

Wokingham Community Safety Partnership

DHR 2 Overview Report

Independent Chair and Author

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CONTENTS

SECTION ONE	3
1.1. Introduction	3
1.2. Purpose of the Domestic Homicide Review	3
1.3. Process of the review	4
1.4. Subjects of the review	6
1.5. Time Period	7
1.6. Terms of reference	7
1.7. Individual management reviews	9
1.8. Diversity	10
1.9. Confidentiality	10
1.10. Involvement of the family	10
SECTION TWO	11
2.1. Introduction	11
2.1.1 Summary of the facts of the case	12
2.2. Analysis of independent management reviews	13
2.2.1 NHS Wokingham CCG – General Practice	13
2.2.2 Royal Berkshire NHS Foundation Trust	17
2.2.3 Wokingham Borough Council – Health & wellbeing	18
2.2.4 Berkshire Healthcare NHS Foundation Trust	21
2.2.5 British Red Cross	24
2.2.6 Crossroads Care Wokingham	26
2.2.7 Home Instead	27
2.2.8 Sue Ryder	28
2.2.9 South Central Ambulance NHS Trust	30
2.2.10 Thames Valley Police	31
2.3. Views of the family	31
SECTION THREE – Key findings	34
3.1. Key findings	34
SECTION FOUR – Conclusions	36
4.1 Conclusions of the DHR panel	37
SECTION FIVE – Recommendations	39

Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Adult A in Wokingham, Berkshire in November 2015.

The Community Safety Partnership of Wokingham Borough Council (WBC) commissioned the DHR in August 2016. . In accordance with the wishes of the family both the victim and perpetrator are referred to as Adult A and Adult B respectively.

On 21st November 2015, Adult A was found deceased at the home she shared with her husband, Adult B. That morning, their daughter, Adult C, visited the house and when Adult B opened the door to her, he told her that her mother was dead. He told her that he had pushed Adult A down the stairs and then strangled her. She also observed that he had blood on his dressing gown and a laceration to his neck.

Adult B contacted NHS 111 who contacted NHS South Central Ambulance service who attended the scene. Paramedics confirmed Adult A was deceased. Having assessed Adult B and finding two puncture wounds to his stomach in addition to the neck laceration, the paramedics then conveyed Adult B to the Oxford University Hospitals NHS Foundation Trust John Radcliffe Hospital in Oxford.

The DHR panel wishes to express its condolences to the family of Adult A and recognise the distress that the incident and subsequent review brings. We hope this report will provide them with assurance that the circumstances of the involvement of local agencies has been properly and thoroughly reviewed.

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR 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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death’*

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

A DHR was recommended and commissioned by the Community Safety Partnership in August 2016 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016. This DHR has used this revised guidance in the development of this Overview Report.

The review process was completed in July 2017. This report was approved by the DHR panel and the Community Safety partnership Board prior to its submission to the Home Office prior to its submission to the Home Office. There was a delay in the completion of the DHR process, in part due to personnel changes within the Borough Council.

The DHR panel has agreed this Overview Report. A full chronology was developed and is available for review if required. It has been shared with the DHR Quality Assurance panel as a separate document but following feedback from other DHR Overview Reports it has not been included in the body of this report.

Panel Membership

Name	Title	Organisation
Steve Appleton	Independent author and Chair of the Overview Report	Contact Consulting (Oxford) Ltd
Joanne Castro	Community Safety & Family First Service Manager	Wokingham Borough Council
Sarah O'Connor	Adult Safeguarding Service Manager	Wokingham Borough Council
Kathy Kelly	Head of Safeguarding Adults	Berkshire West Clinical Commissioning Groups
Stuart Rowbotham	Director of Health & Wellbeing	Wokingham Borough Council
Darrell Gale	Consultant in Public Health	Wokingham Borough Council
Mick Saunders	Detective Chief Inspector	Thames Valley Police
Holli Dalglish	Policy & Strategy Officer	Wokingham Borough Council
Dr. Clare Bannon	General Practitioner	Brookside Group Practice
Emma Kettle	Service Development Manager	Berkshire Womens Aid
Jane Fowler		Berkshire Healthcare NHS Foundation Trust
Antony Hesleton		South Central Ambulance Service NHS Foundation Trust
Patricia Pease	Associate Director of Safeguarding	Royal Berkshire NHS Foundation Trust

The Overview Report author

The independent author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve has had no previous involvement with the subjects of the review or the case. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy. He is a Trustee of a local social enterprise company and is an associate of the Health Services Management Centre at the University of Birmingham.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written a number of DHRs for local authority community safety partnerships.

1.4 Subjects of the review

Adult A

White British female

Date of Birth January 1932

Date of Death November 2015

Adult B

White British male

Date of Birth May 1927

1.5 Time Period

The initial Safeguarding Review Panel set the parameters for their detailed analysis from the period 21 November 2013 to 21 November 2015.

1.6 Terms of Reference and Key Lines of Enquiry:

- Review the effectiveness of local multi agency policies and procedures.
- Identify learning to inform and improve local inter-agency partnership practice, including recommendations for action.
- To review the effectiveness and appropriateness of communication between partner agencies
- To establish levels of engagement and support that statutory services offered or provided to the subjects of the review and to consider the quality and effectiveness of any services offered.
- Liaise with surviving family members to determine what level of involvement they wish to have with the DHR process, and how they may wish to contribute to the terms of reference, the review and the final report.
- Due consideration to be given to engaging significant others, such as friends of the deceased.
- Consideration for consultation with the perpetrator
- To establish the effectiveness and appropriateness of communication between partner agencies
- To recognise where and if the voluntary sector supported or offered support for the couple and their family reviewing its quality and effectiveness.
- To identify good practice and additional learning from this review
- Identify whether the events on 21st November 2015 could potentially have been prevented.
- We will consider the nine protected characteristics of the Equality Act 2010 and determine the relevance in this review, one of which is likely to be age.

Expert Opinion

- We do not anticipate seeking expert opinion at the time of establishing the terms of reference, but this will be subject to review throughout the process.

Time period over which events will be reviewed

- Initially we will review historic events two years prior to the incident, however during the review if relevant information prior to this period is identified, this may also be considered.
- Wokingham Borough Council was informed of the incident and an initial strategy meeting was convened
- A DHR was identified as necessary and it was agreed to proceed

- Criminal proceedings followed and completed on 4th August 2016 with the perpetrator convicted of manslaughter on the grounds of diminished responsibility.
- Instruction to proceed with the DHR from the Chair of the CSP on 10th August 2016. Findings to be concluded and submitted to the Home Office by 10th February 2017 or before.
- Refer to draft chronology of DHR process
- If information gathered in the DHR review process indicates a need to probe further in to any agency's records, the Chair in discussion with the DHR Panel will agree to extend the scope of the timescale of the review and inform the Home Office.

Involvement of Family Members

- We will be explicitly seeking to ensure that the wishes of the surviving family members inform the DHR Terms of Reference and are reflected in the DHR report. Existing family members will be fully supported to receive findings of the DHR.
- We will liaise with the perpetrator to identify if he wishes to be involved and seek his views to be included in the report.

Other parallel reviews

None identified at present, however learning from this review will support other reviews.

Involvement of organisations in other Local Authority Areas

- We will not be seeking views from other local authorities, except where learning can be identified through the themes of the case.

Coroners Inquiries

- The Inquest was opened and adjourned and we will liaise with the coroner regarding the process of the DHR.

Media Coverage/Enquiries

- We will be explicitly seeking to ensure that the wishes of the surviving family members are fully supported in the DHR. Existing family members will be fully supported to receive findings of the DHR and consulted throughout.
- Final DHR report will be anonymised and redacted before publication. Community Safety Partnership will co-ordinate communications and media strategy. Wokingham Community Safety Partnership will identify a lead agency to engage with media if this is required.

