



DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

**Into the death of
Roger in September 2015**

Report Author

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Report Completed: 17 May 2017

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Preface

The Barking and Dagenham Community Safety Partnership and the Review Panel would like to express their sincere condolences to the family of the victim following his untimely death which has led to this Review. The Review Panel and the Partnership sincerely hope that the learning gained from the Panel's enquiries and deliberations, and from the work of Individual Management Review authors will help to prevent similar incidents happening in future. The independent Review chair urges all professionals supporting those with life limiting conditions to take note of this Review's findings and ensure that those with complex and/or multiple needs are supported by taking a multi-agency holistic approach to meet those needs.

The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance¹ under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004, states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition, and avoids the inclination to view domestic abuse in terms of physical assault only.

¹ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2013) Section 2(5)(1)

DOMESTIC HOMICIDE REVIEW

1. Introduction

- 1.1 This report of a domestic homicide review (DHR) examines agency responses and support given to Roger, a resident in the Barking & Dagenham area prior to the point of his death in September 2015. The review will consider agency contact and involvement with Roger the victim, and Sarah the perpetrator, from March 2012 when Roger's health difficulties caused him to be assessed for additional care, up to his death in September 2015.
- 1.2 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

- 1.3 The Barking and Dagenham Community Safety Partnership was notified by the Police of the homicide in their area on 10 September 2015. The chair and divisional director with responsibility for Community Safety took the decision that the homicide met the criteria for a Domestic Homicide Review and the Home Office were notified of the decision on 19 November 2015. A meeting of the Community Safety Partnership took place on 7 December 2015 to discuss the DHR. The independent chair was appointed in February 2016, therefore decision making, notification and setting the terms of reference for the Review were not within the one month timescale of the Partnership becoming aware of the homicide as set out in Section 5 of the statutory guidance. The Review was concluded on 17 May 2017. The requirement to complete the DHR within six months of notification could not be fulfilled due to delays in commencing the Review process which did not fully start until the completion of criminal proceedings in March 2016. Changes in staff, identifying relevant service providers for reports, and questions raised by the Community Safety Board following the first submission of the Review, further delayed the Review process as described in the Methodology section (page 5).

Confidentiality

- 1.4 The findings of this review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.
- 1.5 To protect the identity of the victim, perpetrator, and their family members the following pseudonyms have been used throughout this report.

The victim: Roger aged 67 years at the time of his death.

The perpetrator: Sarah aged 36 years at the time of the homicide.

Both Roger and Sarah are of white British ethnicity.

1.6 Dissemination

- Chair & Board members Barking & Dagenham Safer Community Partnership
- Deputy Mayor for London Policing & Crime
- Chief Executive of the London Borough of Barking & Dagenham
- Director of Adults & Communities, London Borough of Barking & Dagenham
- Borough Commander for Barking & Dagenham, Metropolitan Police
- Chief Officer, North East London Foundation NHS Trust
- Chief Executive, Barking, Havering & Redbridge University Hospitals NHS Trust
- The Chair of Barking & Dagenham Clinical Commissioning Group
- The Chief Officer, Barking & Dagenham Clinical Commissioning Group
- The Independent Chair, Safeguarding Board for Adults & Children, London Borough of Barking & Dagenham
- Medical Director & Nursing Director, NHS England,
- Chief Executive, Victim Support
- The Family's GP Practice

Summary of Circumstances Leading to the Review

1.7 The victim Roger and his daughter Sarah had lived in the Barking and Dagenham area for many years. The victim and his wife held the tenancy of their home from August 1988. Roger was disabled and his daughter was his sole carer for the last 13 months of his life after they cancelled a package of personal care for Roger. This cancellation ended Adult Social Care's involvement. Occasional visits by nurses were the only external agencies involved with Roger's care; the last of their visits having taken place in August 2015.

1.8 In September 2015 a neighbour contacted the Police expressing concern that they had not seen anyone at Roger's home for 3 days. Police attended the property and found Roger deceased. A note was found in the room written by Sarah stating that she had helped Roger to die as he was in pain. Sarah implied that she was going to commit suicide. A high risk missing person enquiry commenced and Sarah was found in Kent the next day and arrested. When cautioned she maintained that she had intended handing herself in the following day.

The Purpose of the Review

1.9 Statutory Guidance (Section 2) states the purpose of the Review 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;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Specific Terms of Reference for this Review

1. To review the events and associated actions that occurred which relate to the victim and the perpetrator between the end of March 2012 when the victim was admitted to hospital which instigated the first referral to Adult Social Care and September 2015 when the victim was found dead. Agencies with knowledge of the victim or alleged perpetrator in the years preceding the timescale for detailed review are to provide a brief summary of that involvement, with the exception of Mental Health Services where detail concerning their involvement with the perpetrator from first referral to case closure should be detailed.
2. Agencies which had involvement with the victim and the perpetrator to assess whether the services provided offered appropriate and timely support, resources, and interventions to meet the needs and safeguarding of the victim, and that procedures were followed.
3. Were decisions concerning the victim's care needs, additional vulnerabilities, living conditions, financial situation, and the services provided informed by:
 - a) Full and up to date facts concerning his living situation and who was living with him at the time.
 - b) Reviews and risk assessments undertaken which were updated in response to his changing needs and changes in circumstances. If so what risk assessment tools or framework were used and was it fit for purpose?
 - c) Effective and timely communication and information sharing between individual practitioners and agency systems.
4. Explore what issues if any prevented the victim accessing appointments or support services offered to support him and whether these barriers were recognised and addressed.
5. To assess whether agencies have robust and up to date policies, procedures, and referral pathways in place which are fit for purpose in assisting staff to identify and practice effectively where domestic abuse is suspected or present.
6. What was the level of training and knowledge of the staff who were involved with the victim and perpetrator in relation to the identification of domestic abuse and coercive control, the additional vulnerabilities affecting older people and those with disabilities, and the application and use of appropriate risk assessment tools and referral pathways to support and protect victims?
7. As the victim's main carer did the perpetrator receive a carer assessment and if so how and by whom was this completed and what was the outcome?
8. What assessment and evidence was gained to assess the victim's decision to have the perpetrator as his sole carer and whether this decision was taken freely, with information about risk, and without coercion?
9. Was an assessment of the victim's mental capacity as defined by the Mental Capacity Act 2005 undertaken to inform assessments and decision making, and if so how and by whom was this completed?
10. Was the victim formally identified as a vulnerable adult up to March 2015, or an adult at risk post April 2015? Or was he in need of services under Section 29

of the National Assistance Act 1948²: Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health 'No Secrets' guidance as:

"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation." No Secrets, Department of Health 2000

Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

*(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

11. Were there any resource, organisational, or systems of working that affected the provision of services or the way in which staff were able to perform their role.

The chair was responsible for contacting family and friends to invite their contributions to the Review.

Methodology

- 1.10 The commencement of the DHR process and the drafting of the terms of reference was outside statutory guidance requirements. The delay in commencing the review was due to the chair not being appointed until February 2016. Difficulties were then experienced in identifying the relevant professionals to organise agency chronologies. The changing landscape in organisational structures and service provision also resulted in delays in identifying IMR authors.
- 1.11 Agencies were contacted and asked to secure their files and to provide a brief chronology of their involvement with Roger and Sarah. These chronologies were combined into a single narrative chronology by the report author and this was provided to the first DHR Panel which met on 14 April 2016. By this time the criminal proceedings were completed and therefore the full DHR process commenced from this date. The terms of reference were drafted at this Panel meeting and agencies required to provide Individual Management Reviews (IMRs) identified. A total of 6 Panels were held during the Review process. There were a small number of alterations to Panel membership over the time of the review due to agency staff changes. An LGBT organisation was contacted to join the Panel, however they did not have the resources to provide a representative.

² A local authority may, with the approval of the Secretary of State, and to such extent as he may direct in relation to persons ordinarily resident in the area of the local authority shall make arrangements for promoting the welfare of persons to whom this section applies, that is to say persons aged eighteen or over who are blind, deaf or dumb, or who suffer from mental disorder of any description and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

- 1.12 An IMR author's briefing was held to explain the process and the methods required to meet the terms of reference, and a debriefing meeting took place following the chair's receipt of the IMRs. The Panel also reviewed the IMRs. IMR author's were independent of case management and direct involvement with the family. It was necessary to return to IMR authors to address gaps in either how the terms of reference were met, or where information between agencies produced conflicting accounts. Facts were identified as the Review progressed which necessitated the chair making further enquiries from additional sources. This included the agency which provided initial care for Roger in 2012 who provided a report and information, and a specialist multiple sclerosis nurse who saw him in 2007 who had not been identified in the first instance. A telephone interview with the nurse was conducted by the chair.
- 1.13 In addition to research and literature accessed by the author which is referenced in this report, Safeguarding, At-Risk Adult, Hospital Access, and Did Not Attend policies were examined, as was the content of local domestic abuse training.
- 1.14 The Review documents agreed by the Panel were submitted to the Community Safety Partnership Board in December 2016 following which questions arose from some members of the Board and a request was made for changes to the layout of the report, notably to delineate and analyse services received by Roger, the victim, and Sarah the perpetrator. As a consequence of the questions and requested changes the Panel was reconvened to reconsider a selection of points, and the author redrafted the final section of the report to address the Board's request to define the analysis of the services and recommendations relevant to Roger and Sarah separately. The further time spend on this process meant an updating of the DHR Action Plan was required which resulted in additional delay. The report was resubmitted to the Community Safety Partnership's Board meeting held on 12 June 2017. The chair would like to apologise to Roger's eldest daughter for this delay in finalising the Review.

Involvement of Family and Friends

- 1.15 With the assistance of the Victim Support Homicide Support Team member who was supporting the family the chair made contact with Roger's eldest daughter firstly by letter accompanied by the Home Office DHR leaflet, and then by telephone to arrange an appointment to meet. At the first meeting the terms of reference were shared and agreed; updates were provided throughout the DHR process. Roger's daughter was also able to assist the chair with the contact details of additional contributors who knew the family. A final draft of the Overview Report was shared with her along with an example of the action plan and the ongoing review process was explained. During this meeting she provided valuable observations and extra information, and these were added to the report by the author at the time with her assistance. A hard copy of the report will be sent to Roger's eldest daughter once it is passed for publication by the Home Office and before it is made available on the Borough's Community Safety website.
- 1.16 Roger's eldest daughter has given permission for the inclusion of the two photographs of Roger's home interior within the Overview Report. She feels that professionals should not just read about the state of the property, but also see examples for themselves. The two photographs included are of areas where practitioners would have had access and were taken by the local authority when they regained access to the house, they are therefore indicative of the state of the house at the time of Roger's death.

- 1.17 The chair interviewed a former friend of Sarah's by telephone and was also able to ask follow up questions via text. This method of communication fitted with Sarah's former friend's availability due to work and family commitments. Their contribution has provided valuable background to inform this review.
- 1.18 A former neighbour of Roger's agreed to be interviewed and the chair visited them and conducted a face to face interview. This provided helpful background information and enabled the chair to visit the location of the family home and to see the access available and local facilities such as the closeness of shops and health centre.
- 1.19 Following the conclusion of the criminal trial the chair wrote to Sarah, the perpetrator, and she agreed via her prison supervisor to contribute to the review. The chair and the safeguarding lead for the Clinical Commissioning Group representative member of the Panel visited Belmarsh Prison to interview her. The interview took place in the presence of her prison supervisor, therefore the chair recognises that this may have affected some of her answers to questions.

Contributors to the Review

- 1.20 The following agencies and the nature of their contribution to this Review are:
- The Metropolitan Police - chronology & Individual Management Review (IMR)
 - The London Borough of Barking & Dagenham Housing Management Team - chronology & IMR
 - The London Borough of Barking & Dagenham Adult Social Care - chronology & IMR
 - Barking, Havering & Redbridge University Hospital NHS Trust - chronology & IMR
 - North East London Foundation NHS Trust (NELFT) - (Community Nursing Services) - chronology & IMR
 - Genesis Recruitment Agency Ltd - chronology, statement & information
 - G P Practice for the family - chronology & IMR
 - North East London Foundation NHS Trust (Barking Community Mental Health Team) -chronology for background

The Review Panel

- 1.21 The Review Panel membership is as follows:

Name	Role & Agency
Gaynor Mears	Independent Chair & Report Author
Vicky Aldred	Regional Lead for Patient Safety/Head of Quality North East Central London, NHS England, London
Anne Clark	Domestic and Sexual Violence Commissioner, London Borough of Barking & Dagenham (LBBD)
Matthew Cole	Divisional Director Public Health, LBBD
Andrea Crisp	Named Nurse Safeguarding Adults, Barking, Havering & Redbridge Hospital University NHS Trust
Sonia Drozd	Community Safety, Offender, & Drug Strategy Manager
Mark Gilbey-Cross	Designated Nurse Adult Safeguarding, Barking, Dagenham, Havering & Redbridge Clinical Commissioning Groups

Alison Hamer	Specialist Crime Review Group, Metropolitan Police
Gordon Hastie	Adult Safeguarding Board Manager, LBBD
Anyse Hassan	Area Manager, Victim Support
Caroline Porter	Housing Manager, Landlord Services, LBBD
Joy Ryan	Manager, Genesis Recruitment Agency (Carer Provider) (one panel only)
Kevin Sole	Assistant Director, Integrated Care Directorate, North East London NHS Foundation Trust (NELFT) (Mental Health Services)
Daniel Stark	Practice Manager, Family GP Surgery
Sangita Lall	Assistant Director, Adult Community Services, North East London NHS Foundation Trust

Chair and Author of the Review.

- 1.22 The chair of this Review and author of this DHR Overview Report is independent DHR chair and consultant Gaynor Mears OBE. The author holds a Masters Degree in Professional Child Care Practice (Child Protection) and an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. The author has extensive experience of working in the domestic abuse field both in practice and strategically, including roles at county and regional levels. Gaynor Mears has experience in undertaking Domestic Homicide Reviews, and research and evaluations into domestic violence services and best practice. She has experience of working in crime reduction with Community Safety Partnerships, and across a wide variety of agencies and partnerships. Gaynor Mears is independent of, and has no connection with, any agencies in the Barking and Dagenham area.

Parallel Reviews

- 1.23 A Coroner's Inquest was opened and following the outcome of the criminal trial the inquest was discontinued. There were no other Reviews undertaken.

2. The Facts

- 2.1 Roger and his daughter lived in the Barking and Dagenham area in a property rented through the Local Authority. Roger and his wife had held the tenancy since August 1988. Following his wife's death in September 2008 succession of the tenancy was granted to Roger himself. It was noted in an assessment at that time that the property was adapted as Roger was disabled and his daughter was also an occupant in the house. It was in this property that Roger was murdered.
- 2.2 Roger suffered from multiple sclerosis and was bedbound for the last few years of his life. Aids to facilitate his mobility had been provided, but in those last years they appear not to have been used. In August 2014 a package of care which was in place to provide personal care for Roger was cancelled and his daughter Sarah took over his care. Roger's case was then closed to Adult Social Care following a home visit to assess the request to end the care. Periodic visits took place by the District Nursing Service the last of which was in August 2015 and there was a visit by the GP practice nurse.

- 2.3 In September 2015 a neighbour contacted the Police expressing concern that they had not seen anyone at the property and the bins which they put out for Roger and Sarah were uncharacteristically empty. Police attended the property and found Roger deceased. A note was found in the room written by Sarah stating that she had helped Roger die as he was in pain. Sarah implied that she was going to commit suicide. A high risk missing person enquiry commenced and Sarah was found in Kent the next day and arrested. When cautioned she maintained that she intended handing herself in the following day.
- 2.4 A typed note found in Sarah's possession explained the circumstances of Roger's death. It explained that in agreement with her father Sarah had placed a bag over his head, her father had held the front of the bag and she had held the back in place until her father's head went heavy. The post mortem found that the cause of death was 'consistent with plastic bag asphyxia'. After the killing Sarah caught a train to the Dover area, having texted the district nurse to visit "asap". However, Roger's body was not discovered for another 8 days.
- 2.5 Sarah was charged with murder and stood trial in March 2016. She claimed that she and her father had made a suicide pact as his illness had become "intolerable". However following the trial a jury found Sarah guilty of murder. In sentencing her, Recorder of London Nicholas Hilliard QC said he accepted that she believed it was an act of mercy. He said the key to the case was that she had failed to establish that her father had agreed and that she would also kill herself in a suicide pact. Recorder Hilliard QC continued: "I accept your evidence that your father did raise the question of ending his own life and he wanted to do that and wanted your help to do so." But the Recorder told Sarah she had unlawfully killed her father "behind closed doors" and no defence to murder applied. She was sentenced to life with a minimum term of 4 years.

Comments from Roger's Eldest Daughter:

- 2.6 The following comments on the Review's findings come from Roger's eldest daughter. Her comments below were read at a Review Panel as she was unable to attend in person. The chair asked permission to include them in the final draft of the report to which Roger's daughter kindly gave her consent:
1. Please express my appreciation to the carers that went beyond the call of duty for my Dad, e.g. visiting him out of hours to help clean the house, feeding the numerous pets that were neglected and providing food for him when he had been left on his own and there was no food left for him. They continually advised other agencies of the condition of the house and the Safeguarding risks this environment imposed on my Dad.
 2. In future it would help vulnerable adults like my Dad if the sharing of information among agencies and health professionals was more vigorous.
 3. The team around my Dad to care and assess his needs fell short.
 4. My Dad`s appointments that were missed for the hospital and the doctors should have been followed up. He was a man with complex needs that fell off the radar of the professionals who could have supported him and his condition. Instead he became a statistic, lost in translation with the countless

referrals that he was at risk, the house needed thoroughly cleaning and him being left on his own.

5. When my Dad decided to end his care package he was signed off without his case being referred for consideration by a senior member of staff. Considering the experiences in the past where Sarah:-
 - Left him without food, medication or a phone nearby.
 - The house was a health hazard to my Dad with the condition it was in.
 - There was limited space for him to have an opportunity to use his hoist and his wheelchair.
 - Sarah`s mental health.
 - It surprises me how staff would be happy to cease a care package without it raising major concerns.
6. I think Sarah should have been assessed thoroughly concerning her mental health and how she was coping on a regular basis.
7. I wish agencies had asked my Dad if there were members of the family they could contact to support him or just contacted me so I could have become involved to support him.
8. The people who truly understood the living conditions of my Dad`s home and his care were the carers. That is because they were exposed to it in its full horror and experienced it. It was tangible. This naturally moved them to request further support for my Dad. Whereas, other agencies and health professionals saw a name and information on a piece of paper. It is then easy to detach from the true picture of what was going on and dismiss my Dad`s appointments as a no show and discharge him.
9. I ask you to think about my Dad`s review and the recommendations with care and consideration. To assist in making changes where necessary so this may not happen to someone else. Also to support and monitor family members who are the carer and any changes in behaviour that may put the vulnerable adult at risk. Maybe if concerns are raised a psychiatric evaluation could be made.
10. At the end of the day imagine your loved one was in my Dad`s situation and ask yourself:-

Would you be happy with the level of care?

Would you consider the living environment safe, secure and acceptable?

Would you want this type of support and team around the vulnerable adult?

My Dad deserved a person centred approach to his care which sadly was lacking in some areas. In future with the review`s recommendations I hope this will no longer be the case.

3. Chronology

Background information:

- 3.1 Roger first became a tenant in the property where he lived in 1988. This was a joint tenancy with his wife. They had two children, one of whom was Simon who later came to identify himself as transsexual and to take steps to transition towards a female identity. He formally changed his name by deed poll in 2008. The Review will therefore refer to her as Sarah from this point. In 2005 when she was 26 years old Sarah wrote to the local authority Housing Department highlighting new tenant rules specifically regarding discrimination against gay and transgender people. She complained that a neighbour had made derogatory comments about her being gay. Sarah stated that she was not gay, but transsexual.
- 3.2 Roger's eldest daughter had a difficult relationship with her mother and during her teenage years this reached the point where she became estranged from the family and moved away from the area. This was the case up to Roger's death, as Sarah did not tell her sister that her mother had died.
- 3.3 Roger was diagnosed with multiple sclerosis in 2000 and he was under the care of his GP and the Neurology Department at Queens Hospital, part of the Barking, Havering & Redbridge Hospital Trust. Roger was seen at outpatient appointments in the early years accompanied by his wife and sometimes also with his then son (later to become Sarah his daughter). Up to approximately 2008 Roger would also be seen by the multiple sclerosis specialist nurse from the hospital at home, the service then changed and the specialist nurses were no longer permitted to make home visits; patients only had the option of hospital appointments.
- 3.4 In May 2007 a specialist multiple sclerosis nurse made a home visit following a call from Roger's wife who was concerned that he had not been seen by the Multiple Sclerosis Team for some time. The specialist nurse noted that Roger had discontinued having Betaferon³ injections 18 months previously, and he had noted a very gradual deterioration in his condition since. Roger was experiencing an increase in the frequency of falls and his left leg was dragging slightly. The main concern however, was his wife's concern that Roger was having episodes of extreme bad temper and aggression. This was said not to be directed at her, but when things were not going as they should. The nurse's report described Roger as finding his current condition very frustrating and difficult to cope with which manifested itself in mood swings and throes of temper. The situation was said to be causing friction between Roger and his wife, and the nurse asked if his GP could consider prescribing anything to relieve the mood swings. Following the nurse's report Roger's GP prescribed an anti-depressant and this appeared to help. Such changes in mood and emotions can be experienced by those effected by multiple sclerosis and prescribing antidepressants is thought to assist⁴. There were no further reports of this nature made to any professional.
- 3.5 The local authority Housing Department was informed by letter of Roger's wife's death on 13 October 2008 and he became the sole tenant from 22 September 2008. Sarah was listed as also living at the property, and it was noted that Roger was disabled. Since his diagnosis with multiple sclerosis in 2000 Roger's

³Betaferon is a disease modifying therapy which can reduce how many relapses someone has and how serious they are. Such therapies can also slow down the damage caused by relapsing MS that builds up over time. <https://www.mssociety.org.uk/dmts>.

