of NI shared their assessments and care plans and certainly no point at which all come together to agree a care plan, though there is evidence of some inter-agency communication. At least one of the IMRs comments on the amount of time spent chasing actions by other organisations. A meeting was arranged by family members to discuss the care of NI, but no organisation was involved in the meeting, which is the family's prerogative. A meeting of all of those involved, including professionals might have been helpful in identifying the vulnerabilities of the family arrangements.

The NICE guidance also includes:
Coordination and integration of health and social care
This should involve:

- *a combined care plan agreed by health and social services that takes into account the changing needs of the person with dementia and his or her carers*
- *assignment of named health and/or social care staff to operate the care plan*
- *endorsement of the care plan by the person with dementia and/or carers*
- *formal reviews of the care plan, at a frequency agreed between professionals involved and the person with dementia and/or carers and recorded in the notes.*

…and
Memory services
Memory assessment services (which may be provided by a memory assessment clinic or by community mental health teams) should be the single point of referral for all people with a possible diagnosis of dementia.[7]

[6] NICE CG42 Dementia: Supporting people with dementia and their carers in health and social care Nov 2006

This is not to say that this type of co-ordination would have changed the outcome for NI, as such an approach would still have been unlikely to reveal the extent of BM's problems.

In relation to support and services for adults with alcohol problems:
Twenty-four per cent of the adult population in England, including 33% of men and 16% of women, consumes alcohol in a way that is potentially or actually harmful to their health or well-being (McManus et al., 2009[8]). Four per cent of adults in England are alcohol dependent (6% men; 2% women), which involves a significant degree of addiction to alcohol, making it difficult for them to reduce their drinking or abstain despite increasingly serious harm (Drummond et al., 2005[9]).

The NICE guidance says:
Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.
Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Alcohol dependence is also associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical disorders.
Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol misuse is also an increasing problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009.
Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. Reasons for this include the often long period between developing alcohol dependence and seeking help, and the limited availability of specialist alcohol treatment services in some parts of England. Additionally, alcohol misuse is under-identified by health and social care professionals, leading to missed opportunities to provide effective interventions. [10]

Although self-report has been found to be a reliable indicator of levels of alcohol consumption in treatment-seeking populations, patients with alcohol in their system

[7] NICE CG42 Dementia: Supporting people with dementia and their carers in health and social care Nov 2006

[8] McManus S et al., Adult psychiatric morbidity in England, 2007: Results of a household survey. The Health and Social Care Information Centre, Social Care Statistics (2009)

[9] Drummond, C et al. (2005). Alcohol Needs Assessment Research Project The 2004 National Alcohol Needs Assessment for England. Department of Health

[10] NICE Guidance CG115 February 2011

at the time of assessment are more likely to underestimate their levels of alcohol consumption (Sobell & Sobell, 2003[11]).

The NICE Guidance also says:
When families and carers are involved in supporting a person who misuses alcohol, discuss concerns about the impact of alcohol misuse on themselves and other family members, and:

- *provide written and verbal information on alcohol misuse and its management, including how families and carers can support the service user*
- *offer a carer's assessment where necessary*
- *negotiate with the service user and their family or carer about the family or carer's involvement in their care and the sharing of information; make sure the service user's, family's and carer's right to confidentiality is respected.*

It is clear from information given by family members that whatever information the family had about BM's alcohol problem, it was not shared with any organisation. They did not perceive BM to be a threat to NI and a number of them have commented on the good care BM took of NI.

The first record of BM seeking help for her alcohol problems is in 2004 although she did not accept services at that time. She was referred to local services in 2009 and her GP practice kept her care under review.

There is no evidence that BM was the victim of domestic violence, though a number of professionals had concerns about the control exercised by her husband in relation to her drinking. Coercive control, though more difficult to define or detect than physical abuse, is increasingly being recognised as part of domestic violence.

During her alcohol treatment programme, BM made occasional references to her husband attempting to control her drinking alcohol and to her feeling that he exercised a powerful control over her. One of the IMRs reflects on whether enough was done to identify whether BM was being coerced into behaving in ways which were against her wishes and that BM was vulnerable in terms of the powerful and controlling nature of her husband. The organisation considers that these statements by BM would now lead to a DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence)[12] risk assessment being undertaken. However, had such a risk assessment been completed, it is unlikely BM would have consented to any referral or intervention to protect her.

16.2. Co-ordination and Communication between Services

The Panel considered the number of services and practitioners involved with BM and NI over the timeframe for the Review and whether better co-ordination would have led to a different outcome.

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[11] Alcohol Consumption Measures *Sobell, L. and Sobell, M.* National Institute on Alcohol Abuse and Alcoholism.2003

[12] ACPO Co-ordinated Action Against domestic Abuse (CAADA) Domestic Abuse, Stalking and Harassment and Honour Based Violence (*DASH* 2009)

It is unlikely that better communication and co-ordination would have changed the outcome for NI. Although BM's alcohol problem was known to some professionals, there was no indication that it could lead to such a catastrophic event. However, better co-ordination of the services to NI might have assisted practitioners and provided better support to the family. It might also have identified to practitioners the range of family members who were providing care to NI.

The Review considered that there had not been a robust co-ordination of the services to NI. A number of possible reasons for this were discussed. There appeared to be a lack of clarity about who should be responsible for care co-ordination. The role of an active extended family may have led practitioners to the view that co-ordination was not necessary (though there is evidence from the family that the involvement of a large family made it more difficult to co-ordinate NI's care). It is possible that NI's needs were not considered sufficiently complex or high risk to warrant a more formal care co-ordination approach.

Multi agency meetings are time consuming and require some effort to arrange. However, if the result is a more streamlined service and less duplication, they can lead to better use of resources.

The commissioners and the LSAB might wish to consider the circumstances under which multi-agency meetings should be held.

16.3. Diversity issues, including ethnicity, religion, language, disability, gender, culture, age, social background and integration.

The Review has considered whether these matters were sufficiently taken into account by services.

This family is well educated, well integrated into the community and either in employment or retired from employment. They are not likely to have appeared to professionals as vulnerable. BM's vulnerability due to her alcohol dependence was largely unseen beyond her immediate family and medical practitioners.