Legal Advice

- We do not anticipate seeking independent legal advice at the time of establishing the terms of reference, but this will be subject to review.

1.7 Individual Management Reviews (IMRs)

IMRs were requested from a range of agencies that had been in contact with or providing services to both Adult A and Adult B. This included statutory and voluntary sector agencies

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both Adult A and Adult B.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This Overview Report is based on IMRs commissioned from those agencies that had involvement with Adult A and Adult B as well as summary reports, scoping information and an interview with their daughter. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the DHR panel.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

1.8 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Adult A and Adult B and if this played any part in how services responded to their needs.

“The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.”¹

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.²

The panel considered the nine protected characteristics in the Equality Act. The panel reflected that Alzheimer’s disease constituted a disability under the terms of the act and sought to ensure that the effects of the disease on Adult A were understood and that their impact on the relationship between Adult A and Adult B were factors in this case.

1.9 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Community Safety Partnership accepts the Overview Report, Executive Summary and Action Plan. The Overview Report uses the initials of the victim and the perpetrator but will be anonymised further prior to publication.

1.10 Involvement with the family

The panel has sought throughout the review to ensure that the wishes of the surviving family members have informed the DHR Terms of Reference and are reflected in the DHR report. The panel has communicated with one of Adult A and Adult B’s daughter Adult D by email and telephone to keep her advised of progress. The independent author has spoken with her to gather information to inform the report. He has also shared the full draft of report with her.

Given the age and physical health of the perpetrator it was decided that it was not appropriate to interview him as part of the DHR. Adult A and Adult B’s daughter Adult C declined to be involved in the review.

Section Two

¹ Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47

² Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

2.1 Introduction

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Adult A and Adult B. The report examines agency responses to and support given to Adult A and Adult B prior to the incident on 21 November 2015.

Eight agencies had records of contact with Adult A and Adult B within the time period covered by the DHR. They were:

- Berkshire West CCGs (Primary Care)
- Royal Berkshire NHS Foundation Trust
- Wokingham Borough Council – Adult Social Care Department
- Berkshire Healthcare NHS Foundation Trust
- British Red Cross
- Cross Roads Care
- Home Instead
- Sue Ryder

Thames Valley Police and South Central Ambulance Service NHS Trust had contact on 21 November 2015 due to their attendance at the incident. Both provided summary reports outlining their involvement.

Domestic Abuse Contact

The DHR has not found any evidence of domestic violence or abuse in this review, either from the IMRs received or the wider work of the panel.

None of Adult A or Adult B's contacts with the agencies prior to the incident were associated with a referral or subsequent assessment and case management associated with domestic violence. Neither had ever sought any assistance from the police, or any statutory or voluntary sector agency in relation to allegations or incidents of domestic abuse.

2.1.1 Summary of the facts of the case

Adult A and Adult B were husband and wife and had been married for 62 years. Both were retired professionals. They have two daughters, Adult C who lives nearby and Adult D who lives in the north west of England.

Adult A had been living with dementia for some time and in the weeks leading up to her death this had begun to accelerate in terms of its effect on her and the daily lives of her and her husband. In part, it has been suggested that the deterioration was affected following an operation carried out under general anaesthetic to disperse kidney stones and the removal of a stent.

Adult B had, until the middle of 2015, been the main carer for his wife. He had been carrying out a range of tasks and was responsible for her daily welfare. This had become harder for Adult B to do. His ability to provide day-to-day care for Adult A was affected by his diagnosis of gastric cancer. The prognosis was not positive and it was expected that he might only have a short time to live. Despite the illness and its affect on his physical health Adult B decided not to undergo further treatment beyond initial radiotherapy because he believed the recovery period from surgery would mean he would be unable to care for his wife and he was advised that the chance of a full recovery was limited to about 33%.

In order to get some respite from his caring responsibilities, Adult B engaged a private care agency, Home Instead. They provided help at home with tasks such as meal preparation and sitting with Adult A while Adult B took a break to sleep, do other household tasks or to leave the house.

On the morning of 21 November 2015, at around 10.30am Adult C visited her parents at their home. She intended to discuss ongoing support with home care with her father. When she arrived she noticed that the garage door was open, that the house curtains were still closed. She assumed that her parents might be having a sleep. When Adult C knocked on the door, Adult B opened it and told her that Adult A was dead. Adult C saw her mother, deceased, on the staircase.

Adult B called NHS 111 and an ambulance was dispatched. When the ambulance crew arrived they confirmed that Adult A was deceased. They asked Adult B what had happened and he told them *'I killed her. I pushed her down the stairs, then strangled her.'*

The ambulance crew examined Adult B and found that he had what they believed to be self-inflicted knife injuries to his neck and torso. They conveyed Adult B to hospital where he was treated for his injuries. Adult B was later assessed under the Mental Health Act 1983 and he was detained under Section 2 at a mental health hospital in Reading. Adult B's injuries were recognised as a serious suicide attempt.

A subsequent post mortem found that Adult A died from blunt force trauma to her head and compression of the neck.

Adult B pleaded guilty to Adult A's manslaughter on the grounds of diminished responsibility and on 4 August 2016 he was found guilty and received a two year suspended sentence. Following a period of inpatient care for his mental health problems, Adult B has now returned to his home address.

2.2 Analysis of individual management reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Adult A and Adult B, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. This is in accordance with the Pemberton Homicide Review conducted in 2008.

It is important that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

2.2.1 NHS – General Practice

The Clinical Commissioning Groups (CCG) are responsible for commissioning the vast majority of NHS services within the areas they serve and every General Practice within the United Kingdom is required to be a member of a CCG. The NHS does not directly employ GPs; they are independent contractors. The GP service is a universal service that provides primary medical care to families 24 hours a day both at the local practice where a family is registered and through the Out of Hours service.

Adult A and Adult B were registered as patients at a local GP Practice. They had been known to their current GP since 12 March 2015 when the GP first met them. That appointment was for a health check for Adult A as Adult B was concerned that she was not eating properly and losing weight.

The GP conducted an examination of Adult A, took blood to be tested and referred Adult A for an ultrasound. The results of these tests were all normal and she believed the symptoms Adult A was showing were as a result of her dementia.

The GP met with Adult B alone on 13 April 2015. Blood tests were conducted and he was found to be anaemic. Adult B was referred to the Gastroenterology Department. In July 2015 he was diagnosed with gastric cancer.

Adult B began to experience physical effects of his illness. He lost a lot of weight, had a poor appetite, experienced light-headedness and according to the GP was becoming increasingly frail. She was concerned about his overall health and knowing he was the main carer for Adult A, became more involved in his care. The GP referred both Adult A and Adult B to the Community Matron, District Nurses and also updated her practice colleagues so they were aware of the situation, should she not be in surgery. She also referred Adult A to a dietician to assist with her eating. Adult A seemed to be stable. Once Adult B had completed his radiotherapy, he was very unwell for a month and continued to lose weight due to loss of appetite as a result of the treatment. By the end of October he did improve a little but remained frail.

Following a request from Adult C, the GP conducted a home visit on 24 September 2015. Adult D was present for this visit. A health check was done with Adult A who was found to be physically well, but her dementia had become worse. The GP spoke with Adult B and Adult D about Adult A's dementia and how it was likely that it would continue to deteriorate. The GP reported that Adult B was not eating well, and was feeling nauseous.

The three of them discussed the option of engaged home care input to provide some respite for Adult B. Both Adult B and Adult D confirmed that it was their intention to do this. The GP also discussed referring Adult B to Sue Ryder³ for nursing input. Although Adult B initially agreed to this, but later declined, as he was concerned that such input was only for end of life support.

