SUMMARY

of

Domestic Homicide Review
DHR Case A

Report into the death of Frank in 2019

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Independent Chair and Author

1. Introduction

1.1. The members of this Review Panel offer their sincere condolences to the family of Frank for their sad loss in such tragic circumstances.

1.2. The family have chosen the pseudonyms Frank and Elsie for the parents and Tom for the son who is the perpetrator.

1.3. We offer our thanks to the members of the family who have contributed to the review.

2. Background

2.1. This Review concerns the death of Frank (in his 90's), who lived with his wife, Elsie (in her 80's) and their son, Tom (in his 40's). Tom has an extensive mental health history and was known to various medical and mental health services. Frank also had significant health problems and both he and Tom were cared for by Elsie.

2.2. On the date of the tragic event in 2019, Elsie heard a commotion in the house and went inside to find Frank with serious stab wounds. She called for emergency services. Frank was deceased. Police Officers attended the house and arrested Tom.

2.3. Tom was charged with the murder of Frank and appeared before the Crown Court where he pleaded guilty by diminished responsibility due to his mental health. Tom was made subject to a hospital order.

3. Establishing the DHR

3.1. Leicestershire Police notified the Community Safety Partnership (CSP) of the circumstances of the death and the Home Office was notified in accordance with Home Office Guidance.[1] A Domestic Homicide Review was commissioned.

3.2. NHS England commissioned their own Independent Review into the care of Tom whilst under mental health treatment. That review and this DHR have worked in conjunction with each other.

3.3. Membership of the DHR Case Review Panel was as follows:

Job Role	**Agency**
Independent Author and Chair of Domestic Homicide Review	Independent
Strategic Lead / Lead Officer	District Council / Community Safety Partnership

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016.

Named Professional Safeguarding Adults	Leicester, Leicestershire & Rutland (LLR) Clinical Commissioning Group (CCG) Safeguarding Team
Lead Practitioner for Safeguarding, Adults and Communities	Leicestershire County Council
Community Safety Coordinator	Leicestershire Country Council
Project Lead for Safeguarding Adults and Children Lead Practitioner for Safeguarding Adults (MCA / DoLS)	Leicestershire Partnership NHS Trust (LPT)
Serious Crime Partnership Manager	Leicestershire Police
Independent Consultant	NHS England
Matron – Adult Safeguarding	University Hospitals of Leicester NHS Trust (UHL)
Supported by	
Officer	Leicestershire & Rutland Safeguarding Partnerships Business Office
Administrative Assistant	Leicestershire and Rutland Safeguarding Partnerships Business Office

4. Areas for consideration

The following areas of consideration were included in the Terms of Reference for the DHR.

4.1. Frank:

4.1.1. Was Frank recognised or considered to be a victim of abuse / coercive and controlling behaviour and did he recognise himself as being an object of abuse?

4.1.2. Did Frank disclose to anyone and, if so, was the response appropriate?

4.1.3. Was this information recorded and shared where appropriate?

4.1.4. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the victim and their family?

4.1.5. When, and in what way, were the victim's wishes and feelings ascertained and considered?

4.1.6. Is it reasonable to assume that the wishes of Frank should have been known?

4.1.7. Was Frank informed of options/choices to make informed decisions?

4.1.8. Was he signposted to other agencies?

4.1.9. Was consideration of vulnerability or disability made by professionals in respect of the victim and perpetrator?

4.1.10. How accessible were the services for Frank and Tom?

4.1.11. Did Frank have any contact with a domestic abuse organisation, charity or helpline?

4.2. Tom:

4.2.1. Was Tom recognised or considered to be a victim of abuse / coercive and controlling behaviour and did he recognise himself as being a perpetrator of abuse?

4.2.2. Did the perpetrator disclose to anyone, and, if so, was the response appropriate?

4.2.3. Was this information recorded and shared where appropriate?

4.2.4. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of the perpetrator?

4.2.5. Were services accessible for Tom? And was he signposted to services?

4.2.6. Was consideration of vulnerability or disability made by professionals in respect of Tom?

4.2.7. Did Tom have contact with any domestic abuse organisation, charity or helpline?

4.3. Additional Health Related Terms of Reference for the Perpetrator (for the parallel Independent NHS England Investigation only):

4.3.1. The NHS England investigation will examine the NHS contribution into the care and treatment of the service user, Tom, from his first contact with specialist mental health services up until the date of the incident and will:

- Critically examine and quality assure the NHS contributions to the Domestic Homicide Review
- Work alongside the Domestic Homicide Review Panel and Chair to complete the review and liaise with affected families
- Provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone.