It is noticeable that very few of the contacts with the family of NI include discussion with her husband. NI's husband had been deaf from childhood and preferred not to speak on the telephone. None of the services involved appears to have identified the difficulties for a person who has grown up deaf (as opposed to a person who has become deaf as an older person). NI's husband must have had considerable difficulty communicating with the range of professionals involved with NI.

There are very few references in the IMRs to deafness although a number of family members are deaf.

A number of family members who are deaf have felt that their needs were not always considered in the courts.

NI was appropriately identified as vulnerable as her dementia progressed, though her capacity to make decisions or express a view at different times was also recognised. However, family members were not seen as presenting a risk to NI.

Family members reflected on the issues arising from age and disability and some of the older members have talked about their experience of caring for others and their own hopes and fears for the future. All family members were very aware of NI's fear and distress at the loss of her independence.

The Panel has reflected on whether the family's social circumstances led to assumptions being made about their ability to care for NI.

16.4. Child Safeguarding

There was no evidence of any referrals for BM's children in relation to safeguarding. BM's youngest child was aged 7 when she first came to the attention of the Police for DUI. However, it is unlikely that a single DUI would trigger a child protection referral and her youngest child would have been aged 20 years by the time BM admitted to her GP in 2009 that she had a significant alcohol problem, although she had referred herself to the Priory in 2004 when her youngest child would have been aged 15 years.

16.5. Support after the incident:

Although not part of the key lines of enquiry for the Review, family members have raised a number of matters which have been considered by the Review:

Family members have said that they think a Family Liaison Officer should have been allocated to the family following the incident when NI was seriously injured.

Discussion with the SIO has clarified that the current policy of Lancashire Constabulary as with other Police services is to appoint a Family Liaison Officer only after a homicide or similar serious matter.

The guidance for the Police[13] says that a FLO should be appointed after:

An unexplained or violent death, particularly in respect of:
– homicide;
– road death;
– mass fatality; and

Any other 'critical incident' where family liaison might enhance the effectiveness of the police response, for example, a missing person enquiry or an allegation of hate crime.

A critical incident is defined by ACPO as:
Any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community.

[13] Family Liaison Officer Guidance. National Police Improvement Agency on behalf of the Association of Chief Police Officers. 2008.

Although the incident in July 2013 was viewed as an attempted murder, it did not meet the criteria for the appointment of a FLO. The incident did not constitute a critical incident such as a large scale missing from home or hate crime.

Following the death of NI on 19 September 2013 a Family Liaison Officer was appointed on 23 September 2013 and the first contact with the family (four of NI's children) was on 24 September.

The main objectives of family liaison are:

To gather material from the family in a manner which contributes to the investigation and preserves its integrity;

To provide information to, and facilitate care and support for, the family, who are themselves victims, in a sensitive and compassionate manner in accordance with the needs of the investigation;

To secure the confidence and trust of the family, thereby enhancing their contribution to the investigation.

The trauma associated with a sudden unexpected tragedy places the family of the victim under immense personal pressures at a time when the needs of the investigation will make heavy demands for detailed information. Sensitivity, compassion and respect for the family's needs and requirements must underpin the approach to gathering material

The term family should include partners, parents, siblings, children, guardians and others who have had a direct and close relationship with the victim.

It was agreed with the family that contact by the FLO would be mainly through a son of NI, as the family's representative. When NI died, the family were asked, after the funeral and again at the Plea and Case Management Hearing at court if they were happy with this arrangement.

The FLO guidance says:
Depending on the size of the family, FLOs may find themselves dealing with just one individual through to many members of a family. In every case a family will vary in structure and size, and the degree of the family's involvement during an investigation cannot be predicted. Many family members (including the extended family) may wish to become actively involved during an investigation; others may not. The main point of regular contact for the FLO would normally be the deceased's partner or closest family member, as long as they are in agreement with this. This is, however, a matter for the family to decide although they may require some guidance in making this decision.

One family member was of the view that there had been a gap in the provision of a FLO after the move of one officer to another case. The FLO records show that the original FLO departed on 15 November and the new FLO took over on 18 November and made contact with the family's representative on that date.

More than one family member has also been critical of the lack of support offered to the family in the immediate aftermath of the incident. The family say that no referral was made to the Victim Support Homicide Service following the death of NI. It is not entirely clear whether there was any earlier referral to Victim Support, though the VS worker is of the view that the referral system generally works very well but it did not in this case.

It has been suggested that NI was considered to be the victim and therefore possibly other family members, though supported by the Police team, were not referred to Victim Support after the initial incident. The SIO in the case has been very keen to learn from the family's experience in this case and to consider this information for the future.

The SIO in the case has moved to a different role but has nevertheless agreed to meet with family members to answer as far as possible their questions about the process.

A number of members of the family are deaf. There was a particular difficulty for them at the local Magistrates Court and at the local Crown Court because there was no loop system. Some members of the family raised this and made complaints. When BM appeared at Liverpool Crown Court arrangements were made for the five family members who needed it to have appropriate assistance and this was positively received.

The response on behalf of the Preston combined Court and the Preston Magistrates' Court is as follows:

Preston Combined Court is a large combined court centre that deals with a large number of court users on a daily basis. Every effort is made to accommodate all of our court users and we have a number of facilities and measures in place in order to achieve this.

In this particular case and the family members that attended who were deaf, we do have hearing enhancement facilities at Preston Combined Court as described within our court information literature. They are available for use by any of our court users that require them, particularly those involved in court proceedings such as defendants, witnesses and family members.

We have a fixed hearing loop system but unfortunately this is only restricted to 3 of our 10 courtrooms. However we do have up to 4 portable hearing loop systems that we can set up in our courtrooms that do not have the permanent loop systems as and when they are required.

For our hard of hearing court users, head-sets are provided which amplifies the sounds in court. For court users who are more profoundly deaf, we provide a device which syncs with their hearing aids if they are compatible. This applies to both our permanent and portable hearing loop systems and they are available for use to all in the courtroom, including those within the public gallery.

In terms of equipment availability, it is helpful to receive advanced notice so that we can accommodate such requests effectively; by ensuring cases are listed in the appropriate courtroom and that the correct numbers of head-sets are made available.

This is usually done in advance through the parties' representatives and/or the Witness Service, but court users can also inform the court of their requirements in person. However there are instances where communications can break down or we are notified at short notice which can have an impact on the facilities being available on the day, although we do strive to put this right if possible and certainly in time for the following day.

