BLACKBURN WITH DARWEN
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT v 0.10

12.04.2016

Victim Adult Female JOAN

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1. INTRODUCTION

1.1 This review is about the homicide of Joan. The perpetrator of the homicide was her husband Albert. Albert and Joan lived together at address one. At 0905hrs on Thursday 09.04.2015 Lancashire Constabulary (LC) received a call from a carer employed by 'Home Care for You' (HCFY). She said she was at address one and that Albert had told her he had killed Joan. Police officers attended address one and found the body of Joan on the floor next to the bed. A post mortem found she had died as a result of stab wounds. Albert indicated to the police officers that he had killed Joan. He was interviewed and charged with her murder. While on remand and awaiting trial he died of natural causes in hospital.

1.2 Albert and Joan had been in relatively good health until about 12.2013 when Albert was admitted to hospital after he was knocked down by a car. His health declined and Albert and Joan needed increased help from relatives with day to day tasks. From early 2015 family noticed Albert's physical health deteriorated markedly, he lost weight and he was admitted to hospital in 03.2015. Around this time Albert also became more confused. However it was only after his arrest for homicide that he was diagnosed with an age-related dementing condition. When he was discharged from hospital to address one Albert was given support by a number of agencies. Following his discharge Albert then made a threat to kill Joan and himself on several occasions to family and professionals and hid a knife under his chair at address one.

1.3 In the context of the above, this report focuses upon Albert and Joan's contacts with a number of agencies from 03.2015 to the date of the homicide. It analysis what information was available to, and what was known by, agencies about those threats; what actions they took to reduce the risk Albert presented and whether agencies had an opportunity to predict or prevent the homicide of Joan. The principal people referred to in this report are:

Name/Identifier	Role/Relationship	Ethnicity
Joan 74 years of age	Victim-wife of Albert	White British
Albert 87 years of age	Perpetrator-Husband of Joan	White British
Adult S (AS)	Sister of Joan	White British
Adult N (AN)	Daughter of AS	White British
Adult D1 (AD1)	Daughter of Albert	White British
Adult D2 (AD2)	Daughter of Albert	White British
Address One	Home of Joan and Albert and scene of homicide	

*Note: Appendix B contains a table of professionals referred to in the report

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Blackburn with Darwen Community Safety Partnership (BwDCS) met on 20.04.2015 and agreed that the death of Joan met the criteria for a domestic homicide review (DHR) as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The Chair of BwDCS agreed to extend the completion date to 31.01.2016 to enable the separate inquests of Joan and Albert to be completed. The DHR Panel established in late January 2016 that the inquest into Albert's death was unlikely to take place before the end of June 2016 and decided the DHR should be completed. A new completion date of 31.03.2016 was set. Any new matters relevant to the DHR terms of reference arising from the inquest will be dealt with as an addendum.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on 7.05.2015. Paul Cheeseman wrote the report. Both are independent practitioners who between them have chaired and written previous DHRs, Child Serious Case Reviews and Multi Agency Public Protection Reviews. Neither has been employed by any of the agencies involved with this DHR and both were judged to have the experience and skills for the task. The first of nine panel meetings was held on 08.06.2015. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

The Panel comprised;

• David Hunter	• Independent Chair
• Paul Cheeseman	• Author
• Andrea Rigby	• Domestic Abuse Lead BwDBC
• Mark Aspin	• Community Safety Manager BwDBC
• Shiqufta Khan	• Blackburn with Darwen Without Abuse
• Peter Soothill	• Head of Adult Social Care and Prevention BwDBC
• Abdul Ghiwala	• Safeguarding BwDBC
• Kathy Bonney	• East Lancashire Hospitals NHS Trust

- Garry Fishwick — Review Officer Lancashire Constabulary
- Vicky Shepherd — Age UK Blackburn with Darwen
- Karen Massey/Sue Clarke — Blackburn with Darwen CCG
- Bridgett Welch/Jane Jones — Lancashire Care NHS Foundation Trust (LCFT)

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- Lancashire Constabulary (LC)
- BwDBC Adult Social Services Department (ASC)
- Home Care for You (HCFY)
- East Lancashire Hospitals NHS Trust (ELHT)
- Blackburn with Darwen Clinical Commissioning Group (GP)
- Lancashire Care NHS Foundation Trust (LCFT)

2.3.2 Other agencies provided chronologies and supplied relevant information as requested. When this material is used within the body of this report it is attributed accordingly.

2.3.3 A supplementary report was commissioned from Doctor Susan Benbow Director of Mind Matters Limited that provides a perspective on dementia.

2.3.4 The DHR Chair and the Director of Adult Social Care, BwDBC, Steve Tingle saw Joan's sister and niece on 02.03.2016. The Chair briefed them on the findings of the review and the Director on the outcome of the disciplinary investigation.

2.3.5 On 11.04.2016 the DHR Chair saw Albert's daughter who was supported by a member of Advocacy After Fatal Domestic Abuse [AADFA]. His daughter's views are incorporated into the report. The Chair also briefed her on the outcome of the disciplinary investigation.

2.4 Additional Information

2.4.1 It was not clear to the DHR Panel whether Albert was suffering from dementia. The pre-homicide screening did not reveal dementia whereas the post homicide examination of Albert by a consultant psychiatrist instructed by the Crown Prosecution Service concluded, "…the likeliest diagnosis in these circumstances is of moderate to severe dementia.

2.4.2 Blackburn with Darwen Borough Council on behalf of the Community Safety Partnership commissioned Dr Susan Benbow[1] to:

"Look at the draft review report alongside the relevant IMRs and offer a view on learning outcomes relevant to the alleged perpetrator's mental health that might be incorporated into the end product".

2.4.3 Dr Benbow's opinion appears in the report as appropriate.

2.5 Notifications and Involvement of Families

2.5.1 Joan was survived by a younger sister AS. David Hunter accompanied by Paul Cheeseman met with her and her daughter AN. They provided helpful background information and a voice for Joan which appears in Section 4.

2.5.2 Albert had two daughters (AD1 and AD2). David Hunter met with AD1 who was supported by a member of the charity Advocacy After Fatal Domestic Abuse (AADFA). AD1 was able to provide helpful background information about her father. Her contribution also appears within section 4 below.

2.6 Parallel Processes

2.6.1 David Hunter and Peter Soothill met with HM Coroner for Blackburn, Hyndburn and Ribble Valley twice. Agreement was reached in relation to the sharing of any information relevant to either the coronial or DHR processes. HM Coroner for Preston and West Lancashire was written to but did not feel it necessary to have a meeting with representatives from the DHR. A separate inquest will be held in Preston in relation to the death of Albert. Up to 11.01.2016 a date had not been set.

2.6.2 In 12.2015 HM Coroner for Blackburn, Hyndburn and Ribble Valley held an inquest into the death of Joan. He found the Local Authority failed to recognise that the threat to the life of Joan was both immediate and credible and therefore failed to prevent her from being stabbed to death in her bedroom at address one on the morning of Thursday 09.04.2015 and he recorded a verdict of unlawful killing.

2.6.3 BwDBC have taken appropriate action in relation to staff employed by them. The DHR panel therefore ensured that their processes followed the advice contained within Section 7 of the Guidance paras 56, 57 and 58.

2.7 Terms of Reference

2.7.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

[1] A psychiatrist and systemic psychotherapist: www.oldermindsmatter.com

- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.7.2 Timeframe under Review

The DHR covers the period 01.01.2013 to the date of the homicide.

2.7.3 Case Specific Terms

1. How did your agency identify and assess any domestic abuse risk indicators, including any threats to kill or harm Joan or others, and what risk assessment[s] were undertaken?
2. How did your agency manage those risks and how did it respond to any new information which may have impacted on the risks?
3. What services did your agency provided for Joan and Albert in relation to the identified levels of risk and were they timely, proportionate and 'fit for purpose'?
4. How effective was inter-agency information sharing and cooperation in response to Joan and Albert and was information shared with those agencies who needed it?
5. How did your agency ascertain the wishes and feelings of Joan and Albert about any domestic abuse and were their views taken into account when providing services or support? Did you seek the views of their families?
6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, including age and disabilities, when completing assessments and providing services to Joan and Albert?
7. Were single and multi-agency domestic abuse policies and procedures followed and were any gaps identified?
8. How effective was your agency's supervision and management of practitioners who were involved with supporting Joan and Albert and did managers have effective oversight and control of the case?
9. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to Joan and Albert or to work with other agencies?

3. DEFINITIONS

3.1 The experiences of Joan fell within the Government definition of domestic violence which can be found at Appendix A. (Hereinafter referred to as domestic abuse)

4. BACKGROUND JOAN & ALBERT

4.1 Joan

4.1.1 As a child and young person Joan lived with her parents and sister in the Blackburn area. After leaving school she worked in a local factory that manufactured slippers. Joan married three times. Her sister AS said that Joan's first marriage in the early 1960's ended in divorce in 1963.

4.1.2 Joan married for a second time although AS said this ended when her husband died. This happened when he was aged about 40 and Joan was about 32. Joan's third marriage was to Albert. There were no children from the three marriages.

4.1.3 AS said that Joan had a nervous personality and was often ill with problems related to her chest. The last job AS recalled Joan having was with the schools meal service although AS said Joan did not work there for very long. Despite her health problems Joan was described as someone who was well liked with a bubbly personality.

4.1.4 AS said Joan liked singing and attending karaoke sessions. AD1 said Joan was a lovely person and they got on very well. She said she remembered lots of good times with Joan and Albert and lots of laughing. AD1 said she could confide in Joan and felt she was like a mother to her.

4.1.5 AS described Joan as someone who was a tiny person. AS said Joan was in good health until about a year before her death when she started to lose lots of weight. AS estimated that latterly Joan only weighed about 5 stone[2].

4.2 Albert

4.2.1 Albert was born in Northern Ireland. He moved to England when he was in his twenties. He was a tool maker, a trade he practised until he retired at 65 years of age.

4.2.2 AD1 described how her parents' marriage ended when she was seven years old. She remained with her mother and Albert later married Joan. As a child AD1 maintained contact with Albert and often stayed with him and Joan who she got on with very well. AD1 said her father was a very private man.

4.2.3 In 12.2013 Albert was knocked down by a car and both AD1 and AS said that from then on his mobility and general health deteriorated, including his psychological well-being. He found it difficult to go shopping and became frustrated at being unable to function as he used to. In 10.2014 AD1 said Albert became more forgetful. He did not like change and was unhappy at having to be admitted to hospital on 03.03.2015.

4.3 Albert and Joan Relationship

4.3.1 Joan and Albert married in 1980 and did not have any children from their marriage. AS described the marriage as normal and said that Joan and Albert were a 'happy couple'. AS recalled that Albert and Joan had a routine and went shopping every Monday. They ate out and then spent the early evening in a local public house

[2] Joan's weight at post mortem was 5 stone 5 lb. (34kg).

before getting a taxi home. AD1 said her father had a loving relationship with Joan; they did many things together and were a close couple. She never saw or heard any arguments between Albert and Joan.

4.3.2 AS said that Joan was unwell in the last years of her life and described her as having problems with her legs. AS said that initially Albert cared for Joan and that he did most of the cooking. AS said there was no indication that anything was wrong between the couple.

4.3.3 AS felt that things changed in the relationship between Joan and Albert after he was discharged from hospital in March 2015 following treatment on his legs. AS described Albert as being different and then becoming 'grumpy'. AS also noticed that Albert started to become forgetful.

The family's view of the events leading to the homicide of Joan

4.3.4 When asked what she thought were the lessons to be learned from the death of her sister Joan, AS said she felt something should have been done about the threats to kill quicker and ASC should have taken the issues more seriously. AS felt that what seemed to be of interest to ASC was whether Joan and Albert had any money for a home. AS believes they could have been put him in a home and the financial issues sorted out later. It is now known that a financial assessment by ASC was running in parallel with the "knife" crisis and not as a result of it. This financial assessment related to the domiciliary care package they were already receiving.

4.3.5 AN felt that ASC took the threats seriously at one point and then not seriously the next. AD1 was shocked by what happened and felt Joan's death was avoidable had action been taken to separate her and Albert for their protection and well-being.

5. KEY EVENTS

5.1 Introduction

5.1.1 The agencies who submitted IMRs are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

5.1.2 There is a significant amount of information concerning Albert and Joan between 01.10.2013 and the homicide on 09.04.2015 particularly relating to their medical conditions and some contact with the police. However the critical issues occur within the week immediately prior to the death of Joan and this section of the report is therefore structured to reflect those issues.

5.1.3 This section of the report uses information provided by agencies either in IMRs or reports, conversations with family members and evidence from witness statements provided to the DHR by Lancashire Constabulary or HM Coroner for Blackburn, Hyndburn and Ribble Valley

5.2 Relevant facts prior to Tuesday 31st March 2015

5.2.1 Lancashire Constabulary (LC) held information on three incidents involving Joan and Albert. The first of these occurred on 21.01.2003 when they received an anonymous telephone call stating that the male and female at address one had been *'rowing for hours'*. The caller said they believed the *'male has really hurt the female this time'*. Police officers attended address one and reported this was not a domestic incident and that both parties were safe and well.

5.2.2 There is no record of who the male and female were. AD1 said the address was a multi occupancy property. The police no longer have a record of who was seen. Therefore the DHR Panel cannot say that the incident involved Joan and Albert.

5.2.3 At 02.00hrs on 16.04.2013 LC received a 999 call from Joan in which she stated that Albert was abusing her. She was heard squealing before terminating the call. Police officers attended address one and spoke with Joan and Albert who were both described as drunk. Joan said that Albert had come home from a club drunk and gone to bed and Joan was unhappy about this. The officers established Joan had poured or dropped the last can of Guinness down the sink. Joan had then asked Albert to go to the shop for more alcohol. He refused and it was for this reason that Joan called the police.

5.2.4 The officers attending found the flat tidy and there was no sign of a disturbance and no evidence of violence or threats. The officer attending therefore concluded this was not a domestic incident.

5.2.5 Joan and Albert had a number of health issues requiring multi-agency input. They were both registered at the same GP practice that had regular contact with them for a number of conditions. Both Joan and Albert were also known to ELHT and LCFT who held information about them.

5.2.6 Albert had poor mobility and was unsteady on his feet and needed to use furniture to aid him in walking. He was noted to have lost weight and was seen as at high risk of falls. While he had a number of medical conditions he had no history of mental health problems.