Specific Areas for review of Health agencies:

- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user

- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family
- Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway.

4.4. Elsie and other family members:

4.4.1. Were the needs of the whole family considered?

4.4.2. Were Carer's Assessments undertaken, if so, what were the outcomes and supporting needs of the carer?

4.5. Practitioners:

4.5.1. Were practitioners sensitive to the needs of Frank and Tom, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator?

4.5.2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

4.6. Policy and Procedure:

4.6.1. Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

4.6.2. Did the agency have policy and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (e.g., DASH) and were those assessments correctly used in the case of this victim/perpetrator?

4.6.3. Were these assessment tools, procedures and policies professionals accepted as being effective?

5. Individual Agency Recommendations and Lessons Learned

Each agency was asked to either complete a Individual Management Report (IMR) or Factual Summary to identify recommendations and learning:

5.1. Leicestershire Adult Social Care (ASC) – Recommendations

1) Reiteration of the importance of linking and creating relationships to inform practitioners of who is involved with Customer Service Centre staff, locality teams and county wide teams. Training in progress.

2) The Approved Mental Health Practitioner (AMHP) report was amended to prompt consideration of onward referrals. If a referral is not made, then the reason for this should be recorded in the case notes.

3) The importance of the whole family approach to be emphasised with Adult Social Care staff and possibly training / Continuing Professional Development (CPD) opportunity to be offered.

4) Training for Carers in progress building on the Core Carers training to include the learning from case studies and onward referrals.

5) Where Health and Social Care are working with people in the same household, they should communicate to share relevant information and document when this has occurred.

6) Continuous embedding or recording in LAS (Adult Social Care recording system) using the RAAN[2] method of recording which prompts analysis to take place and reasons given for actions.

7) Leicestershire Adult Social Care should review the appropriateness of desk top reviews of Section 117 cases where the person is not in receipt of services. This appears to currently be an administrative exercise with no contact or benefit to the service user. Consideration should be given to where face to face reviews are indicated.

8) Discussion with AMHP manager to improve consistent use of paperwork and timely inputting of assessment onto LAS.

9) Leicestershire Adult Social Care will ensure that Occupational Therapists (OTs) are being reminded about the wider picture and potential safeguarding issues through the redeveloped ASC Safeguarding Core training. Lead Practitioners / Principal OT will also ensure that the key messages of learning from this DHR are specifically fed back to the OT Teams.

5.2. Leicestershire Adult Social Care (ASC) – Lessons Learned

1) Failure of the Customer Service Centre staff and subsequent workers to link Tom with Frank on the Liquid Logic system so workers unaware of Tom's mental health prior to visiting. Process is required to ensure all relationships are identified and checked on referral and any subsequent practitioner can facilitate the linking of people on LAS.

2) The AMHP service did not make referrals to ASC related to the verbal abuse identified for consideration under safeguarding. This was a missed opportunity to openly discuss the risks with the whole family and consider safety measures. The AMHP report is to be amended (in progress) to prompt consideration of onward referrals. If a referral is not made, then the reason for this should be recorded.

3) ASC staff worked to individual remits and failed to apply a whole family approach leading to case recording being insufficiently interrogated and important information missed i.e., history of verbal abuse. This led to a missed opportunity within the Carer's Assessment to fully explore the impact of Tom's care on his mother.

[2] RAAN stands for Reason (for contact), Areas covered, Analysis and Next Steps and is how Leicestershire ASC structure their case notes.

4) *Key referrals to support agencies were not fully considered and recorded, such as a referral to the Carer's Support Service, which may have been beneficial.*

5) *Lack of communication between professionals, both internally and externally. For example: staff working with Frank and Elsie did not communicate with the Community Psychiatric Nurse (CPN).*

6) *Omissions in case recording relating to analysis / reasons for certain decisions. All staff to record in LAS using the RAAN method of recording (recently introduced during the Target Operating model redesign). This prompts analysis to take place and reasons given for actions.*

7) *The Section 117 review, which is recorded for March 19, contains minimal information. The Review Manager advised that the current process is to check that Section 117 is still applicable. A desk check is conducted to check the Care Programme Approach (CPA) is in place within Health and, if so, a basic review is entered onto the system. Tom was, therefore, not contacted and an opportunity to discuss his care needs not actioned.*

8) *There are several practice issues related to the AMHP service. These are delays inputting assessments so that assessments are in the wrong order and consistent use of report paperwork.*

5.3. Leicestershire Partnership NHS Trust (LPT) – Recommendations

1) It is recommended that care plans are co-produced with the patient, and this is monitored at a team level in accordance with the Record Keeping and Care Planning Policy and the outcomes are reported to the Trust Quality systems every three months. This should be in place within three months.