According to case records, this particular case was listed 6 times at Preston Combined Court before being transferred to Liverpool. Of the 6 hearings, 5 took place in a courtroom with a fixed hearing loop system, the exception being the first hearing that did not. It's on record that the court was made aware of the defendant's hearing difficulties at the final hearing at Preston but there are no notifications that suggest any requests were made with respect to the victim's families at any of the other hearings.

I have also spoken to the Operations Manager at Preston Magistrates' Court who has provided me with the following with regards to the facilities in place there;

The defendant appeared at the Magistrates' Court twice, each time the matters were sent to the Crown Court; both would have been relatively quick hearings and there are no notes of any reasonable adjustments that were made or requested. The courts that the defendant would have appeared in have infra red hearing loops and if requested, head-sets would have been made available. All counters are also fitted with sound enhancement equipment.

Without further information available from around the time of the case, I'm unable to specifically respond with respect to the logistics that were in place at Preston Combined Court at the time. However, I hope that the information provided above with regards to the facilities that we have on site and the measures we put in place assists with your review.

Family members have also complained that they were not contacted in relation to the licence conditions when BM was due for release from prison, as they would have liked to express their views. There is a limit however to the extent to which family members can influence or obtain information about conditions on a licence.

The aims of the licence period are to protect the public, to prevent re-offending and to secure the successful re-integration of the offender into the community. Licence conditions should be preventative as opposed to punitive and must be proportionate, reasonable and necessary. How they are to be monitored and enforced must be evident.

Victims who qualify for victim contact (either as statutory victims under the Victim Scheme, or those who have been opted into the scheme by the relevant Probation Trust on a discretionary basis) have the right to make representations about licence

conditions that relate to them and must be informed about relevant conditions which are included in the offender's licence under the statute of section 35 of the Domestic Violence, Crime and Victims Act 2004 (2004 Act).[14]

Following a request from the Review, the Lancashire and Cumbria Victim Contact Team responded on 17 September 2014, with a detailed explanation of their actions, confirming that contact has been made with the deceased's relatives as per guidance instructions contained within the Victims Code of Practice, following sentence of the offender. The response has been anonymised for this report. The response states:

Thank you for your enquiry in relation to the above named victim. I can confirm that contact has been made with the deceased's relatives as per guidance instructions contained within the Victims Code of Practice, following sentence of the offender.

A bereaved close relative of a victim, where an offender is sentenced to 12 months in prison or more for a violent or sexual offence or detained in a secure hospital for treatment, will be offered participation in the Victim Contact Services, (only following the sentence). However, if the family member is not the next of kin of the victim, this will be at the discretion of the probation trust. If a family is bereaved as a direct result of criminal conduct, the deceased's close relatives are entitled to nominate a family spokesperson to act as the single point of contact to receive services under this Code. If the close relatives cannot choose a family spokesperson, the Senior Investigating Officer working on the case must choose the family spokesperson. In this case the family spokesperson has been (NI's daughter), the daughter of the deceased.

BM was sentenced at Liverpool Crown Court on 24th January 2014 for an offence of manslaughter. The victim was her mother NI. BM received a 16 month custodial sentence giving a Conditional Release Date of 25th March 2014 and Sentence/Licence Expiry Date of 22nd November 2014. Given the amount of time spent on remand and awaiting sentence, the offender's release date was identified as not too long after the sentence date i.e. approximately two months.

On 5th March 2014 the offender manager for BM contacted Lancashire Victim Contact Team for a victim update. Enquiries ascertained the case had not yet been referred to Lancashire Victims Team by the sentencing area, namely Merseyside.

Witness Care Unit (WCU) undertook a tracing exercise in order to establish the names of the victims relatives and their contact details and on the 21st March contact details for (NI's daughter), the victims daughter, were obtained from Victim Support. It would appear these details were in conflict with enquiries made by the offender manager who highlighted that the next of kin was the victims husband and not (her daughter). Clarification was immediately sought via Witness Care Unit due to the imminent release of the offender (25 March 2014).

With no details provided by the WCU or Office In Charge for (NI's husband) telephone calls were made to (NI's daughter) on the 25th March, 26th March and 27th

[14] National Offender Management Service Instruction PSI 40/2012

March without success. On the 28th March contact was made via telephone and the victim liaison role explained. It was agreed that (NI's daughter) would speak to her siblings and get back to the Victim Liaison Officer (VLO) with any licence conditions they wanted as the majority of the family were in contact with the offender: their sister. Address details for (NI's daughter) were obtained.

On the 28th March (NI's son) made contact. (NI's son) advised that he felt it would not be appropriate to put conditions on to restrict BM from family contact or from Preston as his father wants contact with all his children. (NI's son) advised (BM) and her husband had visited their father when in hospital and the family had made arrangements for paths not to cross, consequentially, (NI's son) felt that all the siblings would respect each others right to privacy. It was left for (NI's son) to call the VLO if he changed his mind and wanted any conditions or further information. To date no further call has been received.

(NI's daughter) confirmed in a telephone call on the 31st March with the VLO that she has spoken to all her siblings. She confirmed she has passed the VLO contact details onto them for them to contact the VLO directly to discuss their views, feelings and concerns should they wish to. To date no calls from (3 of NI's children) have been received. (One son of NI did make contact with the VLO).

16.6 Consideration of BM as a potential risk to others

The Review considered the history of BM and whether she should have been identified earlier as presenting a potential risk to others. Advice was taken from a senior representative of a specialist drug and alcohol treatment service.

It is evident that BM's alcohol problem had persisted for many years. The extent to which this was known to professionals was limited. Even more limited were the events or incidents which might have identified her as a potential risk to others. They include

- a conviction for drink driving in 1996
- BM telling her GP in early 2011 that caring for her mother was stressful
- one incident in December 2011 at the hospital which offered out-patient follow up to alcohol treatment, when a plant pot was thrown
- two incidents in July 2012 when the Police were called but no offences had been committed
- BM's self-report that she became aggressive when under the influence of alcohol

None of these separately or together represents a clear or serious indication of risk to others. The Review had the benefit of hindsight in being able to consider their significance.

The specialist advice considered that BM had been failed by services and that more should have been done to support her. Reference was made to Alcohol Treatment Requirements and Alcohol Specified Activity Requirements.

Support for alcohol misusing offenders has developed mainly in the past 10 years. A policy paper in 2010 suggested:

Figures for alcohol misuse in the general adult and offending populations and for alcohol related offending are very high.