5.2.7 On the 23.12.13 Albert attended the Emergency Department at the hospital following a road traffic accident from which he sustained a head injury and fractured clavicle. He also had chest discomfort and cardiac issues. He was admitted to the Coronary Care Unit and transferred to a Cardiology Ward. He was discharged from the ward on the 03.01.14 and follow up care was arranged. Albert also had Type 2 Diabetes, Hypertension and leg ulcers.

5.2.8 Albert attended outpatient appointments at Blackpool Teaching Hospitals during 2014 in connection with coronary issues. The Consultant who saw Albert did not believe that surgical intervention was in his best interests. However in a letter filed in the notes of Albert the Consultant wrote that *'in fact he (Albert) expressed in clinic today that the only thing limiting him doing what he wants to do is his wife'.* There are no further details to explain this comment, nor was this questioned when Albert was seen in the Cardiology Clinic at the Royal Blackburn Hospital in December that year.

5.2.9 On 28.10.2014 Albert was seen by his GP and was felt to be at risk of dementia. A screening test for that and for depression was conducted with negative results. On 24.02.2015 when Albert was seen by a District Nurse from LCFT a nursing assessment form was started. The assessment included a mental health trigger tool. The cognition section stated the patient had not been more forgetful in the last 12 months. The mood section was not completed. Staff reported no mood issues were identified at that stage of the assessment.

5.2.10 On 03.03.2015 a district nurse who visited Albert noted that he was becoming more confused with his medication. Joan said Albert had been *'wandering most of the night'*. However the nurse reported Albert was not confused on this visit, but was unsure regarding his medication. On the same day Albert was visited by a GP who recorded he had decreased mobility and was *'getting stuck on loo'*. The GP noted that Joan said he was getting *'muddled up'* with his medication.

5.2.11 Later that day, as a result of the GP visit, Albert was admitted to hospital because of concerns for his health. His medical and physical condition was recorded as poor. He was short of breath and had other chest problems. It was felt Albert was more dependent on others to meet his own needs. After a week Albert was deemed medically stable and on 10.03.2015 multidisciplinary discharge planning commenced. Joan visited Albert on the ward and reported how Albert had been struggling at home, including getting *'muddled up'* with his medication.

5.2.12 During his stay in hospital Albert was treated on a ward specialising in the care of older people. No concerns were identified in relation to domestic abuse nor in respect of any threats between Albert and Joan. Joan had opportunities to speak to staff at any point but did not raise any concerns with any of the team in relation to this.

5.2.13 On 11.03.2015 a referral was made to Adult Social Care (ASC) in respect of Albert's discharge from hospital. An overview assessment was undertaken by a social worker at the hospital that day. All areas such as harm or injury to the carer, harm to self and harm to others were assessed as 0 indicating no apparent risk. Albert was discharged home on 17.03.2015.

5.2.14 It is clear from the medical records provided to the DHR panel that during the same period Joan was also unwell. For example on 07.05.2014 a GP visited her at home at the request of a family member. She was described as being unwell, having poor

sleep and not wanting to get out of bed. The GP queried this may be due to anxiety over Albert's cardiology. However the doctor was unable to rule out an underlying malignancy as a cause. AS said Joan also lost a significant amount of weight during this period (see paragraph 4.1.4). Although Albert no longer smoked Joan continued and she was receiving screening for Coronary Obstructive Pulmonary Disease (COPD) during this period.

5.2.15 While Albert was in hospital on 05.03.2015 Joan was also admitted to hospital by ambulance after a call was made to the Out of Hours (OOH) GP service. Joan was complaining of abdominal, chest and shoulder pain and the doctor suspected this was a cardiac issue. Joan was discharged later that day. She felt the pain may be due to lifting Albert. The OOH diagnosed gastritis.

5.3 Relevant facts-Discharge from hospital on 17th March to homicide on 9th April 2015

Tuesday 17th March 2015

5.3.1 Albert was discharged home on 17.03.2015 with a care package and extra support from the Reablement Team which is part of ASC. Referrals were also requested from a number of other professionals in respect of the care needs of Joan and Albert. From that point onwards there are a significant number of routine contacts in relation to those issues. These are not individually documented within this section of the report when there is nothing of relevance to the DHR. However there is reference to Albert being confused and needing direct instructions. One explanation is dementia; there are others such as infections.

5.3.2 During this period a safeguarding alert was made to Adult Social Care in respect of Albert's care. (See Appendix C for a description of the Safeguarding Alert Process). This related to the supply of medication and the splitting of tablets. It was later determined this was not in fact a safeguarding matter. The DHR panel are satisfied this is of no relevance to the homicide of Joan and have therefore not analysed it further.

5.3.3 AD1 says she visited Albert at address one after his discharge from hospital and found he was confused. For example he could not understand why the salad prepared for his meal was cold and he wanted it putting in the oven.

Wednesday 18th March 2015

5.3.4 At 10.20hrs Albert was visited at address one by members of the Rapid Assessment Team (RAT) from Lancashire Care NHS Foundation Trust (LCFT). Its purpose is to provide urgent assessments and interventions to those who may be at risk of admission to residential care or hospital and who, with support, may be able to remain at home during a period of illness. The team put a plan in place for Albert and ordered equipment as he was at high risk of falls.

Thursday 26th March 2015

5.3.5 On 26.03.2015 Albert was re-assessed during a joint visit by a member of the Reablement Team and a social worker. His risk score rose from 21 to 27. However this increase in risk related to Albert falling and did not relate to any risk he presented to Joan or others.

Unknown Date

5.3.6 AN says she visited address one in the week before Easter although cannot be precise as to the date. On this visit AN says Albert said he was going to get a knife and stab Joan and then kill himself. AN told Albert not to say things like that. She thought he was a bit down or depressed because of his poor health. Initially AN did not say anything to anybody as she thought Albert's comment was just a one off *'stupid comment'*.

Monday 30th March 2015

5.3.7 On 30.03.2015 an Age UK 'Here to Help' coordinator' visited the couple and went through an assessment which covered a variety of needs. This was as a result of a referral when Albert was first admitted to hospital. The assessment was about all aspects of welfare. The assessment form recorded poor levels of mental wellbeing and high social isolation. These comments related to the fact Albert did not want to engage with agencies. Joan told a Fire service worker who was also present that she would like to consider sheltered accommodation but Albert would not accept this.

5.3.8 Joan and Albert refused any aids and no more formal support was required from Age UK. The Age UK coordinator spoke to a social worker from ASC who confirmed all formal support was in place. An internal referral was made to Age UK's Advice and Information service for a benefits check.

5.3.9 On the same day ASC made a referral to Homecare For You (HCFY). The agency provide domiciliary care services across Lancashire and the North West. HCFY state the referral from ASC did not include any information regarding domestic abuse and that harm to the carer and harm to others from Albert were both recorded on the referral as 0. This indicated Albert presented no apparent risk. Following the referral HCFY then made arrangements to visit Albert to conduct their own assessment.

Wednesday 1st April 2015

Unknown Time

5.3.10 AN says she was at address one. She believes it was the Wednesday before Easter which, if correct, would be 01.04.2015. AN says Albert made the same comment again about stabbing Joan that he had made to her the week before (see paragraph 5.3.6). Albert also told AN that he wanted to go somewhere else where he could be looked after. AN says she told Albert not to say this and that she would see what could be done about getting him into a home. AN says AS was at address one at this time however AS did not witness the conversation as she was talking to Joan.

5.3.11 AN says she was concerned about what Albert said and sought advice from a friend. This friend told AN she should telephone ASC and inform them. AN said she made a telephone call to ASC the following day (see paragraph 5.3.27). It is not

clear whether AN's visit to address one occurred before or after the visit by HCFY described in the following paragraphs.

09.00

5.3.12 Two members of staff from HCFY (H1 and H2) visited address one to undertake a needs assessment[3]. Albert and Joan were present as was a member of the Reablement team from ASC (RW1). During the visit Albert *said "I'm going to kill her and then I'm going to stab myself"*. RW1 recognised the threats were serious and made a telephone call to their office to describe the conversation they had with Albert. A typed note was made of the call on a separate A4 sheet and retained on the Reablement paper file relating to Albert. It is dated although it does not record who the author was. This typed note contains the threat to kill and has since been confirmed as an accurate record of what happened

5.3.13 A note was also made on the same date concerning the same incident and recorded on the electronic SWIFT system used by ASC. There is no date on the note to indicate when the note was made. However it was believed to have been made by RW1. This electronic SWIFT note does not match the typed note. The electronic SWIFT note contains no mention of Albert making threats to kill and instead relates to him being in a low mood; a substantially different account.

5.3.14 Despite the fact a typed note was made a formal safeguarding referral was not recorded on a form SA1. The reason RW1 says this did not happen is because they discussed the matter with the Safeguarding Team (SG) within ASC and were told that an alert had already been submitted. On returning to their office H1 and H2 also reported their concerns. The HCFY manager says they asked SW1 if they were required to submit an official adult safeguarding alert (SA1) email. The manager says they were told by SW1 it was not necessary in these circumstances.

5.3.15 The panel asked the ASC panel member to seek a detailed explanation from SW1 as to why they advised RW1 and the HCFY manager not to submit an SA1. SW1 says that on 01.04.2015 an urgent call came in from the HCFY manager. The duty social worker was not available and SW1 said they would take the call. The HCFY manager asked SW1 if they were aware of an incident that happened that morning during a handover from the Reablement Team to HCFY when Albert said he was going to kill Joan.

5.3.16 SW1 said they were not aware so they told the HCFY manager they would check with the Reablement Team and then come back to the manager. SW1 went through to the Reablement Team and spoke to a member of staff in there (RW2) and established if they were aware of what had happened. The explanation SW1 says RW2 gave them was that Albert was frustrated at not being able to hear what the support worker from HCFY was saying and Albert did say he would kill Joan.

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[3] HCFY practice is for managers to undertake an initial visit to a client and gather information which is taken back to their offices and from which a risk assessment is completed. The risk assessment for Albert following the visit on 01.04.2015 identified that *'Albert demonstrates some challenging/aggressive behaviour. Threatens to kill his wife and himself'*. The control procedures and arrangements column states '*Monitor and review. Support workers will contact office if any changes. Social services aware of aggressive behaviour'*. In bold and underlined on the first page of the risk assessment was the following statement: **'(Carers are to leave Mr Smith to calm down if he shows any aggressive or challenging behaviour and report it to the office)'**

5.3.17 SW1 says they asked RW2 what happened since then and RW2 said they had spoken to Joan as Albert did not have his hearing aid in. Joan told RW2 that Albert had a bad night and he could not hear what RW1 was saying. However Albert had since had a sleep and felt better. He was asked if he wanted to be seen by a GP and he declined stating he was fine now.

5.3.18 SW1 said they made a telephone call to the HCFY manager and explained that ASC had been made aware of the incident that morning and if there were any further concerns then the manager from HCFY knew who to contact. SW1 was asked what their rationale was for not going back and checking that an SA1 had been raised. SW1 said they were not the duty social worker that day and took the call on behalf of the duty social worker. From the information gathered SW1 assumed that an SA1 had been received and did not recognise the need to check this was the case.

5.3.19 While the typed notes held on the Reablement paper file relating to Albert correctly record the threat, the separate SWIFT electronic record held in ASC differs. The SWIFT notes states the call from RW1 was about Albert being in *'low mood'* and makes no reference to any threat to kill. Neither does the note record the conversation that SW1 had with Reablement or HCFY.

5.3.20 Reablement and HCFY correctly identified there was a threat. However neither of them submitted a safeguarding alert (form SA1). This should have happened irrespective of whether either agency thought the other had submitted one. Because this did not happen an opportunity was then lost to assess the risks that Albert posed to Joan and others such as his carers and then to make a referral to the police.

5.3.21 Although HCFY did not submit a form SA1 following the events on 01.04.2015 they briefed all staff involved in the care of Albert that they had to report any future threats to the HCFY office as well as recording details in the home care plan book.

21.30

5.3.22 The HCFY manager received a call from SW2, another social worker within ASC, enquiring as to how things were with Albert. There are no notes on SWIFT that record the reason for this call. SW2 was asked why they made that call. They said it was to confirm that HCFY were attending Albert and Joan, to ascertain the number of visits per day and check any concerns that HCFY had.

5.3.23 The manager from HCFY was under the impression SW2 knew about the earlier threat. It would now appear that at that point in time SW2 may not have known about the threat. This was because it was not recorded on the SWIFT electronic record held in ASC and on which social workers within ASC rely for information. The threat information was only held on the typed note in the Reablement paper file and in the memories of a few other professionals.

5.3.24 In response to the enquiry from SW2, the HCFY manager then rang the care worker from HCFY who had visited Albert that evening. The care worker reported things were OK and that Albert had not made any threats in their presence. The HCFY manager passed this information back to SW2. HCFY staff continued to provide care to Albert twice a day up to the date of the homicide of Joan.

Thursday 2nd April 2015 (Maundy Thursday)

0900

5.3.25 H3 is employed as a care assistant by HCFY and from 02.04.2015 visited Albert most mornings at 0900hrs. H3 described Joan as being very quiet and said Albert seemed agitated, frustrated and could appear aggressive. H3 said they made notes in a care plan book[4] about everything that happened, for example if Albert used an offensive or threatening word. H3 said Joan never responded to Albert shouting at her. On some visits Albert told H3 he wanted to die. When H3 first started visiting they heard Albert say that he was going to kill her (meaning Joan) and then kill himself.

5.3.26 H3 told Albert he should not think like that and thought it was just something he said because he was old. H3 says they never for a minute took it that he was being serious. H3 says everything was documented in the care plan book. The care plan book was recovered as part of the police investigation and copies were made available to the DHR panel. There were a number of entries in the care plan book relating to Albert's aggressive behaviour including a threats to kill Joan on two occasions. The HCFY panel member said that, despite those entries having been made in the book, no reports of aggressive behaviour by Albert were ever reported back to the HCFY offices by the carers. (Also see paragraph 5.3.65)

5.3.27 HCFY have an audit process in place. Every fourteen days the logs from the care plan books are called in and examined and every twenty eight days a review is undertaken of support needs. Because there were only ten days between HCFY attending Albert and the homicide of Joan the logs were not reviewed.