2) It is recommended that systems are put in place at a team level to monitor that all patients have a Care Plan as per the Record Keeping and Care Planning and assurance should be provided to the Trust Quality systems every three months. This should be in place with immediate action.

3) It is recommended that risk assessments are monitored at a team level in accordance with the Clinical Risk and Management policy and the outcomes are reported to the Trust Quality systems every three months.

4) It is recommended that CPA reviews and process should meet the standards of the Clinical Risk Assessment and Management policy and that this should be monitored at a team and strategic level through the Trust Quality systems every three months.

5) It is recommended that a process is agreed to provide access to the Care Plan in the electronic patient record when they are temporarily not in use, such as an episode of inpatient care. This system should ensure that the full records are available for use in practice, and this should be implemented within three months and monitored through the information management and technology systems in the Trust.

6) It is recommended that caseloads of the multi-professional Community Mental Health Teams be assessed for acuity and limits set to ensure that the clinicians

have the capacity to deliver the services to the required standards. This should be achieved within three months, and monitoring systems put in place to enable escalation if caseloads should breach the numbers.

7) It is recommended that there is a review of the systems and processes of the medical provision in outpatients, to deliver a service which provides appointments to patients when required. This process should commence within two months and report through the performance management systems to the Board of Directors.

8) It is recommended that a 'whole family' approach is taken to deliver care when more than one clinical service is involved, to provide a systematic approach which includes risk assessment and the mitigation of risks. This should be in place within six months and monitored through the Caldicott systems of the Trust every three months.

9) It is recommended that, where there are vulnerable adults living and caring for patients with serious mental illness, safeguarding adult advice should be accessed and, if necessary, an assessment and review performed and documented. Identification of patients in this situation should be made within three months and monitored through Trust safeguarding systems.

10) It is recommended that there should be an effective system in place between inpatient and community service settings to ensure that medication response and dosage is correct and responsive to the patient's needs. This system should be implemented within two months and monitored at the operational level.

11) It is recommended that a 'whole family' approach is taken to the involvement of family and carers in the delivery of care to patients with severe mental illness and assessment and engagement of their needs and the rationale for these decisions is documented, and this is monitored through the Trust quality systems every three months.

12) It is recommended that staff recognise the safeguarding needs of patients and parents of patients in the caring role.

13) It is recommended that observation levels and changes to observation levels are documented accurately.

14) It is recommended that any change of regime in the administration of depot medication be discussed and agreed with the responsible Consultant.

15) It is recommended that clinical staff consider the significant changes in a patient's life and the impact or potential impact they may have on the patient's mental state.

5.4. Leicestershire Partnership NHS Trust – Lessons Learned

1) The LPT electronic patient record does have a specific safeguarding domain to ensure that safeguarding reviews are recorded routinely for all patients and their carers.

2) *The LPT electronic patient record has a section for Care Plans – it was found that this section had been closed down, and therefore the care plans were no longer 'live',*

3) *The LPT electronic patient record provides a system for recording and documenting all information related to the care and treatment of the patient. The patient record was not recorded contemporaneously and the domains for documentation were not completed as would be expected.*

4) *There was no system in place to ensure that Carer's Assessments took place and that these were recorded in the LPT electronic patient record.*

5) *There was no recognition of the life events that had taken place for Tom – this included the loss of the family dog, Frank's illness and community staff visiting the family home. The impact of these events on the patient's mental health should be considered.*

6) *The 'whole family' approach was not implemented and the recognition of the vulnerability of Tom's carers not realised. The impact of the verbal abuse and hostility by Tom and the impact on his carers was not realised as abuse and noted to be part of his presentation.*

7) *The delivery of outpatient appointments on time and the pressure on the Consultant to see their patients within the time specified was not recognised prior to this event.*

8) *The monitoring of the outpatient's appointments on time, and the invitation to patients and their carers regarding forthcoming CPA was not in place.*

5.5. GP Practice – Recommendations

1) Reminder to all clinicians about checking medication instructions from outpatient appointments with repeat prescriptions. Investigate any discrepancies.