In England, 24.2% of the general population (33.2% of men and 15.7% of women) are hazardous drinkers (McManus et al., 2009).
The overall level of mild, moderate or severe alcohol dependence is 5.9% of the general population with 9.6% of men and 3.4% of women (Ibid).
During the year before prison, 63% of sentenced males and 39% of sentenced females were harmful or hazardous drinkers (Singleton et al., 1998).
Of the 44% of probation clients recorded as having an alcohol problem, 48% were found to binge drink, 41% have displayed violent behaviour linked to alcohol use and 48% have a criminogenic need directly related to alcohol misuse (NOMS, 2008).
In 63% of incidents of wounding, 55% of assault with minor injury and 50% of assault without injury, victims believed offenders to be under the influence of alcohol (Home Office, 2010a).
Alcohol is estimated to be consumed before 73% of domestic violence cases, while 48% of those convicted of domestic violence are dependent upon alcohol (Gilchrist et al.,2003).[15]

The authors suggest that the evidence base for offender alcohol interventions should be developed and that all front line staff need basic alcohol awareness and some professionals require specific training and all front-line agencies should provide Identification and Brief Advice (IBA).

However, much of the support now available was not in place in 1996 when BM was convicted of driving under the influence of alcohol.

Nationally accredited Drink Driving Rehabilitation courses were only made available nationwide in 2000.

Alcohol Treatment Orders were introduced in the Criminal Justice Act 2003 and only became available in 2005 so would not have been available in 1996.

An evaluation of Alcohol Treatment Requirement in Lancashire in 2010 concluded that there were positive outcomes for offenders who participated in the evaluation in terms of alcohol use, attitudes, offending, health and relationships (though there were limitations on the conclusions because there had been no control group).

Whilst the use of the criminal justice system as a route through which to engage with illicit drug users is relatively well established in the UK, its use to address alcohol misuse has until recently been an area less focused on. This is beginning to change with the increasing use of alcohol arrest referral, moves to better integrate treatment in prison and the roll out of the Alcohol Treatment Requirement (ATR). The Criminal Justice Act 2003 introduced the power to add the ATR as a condition on a Community Order or Suspended Sentence Order and replaced previous provisions under the Powers of Criminal Courts (Sentencing) Act 2000. ATRs could be required of offenders committing offences from 4th April 2005, however the use of the

[15] A Label for Exclusion. Support for Alcohol-Misusing Offenders. Fitzpatrick R. and Thorne L. Centre for Mental Health. 2010.

requirement has taken some time to roll out across the country while the structures to effectively deliver treatment have been put in place.[16]

An Alcohol Treatment Requirement (ATR) can be made as part of a Community Order or a Suspended Sentence Order where:

- The offender is dependent on alcohol
- This dependency is such that it requires and may be susceptible to treatment
- Arrangements have been or can be made for treatment
- The offender expresses willingness to comply with its requirements

Alcohol Specified Activity Requirements are still not available in all parts of the country.

The availability and take-up of the Alcohol Treatment Requirement (ATR), and the lower level Alcohol Specified Activity Requirement (ASAR), appears also to be highly variable and dependent upon the quality of particular strategic and joint commissioning relationships between probation and primary care trusts, the commitment of front line staff, and the interests of sentencers[17]

It has been suggested that a multi-agency meeting about BM might have enabled information to be gathered to provide a fuller picture of her needs. However, there is no suggestion about who would be responsible for calling such a meeting, or indeed whether such a meeting could have taken place without the consent and attendance of the individual concerned. In order for action to be taken without the consent of the individual, there would need to have been a court order or similar. This could only have been brought about if BM's actions in 2011 or 2012 had been dealt with under criminal justice provisions.

The Community Safety Partnership is keen to ensure that alcohol problems are dealt with at the earliest possible opportunity without the need for serious offences to be committed before individuals are offered support.

In order to impose alcohol treatment on an individual, there needs to be involvement from criminal justice agencies.

The Review considered whether the incidents in August 2012 when the Police were called to incidents at the airport and the family home on consecutive days should have resulted in further action or offers of assistance to BM. However, there was no possibility of criminal charges being brought and offers of help are likely to have been received in the same way as previous offers.

The Review considered whether the incident at out-patient follow up at the private hospital should have resulted in Police involvement, though it is not possible to say that this would have resulted in further alcohol treatment. Successful long term treatment of alcohol dependence relies on individuals being motivated and having

[16] Evaluation of the Alcohol Treatment Requirement Across Five Sites in the Lancashire Probation Area. Baldwin H. and Duffy P. Centre for Public Health Liverpool John Moores University. 2010.
[17] House of Commons Justice Committee Written evidence from Centre for Mental Health 2010

the co-operation of their support systems, including those with whom they are in daily contact.

There is considerable evidence however, that BM was offered support to deal with her alcohol misuse. Whether this would have been more successful had it been offered under a court order is a matter of conjecture.

There is no evidence that BM had ever been physically violent towards another person, though she did say during her treatment at the Priory that she could become aggressive when under the influence of alcohol. There is therefore no suggestion that NI or any other person should have been considered by a Multi-Agency Risk Assessment Conference (MARAC).

16.7 Cognitive bias

There are some possible cognitive biases apparent in practice in this case. The work of Daniel Kahneman (and the late Amos Tversky) has been very influential in identifying patterns of human thinking which lead to errors of judgement.

There may have been an assumption by practitioners that because this was a “nice”, supportive family, nothing bad could happen. This an example of the *halo effect*, where one’s judgments of a person’s character can be influenced by one's overall impression of him or her. This may explain why there does not seem to have been sufficient consideration of the injuries to NI in early 2011.

There was a focus on the individual in the case of both BM and NI and a lack of wider thinking about the implications of the interplay between NI’s needs and those of BM. Around the time of the injuries to NI being observed, in early 2011, BM told her GP that caring for her mother was stressful. The Review has established no connection between these events, but if there had been, a broader view of their needs would have helped to identify it.

This is an example of *overconfidence*. This theory states that when the mind makes decisions, it deals primarily with *Known Knowns*, phenomena it has already observed. It rarely considers *Known Unknowns*, phenomena that it knows to be relevant but about which it has no information. Finally it appears oblivious to the possibility of *Unknown Unknowns*, unknown phenomena of unknown relevance.