⁴ <https://www.mssociety.org.uk/what-is-ms/signs-and-symptoms/mental-health/other-issues>

condition had deteriorated and the property had a stair lift and a ramp for wheelchair access to the house.

- 3.6 In June 2008 Sarah received a home visit from her GP as she was unable to attend surgery due to experiencing agoraphobia. It was noted 'Wanted hormone therapy. Psychologically unstable'. During 2008 Sarah attended a mental health outpatient clinic due to feeling panicky and anxious for which she was prescribed Escitalopram⁵, and then in November that year following the death of her mother Sarah was assessed with low mood and prescribed Quetiapine⁶; she received bereavement counselling for some months. A review at this time references 'to continue medication'. Sarah had been prescribed Citalopram since October 2006, although there were gaps when she was not taking the medication during this time.
- 3.7 During 2009 Sarah continued bereavement counselling and stopped her antidepressants. In the autumn of that year Sarah also took further steps towards gender reassignment and she commenced hormone treatment; her GP referred her to the Gender Identity Clinic, to whom she had been referred in the past, for review and possible antiandrogen⁷ therapy. Annual reviews under the guidance of the Gender Identity Clinic followed. During a GP appointment in October 2009 Sarah was noted as having good and bad days and she requested anti-depressants once more; Escitalopram was prescribed. The dose was reduced at the mental health clinic in May 2010 due to an improvement in mood. However, in October and November 2010 her GP continued to note depression and in addition to her anti-depressant her medication for gender identity therapy was increased. On 14 October 2011 Sarah had a review with her GP; she was prescribed a 1 month prescription for Citalopram 10mg (one tablet per day), Sarah progressed aspects of her physical gender reassignment via a procedure carried out privately. At the end of January 2012 Sarah requested a repeat prescription for Citalopram; this was the last time she was prescribed or requested a repeat of this medication from her GP practice.
- 3.8 On 13 February 2012 Sarah was reviewed by her GP in connection with an aspect of her gender reassignment and she was referred to a hospital. This date was Sarah's last prescription or requested repeat prescription for hormone therapy medication from her GP. Sarah attended the hospital appointment 2 weeks later where no problems were identified. A follow-up appointment for a scan was arranged for May 2012, but Sarah did not attend. In April 2013 Sarah's GP received a letter from the Gender Identity Clinic informing them that despite efforts to contact her Sarah had not responded therefore they were discharging her from the clinic. Sarah was copied into this letter.

Chronology from March 2012 the victim's admission to hospital:

- 3.9 On 29 March 2012 Roger attended Accident & Emergency at the King George Hospital with an infection and difficulties connected with multiple sclerosis; he was admitted for treatment. Roger's GP surgery was informed of his admission. The first reference to contact with Roger by Adult Social Care is 12 April 2012

⁵ Escitalopram (also referred to as Citalopram) is a selective serotonin reuptake inhibitor (SSRI) antidepressant: <http://patient.info/medicine/quetiapine-seroquel> accessed 07.04.16.

⁶ Quetiapine belongs to a group of medicines called antipsychotics. It is prescribed for easing the symptoms of schizophrenia; mood disorders associated with bipolar disorder. *ibid*

⁷ Antiandrogen is a substance that inhibits the biological effects of androgenic hormones and among its uses is to assist the achievement of adequate and desirable demasculinization as part of feminising hormone therapy.

http://www.transgendercare.com/medical/resources/tmf_program/tmf_program_5.asp. accessed 07.04.16

when they received a Section 2 notification⁸ from the King George Hospital; prior to his admission he was not in receipt of any services. The Section 2 mentioned that Roger lived with his daughter Sarah who worked full time. He was assessed as having substantial needs under the Fair Access to Care Services eligibility criteria⁹. Roger declined Grays Court rehabilitation and requested to go home. The following day an occupational therapist visited Roger on the ward to commence an assessment.

- 3.10 During a review with the hospital physiotherapist on 17 April 2012 Roger explained that he mobilised at home by crawling on his hands and knees, but the physiotherapist stated that this would no longer be possible as he now had a long-term catheter in place and he would require a wheelchair for inside and outside the home. Sarah had been asked to move Roger's bed downstairs, but the physiotherapist was unable to contact her. It was noted that Sarah visited the hospital occasionally, but usually at night. The Local Authority were notified of home modifications which would be required. During a follow up physiotherapy session in hospital Roger reported to the physiotherapist that money was going missing from his house. Tradesmen had been in the house, but the only other person with access was his daughter. The physiotherapist tried to pursue this with Roger, but he refused to discuss it. As Roger was deemed to have capacity under the Mental Capacity Act 2005 his wishes for no further action were respected.
- 3.11 Roger was due for discharge on 25 April 2012 with a reablement social care package¹⁰ in place, however the discharge was delayed twice as Sarah was not at home to receive the equipment needed for Roger to be discharged. He was eventually discharged on 3 May 2012 with a package of care involving four calls per day by two carers. A hoist was supplied to assist with moving Roger to and from his bed and a key safe was fitted to the house. However, on 4 May the carers were unable to gain access. They found a note on the door from Sarah saying there was no need to attend for a few days as she was at home settling her father in. When Sarah was telephoned there was no answer. The carers contacted Roger's social worker who attended with a colleague and the Police and Ambulance Service were called to assist entry. Roger was found in bed watching television and Sarah was away from the home at work; she was working on a voluntary basis in a local shop. The risks of being locked in with no phone and unable to mobilise in an emergency were discussed with Roger. There was no evidence of food for Roger only the remains of a takeaway meal, and there was no medication left for him. The social worker reported afterwards to the care agency that Sarah had been called home from work so that she could put a key in the key safe, and she was instructed in its use. The poor state of the property was also mentioned in the call.
- 3.12 On 9 May 2012 the Hospital Social Work Team notes recorded that Roger's daughter appeared not to be coping with the level of care needed, and the agency

⁸ This notification is received by Social Services from an acute hospital to inform them of the need for social services input for a patient under the Community Care (Delayed Discharges) Act 2003.

⁹ Fair Access to Care Services. The Government provided a national criteria to help councils decide who was eligible for support. This was to ensure that councils reach decisions in a fair, consistent and open way about who is in most need of our help and to use the available budget to support them. There were 4 graded levels of support needs, Low, Moderate, Substantial and Critical. When taking into account their budgets local authorities decided at what level they would set their eligibility to services. LBBB in line with the vast majority of authorities at the time set their eligibility criteria at substantial and moderate.

¹⁰ Reablement is a time limited short term package of care provided to support people leaving hospital to regain their independence. Those who are unable to regain full independence are then assessed for ongoing care and support as well as sign posted to universal services.

carers were reporting that there was no food in the house; the house was unkempt. A cat litter tray was overflowing; cat faeces was everywhere, and there were springs protruding from Roger's mattress. The care agency information described the property as being in a state of disrepair with piles of rubbish everywhere which was not being disposed of. The Hospital Social Work Team records noted that Roger's agency carer and a district nurse said he was at risk. A social work home follow up was recorded as being arranged.

3. 13 The District Nursing Service contacted a ward administration clerk at King Georges Hospital by phone on 10 May 2012 as no discharge referral had been received. They were advised to phone back the following day to speak to a ward sister. The clerk was told they would not phone back, but would undertake their own assessment.
3. 14 On Friday 11 May 2012 the District Nursing Service received a fax from Roger's GP practice informing them that he was bed bound and of the 4 carers and equipment put in place for his care. The fax also included information that Roger's daughter worked and she was going on holiday, but she had left enough food for those weeks; Roger crawled on the floor if needed. The district nurse chronology shows an assessment was undertaken; the house was in an unkempt state, the telephone in the house was not working and there was a lack of appropriate food. Arising from this assessment Roger was taken on to the district nurse's caseload for 3 monthly visits. A pressure relieving cushion and mattress were ordered, and an Occupational Therapy referral made for aids.
3. 15 Also on 11 May 2012 the Hospital Social Work Team records show the case was closed by them and passed to a Reablement manager; it was allocated that day to a support planner and care agency manager in the care agency delivering Roger's care. At 12:11hrs that day a district nurse phoned a social worker raising concerns about Roger's living conditions, lack of appropriate food, mattress problems, and carers not arriving early enough to empty his catheter which increased the risk of infection, the home phone was also not working. Action recorded is 'Allocation to support planner Reablement'.
3. 16 This was followed on Tuesday 15 May 2012 by Adult Social Care undertaking information gathering due to what is recorded as the serious concerns raised by one of Roger's carers, and by the district nurse, it was noted that Roger had nowhere to sit even if he was hoisted from his bed. Roger's agency carer reported that Sarah had gone on holiday, and Roger was left in living conditions which caused them concern; there was cat faeces on the floor, Roger was running out of medication, and there was no food in the house. (In interview Sarah maintained that she had left sufficient meals in the freezer for her father before she went away). The carers bought supplies to make sandwiches. Roger was not mobile and was therefore bed bound. Concerns were also raised about Sarah; at the last visit the carer had been told that she was at work, but as the carer was leaving Sarah appeared from upstairs. There were no reported mental health or learning difficulties concerning Sarah on record. Adult Social Care records at 14:41hrs show that the care agency Genesis was to raise a safeguarding alert.
3. 17 The following day on Wednesday 16 May 2012 Adult Social Care case notes record a home visit took place by an Adult Social Care support planner and a Genesis Care Agency manager. A safeguarding concern was raised, however it was not clearly recorded within Social Care records in their chronology by whom or to whom this was raised. The Adult Social Care IMR stated it was raised by the support planner. Later in the Review it was said to be a Reablement Team worker. The Housing IMR records an email being received from an intake manager stating that a safeguarding alert had been received, but not from whom. It was reported

that 'daughter controls all the money' and there were rent arrears. A direct debit for the rent had been cancelled in March 2012 and there was now a £2,000 debt. Emergency funds were granted by Adult Social Care for a new mattress and bed raisers; Roger had been unable to use an air-flow mattress provided by Occupational Therapy due to the poor condition of his existing mattress, a microwave oven was also purchased for meals to be heated as the cooker was deemed unsafe. An additional hour for two carers was arranged to clean. The Housing Department was contacted with regard to rent arrears. On the Thursday 17 May 2012 the Housing Department was contacted and urgent repairs needed to the property were arranged; the Department had previously tried to arrange these repairs, but were unable to gain access.

3. 18 A copy of an email included in the Police IMR shows that on 17 May 2012 at 09:39hrs a Cluster manager in the Assessment and Care Planning Team emailed an officer in the Metropolitan Police Safeguarding section regarding concerns that Sarah had control of Roger's money. The email opens with the fact that the manager had received a safeguarding alert concerning Roger. It mentions that a revenue officer had advised that Roger's rent account was in arrears of £1967.04; a direct debit previously in place had been cancelled, no rent was being paid, and there were concerns that Roger's income was being used inappropriately. Roger had stated that he did not see his bank statements and did not think he received any, however bank statements had been seen in the house. The email stated that it had not been possible to discuss the matter with Sarah as she had gone away on holiday on 12 May and it was not known when she would return. The email stated that following discussion with a colleague 'it appears that (Roger) has mental capacity to make informed decisions'. The manager asked in the email whether, on the basis of the information, the Police could be involved in the investigation as the manager felt there was potential for financial abuse, and they were prepared to carry out a joint visit with an officer allocated to the case.
3. 19 Checks were made with Welfare Benefits as Roger said he was not currently in receipt of any benefits. Threats of eviction due to rent arrears were put on hold. A district nurse contacted the social worker for an update on the query they had raised on 11 May about the environmental state of the property and requesting Adult Social Care review as soon as possible. Concern was also raised once more that Roger did not have access to a working telephone. The District Nursing Service IMR found no record of nurses being informed of the safeguarding alert.
3. 20 Between 17 May and mid July 2012 there was a stream of emails from Roger's care agency to managers in the Assessment & Care Planning department of Adult Social Care highlighting the deteriorating environment in the house. Care staff were reporting fleas, cockroaches and bed bugs, and carers were getting bitten. Until the cats were removed from the house faeces was also everywhere. Staff were on the verge of refusing to carry on. The involvement of Environmental Health was requested and a "blitz" clean as it was too large a job for the care staff. In one email reply on the 24 May 2012 by a Social Care manager it was stated that they had visited Roger and agreed that "he neglects his home environment" however they did not think it necessitated Environmental Health or a "blitz" clean, and added that his "housing officer stated that a regular hoovering of the carpet areas and basic cleaning will improve his home environment".
3. 21 On the 18 May Roger's carers heard faint cries of a cat and found one of Roger's cats was in Sarah's bedroom which was padlocked. Sarah had been away a week by this time. The RSPCA was called and Roger gave his permission for the padlocked to be removed as he did not have a key to allow the cat to be retrieved. The bedroom was found to be extremely cluttered and messy. The RSPCA officer

fed and watered the cat and checked Roger's birds who were also found to have no food and water. Roger was advised by the officer that he should think about giving the animals up, but he refused. The officer said they would call Sarah to come back from her holiday early as the birds were being neglected. Roger's carer called Careline and asked to speak to a duty social worker. Adult Social Care notes record the involvement of the RSPCA on case notes dated 20 May 2012.

- 3.22 The Police emailed Adult Social Care on Monday 21 May 2012 at 10:45hrs to inform them that as the social work assessment was that Roger had capacity and had willingly given his daughter control of his money, no crime had been identified at that time therefore there was no action the Police could take. The officer advised that it needed to be established if the money was still there and who had authority to do what with it. Until the social worker or Roger could say the money was no longer there then "we do not have any offence". The officer wrote that they could be contacted again if evidence of a crime being committed was found. The Reablement Service closed the case and assessment of Roger's long term needs were passed to the appropriate Cluster Team. The outcome of the safeguarding alert does not appear on District Nursing Service records and their IMR found no knowledge of a safeguarding alert when interviewing the staff for this review.
- 3.23 Roger's carer called his social worker on 24 May 2012 regarding the state of the property once more, but was advised that the social worker no longer dealt with the case. They said they would ask Roger's next social worker to call them.
- 3.24 at 17:52hrs on 1 June 2012 Social Care contacted the Police as Roger, who was neglecting his animals, was refusing to give the three cats and one bird to the RSPCA. Police attended and Roger was given a warning by the RSPCA that if the animals were not cared for over the next 7 days they would be removed. Roger insisted that his daughter would feed and look after the pets. However, on 6 June when Roger's carer reported the incident to Adult Social Care they stated that they had been informed by Roger that his daughter no longer lived at his address. Roger's carers reported to their manager that they were refusing to clean the property as conditions were very bad and they were requesting to pull out of the home visits.
- 3.25 Roger's GP practice received a letter from King George Hospital on 7 June 2012 informing them that he had not attended an appointment with a consultant urologist that day. A further appointment had been sent. At this time Sarah appears not to be living at the home with Roger, therefore he would have had no one to assist him to attend the hospital appointment.
- 3.26 Adult Social Care records for 8 June 2012 indicate some confusion about the service being delivered to Roger. Notes record: "Received (Roger's) wife and daughter contact details (not known if wife is deceased? Daughter still appears to be on holiday? To ensure that pets are looked after and access to the property is enabled".
- 3.27 On the 12 June 2012 one of Roger's carers reported that there were marks on his body which they thought might be by one of the cats. The marks and their location on Roger's body are not described in the records. There was also a joint visit by an occupational therapist and a Cluster Team manager to assess Roger's ongoing needs. The following day Adult Social Care case notes record contact between a district nurse and a Cluster Team manager regarding concerns that Roger is in bed all the time. An assessment was made for equipment to enable

him to get out of bed and sitting up. This exchange is not in the District Nurse Service records and it is not clear who instigated the exchange.

3. 28 On 21 June 2012 District Nursing Service records show that Roger was referred to Integrated Care Management; case management was started and as he was known to district nurses he was "put down to green"; this is recorded on GP notes on 28 June 2012. The practice nurse for the elderly and housebound (practice nurse 1) made a home visit on 10 July and found that Roger was bed bound as he was awaiting delivery of a chair which was being provided by Occupational Therapy. His medication was discussed and it was noted that he had carers four times a day and has ready meals. Roger requested his Baclofen¹¹ medication in tablet form due to a burning sensation in his throat. This was to be discuss with the doctor. The following day the nurse visited Roger accompanied by a GP regarding symptoms connected with multiple sclerosis, and a decision was made to refer to a multiple sclerosis nurse to consider physiotherapy.
3. 29 On 3 July 2012 it is recorded that a personal budget for Roger's social care package had been agreed. A referral was also made by Roger's social worker for him to receive Floating Support with completing benefit claim forms as he was in rent arrears and at risk of eviction. The referral form asks if 'this is a domestic violence case' to which the answer was 'no'. It was noted that Roger was vulnerable, had serious health problems and he needed help to access benefits. At a visit by a member of the Housing Access and Referral Team on 10 July Roger admitted that he knew nothing about his money as his daughter dealt with it, but he could not assist them with contacting her. The housing officer recorded that they thought Sarah was living somewhere in Essex. Records note that Roger expressed no animosity towards his daughter (it is presumed that this related to the rent arrears). A referral was also made for the property to be fumigated to eradicate fleas. On the 4 July a referral was made for Roger's home to be "blitz" cleaned.
3. 30 Sarah telephoned the Housing Department on 13 July 2012 stating that she wanted to pay off her father's rent arrears of £2,740 and she would set up a direct debit so that arrears did not occur again. Sarah also agreed to put all her father's paperwork back in his property so that an officer could sort out his housing benefit. This suggests that Roger may have contacted Sarah or she visited him following his meeting with the Floating Support officer. Court action concerning the arrears was suspended.
3. 31 Late in July Roger's cats and birds were removed by the RSPCA as their care was still inadequate.
3. 32 In response to a request by one of Roger's carers practice nurse 2 made a home visit on 31 July 2012 to address problems with Roger's catheter which was blocked and causing him pain. A phone call was made to a district nurse who was going to call to change the catheter. Whilst practice nurse 2 was at the house a special pressure relieving mattress ordered for Roger arrived. The nurse signed for the delivery as Roger was unable to answer the door and receive it, however it was to take a few weeks before this appears to have been put in place. Two weeks later on 16 August Roger's GP visited accompanied by practice nurse 2 to give him a check up and review his medication. His next home visit was 3 months later on 11 December 2012 when practice nurse 1 undertook a routine check. District nurses continued to make almost bi-monthly visits for catheter care.

¹¹ Baclofen is used to treat muscle symptoms caused by multiple sclerosis, including spasm, pain, and stiffness.

- 3.33 On 3 August 2012 a support planner in Adult Social Care noted difficulties in arrangements for the "blitz" clean of Roger's home and the amount of personal care he needed; case notes record "may need double up care for hoisting as mobility is very poor". On 8 August Roger ceased having his personal care provided by carers from Genesis and a service provided by personal assistants paid for from his personal budget began.
- 3.34 There was a duplication of recording 'Dirty or Verminous property' within the Housing Department. One retrospective note added following a conversation with a social worker on 20 August 2012 when it was recorded that the property was cluttered and flea infested and flea treatment was booked. Another record by a housing officer on 28 August noted a breach of tenancy conditions and that the garden was also badly overgrown. Fumigation treatment to eradicate fleas took place on 24 August, however a further treatment had to be undertaken of the house, apart from Roger's bedroom as he was bed-bound. Roger was spoken to regarding tenancy conditions. Later an 'Eyesore warning' letter was sent regarding the state of the garden.
- 3.35 On 13 September 2012 the Housing Advice Service received a homeless application form from Sarah; it records "claims abusive relationship with father. Homeless application taken/applicant advised she will stay with a friend". It would appear that the application was not followed up as on 20 December 2012 records show that the service was unable to make contact with Sarah and the case was closed.
- 3.36 Adult Social Care records of 24 September 2012 note 'Safeguard Closed', and "investigated with no further action but casework was required". A Post Safeguard Review of the case followed on 18 October when it is recorded that there were no concerns and Roger was happy his care.
- 3.37 Roger was on the Integrated Care Pathway and he was discussed at Integrated Care meetings on 25 October and 22 November 2012 and was recorded as "on Amber" due to his complex needs. During the latter months of 2012 activity around Roger's care concentrated on ensuring he had access to the correct benefits and concerns about his immobility; a wheelchair was ordered and a hospital bed delivered, plus aids to help him out of bed and with sitting up.
- 3.38 Roger failed to attend a second appointment made for him to see the hospital urology consultant on 11 October 2012. His GP practice was informed that one further appointment would be offered.
- 3.39 On 22 November 2012 during a home visit by a housing officer the property was found to be in good condition; there were no more cats and it was recorded that Sarah was looking after Roger's affairs. The overgrown garden was referred to an environmental tree officer.
- 3.40 Adult Social Care case notes on 10 December 2012 record that Roger was experiencing leg spasms and had been referred to multiple sclerosis services at Queens Hospital.
- 3.41 Between January and May 2013 the local authority had to resort to court action for rent arrears once more. An eviction letter was served on Sarah on 23 May and she eventually paid the arrears in June 2013. This suggests that no direct debit was in place. The events in the following paragraphs may give context for what was taking place around this time.