PM-Unknown Time

5.3.28 As a result of the advice a friend gave her (see paragraph 5.3.11) AN says she rang ASC and explained about the threats Albert was making and she also mentioned about getting him some residential care. AS says she was advised to ring back after 17.00hrs when she would be able to speak to the crisis team.

19.00

5.3.29 SW2 was on duty covering the emergency duty team when they say they received a telephone call from AS. However it is AN who says she telephoned ASC that evening. SW2 could have confused the voice of AN with AS. The important issue for the DHR is that in the telephone call it was explained to SW2 that Albert was being verbally abusive towards Joan. A note of the call was made on SWIFT and this did not contain the threat to kill.

5.3.30 As a result of this call SW2 made a telephone call to Joan and told her of concerns raised with them in the call from the family member. Joan told SW2 she was fine and she said Albert could be difficult to deal with and if that was the case she went into the kitchen to have a smoke. SW2 asked Joan if Albert had ever hit or assaulted her and Joan said *'no never'*. SW2 left Joan their telephone number to ring in the event of any problems. SW2 says Joan appeared very relaxed about the situation. SW2 then rang AN and told them that they would look into arranging additional lunch time visits to Albert.

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[4] HCFY undertake a personalised care needs assessment for each client. Management undertake a risk assessment of the client. A support plan is then formulated. This stays in the client's home and is available for anyone to read (i.e. family, district nurses etc). When care visits are undertaken by HCFY staff a visit log is kept listing tasks undertaken, incidents and new information.

5.3.31 As the form SA1 was never submitted following the threats Albert made on Wednesday SW2, who spoke to the family, was possibly unaware of that event. Consequently, when speaking to the family SW2 may not have seen the potential risks, or urgency, to make alternative support arrangements in the light of this further information.

5.3.32 Following this conversation between the family and SW2 no follow up visit was made to Albert so that a fresh assessment could be made. This could have been another opportunity to submit an SA1 in relation to safeguarding. The record of this event on SWIFT was modified on Wednesday 08.04.2015. SW2 confirmed they made this modification in order to correct a typing error. This happened because the emergency duty team work nights and out of hours and therefore team members have modification rights due to the nature of their work. Attempts have been made to retrieve the original electronic note without success. It has therefore not been possible to identify what the differences are between the two documents.

Friday 3rd April 2015 [Good Friday]

10.00hrs

5.3.33 On the morning of 03.04.2015 SW2, who had worked the previous night shift, stayed on duty to follow matters up. This included telephoning a crisis support team to discuss the possibility of putting in a lunch time visit to Albert and Joan over the remaining days of the bank holiday period. ASC were informed later that day it was not possible to provide this visit.

5.3.34 SW2 also made a call to the Rapid Assessment Team (RAT) at LCFT to discuss support options that might also include a rehabilitative placement. The RAT notes record a telephone call from SW2 at 10.00hrs. In it SW2 states the family of Albert had requested rehabilitation for him as he was still weak and becoming frustrated and angry with Joan. In that conversation SW2 said Albert had threatened to stab himself and his wife. RA1 advised SW2 that Albert would need a mental health assessment. The threat to stab himself and Joan was recorded in the RAT note of the telephone call.

5.3.35 This was the first time that SW2 made any reference to Albert making a threat to stab Joan. Nothing about this threat is recorded on the SWIFT entry relating to Thursday 02.04.2015. Therefore the panel asked the ASC panel member to clarify with SW2 where they received this information from. SW2 said that on the evening of 02.04.2015 they spoke with various family members of Joan and Albert, as well as with HCFY on the morning of 03.04.2015. SW2 says that from the information given by the RAT team it must be that in those conversations the reference to Albert making threats to stab was mentioned. SW2 says they were aware this was a concern raised in a general discussion but cannot recall exactly when it was initially raised.

10.15

5.3.36 RA1 then rang Joan and spoke to her on the telephone. She said Albert was getting grumpy and frustrated and taking it out on her verbally. Joan disclosed that a doctor had not reviewed Albert since his discharge from hospital. RA1 confirmed

that until this point they had no knowledge of Albert becoming angry or frustrated and no previous disclosure had been made to them regarding an intent by Albert to harm himself or Joan.

10.25

5.3.37 RA1 then contacted ASC and spoke to SW6. They were advised that SW2, the social worker who had discussed the case earlier, was not available. RA1 say they told SW6 of their concerns regarding the comment SW2 had made at 10.00hrs concerning the threats by Albert to stab himself and Joan. RA1 said Albert needed a mental health and GP assessment as soon as possible.

5.3.38 SW6 says in their witness statement that it was only when RA1 mentioned that Albert had made this threat that SW6 became aware of it. However SW6 then goes onto say that SW2 may have mentioned to them when handing over cases earlier in the shift that Albert had made this threat. While it cannot be established with certainty at what point SW6 first became aware of the threat it can be said with certainty that from 10.25 on Friday 03.04.2015 they knew about it.

5.3.39 RA1 documented that SW6 seemed very rushed on the telephone. SW6 said to RA1 that they were assessing the situation and taking measures by increasing visits and getting feedback from the carers. RA1 says they advised SW6 that a mental health/GP assessment should take priority for ASC. There is no record in either agencies files that feedback was provided by ASC to RAT. Following the conversation with RA1, SW6 contacted HCFY and asked them to undertake additional visits to address one.

13.15

5.3.40 RA1 contacted address one by telephone and spoke to Joan. She said that neither the GP nor ASC had been in contact with her. Joan was asked if she felt threatened by Albert. Joan said Albert had said something that wasn't very nice but she did not want to say what it was. RA1 told Joan they were pursuing a doctor review.

13.30

5.3.41 An attempt was made by RA1 to ring the emergency duty team at ASC. The call was placed in call waiting as number one. After five minutes a message told RA1 no one was available at this time and they should call back. The call was then disconnected. RA1 then contacted the out of hours (OOH) medical service in Blackburn.

13.46

5.3.42 East Lancashire Medical Services (ELMS) handle OOH calls and recorded a contact from RA1 at this time. The correct procedure for OOH calls is for these to pass through the 111 service. However RA1 telephoned directly to the OOH centre, where her call was picked up by a supervisor. RA1 explained that she had received a call from ASC that morning asking for assistance with Albert's mobility. During the call RA1 told the supervisor that Albert had threatened to stab himself and Joan earlier in the week. Due to the seriousness of her concerns, the supervisor did not insist that RA1 re-dial 111 and instead put her call through to a call handler to take the details and arrange for a GP to call RA1.

5.3.43 The OOH supervisor did not record any details of the original call from RA1 on Adastra, the OOH computer system. This was because the supervisor made the reasonable assumption the call handler and the triaging GP would be given the same information the supervisor received.

5.3.44 RA1 provided the call handler at OOH with Albert's details and brief clinical information and requested that a GP call them back. RA1 told the call handler they were working in the emergency department that day and with a poor signal maybe unable to answer. RA1 gave the call handler the number for the duty mobile telephone. Because no contact was made by the GP to the duty mobile telephone of RA1 prior to the end of their shift at 18.00 hours, RA1 presumed the visit had taken place.

5.3.45 The DHR panel asked the LCFT panel member to clarify whether the assumption RA1 made, that the visit by the GP had taken place, was a reasonable one to reach. The LCFT panel member says RA1 was not case managing this patient and made an assumption that because they had spoken to the OOH service directly, that this would have been actioned. The LCFT panel member believes this is a reasonable expectation. The LCFT panel member believes a learning outcome for their agency could be to follow up when they have passed a patient on for review consistently and especially during out of hours-time.

5.3.46 The case was entered onto Adastra, the OOH system, with the clinical details *"Change in behaviour, making threatening remarks about him and wife*". The vital information about the threats to stab Joan and himself was not entered on the system. GP1, the triaging GP from OOH, twice attempted to contact RA1 on their mobile. The first attempt was logged as a "failed contact". According to the ELMS computer records on the second attempt GP1 misdialled the number.

13.57

5.3.47 GP1, who was responsible for triaging the call, spoke to Joan by telephone. She was described as *'anxious'*. She said Albert's behaviour was strange and that *'there is something wrong with him'*. He *'shouted at carer'* and Joan sounded overwhelmed.

15.25

5.3.48 Joan and Albert were visited at their home by GP2 a doctor working from ELMS. GP2 doctor received a computerised message from GP1 requesting they visit address one. This message *read 'I spoke to patient's wife. Seems to be very anxious. Patients wife saying "there is something wrong with him" strange behaviour. This morning he was "shouting at the carer" also not eating. Patient wife sounded overwhelmed'.* The message contained no information about any threats having been made by Albert to Joan.

5.3.49 Joan told GP2 that Albert was always in a mood, shouted for nothing and didn't seem to sleep. The doctor recorded *'not a new problem'* although it is not clear whether this referred to not sleeping or the entire situation. Albert said that Joan controlled him, didn't care for him and served him cold food. GP2 recorded that Albert looked depressed but not confused or aggressive. A physical examination of

him was normal and GP2 advised him to contact his own GP as they may prescribe him anti-depressants.

5.3.50 Later that evening Joan contacted SW6 by telephone and informed them that a GP had been out and prescribed antidepressants. SW6 asked Joan if she was alright or worried about anything. Joan said she was not worried about anything. SW6 asked her if Albert had been aggressive towards her. Joan said to SW6 *'we have been married for 30 years and he's never laid a hand on me, I am not frightened of him'*. SW6 says Joan laughed.

Saturday 4th April 2015

AM

5.3.51 RAT staff contacted the ASC emergency duty team after their call to Joan and they were told that the GP had visited the previous day and was prescribing anti-depressants to Albert. They were also assured that a referral had been sent to the Older Adult Mental Health Team and a consultant would assess Albert on Tuesday the 07.04.2015[5]. They were also informed that there had been a discussion with Joan and AN, and an increase made in carers to support them. A member of the RAT staff documented they were told that the family felt they were managing. As a result of this contact, RAT staff felt that the situation was being dealt with and appropriate assessment and support had been actioned. While there was no further professional contact from ASC that day visits continued to be made to address one by care workers from HCFY.

Monday 6th April 2015 Easter Monday

09.05

Examination of the log sheets from the Home Care plan for this date disclosed an entry made by H3 which reads;

'On my leave was gone attack wife, left her in kitchen'

Although H3 made no specific mention of this incident in their statement to the police it appears to have been another threat by Albert to kill Joan. There is no evidence this was reported by H3 to HCFY.

14.00

5.3.52 Around this time AD1 visited address one with her husband. She spoke to Albert who made a number of distressing comments to her including that *'I'm a prisoner and I can't get out'*. AD1 felt it was very strange as Albert was saying random things and displaying signs of being confused. AD1 spoke alone to Joan who said Albert had taken the kitchen knife and hidden it and she did not know where it was.

[5] The panel asked the LCFT panel member to check whether their agency received this referral from ASC. The panel member reported that LCFT did not receive a referral from ASC in respect of this matter. The only referrals they received were from Lancashire Constabulary (post homicide) on 09.04.2015 and 11.04.2015 relating to the homicide of Joan and on 11.05.2015 from a Consultant from Secure Services requesting Albert be admitted to a mental health bed.

5.3.53 Later that afternoon Albert said to AD1 *'I've got it....I've got a knife'.* AD1 asked why he had a knife and Albert told her it was because he was a prisoner, everyone was being cruel and he had to get his own food. AD1 asked to see the knife and after lifting the cushion of Albert's chair found under it a brown handled kitchen knife about four inches long.

5.3.54 There were other items under the chair including money and a spoon. When AD1 asked why he had all these items Albert said it was because everybody kept taking things from him. AD1 took the knife into the kitchen and put it in a drawer. She suggested to Joan that she moved all the knives from the drawers. Joan said *'I knew the knife was missing. When I asked him where it was he said that he was going to stick it in me'.*

15.20

5.3.55 A district nurse (RN1) made a routine visit to review Albert's dressings. While she was doing this RN1 heard Albert ask AD1 to help him as she was the only one he could turn to. Albert was also heard to say that Joan was nice to him when everyone was there and horrible when they left. RN1 asked AD1 if Albert had any form of dementia. AD1 said she didn't know. A discussion took place regarding respite care. Albert said he would like to be cared for and referred to an atmosphere between himself and Joan although he felt safe to stay at home.

5.3.56 AD1 asked RN1 if they could speak and they went and sat in RN1's car. RN1 says AD1 said she was concerned about Albert because she had found a knife under his chair and that Albert had said he was going to stab Joan. RN1 rang her manager who advised her to contact ASC. RN1 telephoned ASC and spoke to SW6. RN1 says she told SW6 about the disclosure by AD1 and of the knife. AD1 says when she spoke to SW6 she told her about the finding of the knife and that she thought Albert should be moved for his safety and that of Joan.

5.3.57 SW6 says she spoke with both RN1 and AD1 about contacting the police. SW6 says she advised them that they needed to do this as they had the information and facts. SW6 felt if they informed the police this would be third hand information. SW6 says AD1 dismissed this and told SW6 that in her line of work she was aware that the police would not do anything with this as no crime had been committed and she did not want to see her father as a criminal.

5.3.58 SW6 says they told AD1 they were from the emergency team and that Albert would have to be assessed first. SW6 was aware of the threat by Albert to harm himself and Joan. SW6 says they asked AD1 if someone could stay with Albert until ASC could sort something out. AD1 said this was not possible because of her work commitments. RN1 says she was told a joint visit would be carried out within a few hours and that ASC would assess the safety of Albert and Joan and would also consider regular checks at address one. ASC arranged for two welfare visits to be made during the night. RN1 liaised with her senior sister to inform them of the situation.

5.3.59 The Panel asked the LCFT panel member if it would be usual practice for a District Nurse such as RN1 to discuss their contact with ASC with their line manager before contacting them, as well as after such contact. The LCFT panel member has confirmed that a District Nurse is an autonomous practitioner and would not need to contact the senior nursing team lead prior to speaking to ASC. District nurses frequently refer cases to safeguarding and it is a routine part of their job. RN1

spoke to the senior sister after her contact to keep them updated on the case and the plan of action as would be expected of them. Patients do not always see the same District Nurse so it was important for RN1 to share this information regarding the action plan.

5.3.60 Following their conversation with RN1 and AD1, SW6 says they spoke by telephone to AN as they wanted a member of the family to be present when SW2 made a visit to address one later that day. SW6 says they told AN about the knife being found and that as a result of the previous threat being made by Albert an assessment was needed.