Kahneman[18] explains that humans fail to take into account complexity and that their understanding of the world consists of a small and not necessarily representative set of observations. Furthermore, the mind generally does not account for the role of chance and therefore falsely assumes that a future event will mirror a past event.
There seems to have been a focus on the needs of NI’s husband as the main carer for NI and therefore little attention paid to the needs of other family carers as well as an assumption that carers with less involvement do not present a risk to a vulnerable adult.

[18] Kahneman D. Thinking Fast and Slow. Macmillan. 2011

There does not appear to have been, in the minds of practitioners, any thought about the implications of BM's behaviour, related to her alcohol use, and the possible risk to others (children, grandchildren, vulnerable adults, the general public).

16.8 Good Practice

A number of family members commented on examples of what they felt was good practice, in particular their experience of

- the Lancashire ASC Social Worker
- Styal Prison
- Royal Preston Hospital.
- Home Care Mellor

17. Learning from previous domestic homicide reviews

In 2013 the Home Office published **Domestic Homicide Reviews** Common Themes Identified as Lessons to be Learned, a summary of themes from 54 DHRs completed between April 2011 and March 2013.

Themes include:

- Awareness raising and training particularly for GPs and health professionals.
- Review your communications to ensure that all forms of domestic violence and abuse are covered.
- Review your internal training to ensure these key messages are highlighted. The Identification and Referral to Improve Safety (IRIS) project, is a general practice-based domestic violence and abuse training support and referral programme, based on collaboration between primary care and third sector organisations specialising in domestic violence abuse. It can be commissioned by clinical commissioning groups.
- The importance of information sharing and the challenge of accessing information from other areas.
- Complex needs: domestic violence was not always identified because the focus was on the mental health/substance misuse issues and there is a need for drug and alcohol services to undertake robust risk assessments. In a number of cases the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, sexual abuse, alcohol, substance misuse and mental health illness. In some cases the domestic violence and abuse was not always identified because agencies were focusing on addressing, for example, the mental health or substance misuse. In these cases there was often more silo working which meant an appropriate multi-agency intervention was not considered. There appeared to be a need to raise awareness and understanding of how best to engage and work with those with complex needs.
- Drug and alcohol services should review, amend and make robust use of their risk assessment frameworks, which involve assessment of risk in relation to violence and abuse.
- Promote the Against Violence and Abuse (AVA) Complicated Matters toolkit and training with local practitioners

- Promote the Co-ordinated Action Against Domestic Abuse (CAADA) guidance on attendance of mental health and substance use services at MARAC.

Whilst a number of these actions would improve the services' ability to respond to domestic violence, there is no suggestion that addressing these issues would have significantly changed the outcome for NI.

A recent research study "Exploring service responses to domestic abuse in later life" concluded that further work needs to be done to explore these issues because:
There are a number of factors which may contribute to the deficit in current knowledge surrounding domestic abuse within older populations, for example, social and cultural barriers to disclosure and the failure of professionals and organizations to recognize domestic abuse as occurring in this age group (McGarry et al, 2011)

The blurring of the boundaries between elder abuse and domestic abuse has also been highlighted as a potential barrier to effective recognition of domestic abuse

Assumptions that have pervaded elder abuse fail to appreciate the significance of the underlying complexities of 'the nature of power relations within abusive relationships in later life' (Penhale, 2003)[19]

The Review considered whether a diagnosis of dementia should become a trigger for an automatic assessment of risk of domestic abuse, though in this case it is unlikely to have identified BM as a source of risk to NI.

18. Conclusions and recommendations of the Review

Status and ownership of the Action Plan

This DHR has been jointly conducted by the Preston CSP and the Cheshire East CSP. The OR will be presented to a joint meeting of the Partnerships in November 2014.

Each CSP will be responsible for implementing and monitoring the Action Plan in relation to its own partner organisations.

Individual Agency Recommendations

1. Age Concern Central Lancashire (Withy Trees Day Centre) Recommendations

1) The organisation will insist that any referral made to Day Support must be supported by an overview assessment prior to commencement. The overview assessment will/should inform appropriate staff of an individual's needs, wishes and concerns which will provide a baseline for an individual's personal/support plan

[19] Dr Julie McGarry, Christine Simpson and Kathryn Hinsliff-Smith. University of Nottingham 2012

2) All contacts to the centre in relation to service user non-attendance must be recorded in the individuals Personal/Support Plan, with the named communicator.

2. Cheshire and Wirral Partnership NHS Foundation Trust (Cheshire Psychological Therapies) Recommendations

From the learning points identified in section 9 of the IMR the following recommendations are made:
1) Use of the "abuse" question

- Improving Access to Psychological Therapies to adopt the good practice guidance in ensuring the abuse question is asked
- Managers in Improving Access to Psychological Therapies to ensure all practitioners are knowledgeable of the requirement to complete the abuse question, this will be achieved by cascading via team meetings and email to individuals (see recommendation and action on training)
- An audit to ensure the question regarding whether the abuse question was asked and if not why not. Audit to be completed by March 2015
  2) Provide assurance of the use of Clinical Assessment of Risk to Self and Others in IAPT
- IAPT to spot check cases during supervision with individual practitioners over the next 6 months and from there on.
  3) Raise awareness of domestic abuse, recognition and signposting
- Develop bespoke domestic abuse training package
- Deliver training to IAPT clinical staff

3. Home Care Mellor (Home Care agency provider for NI) Recommendations

1) Change in procedure around reporting of bruises, marks etc. Amend current policy and procedure surrounding the reporting of any concerns.

- All bruises etc. to be documented in the diary sheets and on body maps.
- CSWs to enquire with the service user about any bruises
- When a report comes to the office, staff should review any previous reports to identify if a pattern is occurring or if the matter needs to be escalated.
- Disseminate this change to all staff members via an important memo.

2) Develop short code/key words to alert office/staff member of an incident. Universal key words to be agreed upon.

- Codes to be printed on reverse of ID Badges (so always handy)
- New procedure disseminated to staff via memo.
- Emergency Procedures Policy updated

3) Further training on Domestic Violence.

- Increase awareness of the signs of domestic violence. Source training on domestic violence, especially recognising signs and also enquiring with service users about bruises etc.
- Disseminate training to staff.

4) Improved documentation. Introduce a new standard of working with regard to documentation. Best practice guidelines for documenting.