3. 42 On 23 January 2013 a friend of Sarah's contacted the Police to report what she said was a burglary at her home. No items were stolen, but clothing belonging to Sarah was found in the victim's wardrobe. Sarah was interviewed on 21 March and provided a sample of DNA which matched that found on clothing at the victim's property. The entering into the friend's house and the trying on of clothes would later be recorded as criminal damage (see paragraph 3.47). The victim of the burglary phoned the Police once more on 22 March to report that she had received a text message from Sarah stating that she was going to commit suicide. The Police visited Roger's home to check for Sarah, accessing the house using the key safe. Roger reported that he had seen Sarah earlier that day and her mood appeared normal. He was unaware of the Police investigation regarding the burglary. Roger tried to phone Sarah's mobile, but there was no answer. This was followed by a second call to say that the victim of the reported burglary had spoken to Sarah and she was no longer considering taking her own life.
3. 43 On 31 January 2013 Roger's GP practice received a letter from the hospital consultant urologist informing them that he had not attended the third appointment sent to him and he had been discharged.
3. 44 At 03:39hrs on 23 March 2013 the Police received a call from Roger requesting an update on his missing daughter. He was advised to contact the Missing Persons Unit, but he was unable to write the number down. Roger said he would call back in the morning to be put through. Roger phoned again at 08:30hrs again asking for any updates and was again advised to contact Missing Persons. Once more Roger said he would call back as he was unable to write the number down. At 11:54hrs the Police received a call on behalf of Roger requesting an update on Sarah. The operator phoned back, but there was no reply. A marker was put on the CAD system to transfer the caller to Missing Persons when they called again. At 16:22hrs Sarah's friend and victim of the burglary phoned informing the Police that she had received a letter from Sarah saying she would never be accepted & saying goodbye. Her friend felt this was a suicide note. The Police attended Roger's home at 14:07hrs and Sarah was seen getting out of a taxi. When spoken to she apologised for the fuss she had caused. She said she had needed some time alone, she did not intend to harm herself and she would see a doctor if she felt depressed again. Sarah told officers that she had been on trains and buses visiting two towns and had been to visit her mother's grave. The missing person report was cancelled.
3. 45 The North East London Foundation Trust (NELFT) tried to deliver a wheelchair for Roger to his home on 12 March 2013, but there was no reply. Attempts to reach Roger and Sarah by telephone were unsuccessful. An appointment letter was sent for 8 April 2013. Sarah had been informed that the room needed to be clear to test the wheelchair, however, this was not done consequently the wheelchair could not be tested and another appointment was given.
3. 46 Roger was discussed at an Integrated Care Pathway meeting on 1 May 2013 and records note 'More details to be scanned'. The next Care Pathway meeting on 4 July 2013 records the same note.
3. 47 On 14 June 2013 Sarah was arrested and interviewed in connection with the burglary reported by her friend on 23 January 2013, she admitted entering the victim's house and trying on her clothes. Photographs of the victim (her friend) were also found in her possession. Sarah was charged with criminal damage and pleaded guilty; she was fined £100, with £10 costs and £20 compensation. A 5 year restraining order was also imposed not to attend the victim's property.

3. 48 Roger was discussed once more at an Integrated Care Pathway meeting on 18 July 2013 and it is recorded "step down to Green". On this day NELFT successfully delivered a wheelchair for Roger. Its functions were shown to both Sarah and to Roger's carers. It was noted that Roger was keen to get out and about in the wheelchair. A headrest was provided for the chair two weeks later.
3. 49 Roger continued to have problems with his catheter, and on 7 October 2013 at 08:08hrs Sarah phoned NHS 111 reporting that his catheter was 'playing up' and causing her father pain. She was advised to contact her GP within 2 hours. A home visit was made that day by a community nurse from the Community Treatment Team¹² and the problem was treated. Antibiotics were requested and subsequently prescribed and Roger was advised to drink plenty of fluids. He was discharged from the Team with the invitation to his GP practice to refer again if required. Also on the 7 October Sarah had an appointment at the GP surgery for abdominal pain. This is her last recorded medical appointment with her GP.
3. 50 During a home visit for medication review on 18 October 2013 by practice nurse 1 it was noted that Roger had a carer in the morning for personal care, but was staying in bed most of the time. He had a new electric scooter, but his legs felt uncomfortable (he suffered from leg spasms connected with multiple sclerosis), hence he had only used it once. It was recorded that his daughter stays at home to look after him. Roger requested his Baclofen liquid in tablet form as he did not like the taste of the syrup.
3. 51 On 30 October 2013 the GP practice received a telephone request for a home visit by 'a relative' (this was likely to be Sarah in the absence of record). Roger's catheter had been changed the previous day and there were problems, plus Roger's leg spasms were increasing. The problem was dealt with by district nurses and a prescription for antibiotics was issued following tests.
3. 52 On 8 November 2013 an occupational therapist made a home visit, but no one appeared to be at home, no phones were answered, and the key safe was empty. A call was made to Roger's GP practice who confirmed that they had phone contact with Sarah on the 6 November. A further visit on the 14 November was successful and confirmed that all the equipment provided was working and being used by Roger (this is contrary to observations by practice nurse 1 that Roger had only used the scooter once see paragraph 3.48). There is nothing in the notes to indicate whether Roger was in fact at home at the previous visit and why the key was missing from the key safe.
3. 53 On 22 November 2013 Roger's GP wrote to a doctor in the Department of Neurology at Barking Hospital asking for Roger to be seen pointing out that he was known to the Department of Neurology and the Multiple Sclerosis (MS) nurse at Queens in the past, and according to surgery records the last time he was assessed by the MS Nurse was in 2009. The letter included information that

¹² The Community Treatment Team (CTT) are a rapid response team. The service is for people aged 18 years and older, living in Barking and Dagenham, Havering or Redbridge, and provides short term intensive care and support to people experiencing a health and/or social care crisis. The service aims to contact patients within two hours, and support them to remain at home, rather than calling an ambulance or going to the accident and emergency (A&E) department. A patient would not have Team's number unless they had visited before following a request from the GP. Roger received a service from the Team on occasions in response to the District Nursing Service rapid response calls up until January 2015. Therefore Roger and Sarah would have had the Team's contact details and be able to call them.

Social Services were involved in Roger's care and they had requested that he be referred back to the MS Nurse for assessment. The practice had spoken to a multiple sclerosis nurse that day regarding the request and was seeking the doctor's further advice and intervention. As a result of this letter an appointment was made for Roger, but twice he did not attend. There is no indication that a community based MS nurse was arranged to visit.

3. 54 A practice receptionist spoke to Sarah by phone on 5 December 2013 and informed her about medication prescribed by a doctor for Roger due to regular urinary tract infections (UTIs). The note records "No consent for seasonal influenza vaccination as per the discussion in ICS meeting". This was based on advice from a hospital doctor due to the multiple sclerosis.
3. 55 On 29 December 2013 Roger was admitted to the King George Hospital via Accident & Emergency due to a blocked catheter and infection. His GP practice was informed.
3. 56 NELFT Wheelchair Services had a telephone call with Sarah on 14 January 2014 following a referral made by Occupational Therapy for a power chair. Sarah cancelled the assessment appointment stating that her father did not want a power chair. This is counter to Roger's earlier keenness to get out and use the wheelchair which was delivered the previous July. There is no information to confirm that Roger was seen alone to confirm that this was his wish.
3. 57 On 7 March 2014 there were more than 4 weeks rent arrears once more and recovering action was to be taken; the rents officer tried to contact Sarah on 9 May by phone, voicemail and text. It would appear that this was resolved as the next reference to rent arrears is on 18 June 2015 when it is noted that the tenant seemed to make payments to reduce arrears and was usually in credit.
3. 58 On 25 March 2014 Roger was send a letter from a consultant neurologist at Queens Hospital to attend the neurology clinic. He did not attend. A further appointment was sent on 19 August 2014 and again Roger did not attend. A follow up appointment was to be sent in 3 months time.
3. 59 On 24 July 2014 Sarah phoned Adult Social Care and cancelled Roger's carers as she said she wanted to look after her father herself. Attempts to reach Roger or Sarah by calling both landline and mobile phones on the 31 July were unsuccessful, and so a letter was sent to Roger from Adult Social Care letting him know that a reassessment was required. This was followed by a home visit on 8 August 2014. The social worker undertaking this visit was not aware of the extent of Roger's previous care i.e. the need for 2 carers for moving and handling, nor of the safeguarding alert in 2012. Roger confirmed that he did not want to continue with the care package as Sarah was now going to provide all his care. Case notes record that Sarah was offered a carers assessment and she was advised about carers allowance. It is not recorded whether or not a carers assessment was completed; from the absence of records it is assumed Sarah declined. Roger stated that he was happy with this arrangement. It is not known whether he was seen on his own during this visit, and the outcome of this reassessment was not loaded onto the Social Care database. On 14 August 2014 Roger and Sarah signed the consent for withdrawal of the care package and there is a case recording on that day confirming the termination of care had been discussed by the social worker with their manager and closure agreed. No closure summary was on the database.
3. 60 A home visit to assess Roger took place by the practice nurse for the elderly and housebound on 22 September 2014. Sarah was present and it was recorded

that she was now Roger's main carer. Roger remained in bed; there were no catheter problems. The missed appointments to attend the neurology clinic was raised and it is recorded that no first invitation was received; a further appointment 3 months from August was to be sent. It is not recorded who said that the invitation was not received, but as Roger was bed bound and Sarah dealt with post it is highly likely that it was her. In interview Sarah reported that her father did not attend the appointments as it was too painful for him to get out of bed and make the journey to the hospital and he felt there was nothing that could be done anyway. Asked why she did not cancel the appointments she admitted that she should have done.

3. 61 The next assessment home visit for Roger took place 4 months later on 23 January 2015 by the practice nurse for the elderly and housebound. Sarah was present. There were no catheter problems; the district nurse visited if there was a problem. Roger requested Baclofen in tablet form as he did not like the taste in liquid form; this was the third request by Roger for this change which was first made in July 2012. It was noted that this would be discussed. An assessment for dementia was undertaken, and it was noted that Roger was conversant and slow due to multiple sclerosis. Roger was bed bound and watched television most of the time. This is the last entry in Roger's GP record before he died in September almost 9 months later.
3. 62 During March, April, May and July 2015 there were seven attendances to treat Roger for a blocked catheter by the out of hours nursing service. District nurses made routine visits in June and July 2015 for catheter care and pressure area monitoring.
3. 63 Contact was made with one of Roger's personal assistants on 10 April 2015 by an Adult Social Care manager requesting that they made a welfare visit to see how Roger and Sarah were coping without a formal package of care. However, the personal assistant was unable to feedback the results of her visit as she was unaware who she had been contacted by, and the team manager did not call back. The former personal assistant reported in interview for the review that generally everything seemed to be going well.
3. 64 There were signs that the garden of the property had become overgrown and neglected when on 10 April 2015 a Garden Assist Request was made by a local ward constituency panel stating that this had been requested on 10 occasions. Records show this as 'case closed' and 'referred to other department'. No further notes were made.
3. 65 In July 2015 one of Roger's neighbours contacted the Local Authority with concerns that Roger's garden and a tree were overgrown and as he was disabled he required assistance. An officer was requested to provide a report, however, there are no records to show that a visit to the property took place. On 24 July 2015 there was a stair lift service and repair visit to Roger's home.
3. 66 On 13 and 21 August 2015 a district nurse made a routine visit to Roger for catheter care and pressure area monitoring; no issues were recorded. This was the last visit by a professional before Roger was killed.
3. 67 On Thursday 10th September 2015, uniformed police officers attended Roger's home address to conduct a welfare check in response to a call from a concerned neighbour. The neighbour informed the Police that Roger was an unwell man who required constant care and that his daughter, Sarah, was his carer. The neighbour stated that the hallway light, usually on, had not been lit for a number of nights.

3. 68 At 11:28hrs, officers forced entry to the front door and made their way into the address. Officers discovered Roger's lifeless body in the rear ground floor room. Laid out on a sofa in this room were three pages of handwritten notes. The content of the notes stated that the writer had killed the male who was referred to as Dad. It was evident that Sarah had written the notes. There were further references to Roger suffering, and to Sarah killing herself now her father had died. Within the room with Roger were a suit and a teddy bear. Sarah made reference in a note to the suit and toy stating that her father should be buried in the suit and the toy placed in the coffin. A search of the address revealed no sign of Sarah. At 15:45hrs Roger was pronounced life extinct.
3. 69 Following extensive enquiries Sarah was traced to a hostel in a town in the south of England. On arrest and caution Sarah replied "I just wanted to explain that I've been speaking to the Mental Health Nurse at Catching Life Centre and I was planning with them to hand myself into police tomorrow morning with them". Whilst in custody a search of her belongings was conducted and a typed note was recovered from her holdall. The content of the typed note is shown below.

"Dad couldn't go on anymore being bed bound, he asked me to help end it. Now I have to end it too as helping my dad to stop suffering is classed as a crime if it were an animal you would put it out of its misery but a human you want to suffer as long as possible. We have the cheek to call us civilized. I have left to end it for sure with nobody finding me before I am gone. Dad is to be buried with his wife. He has already paid for a triple plot he is to be buried in the suit laid out by this book. The stuffed toy on the suit and the one with him are to be placed in his coffin with him. I don't care what happens to me. He is a wonderful man. Whoever finds this needs to know what a good, good man dad was. He did not deserve to get ill. He is such a great dad he was a selfless wonderful person. I love him so, so much."

3. 70 The post mortem gave cause of death as 'consistent with plastic bag asphyxia'. It was noted that this finding was reliant on information provided by the defendant, and should be reviewed if further information became available.
3. 71 The Police investigation identified that a text had been sent to the District Nursing Service on 2 September requesting them to visit the patient that night. There is no record or action to suggest this text was read, otherwise Roger's body could have been discovered 8 days earlier. The Review Panel was informed that the District Nursing Service night service do not usually receive referrals or requests by text, they have small mobile phones on which the receipt of a text is indicated by a small envelope and in this case the staff did not see it. Early learning from this was that a revised process was set up in October 2015. Details of this process appear in the Early Learning section of this report on page 58.

4. Overview

Summary of Information Known to Agencies

- 4.1. All agencies knew that Roger suffered from multiple sclerosis, was disabled by this condition, and that he was bed bound and house bound during the last few years of his life. He had home visits from various professionals, including his GP, and failed to attend hospital out-patient appointments, although it is debatable as to whether Roger himself knew about the letters containing these appointments.

- 4.2. Professionals who visited Roger's home were aware of the deteriorating environment, particularly when there were cats in the house. However, there appeared to be different thresholds of acceptance with regard to the unhygienic and very cluttered conditions which appear to have endured past the "blitz" cleaning of the property in 2012.
- 4.3. There were times when full information was not achieved to accurately inform assessments. For example Roger was discharged from hospital without the recognition that his bed mattress was far from suitable and other aids were not in place before he went home.
- 4.4. Most crucially information known to agencies surrounding the safeguarding alert in May 2012 appears to be ambiguous, with some agencies unaware that an alert had been raised or that it concerned possible financial abuse.
- 4.5. There were times when some agencies knew Sarah was living with her father and others did not. It has also been very unclear from the information available to this review when this was the case. At least two agencies appear to have mentioned contact details for Roger's late wife and were unaware she died in 2008.
- 4.6. Information available to agencies in the final 13 months of Roger's life was limited by the fact that he and Sarah had cancelled his package of care. Thus an external view and information about the household was limited to the regular visits by district nurses, two visits by the practice nurse for the elderly and housebound, and a visit arranged by the Housing Department to service the a stair lift which was not actually used by Roger.
- 4.7. **Information about the Victim**
- 4.8. Roger and Sarah lived an isolated life in the last 13 months before his murder. Contributors to this review who knew them over differing periods of time confirm that even before Roger was diagnosed with multiple sclerosis in 2000 he and his wife did not socialise, and he did not keep in touch with former work colleagues after his retirement. Roger's wife suffered from depression for many years, and there was a history of contact with mental health services. Roger's wife is described by contributors who knew her as controlling. For example if Roger went to talk to his neighbour she would say there was a phone call for him to make him go inside when there actually was no phone call for him to answer, and she would control who the family saw.
- 4.9. Roger is described by contributors as a lovely man. His hobbies were playing the guitar and the banjo. His instruments were found in the house after he died, although it is not known if he played them in the latter years due to his disability. Sarah said her father liked wildlife, comedy and science fiction television programmes. Prior to his illness Roger had also enjoyed photography and model making, but he could no longer manage these interests as his medical condition progressed. Roger's eldest daughter also reported that he and his wife were keen gardeners and Roger continued to keep the garden in order after her death while he was still able. Given what is describe as Roger's passion for his garden, his eldest daughter believes it must have been very disheartening for him to see his garden become as overgrown as it did.
- 4.10. One contributor remembered meeting Roger on his mobility scooter on one occasion; this meeting was thought to be around 2 years before Roger went into hospital 2012, but there is no indication that Roger used his mobility scooter in

recent years. However, it does demonstrate that Roger was not a recluse and he did go out into the community at that time. Where he lived was near to shops and a health centre with good footpaths over level ground giving ease of access by mobility scooter if he so chose. Roger's daughter confirmed that his neighbour told her that in the past Roger regularly visited his wife's grave on his mobility scooter and he would go to the park.

- 4.11. Sarah reported in interview that before the admission to hospital, Roger was "wall-walking" and a stair-lift was in use at the family home, although Roger told hospital staff that he mobilised by crawling on all fours, and he had been told that this would not be possible on returning home due to his catheter. Upon discharge from hospital in May 2012 he became increasingly bed bound, and developed problems with leg spasms. From this point his condition remained the same, with no marked improvements or deterioration. Roger's eldest daughter was deeply moved and upset at learning how undignified this must have been for him; she remembers her father as a very independent person and he would have done anything to remain independent. However, it is clear that he would have needed help to achieve this, to move into his wheelchair, to go outside etc, but it appears that Sarah did not give him this assistance.
- 4.12. There is evidence to suggest that as his illness progressed unsurprisingly Roger's mental wellbeing was affected. As noted in the chronology (paragraph 3.3) the report by the multiple sclerosis nurse to his GP in May 2007 reported that he was 'experiencing episodes of extreme bad temper and aggression'. Roger was frustrated by his condition and found coping with it difficult. The mood swings were causing friction between Roger and his wife. Roger had discontinued Betaferon injections 18 months previously and there had been a gradual deterioration since that time. It is not recorded why he discontinued Betaferon therapy. Following this report Roger was prescribed an anti-depressant which is reported to have helped. However, this medication was stopped by a different doctor in September 2010 because he appeared to be better.
- 4.13. The MS Society suggest that perhaps 50 per cent of people with multiple sclerosis experience clinical depression or something more severe at some point, in addition a variety of factors can contribute to mood and emotional and behavioural changes ranging from MS-related nerve damage, a psychological reaction to MS, depression, or the side effects of medication.¹³
- 4.14. Because Roger was bedridden in later years he was only seen by health professionals and Sarah in his final months of life. His neighbour reported that apart from entering the house briefly with the Police when they attended and found Roger's body they had not seen him for a long time as they would not go in the house due to what they described as the unhygienic state of the property.

Information about the Perpetrator

- 4.15. When she was a young boy Sarah is said to have been bullied at school, but instead of resolving the matter with teaching staff Sarah was taken out of school at around the age of 14yrs and home educated. In fact Sarah explained that this entailed collecting work from school and returning it when it was completed. She did not take any exams and therefore ended her formal education years with no qualifications. Sarah is said to have had solitary hobbies such as stamp collecting.