At the end of October 2015 Adult A had been experiencing pain and had renal colic⁴ treatment. When she returned from the first hospital stay on 4 November, Adult D noticed a decline in Adult A's abilities and an increase in confusion. On return from the second hospital attendance on 17 November, Adult C was told by a nurse that she had done an assessment of Adult A's dementia and that it was very advanced.

The GP did liaise with the Community Matron in order to increase support, and referred Adult B to the Sue Ryder palliative care team for additional support and advice, reiterating they were not only engaged in end of life care. The GP was concerned about Adult B's physical health and felt he might benefit from engaging with Sue Ryder. Adult B was sometimes reluctant to accept help and support and needed some encouragement. The GP felt it was important to talk with the family, the Sue Ryder nurse and the community matron to allow them all to discuss their concerns and take

³ Sue Ryder is a charity that supports people with complex needs and life-threatening illnesses across the UK and internationally

⁴ Renal colic is a type of abdominal pain commonly caused by kidney stones

a proactive approach, with or without Adult B's agreement; although he had agreed to the GP contacting both the Community Matron and Sue Ryder. The overriding concern was Adult B's risk of becoming ill and needing a hospital admission.

Following the episode of renal colic and surgery, Adult A was becoming physically better and making a good recovery, however mentally she appeared to be deteriorating with her dementia. Both Adult B and his daughters stated that Adult A was unsafe to be left on her own as she was confused and may have been at risk to herself.

The GP was informed at this stage that a carer from the care agency attended for three hours a day. This was subsequently reduced to two hours daily. Additionally, once a week a lady from the Red Cross would sit with Adult A. There was also informal help from friends. Adult B told the GP that he and his daughters were in discussion with the care agency to increase the level of care.

On the 10th November 2015, the GP spoke with Adult B on the phone. He said that he was struggling with looking after his wife as her dementia was getting worse. The GP arranged to attend their home on the following day. The IMR states that the GP made this decision in accordance with the risk and clinical assessment that there was no immediate risk of harm to warrant any earlier visit.

On the 11th November 2015 the GP conducted the home visit and conducted several health checks with both Adult A and Adult B. Adult B told the GP that he was worried about the future of his wife. Physically she was well but he was concerned about what would happen to her if he died first. He said that Adult A now struggled if he was out of sight for even a short amount of time. He said that he found the situation very stressful as he was caring for his wife more and more.

They discussed increasing support with the care agency, increasing support from the memory clinic (they were involved with her care), community elderly care, district nursing, community matron and palliative care. The GP also recommended that Adult B talked to his daughters and felt confident that he would do so, but also felt it was important that she and the community matron have discussions with them as well.

The GP's last contact with Adult B was on 19 November 2015. This was an unplanned phone call. Dr. CB often called to talk to Adult B as she felt it was good practice to regularly review the situation given her concerns about both Adult A and Adult B. During this call Adult B stated that he was feeling overwhelmed by the situation. He did not mention any thoughts of harming himself or Adult A during this call, nor had he done in any previous contact. Adult B had not shared his sense of being overwhelmed with either of his daughters

The GP reports that Adult B's mood, feelings and discussion about his stress was assessed during this conversation and there was no indication that he indicated risk to self or others. Adult B confirmed he would call his daughter for help if needed. The GP did not ask directly if Adult B was suicidal or had any plans. The concern from the GP was more that Adult B may become exhausted and she wished to review the level of intervention to support them

Analysis of General Practice involvement

Adult A and Adult B were offered GP care and both used the service appropriately appearing to seek health care advice when required. They were seen at home and in the surgery. The GP appeared to have a positive professional relationship with them both. It is clear from the IMR that she had built an effective and trusting relationship with Adult B.

It is also evident that she was appropriately concerned about their welfare and made additional efforts to ensure she remained in contact, explored appropriate care options and responded to requests for consultations in a timely way. The GP is to be commended for her good practice and her commitment to providing a high quality GP service.

There was good and regular communication with the community based services and although it appears that at times Adult B was reluctant to seek or receive support, the GP carefully and respectfully encouraged him to do so. It is clear from the IMR that Adult B did seek contact and support from the GP and the health teams appropriately and these approaches were responded to.

It is evident from the IMR that there was ongoing concern about the home situation and for the welfare of both Adult A and Adult B. This was largely in the context of their health problems, their ability to remain independent and Adult B's caring role. There was concern about his anxiety and the associated stress of this role, coupled with his physical illness.

Despite his anxiety, which was well articulated and known, the IMR is clear that there was no evidence of any risk of harm to Adult A from Adult B, nor was there any evidence of Adult B being a risk to himself or anyone other than Adult A.

The decision-making by the GP and the associated community teams was in line with expected practice and was appropriate given the knowledge they had.

It appears that the relationship with other family members was positive. The GP and those community teams respected the views of the family and were rightly willing to allow them to take decisions about Adult A and Adult B's home care needs.

Lessons learnt

The key lessons from the primary care IMR are the value and importance of effective and regular communication and of a multi-disciplinary approach. The IMR makes no recommendations for action arising from the review.

2.2.2 Royal Berkshire NHS Foundation Trust

The Royal Berkshire Foundation Trust (RBH) provides acute medical and surgical services to the people of Reading, Wokingham and West Berkshire and specialist services such as cancer, dialysis and eye surgery to a wider population across Berkshire and its borders.

RBH provided care to both Adult A and Adult B. Their involvement with Adult A was limited prior to October 2014, when she attended outpatient clinics for a nasal complaint.

On 30 October 2015 Adult A attended the emergency department. A scan revealed the presence of kidney stones. On 3 November 2015 Adult A was admitted to the RBH and was assessed including an assessment of her mental capacity in line with the Mental Capacity Act 2005. Following the insertion of a stent under anaesthetic on 4 November, Adult A was admitted to the BUPA hospital two weeks later on 17 November for a further (day only) surgical procedure under anaesthetic, which was the removal of the stent by the same surgeon. Although neither procedure required a general anaesthetic, it was felt that it have been impossible for them to be carried out under a local anaesthetic due to Adult A's advanced dementia and the difficulty of explaining what needed to be done.

Adult B was seen at RBH on 1 June 2015 for an endoscopy. This and a subsequent biopsy in July 2015 led to a diagnosis of gastric cancer. Following a series of outpatient consultations it was agreed that Adult B would prefer to have radiotherapy rather than surgery.

A series of letters and communications are set out in the IMR that demonstrate ongoing communication between RBH, the Comprehensive Care for Older People with Cancer service (COCOC), Dr. CB and Adult B.

Analysis of RBH involvement

The IMR clearly shows that RBC clinicians and staff were aware that Adult B was the main carer for Adult A.

It is also clear that in relation to Adult A's care, RBH staff were aware of and properly assessed her mental capacity. Adult B was clearly involved in decisions about his wife's care and consideration was given to his desire for his wife to come home and

receive care following her surgery. They rightly assessed the benefit of discharge in Adult A's case, given that prolonged aftercare in hospital may have caused her distress and confusion due to her dementia.

RBC and COCOC staff appropriately shared concerns about Adult B's ability to care for Adult A given his physical health. Although the IMR discusses whether staff might at times have been more challenging when Adult B declined referrals for support, on balance, their response seems appropriate based on the information they had. Any referral would have required his consent and there was nothing that indicated that no referral for additional support would have contributed to the incident happening.

Lessons learned

The complexity of risk assessment for acute healthcare staff when a referral to social services for assessment is offered but not accepted when there are no obvious safeguarding concerns

The need for better understanding of the stressors for carers who are patients and the possible impact on their mental capacity to make some decisions, particularly when there is a diagnosis of cancer or similar life changing diagnosis.