2) Make individual risk assessments for patients who do not attend for Shared Care Agreement (SCA) drug physical check and document decisions about continuing to prescribe. Inform secondary care team (if still involved in the patient's care) of the assessment and decision.

3) For patients who DNA/decline their Primary Care Annual Mental Health Review, the secondary care team, if still involved, should be informed.

4) Mental Health register reviewed by the registered GP.

5) Review the coding issue where the exception code was being used incorrectly for patients who in remission and for patients who should have been removed from the register because their diagnosis was not appropriate for the Mental Health (MH) register.

6) Registered GP reviewed notes of all patients on MH register to resolve coding problem. All remaining patients to receive further invitation to attend surgery or to have a home visit, from their own GP, tailoring the offer to best enable them to access care.

7) To take an opportunistic approach so that patients due a Mental Health review who contact the surgery on another matter are offered an opportunity to book at a convenient time.

8) The Practice to focus on Carer identification as the patient concerned was known to be a Carer but was not formally added to the Practice Carer's Register.

5.6. GP Practice – Lessons Learned

Tom

1) *Prescription states administration of depo medication every 3 weeks. This is the frequency stated on the SCA dated June 2018. Clinic letter from September 2018 and frequency of visits suggests 2 weekly administration. No reference in letters to change in frequency of administration. No evidence of this being queried. Medication issue frequency and records show no problems with frequency of supply of medication. No evidence of medication not being given.*

2) *No communication from Community Mental Health Team (CMHT) between outpatient appointments.*

Frank

3) *Was there an opportunity to proactively ask about any concerns regarding Tom?*

Elsie

4) *Was there an opportunity to proactively ask about any concerns regarding Tom? Would a formal Carer's review appointment have facilitated such a discussion?*

5.7. NHS England Independent Report Recommendations

1) The first recommendation is designed to improve knowledge and practice when NHS and police staff overlap and when operational manners and procedures challenge patients. We urge the Trust and the police to discuss together (for example, in a workshop or a series of seminars focused on best practice) how they might consider developing knowledge, understanding and improve practice when patients need to be taken to the Health Based Place of Safety (HBPOS) under S.136 of the Mental Health Act and/or who are already detained under Section of the Mental Health Act and need help to be returned to hospital.

2) The second recommendation concerns the need for Trust clinical teams and leaders to improve learning, awareness, motivation and responsiveness to safeguarding practice. Whilst safeguarding staff, policy and systems exist in the Trust, operational routine practice is not currently embedded. We recommend that the Trust should take action and demonstrate metrics as well as qualitative feedback after six months.

3) The third recommendation concerns the impact of the community transformation. Our team recommends that the Trust should show how basic care processes (e.g., care planning, risk assessment, and access to outpatient appointments, etc.) are being delivered during the transformation. Our team urges particular special attention to the quality and content of risk assessment, an area of concern in Tom's case.

4) The fourth recommendation is for the NHS England team to re-visit the Trust after six months. The aim is to examine reports and data relating to the above recommendations and discuss with the independent team.

6. Author observations and recommendations

6.1. Leicestershire Adult Social Care (ASC)

6.1.1. Tom was referred to the Inclusion Support Service (ISS) but, at his decision to disengage from that service, the impact his decision was likely to have on his mental health was not considered.

6.1.2. Although there was a Carer's Assessment in respect of Elsie, the Leicestershire ASC IMR Author was of the opinion that the Carer's Assessment was superficial and there was a lack of exploration regarding the impact on Elsie of caring for two people with very different needs. Tom's mental health issues were not explored and, therefore, the challenges of this could not be explored. It was established that the first Carer's Assessment with regard to Elsie was completed by an Occupational Therapist newly in post and the training and supervision of this person were debated during a Panel meeting. It was suggested that further training would be provided for Occupational Therapists which would include the wider aspects of safeguarding issues.

6.1.3. In addition, the occasion when the Carer noted bruises on Elsie's face, caused apparently from falling up the stairs, was not explored sufficiently enough and Elsie's explanation was accepted. It is noted that Elsie was known to minimise situations to keep Tom at home rather than him being admitted to hospital.