¹³ <https://www.mssociety.org.uk/what-is-ms/signs-and-symptoms/mental-health>

- 4.16. Sarah is described as loving her father, but she was much closer to her mother, some thought unusually so. When she was around 13 or 14 years old Sarah said she was a carer for her mother who had depression and also a bad hip at that time. A contributor to this review has denied that Sarah needed to care for her mother at this time. One contributor believed her mother's death affected Sarah greatly, and indeed she had bereavement counselling for some months.
- 4.17. Sarah began the process of transitioning before her mother died in 2008. She states that both her mother and father were supportive of this and it did not cause any tension between them. Sarah stated that her mother had said "I'm sad to be losing a son, but happy to be gaining a daughter", and that her father had said "As long as you're happy then I'm happy". As is evident from Sarah's contact with the local authority in 2005 (paragraph 3.1) she is clear about her identity and sees herself as transsexual, her outward appearance is female, and she is equally clear that she is not gay. Sarah said that she had a few short term relationships when she was younger, but nothing in recent times; she stated that she had all her needs fulfilled by being at home and caring for her dad. She explained that they had no social visitors; as a family they were "very insular and didn't have friends". Sarah stated that she did not really have any friends apart from one (this friendship ended in 2013). When asked what she liked to do for fun Sarah said that she had fun with her dad. Due to her agoraphobia she did not like to go out or socialise, and everything she needed was at home.
- 4.18. A contributor confirmed that they rarely saw Sarah in the last year; she would take a taxi in the morning or at night to go shopping, and takeaway meals were delivered. The bins were always full of takeaway cartons. Sometimes she would say hello, other times she would dart in doors quickly to avoid speaking. The contributor described Sarah as becoming a recluse.
- 4.19. When interviewed and asked if she was ever employed Sarah said she had a voluntary position at a friend's shop which she ended some time in 2013-14 when she became full time carer for her father. There were in fact personal assistants providing care to Roger until August 2014. The owner of this shop described how in around 2010 Sarah would keep coming to the shop and hanging around until eventually the owner let her start helping. At one stage the owner reported to the author that she was "feeling stalked" by Sarah around this time as she kept turning up. This voluntary position developed into full time work and Sarah would serve customers, carry out stock control on the computer, and on occasion would open the shop. Sarah would also socialise with the owner and her family and friends, going shopping together and to parties. The author has seen a photograph of Sarah and a group of friends at one of these occasions and it portrays someone, who at that time, presented as having a lifestyle which is contrary to that of someone who has a history of agoraphobia.
- 4.20. On one occasion a contributor interviewed for the Review recalled that Sarah was particularly stressed and crying and disclosed that she had hit her dad. The contributor thought this was in the summer of 2012. Sarah was told this was unacceptable and that she should not hurt her dad. She was advised to get carers in to help and that she had to do something for her dad. At this time carers were attending her father four times a day.
- 4.21. Another contribution to the review described how Sarah went to stay with a couple who were friends for 4 or 5 weeks. She slept on their sofa until she was asked to leave when the couple found bottles of urine and drugs behind the sofa. When challenged about the find Sarah denied she was responsible, but she was the only person using the room apart from the couple.

- 4.22. Asked how she felt about having carers for her father Sarah said she found it difficult it "freaked me out". She explained that this was the reason she had gone away on holiday shortly after her father came out of hospital. Sarah maintained that she had informed the carers she was going away; that she was away for a week (information from carer agency records indicate Sarah was away at least 2 weeks) and she had left food in the freezer for her father. She reported that the carers would go into other parts of the house including upstairs searching for clothes for her father instead of asking her (carers reported only seeing Sarah once when they were there). She said they even went into her room (this was with Roger's consent with the RSPCA to release a trapped cat). Sarah related one occasion when she said she had been getting changed and a carer had come into her room. This had 'freaked her out' and she said this was the reason she left for a few days.
- 4.23. During interview Sarah was asked about her agoraphobia and why she had not returned to her GP for help given that she had received medication before (in 2008 when a GP visited her at home). Sarah agreed that she had not seen her GP for some time (her last GP appointment was October 2013 for a minor illness; 2 years before she killed her father). She said she had been taking Citalopram for anxiety, and had counselling which she felt was not helping, so she decided to self-manage. She said she had not had medication for agoraphobia but had a prescription for depression. At the time of Roger's death Sarah had not been in receipt of any prescribed medication from her GP practice for depression or anxiety since January 2012, or for hormone therapy since 13 February 2012.
- 4.24. Sarah reported experiencing aggravation at work from young people who came into the shop and this had increased her agoraphobia. When asked how she had managed to go to Dover after the fatal incident she said she intentionally left home very early in the morning to avoid people, but it was difficult; she said she was very sweaty and felt all eyes were on her. Sarah described that she had seen on line that the cliffs at Dover were known as a place where people went to commit suicide and this is why she was going there.
- 4.25. When asked whether her father could have been depressed (acknowledging that she was not medically trained) Sarah said she did not think so. He seemed to 'get annoyed at his condition' and he did get frustrated with his legs and being stuck in bed. When it was put to Sarah that there had been medical advances in treating multiple sclerosis since her father was diagnosed which could have helped his condition, she reiterated the view that as Professor Hawkes had said when her father was diagnosed, there was nothing that could be done therefore they thought there was no point in going to hospital appointments. Sarah also said "had we known of anything which could have helped my dad, even if the leg spasms were dealt with, he would still have been fed up with his life and the four walls." When asked if her father had expressed a wish to end his life before the time of the incident Sarah said every day he had a grumble.
- 4.26. Roger's eldest daughter attended the trial and observed that Sarah appeared to be removed and disengaged from the seriousness of the crime. The report author observed this demeanour in Sarah when interviewing her in prison. During the trial a witness giving evidence about their interview with Sarah as part of an assessment for their charity's services stated that Sarah reported that she had been homeless for the past month and told them that she had 'fallen out of love with her father' and this was why she was homeless. Sarah denied this in court. When asked in court why she had said she wanted to make a 'fresh start' Sarah said she didn't want to tell the truth about her father's death as she wanted to find the 'right person' to tell. Sarah was arrested before she told anyone.

Equality & Diversity

- 4.27. Under the Equality Act 2010 it is illegal to discriminate against anyone on the grounds of their age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; or sexual orientation. This review has found no evidence of Roger having been subject to discrimination on the grounds of his disability or his age. For example when it was discovered that he was not claiming any benefits to which he was entitled these were arranged. Appropriate aids were provided or offered commensurate with his level of disability.
- 4.28. It is difficult to judge if Roger would have kept his hospital appointments if more pro-active actions had been taken to assist him attending the hospital. There is a process for arranging hospital transport, but this was not arranged for Roger. However, this can often involve long periods of time in the vehicle and extended waiting in the hospital whilst others using the transport complete their appointments. If, as Sarah stated, Roger found it too painful to get out of bed due to his leg spasms, then this indicates an additional need which at that time was not being met and which was impeding his ability to reach the hospital. The Review has learnt that there is now a community based specialist multiple sclerosis nurse who is once more able to see patients in their own home. Whether access to this specialist could have alleviated the symptoms which caused Roger pain, low mood, and frustration, it is not possible to speculate, but more could have been done to assist Roger's access to the hospital and the specialist care he required. It is also arguable that had Sarah been so minded she could have arranged a wheel chair accessible taxi to take her father to hospital.
- 4.29. The Review found no evidence of Sarah being discriminated against on the grounds of her gender reassignment by services. She was offered appropriate support from her GP, Gender Identity Clinic, and Mental Health Services with the transition she was seeking to meet her gender identity needs, but Sarah chose to disengage from continuing care for this. Agencies with whom she was in contact amended their records with her change of name and referred to her appropriately as Roger's daughter from that point.
- 4.30. Although the Equality Act was not enacted at the time, Sarah was able to use her local authority's tenants policy to report what was termed 'derogatory remarks' about her sexuality in 2005 (paragraph 3.1), stating that she was transsexual and not gay. Although it has not been possible to find the outcome of her contact concerning this due to the time which has elapsed.

5. Analysis

- 5.1 This analysis will draw on information from agency IMRs and from the contributors who were interviewed for the review. For ease of reference the analysis will aim to address each of the terms of reference.
- 5.2 ***Term of Reference 1.*** *To review the events and associated actions that occurred which relate to the victim and the perpetrator between the end of March 2012 when the victim was admitted to hospital which instigated the first referral to Adult Social Care and 10 September 2015 the date the victim was found dead. Agencies with knowledge of the victim or alleged perpetrator in the years preceding the timescale for detailed review are to provide a brief summary of that involvement, with the exception of Mental Health Services where detail*

concerning their involvement with the perpetrator from first referral to case closure should be detailed.

5.3 This term of reference has been addressed in the chronology. The events will be examined in line with the specific areas set out below. In respect of Mental Health Services their background information was concerned with the assessment process for Sarah's transition and the detail given in their chronology was sufficient to show that this was not directly relevant to the events which brought about this review, however it has been touched upon in the background information.

5.4 **Term of Reference 2.** *Agencies which had involvement with the victim and the perpetrator to assess whether the services provided offered appropriate and timely support, resources, and interventions to meet the needs and safeguarding of the victim, and that procedures were followed*

This term of reference will be addressed under the key subject areas and incidents under review.

5.5 **Roger's Health Condition**

5.6 There is no cure for multiple sclerosis, a degenerative disease which is the most common cause of progressive neurological disability affecting young people with an estimated 100,000 patients in the UK. The median age of onset is around 30 years of age although it can also affect middle-aged adults. The cause is unknown, but is thought to be multi-factorial, with genetic and environmental contributing factors¹⁴. The most common form of the disease affecting about 85% of people is characterised by the patient experiencing attacks of new or worsening symptoms. For example Roger experienced increasing levels of leg spasms and contractions which greatly impeded his mobility and caused him pain and discomfort. Patients may find attacks are followed by periods of improvement or stability.

5.7 Roger's GP practice IMR is open in its findings that more could have been done medically to support Roger and the IMR identifies major guidelines which when followed can produce a good clinical outcome. A clinical review has found that quality of life has improved since neurologists have introduced disease modifying drugs, quality of existence is improved and relapses shortened in a clinically significant way. As the IMR points out however, Roger did not access the clinical care at the practice or the hospital, even though the practice wrote to him and referrals were made to the hospital for support with his symptoms. The possible barriers to Roger seeking or accessing the help offered is explored in paragraph 5.19 and in Term of Reference 4 below.

5.8 Unfortunately, Roger appears not to have been referred to, or engaged with, the MS Society. There is no GP note on file indicating that this was explored or plans made for this to be done. The multiple sclerosis specialist nurse stated when interviewed that patients are given information leaflets when they are new to the service, however, in the early stages when a patient is still active and mobile these sources of support may seem superfluous at the time and a patient may put them aside. The reintroduction of information about informal support organisations may well be needed more than once and at different stages of the illness.

¹⁴ Multiple Sclerosis: Clinical Review. Western General Hospital, Edinburgh

- 5.9 In the analysis of the GP IMR the author found there were efforts made to offer good care by a variety of agencies, however it was felt with hindsight to be short of ideal. The IMR suggests "a picture of complacency and apathy on the part of carer and subject" which was not addressed by any agency. The complacency and apathy referred to appears to be a justified hypothesis which is confirmed by Sarah's opinion that having been told at diagnosis there was nothing to be done, there was no point in going to hospital appointments when her father would find this painful and uncomfortable. Nevertheless there appears to have been no challenge to this perception either practically or psychologically with Roger and Sarah, nor a referral on to specialist support such as the MS Society which may have provided peer support with which Roger might have engaged.

The recommendations appearing within this Analysis section are numbered as they appear in the Action Plan accompanying this Review, not numerically as they appear here.

Recommendation 4:

All agencies working with those with long-term illnesses should ensure that each review routinely includes an assessment of a person's psychological and mental resilience and wellbeing, the up to date management of any adverse symptoms, and information about informal sources of specialist support.

Recommendation 26:

A record of all services with whom a patient is engaged (i.e. MS society, Integrated Care Team, Social Services, etc) and the interactions these services have with the patient, must be routinely recorded on the patient's medical record. If the patient's home has a key safe, all agencies must be informed that the key safe code lies with the GP.

Recommendation 29:

In addition to ensuring all patients with multiple sclerosis are referred to the community MS specialist nurse, the practice should ensure that patients are referred to a suitable support agency such as the MS Society or MS Trust UK.

Recommendation 30:

The practice should put in place a clear strategy for managing patients with multiple sclerosis in line with best practice which includes multidisciplinary reviews of their mental wellbeing as well as their physical symptoms, and consideration of how their carer is coping.

- 5.10 The GP practice was found not to have a register of patients who were carers. It would be advisable for the practice to rectify this as it can help clinicians to identify any conditions in a patient which may have a link to their caring responsibilities, and for appropriate support to be provided promptly.

Recommendation 27:

The GP practice should ensure that they hold a register of patients who have caring responsibilities to inform any need for additional support. The register should be reviewed annually to ensure its accuracy.

- 5.11 District nurses and the out of hours Community Treatment Team provided timely and effective care concerning Roger's catheter management. There were a high number of callouts, but unfortunately Roger did not attend appointments with the consultant urologist which may have alleviated the problem. The District Nursing Service IMR made a recommendation concerning this area of his care. As this involves clinical decision making this will be addressed internally by this service.

Roger's discharge from hospital in May 2012:

- 5.12 Roger's pre-discharge assessment in hospital was appropriately informed by a hospital physiotherapist and occupational therapist. Prior to admission for leg spasm/weakness and a urinary tract infection Roger had been independent as far as washing and dressing was concerned, he had no carers and lived with his daughter. Post admission the physiotherapist's review identified an inappropriate 'social set up' (it has not been possible to clarify this point as the physiotherapist no longer works at the hospital) no package of care, and concerns about accessing a stair lift; what the concerns about the stair lift were is not recorded.
- 5.13 During a follow up physiotherapy session in hospital Roger reported to the physiotherapist that money had gone missing from his house; tradesmen had been in the house, but the only other person with access was his daughter. The physiotherapist rightly tried to inquire further with Roger, but he refused to discuss it. Whilst the physiotherapist identified Roger as a 'vulnerable adult' due to the financial concerns this was not formalised via a safeguarding alert as Roger did not want to take it further; this was on the grounds that the victim has a right to make choices. Roger also had mental capacity as described in the Mental Capacity Act 2005. Adult safeguarding procedures in place at the time required the following:

A record must be made of the concern, the adult at risk's decision and of the decision not to refer, with reasons. A record should also be made of what information they were given. It is recommended that organisations have a separate part of the adult's file or record that is clearly labelled 'Safeguarding'. (2.3.3.1 Making a decision not to refer¹⁵).

- 5.14 The hospital healthcare notes do not record whether Roger was given any information should he change his mind about taking the matter of his missing money further. Although an allocated social worker has access to these healthcare records in the hospital it is not known if they did so as it is not recorded. There was no separate safeguarding section in the file notes as recommended in London Adult Safeguarding procedures which applied at the time. However, it is understood that at the time of Roger's assessment in 2012 Barking University Hospital Trust had their own stand alone safeguarding policy. As the physiotherapist no longer works at the hospital it has not been possible to determine if they discussed the matter in supervision or on a 'what if' basis with a safeguarding adult manager.
- 5.15 Roger made reference whilst in hospital that Sarah was "the boss" and that she was the one to "clear things with". However, the occupational therapist had continual difficulties in contacting Sarah to arrange a home access visit which would be essential for arranging pre-discharge aids and equipment. This should have raised a question about the level of care and commitment which Sarah would be able to provide once Roger was back home. Her work was not formal

¹⁵ Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (2011) Produced by the Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board

paid employment and there would have been no barrier to her taking time off to facilitate arrangements for Roger's return home. Was this prevarication to delay Roger's discharge to give herself a break? There is no evidence of a carer assessment taking place before Roger's discharge to check how Sarah felt or how she would be able to cope with Roger's reduced level of mobility. NICE guidance¹⁶ recommending best practice for the transition from discharge to home provides an excellent model to address the carer role. This is discussed further under term of reference 7.

- 5.16 The access visit eventually took place on 16 April 2012. Roger, Sarah and 2 occupational therapists were present. The cleanliness of the property was highlighted as a concern particularly as carers would have to enter the property. This issue will be covered separately. During interview for the review Sarah stated that neither she nor her father were aware that carers would be coming to help look after her father on his return home, and she said it was a shock to have them in the house. This visit contradicts that assertion. Also Roger's care plan would have been gone through with him, and he would need to sign it. The author has seen a copy of the plan, however it is not a scanned signed copy therefore no signature is visible to prove this. It would be good practice to download a scanned copy of signed documents to store on a service user's electronic record.

Recommendation 12:

A scanned copy of all service user signed documents should be uploaded onto their electronic record within 7 days of signing to ensure clarity and confirmation of agreements and provision of services.

- 5.17 Roger was offered, but declined residential rehabilitation and respecting his choice an alternative package of care was arranged to keep him in his own home. This may not have been the best option for his medical needs, but it met his emotional needs to return home. A comprehensive Therapy Report which was sent to the Rehabilitation Team recorded that Roger had mental capacity and this had made issues such as adult protection difficult, and the dynamic between Roger and his daughter was complex. This mention of complexity around their relationship, and a recommendation that Roger's discharge be subject to 'close community follow-up' is ambiguous. It has not proved possible to determine what is meant by 'complex relationship' or why community follow-up was felt necessary. This and other records found to be lacking clarity and detail during the review highlight the need for clear, reflective, analytical recording which states reasons for assessments backed up by evidence or examples which provide an explanation for any professional judgement or statements.

Recommendation 5:

All practitioners should ensure that their case recording is detailed and clear and all assessments are reflective and state reasons for assessment decisions backed up by examples which provide evidence for professional judgement. Quality should be addressed by management in supervision and via annual file audits.

¹⁶ Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guidelines [NG27] Published date: December 2015.
<https://www.nice.org.uk/guidance/ng27/chapter/Recommendations>. Accessed 15.8.16

- 5.18 Despite Sarah's lack of cooperation with regard to being present to accept the delivery of equipment which delayed his return home, Roger was eventually discharged with a good package of care and good communication between disciplines. However, the fact that the state of his bed and its mattress seems to have been missed before his discharge is disappointing although it is noted that Sarah was tasked with bringing the bed downstairs ready for her father and she may not have done this at the time of the visit.

Safeguarding Alert

- 5.19 The fact that Roger did not want the matter of missing money taken further after disclosing this to the physiotherapist is not an unusual reaction. Many victims of domestic abuse do not wish their abuser/family member criminalised, or they may be fearful of the consequences after the investigation is over. Roger may have had suspicions that Sarah was responsible, and the consequences for him might have involved the loss of a potential carer, and needing to go into residential care as a result.
- 5.20 The experience of the author in trying to work out the communication and actions around the concerns raised about rent arrears, Sarah's management of Roger's finances, squalid and unhygienic state of the property, and Sarah going away leaving her father with inadequate food and medication, mirrors the confusion expressed in some agency's IMRs in trying to understand what was going on at the time.
- 5.21 Attempting to discern from different agency's chronologies and IMRs who raised the safeguarding alert in itself has proved difficult as there are case records of 'concerns' being raised, but no formal safeguarding referral form is mentioned as completed. However, it is acknowledged that the final draft of the Adult Social Care IMR did confirm that the IMR author had seen the safeguarding alert on the electronic records system. The final draft of the IMR also identified the instigator of the safeguarding alert as the support worker in the Reablement Team. The email correspondence with the Police and visit to Roger was undertaken by a qualified social worker, the Cluster Team manager.
- 5.22 What is clear is that safeguarding procedures and timescales were not followed. There is no record of the social worker who took the calls regarding the 'concerns' having had a discussion with their manager or safeguarding adult's manager (SAM). Safeguarding procedures in place in 2012 required an immediate or within 4 hours consultation with a manager as to whether a safeguarding referral was appropriate and this should have been recorded. It is good practice in all safeguarding that the time, date, the names and agency of those contacted, and all discussions are recorded accurately and contemporaneously as there is always the potential that details could be needed for a court report or statement.

Recommendation 6:

All agencies must ensure their staff are fully trained and compliant with safeguarding procedures and that concerns and alerts are fully and accurately recorded including time, date, who made the contact and name of person contacted, discussions with managers and actions agreed. Consultation with all involved agencies must take place before closure of the safeguarding alert. Auditing of staff training and compliance with procedures to be built into supervision, and annual staff development plans.

- 5.23 Adult Social Care records are sometimes ambiguous: A call at 14:41hrs on 15 May 2012 with the care agency shows 'Genesis to raise a safeguarding concern. DN (district nurse) confirm similar concerns'. However, in the action taken of the chronology it states 'Information gathering for assessment. Agency raised safeguarding alert'. Information gathering was the correct procedure, but there should have been clearer recording of who precisely raised the alert, and it is not clear who called whom. There are no records that Roger's GP was contacted at the time of the safeguarding alert either for information or to inform them of the concerns and the alert. Given Roger's health needs this is a serious gap in information sharing. The district nurses were also unaware that a safeguarding alert had been raised due to suspected financial abuse by Sarah.
- 5.24 There was also ambiguity around whether Roger had mental capacity and who had assessed him as having mental capacity. It would appear that the various professionals who met Roger found that he was perfectly able to understand what was taking place and to express his views, therefore there was no reason to undertake a formal mental capacity assessment. Nevertheless, recording of this in assessments would be helpful, especially where safeguarding concerns arise.