18.00

5.3.61 At this time SW2 came on duty and say they received a handover from SW6. A visit had been arranged by SW6 for SW2 to attend address one. This was made as a result of the telephone call from RN1 and AD1 to SW6 regarding the knife having been found.

21.30

5.3.62 SW2 visited address one and spoke with Albert away from Joan who was with AS in the kitchen. AN and her husband were present while SW2 spoke to Albert. SW2 says Albert presented as a frail elderly man who clearly had mobility issues. Albert told SW2 that Joan did not do what he asked. When SW2 mentioned the knife that had been found Albert said words to the effect of *'that was a stupid thing to do, I don't know why I did that. I don't want to harm my wife'.*

5.3.63 AN recalls the conversation SW2 had with Albert and also states that Albert said *'if I stab her then I'll go to prison where I'll get looked after'*. Albert told SW2 he wanted some residential care for himself. By this stage Albert's position on that matter had changed; from one of not wanting to be separated from Joan, to a position of willingness to accept short term residential care. SW2 explained this arrangement could not be sorted out that night and that it would need to be looked into.

5.3.64 SW2 then went into the kitchen and spoke with Joan and AS. SW2 explained to them that extra welfare visits had been arranged for that night and a follow up would be made in relation to residential care. SW2 says Joan appeared content with the situation, did not make any mention of threats and was happy to stay in the house. SW2 says Joan and AS then showed him a small paring or fruit knife which they said was the one found in the bedroom. This was then placed on top of a cupboard so as to be out of Albert's reach. SW2 then left Joan and Albert with the emergency telephone number for ASC in case they needed anything else. SW2 then arranged with Crisis Home Care for their workers to carry out two additional visits during the night at 01.30 and 05.30hrs.

Tuesday 7th April 2015

AM

5.3.65 Before the end of their shift that morning SW2 made a handover telephone call to SW3. SW2 says they explained to SW3 the urgency of the case and the need for an urgent follow up regarding residential care for Albert. SW2 says they also told SW3

that whoever was dealing with the matter could ring SW2 within the next hour as they needed to go to bed.

09.05

5.3.66 Examination of the log sheet from the Home Care Plan for this date disclosed an entry made by H3 which read;

'(Albert) want to kill her and himself'

This threat was not reported to the HCFY offices.

10.45

5.3.67 Following the telephone call from SW2, SW3 said they discussed the case with SW4 who allocated the case to SW5, the duty social worker that day. SW5 rang address one and spoke to Joan by telephone and discussed the issues that had arisen over the previous few days.

5.3.68 SW5 say they asked Joan three times if everything was alright. On each occasion she said that everything was alright. SW5 then spoke to Albert and had to shout because of his deafness. SW5 asked him if he was aware the emergency duty team had visited and Albert said he was. Albert agreed they had talked to him about residential care and SW5 explained they would get a review brought forward. SW5 said they would try and get this done before the end of the week. SW5 say they were happy that Albert and Joan knew what was going on and neither of them voiced any concerns to SW5.

5.3.69 SW5 left a message for AD1 and also contacted HCFY to see if they had any concerns. SW5 was told by HCFY that Albert could be rude to Joan, however HCFY were content to continue to go into address one until the review was undertaken. SW5 then went and explained to SW4 what they had done. SW5 believes SW4 then made arrangements for a review to be carried out. SW3 sent an e mail to the Reablement Team requesting an urgent joint review.

5.3.70 SW5 says some people thought Albert was suffering from mental illness. SW5 did not believe that was the case and instead believed he had not been looking after himself and taking his medication properly before being admitted to hospital. SW5 says Albert was also profoundly deaf and that may have given the appearance to some people that he had mental health issues. Although SW5 did not see the couple on this occasion they did have previous experience of Albert and Joan.

AM

5.3.71 At some point the same day Thursday 07.04.2015 the district nurse RN1 contacted the social work team to establish what action had occurred. This was because she remained concerned regarding the disclosure about the knife. She was informed that no record of a visit could be seen on the system.

5.3.72 The call was passed to SW5 who told RN1 a meeting was to be held the next day to discuss short term residential care. RN1 reiterated the safeguarding issues and the possible need for a mental health act assessment and asked if Albert had been visited the previous evening. She was told that social workers had made a visit at 21.45hrs.

5.3.73 RN1 then asked SW5 what the plan was for Albert because of the risk identified. The version of events given by SW5 and by RN1 are at variance from this point onwards. It appears a disagreement then ensued over a belief by SW5 that RN1 was challenging their judgment. The panel made a decision that it was not within its remit to analyse or comment on the language or behaviour of either SW5 or RN1, save to say that it was not conducive to good communication.

5.3.74 The record made on SWIFT in respect of this telephone call was subsequently altered and was part of an investigation by BWDC. The alteration to the SWIFT record has no material bearing on the matters under review within this DHR. The key issue for the panel was not the fact the record was altered, rather a disagreement took place because RN1 asked questions in relation to the risk that Joan faced.

Wednesday 8th April 2015

Unknown time

5.3.75 SW5 contacted the manager of HCFY and informed them ASC were looking into the possibility of offering Albert a short term residential respite service. The same day the financial assessment on Albert was completed by a BwDC finance officer. The note concerning this indicates Albert did not want Joan present when discussing money and he said she kept *'listening at the door'*. The same day the SWIFT record shows that a joint review was arranged with RW2 for 13.00hrs on Thursday 09.04.2015.

20.30

5.3.76 H4 is employed as a care assistant with HCFY. H4 visited Albert and Joan most weekday evenings. They thought that Albert had dementia as Joan had told H4 this when they first visited. H4 checked the care plan for Albert and his condition was documented as *'confusion'*. H4 believed Albert had the symptoms of dementia as he forgot a lot of things. H4 based this belief on their experience of working with dementia sufferers. H4 has undertaken dementia training and holds a dementia certificate. The panel recognised this was H4's view based upon their experience. At that time there was no documented diagnosis that Albert suffered from dementia. As will be seen later Albert was screened for dementia on 28.10.2014 with a negative result. This was five months before the homicide.

5.3.77 During their visits to Albert and Joan H4 recalls that Albert said a number of times that he wanted to die and would scream loudly so as to give himself a heart attack. H4 say they reported these conversations to their supervisor[6]. During one conversation Albert also told H4 that Joan was seeing a man downstairs. H4 spoke to Joan about these conversations. Joan told H4 that Albert was always saying these things and to ignore him.

5.3.78 When H4 visited on the evening of 08.04.2015 Albert said he had not had a good day. He again told H4 that he felt like shouting hard to give himself a heart attack. Albert had turned the TV off while Joan had been watching it because he could not hear it. This had upset Joan because she had been watching a programme she

[6] Although H4 said they reported the threats she heard to the HCFY office, and named a supervisor, that supervisor had left the organisation by the date H4 says they told her.

liked. Joan told H4 she was upset and said she was going to have an early night as Albert said he would not put the TV on. When H4 left address one everything seemed normal. Albert was sat sitting in a chair in the lounge and Joan was sat in the kitchen.

21.30

5.3.79 About this time AD1 telephoned Joan to see how things were. Joan told AD1 that Albert was getting worse. Joan said *'I can't stay on the phone for too long, he's getting worse. He's asleep in the chair but he's getting worse'*. AD1 said Joan sounded very worried, weary and not herself. That was the last conversation AD1 had with Joan.

Thursday 9th April 2015

09.00 (Approx.)

5.3.80 As H3 arrived at address one a community rehabilitation assistant from LCFT made a telephone call to the address to confirm a grab rail had been fitted. They spoke to Albert and H3 on the telephone. A few moments after the call ended Albert said to H3 *'I've killed her'*. H3 told Albert not to say things like that to which Albert said *'I'm not joking. I'm being serious'*. After consulting with their office by telephone H3 entered the bedroom at address one and saw Joan's body on the floor. Lancashire Constabulary received a 999 call from H3 at 09.05 hrs and officers attended with an ambulance a few minutes later.

09.30

5.5.81 Joan was pronounced dead by the attending ambulance crew. Albert was arrested on suspicion of murdering Joan and taken into custody. On this occasion a safeguarding alert was made on form SA1 and added to SWIFT.

Subsequent Events

5.5.82 While in custody Albert made a number of verbal admissions to various police officers and staff that he had killed Joan. He did not make any replies when he was later interviewed by the police.

5.5.83 Albert was remanded to prison and then admitted to hospital. On 11.04.2015 Albert was seen by a clinical nurse specialist. A CT scan of his brain showed 'age-related brain atrophy (wasting) and periventricular white matter ischaemic changes'. A mini-mental state examination (MMSE - a screening test for dementia) showed a score of 22/30 indicating mild cognitive impairment. The nurse was unable to confirm or deny a cognitive problem.

5.5.84 On 24.06.2015 a Consultant Forensic Psychiatrist instructed by the Crown Prosecution Service visited Albert and prepared a report addressing his fitness to plead. In their report the Psychiatrist states it is possible that some of the mental symptoms in the weeks prior to the homicide were the result of depressive episode. However, given the progressive cognitive decline that was noted since Albert's arrest, the likeliest diagnosis in these circumstances is of moderate to severe dementia.

5.5.85 In the opinion of the Psychiatrist, Albert was suffering from an age related dementing condition probably complicated by cerebro-vascular disease. He was unfit to plead. Albert died of multiple organ failure on 07.07.2015.

5.6 Dr Benbow's Opinion

5.6.1 This appears at paragraph 6.1.16.

6. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

6.1 How did your agency identify and assess any domestic abuse risk indicators, including any threats to kill or harm Joan or others, and what risk assessment[s] were undertaken?

6.1.1 While the risk of domestic abuse was the key issue for the panel, they also felt it was important to consider opportunities to identify whether Albert's changing behaviour was linked to his mental state. This was because they felt this may have influenced the way that he behaved towards Joan. In particular the panel felt it was important to consider opportunities to assess Albert for dementia.

6.1.2 The panel took into account that patterns of behaviour, such as confusion, may have causes other than dementia (for example a urinary infection). The panel carefully considered every occasion when they felt there was an opportunity to assess the possibility Albert had either dementia or that he presented a risk of harm to either himself, Joan or others. To assist the reader these are set out in a table at Appendix D.

6.1.3 The couple's family, who probably knew as much as any agencies did about their personal relationships, say Albert and Joan were happy and cared for each other. They appear to have been mobile until the last year or so of their lives and to have enjoyed socialising together. There was not a known history of domestic abuse between the couple. Only Lancashire Constabulary held any relevant information that might have indicated domestic abuse.

6.1.4 The first of piece of information concerned a visit they made to address one on 21.01.2003 to a report of a couple arguing. It was classified as a domestic incident and both parties were said to be safe and well. There was no sign of a disturbance, no injuries and no allegations. The second event on 16.04.2013 occurred when Joan rang the police after Albert refused to go out and buy some drink. Joan was said to be heavily in drink. The panel agreed that the decision not to record these as domestic incidents was reasonable.

6.1.5 With the exception of these two incidents nothing came to the attention of agencies, or was there to have been discovered by them, to indicate there was domestic abuse or any risks to Joan until Wednesday 01.04.2015. In the intervening period, while Joan and Albert's health had been in decline, neither of them behaved in a way that should have raised concerns about domestic abuse.

6.1.6 Albert was screened for Dementia on 28.10.2014 with a negative result. He then appeared to become more confused which led to his admission to hospital. A risk assessment carried out by the hospital discharge team on 11.03.2015 did not identify any risks to himself, carers or others. Neither did a second assessment on 26.03.2015. The panel are satisfied that, while there was a rise in the risk score, this related to a risk of him falling as opposed to him causing harm to others.

6.1.7 The threats made by Albert towards Joan on 01.04.2015 in the presence of RW1, H1 and H2 were the first opportunities for agencies to identify there was a risk of harm. The panel felt the failure by ASC to record risk on that occasion was a missed opportunity. While those risks were identified and reported by RW1, H1 and H2 they were not recorded nor managed by ASC for the reasons set out at paragraph 5.1 et al. In particular an adult safeguarding alert was not raised.

6.1.8 The next opportunity to consider threat and risk occurred when AN rang ASC and spoke to SW2 on Thursday 02.04.2015. On this occasion Albert had made a clear threat in the presence of AN saying he wanted to die and would stab Joan first. Again the panel felt this was another significant event in the chain and should have been followed up with the completion of a risk assessment by someone within ASC and a safeguarding alert recorded. While the threats Albert made related to himself and Joan, the panel felt there was also a need to consider whether others, such as carers and family, who were going into address one were at risk. The panel also felt this was a missed opportunity to contact Lancashire Constabulary and seek advice.

6.1.9 H3 also says that during some of the early visits they made to Albert they heard him say that he was going to kill her (meaning Joan) and then kill himself. H3 says that everything that happened was recorded in a care plan book. However there is no record within the HCFY chronology or IMR to indicate H3 informed HCFY management of these threats. The HCFY panel representative states there is no record within their agency documentation that H3 ever reported these threats.

6.1.10 While nothing further had reported to suggest Albert had said or done anything that increased the risk he presented, the fact that no mitigating actions had been put in place in the intervening period meant the threat he presented was still there the following day when SW2 spoke to RA1. The conversation between the two professionals occurred primarily because SW2 was seeking a rehabilitation assessment for Albert. However it was another opportunity to identify and discuss risk. RA1 seems to have recognised the potentially serious nature of what SW2 disclosed to them as RA1 then initiated a call to Joan to establish the facts.

6.1.11 The visit by the OOH GP2 to see Albert on 03.04.2015 was the next event which presented an opportunity to identify and assess ay threats. However for a variety of reasons the important "threats to kill" information remained unknown to GP2 which prevented them identifying and assessing risk of domestic abuse. The reasons for this are discussed more fully at section 6.2.

6.1.12 The next occasion when risk was identified was when SW2 visited address one on Easter Monday 06.04.2015 following a call from RN1. This was made because RN1 had been made aware by AD1 of a threat Albert had made that he would stab Joan. The panel believe that the presence of a knife under Albert's chair significantly increased the level of that risk. They believe Albert's threat demonstrated he was motivated and the fact he was keeping a knife under his chair was evidence of a preparatory act. The attendance of SW2 at address one later that night was an opportunity to assess that risk and put steps in place to reduce the risk. The panel also felt there was a missed opportunity that night to contact Lancashire Constabulary and seek advice.