6.1.4. There is no record of Frank ever considering himself a victim of abuse. All of Tom's aggression was directed towards Elsie. Frank relied heavily upon Elsie to make major decisions in his life. This was due to the effect of a stroke he suffered. Consideration was given to the need to conduct a Mental Health Assessment on Frank but, as he was not objecting to his care, this was thought unnecessary.

6.2. Leicestershire Partnership NHS Trust (LPT)

6.2.1. The LPT IMR detailed the findings of the Serious Incident Investigation and identified several areas where improvements are required. They are:

- Record keeping and documentation
- Information sharing
- Vulnerability and safeguarding needs
- Care planning
- Medication
- Physical health

6.2.2. Details of the recommendations outlined in the LPT IMR are contained in this report.

6.3. GP Practice

6.3.1. The family had been registered with the local GP Practice for many years. It was noted that Tom had mental health issues and he was reluctant to engage with the surgery. It was also noted that Elsie was part of the decision making around Frank's needs. Records show a holistic approach towards Elsie and Frank's medical needs with joint in-house services for both of them. The surgery made a number of recommendations as well as identifying good practice in relation to all three patients.

6.4. University Hospitals of Leicester NHS Trust (UHL)

6.4.1. UHL's dealings with both Frank and Elsie did not indicate any suggestion of domestic abuse within the family. The Trust's IMR indicated that all policies and procedures were adhered to, and the Trust did not make any recommendations.

6.5. MARAC and MAPPA

6.5.1. It is always necessary in DHRs to consider whether those involved were, or ought to have been, subject to MARAC (Multi-Agency Risk Assessment Conference) or MAPPA (Multi-Agency Public Protection Arrangements). In formulating the Terms of Reference, consideration was given to both processes with regard to Elsie, Frank and Tom but agencies considered that none of them reached the threshold for referral to either MARAC or MAPPA.

6.6. Returning patients to hospital – Learning point

6.6.1. An incident regarding returning Tom to hospital in April 2018 was the subject of some debate during the DHR Panel meetings. The guidance to Leicestershire Police with regard to returning patients to hospital is clear that Police should only be asked to intervene if necessary and consideration should be given to the mental health profession obtaining a warrant under Section 135(2) of the Mental Health Act 1983.

6.6.2. The NHS England Independent Report makes comment and a recommendation about this issue and states:

"It is not uncommon for misunderstandings (about protocols and the scope of the law) to occur in such circumstances. We would urge the Trust to work with the police to develop a policy or memorandum of understanding to cover the occasions when a patient detained under Section of the MHA (when a warrant for a S.135 would not be needed) has to be returned and is behaving in a threatening manner. This might usefully also clarify arrangements for detention under S.136[3] of the MHA and the arrangements for removal to the Health Based Place of Safety (HBPOS)[4]."

[3] S.136 of the MHA permits Police to take someone from a public place to a place of safety if they believe that due to mental ill health the person needs 'care or control'.

[4] A health-based place of safety is a location provided by the NHS where a person detained on S.136 of the MHA can be managed safely while an appropriate assessment is undertaken by a psychiatrist and an approved mental health professional (AMHP).

6.6.3. The DHR Panel discussed this at length and considered that, rather than a recommendation, and because different agencies already have policies regarding returning patients to a place of safety, this ought to be acknowledged to be a 'learning point' about clear reporting, information sharing and articulation of risk and risk assessments. This should result in a clear understanding of the existence of other agencies' policies and procedures and every agency's role and responsibility in these circumstances.

6.6.4. A suggestion was made that professionals were put at risk with regard to carers visiting the household to care for Elsie and Frank and not knowing about the mental health condition of Tom. This is a difficult area around confidentiality. The carers pertained to Elsie and Frank and not Tom, so unless there was a direct threat or risk to the carer's well-being, it is difficult to justify disclosing health information about Tom to carers.

7. Recommendations

7.1. There were numerous occasions where Tom was non-concordant with his medication and an occasion when Elsie mentioned to a health professional that Tom's behaviour had deteriorated due to him failing to take his tablets. His non-concordance with his medication was not identified as a risk factor and the following recommendation is made:

Recommendation No. 1

All Health agencies to ensure that staff are cognisant that non-concordance with medication should be considered a trigger for a re-assessment of the risk the patient is to themselves and also to others within the environment the patient is located.