<p>Recommendation 14 : All staff to have regular training with regards to safeguarding, risk assessment and issues of mental capacity. London Borough of Barking & Dagenham to consider setting a mandatory timescale for refresher courses.</p>
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- 5.25 The diary sheet on the next page may help the reader to ascertain what took place when during the alert period in May 2012.

April						~ May 2012 ~		June	
Sun	Mon	Tue	Wed	Thu	Fri	Sat			
	30 April Discharge form hospital fails -no contact with Sarah to receive equipment	1	2 Roger still on ward - still trying to contact daughter	3 Key safe ordered & hoist put in place. Roger discharged home with package of care 4 x day 2 carers	4 Carers start: 10:07. Note on door by Sarah saying no care required. Cannot raise Roger on phone. Carer reports to social worker. Police & ambulance called - gain access. Roger in bed Sarah at work. only food remains of takeaway. No meds. Case transferred to Community Team to monitor	5			
6	7	8	9 09:41 Carer speaks to SW re: springs poking out of bed & state of property. Cats mess everywhere. No evidence of Roger eating. Hospital SW Team - Daughter appears unable to cope. Carers & District Nurse say Roger at risk. Action: Social work home follow up arranged.	10	11 Case passed to Reablement Manager - will allocate to Cluster when reablement ceases. 12:11 Community nurse - Concerns raised with Social Care re living conditions/ lack of appropriate food/mattress/hoist not used/ no phone/ carers not early enough re: catheter. Action allocation to support planner Reablement	12			
13	14 Rent Dept email to Housing officer to inform of rent and council tax arrears. Message left on tenants answer machine.	15 14:41 Carer & District Nurse raise serious concerns re Living conditions. No reported mental health or learning difficulties re daughter. Told daughter at work then she appeared. Genesis raise safeguarding alert. District nurse confirmed similar concerns. Reported daughter gone on holiday Action: Information gathering & Agency to raise safeguarding alert	16 H/V with support worker and Genesis Manager. Daughter controls money. D. Debit cancelled & rent arrears. Cold call by housing officer-property unkempt. Emergency fund paid for airflow mattress but cannot be used due to bad state of current mattress. Microwave used for meals cooker unsafe. Additional hour for 2 carers to visit to clean. Urgent repairs needed. Safeguarding alert raised by support worker. Contact Housing re rent arrears & repairs. Email Police re daughter's control of money-Roger thinks bills being paid. Benefit checks -risk of eviction-put on hold.	17 District nurse contacts social worker for update on concerns raised on 11 May re state of property & requesting Social Services review asap. Concerns re: no working phone in the home. Note: Nurse not aware of safeguarding alert re financial abuse. Housing receive safeguarding alert. Home visit by Cluster manager.	18 Carer identifies cat is locked in Sarah's bedroom upstairs. RSPCA called. Roger gave permission for padlock on door to be unscrewed. Cat released. Sarah's room was a 'complete mess'. Cats and birds fed and watered. Advised Roger to think about giving birds up as they are neglected. He refused. RSPCA officer to try and call Sarah to sort out and get her home early to sort out.	19			
20	21 Email from Police re safeguarding - Roger has MC & gave daughter control - no action unless crime proved i.e. missing money. Case closed to Reablement & passed to Cluster Team. Email from Genesis re: RSPCA visit & state of Sarah's room.	22	23	24 Genesis raise concerns about house conditions - blitz clean needed as job too great for their staff. Previously informed Environmental Health/blitz clean would be arranged now told not.	25	26 Sarah due back. still appears on holiday by 8 June			
27	28	29 Email Cluster manager from Genesis- further email re state of property and cleaning needed. Further email sent by Genesis on 14 June due to deteriorating conditions & care workers becoming sick & unwilling to go there - property flea infested.	30	31	<p>Notes: Re Safeguarding Alert Procedures</p> <p>No consultation with manager noted re: alert (should take place within 4hrs). No record of Safeguarding Adults Manager (SAM) contact as per procedures</p>				

5.26 Social Care are not the only agencies to fall short on following procedures however. By undertaking a 'cold call' due to rent arrears the rents officer, became

aware of the rent arrears/possible financial abuse, the 'squalid conditions' in the house, and Roger's medical needs, all of which should have classed him as a vulnerable adult in addition to the safeguarding needs. The Housing Department IMR found that it was unclear whether any member of their staff had raised a safeguarding alert following their concerns, and they had no records of any safeguarding meetings or minutes scanned onto the information system.

- 5.27 An earlier visit than the rent officer's was made to Roger by a district nurse who undertook an assessment on 11 May 2012, they too contacted Roger's social worker requesting a reassessment of his living conditions, but did not raise a safeguarding alert. An occupational therapist had also raised the issue of the state of the property at their pre-discharge assessment visit.
- 5.28 Whilst the concerns about financial abuse were appropriately discussed with the Police, the other concerns regarding the squalid and unhygienic state of the property, Sarah going on holiday without warning, and Roger being left with insufficient food and medication, appear to have been ignored in terms of warning signs of neglect and/or Sarah not being able to cope. Sarah maintained in interview that the carers were informed that she was going on holiday for one week and the length of the holiday did not change as she said she had pre-booked it. However she was reported to be away from the home longer than one week.
- 5.29 The involvement of the Police in this case throws some light on Sarah's life at a particular point in time and reveals some aspects of her character i.e. the criminal damage charge, and a restraining order requirement not to go near her former friend. Apart from liaising with Roger over her temporary disappearance in June 2013, there is little Police involvement apart from the contact with the social worker over the possibility of financial abuse. This call was not recorded on the Police system. This was explained as being because the safeguarding officer often had calls from social workers where calls or emails start with "can I just run this by you". The officer thought as there was no feedback from the social worker the enquiry was of this type, otherwise the matter would have been on the Police CRIS electronic records. The officer assumed that proof of a crime was not present. The latest Metropolitan Police toolkit for safeguarding adult referrals dated the 24/3/2016, would require the police to complete a Merlin "Adult Come to Notice" and a "Crime related Incident" CRIS record in the circumstances of this referral. This is a positive change in practice as any subsequent enquiries or callouts should see any previous records which could reveal a pattern of behaviour.
- 5.30 The investigation into possible financial abuse appears to have been cursory with no evidence that checks had been made to fully explore the use of Roger's money and his bank accounts, especially in light of the cancellation of the rent direct debit with the resultant rent arrears. It is of note that a credit card bill seen in the house almost equalled the amount of the rent arrears. The fact that Roger was deemed to have mental capacity and able to determine how he ran his financial affairs did not mean that he could not be exploited. Many people are victims of fraud regardless of their mental capacity for understanding. The fact that rent arrears had begun to happen, and continued, indicates at best that Sarah was not necessarily capable of running her father's finances; at worst she was misusing his money. There is no suggestion that Roger was advised to formalise the finance arrangement by going down the Power of Attorney route. The matter should have been investigated more thoroughly.
- 5.31 It is disappointing that no multi-agency strategy meeting was held to share information and to discuss the concerns regarding the safeguarding alert. There

was also no formal acknowledgment to other agencies, or views being sought from practitioners involved with Roger before the safeguarding matter had been closed.

Condition of the Property

- 5.32 Roger had a serious health condition and yet the conditions in which he was living were potentially very injurious to his health. Apart from extreme clutter, which is referred to in the Adult Social Care IMR as 'appeared to be a hoarding environment', there was overflowing cat litter trays, cat faeces around the house, fleas and other pest to the extent that fumigation was needed. Carers were being bitten.
- 5.33 These concerns had first been raised by the occupational therapist following a home visit on 16 April 2012, then by others. GP electronic notes also record the home environment hygiene as being really poor, and yet it took until 4 July for a referral to be made to 'blitz clean' the house and the flea infestation was not dealt with until 24 August. This was not a timely intervention and delivery of service.
- 5.34 There is evidence that the separate departments within Housing worked together to assist Roger at the time of the safeguarding alert in 2012, and there was liaison with Adult Social Care, the Housing Access Referral Team, and Independent Living Association to prevent his eviction. Coordination took place to ensure the property was kept in good order. However, this was the last time that details of Roger's living and home situation was accurately recorded. There were no further visits or contact with other agencies from this point.
- 5.35 The most vociferous voice in trying to have the conditions improved was the care agency who delivered Roger's care up to August 2012 when the provider was changed. The agency were not only concerned about Roger, but their care staff were also being affected; one staff member who visited to do a risk assessment had an asthma attack, and another was given body spray when they returned to the office due to the smell having been to Roger's home. Roger's neighbour also related in interview the terrible state of the house. It is disturbing that, in the frequent email contact from May to the end of July between the care agency and the Cluster Team, that one manager who had visited Roger at the end of May 2012 wrote that having visited him "I agree with you that he neglects his home environment, however the state of his accommodation has not necessitate the involvement of Environmental Health or blitz cleaning". Given that Roger was very disabled and bed-bound saying the *he* neglects his home is a most insensitive and unjust comment.
- 5.36 Although the "blitz" clean and fumigation appeared to improve Roger's living conditions for a while, it is clear that at some stage, probably when Sarah became Roger's only carer, the extreme clutter and lack of cleanliness returned. After Roger's death the local authority had to spend many thousands of pounds clearing and repairing the property. Roger's neighbour reported that men clearing the house wore protective clothes and said the state of the house was one of the worst they had seen.
- 5.37 It is disappointing that the nurses, who were the only professionals still visiting Roger in the last year of his life, did not find his environment concerning as they had before. It may be that a high threshold of tolerance and acceptance for the state of his home had developed and the hoarding environment was ignored, but for a man with his health condition it is arguable that this should not have been tolerated for health reasons alone. Infections and other illnesses can be very

damaging for a person already weakened by the effects of multiple sclerosis and infections such as stomach bugs, or bladder infections can trigger a relapse¹⁷.

- 5.38 The evidence of hoarding and clutter alluded to earlier is substantiated by photographs of the interior of Roger's home before it was cleared. Both upstairs and down were affected. When interviewed about the amount of things in the house Sarah said that since her mother died her father did not like to throw anything away. Bearing in mind Roger was confined to his bed in one room downstairs and had been since 2012 this is highly unlikely. As Sarah was the only other person living there it is undoubtedly her who was hoarding and not tidying up, and it was her who probably found it difficult to dispose of things since her mother's death. The lack of cleanliness also reflected her inability to maintain the home to a suitable standard for her father's health needs. The following photographs are included to make managers and practitioners aware of the importance of considering the home environment in assessments especially where those living in such conditions have life limiting illnesses or disabilities and cannot clear up for themselves. It must have been difficult for Roger being surrounded by such mess; any use of a wheelchair in such conditions would have been impossible.



A corner of Roger's bedroom. Note disused hoist.

¹⁷ <https://www.mstrust.org.uk/a-z/relapse>



A corner of the kitchen

5.39 Roger's GP initiated and applied for a home safety fire check on 12 July 2012 which was thoughtful and good practice. The reasons for doing this are not known; it may have been due to Roger being bed-bound. However, there is an increased risk of fire in homes where hoarding takes place, but there is no record to indicate that Roger's GP was aware of the hoarding environment in the home.

5.40 There are three definitions of hoarding which could possibly apply to Sarah:

1. Compulsive acquisition of objects, with marked and gross associated difficulties with discarding, creating avoidance of discard behaviour.
2. Living spaces becoming so full of objects (i.e. excessively cluttered) that the use of rooms becomes circumscribed or very restricted. For example, the person may be unable to use the bathroom, or sleep in their own bed because of the accumulation of belongings/possessions.
3. Significant associated distress and/or functional impairment. The key thing here is it does not have to be both. People can struggle with hoarding with extreme functional impairment, without apparent significant distress. For such people, the hoarding is described as ego syntonc.¹⁸

Other aspects of Sarah's life such as her assertion that she suffered from agoraphobia, resonate with findings that 25 per cent of people with hoarding difficulties have social anxiety, and social isolation is a particularly key issue for

¹⁸Ego syntonc: denoting aspects of a person's thoughts, impulses, attitudes, and behaviour that are felt to be acceptable and consistent with the rest of the personality *Miller-Keane Encyclopaedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition*. © 2003 by Saunders. <http://medical-dictionary.thefreedictionary.com/ego-syntonc>

people with hoarding difficulties¹⁹. The possibility that Sarah herself may be in need of support does not seem to have occurred to anyone, although her social isolation, particularly in the last year of her father's life, did make her accessibility to assessment difficult. It is understood that the local authority has recently introduced a hoarding policy.

- 5.41 There were numerous complaints about the overgrown state of the garden of Roger's property. However, responses to the numerous referrals for this to be dealt with were not timely, and in some cases were not acted upon at all. The Housing Department IMR identified that housing officers did not visit the property to check conditions themselves and either closed the case as not meeting service requirements because Sarah was in occupation, or referred on to Garden Cultivation or the Tree Department. Had a visit taken place the condition of the property would have come to light and the matter dealt with via breach of tenancy agreement or a referral. Similarly if the first incidence of rent arrears which initiated a home visit and concerns raised about the property had been repeated for next 3 occasions rent arrears occurred, then the conditions that Roger was living in might have been highlighted and further alerts may have been raised, but this did not happen. Such neglect of a property is not only contrary to tenancy agreements, but can be indicative of the occupants not coping. Sarah would have been physically capable of keeping the garden tidy, but was not doing so. Before her mother's death the garden was kept up, but it gradually deteriorated afterwards. A number of recommendations have been made within the Housing Department IMR to reflect the concerns raised here.

Recommendation 19:

Where a vulnerable tenant has been identified by a housing officer they should discuss this with their manager as to the required frequency of the next tenancy audit. Discussion should focus upon at least annual visits unless evidence suggest that this is not required.

Recommendation 20:

All housing officers should complete Adult Safeguarding Training and Domestic Abuse Training.

Recommendation 21:

Social worker and other support staff's details are to be recorded on the contact screen by housing officers and rent officers within 24 hours of capturing this information.

Recommendation 22:

Where a request for garden cultivation is requested the housing officer should complete the application form with the tenant at their property to ensure that the home is also inspected.

Recommendation 9:

Agencies should ensure that staff are aware of the local authority hoarding policy, of the issues around hoarding including its impact on mental health, day to day functioning, and home safety, and the steps to take where hoarding is identified.

¹⁹ Holmes S (ed) (2015) A Psychological Perspective on Hoarding DCP Good Practice Guidelines, British Psychological Society Division of Clinical Psychology

Missed Hospital Appointments

- 5.42 Roger did not attend 7 outpatient appointments in total which were sent from the Neurology and Urology Departments of the hospital to which he had been referred by his GP, and apart from letters to his GP informing them of this no further action was taken and Roger was discharged from these clinic appointments. The Hospital IMR expresses disappointment that although due process was followed between June 2012 and April 2015 (letters were sent copied into Roger's GP and up to 3 appointments offered) there was no further consideration of Roger's individual circumstances before he was discharged.
- 5.43 Neither GP practice nor the hospital clinics to which he was referred remembered or considered that Roger was considerably disabled at this point, and no consideration was given that he might need transport to take him to appointments, or make enquiries into his wellbeing as to why he was missing appointments. It was not until 2015 that the lack of attendance was mentioned by the practice nurse for the housebound and elderly during her last visit that this problem was mentioned. The nurse was told by Roger that an appointment had not been received. However, Roger had lived in his home since 1988 and it is unlikely that the letter would not have been delivered. We know that Roger left his finances to Sarah and he would not be able to pick up his post himself as he was confined to his bed, therefore it is highly likely that Sarah was dealing with all mail to the house. That Roger reported receiving no hospital appointment suggests that Sarah did not open the post or did not inform him of any appointments or discharge letters. There was supposed to be a further appointment sent in 3 months time, but there is no record of this, and there was no further follow up by the GP practice or nurse before Roger's murder.
- 5.44 Sarah stated that Roger decided that he did not want to attend any appointments as the consultant neurologist, who Sarah said was a leading MS consultant, had informed him that his illness was degenerative and there was no further treatment available. The same reason was given for non-attendance at appointments with the multiple sclerosis nurse. This fatalistic and apathetic attitude appears to confirm the GP IMR author's hypothesis concerning the mindset of Roger and/or Sarah.
- 5.45 When questioned, Sarah stated that they did not have their own means of transport to get to appointments. She also stated that she did not think about letting professionals know that her father would not be attending his appointments. In addition Sarah explained that her father was in a lot of pain whenever he tried to use the wheelchair or sit in a chair and he could not bear it. He could not face travelling to the hospital. Sarah described how her father suffered from leg spasms; his legs could not be stretched out straight - he was in the foetal position and even sitting in a wheelchair was not pain free as his legs were bent at a more acute angle than the wheelchair could accommodate.
- 5.46 Roger's former multiple sclerosis specialist nurse confirms the symptoms described could result in pain as the MS becomes more progressive. She also confirmed that some other MS patients feel the same about the effort it takes to attend hospital out-patient appointments as they have to be picked up by transport early in the morning and may have to sit for hours in wheelchairs until the transport is full and ready to return after the clinic.
- 5.47 It appears that the cessation of home visits by specialist multiple sclerosis nurses led to Roger, and possibly other patients, falling through the net. An MS nurse based in the community has been restarted, but it was not funded to cover Barking and Dagenham until April 2014. However, as there is no local register of

MS patients the new service is reliant on referrals from professionals and patients themselves. This review has found that professionals involved with Roger did not know there was a community multiple sclerosis specialist nurse, not even the district nurses who work for the same Trust, therefore Roger was never referred to this service as an alternative to hospital appointments. Roger's case demonstrates how the constant state of structural change within the Health sector is, at the end of the line, resulting in a diminution of service to meet individual patients needs which is contrary to NICE guidelines for a person-centred approach.

Recommendation 33:

The Trust should publicise the Community Specialist Multiple Sclerosis Nursing Service within Barking & Dagenham among GPs, Adult Social Care, Occupational Therapy, and allied professionals, and patients and families affected by the disease as soon as possible. This should be completed no later than December 2016. (*This has been completed -See Action Plan*)

Recommendation 34:

Details of the allocated MS Nurse for each Directorate within NELFT should be identified to the relevant District Nursing teams to ensure timely referrals may be made when additional support may be required to an individual patient.

- 5.48 The Barking, Havering & Redbridge University Hospitals Trust has a Patient Access Policy (April 2015) which includes sections on 'Did Not Attend' (DNA) procedures (pages 20 & 26). Paediatric 'Did Not Attends' are covered with procedures for staff to follow (page 21) including consultant level risk assessment, but whilst vulnerable adults appear in a list of those to be offered further appointments if they do not attend, risks to be considered when vulnerable adults do not attend is not covered with specific guidance to staff. It would be helpful if the policy could prompt staff to consider such issues as whether the adult could have missed the appointment due to self neglect, be prevented from attending due to neglect or control by their carer either deliberately, or due to their carer's own problems. Bearing in mind the range of staff using this policy, including administrative staff responsible for appointments, the policy could be improved by further staff guidance.

Recommendation 37:

Barking, Havering & Redbridge University Hospitals NHS Trust to strengthen their Patient Access Policy section on Did Not Attend with the addition of issues to consider when vulnerable adults Do Not Attend, and guidance to staff of steps to take when they have concerns.

- 5.49 Missed hospital appointments are highlighted as an area for concern in North East London Foundation Trust (NELFT) Missed Appointments/Non Attendance for Adults & Children's Health Appointments Policy issued in July 2014. The policy points out that missed appointments by an adult potentially at risk could indicate their care is being neglected where they are reliant on others to reach appointments, or there could be self neglect. Either of these scenarios might have applied to Roger. The policy Equality Statement (page 10) states that it recognises that a service can unintentionally put barriers in place to enable access to services, and that it is continually working to overcome this. Roger had significant barriers in place due to his health and ability to access the hospital, but this does not appear to have been recognised. However, there is no indication that the District Nursing Service which is part of NELFT appears to have

been aware that Roger was not attending hospital appointments arranged for him.

- 5.50 GP practices are best placed to know the situation within which their long term ill patients are living. It is surprising that Roger missed so many hospital appointments to which his GP had referred him and yet no one in the practice questioned or challenged why. Apart from the one mention by a practice nurse no action was taken. Whether transport was needed, or there was self neglect on Roger's part due to a sense of resignation that nothing could change was not considered. Least of all for consideration was that his daughter might be withholding the appointments from him, or persuading him that it was not worth attending. Abuse, including control, by a family member and carer must be part of any considerations in such cases. The GP practice needs to build these issues into their DNA and domestic abuse policies and practice staff training along with a process for follow-up home visits where a patient is disabled.