The challenge of application and knowledge of the Mental Capacity Act and Care Act in an acute health care setting, particularly day care or out patients settings where time is limited and the person who lacks capacity is not the patient

The adequacy of documentation and information sharing

The IMR makes eight recommendations, of which require multiagency action, which can be found at Section Five.

2.2.3 Wokingham Borough Council Health & Wellbeing

Wokingham Borough Council (WBC) is the Unitary Authority serving the population of the Borough of Wokingham in Berkshire. It has the statutory duty to provide both adult's and children's social care services; in addition to a wide range of both statutory and non-statutory services to its resident population.

The Adult Social Care (ASC) department was notified of the death of Adult A on the 23 November 2015, via the Berkshire Emergency Duty Service. At this point all electronic records were appropriately secured and senior personnel informed. WBC does not operate a paper record system; all contact records are made directly into the *Frameworki* system.

The contact between Adult A, Adult B and WBC was minimal. In February 2013 initial contact was made with the duty service regarding support relating to Adult A's dementia. A referral was made to the Community Older Adults Mental Health Service (COAMHS) and an assessment was offered by that service. The IMR does not indicate if the assessment was carried out and if it was, what the outcome was. During this initial contact period, Adult C made contact with the ASC about accessing support for Adult A and for Adult B following a deterioration in his health, having been discharged from hospital. It appears from the IMR that no assessment of their care needs at home had been made prior to discharge. Advice about assessment processes and timescales was provided to Adult C.

In July 2015 Adult C again contacted the ASC, this followed Adult B's cancer diagnosis. A carers assessment was undertaken four weeks later (August 2015). This assessment found increased carer stress, Adult B was concerned about what would happen to Adult A should he die before her, a possibility given his cancer diagnosis. Following the assessment an allocation of the maximum carers budget and advice on making arrangements for privately commissioned care was made by ASC. The request for budget allocation progressed swiftly and did not delay Adult B arranging a sitting service via the Crossroads service.

In September 2015, Adult C contacted ASC to advise that Adult B had undergone treatment for his stomach cancer. Adult C made clear that that her parents did not want to be separated, although Adult B was, in her view, unable to care for Adult A as he was very weak following his radiotherapy.

A response call was made on the same day to Adult C and she was advised to focus on encouraging Adult B to accept a few hours a day so that he could rest. No other intervention or assessment was offered as the worker involved was advised that Adult B was seeing a care agency later that week. The worker, LT (*who is no longer employed by WBC*) advised that she was going on leave but would review the situation on her return.

In October 2015, following her annual leave period; LT called Adult B to review carers service. Adult B advised that he had now completed radiotherapy treatment and that he was very happy with the carers respite service. LT advised that she would write to Adult B to confirm who he should contact in the future as she was leaving the organisation.

In November, shortly before the incident, contact was made by ASC with Adult B Crossroads to review the sitting service. This was the last contact with Adult B.

On 23rd November 2015, notification was made to the Director of Health and Wellbeing and Adult social care by the Berkshire Emergency Duty Service of the death of Adult A and the attempted suicide of Adult B.

Analysis of Wokingham Borough Council Health & Wellbeing involvement

The initial contact in 2013 was appropriate and correct advice was given about the entitlement to an assessment by ASC, but this was not requested by Adult B at that time and as such contact was not taken forward. The IMR rightly highlights that changes in legislation with the introduction of the Care Act 2014 would require a different approach to assessment of need and of carer need. The introduction of the Act resulted in a review of ASC approach.

In June 2015 a carers assessment was requested and was undertaken by ASC in accordance with the Care Act 2014. A waiting list for these assessments was in place at the time. The waiting period was four weeks from the referral to allocation. The risks relating to waiting times were identified as part of a safeguarding review by ASC and all lists were reviewed and risk rated with a priority on reducing and removing waiting time delays.

The IMR finds that despite the assessment being conducted in accordance with the extant practice guidance, there was no recognition or exploration of the risks relating to the psychological impact on the couple of having to wait.

By the time of Adult C's contact in September 2015, the needs of Adult B as a carer were increasing and that he was more vulnerable. Adult C did express Adult B's view that he did not want additional care for Adult A.

It appears that there was little or no recognition of the vulnerability of Adult A as a result of Adult B's increasing frailty. Nor was there any exploration of the capacity of Adult B or Adult A regarding the risks of not accepting additional care and support. There was no communication between COAMHS to clarify accountabilities and best interests decision making under the Mental Capacity Act 2005.

The contact made in November 2015 by ASC to review the Crossroads sitting services represented a missed opportunity to explore with Adult B the impact of his caring role in periods of his own poor health and discuss the couple's entitlement to additional support as a couple and individually to provide assurance for the future.

Lessons learned

There does not appear to have been a clear approach towards establishing the coping strategies of carers, especially where the carer themselves has a significant and deteriorating health condition. Stoicism amongst older people and the consequent minimisation of their needs may lead to social care staff accepting at face value comments which suggest that they are coping.

Following a previous DHR, which has some similarities to this case, a range of actions has been implemented. This case has demonstrated that ASC require further support and training on the identification of cases of co-dependent risk and their analysis, in addition to collaborative joint working arrangements with mental health services for older adults in such cases to ensure the appropriate level of support is offered.

Reflection sessions and supervision support were offered to LT before her departure from the organisation in relation to this case. These identified that LT had followed the correct carers assessment and internal process in this case. However the assessment of risk and multi-agency coordination on agreed risk levels, informing intervention and the framework for decision making under the legislative requirements of the Mental Capacity Act 2005 were not recorded or fully recognised and considered.

The IMR raises the important question of whether in cases of carers for people with mental health difficulties, such as dementia, a practitioner with mental health experience should undertake these assessments due to the complexity and specialist knowledge required to assess impact and risk in such cases.

The IMR makes four recommendations which can be found in Section Five.

2.2.4 Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust (BHFT) is a provider of community mental health and physical health services across Berkshire for children and adults which are commissioned by Berkshire CCGs. It has a number of outpatient clinics, inpatient rehabilitation units and an acute mental health inpatient unit, a forensic liaison service and an outreach health service for the homeless community. BHFT dementia services include memory clinics, which are situated across Berkshire. Patients are referred by their GP and treatment and review assessments are undertaken under shared care protocols with GPs.

Adult A was referred to BHFT memory clinic by her GP on 2 December 2010. With her consent, a memory clinic practitioner, in the presence of Adult B, undertook an initial assessment at her home. Adult A was diagnosed to have Alzheimer's disease in 2011 and was admitted into BHFT dementia services. At this time she consented to assessment and treatment and attended the services offered accompanied by her husband Adult B. The IMR reports that Adult A was always comfortable in her husband's company and they are referred to as a very close couple. Adult B was described as a very caring husband who advocated well on behalf of his wife. He was key to ensuring that Adult A's treatment plan was administered appropriately and medication was monitored for side effects.

Adult A had 50 consultations with BHFT professionals including follow up phone consultations. She also attended two dietetic appointments, one for assessment and

intervention regarding weight loss and a follow up two weeks later for review, which identified a weight gain following a successful nutritional support plan. Adult A was assessed by the community matron service (part of the community nursing service) on three occasions and was treated for an acute infection, which prevented an admission to hospital.

Adult B also received care and treatment from BHFT services, which included a one off consultation with the cardiac rehabilitation exercise instructor in April 2013 following treatment for a cardiac condition in February of that year. Following a diagnosis of Gastric cancer in September 2015, B was referred to the community matron service and was supported with symptom management and care support advice jointly by the GP and community matron service. Up to November 2015, Adult B had 14 healthcare interventions.