6.1.13 SW2 appears to have recognised that there was a risk. This is demonstrated both by the fact that while he was with AS and Joan the knife that was found was placed on top of a cupboard, and also because SW2 then made a call to SW3 to alert them

to the urgency of the case. This demonstrates that SW2 recognised that what they were dealing with was potentially serious. However an opportunity was missed to formally record an assessment of risk, who was at risk and what actions needed to be taken to reduce or remove the risk. The panel also felt this was a further missed opportunity to contact Lancashire Constabulary and seek advice.

6.1.14 The panel felt that, although there was a paucity of documentation about the risk following SW2's visit, SW2 provided sufficient information to SW3 to then allow the matter to be escalated within ASC. While SW5 telephoned Joan on the morning of Tuesday 07.04.2015 the fact that they made a telephone call, and not a personal visit to address one, indicated to the panel that they failed to understand how serious the risk was that Joan may come to harm.

6.1.15 The panel believe RN1 did recognise the nature of the risk that Albert presented and this is demonstrated by the fact they made a telephone call to ASC and spoke to SW5 later on the morning of Tuesday 07.04.2015. This was a key opportunity for two professionals to consider the risks Albert presented to himself, Joan and others. Instead the discussion became clouded by what appears to have been a professional dispute between the two. Another opportunity was lost to consider and assess that risk and to put actions in place to mitigate it.

6.1.16 Dr Benbow notes, "Albert's score on the MMSE on 11.4.2015 does not suggest that he had a moderate or severe dementia at that time. If he had dementia at all (which is arguable) then it was only mild around the time of his wife's death. It may have been that his cognitive impairment was secondary to physical illness, which would explain his rapid deterioration…"

6.1.17 In summary the panel felt there were a number of missed opportunities for agencies to manage the risks of domestic abuse and put actions in place to remove or minimise the risk. These opportunities are clearly identified and summarised at Appendix D. The following paragraphs provide further analysis of those opportunities and the panel's findings in relation to the actions of the agencies.

6.2 How did your agency manage those risks and how did it respond to any new information which may have impacted on the risks?

6.2.1 The two risk assessments carried out in relation to Albert on 11.03.2015 and 26.03.2015 contained a specific section which considered the risk to others (see Appendix C). No such risk was identified and while there was a rise in the risk score this was because of a concern that Albert might fall. Until Albert made the threat to kill himself and Joan on Wednesday 01.04.2015 Albert's behaviour towards others did not give cause for concern. The panel therefore carefully considered how agencies managed risk on that date and after. They concluded there were several missed opportunities.

6.2.2 Only one set of notes in relation to the threats Albert made to kill Joan on 01.04.2015 were made. These were completed by the Reablement team. They were kept as a typed A4 sheet attached to a paper file held within the Reablement team. Although this note was made by Reablement team, they would not be expected to update the risk assessment; this should have been done by a social worker. A note is recorded on SWIFT regarding this incident. It contains information about RW1 telephoning the ASC office. The action of making this note was correct. However it does not match the version of events held on the

Reablement file and omits any reference to Albert making threats to kill. Instead the SWIFT note states Albert was in a low mood. The DHR were informed by the panel member for ASC that improvements have already been made to the way in which records are now kept so as to avoid such failings in the future[7].

6.2.3 No action was taken within ASC to respond to, or manage the risks that had been raised by RW1, H1 and H2. While two risk assessments (known as risk profiles within ASC) had been completed on 11.03.2015 and 26.03.2015 these were not updated to reflect this increase in risk (identified on 01.04.2015). As the SWIFT note was the primary source of information for anyone who needed to consider the risk Albert posed the omission of the information about his threats was a lapse. The report considers the issue of record keeping further at paragraph 6.4 post.

6.2.4 Because of these lapses, when SW2 later received information from the family on 02.04.15, SW2 was most probably unaware of the fact that the risk Albert presented had changed from that last recorded on 26.03.2015. The SWIFT record relating to the conversation with the family on 02.04.2015 simply refers to Albert being 'verbally threatening'. Because the risk on 01.04.2015 was understated the two pieces of information could not be matched together to identify the continuing risk presented by Albert. The failure of SW2 to submit a safeguarding alert (form SA1) in response to this new information from the family was an omission that compounded the failure to record the rise in risk on 01.04.2015.

6.2.5 When SW2 then made a telephone call to the Rapid Assessment Team (RAT) on 03.04.2015 it appears from the conversation with RA1 they were aware a threat to stab had been made. It is not clear whether SW2 gained that information when they spoke to the family the previous day (paragraph 6.2.6) or whether they had come into possession of it in the intervening period. Perhaps while in conversation with another member of staff. If they came by this information from the family on 02.04.2015 and did not record it on SWIFT this was an omission to document and assess an increase in risk.

6.2.6 Certainly when SW2 had the conversation with RA1 at 10.00hrs on 03.04.2015 they had the information about a threat to stab because they told RA1 who recalls the conversation. While SW2 requested rehabilitation for Albert there is no indication what part that formed of any overall plan to deal with the risk Albert presented.

6.2.7 Despite the fact the SWIFT records did not document the nature and extent of the risk Albert now posed it seems that SW6 was aware there was a need for action. This is because they told RA1 that the situation was being assessed and that measures were being taken to increase visits. SW6 therefore also had an opportunity to document risk and contribute to the development of a plan.

6.2.8 RA1 clearly did recognise there was a change in risk because they rang ASC back to follow up the information they received earlier from SW2. The response SW6 provided to RA1 was not adequate; there was no clear plan and no agreement as to who should have ownership for managing the risk Albert presented. When considering why SW6 did not respond adequately recognition should be given to

[7] A change has been made so as to ensure any critical incidents are recorded on a 'word' document and linked with the relevant social worker or team. This change was put in place immediately after this incident. The roll out of a new computerised system will make this more robust.

the fact it was a bank holiday and demand was high. This may be why RA1 felt SW6 appeared 'rushed' when the conversation took place between them.

6.2.9 During the call that RA1 made to the East Lancashire Medical Service OOH service they outlined the threat Albert had made to stab himself and his wife and requested a GP visit Albert. The supervisor who took the call directed RA1 straight to a call taker who took details. The supervisor did not make a record of the call, working on the reasonable assumption the call handler would take all details.

6.2.10 While RA1 provided the clinical information and background details required, they did not outline to the call handler- as they did to the supervisor - the exact nature of the threats that had been made. The case was recorded on the OOH computer system (Adastra) and instead showed *"Change in behaviour, making threatening remarks about him and wife"*.

6.2.11 While the panel agreed the actions of the supervisor were reasonable, and were done for the right reasons, they felt there was a lesson here. That is, had RA1 followed the correct procedure of ringing 111 there would only have been one conversation. That would have been between RA1 and the call taker, and it is likely the important information about the threat would have been captured in that one call.

6.2.12 Instead there were two conversations, one between RA1 and the supervisor and one between RA1 and the call taker. The panel felt that in speaking directly to the supervisor RA1's intention was to try and get the urgency for a GP visit across. However that increased the possibility that different information was given to the two different recipients of the call from RA1.

6.2.13 The triaging GP1 in the OOH service spoke to Joan by telephone. While Joan disclosed that Albert wasn't eating and was being "contrary" Joan did not volunteer any information about threats. GP1 could have asked Joan for more information about the nature of the threats and recognised the possibility of domestic abuse being present even if they did not know a weapon was involved.

6.2.14 When the attending GP (GP2) made a visit to address one it seems they had read GP1's notes but not the note made by the call taker about threatening remarks. While GP2 spoke to Albert and Joan there was no discussion about threats. Although Joan said Albert was always shouting there was no exploration by GP2 of the potential for domestic abuse. Instead GP2 made a diagnosis of *"? depression"*[8] and advised Joan to contact their own GP for a review as Albert may need antidepressants.

6.2.15 There were a number of reasons why the opportunity available to ELMS staff to identify, assess and respond to risk was lost. The primary reason was that the initial call from RA1 that included threats to stab was not documented. There would have been an opportunity to recover this position had GP1 been able to speak to RA1. That did not happen because the first telephone calls GP1 made failed to connect and GP1 dialled an incorrect number on the second occasion. That failure to exchange information would not have been so critical had GP1 then asked Joan about the nature of the threats Albert made. GP1 does not know why he did not

[8] Depression is a common metal disorder: www.mentalhealth.org.uk

ask her about that. It should be noted these events happened on a bank holiday; a very busy period for the OOH GP service. Finally, because GP2 did not read the notes made by the call taker they were not aware of the threats.

6.2.16 There was also a lost opportunity to identify and assess risk by the GP practice where Albert and Joan were registered. While the practice received a faxed copy of the OOH visit by GP2 it did not contain the vital information from the call handler about threats. It does not appear the GP practice did anything with the information they did receive. While the practice would not have been aware of the threats there was other information within the fax that was relevant. For example comments made by Joan that there was something wrong with Albert, that he was always in a bad mood and shouting at the carer. This information could have triggered enquiry by the GP practice. The fact it did not was another example of a lost opportunity to identify and assess the risk of domestic abuse.

6.2.17 The next lapse in identifying and responding to risk was on Easter Monday, 06.04.2015 when RN1 informed ASC about the information that Albert had made threats and a knife had been found under his chair. It is clear that RN1 acted correctly in raising their concerns. Albert's daughter and the ASC worker discussed whether the police should be told and his daughter felt that the ASC worker should have taken responsibility for whether to involve the police and not left it to her to decide. The DHR Panel felt this was a reasonable point. As a result of that information being fed into ASC SW2 was sent to address one. The panel believe their response to that information, of arranging for additional night visits, reflected a belief that Albert presented a degree of risk. He had assured SW2 he didn't mean to do any harm to Joan. The panel agree that, based on Albert's presentation to SW2-being a cared for frail and unwell elderly man, professionals did not consider he posed a threat in the same way a younger more able person would have.

6.2.18 The presence of a weapon coupled to the threats Albert made that day and on earlier occasions represented a significant increase in risk. Steps should have been taken to ensure that risk was removed or reduced to an acceptable level which protected Joan, Albert and anyone else in address one. The panel believe SW2 simply accepted Albert's assurance that he could not be physically aggressive or stab anyone. The panel believe that SW2 may also have not recognised that the perpetrators of domestic abuse can often minimise their actions and the victims their fears. Additionally, the Panel believed, through professional experience, that victims very often simply do not understand that they are at risk and therefore their views, while being listened to, should be treated with caution. The panel believe a lesson from this event is that assumptions should not be made when assessing risk.

6.2.19 The panel carefully considered the actions SW2 took that night of arranging additional checks on Albert and Joan. The panel avoided applying hindsight and based their views upon the levels of risk SW2 seems to have perceived as opposed to what they probably were. The panel concluded the actions of SW2 in arranging for additional checks were proportionate. Although they would have benefitted from additional controls to ensure Joan's safety. These extra measures could have included arranging for a sitter to be in the house; the physical separation of Albert from Joan and reporting the matter to the police.

6.2.20 Once day time services were in place the following day, SW2 and SW6 did not raise an SA1 safeguarding alert. While SW2 discussed priority with SW3 they did not raise this separately with the Safeguarding Team, which breached ASC Policy. By

this stage the family (Joan, AN, AD1 & Albert) had expressed a wish for Albert to be provided with alternate accommodation. The panel therefore believe that on this occasion SW2's and SW6 response was not proportionate and hence somewhat inadequate.

6.2.21 In making the call to SW3 before they went off duty the following morning 07.04.2015 the panel believe SW2 recognised there was a risk and that more needed to be done. However in the chain of events that then followed, involving SW3, SW4 and SW5, it is not clear what the plan was for manging that risk. At no point did SW3, SW4 or SW5 raise a SA1 with the Safeguarding Team[9]. The panel felt the actions of SW5 in making a telephone call to Joan and accepting her assurances that she would *'keep out of his way'* was not an appropriate way to manage the risk Albert now presented. Again the panel reflected on the fact that it is well documented that family members and victims can often minimise, or simply not understand, events and the abuse they suffer[10]. This can lead to professionals simply accepting what they are told instead being inquisitive. The panel consider this is what may have happened on this occasion.

6.2.22 When RN1 rang ASC on the morning of Tuesday 07.04.2015 and spoke to SW5 it is clear they had concerns and wanted to know what the plan was for managing the risk Albert presented. RN1 thought the case was already open to safeguarding and that she was raising an additional alert and did not need to submit an SA1. RN should have followed policy by ringing through the alert as she did and then submitting an SA1.

6.2.23 The panel has not probed the details of the language that was used nor of the nature of the disagreement between RN1 and SW5. They believe the discussion became clouded by what appears to have been a professional dispute between the two. However the panel is very concerned that what SW5 did not appear to recognise during their conversation with RN1 was that there was an opportunity to assess and agree risk and to develop a plan to manage it that should have involved, amongst others, District Nursing. The fact SW5 acted in the way they did, and RN1 did not submit an SA1, allowed an important opportunity to assess and manage risk to be lost.

6.3 What services did your agency provide for Joan and Albert in relation to the identified levels of risk and were they timely, proportionate and 'fit for purpose'?

6.3.1 This review has focussed upon the risks of domestic abuse that Albert presented to Joan, how agencies identified, assessed and responded to those risks and what services they provided in relation to those risks. Albert and Joan had complex health and social care needs and a number of agencies provided services to them over the relevant period of this review. While some agencies have provided assurances that those services were fit for purpose the review has not analysed or tested the quality of the health and social care services that were provided except

[9] ASC Policy is that other teams discuss and raise SA1s with the Safeguarding Team

[10] Domestic Violence London: A resource for health professionals*; 'health professionals should also be mindful that some victims may be minimising violence as a coping mechanism. If in doubt assume that the risk posed are more serious rather than less serious'.*

in so far as they touch upon the identification and management of the risk of domestic abuse.

6.3.2 There were shortcomings in relation to the services provided by ASC in response to the threats that Albert made to harm Joan and himself. ASC have clear policies and procedures for identifying and responding to risk and on occasions these were not followed. The panel therefore does not believe that some of the services provided by ASC in relation to the identification and management of the risk of domestic abuse were adequate and, for the reasons outlined in sections 6.1 and 6.2, were not fit for purpose[11].