4. Lady Elsie Finney House (Home for Older People) Recommendation

LEFH have identified the following agency recommendations in relation to the evidence reviewed and contained within the report:
1) A review of governance of personal data

5. Lancashire Care NHS Foundation Trust

1) The CMHT & MAS should include both 'main carer' and 'other significant carers' for signposting to local authority for carer's assessments.

2) The podiatrists should ensure care plans are in their clinical records

3) The MAS complete a risk assessment for patients during assessment.

4) The waiting times for MAS should decrease as a result of reviewed care pathways and efficient working practices.

5) The CMHT should be given clearer guidance about rating referral information and working to agreed timescales to action a referral to assessment completion.

6) The CMHT clinicians should be more aware of how and where to carry out the most accurate and informative assessments

7) Explore both the risk to the patient and the risk presented to others by the patient thoroughly.

8) The CMHT should be given clearer guidance about rating referral information and working to agreed timescales to action a referral to assessment completion.

9) If a case is discussed in supervision a note should be made in the patients clinical record to record the supervision outcomes and agreed action if any.

6. Lancashire Adult Social Care Recommendations

1) Carers Assessments
All carer's assessments are now undertaken by Carers Centres, as part of structural change within Adult Social Care. This will provide an independence from the local authority in undertaking carers' assessment and within their service level agreement, identification and consideration of other carers in a vulnerable adult's life will be identified.
Recommendation:
Improved identification of hidden Carers. Carers Centres identification of "hidden Carers". To review SLA to ensure this is accountable if not to review SLA to account for this.

2) A consistent social care worker approach
Adult Social Care will be restructuring shortly to reflect 1 worker 1 case to ensure a consistent approach with vulnerable adults, the learning from this IMR will be taken

into that process along with contact details when the allocated worker was not available.
Recommendation:
Improved contact and customer care. To ensure the transformation team apply the learning of this IMR. Development of contingency arrangements when allocated worker is not available.

3) Recommendation:
Improved identification of hidden Carers. Carers' identification for personal social care. To ensure the Principal Social Worker take the learning from this IMR. Learning to be developed by Advanced Practitioners.

7. Mid Cheshire Hospital NHS Foundation Trust

1) Increase the confidence and competence of staff at Mid Cheshire Hospital NHS Foundation Trust (MCHFT) around the recognition and response to incidents of domestic abuse and potential safeguarding triggers (such as alcohol misuse).

- Inclusion of Domestic Abuse information within Mandatory Induction session; applicable for all new employees to the organisation.
- Inclusion of Domestic Abuse information within Mandatory BEMU sessions; update delivery applicable for all staff every other year.
- To commence ad-hoc training sessions on Domestic Abuse Awareness; to be offered throughout the organisation by the IDVA to Wards / Departments.
- To commence annual training sessions on Domestic Abuse Recognition / Response – for key frontline practitioners; including Emergency Department, Paediatrics, Midwifery and Sexual Health.
- To introduce a Domestic Abuse Notification form; for use by practitioners throughout the organisation. It will detail patient details, nature of concern, action taken and then submitted to the IDVA for follow up / review.
- To introduce a specific Domestic Abuse policy; detailing expected levels of recognition and response to incidents of Domestic Abuse.
  2) Increase the confidence and competence of staff at Mid Cheshire Hospital NHS Foundation Trust (MCHFT) around the recognition and response to incidents of domestic abuse and potential safeguarding triggers (such as alcohol misuse).
- Inclusion of Vulnerable Adult information within Mandatory Induction session; applicable for all new employees to the organisation.
- Inclusion of Vulnerable Adult information within Mandatory BEMU sessions; update delivery applicable for all staff every year.
- Vulnerable Adult Information Booklet to be disseminated at all Level 2 Safeguarding Children training sessions; detailing concern triggers and sources of advice and support.
- Vulnerable Adult Information Booklet to be disseminated at all Level 3 Safeguarding Children training sessions; detailing concern triggers and sources of advice and support.
- Utilization of the Vulnerable Adult Safeguarding Flowchart within the organization; reinforcing advice and support mechanisms.
- Introduction of the Vulnerable Adult Policy within MCHFT.

8. NHS England Lancashire Area Team/NHS Chorley and South Ribble Clinical Commissioning Group (Lancashire GP) Recommendations

1) Raise awareness within the practice re vulnerable adults and the link to abuse.
In practice "Significant Event Analysis", ideally facilitated by a member of the CCG safeguarding team and to include the whole practice if possible.
To include discussion on:

- Risk factors for and the identification of abuse and how to make an alert
- Mental Capacity Act
- Risk assessment
- Carer support

2) Updating of the practice vulnerable adults policy

- Immediate update of phone numbers
- Practice to consider adopting new sample policy from CCG (imminent)

3) Review by the practice of their current provision for patients on waiting list for memory clinic and those who have a diagnosis of dementia.
In practice review, ideally with input from the mental health services, for clinical staff.
To include discussion on:

- Referral / how to support families whilst waiting for diagnosis (what can other agencies offer??)
- Dementia reviews in general practice – how to avoid these being a tick box exercise
- Importance of actively looking for safeguarding issues and carer support
- Dementia prescribing shared care agreement

4) Encourage multi-disciplinary approach for patients with dementia.

- GP practice to consider all patients referred to memory clinic or who have a diagnosis of dementia for discussion within their integrated neighbourhood team meetings

9. NHS England Cheshire Warrington and Wirral Area Team/Eastern Cheshire CCG (Cheshire GP) Recommendations

NHS England

- Shares the findings of the final DHR report and its recommendations with all GP Practices across Cheshire, Warrington & Wirral Area Team.

East Cheshire Clinical Commissioning Group

- Designated Nurse Safeguarding Adults incorporates the findings of the final DHR report into relevant training for GPs across East Cheshire.
- Designated Nurse Safeguarding Adults reviews CCG safeguarding policies and procedures to ensure any lessons learnt from this case are incorporated.

GP Practice

- Review all practice safeguarding policies and procedures to ensure they are up to date and all staff are aware of these.
- Ensure all staff have received up to date safeguarding training including domestic abuse training.
- Considers the use of a Dementia Carers Assessment when patients disclose caring responsibilities for relatives with Dementia.

10. Priory Hospital Altrincham Recommendations

1) Non-violent domestic abuse must be considered as an **adult at risk safeguarding issue** in all cases where this is known or suspected.