In October 2015 Adult B was struggling to manage his cancer symptoms which initiated increased community matron and specialist palliative services. His ability to cope with caring for his wife during this time was affected because of the impact of cancer treatment.

He was being supported to care for Adult A by Crossroads care agency, a befriending support worker who took Adult A out for a walk once a week to offer some respite. The IMR states that Adult B was finding it difficult to come to terms with accepting extra support in their home to manage Adult A's needs.

There was a period of four days from 17th November 2015 when the need for care support became more necessary. The community matron service were working with Adult B and the family encouraging him to accept extra help, which they were to commission privately because Adult A did not meet the threshold for the local authority to provide services. In the last two days, options for respite care were being explored. Adult B was resistant to a care home admission for Adult A, feeling she would not like to be away from him and their home.

Analysis of BHFT involvement

Adult A and Adult B were receiving care and support from a number of agencies and treatment interventions from the memory clinic team, community nursing, dietician service, and GP services. All health services were liaising with the GP with up to date detail on reviews and treatment plan in a shared care arrangement. Adult A's health records demonstrate that this practice was achieved promptly and to a high standard of detail.

Throughout their care and treatment records and interviews with key staff evidence the high standard of respect, dignity and compassion afforded to Adult A and Adult B. Services were responsive and flexible with regard to appointments and treatment

planning. The IMR shows that regard for Adult A's ability to make decisions was preserved for as long as it was possible to do so and records evidence that at every intervention her views were sought regarding her experience of health and wellbeing in line with the values and principles of the Mental Capacity Act.

Communication with their GP was of a high standard and the couple received written and verbal information about community resources for care and support needs. Adult B's caring role was considered as part of Adult A's clinic reviews and he was referred to the adult social care team in the local authority for a carer needs assessment (Care Act 2014). Adult A attended the memory clinic Cognitive Stimulation Therapy course lasting fourteen weeks and Adult B attended the Understanding Dementia awareness course accompanied by their daughter Adult C.

In relation to contacts by BHFT just prior to the incident, the IMR finds that risk assessments did not include indicators of carer stressors as risks in the section on risk from others; although domestic abuse is listed it was interpreted as disclosures of domestic abuse. Therefore risks from the stressors communicated by Adult B as a carer were not measured as part of holistic risk assessment.

The IMR also reveals that there were also some areas where healthcare services could improve their practices. These include specific advice from safeguarding leads to healthcare professionals that regardless of funding arrangements for care and support needs for patients in the community, healthcare professionals should offer referrals to the adult social care team so that a Care Act assessment can be offered or completed to determine level and appropriateness of care input required.

The IMR shows that staff providing services made all reasonable efforts to ensure that Adult A and Adult B's needs were met with respect to care and support.

Lessons learned

Adult A's expressed wishes and values were respected with regard to her husband's advocacy on her behalf and the comfort she took in having his support during healthcare appointments and interventions. These wishes were upheld by staff when she was no longer able to make decisions about her care and treatment. This was good practice

There were two occasions where Adult B contacted the memory clinic and expressed concerns that he was waiting for a return call regarding a previous enquiry. The IMR recommends that staff taking calls from patients should create a record which enables trained staff to return patient calls the same day which will promote good working and therapeutic relationships with patients and their carers and support good practice identified earlier.

In relation to decision-making and matters of capacity, BHFT have identified a need to improve and embed knowledge of the Mental Capacity Act 2005. The learning from the IMR is being used to inform training and development within BHT to support practice which safeguards the interests of adults who lack capacity to make significant decisions and are dependent on others for care and support.

The IMR makes six recommendations which can be found in Section Five.

2.2.5 British Red Cross

The British Red Cross (BRC) is a charitable organisation that helps people in crisis. As part of their work they operate an Independent Living Service that provides time-limited support to people who find it difficult to cope at home. This might follow a stay in hospital, avoid them being re-admitted or prevent reliance on higher intensity social care. The aim of the service is to support and promote independence, dignity and respect and involves service-users in decisions about their support.

In 2015, the BRC was operating a service called 'The Comprehensive Care for Older People with Cancer (COCOC)' as a partnership project with Macmillan Cancer Support and the Royal Berkshire Hospital Foundation Trust. This service is no longer in operation, but at the time, provided support to around 70 people in the west of Berkshire.

Adult B was referred to the COCOC on 15 September 2015. The referral request was for the provision of support to Adult A in order to provide Adult B with some respite from his caring responsibilities. This was in the context of the physical demands on Adult B, which he was finding harder to cope with as a result of his cancer treatment. The service was offered initially for a period of three months. A 'buddy' was to be provided who would spend time with Adult A, usually on a Wednesday, giving Adult B a chance to rest or attend to other tasks.

On 16 September 2015 COCOC made contact with Adult C to outline the details of the service that could be provided and to offer an assessment visit at Adult A and Adult B's home.

On 7 October 2015 a home visit was completed by the Service coordinator with Adult A, Adult B and Adult C present. During this visit a support plan was agreed. COCOC completed a risk assessment of the home to identify any physical risks and for lone working. No risks were identified. During the assessment Adult B stated that he was exhausted. The visit also confirmed for COCOC that other services were in place, from Home Instead and Crossroads Care, as well as family support. In the course of the

assessment and visit, the COCOC worker did not find any evidence for any concern about risk to Adult A from Adult B.

The Service coordinator made three home visits. These took place on 14 October, 11 November and 18 November 2015. On the final visit on 18 November 2015 Adult B cancelled the next planned visit as he had a hospital appointment and had arranged for Crossroads Care to support Adult A that day. The visit on 18 November 2015 was the last contact and COCOC was notified of Adult A's death on 23 November 2015.

Analysis of BRC (COCOC) involvement

COCOC responded swiftly to the referral and made an appointment for an assessment within one working day. The assessment took place three weeks after the referral. Adult A and Adult B's needs were assessed using a standard assessment form. Although the COCOC participated in multi-disciplinary meetings with colleagues from the Royal Berkshire NHS Foundation Trust, these contacts were not documented.

The first home visit was delayed due to the Service Co-ordinator having a cold and not wishing to pass this on to Adult A or Adult B. The IMR states the family was supportive of this and that other support services were in place at this time.

The service was well established and was able to offer appropriate support to Adult A and Adult B. The IMR indicates that the relationship between the Service coordinator and Adult A, Adult B and family was open and positive.

Involvement was limited to the assessment and three home visits. There is no evidence of any recorded concerns about risk towards Adult A from Adult B in relation to domestic abuse. It is clear that the needs of both Adult A and Adult B were well known to COCOC, and the service provided was appropriate and of a good standard.

Lessons learned

The IMR does not identify any specific lessons to be learned. However, it does recognise need to ensure appropriate recording of contact with statutory agencies. The IMR does not make any recommendations for action.

2.2.6 Crossroads Care Wokingham

Crossroads Care Wokingham (CCW) is a voluntary sector provider of home based respite care and breaks. It works across Wokingham and Bracknell and has been in operation since 1994.

Adult B referred himself to CCW in July 2015. He was a self-funder and was to pay for the service himself. He requested their Back Me Up service. The Back Me Up scheme operates 24 hours a day, 7 days a week, every day of the year. It provides urgent support to the cared for person in the event of a carer being unable to care because of sudden illness, accident or another unplanned event. The scheme offers carers peace of mind knowing there will always be someone available to call should they be needed. The Back Me Up scheme also provides cover for carers who need time off for a health related event such as hospital, GP, Dental appointments.