7.2. At the time of the death of Frank, there was not an up-to-date Care Plan in place for Tom. There was a Care Plan in existence until he was discharged from hospital in June 2019, but after that the Care Programme Approach guidance was not complied with and his family were not formally involved in any decision about his case.

7.3. The Leicestershire Partnership NHS Trust IMR makes a clear recommendation for the Trust to consider the Care Programme Approach issues and the NHS England Independent Review states:

"CPA and Risk assessment training have now been reviewed and Care Plans audited since the time of the incident and our team was assured that systems are now stronger."

7.4. In this case there was a lack of a care plan and a lack of effective risk assessments carried out concerning:

- The family's concerns
- Tom's non-concordance with his medication
- The effect that non-concordance may have been having on the family and others in the household.

Recommendation No. 2

Leicestershire Partnership NHS Trust to use the opportunity of the transformation programme to instil into training and awareness of all staff the need for adherence to the requirements of the Care Programme Approach to assess the risks involved in managing patients who have been detained for treatment and are being discharged paying specific attention to:

- **The family's wishes and concerns**
- **The patient's concordance with medication**
- **The effects of non-concordance of medication may have on the family and others in the household**
- **To consider the 'whole family approach'**

7.5. Over the next 2 years there will be a programme of transformation of the Care Programme Approach which will amalgamate specialist teams (e.g., Assertive Outreach) into Community Mental Health Teams. This will ensure there are more professionals available to work the team caseloads, but there will also be specialist skills available.

7.6. The review found that the three members of the family were dealt with in isolation of each other when medical and mental health care was required. There was not a 'whole family approach' to the family's needs.

7.7. Leicestershire Partnership NHS Trust indicates in the list of learning points within their IMR that:

> *"The 'whole family' approach was not implemented and the recognition of vulnerability of the [Frank's] carers was not realised. The impact of the verbal abuse and the hostility by [Tom] and the impact on his carers was not realised as abuse and noted to be part of his presentation."*

7.8. This review highlights an opportunity to extend to all agencies a recommendation that, when dealing with multi-generational families, to think 'whole family' and not consider each person individually.

Recommendation No. 3

When dealing with multi-generational families, all agencies must consider the 'whole family' approach and how they react and respond to each other within the family settings and how an individual's physical or mental health and circumstances may impact on other members of the family present. This issue should be embedded in training within each agency

8. Conclusions

8.1. This Domestic Homicide Review describes a very sad set of circumstances. An elderly couple with significant health problems of their own were living with their severely mentally ill son. Elsie was the recognised carer for Frank and Tom, each of whom had their own needs. There was significant medical input to all three people

over several years and numerous hospital admissions for each of the family members.

8.2. There was a lack of professional curiosity and analysis of how much the mental ill health of Tom was affecting the parents, Elsie in particular. There were numerous occasions when Elsie expressed her concerns about managing Tom which were not acted upon – for instance, her ability to cope, his non-concordance with his medication, the effects of that on her caring role and the loss of his protective factor, his dog.

8.3. The Care Programme Approach process, designed to care for patients after their discharge from hospital, was not effectively managed and failed to protect any of the family members.

8.4. Risks were not managed effectively across several domains:

- The management of Tom's mental ill health
- The management of the care and support of vulnerable, elderly parents
- The management of assessments
- The management of environmental and social determinants of Tom's behaviour.

8.5. Warning signs that the mental health of Tom was deteriorating were not recognised and acted upon. His non-concordance of his medication, his refusal to return to hospital and his behaviour in hospital went unnoticed, as did the variety of events prior to the death of Frank that no doubt had an effect on Tom's mental stability – the death of his dog and Frank being discharged from hospital and requiring additional care.

8.6. There was a lack of professional curiosity and analysis regarding safeguarding and domestic abuse concerns, where agencies could have made a difference to the lives of Frank, Elsie and also Tom.

8.7. Taking the research of Safer Later Lives[5] into account, if anyone entered this household and observed abusive behaviour within the family setting, it is not clear whether they would recognise and acknowledge this as being domestic abuse.

[5] "Safer Later Lives: Older People and Domestic Abuse", Safe Lives, October 2016. The report is part of the SafeLives 'Spotlights' series, which will focus on hidden groups of domestic abuse victims throughout 2016 and 2017 and propose recommendations for both practitioners and policymakers.