6.3.3 While there were shortcomings in the services provided by ASC the panel also believes the services of some other agencies fell below multi-agency expectations. The panel felt that, while ASC should have taken the lead in respect of managing the risks Albert presented, there appeared to be an over expectation within some agencies that all actions would be taken by ASC. An example of this was H1-H4, who were employed by HCFY. From the chronology and statements made available to the panel it seems they identified additional risks and needs for Albert and Joan. There is no evidence they referred them to their managers to refer them to statutory services. Additionally, the couple's family told ASC they felt he should be placed in short term residential care. See paragraph 6.5.11 for details.

6.3.4 Whilst risk at the time of discharge was not about domestic abuse, there was risk to the wellbeing of Albert and Joan. While the ELHT chronology does not give sufficient detail, on the aspect of wellbeing from what is available it appears that not all identified need at discharge had been met.

6.3.5 The LCFT IMR author identifies their staff did not pass information they held to HCFY who regularly attended to Albert and Joan. This should have occurred and the author states there was an assumption made that ASC would liaise with HCFY.

6.3.6 While the HCFY IMR author states all their safeguarding policies were followed and risk assessments updated, there is no record of the comments Albert made to H3 that he would kill Joan and himself. HCFY state that all staff were contacted and instructed to let the office know of any further issues or concerns. H3 says *'everything was recorded in the care plan book'*. The comments made to H3 were either not communicated to the HCFY office or, if they were, they were then not raised as a safeguarding issue on a form SA1 by staff from HCFY.

6.3.7 Neither the medical practice where Albert and Joan were registered, nor the ELMS OOH GP service provided any services specifically in relation to the identified levels of risk. This is because neither agency identified there was a risk of domestic abuse. However, for the reasons set out below, both agencies had opportunities to identify and respond to risk that they did not explore. The DHR panel therefore believe that processes for information sharing and receipt of information and/or assessment where not robust.

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[11] For example, the family (Joan on 30.03.15 & 07.04.15; AN on 02.04.15; AD1 on 06.04.15; and Albert on 06.04.15) & RN1 (06.04.15 & 07.04.15) requested that Albert be placed in a residential home for his health and safety and Joan's safety – this service to reduce risk was never provided by ASC. SW2 & SW6 assured family (AD1 & AN) and RA1 on 04.04.15 that additional care visits and referral to services were being made but no evidence, besides two welfare visits, that any action (service provided) was really taken to reduce risk.

6.3.8 The details of the initial call including threats to stab were not documented in the OOH call centre. This was because when RA1 held the second conversation with the call handler, they did not repeat to the letter all the information they gave in the earlier conversation they held with the supervisor. GP1 was not able to speak to RA1 to clarify what they knew because information about their mobile phone reception was not passed on. GP1 then misdialled the telephone number. GP1 did not inquire about Albert's threatening remarks. GP2 did not then read the call handler's note about threatening remarks before visiting address one. The information recorded by the call handler was not included in the notification sent to the medical practice. The medical practice then took no action in relation to the information received from the OOH service. Finally the GP IMR author states there does not appear to have been formal multi-disciplinary meetings or a lead clinician. Given the co-morbidities of both AV and AP it may have been helpful for one designated individual to have oversight of the case.

6.3.9 On 03.04.2015 (see paragraph 5.3.23) SW2 made a telephone call to RAT requesting additional services to aid rehabilitation at home. This request was overtaken by RA1's view that Albert needed mental health and GP assessment as soon as possible. Given Albert had not complied with RAT services so far, he was discharged from their service on 04.04.15.

6.4 How effective was inter-agency information sharing and cooperation in response to Joan and Albert and was information shared with those agencies who needed it?

6.4.1 While RW1 from the Reablement Team and H1 and H2 from HCFY followed their agencies policies and informed ASC of their safeguarding concerns there was a breakdown in communication within ASC. Key information that would have helped identify and respond to risk was either not recorded or was recorded in the wrong place. For example on 01.04.2015 there was a comprehensive note made within the Reablement team files that outlined the threats made by Albert to Joan. However this did not match the SWIFT record that contained nothing about the nature of the threat. SWIFT is the primary source of information and consequently the events of 01.04.2015 were not available to share amongst other staff in ASC nor with other agencies.

6.4.2 The panel explored with the ASC Panel member why the SA1 safeguarding alert was not made. SW1 was not the duty social worker that day and took the call on their behalf. It seems SW1 assumed that an SA1 had been received and did not recognise the need to check this was the case. The panel believe this was an oversight on the part of SW1.

6.4.3 There were further examples of poor information recording within ASC for example on 02.04.2015 and on 06.04.2015 in relation to threats and the discovery of the knife. The fact safeguarding alert forms SA1 were not completed on these occasions, and the risk assessment for Albert revisited, meant that other agencies did not have all the information they needed. For example when SW2 spoke to RA1 on 03.04.2015 this was the first occasion that LCFT staff were made aware that Albert had become angry and frustrated and that he had made a threat to harm Joan and himself.

6.4.4 As outlined at paragraph 6.3.4 LCFT staff did not pass on information they held to staff working within HCFY. H3 witnessed threats from Albert and states that all relevant information was recorded in a care plan book. It does not appear that information held in that book was shared with LCFT either. There is also no record that LCFT staff contacted the GP practice to discuss whether Albert's assessment had been progressed. This would have been an option particularly if they were concerned regarding the follow up from the ASC duty team.

6.4.5 The disagreement between SW5 and RN1 on 07.04.2015 was an example of poor inter-agency working. Whatever language or accusations were made it is clear that RN1 had every right to ask questions about what was being done to manage the risks presented by Albert. What should have been routine and acceptable professional curiosity became translated into a disagreement that then diverted attention away from the issue of managing risk. This was a breakdown in inter-agency cooperation.

6.4.6 Other agencies also failed in the way in which they recorded, handled and shared information. The GP IMR author believes there does not appear to have been formal multi-disciplinary meetings or a lead clinician. They state that, given the co-morbidities of both Albert and Joan it may have been helpful for one designated individual to have oversight of the case. Although a large number of agencies were involved the IMR author believes they appeared to have worked "in silos" with important information not being communicated appropriately.

6.4.7 It is clear a number of agencies had received information about Albert's threats of violence. Other than RA1's telephone call to the OOH GP service this risk was not communicated to primary care. The GP IMR author believes not only was Joan at risk, but there may also have been a risk to clinicians visiting the home.

6.4.8 The failure to communicate information within the ELMS OOH GP service has already been outlined in section 6.3. However the panel believe the most significant failure in relation to the sharing of information and interagency working was that no services made contact with Lancashire Constabulary to report the crime of making a threat to kill.

6.4.9 When AD1 spoke to SW6 on 06.04.2015, AD1 states SW6 specifically asked her if she had contacted the police. AD1 said she had not as she did not feel it was a police matter. This was the only instance the panel found that consideration had been given to contacting the police.

6.4.10 The actions of Albert in making threats to Joan were, by definition, both an example of domestic abuse and of a threat to kill. The latter is a serious criminal matter. When the threats Albert made moved to a position in which he obtained the means to carry them out (i.e. he acquired and hid the knife) the panel believe there should have been a referral to Lancashire Constabulary.

6.4.11 In reaching this conclusion the panel gave careful consideration to the role and powers of the police and sought guidance from the panel member from Lancashire Constabulary. The panel recognises there will be many occasions when professionals have direct or indirect knowledge about threats made by one person against another. The panel understand that it would simply not be practical to expect that on every occasion threats are made they are reported to and then investigated by the police. Simply 'shunting' all such cases to the police would run

counter to the ethos of inter-agency cooperation and working. It is therefore important that professionals are able to understand the information they receive and judge the nature of the risk that might be present.

6.4.12 The challenge for professionals dealing with cases such as this is to distinguish between threats or comments made out of frustration, from those which contain evidence of intent. In this case there was a clear escalation towards intent when Albert acquired a knife, the means to carry out his threat, and hid it under his chair. In the view of the panel that moved this case over the threshold at which that information should have been shared with the police.

6.4.13 The panel discussed in depth the actions of ASC. While the panel have identified shortcomings in the services ASC provided they also believe there was a tendency by other agencies to over rely on ASC and assume they had all the necessary information and would take all appropriate actions. The panel believe a key lesson here is the need for greater professional curiosity; both in analysing and assessing risk and in ensuring appropriate actions have been taken to mitigate those risks.

6.4.14 While the panel believe ASC should have reported the threats Albert made to Lancashire Constabulary, they also consider that similar action could have been taken by any of the other agencies that held that information. The fact no other agency took such action or raised it as a consideration for multi-agency discussion reinforces the point that greater professional curiosity should have been exercised by all agencies involved in this case.

6.5 How did your agency ascertain the wishes and feelings of Joan and Albert about any domestic abuse and were their views taken into account when providing services or support? Did you seek the views of their families?

6.5.1 There were no direct discussions with Albert or Joan about the issue of domestic abuse. It was only after Albert made his first threat to Joan on 01.04.2015 that the possibility of domestic abuse occurred. However the issue of domestic abuse was never discussed directly with either of them.

6.5.2 Albert and Joan did express their wishes on their future to different agencies and to their family and these views changed over time. For example on 30.03.2015 Joan told a Fire service worker that she would like to consider sheltered accommodation but Albert would not accept this. On 01.04.2015 Albert told AN that he wanted to go somewhere else where he could be looked after. On 02.04.2015, and on other visits made by H3, Albert said he wanted to die. On 06.04.2015 Albert told RN1 he would like to be cared for. Later that day Albert told SW2 he wanted some residential care for himself.

6.5.3 There was a clear shift in Albert's position from not wanting to be parted from Joan to a position in which he wanted to be placed in residential care. By 01.04.2015 when agencies first became aware of Albert making a threat to Joan he had altered his position to one of wanting to be looked after. That change in position presented an opportunity to start the process of assessing Albert with a view to moving him into residential care. That step would also have been a means of protecting Joan from Albert. However it was not until 06.04.2015 that ASC started to make steps towards assessing Albert. That assessment was arranged for 09.04.2015. It did not take place because of the homicide.

6.5.4 Joan did make a number of comments to her family and staff about Albert's increasingly difficult behaviour. However it does not appear these were ever adequately probed by professionals and there were a number of missed opportunities to identify, assess and manage risk as outlined earlier in section 6.1 and 6.2.

6.5.5 There were a number of occasions when Joan's views were sought about the way she felt as a result of Albert's behaviour. When the views of Joan were sought the panel considered whether professionals made assumptions about her responses. For example it was known by professionals that Joan would stay out of Albert's way when he started making comments and would sit in the kitchen where she liked to smoke. It seemed Joan was almost 'light hearted' in the way she would respond to Albert's behaviour. On 03.04.2015 Joan was asked by SW6 if she was worried and whether Albert had threatened her. She told SW6 *'we have been married for 30 years and he's never laid a hand on me, I am not frightened of him'* and laughed.

6.5.6 When SW5 contacted Albert and Joan on 07.04.2015 this was done by telephone. SW5 states Joan was asked three times if everything was alright and agreed it was. SW5 went on to say that neither Albert nor Joan voiced any concerns. SW5 knew that SW2 had raised concerns about Albert and Joan and the need for an urgent follow up in relation to residential care yet they did not make a personal visit to address one and instead relied upon what Joan said on the telephone.

6.5.7 The panel did not feel that a telephone call was an adequate response in these circumstances. Again the panel highlighted the danger of making assumptions based upon limited information. Victims of domestic abuse can often minimise their experiences as can the perpetrators and a telephone call in which no concerns are voiced was not an adequate means of assessing risk when it was known that Albert had made threats to kill Joan and had hidden a knife.

6.5.8 The family of Albert were involved in discussions with professionals. It was the family that raised concerns with SW2 on 02.04.2015 about the verbal threats that Albert was making. It was also the family that identified to RN1 that Albert had acquired and hidden a knife. While the issue of domestic abuse was never directly discussed it is clear the family themselves recognised there was a risk of harm. Albert's daughter said she would have welcomed ASC contacting her and pointed out that she had known Joan since being seven years old and while she never lived with Joan, did view her as her mother.

6.5.9 The panel have considered whether the actions agencies took adequately addressed the families concerns. Following the concerns AD1 raised on 06.04.015 with RN1 and through them SW6, assurances were provided to the family that a visit would be made to assess the safety of Albert and Joan. This took place when SW2 visited later that day. In the meantime SW6 contacted AN to apprise them of the assessment by SW2.

6.5.10 SW2 undertook a visit to Albert and made an assessment. The knife that Albert had hidden was put on top of a cupboard so as to be out of harm's way. SW2 ensured two visits would be made during the night and the following morning took steps to raise with SW3 the need for an urgent assessment. The panel believe SW2 did not recognise the level of risk Albert presented because they wrongly assumed he was a frail elderly and sick man. Avoiding the test of hindsight the panel believe the steps SW2 took were appropriate based upon what they knew and believed at that

time. However, for the reasons set out in paragraph 6.5.6 and 6.5.7, the panel do not believe that the actions taken from that point onwards adequately addressed the concerns of the family.

6.5.11 There is no evidence that a carer's assessment was undertaken for Joan.

6.5.12 The panel believe the changing response to Albert's needs and wishes for residential care were not addressed quickly enough. Five requests were made by family members to place Albert in a short term residential setting to improve his health and safety. By Joan on 30.03.15 & 07.04.15; AN on 02.04.15; AD1 on 06.04.15; and Albert on 06.04.15. These wishes were not responded to in a timely manner.

6.6 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, including age and disabilities, when completing assessments and providing services to Joan and Albert?

6.6.1 When public bodies make decisions as to services there is a duty under the Equality Act 2010 to take into account the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different parts of the community. Among other things this duty covers age and disability and therefore the panel considered to what extent the professionals involved in this case met that duty in respect of the services delivered to Joan and Albert.

6.6.2 It appears that agencies recognised that Albert and Joan were elderly and there health and care needs were increasing. Assessments were carried out on Albert in relation to his mental health and nursing needs (28.10.2014 and 24.02.15). In addition two comprehensive overview assessments were undertaken on Albert (11.03.2015 and 26.03.2015) that covered a number of issues relevant to someone who was very elderly and infirm. These included consideration of daily living skills, social participation and inclusion, caring for others, safety and risk, ongoing support and next steps.

6.6.3 When Albert was discharged from hospital on 17.03.2015 a number of measures were put in place to support his care needs. These included an assessment by age UK and daily support from HCFY. Regular visits to address one were also made by District Nurses and by Albert and Joan's family. There were also discussions with Albert about his needs and what he wanted to achieve.