Recommendation 28:

Where a patient known to have a debilitating or life limiting illness fails to attend hospital appointments more than once there should be follow up including a home visit, to ensure that the patient knows they have an appointment, has the means to attend, and are not being prevented from attending for any reason.

The Cancellation of the Care Package

- 5.51 When Sarah contacted Adult Social Care on 24 July 2014 to cancel her father's care a home visit took place for assessment purposes. This was the first visit by a social worker since a post safeguard review of the case on 18 October 2012. An annual review did not take place in 2013, although there was a review of the manual handling need by an occupational therapist in October 2013 a full review of the social and care needs did not take place as it should.
- 5.52 The social worker allocated to make the assessment visit on 8 August 2014 was relatively newly qualified (July 2013). They were unaware that the care package included visits by two carers and crucially the social worker was unaware of the safeguarding alert of 2012. In the opinion of the IMR author the layout of the Adult Social Care database contributed to this, as they too found it difficult to navigate even with the assistance of those familiar with the system. Key assessments and support plans are not easily found, and trying to access the occupational therapy report brought up a 'Fatal Error' message. As mentioned at paragraph 5.13 safeguarding procedures recommend that organisations have a separate part of the adult's file or record that is clearly labelled 'Safeguarding'. Such a crucial piece of information needs to be prominently flagged. It is understood that a new database is to be commissioned and a recommendation has been made to highlight the above difficulties in the hope that this will feed into the design of a new database.

Recommendation 15:

The new electronic data base planned by the Borough needs to have the functionality that enables key information, current or previous safeguarding alerts, and risks to be identified quickly by social workers not familiar with the case.

- 5.53 Nevertheless, it is disappointing that the social worker was not adequately informed of the background to Roger's case given the prior safeguarding issues and the complexity of his needs. The fact that a carer assessment had not

previously been undertaken also contributed to the lack of information about Sarah's potential as the sole carer of her father and her ability to cope with that responsibility. Therefore whilst the service provided to undertake what was a termination of care assessment was timely, it was not suitably or adequately informed by background information to assess whether Sarah could manage Roger's care on her own. Had all the background been known the IMR suggests, it could have triggered discussions with all those involved in Roger's care i.e. GP, district nurses, his personal assistant carers and occupational therapist as well as family. For someone with Roger's degree of support needs, and where other professionals are involved with a service user, it is always good practice to automatically consult with those professionals before confirming the safety and efficacy of terminating care, therefore this should always take place. In interview for the IMR Roger's occupational therapist and personal assistant both said that had they been consulted they would have expressed concern about the termination of his care.

Recommendation 16:

Checks with all professionals involved with a service user should be part of all case closure processes as standard, recorded clearly, and checked for completion before management sign-off. Auditing of this process to be built into management supervision and an annual compliance audit implemented.

- 5.54 In line with policy and practice expectations the social worker did offer Sarah a carer assessment on the occasion of this visit, but it appears that Sarah declined. She was given appropriate advice about allowances and future support if required. The social worker was told by Sarah that district nurses would continue to visit for catheter care, therefore the social worker believed that Roger and Sarah would not be totally isolated from professionals. This was taken at face value and no checks were made before closure with the nurses or GP to seek confirmation of this. This suggests a lack of appreciation for the importance of inter-disciplinary working.
- 5.55 The IMR found that as the visit was for a termination of care the assessment was not entered onto the data system, therefore the content and audit trail of this assessment is lost. However, the Adult Social Care IMR author was informed by a group manager that at the time this was the correct practice. Case recording on 14 August 2015 evidences that the social worker consulted with the team manager at the time of the termination. It is surprising that the process at that time did not require management supervision, the uploading of the assessment, and management sign off for such a key intervention and closure for a service user with such high needs.

Recommendation 17:

Reassessments at the time of case closure must be fully entered onto the Adult Social Care database ensuring that the rationale for closure is recorded, risk assessed and how any risks will be managed in future. Procedures to be updated and auditing of this process to be built into management supervision and an annual compliance audit implemented.

- 5.56 On 10 April 2015 it appears that the manager became concerned about the termination of care, and asked Roger's former personal assistant to make a welfare call to see how they were coping without formal care. The personal assistant when interviewed for the IMR explained that they thought the manager was unaware that the care had ended. This may have been affected by the lack of

recording on the database of the final assessment. When interviewed for the IMR the personal assistant confirmed that in general everything seemed to be going well, however she noted that Sarah seemed stressed, and whilst both declined the offer of support she reported that had Roger been seen on his own he may have agreed to support. The personal assistant did not know the name of the person who called and had no way of providing this feedback. However, the IMR suggests this should have been a matter for professional judgement by a team member, and the author supports this view. It is concerning that having asked the personal assistant to make the welfare check there was no follow up call from the manager.

- 5.57 At interview Sarah was asked how she managed her father's care on her own bearing in mind his package of care had been for 2 carers to help move him safely. She explained that because of the position of his legs she would wash her father by turning him from side to side. Sarah said that caring for her father was easy as he was not a big man therefore he was not difficult to move; he was a short, slim man, and as both legs were contracted (foetal position) this made turning him in bed easy. Sarah reported that he did not like the hoist or the wheelchair as it was painful, and he had an air mattress to prevent pressure sores.
- 5.58 Sarah said that she was never offered, requested or required respite care for her father. He was not totally dependent, he was able to feed himself, change TV channels, read newspapers and have conversations, and she attempted to maintain his independence where possible.
- 5.59 Sarah was asked if she thought her father was depressed, and she stated that he was annoyed at his condition but not "depressed like mum was". He was frustrated with himself, his legs and the fact that he was "stuck in bed".
- 5.60 When asked who decided to end the care package in 2014 she said there had been an occasion when her father had had 'an accident' and she had cleaned him as the carers were not due for some time. It was then decided between them that if she could manage that level of intimate care they would not have outside carers anymore. Sarah said she got so used to doing her father's more intimate care that she became desensitised and it became easier. When asked whether she could recall being offered a carer's assessment Sarah confirmed she was asked by the social worker who visited (in August 2014). This was the first time she had been asked, although it was not clear whether she fully understood what this would entail; she did say that she was not offered a break of any kind. However, she said care of her father was not 24/7, she was able to sit down occasionally and her father could feed himself. Sarah commented that she "was wary of not taking away too much from him".

Services for Sarah:

- 5.61 From the background information available to the Review it appears that Sarah received timely access to support and the resources required associated with her gender identity and the transition she wished to achieve. Sarah also chose to access private treatment. When she sought support with depression or anxiety her GP responded, including on one occasion, a home visit when Sarah felt unable to leave the house to attend the surgery. She also received bereavement counselling following her mother's death. It is somewhat surprising that having gone through so much treatment that Sarah ceased requesting repeat prescriptions for both her anti-depressant medication and her hormone therapy in the first few months of 2012. She failed to keep a follow up hospital appointment

for a scan, and to maintain the support offered by the Gender Identity Clinic by responding to their letters. Instead as Sarah stated she chose to 'self manage'.

- 5.62 This section's term of reference is not simply about services delivered to the perpetrator. It asks whether '*services provided offered appropriate and timely support, resources, and interventions to meet the needs and safeguarding of the victim*'. Many of these issues have been covered in the preceding section, however, in relation to the perpetrator it is right to ask whether services could have been delivered to Sarah which might have contributed to the safeguarding of her father. As previously mentioned (paragraph 5.56) the only time Sarah was offered a carer assessment was at the time of the closure of the care package, and yet Health and Social Care agencies knew that she was living alone with her disabled father and it was clear from the state of the house on more than one occasion that she was not coping. Whilst it is debatable whether Sarah would have accepted any carer support (she turned down the one carer assessment offered), it was a serious oversight that no assessment of her needs, and importantly her ability, to care for her father took place before August 2014. It is acknowledged that the Care Act 2014 was only enacted in April 2015 making it a local authority responsibility to undertake a carer assessment, but prior to this date local authorities could provide support at their discretion.
- 5.63 The issue of the state of the property and hoarding has been discussed in paragraph 3.59, but here too there was a shortfall in assessing Sarah to determine whether (a) she needed mental health support, or (b) she was simply not coping with keeping the home clean, hygienic, and safe.
- 5.64 All of Sarah's actions suggest that she was resistant to outside help and she kept 'outsiders' at arm's length; she left temporarily when the carer service commenced, she stayed in her room when they were there, and eventually cancelled carers coming to the house. This is not totally surprising when one considers that she was brought up in a household where socialising with friends or having visitors was not the norm. She did not attend school from her early teens onward, therefore the family and Sarah were for the most part socially isolated and self contained until carers were required after her father's discharge from hospital in 2012.
- 5.65 **Term of Reference 3.** *Were decisions concerning the victim's care needs, additional vulnerabilities, living conditions, financial situation, and the services provided informed by:*
- a) *Full and up to date facts concerning his living situation and who was living with him at the time.*
 - b) *Reviews and risk assessments undertaken which were updated in response to his changing needs and changes in circumstances. If so what risk assessment tools or framework were used and was it fit for purpose?*
 - c) *Effective and timely communication and information sharing between individual practitioners and agency systems.*
- 5.66 Roger's living situation has been discussed in the previous section, particularly around the state of the home. Agency records for those involved in Roger's care are often ambiguous about whether Sarah was living with him or not. It is not until late 2012 when Sarah is consistently present that this becomes clear. Her behaviour of remaining in her room when carers were present may have masked not just her presence, but her difficulties with social interactions and propensity for social isolation and possibly agoraphobia.

- 5.67 In 2012 no formal risk assessment had been completed other than those built into the FACE Assessment²⁰ and Review documentation completed by the social worker and the occupational therapist. Communication between the therapists, particularly the physiotherapist, and the social worker in the Community Rehabilitation Team was judged to be excellent to facilitate Roger's discharge from hospital. The safeguarding alert triggered a reassessment on the 17 May 2012, but Sarah was not present for the assessment as she was away on holiday. The FACE assessment has limited questions to assess risk of abuse, and no DASH²¹ risk assessment appears to have been considered. Other agency's risk assessments were of the nature to support the care they were providing i.e. risks regarding pressure sores, risks to carers due to the working conditions in the house.
- 5.68 The Community Treatment Team undertook an assessment with Roger on 7 October 2013 which included a depression screening tool when no onward referral or assessment was deemed necessary. There is no record that this was shared with his GP. It would appear that this was a 'one off' visit as there were no follow-up reviews of this assessments in 2014.
- 5.69 There is no evidence that a full risk assessment was undertaken examining the risk which Sarah may pose to her father, or the neglect that descriptions of his situation in 2012 suggest should have been investigated. The removal of the house key from the key safe by Sarah on more than one occasion was not seen as a risk factor or in the context of neglect and a means of controlling who went into the house for access to support her father. Similarly, the fact that Sarah left her bed bound father alone for long periods of time with no working telephone in cases of emergencies suggests at best a lack of awareness of the dangers, or at worst neglect or care for his wellbeing. Either way it brings into question her capability to be her father's carer.
- 5.70 The risk of financial abuse appears to have taken precedence, but then this disappeared from assessments following the Police advice that if a crime could not be proved then they could not act. There is no suggestion that Roger was advised to arrange Power of Attorney to formalise his financial arrangements for Sarah to manage his finances. Indeed when asked during interview about Power of Attorney for her to manage her father's financial affairs Sarah appeared to be unaware of such an arrangement. The purpose and process was explained to Sarah and how this gave people protection from accusations of fraud and a legal status for managing another's bank account. When asked how they managed to get into rent arrears when direct debits were meant to be in place; Sarah said this was caused by rent increases which they had not known about and therefore had not increased the payments. She said she had always addressed this and paid outstanding amounts when informed. Housing records do show that Sarah paid arrears, but often not until a court order for eviction was almost about to be actioned. However, the arrears were too large to have accumulated from slight rent increases and it is confirmed that the direct debits were actually cancelled, rather than merely not increased to keep pace with rent rises. This undermines Sarah's account of the situation. The fact that she was never interviewed at the time means this discrepancy was not discovered.

²⁰ FACE assessment tools are nationally-accredited by the Department of Health and used throughout the UK and Ireland by NHS, social care and independent sector organisations. The FACE toolsets are a complete documentation system tailored to the needs of the relevant care group. The toolsets include both generic and specialist tools covering a range of support needs.

²¹ Domestic Abuse Stalking & Harassment risk assessment checklist.

Recommendation 8:

Taking into account the learning from the review, assessment and review templates should be reviewed to ensure that their design triggers questions to examine risk to service users with additional needs which includes seeing the person alone, and assessing carers who are family members.

- 5.71 As highlighted in the previous section when examining safeguarding there appears to be no formal feedback to the other agencies involved with Roger following the safeguarding alert, and there is no record on other agencies files of the alert closure which did not take place until September 2012. Indeed the district nurses were even unaware that financial abuse was a consideration.
- 5.72 Roger's first care providers were in regular communication with Social Care staff regarding their concerns and the risks which the house conditions posed, and the trail of email communications at this time show this was necessary for some months until the "blitz" clean and flea fumigation took place. Given the squalid conditions and Roger's health condition the length of time taken to deal with this problem was unsatisfactory.
- 5.73 Reviews of Roger's package of care were not undertaken as they should have been. The occupational therapist's review in October 2013 was no replacement for the social care review which should have taken place; they review different things from different perspectives. Asking a personal assistant to do a welfare check 8 months after case closure may on the face of it appear a positive intervention, however, it was also inappropriate to give that responsibility to a person who does not have the training for the level of assessment needed. This act is suggestive of a manager suddenly having second thoughts about the previous closure decision and wanting to check that all was in fact well. However, there was a failure to follow this up; there was no further communication with the personal assistant. The closure of the package of care was not shared with the key agencies involved in Roger's care either to gain their views on this decision or to inform them of the closure. This particularly left his GP and the nurses visiting him in the dark. In interview for the IMR both Roger's personal assistant and the occupational therapist said they would have expressed concern about the care being terminated had they been consulted. On the other hand district nurses reported no concerns about Sarah's care of her father, but they were not told of the care termination.
- 5.74 There is evidence that the separate departments within Housing worked together to assist Roger at the time of the safeguarding alert in 2012, and there was liaison with Adult Social Care, the HART Team and Independent Living Association to prevent his eviction and to ensure the property was kept in good order. However, this was the last time that details of Roger's living and home situation was accurately recorded. The Housing Department failed to carry out follow up reviews after the problems with the property were resolved in 2012. There were no further visits or contact with other agencies from this point. The housing officer responsible had been moved to another area which may have contributed to the break in oversight and the organisational memory of what had taken place at the time of the safeguarding alert. The IMR confirms that Mandatory Tenancy Audits were not implemented until the end of 2013 and the housing officer has until the end of 2016 to visit each of their tenants in their home and put a risk assessment in place as to when the tenant needs to be visited again. Had this system been in place in 2012 there would have been a review mechanism in place to alert the housing officer for the need to visit to monitor and respond to Roger's needs.

Recommendation 23:

All first Tenancy Audits to be completed for all Council properties by the existing deadline of 30 November 2016. *(Not fully completed by this date - being monitored by Action Plan).*

- 5.75 The Housing IMR also identified that contractors carrying out repairs and servicing for gas and stair lift had raised no concerns or any risks, and the property was noted to raise minimal repair issues considering the length of time Roger had been a tenant. This may indicate a high level of tolerance for a house in disrepair, or mental health problems where an occupant is too unwell to go through the reporting process, or perhaps as may have been the case here, Sarah and Roger did not want the intrusion of strangers in the house. Repairs arranged for blocked sinks etc were arranged by the care agency not Roger or Sarah. Contractors should have a procedure in place to raise any concerns with a housing officer, but there is always the chance that a service engineer with a pressing schedule of jobs will not see it as their role to report on an excessively cluttered house and an overgrown garden.

Recommendation 24:

At the time contractors carrying out repairs, or at the annual inspection made by gas engineers, the housing officer should be updated within 24 hours where a property is found to be in an unacceptable condition.

- 5.76 Communication between the housing officer who made the initial visit and Adult Social Care was good, but communication the other way round appears lacking. However, communication is a two way process and the housing officer could equally have called the social worker to obtain an update. The Housing IMR also identified that after the initial alert there was a breakdown in internal communication both between teams and on systems. Essential information such as an advice note to alert the different sections within Housing of Roger's health conditions, the different officers involved, and previous concerns, had not been added to the Capita system. The advice note appears as a green triangle on the front screen to inform other users that the file contains useful advice.

Recommendation 25:

Advice notes are to be loaded by housing officers with details of tenants' disability as per the new 2016 procedures.

- 5.77 The district nurses responded to Roger's care needs on a regular basis for his catheter care, they also responded promptly when there were problems, and they liaised with agencies appropriately during the safeguarding alert period. Their response to Roger's condition was judged by the GP IMR to be impeccable and they made his life bearable and comfortable. Sarah confirmed in interview that the only agency staff they saw once the care package was cancelled was the district nurses who visited every 3 months to change her father's catheter, and a nurse from the surgery also called. When asked her views of agencies who provided services to her father or herself, Sarah said the district nurses were excellent; they had an excellent bedside manner and were good at reassuring her father and her.
- 5.78 Although there was no adverse effect on the care delivered to Roger, the method for district nurses recording visits was only by paper records kept in the home and not via the Trust electronic system "RIO". If the number of visits had been

electronically recorded it may have been possible and easier for a pattern of behaviour to be established and for the large number of callouts to be identified and acted upon. The lack of electronic records available in the office may contribute to a lack of records of inter-agency discussion about the state of the property and concerns about Roger which would not have been added to his handheld notes at home. This shortfall in recording should be resolved. The information in the GP and District Nursing Service IMRs suggests that updates were not routinely taking place between the district nurses and GP practice; there is no record of feedback between the two.

Recommendation 31:

A system of regular updates on a patient with long term illness should be established between the GP practice and the District Nursing Service and Community Treatment Team.

Recommendation 32:

The District Nursing Service should review their recording system to ensure that there is electronic back-up to handheld patient notes which can be shared by nurses prior to and after visiting patients and to record any safeguarding concerns or alerts.

- 5.79 The lack of information from others to inform risk when Roger's care was terminated has already been covered. However, of particular note is not consulting Roger's existing personal assistant. In interview for the IMR the personal assistant stated that she had daily contact with him much of which was in the absence of Sarah. She reported no concerns regarding observations of physical bruising, tone of voice or body language regarding Roger or Sarah, nor did she witness any behaviour which may have pointed to Roger being controlled and coerced whilst she was employed as his personal assistant. She viewed the relationship to be a positive one with Roger showing genuine concern when Sarah went missing for a couple of days. However, if most of the contact was in Sarah's absence she may not have seen Sarah in a relaxed manner to exhibit her normal interaction with her father, and Roger may not have felt able to complain about Sarah in case the consequences resulted in a change to his ability to remain at home.
- 5.80 **Term of Reference 4.** *Explore what issues if any prevented the victim accessing appointments or support services offered to support him and whether these barriers were recognised and addressed.*
- 5.81 This matter has been dealt with in previous sections namely: According to Sarah Roger found it painful to mobilise into a wheelchair or seat and felt there was little purpose in attending as his condition could not be improved. His lack of attendance was not followed up by his GP practice or the hospital, both of whom knew that he was disabled and would have needed assistance to attend any appointments. It is disappointing that this was not recognised. The multiple sclerosis specialist nurse, in providing context for this, has explained that there have been redundancies and there is now only one specialist multiple sclerosis nurse in the hospital whereas previously there were 2½ full time multiple sclerosis specialist nurses. One nurse now has between 700 and 800 active patients and there is no time to follow up patients who do not attend who are now discharged after two lack of attendances.