- Face to face level 3 safeguarding adults training up to be delivered to all clinical staff.
- Workshops on domestic violence DASH risk assessment to be delivered to all clinical staff.
- "Risk Bulletin" to be sent out to all staff highlighting the signs, indicators and risks for domestic abuse and actions required in the assessment and risk management plans

2) A GP referral letter should be a requirement of acceptance for admission onto the Addiction Treatment Programme.

- Update local procedure for admission to hospital.
- Reinforce the procedure with clinical staff through staff meetings and supervision

3) The initial ATP therapist assessment should form part of the contemporaneous record for a patient.

- Reinforce expectations regarding standards of documentation with all clinical staff.

4) Vulnerabilities of close relatives/dependents and associated care arrangements should be recorded upon admission and reviewed regularly thereafter.

- Risk bulletin to be sent out to nursing and medical staff to ensure that the questions about vulnerable relatives/dependents are asked and properly recorded in the family relationships section of admission documentation.
- Reinforce the process of referral of adult at risk concerns relating to people who are not patients of the hospital.

5) All disabilities should have an associated care plan which is agreed with the patient and communicated effectively with the Multi Disciplinary Team.

- Reinforce expectations of standards regarding care planning specifically for disabilities in line with company policies and local procedures.

6) Attendance at ATP aftercare groups should be more effectively recorded and communicated to professionals where indicated.

- A register of attendance at ATP aftercare is to be kept.

- Any extraordinary contacts with attendees at aftercare are to be recorded in the care notes for that person.
- Any extraordinary contacts with attendees at aftercare are to be communicated to the individual's GP.

7) Outcomes of Quarterly Priory Addiction Recovery Questionnaires to be communicated to GPs.

- Draft a new local procedure for the communication of PARQ to GPs, to incorporate urgent risk management procedures.

8) Make 1:1 therapy available to ATP service users/patients where engagement in group therapy is difficult.

- Increase availability of 1:1 ATP therapy

19. Additional Recommendations for local organisations from the Review

Home Care Agencies

In addition to the recommendations in the Home Care Mellor IMR, the Review recommends that

1) All home care workers are required to undertake basic training in recognition and referral of safeguarding concerns.

2) All home care workers are offered regular opportunities for reflective supervision

3) The home care agency institutes a means of monitoring the effectiveness of training and supervision

Adult Social Care

In addition to the recommendations in the Adult Social Care IMR, the Review recommends that

4) Any referral made to Day Support should be supported by an assessment prior to commencement.

5) Reviews of care plans for adults at risk should include the organisations providing care. Reviews of the quality of care should not be undertaken solely by the organisation providing the care.

Multi Agency Recommendations

Lancashire Safeguarding Adults Board

6) That the LASB monitor organisations in Lancashire providing personal care to adults at risk in relation to arrangements for the provision of safeguarding training, adequate supervision of workers and compliance with safeguarding procedures.

Commissioning Arrangements

7) LCC and the CCGs should consider extending the role the use of multi-agency planning and review meetings in complex cases where there is a number of organisations involved. The Review was told however that recent local changes had resulted in more multi agency meetings being held.

8) Health Commissioners be asked to clarify responsibilities for the co-ordination of health care for adults at risk.

9) Lancashire County Council, as commissioner of home care and day care services be asked to ensure in contract monitoring arrangements that all providers of home care and day care services (whether commissioned by the County Council or by families and individuals) have adequate safeguarding training and monitoring arrangements in place.

10) Health and Social Care Commissioners should ensure that practitioners in all organisations are better informed about responsibility for conducting carers' assessments.

Other multi agency recommendations

11) None of the organisations involved appeared to know whether there was a lasting power of attorney in place in relation to NI. In fact a power of attorney was signed, agreeing that BM and NI's son would be the appointees, though this was never invoked because the need did not arise. Although this did not affect the events considered by the Review, it appeared to the Panel to be an important omission. It would be of great benefit if this question could be routinely included in all documentation and assessments for patients with dementia, in NHS and Social Care organisations.

20 Issues for National Policy

The Home Office may wish to consider the following:

Care Co-ordination

The Review was concerned that there appeared to be a lack of clarity amongst professionals generally, in relation to NI, about who should take responsibility for care co-ordination and communication amongst the services involved with NI.

There are now many older adults who have a combination of dementia and other conditions associated with ageing, requiring the involvement of a number of services. It is of particular concern that the GPs, while they were attentive and caring in their responses to NI, did not know who the Social Worker was and had difficulty making contact with professionals in the CMHT.

These difficulties are inherent in the complex "web" of services involved and are not easily addressed by simplistic recommendations to provide yet more guidance or

exhortations to professionals to co-ordinate their efforts better. Information systems do not always assist practitioners to identify each other's involvement.

However, the use of multi- agency meetings (along the lines of the "team around the child" in children's services) in complex cases might have helped NI and her family. In order to be useful there would need to be some clarity about the ability of any professional to request or initiate such a meeting.

Views of Victims' Families

The family of NI have views about how they have been dealt with in relation to the Family Liaison system and the National Offender Management Service. Whilst the Review has concluded that these services operated in line with current guidance, the definition of a "victim" in the view of this family was clearly much wider than the current guidance describes.

It may be that consideration could be given, within the new initiatives for victims proposed by the government, to broadening the definition of "victim" and "next of kin" in the guidance about the Family Liaison Officer role following a death by homicide and in the NOMS guidance about Licence conditions following release from prison, to encourage organisations to think more widely about the needs of family members who have been bereaved.

The proposed Victims' Information Service may provide a point of contact and a means of communicating to families what they can expect and to services the needs of family members.

Adults at Risk

It is becoming increasingly apparent that dementia and the stress of caring for a family member with the condition are risk factors for vulnerable adults becoming victims of domestic abuse. It may be that questions about domestic abuse should be asked routinely in a number of settings (in the way that questions are routinely asked in midwifery and accident and emergency services).