6.6.4 However it seems that the needs of Joan were less readily understood. She was also elderly and her health had suffered which affected her mobility. At the time of these events she seemed to have taken on the role of carer for Albert's needs. This should have initiated a carer's needs assessment by ASC for Joan. This did not happen and therefore her needs do not appear to have been fully understood, documented and responded to.

6.6.5 A key issue for the panel has been to consider Albert's had dementia and the relationship that might have had with domestic abuse. The opinion that Albert had dementia was given after the homicide. An assessment for dementia was made on 28.10.2014 and that was negative. However there was a significant change in Albert's behaviour from the beginning of 2015 when he became much more forgetful. Professionals did query whether Albert may have been suffering from

dementia, for example RN1 asked AD1 on 06.04.2015 whether her father had dementia. H4 believed Albert had symptoms dementia and says Joan told them Albert had this condition.

6.6.6 However other professionals did not believe Albert was suffering from any mental health problems, for example SW5 felt Albert's behaviour was due to his profound deafness. As health professionals on the panel have identified, the types of behaviours Albert displayed could have been caused by other conditions, for example a urinary infection. However it is still uncertain whether Albert had dementia.

6.6.7 Agencies did not recognise that Albert's behaviour may have been influenced by dementia. The Panel believes that action should have been taken more quickly when his behaviour turned from forgetfulness to threatening. The panel concludes that practitioners did not adequately address the issues of diversity in this case in respect of Albert's age. There seemed to be an assumption that because Albert was an elderly, ill and infirm man who was confused and forgetful he was not capable of carrying out the threats he made. Consequently the risk he presented when he made threats was not accurately assessed. That in turn led to a lack of decisive action in arranging for an assessment for residential care on 07.04.2015 that in turn would have protected Joan.

6.6.8 The panel believe this case presents opportunities to learn more about elderly people, dementia and the potential for domestic abuse. Dr Benbow's helpful report and recommendations support that view.

6.7 Were single and multi-agency domestic abuse policies and procedures followed and were any gaps identified?

6.7.1 ASC has a policy that was last updated in 05.2014. Appendix C provides a summary of that policy and the processes that should be followed when information becomes available that a person is at risk of harm. Domestic abuse is described within that policy although there is no separate process or protocol for staff to raise concerns of domestic abuse. The expectation is that when information comes to light about domestic abuse it will be dealt with as a safeguarding issue. At the time of the homicide of Joan that policy did not specifically cover the point of reporting threats to kill to the police. That learning point has now been picked up.

6.7.2 The panel believe that on a number of occasions in this case professionals from ASC did not follow the policies and procedures of their own department. These occasions have been identified and discussed earlier in this report. In 12.2015 HM Coroner for Blackburn, Hyndburn and Ribble Valley held an inquest into the death of Joan. He found BwDC failed to recognize that the threat to the life of Joan was both immediate and credible and therefore failed to prevent her from being stabbed to death. BwDBC have taken action in relation to staff employed by them.

6.7.3 The IMR author for LCFT state their agency has a Domestic Abuse Policy incorporating Forced Marriage, Honour Based Abuse and Female Genital Mutilation. The aim of the policy is to ensure the safety and protection of victims of domestic abuse, forced marriage, honour based abuse and female genital mutilation in line with statutory guidance. Staff within LCFT are encouraged to follow the National Institute of Clinical Excellence Guidance regarding Domestic Violence and Abuse (PH50).

6.7.4 On 03.04.2015 RA1 became aware from a conversation with SW2 that Albert had threatened to stab Joan. As a result RA1 made a telephone call to ELMS OOH GP service to arrange a GP assessment. However they did not follow the referral policy by making the call on the 111 system. That in turn led to information relayed to the supervisor not being recorded and passed onto GP1 and GP2.

6.7.5 On 06.04.2015 RN1 was at address one when AD1 disclosed information to them about Albert having hidden a knife. RN1 made a call to their supervisor and then ASC. RN1 thought the case was already open to safeguarding and thought she was making an additional alert to pass on information and therefore did not submit an SA1. However, RN1 should still also have completed and submitted a form SA1 safeguarding alert. It appears that neither RA1 nor RN1 recognised what they saw with Joan and Albert was domestic abuse and they did not follow their agencies own policies.

6.7.6 The HCFY IMR author states their agency was not aware of any history or suggestion of domestic abuse. They state HCFY were given the impression that the threats that were made during their assessment of Albert on 01.04.2015 were out of character for him, an isolated incident, and as a result of how he was feeling after coming out of hospital. The author states HMCFY policies around safeguarding and reporting were followed.

6.7.7 The panel accept the HCFY manager was told by SW1 that it was not necessary to submit an SA1 safeguarding alert. However the IMR and chronology provided by HCFY does not provide sufficient detail to assess their policies. The panel believe the single entry that is contained on their chronology is not sufficiently comprehensive to describe all the contacts HCFY had with Albert over the ten days they attended him.

6.7.8 For example the witness statement provided by H3 contains information that Albert told H3 when they first started visiting address one that he was going to kill Joan and then himself. While H3 states everything was documented in a care plan book there is no reference in the chronology to those events. Either H3 did not pass those concerns on or, if they did, they should have been recorded in a safeguarding alert form SA1 and referred to ASC as per multi-agency policy on safeguarding.

6.7.9 ELMS has a safeguarding Adult Policy although not a separate Domestic Violence and abuse policy[12]. The clinicians who work in the out of hours service are independent subcontractors. All practitioners are trained to respond to domestic abuse and the Safeguarding lead has undertaken further training (September 2015) and is able to advise and support staff with any arising issues. The medical practice providing GP services to Albert and Joan did not have a domestic violence policy. However the IMR author state they would follow their adult safeguarding policy and advice when anybody discloses that this has happened; in this case that would have meant telling ASC. Interestingly the author states patients are also advised to notify the police so that they are also aware of the on-going situation.

[12] Providers need to complete a self-assessment as part of their contractual responsibility. The CCG have reviewed the ELMS self-assessment and advised the safeguarding policy needs to be inclusive of domestic abuse and this should be included in the ELMS review and update of the policy.

6.7.10 Albert was discharged from hospital by ELHT on 17.03.2015 with a support package. During the time he was under the care of ELHT he was not asked if there were any potential or actual risks of abuse to himself. Joan was not asked if there were any potential or actual risks to herself during any hospital episode, either as a patient or carer. ELHT identified within their IMR that, while staff are trained in relation to domestic abuse and are in a position to respond, they do not routinely ask the question in all services. There is also material displayed throughout the Trust in relation to receiving help if a person needs support for Domestic Abuse.

6.7.11 The panel believe the key policy gap is the need for practitioners involved in cases like this is to recognise that threats to kill may comprise a criminal offence as well as domestic abuse. Having recognised this, practitioners should have understood that the threat needed to be documented and reported to the police as soon as possible. The police have the experience and training to assess and advise on whether that threat reaches the threshold for considering some form of criminal justice pathway. Alternatively the police may advise that it is dealt with in some other way. While contact is established with the police and they make an assessment, the key issue for practitioners in other agencies that are in contact with the victim and perpetrator is to ensure the risk of harm is reduced or removed.

6.7.12 The panel also felt a learning outcome that emerged is the extent to which agencies policies took account of the potential links between domestic abuse and dementia. While there is a recognition from research and previous cases that such a link exists, the panel feel that policies need to be reviewed and revised so as to ensure the possibility of dementia is specifically considered when the indicators of domestic abuse are found within elderly people's relationships.

6.8 How effective was your agency's supervision and management of practitioners who were involved with supporting Joan and Albert and did managers have effective oversight and control of the case?

6.8.1 It appears to the panel that, while supervision arrangements were in place within all the agencies that had involvement in this case, there were some lapses as set out below.

6.8.2 The IMR author for HCFY states that after concerns were raised about Albert's behaviour during their first visit, the Registered Manager contacted all the care staff who would be supporting him and made them aware of what had happened. They state that staff were told about the concerns raised by HCFY management and that they must contact the office if there were any further issues or cause for concern. Prior to the homicide of Joan HCFY state that no further concerns were raised with the office by care staff.

6.8.3 However H3 in their witness statement outlined that when first visiting Albert he said he was going to kill Joan and then himself. H3 says they did not believe Albert was serious and that everything was documented in the care plan book. H4 was also employed by HCFY and states that Albert said a number of times that he wanted to die and would scream loudly so as to give himself a heart attack. H4 says they reported these conversations to their supervisors. The HCFY panel member has checked the records their agency holds and can find no reference to H4 having reported these conversations.

6.8.4 However the panel has seen no evidence that this information was ever reported back to HCFY managers. The single line within the chronology that covers the ten day period that HCFY staff visited Albert contains no reference to either the threats Albert made or that he wanted to die.

6.8.5 In relation to LCFT the IMR author states Therapy staff and District nursing staff both consulted with senior leads within their service area when risks were identified to seek advice and support on appropriate next steps. This ensured appropriate requests were made for further assessment and information passed to colleagues to ensure follow up was progressed. However the panel recognised that after speaking verbally to ASC both RA1 and RN1 should each have completed and submitted form SA1.

6.8.6 While managers within ASC had knowledge of the case it appears they did not then maintain effective management of those whom they tasked to deal with it. The most significant failure to effectively manage this case occurred after the visit of SW2 on 06.04.2015 following the discovery that Albert had hidden a knife. The panel avoided the hindsight test and concluded that the actions of SW2 that night were adequate to protect Joan. The panel concluded the actions of SW2 in arranging for additional checks were proportionate but would have benefitted from additional controls to ensure Joan's safety. These extra measures could have included arranging for a sitter to be in the house; the physical separation of Albert from Joan and reporting the matter to the police.

6.8.7 However there was then a need for more immediate action. SW2 recognised this and brought their concerns and the need for urgent follow up to the attention of SW3 when the case was handed to them on the morning of 07.04.2015. SW2 also updated the SWIFT system. This entry included the erroneous information that a knife had been found in Albert's bedroom. The knife had been found by AD1 under a cushion on her father's chair in the living room and place in a drawer in the kitchen. This information was available to be read by staff and management within ASC. While SW2 did not undertake a risk assessment nor submit an SA1, there was sufficient information within the SWIFT entry such that an assessment of risk could have been undertake by other staff within ASC on the morning of 07.04.2015. No assessment of risk was undertaken despite SW2 making it clear that an urgent follow up was required. From the statements provided to the police and HM Coroner the following sequence of events sets out what happened within ASC on the morning of 07.04.2015.

6.8.8 SW3, who had spoken to SW2, then went and saw their manager SW4. SW3 says they told SW4 what SW2 had told them regarding the case needing following up. SW4 told SW3 they were aware of the case and that SW5 was dealing with it. SW3 then spoke to SW5 and told them SW2 had contacted them regarding Albert and Joan. SW5 told SW3 they were already dealing with the case and they would contact SW2 if they needed to. SW5 did not contact SW2 to obtain further information despite SW2 having said they would remain available for a while before going to bed. SW5 says they read the entry on SWIFT concerning a knife having been found in the bedroom.

6.8.9 SW5 says that from the note SW2 made on SWIFT concerning their visit the previous night it did not appear to SW5 that SW2 considered Albert to be a danger to himself or his wife. SW5 believed SW2 felt content to leave Albert in address one. SW5 then made the telephone call to Albert and Joan during which SW5 says

they asked Joan if everything was alright and received assurances from Joan they were alright. It does not appear that SW5 explored with Joan the issue of the knife nor any of the risks she faced and simply relied upon the fact that neither of them *'voiced any concerns to me'.* SW5 says they tried to make contact with AD1 and could not do so and left a message for them instead. SW5 also says they contacted HCFY to see if they had any concerns. SW5 says they were told by HCFY that Albert could be rude to Joan but they (HCFY) were content to go in until the review was done. SW5 says they then went and told SW4 what they had done and SW4 *'appeared content with that and had no issues'* and that as far as they were aware SW4 then went to get a review underway which SW5 believed would take place on 09.04.2015.

6.8.10 From SW2 & SW6 case notes both level of risk and action required to reduce that risk were clear. It appears that within the sequence of events at ASC on 07.04.2015 the risk Albert presented and the need for urgent action then became diluted. There is no evidence that management took any active involvement in this case such as reading the SWIFT entries, identifying what the risks were, setting staff clear actions and timescales and then assuring themselves they have been carried out. Instead there seems to have been an assumption that everything that needed doing had been done, summed up in SW5's comment that SW4 *'appeared content with that and had no issues'.* There are a number of reasons that information may have became diluted and hence the risks under stated. However it seems to the DHR Panel the underlying thread running through this case was that professionals did not believe that Albert, a frail, confused, infirm and unwell man was capable of killing his wife. Consequently, on 07.04.2015, Albert and Joan's case assumed no particular degree of priority.

6.8.11 HCFY were contacted by SW2, SW6 & SW5 over the period 02.04.15 to 07.04.15 on at least three occasions to discuss their experience with Albert. These calls would have been to the office and not direct to workers. As a result of these calls HCFY managers could have raised an SA1 safeguarding alert. The discussion between SW5 & HCFY on 07.04.15 in which it was concluded that HCFY were agreeable to carry on delivering their service until Albert was reviewed suggests there may have been a conversation about the insufficiency of the existing care package.

6.8.12 The events at address two on the evening of 08.04.15 witnessed by H4 (see paragraph 5.3.77) could have been reported by H4 to their manager at HCFY and then to ASC emergency duty team.

6.8.13 Finally, the GP Practice responsible for Albert should have reviewed the note that the out of hours GP sent to the surgery regarding their attendance at address one on 03.04.2015. It contained important information about a request to prescribe medication for depression. This should have been progressed by Albert's surgery and may then have led to a GP from that surgery visiting Albert. That visit would have presented another opportunity to take stock of what was happening with Albert and to assess any risks.

6.8.14 Paragraphs 6.8.11-6.8.14 identify how, on 07.04.2015, other agencies could have taken action. The panel also recognises that a cumulative effect of inaction can lead to further inaction, as subsequent practitioners may not consider the action of previous practitioners to be insufficient. Had those opportunities been taken they may, or may not, have led to the risk Albert presented being correctly identified and mitigated.

6.8.15 However, by the morning of 07.04.2105, the panel believe the primary responsibility for taking action to respond to the increased level of risk and assess the needs of Albert and Joan and then to do something about it rested with staff within ASC and their managers. In reaching that view the panel have taken cognisance of the findings of HM Coroner. He had the opportunity to hear key witnesses give evidence in chief and to cross examine them. The panel therefore believe that ASC failed to recognize the threat to the life of Joan was both immediate and credible and by not acting more quickly to ensure an assessment was undertaken on 07.04.2015 they failed to prevent Joan from being killed by Albert.