- 5.82 The district nurses still providing care to Roger and his GP were unaware that there was a community MS specialist nurse available covering their area from April 2014. Therefore there were no referrals for Roger to have home visits. A recommendation concerning the publicising of this service has been made.
- 5.83 The family's GP liaised with district nurses when necessary, but this appears to be infrequent; the practice elderly and house bound nurse visited Roger periodically for review. Communication between the hospital and GP regarding missed appointments and discharge summaries was effective. The GP IMR cites a community care assessment on its records which was not identifiable in the notes. This had taken place in October 2013; a paucity of detail was noted.
- 5.84 The GP IMR notes that there were no visits or mention of the MS Society, Safeguarding Services, or Community Care Team contributions on their records. Nor were details of community matron visits or from any other allied agency noted. This is a significant gap in the coordination of key services for Roger as GPs need to be kept informed. The early Integrated Care Meetings which took place represented good practice in coordinating his needs. It is disappointing that this model of coordination and review could not have continued so that agencies could share information and take an holistic approach in responding to changes in need, caring arrangements, and addressing the missed hospital appointments. The GP IMR states that "when multi-agency interaction occurs client care moves into the realm of excellent clinical outcomes". However, it also acknowledges that "Unfortunately, the level of interaction was considerably wanting" in Roger's case.
- 5.85 A further barrier to Roger seeking support has been discussed in paragraph 5.19, namely reporting any dissatisfaction or concerns about the care Sarah was providing had the possibility of ending that relationship, and thus his ability to remain in his own home.
- 5.86 **Term of Reference 5.** *To assess whether agencies have robust and up to date policies, procedures, and referral pathways in place which are fit for purpose in assisting staff to identify and practice effectively where domestic abuse is suspected or present.*
- 5.87 **Term of Reference 6.** *What was the level of training and knowledge of the staff who were involved with the victim and perpetrator in relation to the identification of domestic abuse and coercive control, the additional vulnerabilities affecting older people and those with disabilities, and the application and use of appropriate risk assessment tools and referral pathways to support and protect victims?*
- These terms will be reviewed together.
- 5.88 The Housing Department confirms that it works under the local domestic violence policy, procedures and referral pathways, and they have safeguarding leads for staff to consult if required. Staff are encouraged to attend training through their one to one development plans. However, it is advisable that due to the scope of their role housing officers should maintain up to date training on safeguarding and separate training for domestic abuse. A recommendation concerning training has already been made on page 40.
- 5.89 The Borough adopted the new London Multi-Agency Safeguarding Policy and Procedures in April 2015. Prior to that point they had their own policy which would have been in place during the period of the involvement with Roger and Sarah. This policy did not make specific reference to domestic abuse or coercive

and controlling behaviour. The new pan London policy does, however it would be helpful if it contained a referral pathway flow chart to assist staff. The social workers in this case are confirmed as having undertaken a number of short courses including Safeguarding and Risk Management (Advanced), however no specific domestic abuse training had been completed. Given the prevalence of domestic abuse across the age ranges, and those with disabilities being particularly vulnerable to abuse, this training should be mandatory for social workers and any staff involved in supporting adults.

- 5.90 NELFT who provide the district nursing service confirm that they have a specialised Domestic Violence and Harmful Practices Policy and Safeguarding Adults and Mental Capacity Policies. The staff interviewed who were involved in Roger's care were all up to date with their mandatory enhanced safeguarding training which incorporates domestic violence and the Mental Capacity Act. The staff had not accessed the specific Domestic Violence & Harmful Practices training which is not currently mandatory. This training is confirmed as including DASH risk assessment, Multi-Agency Risk Assessment Conferences²² (MARAC), and IDVA Services information. Band 5 staff have face to face training, non-patient facing staff can undertake online training. Given the district nurse role and the fact that they are sometimes the only professionals visiting patients in the home it would be advisable to also make domestic violence and abuse training mandatory.
- 5.91 The GP practice states that all staff are trained, and they are encouraged to provide evidence of participation in domestic abuse training at Continuous Professional Development (CPD) level. The practice has recently introduced an updated At-Risk Adults Policy which is informative, and which provides clear steps to take if abuse is alleged. However, the Investigation of Allegations of Abuse section of the policy does not cover where the alleged abuse is a partner, former partner or a family member. The risks and dynamics of domestic abuse are different from those where the abuser is a non-related carer or a member of staff. Therefore it is recommended that the practice have a separate section to their policy which includes a pathway for dealing with disclosures of domestic abuse²³.
- 5.92 Hospital staff involved in Roger's assessments for discharge in 2012 had received level 2 Safeguarding Adult Training. The domestic abuse component is not in enough depth when combined in Safeguarding training, therefore it is highly unlikely to deliver the necessary skills needed when working with patients with complex needs and their carers. The Trust has a Protecting Adults at Risk Safeguarding Adults Policy which covers domestic abuse. Since September 2015 the Trust has employed an independent domestic violence advisor (IDVA) who is available to offer support to patients and staff who are victims of domestic abuse. A Trust wide Domestic Abuse policy is also available to staff on the Trust's intranet. The Hospital Trust has an Access Policy which covers 'Did Not Attend' issues. The policy lists children, and vulnerable adults among the group to be granted a second appointment if they did not attend, and additional guidance is given for staff under Paediatric Did Not Attend (paragraph 4.30 of the policy) for the process to follow in the event of a child not attending to ensure safeguarding issues are considered. No similar process is given for staff to follow in the event

²² MARAC is a multi-agency meeting to which agency can refer those considered to be at high risk of harm due to domestic abuse. Information is shared and a safety plan developed to protect the victim.

²³ The practice may wish to view Responding to domestic Abuse: Guidance for general practices by The Royal College of General Practitioners, IRIS & CAADA see:
<http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~media/Files/CIRC/Clinical%20Priorities/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx>

of a vulnerable adult repeatedly not attending an appointment. A recommendation to strengthen this policy has been made previously in this report on page 42.

- 5.93 The 2011 Pan London Safeguarding Adults policies and procedures highlighted the fact that "approximately one in five homicides in London are domestic related, with the murder of a parent by a son being prevalent"(p15). Therefore, it is important that all agencies are aware of this and take it into account in risk assessments. Practitioners need to suspend their disbelief that someone who outwardly appears to care for a close relative, such as a parent, can cause them harm and that mental illness is an added risk factor.
- 5.94 The author has viewed the content of training available within the Borough over the period under review. Whilst the training covers the basic elements of domestic abuse training there is a need to develop higher level training for practitioners who are undertaking assessments and making home visits. Training which covers specific areas of domestic abuse in great depth rather than awareness level is needed. Particularly pertinent to this case is the need for specific training on domestic abuse in families where an adult child has a caring role for a parent who has additional needs such as disability or mental ill-health.
- 5.95 There is an overall sense that no one considered domestic abuse and its range of behaviours in relation to Roger and Sarah's relationship. Training in the Borough needs to bring domestic abuse to the fore to make all practitioners and managers more aware of the need to think what may seem the unthinkable in the carer/cared for relationship. The training needs to be stand alone training to enable sufficient time and depth to be given to this complex subject.

Recommendation 10:

All staff who have responsibility for adult assessments or visiting patients/service users in their own homes must have in-depth domestic abuse training which also includes elder abuse by partners and family carers, and high risk groups such as those with disabilities and/or mental illness. It is recommended that this training is mandatory.

Recommendation 11:

Up to date and easily accessible information and resources available for front line practitioners around hoarding, domestic abuse, and coercive and controlling behaviour should be reissued and publicised to staff.

- 5.96 **Term of Reference 7.** *As the victim's main carer did the perpetrator receive a carer assessment and if so how and by whom was this completed and what was the outcome?*
- 5.97 The only carer assessment offered to Sarah was during the final social work visit for the termination of care assessment. This was in line with the Care Act 2014 which requires the local authority to offer an assessment of a carer's needs. She declined the assessment. There is no record of the assessment itself as the final summary was not uploaded onto the system, therefore what was covered, its content and how it was undertaken are not available. The only outcome we know is that Sarah declined the assessment. However, case notes indicate that she was advised about carer allowances, and told she could contact the service in future if she needed.

- 5.98 During an assessment by a social worker undertaken with Roger on 17 May 2012 it was recorded that he was not keen to discuss his family composition, however he shared enough for the social worker to feel that she could assess his daughter's ability to support him as 'Moderate' – “Carer often has time to engage in valued activities but also experiences some significant restrictions in activity”. The IMR judged this to be contrary to best practice as an assumption should not be made about a person's ability and willingness to take on a caring role without speaking to them in person. However, it was noted that Sarah avoided contact with professionals and was frequently difficult to contact.
- 5.99 NICE Guidelines published in December 2015²⁴ now recommend that a hospital based multidisciplinary team should discuss the practical and emotional aspects of the caring role with potential carers and in assessments taking into consideration the following:
- The willingness and ability of the person to provide support
 - Their circumstances, needs and aspirations
 - Their relationship with the person
 - The need for respite
- 5.100 The guidance also recommends that training should be offered to carers either at the hospital or in the home after discharge (paragraphs 1.5.32 to 1.5.34). Whether Sarah would have accepted such training had it been available is debatable, however, for many about to take on the caring role it could help both with practical skills and with the psychological and emotional adjustments involved. It could also help a potential carer decide whether they really are able to take on the role.
- 5.101 It is vitally important that those undertaking carers assessments or providing training receive the appropriate training themselves. How the carer assessment is offered and undertaken requires skill. The assessor needs to judge when a carer is capable of the role and when they may be taking it on unwillingly out of duty, or perhaps for more malevolent reasons such as maintaining control within the relationship.

Recommendation 18:

Training should be provided to enhance the skills of all staff involved in undertaking carer assessments to ensure the willingness and ability of a potential carer and to encourage the uptake of carer training as recommended by NICE Guidelines. The staff must have previously undertaken domestic abuse training to qualify for this.

- 5.102 Other practitioners not necessarily undertaking formal carer assessments, but who are involved with supporting or treating vulnerable adults, also need to consider the role and abilities of the carer.

Recommendation 35:

There should be a strengthening of the Think Family approach when nursing staff are providing services for adults with care and support needs. Staff should use professional curiosity regarding carers, being aware of the carer's needs assessment and outcome as this affects patient care.

²⁴ Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guidelines [NG27] Published date: December 2015.
<https://www.nice.org.uk/guidance/ng27/chapter/Recommendations>. Accessed 15.8.16

5.103 The NICE guidance also advises (paragraph 1.5.35) that a community-based multidisciplinary team should review the carer's training and support needs regularly (as a minimum at the person's 6-month and annual reviews), taking into account the fact that their needs may change over time. The guidance suggests the make-up of this multidisciplinary team could be:

- GP
- Community nurse
- Community mental health practitioner
- Social worker
- Housing officer
- Voluntary sector practitioner
- Community pharmacist
- Therapists

5.104 This type of review would have been helpful in Roger and Sarah's case. It is to be hoped that in light of this review such a scheme will be adopted not only locally, but nationally.

Recommendation 7:

The formation of a multidisciplinary team as recommended by NICE Guidance (NG27) December 2015 should be put in place for those with complex needs and life limiting illness who are living at home to ensure an holistic approach is taken to risk assessment and their needs, which includes the identification of a named coordinator, and a structure of regular multi-disciplinary reviews. It is recommended that the Camden High Risk model is investigated.

5.105 **Term of Reference 8.** *What assessment and evidence was gained to assess the victim's decision to have the perpetrator as his sole carer and whether this decision was taken freely, with information about risk, and without coercion?*

5.106 At the time of the assessment for the termination of the care package there appears to have been no evidence sought by the social worker or raised by their manager in supervision to assess whether Roger's decision to dispense with carers was taken freely and without coercion from Sarah. No other professionals who knew him well over a period of time and who were involved in his care were contacted for their views.

5.107 Interviews undertaken for the IMR with staff and Roger's former personal assistant did not identify evidence to support the view that he might have been coerced to give up the carers by Sarah. Bearing in mind she maintains she was agoraphobic at least during the last year of her father's life, and she expressed the view when interviewed that she did not like having carers in the house, we will never know whether Roger was genuine in his wish to end the carers, or whether he was doing this to please Sarah. The word coercion has a menacing tone, but there are subtle ways to bend someone to a view they may not have originally held. One brief visit for an assessment would not discover this.

- 5.108 NICE Guidance²⁵ (paragraph 1.5.3) recommends that service users and their carers continue to be offered information and support even if they have declined it previously, in recognition that long-term conditions can be changeable or progressive, and people's information needs may change.
- 5.109 **Term of Reference 9.** *Was an assessment of the victim's mental capacity as defined by the Mental Capacity Act 2005 undertaken to inform assessments and decision making, and if so how and by whom was this complete?*
- 5.110 One of the 5 principles of the Mental Capacity Act 2005 is the presumption of capacity as the starting point. During an assessment by a social worker on the 17 May 2012 Roger was deemed at that point to have capacity to make decisions. This view was gained from his ability in interview and assessments with him to make his own informed decisions. It was noted that he "has mental capacity to make informed decisions and planning". All professionals had worked on the assumption of capacity.
- 5.111 During the review and IMR process there was ambiguity around whether a Mental Capacity Act assessment had been undertaken as recording was not clear. The Adult Social Care IMR therefore made a recommendation concerning this.

Recommendation 13:

Assumptions or not of mental capacity must be clearly recorded as well as the reasoning behind the assumption. Where capacity is doubted then formal assessment should take place and be recorded.

- 5.112 **Term of Reference 10.** *Was the victim formally identified as a vulnerable adult up to March 2015, or an adult at risk post April 2015? Or was he in need of services under Section 29 of the National Assistance Act 1948:*
- 5.113 Roger met the criteria under all these pieces of legislation. He was identified as a vulnerable adult in 2012 when the safeguarding alert was raised. However, it has not been absolutely clear that he was recognised and treated as a vulnerable adult, or an adult at risk during the period under review post 2012. There appears to have been an assumption that he was safe and being cared for adequately by a family member, but there was no oversight of his home care and the conditions within the property did not raise concerns as they had done in 2012.
- 5.114 A review undertaken in 2013 by an occupational therapist was an assessment of manual handling and mobility needs, not a review of his care package in place at the time or the informal caring role performed by Sarah. This meant that the last holistic social care review was undertaken in October 2012. After 2012 no assessments, including the termination of care assessment in 2014 explicitly acknowledged his vulnerability as defined by the Department of Health:

"An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or

²⁵ Older people with social care needs and multiple long-term conditions, NICE guidelines [NG22] Published: November 2015.
<https://www.nice.org.uk/guidance/ng22/chapter/recommendations#supporting-carers>. Accessed 15.08.16

*herself against significant harm or serious exploitation.” No
Secrets, Department of Health 2000*

Roger was in receipt of care services until August 2014, he was disabled due to illness and unable to take care of himself, or protect himself.

5.115 Under the Care Act 2014 enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

- (a) has needs for care and support (whether or not the authority is meeting any of those needs),*
- (b) is experiencing, or is at risk of, abuse or neglect, and*
- (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

It is clear that (a) and (c) apply to Roger. It is arguable that had missed hospital appointments, the state of the house, and the reclusive nature of Roger and Sarah's lifestyle been taken into account the fact that Roger was 'at risk' of neglect might have been recognised.

5.116 The National Assistance Act 1948 Section 29(1) defines a 'disabled person' as a person "aged 18 or over who are substantially and permanently handicapped by illness, injury, congenital deformity or such other disabilities as may be prescribed by the Minister". The legislation sets out the duties for which Social Care Services have legal responsibility which includes a duty to provide social work services and advice to facilitate "rehabilitation and adjustment to disability", and "occupational, social, cultural, recreational activities". The Chronically Sick & Disabled Persons Act 1995 also directs that needs must be assessed in addition to the NHS & Community Care Act 1990. When Roger came out of hospital in 2012 his needs were met under this legislation but his holistic needs were not assessed after that date.

5.117 **Term of Reference 11.** *Were there any resource, organisational, or systems of working that affected the provision of services or the way in which staff were able to perform their role?*

5.118 There is evidence that structural changes during the period under review have had a significant effect on this case. Changes of staff have removed the source of knowledge of the family and the local area, and lack of full recording on systems contributed to a shortfall in knowledge of the family.

5.119 Where case recording is inadequate or not completed vital information becomes lost, and while this is sometimes down to staff performance, it is also exacerbated by poorly designed databases which do not facilitate the easy retrieval of information and the flagging of vital information. With constant organisational change having accurate and up to date details on systems is an essential tool for short term multi-worker involvement, or to be the repository of information when staff are transferred or leave. Data systems also need to be fit for purpose in having a facility to flag safeguarding and other important information and crucial documentation so that they can be easily found. A recommendation has already been made concerning databases. The NELFT IMR also made a recommendation to assist district nurses.

Recommendation 36:

To continue the roll-out across all NELFT directorates, agile working to allow staff to remotely access electronic patient records and update accordingly.

- 5.120 The end of specialist MS nursing staff being able to make home visits resulted in Roger slipping through the net when the community specialist nurse staff were withdrawn. It is to be welcomed that a specialist nurse has been reintroduced into the area once more, but greater publicity needs to take place to promote this service to patients, GPs and district nurses.
- 5.121 In 2014 when Roger's care ended there appeared to be no system in place for ensuring that with the end of Social Care involvement another named coordinator would be in place for Roger. NICE guidance²⁶ issued in November 2015, sets out the need for those with long term health needs to have a named coordinator²⁷ who could be for example, a social worker, practitioner working for a voluntary or community sector organisation, or lead nurse. The Panel could not confirm within the timescale of this review that this aspect of the NICE guidance is in place today.
- 5.122 No issues around workload were raised by practitioners interviewed for the review.

6. Conclusions

- 6.1 Despite the concerns raised in 2012 and the state of the property, no one could have predicted that Sarah would kill her father. She had no previous history of violence and in later years she was seen as caring for her father adequately, for example she acted promptly when her father's catheter was blocked.
- 6.2 However, although concerns about the unhygienic condition of the property was raised by some practitioners in 2012 who recognised the risk to Roger, some did not appreciate the risk or the implications. It took too long for the relevant organisations to whom a referral was made to address the problem. For example despite a stream of emails between May and July 2012 it was not until late August that the first fumigation for pests commenced. In the latter years before Roger's death professionals' tolerance of the very unkempt and excessively cluttered state of the home suggests an acceptance and normalisation of this environment despite the risks to Roger. That the state of the property may indicate an inability of Sarah to cope adequately, or that the large amount of clutter was of a nature which represented hoarding was not recognised.
- 6.3 The British Psychological Society Division of Clinical Psychology is now recognising hoarding as a distinct mental health difficulty in its own right, with specific issues affecting access to services and psychological intervention²⁸. However, Sarah's mental wellbeing was not questioned by those with whom she had contact. It is not possible to say whether her reclusive way of living in later years was due to the effects her upbringing, or whether her transgender identity with which she herself identified impacted upon the way she lived. Transgender has been described as a mismatch between the biological sex a person is born with and the gender identity that a person 'identifies' with or feels themselves to be. This can

²⁶Older people with social care needs and multiple long-term conditions, NICE guidelines [NG22] Published: November 2015. Endorsed by the Department of Health as required by the Health and Social Care Act (2012).

²⁷ <https://www.nice.org.uk/guidance/ng22/chapter/recommendations#named-care-coordinator>. Accessed 15.08.16

²⁸ The British Psychological Society (2015) *A Psychological Perspective on Hoarding DCP Good Practice Guidelines* (Edited by Holmes S). http://www.bps.org.uk/system/files/Public%20files/a_psychological_perspective_on_hoarding.pdf

lead to distressing and uncomfortable feelings called gender dysphoria. Gender dysphoria is a recognised medical condition for which treatment is sometimes appropriate; there is evidence that Sarah felt this was the best option for her as she did access treatment, although she did not maintain contact with health professionals following treatment. However, gender dysphoria is not seen as a mental illness²⁹.

6.4 One way that Roger's death might have been prevented could have been if he had been in residential care, but from his expressed wish to return home from hospital in 2012 instead of going to residential rehabilitation for a period of time, it might be reasonably assumed that his wish to live at home would have remained the same. However, there is no evidence that a reassessment of his wish to remain at home as his condition deteriorated was undertaken; holistic reviews did not take place after 2012. Alternatively, had there been:

- a) a more robust carer's assessment and recognition that Sarah was not coping;
- b) more holistic treatment of Roger's physical and psychological health needs;
- c) better living conditions arranged for him;
- d) a fully informed decision made to continue with his carers

An intervention including some or all of these components may have led to a different outcome and Roger may not have died a violent death.

6.5 Inter-agency working was mostly reasonable at the start of the safeguarding alert in 2012, however there appears, on paper and from interviews, some confusion about the alert being raised and for what reason. It appears to be on suspicion of financial abuse, but there is evidence of Roger being neglected and put at risk by omission of care, and yet neglect was not explicitly raised and named in any records. There were shortcomings in following procedures, and in clear and open communication about the nature and outcome of the alert. There is also no evidence that the alert closure was shared with the relevant partner agencies who had been a party to the various concerns raised. A serious omission was not to inform Roger's GP practice of the concerns and the safeguarding alert.

6.6 All agencies are responsible for following procedures around safeguarding, and whilst Social Care may be the hub and receiver of alerts others too have a role. It is good practice for Adult Social Care staff as the receiver of a referral to provide feedback to a referrer; it is also the responsibility of the referrer to follow-up if they have not received an update. If an alert has been raised and partner professionals realise they have not received the appropriate feedback they must have the confidence to follow up, and if necessary to challenge processes that are not working as they should.

6.7 The lack of inter-agency consultation over the termination of the care package for Roger is another episode of practice which demonstrated a lack of appreciation for multi-agency working. It is all too easy when resources become stretched or caseloads increase to retreat into silos. However, for cases such as Roger and Sarah's the lack of coordination and information sharing can result in missing the whole picture as was the case here.

6.8 A relatively inexperienced social worker was given the case to carry out the termination of care assessment for what had been termed a complex case by the professionals that knew the family. This may not have been the wisest allocation

²⁹ Source: <http://www.nhs.uk/conditions/gender-dysphoria/Pages/Introduction.aspx> accessed on 26.6.16

on behalf of the manager. The lack of background research before the visit meant the social worker was ill equipped to fully appreciate the dynamics of the case; this was exacerbated by a database which was difficult to navigate. Given that case notes indicate that there was discussion with the manager following the visit it is surprising and disappointing that the social worker was not guided by their manager to consult the other professionals involved with the family. To seek their views and to let them know that the care was to end and Sarah would be sole carer would have been good practice.