CCW visited Adult A and Adult B on 29 July 2015 to conduct a general and risk assessment. The purpose of this was to collect information, assess the level of need and agree a care support plan.

During the assessment it was agreed that Adult B would contact CWW to support Adult B when he had hospital appointments related to his treatment for gastric cancer. The care support plan was defined as being to provide a person to sit with Adult A, or take her out for a walk, assist with ensuring she had a drink and food and provide reassurance to her while Adult B was absent at his appointments.

When Adult B returned from his appointments the CWW worker would stay on for a while to ensure he had a rest and if this needed to be extended this would be agreed between the worker, Adult B and the CWW office.

Visits were provided between March and November 2015. Throughout their involvement CWW had regular contact with Adult C.

On 23 November Adult C contacted CWW to advise of Adult A's death.

The IMR sets out clearly the policies and procedures that CWW had in place at the time of their involvement and these are those that would be expected. There is no evidence that any concern about domestic abuse or the risk of domestic abuse was present during CWW's involvement.

Lessons learned

There are no specific lessons to be learned from the IMR relating to CWW. CWW has restated its commitment to safeguarding, partnership working and effective liaison with families. The IMR does not make any recommendations.

2.2.7 Home Instead

Home Instead Senior Care is a national domiciliary care provider organisation with over 170 offices across the UK. The office in Reading has been established since December 2011 and currently employs in excess of 50 people who are engaged in the delivery of support to people in their own homes, supported by an experienced team of managers and supervisors. The office concerned with this case operates solely in the greater Reading area.

The organisation provides companionship based care services to its clients and delivers care packages where call lengths are at least an hour and where particular focus is placed on supporting clients emotional needs in addition to their physical needs. The majority of their clients, like Adult B, are self-funders.

On 6 July 2015, Adult B's daughter Adult D contacted Home Instead to request information about their services. She was aware of the organisation through a friend who had used their services in the North West of England.

An initial assessment visit was arranged and took place on 7 July 2015. This took place in the presence of Adult B and Adult D. It was agreed that a schedule of daily visits to provide companionship to Adult A. Following that meeting and on the same day Adult D called Home Instead. The family had reflected on the plan and felt daily visits of 2-3 hours would be too intrusive. Adult B requested that the care package be put on hold and he would contact to arrange a trial visit.

On 20 July 2015 this trial visit of 2 ½ hours took place. No further request for further visits was made until 29 September 2015, when Adult B contacted Home Instead to ask for a return assessment visit with a view to re-establishing home visits.

On 2 October 2015 a meeting was held and it was agreed that a daily schedule of calls (initially 3 hours in duration) between 14.00 and 17.00 would be put in place. The aim of the calls was to enable Adult B to have some rest. On 12 October 2015 the new schedule of calls was initiated, after two days the duration of the calls was reduced to two hours.

From 14 October 2015 a regular pattern of calls commenced with a few odd shifts cancelled due to other family activities. There were also requests for some calls at weekends as well. On 21 November 2015 Home Instead was advised by the police that Adult A was deceased.

Lessons learned

The IMR states that frequent changing of the agreed pattern of calls by the family. It appeared to Home Instead that the family were having discussions after the meetings and deciding to change the agreement. The result for Home Instead is that they felt that it was difficult to establish a regular pattern of visits which would allow the carers to build a routine with Adult A and provide the set periods of rest that Adult B had originally requested.

Clearly as a self-funder, Adult B and his family were perfectly able to make requests for changes to patterns of visits. However, it may be that organisations such as Home Instead need to be cogniscent of the need to be flexible, but also clear with clients about what is possible and what is not at the outset of any engagement.

The IMR also highlights a key learning point in relation to the understanding of the psychological impact on carers. The IMR suggests that further work could be done with Home Instead to equip its staff to respond to this and to factor it into their risk assessment and general assessment processes. The IMR makes one recommendation that can be found in Section Five.

2.2.8 Sue Ryder

Sue Ryder is a charity that supports people with complex needs and life-threatening illnesses across the UK and internationally. Although Adult A was not a patient of Sue Ryder, Adult B was referred to their Community Specialist Palliative Care Team in Wokingham for symptom control in relation to his cancer.

Sue Ryder provides specialist palliative care advice to patients, families and other professionals involved in a patients care such as GP's. They provide the service on their inpatient unit, at home via their Community Specialist Nurse (CNS) team and from their day services. The service is delivered using a holistic approach to their services but their work is dominated by provide specialist symptom management and emotional support to families approaching end of life. They do not provide physical care in the community.

Adult B was referred to the CNS team based in Wokingham on 22 September 2015. He was seen by the service on 9 October 2015, somewhat outside the standard seven day standard for response, though contact was made following referral within 24 hours. The assessment conducted was thorough and covered appropriate issues relating to needs of Adult B, Adult A and the home situation.

Phone calls were made by the service on 19, 21, 22, 26 October but there was no reply, messages were left on Adult B's answering machine. No service input in place at that time.

On 18 November the service had a phone call with the Community Matron. She had seen Adult Band stated he was at 'crisis' stage (her description not that of Sue Ryder) with his wife, she had recently been in hospital and Adult B was finding it more difficult to care for her since she has been back home. The Community Matron was going to attempt to speak with Adult B's daughters. The IMR highlights that there was a question about offering day centre support or an alternative plan to support Adult B to care for Adult A. Sue Ryder service were to get back to GP who has left message earlier today and arrange to see him again.

On 19 November the CNS spoke with Adult B's GP. The concern from the GP was that Adult B was getting to a crisis point in relation to his caring role. This was followed by a phone call on 20 November between the CNS and Adult C. During this call Adult C articulated her view that Adult B was increasingly struggling with his caring role, and was worried about Adult A given her deterioration. Adult C reported that she and Adult D had suggested additional care support for Adult B but that he had been reluctant to accept this. Plan was for CNS to visit on Monday 23 November.

On 23 November the CNS returned a call to Adult C, who had left a message earlier the same day. During this call Adult C confirmed Adult A's death. There was some limited phone contact after the incident via Adult C who informed CNS about Adult B's move from hospital in Oxford to Prospect Park Hospital in Reading.

Lessons learned

There was effective and regular communication between the CNS and statutory agencies including the GP. The assessment process was robust and thorough.

The client led model meant that the Sue Ryder team were rightly mindful of Adult B's wishes and as such could not and would not impose care and support upon him. They attempted to be flexible and made sure he knew how to contact them if he wished to receive support.

At no point in the engagement of the Sue Ryder team was there any evidence of any risk or incidence of domestic abuse by Adult B towards Adult A, nor was there any indication of risk to himself in respect of self harm.

There are no further lessons learned and the IMR does not make any recommendations.

2.2.9 South Central Ambulance NHS Foundation Trust

South Central Ambulance Service NHS Foundation Trust (SCAS) was established on the 1 July 2006 following the merger of four ambulance trusts. On 1 March 2012 it became a Foundation Trust. It serves the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire, an area of approximately 3,554 square miles with a residential population of over four million. Its three core responsibilities are:

- The accident and emergency service to respond to 999 calls
- The 111 service for when medical help is needed fast but is not a 999 emergency
- The Patient Transport Service

SCAS's only involvement was in response to the incident on 21 November 2015. At 11.10 on 21 November 2015 a call was received by SCAS from NHS 111 requesting a double manned ambulance to be dispatched to the home of Adult A and Adult B. At 11.14 the ambulance was dispatched. This followed some discussion about the coding of the call. It had been coded as a Red 1 Response (a life threatening incident for which response is 8 minutes). The emergency call taker queried this based on information from Adult B to NHS 111 that Adult A was already deceased. Ultimately a Red 1 Response was correct and was applied to this incident.