APPENDIX 1

Enquiries were made of the following organisations:

- Addaction
- Age Concern Central Lancashire (Withy Trees Day Centre)
- Alzheimers Society (Dementia Advisor)
- Banksfield Nursing Home
- Cheshire and Wirral Partnership NHS Foundation Trust (Cheshire Psychological Therapies)
- Home Care Mellor (Home Care agency provider for NI)
- Lady Elsie Finney House (Home for Older People)
- Lancashire Care NHS Foundation Trust
- Lancashire Constabulary
- Lancashire County Council (Adult Social Care service)
- Lancashire Teaching Hospitals NHS Foundation Trust
- Mid Cheshire Hospital NHS Foundation Trust
- NHS England Lancashire Area Team/ NHS Chorley and South Ribble Clinical Commissioning Group (Lancashire GP)
- NHS England Cheshire Warrington and Wirral Area Team/South and Eastern Cheshire NHS Clinical Commissioning Group (Cheshire GP)
- Priory Hospital Altrincham

The following organisations were identified as having had significant involvement and were asked to provide IMRs:

- Age Concern Central Lancashire (Withy Trees Day Centre)
- Cheshire and Wirral Partnership NHS Foundation Trust (Cheshire Psychological Therapies)
- Home Care Mellor (Home Care agency provider for NI)
- Lady Elsie Finney House (Home for Older People)
- Lancashire Care NHS Foundation Trust
- Lancashire County Council (Adult Social Care service)
- Mid Cheshire Hospital NHS Foundation Trust
- NHS England Lancashire Area Team/ NHS Chorley and South Ribble Clinical Commissioning Group (Lancashire GP)
- NHS England Cheshire Warrington and Wirral Area Team/South and Eastern Cheshire NHS Clinical Commissioning Group (Cheshire GP)
- Priory Hospital Altrincham

The following organisations had little or no information relevant to the KLoE and were asked to provide reports rather than IMRs:

The Alzheimer's Society confirmed on 2 June 2014 that a Dementia Advisor had paid one initial visit to NI on 29 April 2011. No other services had been provided. The

Central Lancashire Dementia Adviser Service provides information and guidance to people with dementia, their families and carers.

Lancashire Constabulary had no information about NI prior to the incident on 23/24 July 2013. There was one contact with BM in 1996. Lancashire Constabulary provided a helpful report summarising the information available. Cheshire Police had had two calls relating to BM in July 2012 and, while the information was useful in creating a picture of BM's difficulties, there were no offences reported and no further involvement.

Banksfield Residential Care home was unable to provide information about NI's short stay in May 2012. The home had been in special measures for some time following this contact. A new manager had arrived in 2013 and all of the care staff have been replaced. Record keeping was identified by the Care Quality Commission as one of the issues which needed attention and the home has been unable to locate any useful record of NI's stay.

Addaction (service for substance misuse) had been involved with BM. However, these services were provided under contract to Cheshire and Wirral Partnership NHS Trust and are therefore dealt with by that organisation's IMR.

The extent of the involvement of some organisations only became apparent as the DHR progressed and therefore some requests for IMRs were made later than others. This was in large part because services to NI were not all commissioned directly by health or social care commissioners but were engaged by the family through the provision of "self-directed" care and the provision of vouchers. It therefore took some time for the Review to identify all of the organisations which had offered care to NI.

The following organisations were asked to comment on specific matters arising from the family's contribution and their responses are referred to in Section 16.5

Lancashire Constabulary
The SIO agreed to a further meeting with the Overview Author to discuss the family's comments about the Family Liaison Officer's role.

Preston Magistrates Court
Preston Crown Court

A response was received on behalf of both courts on 15 October 2014.

National Offender Management Service/National Probation Service

A response was received from the Lancashire and Cumbria Victim Contact Team on 19 September 2014.

APPENDIX 2

Preston Community Safety Partnership,
Governance Directorate,
Town Hall,
Preston.
PR1 2RL

23rd May 2014

Dear Sir,

Preston DHR Case B

On 13th January 2014, Preston Community Safety Partnership gave notification to the Home Office of a Domestic Homicide Review in relation to the death of an elderly lady, who died as result of injuries sustained in an assault by her daughter. The Chair of the Community Safety Partnership, Angela Harrison, appointed an Independent Chair and Overview Report Author, Annie Dodd, in January 2014, to oversee the review with a view to completing it by early July 2014.

The Independent Chair commenced the review promptly, with the appointment of a Domestic Homicide Review Panel, agreement of the Key Lines of Enquiry and the timeline for a six month review. Enquiries were made at the outset to establish the extent of the involvement of organisations with the victim and the perpetrator. As a consequence, several organisations conducted Individual Management Reviews in keeping with the original six month timescale, including the preparation and implementation of single agency action plans.

The victim was part of a large family and several close family members were involved in her care. Meetings with the family provided a greater insight into the extent of the care requirements by the victim over the four year period prior to the assault. As a result, other care providers engaged by the family have recently been introduced into the Domestic Homicide Review, due to the extent of their involvement with the victim.

The DHR Panel recognised that the introduction of additional organisations into the review will require adjustments to the original timescale for completion. The Independent Chair sought agreement from the Community Safety Partnership to extend the timescale by four months, until 13th November 2014. The purpose of the extension would be to allow for the IMRs to be conducted by the recent group of organisations. Angela Harrison has agreed the extension on behalf of the partnership and is joining with Annie Dodd to formally notify you of the progress with the Domestic Homicide Review request an extension for its completion, until mid-November 2014.

Yours Faithfully,

Angela Harrison
Chair
Preston Community Safety Partnership

Annie Dodd
Independent Chair
Domestic Homicide Review

Home Office,
2 Marsham Street,
London.
SW1P 4DF

APPENDIX 3

GLOSSARY

ASC	Adult Social Care
ATP	Alcohol Treatment Programme
CARSO	Clinical Assessment of Risk to Self or Others
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CSP	Community Safety Partnership
DAFSU	Domestic Abuse Family Safety Unit
DASH	Domestic Abuse Stalking Harassment
DVLA	Driver and Vehicle Licensing Authority
FLO	Family Liaison Officer
IAPT	Increasing Access to Psychological Therapies
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LASB	Lancashire Adult Safeguarding Board
LCC	Lancashire County Council
LCFT	Lancashire Care NHS Foundation Trust
LEFH	Lady Elsie Finney House
MARAC	Multi Agency Risk Assessment Conference
MAS	Memory Assessment Service
MCHFT	Mid Cheshire Hospital NHS Foundation Trust
NOMS	National Offender Management Service
NWAS	North West Ambulance Service
OT	Occupational Therapist
RPH	Royal Preston Hospital
SAMM	Support After Murder and Manslaughter
VS	Victim Support