6.9 Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to Joan and Albert or to work with other agencies?

6.9.1 Overall the panel do not believe that capacity or resources affected the ability of any agency to provide a fit and proper service in this case. The panel recognise that some of these events took place over the Easter period when there were two bank holidays. The panel noted the comment made by RA1, that on Good Friday SW6 appeared rushed (see paragraph 5.3.38). While the bank holidays mean some routine services and processes were not available, key services in health and ASC were operating.

6.9.2 The panel believes this is a case in which there was a failure to recognise, understand and record the risks Albert presented and to develop plans that would ensure that risk was either removed or reduced to a level which ensured lives were protected. The reason that did not happen was not due to a lack of resources or the presence of bank holidays.

7. LESSONS IDENTIFIED

7.1 Introduction

7.1.1 In summary the lessons identified in this review are centred on;

a. Not following the well-established adult safeguarding alert procedures;

b. Risk Formulation; including threats to kill and their Management;

c. Practitioners being faced with scenarios outside of their experience.

Lesson One-Panel Recommendation One Applies
Narrative The agencies involved in this domestic homicide review have clear pathways for raising safeguarding alerts. In this case those pathways were not followed because assumptions were made that someone else had done it.
Lesson Not raising formal adult safeguarding alerts, or checking that they have been raised, means that the opportunity to formulate risk in a structured manner is missed.

Lesson Two-Panel Recommendation Two Applies
Narrative Having missed the opportunity to formulate risk under the adult safeguarding alert framework, the position could have been rectified, had a professional in any agency been identified or identified themselves as the lead worker for what was a complex case requiring a multi-agency approach.
Lesson The uncoordinated approach to this case meant that all the risk factors known to agencies and the family were not brigaded into a single risk assessment that would have protected: Joan, Albert and professionals providing services in the home.

Lesson Three-Panel Recommendation Two Applies
Narrative The review has identified that agencies have different internal databases and sources of information, and that information, which had a bearing on the risk Albert presented Joan, was placed on separate systems. Some of the information was not as full as it should have been.
Lesson Having information, some of it of variable quality, within the same agency on different databases made it more difficult to readily identify the risk factors and share, a complete agency picture, within and outside the organisation.

Lesson Four-Panel Recommendation Three & Four Applies
Narrative The risks faced by Joan from Albert were not accurately assessed and that Albert's threat to kill Joan was not recognised as domestic abuse.
Lesson Inaccurately assessed risks means that the risk management plan was not robust. In this case Joan was left more vulnerable than she should have been.

Lesson Five-Panel Recommendation Four Applies
Narrative Joan was almost 75 years of age and Albert was 87 years of age. Albert had complex medical needs. It is likely that their ages and Albert's medical condition meant that professionals viewed Albert's threats and Joan's risk differently than had the circumstances pertained to younger adults. In simple terms the Panel felt professionals were faced with something that was outside of their experience.
Lesson Professional should learn from this case that elderly people's threat to kill should be taken as seriously as those made by younger people. Any threats should be discussed with line managers and consideration to be given to informing the police as well as referring to adult social care. Policies need to be explicit around the action to be taken when there are threats to kill and this should be included in both safeguarding and domestic abuse policies.

8. CONCLUSIONS

8.1 Albert and Joan were an elderly couple who were in a caring relationship. Until the last few months before the homicide of Joan they enjoyed relatively active lives and liked socialising together. Their family describe their marriage as being good. While Lancashire Constabulary made two calls to address one, on neither of these occasions did they find evidence of domestic abuse. Their family, who visited them frequently, held no information about domestic abuse until around the time Albert made threats to kill Joan on 01.04.2015.

8.2 The health of both Albert and Joan started to decline. Some of this may simply have been the process of aging. Joan was described by her sister AS as very underweight and it appears from the medical records that Joan smoked and suffered from COPD. Albert had also been involved in a road traffic collision when he was knocked down by a car. While there is no medical evidence to substantiate this claim, AS believed that incident marked a tipping point after which his health started to decline.

8.3 At first Albert appeared to be the person upon whom Joan relied for her care after she was discharged from hospital. After Albert's health declined the situation was reversed and his mobility started to suffer. There is evidence from family members and from medical records that Albert's mental state changed and he was described as becoming increasingly confused. Whether or not Albert was suffering from dementia, including the degree, at the time he killed Joan is subject to opinion. However, agencies first responsibility was to safeguard Joan and Albert. Thereafter, investigations could have happened in slower time to determine his mental health needs. The panel considered whether there were any missed opportunities to diagnose dementia before Albert killed Joan. The panel believe this case illustrates there is a need to understand more about dementia in the elderly and whether this may increase the risk of domestic abuse.

8.4 The panel found no evidence that Albert made any threats to Joan nor presented a risk to her prior to his admission to hospital on 03.03.2015. While in hospital the first of two overview assessments were carried out. These included an assessment of whether Albert presented a risk of harm or injury to a carer, himself or others. No risk of this was identified. While a further assessment on 26.03.2015 showed risk levels had increased the risk of harm or injury to a carer, himself or others did not increase.

8.5 The first known occasion that agencies knew Albert presented a risk of harm to Joan was when he made threats to kill her and himself on 01.04.2015. The panel believe that, because of an oversight in not ensuring a form SA1 safeguarding alert was submitted, ASC missed an opportunity to assess and manage that risk. The failure to document the event on SWIFT also meant that other professionals in ASC and other agencies were unaware of the increased risk. If they visited address one they were also unknowingly exposing themselves to increased risk of harm.

8.6 Other agencies also missed opportunities to share information about the risk of domestic abuse. On 01.04.2015 HCFY should have submitted a form SA1 but did not do so as SW1 told them it was not necessary. However H3 states Albert also told them he would kill Joan and himself. There is contrary evidence on whether this information was passed back to HCFY managers, but in any case a safeguarding alert SA1 was not raised. A safeguarding alert should have been submitted and not doing so was contrary to both agency and multi-agency policy.

8.7 While the failure to identify risk on 01.04.2015 was an oversight, the position could have been recovered on a number of occasions between then and the homicide of Joan. The second opportunity to recover from the misunderstandings of 01.04.15 was 02.04.15 when AN rang to request Albert be removed from the home; RA1 & SW2 conversation on 03.04.15 was the third opportunity.

8.8 The fourth missed opportunity involved a chain of events in which the important information RA1 held was not recorded on the ELMS system. This occurred because RA1 did not communicate the same information about risk and the same information to both the supervisor and call taker. While that was the case, the nature of the call meant there was still an opportunity for GP1 to ask detailed questions about the possibility of domestic abuse. That opportunity was missed. As was an opportunity by GP2, who had not read the notes that had been taken by the call taker.

8.9 Greater professional curiosity by GP1 and GP2 might have uncovered important information about the risk of harm to Joan. The GP practice that received faxed information about the OOH call also missed a similar opportunity to probe further as they took no steps to follow this information up. In addition there was no clear clinical oversight within the GP practice for Albert and Joan.

8.10 The risk Albert presented was raised to a much greater level when RN1 was told by the family of Albert that he had hidden a knife under his chair. That was significant information and meant that Albert had acquired the means to carry out the threat he had made on at least two occasions. With the intent and the weapon it meant that by now Albert was only one step away from carrying out his threat; he had the motive and the means; all that needed to occur now was the opportunity. While RN1 thought they were making a safeguarding alert when they telephoned ASC they should have also submitted a safeguarding alert form SA1. A safeguarding alert should have been submitted and not doing so was contrary to both agency and multi-agency policy. This was a fifth missed opportunity.

8.11 The sixth missed opportunity occurred on 06.04.2015 when SW2 visited address one in response to the information from RN1 and AD1. The panel avoided the hindsight test and decided the actions SW2 took on the night of 06.04.2015 were adequate based upon what SW2 believed were the risks presented by Albert. The panel believe SW2 understated these risks. Albert was an elderly, frail, ill and infirm man. He had assured SW2 he couldn't kill. This was also one of a number of occasions in which Albert or Joan may not have understood the nature of the risk present in the relationship. The panel felt it was important that in future all professionals recognise that very often victims may not understand what constitutes risk. This in turn leads to assumptions being made that risk is lower than it actually is.

8.12 SW2 recognised there was a need for an urgent assessment to be made of Albert and Joan. They updated the SWIFT record with information about the finding of the knife. While SW2 did not submit a form SA1 safeguarding alert nor update the risk assessment there was sufficient information available to staff within ASC on the morning of 07.04.2015 to identify that the risk Albert presented had increased and to update the risk assessment. LCFT, HCFY & GP could also have taken action.

8.13 One of the steps that could have been taken by any agency was to consider sharing information with Lancashire Constabulary who would have been able to advise on what was now a criminal act, albeit committed by an elderly and infirm man. While

SW6 asked AD1 if she had done this, no further steps were taken towards making a referral to the police. By not contacting the police agencies missed an opportunity to share information about the threats Albert made and receive advice that could have been used to manage the risk he presented.

8.14 By 07.04.2015 LCFT, HCFY and the GP had actions that, if taken, might have led to identification and reassessment of the risk Albert posed. However, on 07.04.2015, the primary responsibility for doing something to identify and manage risk rested with ASC. However it appears the risk Albert presented and the need for urgent action became diluted within ASC. The seventh missed opportunity occurred when SW5 made a telephone call to Joan that morning and accepted her assurances that everything was 'alright' rather than visiting in person.

8.15 Line management in ASC appear to have assumed that everything that needed doing had been done. An example of this, and the eighth missed opportunity, was when issues became clouded following the disagreement between RN1 and SW5 on 07.04.2015. While line managers within ASC were told by SW5 of the disagreement they did not intervene. As well as considering those eight missed opportunities to identify and assess risk, there were also five requests from the family of Albert to remove him from address one.

8.16 The panel recognised that the short period of time between the first and last opportunities may not have assisted. Safeguarding and adult protection work is complex and demanding, however practitioners should be skilled in making complex assessments and judgements in a short period, sometimes with limited information. The training for most of the professionals besides HCFY workers is about seeking out the additional information required to fill any gaps. This requires professionals to be respectful while being inquisitive and, when necessary, sceptical.

8.17 While there are a number of reasons opportunities were missed for that the panel conclude professionals simply did not believe or understand that Albert, a vulnerable, frail, confused, infirm and unwell man was capable of killing his wife; it was simply outside their experience. While Albert's condition may have explained why ASC, LCFT, GP and HCFY did not follow domestic abuse policy, it does not explain why none of the agencies, including different teams within the same agency, did not raise an SA1 safeguarding alert. Raising an SA1, frail old people placing themselves and others at risk, is not outside the experience of any of these agencies.

8.18 The report by Dr Benbow illustrates that the diagnosis of dementia can be more difficult for people who have other physical conditions and mental health needs and that by itself, dementia does not necessarily make people violent.

8.19 The panel agreed with HM Coroner that, in completing their work on this DHR, they would consider the issue of whether or not there was a systemic failure within some or all of the agencies involved. Systemic failures are failures even after following policies or procedures, or an absence of them given research that actually exists to say policies should be in place. The panel has analysed the circumstances of this homicide in depth and sought further explanations from agencies where there have been gaps in the information provided. The panel concludes that the failures and oversights in this case were because established procedures were not followed, rather than a systemic failure. Nevertheless, because there were so many missed opportunities the panel felt some common factor possibly influenced decision making. As identified above it was probably the simple explanation that the

events, and particularly, the ages and health profiles, of Joan and Albert, were outside the experience of what constituted risk. The focus of practitioners was on the care element of the couple and the risk element was not dealt with appropriately.

9. PREDICTABILITY/PREVENTABILITY

9.1 Albert made a number of threats to kill Joan and then himself. However when he hid the knife, the means to carry out that threat, the risk he might kill or cause serious harm to Joan increased significantly. The panel therefore conclude that, on the balance of probabilities, from the 06.04.2015 it was predicable that Albert might carry out his threat.

9.2 Consequently the panel believe that urgent action was needed by ASC to carry out an assessment. If that assessment had taken place on 07.04.2015 it is probable that Albert would have been moved into residential care and Joan would have been protected from the risks Albert presented to her. The panel therefore believe the homicide of Joan was preventable.

10. RECOMMENDATIONS

Note: The progress of the agency and DHR Panel's recommendations will be monitored by Blackburn with Darwen Safeguarding Adult Board who will ensure they are competed.

10.1 The Agencies recommendations appear in the Action Plan at Appendix 'E'. The DHR panel recommends that;

i. Blackburn with Darwen Safeguarding Adult Board satisfies itself that its constituent agencies understand the adult safeguarding alert procedures and when to apply them, including cases involving threats to kill;

ii. Blackburn with Darwen Community Safety Partnership satisfies itself, that its constituent agencies, know that it is necessary to search all of its databases and paper records, to produce a full picture of the domestic abuse risk factor they hold;

iii. Blackburn with Darwen Community Safety Partnership satisfies itself, that its constituent agencies know;

- That threats to kill can be domestic abuse;
- When it is necessary to refer people for mental health assessments, including the application of the Mental Health Act 1983;
- When to undertake carer's assessments;
- How to assess risk of serious harm;
- How to produce good risk management plans;

  and

- Review their domestic abuse policies to ensure that they address the need to refer older people with mental health problems to appropriate service

iv. Blackburn with Darwen Safeguarding Adult Board and Blackburn with Darwen Community Safety Partnership determines whether its present training and single agency training on domestic abuse specifically includes abuse between elderly people, including coercive and controlling behaviour {and the new legislation[13]} and factors in recognition of dementia and what that might mean for risk, and if not consider how the lessons from this case can be incorporated into domestic abuse training;

v. Blackburn with Darwen Community Safety Partnership use the findings of this review in staff briefing and training.

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[13] Serious Crime Act 2015 Section 76 Controlling or coercive behaviour in an intimate or family relationship

vi. Any future domestic homicide reviews within the Blackburn with Darwen Community Safety Partnership area include training for agencies on the DHR process and completion of IMR's.

vii. Blackburn with Darwen Adult Social Care ensure that staff responsible for securing the welfare of individuals recognise the importance of not creating perceptions with victims and their families that financial considerations have a higher priority than reducing the risk of harm.