On arrival the ambulance staff were met by Adult C and she directed the crew to the stairs. Adult B who was present allegedly told the ambulance crew that they would not need their equipment. He informed the crew that he had killed Adult A by pushing her down the stairs and then strangled her.

The crew examined Adult A and also contacted the police and requested their attendance. They determined that Adult A was deceased and based on examination and Adult B telling them the incident had occurred at around 08.30 they determined that Adult A had been deceased at least two hours prior to their arrival.

The ambulance crew established that Adult B had injuries to his neck and abdomen and these were self-sustained stab wounds. It appeared he had used a large kitchen knife to inflict these wounds upon himself. Adult B told the crew he had done this approximately one hour before their arrival.

An air ambulance was dispatched, and though crew from the helicopter attended, Adult B was transported to the Oxford Radcliffe Hospital by ambulance having been treated at the scene.

Lessons learned

Although there was confusion about the coding of the call, there was no delay in dispatching an ambulance.

The ambulance crew acted appropriately while attending the scene.

The IMR does not identify any lessons to learn and does not make any recommendations.

2.9.10 Thames Valley Police

Thames Valley Police (TVP) is the police service covering Buckinghamshire, Berkshire, Oxfordshire and Milton Keynes. It is the largest non-metropolitan force in England.

The involvement of TVP was limited to their response to the incident. They provided a report of their involvement, which included much of the background information that is described in the key facts of the case earlier in the report. There are no lessons learned or recommendations to be made arising from the TVP report.

2.3 Views of the family

The independent author of the Overview Report spoke with Adult A and Adult B's daughter, Adult D as part of the review. The purpose of this discussion was to explain the process of the DHR and to gather any further relevant and helpful information about Adult A and Adult B that might assist the DHR.

Adult A and Adult B settled in Berkshire in the early 1960's. They both worked as professional people and had successful careers. Adult B undertook a lot of charitable voluntary work over a period of 40 years. He ceased his voluntary work following Adult A's dementia diagnosis to allow him to be able to care for her.

Adult A was a social person. Adult D described how she took great care over her appearance and always looked immaculate. She was, according to Adult D a lady of routine, who liked things to be done at certain times and on specific days.

In the discussion Adult D was clear that Adult B had always been respectful of Adult A throughout their marriage and that this continued with the onset of her dementia. He made efforts to ensure she was stimulated through conversation, he felt this might help to slow any deterioration in her memory. He also made efforts to maintain her social engagement. As her dementia advanced, both Adult A and Adult B became more socially isolated, especially in the final few months of Adult A's life.

Adult D felt that Adult B's care for his wife had been exemplary. Adult A enjoyed being with Adult B and he managed her needs sensitively, but Adult D recalls that the strain of caring was causing him stress and fatigue. He was clear that he did not want Adult A to go into residential care and he did not want full time help at home.

Adult D was very clear that there was no history of physical abuse of any kind, nor any form of coercion or control.

Adult B's main fear following his cancer diagnosis was what would happen if he died before Adult A. He did not mention his cancer to Adult A, relating only that he had 'stomach trouble'. Adult B was also experiencing a deterioration in his eye sight. He had two types of macular degeneration and continues to receive treatment for one type that began in the period prior to the incident. The possibility of losing his sight was a particular anxiety for Adult B as he could not envisage how he would care for his wife if he was unable to see.

Although Adult D lives in the North West she was actively involved in decisions about Adult A's care and was in regular contact not only with Adult B but also with her sister, Adult C who lived near to their parents home. Between them they arranged care to support Adult B and give him some respite.

Adult D described how as Adult B became more unwell as a result of his treatment for cancer, the normal household routine began to break down. At the same time Adult A had to have surgery for kidney stones. It was when she was discharged following this surgery that her condition became markedly worse.

Prior to the incident, Adult D spoke with Adult B on the Wednesday night, 18 November 2015. She described how he did not seem to be himself and didn't seem to follow the conversation they were having. She tried to persuade him to accept additional home care support as he was not coping. Adult D had a further phone conversation with Adult B the following day, 19 November 2015 and again encouraged him to accept additional help. He was reluctant to do so.

On Friday 20 November 2015, Adult D describes how Adult B went to the supermarket, but came home empty handed. She called him on the phone that evening and agreed that she and her husband would travel down to Berkshire. At this point Adult D felt the only danger was to Adult B and the risk that he might die, perhaps through exhaustion. She did not call her sister at this stage because she believed she too was exhausted and did not want to disturb her.

On Saturday 21 November 2015 Adult D called her sister on the phone and advised that she had decided to come down to visit. They also advised a friend of the family. All agreed the home situation had become critical.

On the way down, Adult D's son had been trying to contact her, but her phone battery was flat and she did not get the message to call him for some time. She tried to call her sister Adult C but got no response. (It is believed that Adult C was already at her parents' house). Adult D then rang Adult B's home phone and he answered, but handed the phone to the ambulance crew who spoke to Adult D who informed her of her mothers' death. Adult D spoke to her son who provided her with the detail of what had happened.

Adult D had raised no specific issues in relation to the conduct of the agencies involved, other than to say that she felt that Adult A's discharge from hospital did not seem completely satisfactory. This relates to the provision of paracetamol for pain relief, which Adult D felt was not necessarily adequate.

Adult D said that the only change in Adult A's behaviour had come as her dementia worsened in the final weeks before her death. She had been a "docile" person but had begun to be slightly more agitated and sometimes argumentative.

Adult D felt that one thing that would have helped would have been a case conference at the point of Adult B's diagnosis of cancer to more effectively plan any support package.

Section Three

Key findings

3.1 Key findings

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by family members the panel has identified a range of key findings:

- Adult A and Adult B had been married for over 60 years and had enjoyed a strong relationship. They had been active professionals and successful in their careers.
- The relationship with the daughters was good and both Adult D and Adult C were especially supportive of their parents, particularly in the period leading to the incident, where Adult A's care needs and those of Adult B had become more acute.
- The impact of Adult A's dementia was significant. It had led to Adult B taking a caring role on a full time basis, and for much of this time, other than family support, he did this alone.
- Adult B was committed to enabling Adult A to remain at home and to caring for her. He was reluctant to accept additional help, but did engage self-funded support through voluntary and independent sector care agencies. Adult A maintained his role as Adult A's primary carer throughout.
- Adult B's role as a carer was well known and understood. However, the IMRs point to there not being a clear approach to gathering information about the pressures upon him in his caring role resulting not only from Adult A's worsening dementia, but also of his own illness.
- The impact of Adult B's cancer and related treatment had a significant impact on his ability to continue to care for Adult A in the way he had previously. He was often exhausted and experiencing stress. He was especially anxious about what would happen to Adult A if he died before her.
- Agencies acted to ensure that decisions about care and support were made with Adult B. Adult A's mental capacity was appropriately assessed.
- Communication between the various statutory agencies was regular and appropriate. There is evidence of multi-disciplinary working, although in some instances the communication was not always properly recorded.

- Agencies rightly respected Adult B's views in relation to his reluctance to receive additional support. This was good practice within the legal frameworks in place. However, the question of whether it would been appropriate to press more firmly or to enquire more curiously about the home situation is one that should be considered.
- There were three agencies involved in caring for Adult A and providing Adult B with respite. The extent to which each was aware of the others involvement is not clear, but it appears there was little in the way of knowledge sharing (with appropriate confidentiality restrictions). Had this been the case, a more rounded picture of the home situation and how best to collectively respond to might have emerged.
- Independent or voluntary sector organisations were engaged on a self-funded basis. Liaison and communication with statutory agencies including the NHS is key to a co-ordinated multi-sector approach.
- The reluctance of Adult B to accept support, either at an agreed level or on an enhanced basis impacted on the consistency of engagement of some of the home care agencies.
- The GP provided regular consultations and engaged in additional proactive communication with Adult B. She demonstrated care and concern for the welfare of Adult A and Adult B and acted effectively in communicating with other professionals.
- The confusion in coding the SCAS response had no impact on the incident, nor on their response time.