- 6.9 Sarah avoided professionals and Roger's carers for the most part, but this behaviour only raised a question once from the first care agency. Her behaviour raised no concerns. She had become increasingly reclusive and whereas Roger would go out in his mobility scooter before 2012 this ceased afterwards as he was not helped to do this. Sarah was undoubtedly the hoarder in the family, but her behaviour and anxieties were invisible to professionals as they were subsumed by caring for her father with a concentration on her father's physical wellbeing. The clutter in the house would have made it impossible for Roger to mobilise at home, therefore this contributed to him being bed bound. It is recognised that the premise that hoarding is a mental health condition which can justify mental health and social care support and intervention is contentious. Nevertheless whether Sarah would ever have accessed such support is debatable, but this was never offered as hoarding was ignored. The local authority now has a hoarding policy which has the potential to make this problem more visible.
- 6.10 There was no effective follow up to the missed hospital appointments to which Roger had been referred by his GP and which could have alleviated some of the adverse impact of his illness. Nurses and his GP knew he was disabled and would have found it difficult to reach the hospital, but no transport was arranged nor was it checked that this was the reason for non-attendance. The idea that Sarah had not informed her father of his hospital appointments and therefore possibly controlled his ability to attend was never considered. All the staff involved had received safeguarding training which includes a component on domestic abuse, however the lack of consideration of domestic abuse suggests this is not sufficient to give practitioners the skills they need.
- 6.11 Roger had complex needs, of which his physical needs appear to have been well catered for by the district nurses and the practice nurse during his final year. Roger had experienced many losses in his life; the death of his wife; the loss of his health and mobility; his independence, and even his pet animals had to be removed by the RSPCA. Any reasonable person in such a situation would find this difficult to cope with. Whilst his physical needs were being tended to, the impact of these losses on his mental wellbeing do not seem to have been recognised. He clearly had psychological and emotional needs which were not met, but the isolated lifestyle he and Sarah lived did not facilitate him accessing the services and support which could have helped. Roger relied on Sarah to contact health professionals, and whilst she did this with regard to catheter care, she did not contact his GP concerning his low mood. It is of concern that, if as she said, her father wanted to end his life, that she did not seek help for his suicidal thoughts from his GP and mental health services who could have helped to improve his state of mind.
- 6.12 When viewed in total, on occasions Sarah's behaviour and the range of incidents described in this review, present a picture of neglect. Whether this was by omission due to lack of understanding, or Sarah putting her own needs first and deliberately manipulating professionals to keep them at arm's length it is not

possible to judge. However, had all these individual actions been assessed together the risk to Roger would have been clearer.

Early Learning

6.13 At the time of the first Panel meeting when the combined chronology was available it was clear to Panel members that there was a lack of follow up to Roger's failure to attend hospital appointments arranged for him by his GP. To highlight this early in the review process the chair wrote a letter in April 2016 to the hospital, GP practice, and the North East London Foundation Trust who provide the District Nursing Service detailing the Panel's concerns. Recommendations concerning this issue have nevertheless remained in the review report to ensure adequate governance of the progress made to address this problem.

6.14 As a result of the text message sent from Sarah to the District Nursing Service being missed and unread, the service addressed this early learning and introduced a new process. For transparency and to increase the learning of others the revised process is as follows:

1. All Staff whose patients have access to their work mobile phone number are to check their work phones for text messages every shift.
2. On receipt of any text message the nurse on duty will telephone the sender to discuss and risk assess the situation.
3. If the reason for a visit is confirmed and a visit is necessary and safe following risk assessment the staff member to visit and assess.
4. If following risk assessment the staff feel it is unsafe to visit they should contact their line manager to discuss or the manager on call via the switch board for support (out of hours).
5. Following triage and risk assessment by phone and if no visit is required the appropriate team should be made aware and recorded on RIO (database used by the service).
6. If the client needs sign posting to another service e.g. GP on call, ambulance services, 111, mental health for advice the member of staff should do so and document in progress notes on RIO.

Lessons Learnt

6.15 The learning outlined here is an overview from a strategic position rather than drawing out individual agency learning which is described in the Analysis section and in agencies' recommendations.

Lessons concerning Roger's care:

6.16 The care of those with life limiting long term illness should aim to be the best it can be. Roger had experienced a number of significant losses including the death of his wife and the loss of an active able life, but this and the psychological impact of his illness appears to have been missed. In such cases the whole person needs to be taken into account not just the physical being. This did not feel to be the case for Roger. Even the exceedingly cluttered and squalid environment in which he was living appears to have become accepted and

invisible over time. Care plans should take account of the latest research, developments, and best practice and utilise all resources necessary for the mental as well as the physical wellbeing of a person with such life limiting illness.

- 6.17 There is no evidence that effective risk assessment of domestic abuse or the potential for such abuse took place other than for each agency's particular area concerning Roger's care. The FACE assessment for example contains little to encourage effective risk assessment of domestic abuse within family or carer relationships. There are two boxes entitled 'risk of abuse/neglect by others' and 'risk to relationships'. These are the only questions likely to engender such discussion among the many other question in this assessment, and if these assessments are undertaken with a carer in the room, those questions are unlikely to be asked. This is a difficult and sensitive area of work and staff need the support of clearer risk assessment tools to fit such cases as Roger's and adequate training and managerial support and supervision to do this commensurate with their experience.
- 6.18 The level of training in domestic abuse by those with responsibility for assessments and/or treating people in their homes was either basic awareness or minimal as part of safeguarding training. Professionals need to be more aware of the prevalence of domestic homicides involving adult children as carers for parents with additional needs such as disabilities or mental ill-health, and to be able to think the unthinkable when undertaking assessments. In order to do this they need in-depth specialist domestic abuse training which includes abuse by partners and family carers including high risk groups. For those expected to assess and support this client group the training should be mandatory.
- 6.19 It is understood that the Borough has now adopted the new London Multi-Agency Safeguarding Policies and procedures which includes domestic abuse. Other agencies also include domestic abuse as part of safeguarding policies. The power dynamics around domestic abuse and the specific safety needs of victims warrant a separate referral pathway to assist practitioners. Staff must also be given adequate training in procedures and be supported by management supervision to avoid the pitfalls of the 2012 safeguarding alert, for in this case procedures were not followed and there was a disappointing lack of inter-agency communication and joint working to protect Roger from neglect.
- 6.20 The unilateral decision to close the safeguarding case, and to end Roger's package of care, both without consultation, showed a disregard for the importance of inter-agency communication and a disrespect for the views of fellow professionals who knew Roger and his circumstances better than Adult Social Care. This does not dismiss the value of a 'fresh pair of eyes' on a situation, but a single pair of eyes will not gain the full picture in such cases. Those who feel uninformed, or who are aware they are not fully informed regarding a safeguarding case, need to be knowledgeable about procedures and confident to challenge partners when they are unsure or believe that procedures are not being followed. Again feedback and communication are key.
- 6.21 This Review has highlighted the importance of the need to follow up when a patient with serious health problems fails to attend numerous hospital appointments, especially when they have a physical disability as Roger did. Roger appeared to be unaware of his appointments which suggests that Sarah was either not opening the letters or not informing him of hospital correspondence, thus impeding his treatment. That such scenarios may be preventing a patient attending appointments needs to be recognised.

Lessons relating to Sarah:

- 6.22 There is a need to make the carer less invisible and to see them as a person in their own right, to identify any tensions caused by the caring role or shortcomings in the care provided, and to assess the suitability of the person to be a carer. It is arguable that Sarah's frequent absences from the home when Roger was discharged from hospital in 2012 should have raised concerns about neglect and her ability and preparedness to be her father's carer. Her suitability for this role should have formed part of the safeguarding assessment before it was closed. Had Sarah been living alone in the cluttered and squalid conditions in the home, attention to her social anxiety and other issues might have attracted a different response.
- 6.23 The state of Roger's house both inside and out was almost a manifestation of the inability to cope that was taking place inside. Whether we believe that Sarah killed her father at his request or not, either Roger was not coping with his life, or Sarah was not coping with caring for him any longer; the two may be interlinked. There are lessons to be drawn that all is not right in someone's world to live in that way and tolerating squalid conditions, hoarding, or excessively cluttered interiors and overgrown neglected exteriors is not an option. The conditions which existed should have triggered assessment and support for Sarah in line with practice recommended by the British Psychological Society Hoarding Guidance referenced in this Review. If she resisted such agency support, as previous experience suggests may have been the case given Sarah's tendency to hold agencies at arm's length, then when a vulnerable adult's life is also affected, safeguarding procedures may have to be considered.
- 6.24 A carers assessment should have been offered as a positive service to Sarah from the beginning. Those with a caring role should be recognised within their GP practice so that they are aware of that role and any additional stress this might bring. The NICE guidelines on assessing carers ability and willingness to care prior to transition from hospital discharge to home needs to be widely adopted and the recommended review process put in place.
- 6.25 In common with Roger, Sarah too did not attend clinic or hospital appointments made for her despite three reminder letters, the final of which informed her that her case would be closed. Her GP was copied into this letter and was also aware of her failure to attend. This meant the family GP practice who were aware of both Sarah and Roger's health needs knew of their persistent failure to attend hospital appointments. Given the complexity of their situation further enquiries could have been made.

Other lessons for agencies:

- 6.26 In common with so many DHRs and Serious Case Reviews communication and information sharing is a key issue in this Review. When silo working takes hold lines of communication suffer and professional relationships become weakened or fractured. Cases where there are complex and multiple needs such as Roger's warrant a multi-disciplinary coordinated approach to facilitate communication, assessments and joint work.
- 6.27 This case demonstrates the importance of effective tools for the job and that they are used. There were examples of databases not having data entered which then caused a break in working processes and the sharing of information. Also of a database which was not user friendly and which did not facilitate the sharing of vital information such as safeguarding alerts in a fast and visible format. These systems impeded access to information which should have been clearly and

easily visible. The social worker who undertook the reassessment to end Roger's package care, was relatively newly qualified and did not know about the previous safeguarding alert or that he needed two carers. This was put down in part to the difficulty in finding such information on the database.

Recommendations

- 6.28 The following recommendations arise from agency's IMRs, lessons learnt during the review and Panel discussions. Discussions with Roger's eldest daughter when sharing the report and her comments on the contents and findings have also informed a number of the multi-agency recommendations. Two Safeguarding Adult Board and one Clinical Commissioning Group recommendations do not appear in the Analysis/Lessons Learnt section; they are added with the intention of strengthening systems with the aim of providing strategic 'back up' to the recommendations which follow.
- 6.29 The recommendations below are grouped according to their relevance to Roger the victim and Sarah the perpetrator. Actions and timescales for the recommendations to be achieved appear in the DHR Action Plan. Responsibility for the recommendations in the Action Plan are grouped under multi-agency and individual agency headings and are not in the same order as they appear below.

Recommendations Arising from Roger's Contact with Agencies:

- ❖ All agencies working with those with long-term illnesses should ensure that each review routinely considers a person's psychological and mental resilience and wellbeing, the up to date management of any adverse symptoms, onward referral and information about informal sources of specialist support.
- ❖ All agencies must ensure their staff are fully trained and compliant with safeguarding procedures and that concerns and alerts are fully and accurately recorded including time, date, who made the contact and name of person contacted, discussions with managers and actions agreed. Consultation with all involved agencies must take place before Adult Social Care closure of the safeguarding alert and be recorded by all agencies before closure of the safeguarding alert. Auditing of staff training, compliance with procedures, and impact on practice to be built into supervision, and annual staff development plans.
- ❖ The formation of a multidisciplinary team as recommended by NICE Guidance (NG27) December 2015 should be put in place for those with complex needs and life limiting illness who are living at home to ensure an holistic approach is taken to risk assessment and their needs, which includes the identification of a named coordinator, and a structure of regular multi-disciplinary reviews. It is recommended that the Camden High Risk model is investigated.
- ❖ Taking into account the learning from the review, assessment and review templates should be reviewed to ensure that their design triggers questions to examine risk to service users with additional needs which includes seeing the person alone, and assessing carers who are family members.
- ❖ Assumptions or not of mental capacity must be clearly recorded as well as the reasoning behind the assumption. Where capacity is doubted then formal assessment should take place and be recorded.

- ❖ All staff to have regular training with regards to safeguarding, risk assessment and issues of mental capacity. LBBDD to consider setting a mandatory timescale for refresher courses.
- ❖ The new electronic data base needs to have the functionality that enables key information, current or previous safeguarding alerts, and risks to be identified quickly by social workers not familiar with the case.
- ❖ Checks with all professionals involved with a service user should be part of all case closure processes as standard, recorded clearly, and checked for completion before management sign-off. Auditing of this process to be build into management supervision and an annual compliance audit implemented.
- ❖ Reassessments at the time of case closure must be fully entered onto the Adult Social Care database ensuring that the rationale for closure is recorded, risk assessed and how any risks will be managed in future. Procedures should be updated and auditing of this process to be build into management supervision and an annual compliance audit implemented.
- ❖ Where a vulnerable tenant has been identified by the housing officer they should discuss this with their manager as to the required frequency of the next tenancy audit. Discussion should focus upon annual visits unless evidence suggest that this is not required.
- ❖ Advice notes to be loaded by housing officers with details of tenants disability as per the new 2016 procedure.
- ❖ A record of all services with whom a patient is in engaged (i.e. MS society, other specialist voluntary services, Integrated Care Team, Social Services, etc) must be routinely recorded on the patient's medical record. Where a GP practice has been given the code if the patient's home has a key safe, all agencies should be informed that the key safe code lies with the GP.
- ❖ Where a patient known to have a debilitating or life limiting illness fails to attend hospital appointments more than once a follow up contact with the patient themselves should be undertaken which may include a home visit to ensure that the patient knows they have an appointment, has the means to attend, and are not being prevented from attending for any reason.
- ❖ In addition to ensuring all patients with multiple sclerosis are referred to the community multiple sclerosis specialist nurse, the practice should ensure that patients are referred to suitable support agencies such as the MS Society and MS Trust UK, or other relevant organisation according to their needs.
- ❖ The practice should put in place a clear strategy for managing patients with multiple sclerosis in line with best practice which includes multidisciplinary reviews of their mental wellbeing as well as their physical symptoms, and consideration of how their carer is coping. The strategy to include:
 - A review by the practice manager of important case activity once a quarter.
 - A health care assistant to visit all MS patients once in 8 weeks on a routine basis and to report any concerns.
 - A designated nurse representing the vulnerable and safeguarding services included in the care pathway.
 - Adopting clinical management of the patient as recommended in the GP practice IMR.

- ❖ A system of regular updates for patients with long term illness should be established between the practice and the NELFT District Nursing Service and Community Treatment Team.
- ❖ An IMR recommendation for the North East London Foundation Trust concerning the large number of callouts to Roger for catheter care relates to clinical decision making and is not included here. NELFT are requested to note and act on this recommendation.
- ❖ The Trust should publicise the Community Specialist Multiple Sclerosis Nursing Service within Barking & Dagenham among GPs, district nurses, Adult Social Care, allied professionals, and patients and families affected by the disease as soon as possible. This should be completed no later than December 2016. (This recommendation has been completed)
- ❖ Details of the allocated MS Nurse for each Directorate within NELFT should be identified to the relevant District Nursing teams to ensure timely referrals may be made when additional support may be required to an individual patient.

Recommendations Arising from Sarah's Contact with Agencies:

- ❖ The Safeguarding Adult Board Training Sub Group should note the findings of this review and ensure that learning is disseminated and included in future safeguarding training and that staff receive separate training on domestic abuse, and assessment and support of carers.
- ❖ It is recommended that a review takes place of the current hoarding policy and practice guidance which takes into account the London Fire Brigade Clutter Rating Guide and the British Psychological Society (2015) A Psychological Perspective on Hoarding DCP Good Practice Guidelines to ensure the policy represents up to date best practice.
- ❖ Agencies should ensure that staff are aware of the local authority safeguarding policy section dealing with hoarding, and have a greater awareness of the impact of hoarding including on mental health and day to day functioning, home safety, and the steps to take where hoarding is identified.
- ❖ Training³⁰ should be provided to enhance the skills of all staff involved in undertaking carer assessments to ensure the willingness and ability of a potential carer, and to encourage the uptake of carer training as recommended by NICE Guidelines [NG27] December 2015. The staff must have previously undertaken domestic abuse training to qualify for this.
- ❖ The GP practice should ensure that they hold a register of patients who have caring responsibilities to inform any need for additional support. The register should be reviewed annually to ensure its accuracy. Each carer should have an annual review as a minimum to assess their needs.

Recommendations Relevant to both Roger and Sarah's Agency Contact:

- ❖ The Clinical Commissioning Group should note the findings and recommendations within this review and ensure that their commissioning

³⁰ The Local Authority may wish to consider Carrying Out Assessments Under the Care Act training course provided by Carers UK: <http://www.carersuk.org/for-professionals/training/upcoming-courses/trusted-assessor-carrying-out-assessments-under-the-care-act-16-nov>

processes and procedures set robust requirements of providers which address the concerns raised which are relevant to the service sector. This should include 'Did Not Attend' policies, staff training in respect of safeguarding, and domestic abuse.

- ❖ All staff who have responsibility for adult assessments or visiting patients/service users in their own homes must have domestic abuse training suitable for their role which also includes elder abuse by partners and family carers, and high risk groups such as those with disabilities and/or mental illness. It is recommended that this training is mandatory.
- ❖ Where a request for Garden Cultivation is requested the housing officer should complete the application form with the tenant at their property to ensure that the home is also inspected.
- ❖ At the time of contractors carrying out repairs, or at the annual inspection made by gas engineers, the housing officer should be updated within 24 hours where a property is found to be in an unacceptable condition.
- ❖ There should be a strengthening of the Think Family approach when caring for adults with care and support needs. Staff should use professional curiosity regarding carers, being aware of the carer's needs assessment and outcome as this affects patient care.
- ❖ Taking the learning from this Review, Barking, Havering & Redbridge University Hospitals NHS Trust should strengthen their Patient Access Policy 'Did Not Attend' section with the addition of issues to consider when vulnerable adults do not attend, and guidance to staff of steps to take when they have concerns.

Recommendations Arising from Agency Processes and Practice:

- ❖ The Safeguarding Adult Board Learning and Development Board sub group should examine supervision templates used by agencies to ensure that safeguarding is a routinely discussed topic, and on completion any relevant changes required made.
- ❖ All practitioners should ensure that their case recording is detailed and clear and all assessments are reflective and state reasons for assessment decisions backed up by examples which provide evidence for professional judgement. Quality should be addressed by management in supervision and via annual file audits.
- ❖ Up to date and easily accessible information and resources available for front line practitioners around hoarding, domestic abuse, and coercive and controlling behaviour should be reissued and publicised to staff.
- ❖ There should be regular audits of staff training to ensure that all safeguarding training is completed and up to date, and that staff are confident in the execution of procedures and in the ability to challenge partners when necessary.
- ❖ A scanned copy of all service user signed documents should be uploaded onto their electronic record within 7 days of signing to ensure clarity and confirmation of agreements and provision of services.
- ❖ All Housing Department staff should complete Adult Safeguarding Training and Domestic Abuse Training.

- ❖ Social Worker and other support worker's details to be recorded on the Housing Department contact screen by housing officers and rents officers within 24hours of capturing this information.
- ❖ All first Tenancy Audits to be completed for all Council properties by the existing deadline of 30th November 2016. (Actions for this recommendation were taking place, but not completed at the time the Review was completed).
- ❖ The District Nursing Service should review their recording system to ensure that there is electronic back-up to handheld patient notes which can be shared by nurses prior to and after visiting patients and to record any safeguarding concerns or alerts.
- ❖ To continue the roll-out across all NELFT directorates, of agile working to allow staff to remotely access electronic patient records and update accordingly.



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Anne Bristow
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Service Development & Integration
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IG11 7LU

6 December 2017

Dear Ms Bristow,

Thank you for submitting the Domestic Homicide Review (DHR) report for Barking and Dagenham to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 October 2017. I very much regret the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a detailed, thorough review which presented the information in a well structured report. The Panel particularly commended the chair for the further inquiries made from additional sources throughout the review, especially where there were conflicting facts. The report has also been enhanced by the participation of family and friends.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- The Panel felt that presenting the letter written by the victim's eldest daughter near to the beginning of the report would provide helpful context to the narrative and analysis that followed;
- The Panel noted the creative use of photographs in the report, however they advised that these should be carefully reviewed to ensure they do not reveal anything inappropriate or compromise anonymity;

INVESTORS
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- It would be helpful if the report could confirm whether the family were offered advocacy services by the Family Liaison Officer to assist in their engagement in the review;
- Please proof read for typing errors before publication.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the Mayor's Office for Policing and Crime for information.

Yours sincerely

Hannah Buckley

Acting Chair of the Home Office DHR Quality Assurance Panel