Section Four

Conclusions

This section sets out the conclusions of the DHR panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The chair of the DHR is satisfied that the review has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will contribute to the improvement service responses for all vulnerable people through improved intra and inter-agency working.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and draws them together to present an overall set of conclusions that can be drawn about the case.

4.1 Conclusions of the DHR panel

It is important to acknowledge that this was a violent incident. Although it appears to have been an isolated event and that there was no history of such violence, it must have been particularly frightening for Adult A to have experienced this violence from someone who she loved and who had cared for her so diligently.

The review has received information from the organisations who had contact with Adult A and Adult B. The evidence included in the IMRs demonstrates consistency in relation to the description of the home situation.

There is no evidence from any of the information received and reviewed that there was either any history of domestic abuse, violence or coercion and control in the relationship between Adult A and Adult B.

It is clear that Adult B was a committed carer who continued to support Adult A despite the impact on his physical health and overall wellbeing. He sought to cope as best he could and was reluctant to accept additional outside support.

Although the caring role of Adult B was assessed or understood, the wider impact of that role in the context of his own physical health was not considered in enough depth. There is no evidence to indicate that this contributed to the incident directly, but it would have been beneficial to shaping an ongoing appropriate and responsive care package.

Adult A's dementia means that her voice is not directly heard in the IMRs or in this report in the way it might have been had she not been living with the effects and impacts of her illness. Despite this, there is evidence that her needs were properly assessed and considered, her mental capacity was appropriately considered and that the agencies involved in caring for her delivered their services to a good standard.

The systems, policies and processes of the agencies in contact with Adult A and Adult B did not impact directly on the incident itself.

Where people are caring for those with mental health problems, including dementia, an assessment of need would be enhanced if it were undertaken by or with a practitioner with skills in mental health or dementia.

Although professionals involved in considering Adult A's care needs and support for Adult B rightly accepted his wish not to receive additional support, they may have probed further and offered alternatives to support him in his caring role. This case has some similarities to a previous DHR in Wokingham. In particular this relates to the age profile of the individuals involved, but also the impact of caring and the uncertainties that older people face when experiencing significant illness.

As with that previous DHR, the panel concludes that professionals need to take proper account of the new contract between them and customers or patients. The promotion of increased levels of self-care and self-management are right and proper, but should not blur or dilute the statutory responsibilities of public bodies and their staff.

Section Five

Recommendations

5.1 Recommendations

This section of the Overview Report sets out the recommendations made in each of the IMR reports and then the recommendations of the DHR panel.

5.1.1 Recommendations made in the individual IMRs

The WBC IMR made four recommendations:

- A review of whether assessments of people caring for those with mental health difficulties, be undertaken by a specialist mental health practitioner or a generalist practitioner should be undertaken.
- Undertake an audit of cases open to adult social care which have a similar domestic profile to the case of Adult A and Adult B, and those of the couple in the first DHR. This audit will include a risk analysis of cases and provide recommendations for further operational review.
- Develop joint working arrangements for couples with this domestic risk profile.
- That the learning from this DHR be disseminated to all Adult Social Care and COAMHS staff, drawing attention to the similarities with the first DHR. This learning should include training on any changes to practice resulting from the previous three recommendations.

The RBH IMR made eight recommendations:

- In cases where patients with significant health needs of their own are carers the mechanism of interagency assessment at the time of diagnosis should be reviewed to ensure a more holistic process involving health care providers, adult social care, other relevant agencies, the patient and family
- That an interagency pathway and pathway document should be developed with the support of patient representatives e.g. Alzheimer's Society so that early assessment and referral taking into account the needs of the carer and the vulnerable adult and recognising the emerging vulnerability of the carer is developed

- That the learning from this case should inform the development of the RBFT Carers Strategy as part of the Berkshire West Carers Strategy being led by the CCG
- That learning from this case should inform the RBFT Strategic Safeguarding Priority already identified for 17/18 – ‘In line with the Care Act and the principles of Making Safeguarding Personal new evidence review our approach to ensuring the knowledge and competency of our staff in practice in relation to the Mental Capacity and Mental Health Acts, DoLS, best interest assessments and consent’.
- RBFT discharge letters to GPs should include referrals made but also if and what referrals were declined
- Berkshire Cancer Centre (BCC) will improve assessment documentation and interagency sharing of documentation.
- This case should be used to explore opportunities for peer support within the therapies team and the learning included in Adult Safeguarding, Dementia and risk management training
- Feedback learning from this case within the RBFT to Oncology Clinical Governance, Planned Care Clinical Governance, Patient Experience Committee and Quality Assurance and Learning Committee.

The BHFT IMR made six recommendations

- In cases where elderly carers with significant health needs of their own and are responsible for providing support to vulnerable adults who may not have capacity to make their own decisions about care and support, consent to share information should be sought for the purposes of ensuring that the dependent adults needs are prioritised and care act assessments are sought from adult social care partners for carers and their dependents. This recommendation should inform multi-agency partnership work to provide joined up approach to meeting the needs of people who access dementia services

- A new risk form has been developed by the Trust to identify risks to vulnerable adults due to carer stress. This new risk form has been supported with staff training and a recommendation from this IMR is that learning from this IMR will be included in risk management and adult safeguarding training and shared with partner agencies to enhance safeguarding adult practice and learning across partner agencies.
- Develop consistent partnership approach to MCA training which includes practitioners from a variety of health and social care disciplines in order to improve our shared knowledge and skills in mental capacity act practice .
- Healthcare professionals should advise the adult social care team so that a Care Act assessment can be offered or completed to determine level and appropriateness of care input required regardless of funding arrangements for care and support needs for patients in the community, especially when a patient lacks capacity to make a decision regarding these needs.
- The need to establish the legal representative for patients who lack capacity to make decisions about their care and treatment to be incorporated in BHFT mental capacity act training.
- Review and improve record keeping systems in memory clinic to ensure that administration staff taking calls from patients record the call and identify a staff member to return the call in a timely manner.

The Home Instead IMR made one recommendation

- To make the whole risk assessment process for supporting people living with dementia more robust. As previously described in the IMR, the risk assessment process encompasses an assessment of the person, their environment and their physical and mental capacity. However, our risk assessment process also needs to evaluate potential risks to the main family carer arising from the behaviours of the client and the change in their relationship.

5.1.2 DHR recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs.

The DHR panel therefore offers the following overarching recommendations for action:

1. We recommend that a system be put in place for a multi-disciplinary case conference to be held to review and plan care needs where the carer of a person with a life limiting physical or mental illness, in particular dementia, also experiences a life limited or potentially life ending physical or mental illness. Wherever possible, family members should be present at this conference to gain a full understanding of the needs and potential issues.
2. We recommend that health and social care professionals receive clear guidance about how to effectively engage with those carers who are reluctant to accept support and reiterate the importance of clearly and accurately documenting those conversations.
3. We recommend that the local NHS and Adult Social Care engage with representatives of independent and voluntary sector organisations to agree protocols for ongoing communication and involvement in multi-agency care planning that will encourage more effective joint working across sectors.
4. We recommend that the findings, conclusions and recommendations of this DHR be disseminated widely and used to directly inform service change and practice improvement processes. In particular the similarities between this case and DHR1 should be reviewed and used to inform the approach to assessments and service delivery to older people and specifically those with caring responsibilities.

