SAFER SLOUGH PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

REPORT INTO THE DEATH OF MR F

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Minor amendments agreed by the Safer Slough Partnership

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Contents

1. INTRODUCTION

1.1. This report of a domestic homicide review (DHR)examines agency responses and support given to Mr F, a resident of Slough prior to his death on 6th June 2014. The review will consider agencies' contact and/or involvement with Mr F and Mrs F from January 2012 to June 2014.

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

1.3. This review was originally commissioned as a Safeguarding Adults Review (SAR) by the Slough Safeguarding Adults Partnership Board (SSAPB). Careful consideration was given to the circumstances of the case and the open Police investigation in deciding the most appropriate review to be undertaken. In consultation with the Safer Slough Partnership (the Slough Community Safety Partnership) it was decided that a SAR was the most appropriate course of action given the limited information available and the wish to start a review without undue delay. However, this decision was made with the understanding that should the Police investigation reveal further relevant information then a decision may need to be made to transfer the SAR review to the DHR process.

1.4. The case had been referred by Thames Valley Police (TVP) to the Crown Prosecution Service (CPS) but no decision had been made about this at the point when the SAR started. In May 2015 the CPS, after consideration of specialist evidence, gave TVP authority to charge Mrs F for the manslaughter of Mr F through her gross negligence, which they duly did on 1st June 2015.

1.5. These decisions clearly changed the context of the review and discussions took place between representatives of the Safeguarding Adults Partnership Board and the Safer Slough Partnership (SSP) about the future of the review. Discussions focused upon the relevance of the domestic homicide review in this case given that the new evidence indicated that Mr Fs death may have resulted from neglect. The Domestic Violence, Crime & Victims Act (2004) states that a 'domestic homicide review' means 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'. On 26th June 2016 the Chair of the SSP confirmed the decision to instigate a DHR together with her preference to continue to work with the existing SAR panel so that the two review processes in effect ran concurrently. This avoided duplication and ensured that the learning from the reviews was available and acted on as soon as possible. A representative of the SSP joined the panel at the point of this decision. The review and its

overview report are therefore identified as a DHR, in accordance with national requirements. Terms of Reference for the DHR were drawn up and can be found at Appendix 1. They cross-refer to the SAR Terms of Reference which are at Appendix 2.

1.6. This review began on 11th February 2015 and was concluded in September 2015.

1.7. The findings of a DHR are confidential. Information is available only to participating officers/professionals and their line managers.

1.8. At the point of the report's completion the only people with whom the report has been shared are the members of the review group.

2. THE REVIEW PROCESS

2.1. This summary outlines the process undertaken by Slough Safeguarding Adults Review / Domestic Homicide Review Panel in reviewing the death of Mr F. Mrs F is currently awaiting trial on a charge of manslaughter of Mr F by gross neglect.

2.2. Mr F was an 82 year old man with Parkinson's Disease. Prior to the period under review he had been receiving podiatry care and between September and November 2011 was referred both to the falls clinic, following an Emergency Department attendance after a fall at home, and to the Parkinson's Disease Clinic. The falls clinic in November noted that he had had several falls without loss of consciousness, and there were further ambulance attendances in May and June 2012 following falls at home. In May he received treatment for a dislocated shoulder and was initially transferred from Wexham Park to Heatherwood hospital as there were concerns about whether it was safe to discharge him home, and that further rehabilitation was needed. After three days, however, he was cleared for discharge, with support from community physiotherapy.

2.3. Following assessment on 15th June 2012 Mr F was discharged home with out-patient follow up. On that occasion the ambulance service contacted the First Contact team at social services. They contacted Mrs F to offer social care support, which she declined. The Community Physiotherapist reported on 26th July that when she rang to make a further appointment Mrs F had been verbally abusive to her, which was unusual. In October that year the Parkinson's Disease clinic noted Mr F reporting a "high number" of falls.

2.4. All these points are noted here because they are early indications of issues that became significant in the events during 2013 and 2014 that resulted in this review.

2.5. The first concerns raised about Mr F's more general welfare followed two hospital admissions in March 2013. On 13th March the ambulance was

called because he was unable to mobilise onto his feet and he was assessed at the Emergency Department. The Occupational Therapy assessment recommended inpatient rehabilitation, but this was refused (it is not clear whether by Mr F or Mrs F) and community physiotherapy accepted. It was also proposed that the community Occupational Therapist (OT) would follow up and social services be informed. In referring on to the community OT, the hospital OT mentioned safeguarding concerns about the relationship between Mr and Mrs F as Mrs F had been verbally aggressive to the OT and had answered for her husband in the assessment discussion. The hospital social work team were informed, including these concerns, but not as a specific safeguarding referral.

2.6. On 25th March 2013 Mr F was brought to hospital again by the ambulance service following a fall at home as Mrs F could not get him up. On this occasion the hospital Tissue Viability Nurse raised safeguarding concerns because of the pressure ulcers found on Mr F and South Central Ambulance Service also raised concerns about the home environment, which was described as cluttered, and Mrs F not coping. The Ambulance log reported that he had been on the floor for two days after his fall before the ambulance was called, though the hospital record states approximately 12hrs.

2.7. Mr F had an extended period of assessment and treatment in hospital including a Mental Capacity Act assessment in hospital in May 2013 which identified him as not having the capacity to make decisions about where he wanted to live. However, as set out more fully in section 6 of the report, this assessment was not acted on and planning continued to involve him as if he had capacity. He wished to live in Great Yarmouth with his daughter and moved there in July 2013 following detailed work by adult social care services in Slough and Great Yarmouth. However, these arrangements broke down after only two weeks, so he moved to a care home in Great Yarmouth while further plans were made.

2.8. These resulted in him returning to Slough in December 2013 to live in a care home. Mr F then expressed a wish to return to live at home with his wife who supported this proposal. Again, Mr F was considered to have capacity to make this choice, and plans progressed to enable him to return home, including arrangements for domiciliary care support to Mrs F in caring for Mr F.

2.9. Mr F returned home on April 15th 2014 but Mrs F did not answer the door when the domiciliary care service made their first visit that day. A follow up visit was made on 16th by the social worker and a member of the brokerage team. They asked why the carers had not been admitted as agreed in the discharge plan and Mrs F said she did not want the service as she would have to pay for it. She also declined re-ablement support for Mr

F, even though there was no charge for this, and assistive technology support. Mr F was asked directly for his views and he said that his wife was capable of looking after him. The couple were told that the case would be closed if they did not wish to accept support and they agreed to this.

2.10. Mrs F did accept the assistance of the district nursing team, who continued to encourage Mr and Mrs F to accept other support, but with no success. By 8th May Mr F's pressure areas were all healed so the district nurse completed a thorough assessment of Mrs F's ability to care for Mr F and was satisfied that she was providing adequate care, though she still felt Mrs F should consider some support. Mr F was discharged from the District Nurse caseload.

2.11. After the district nursing team ended their work with the family, Mr F had a further fall. It appeared that Mrs F did not call for assistance immediately, though it is not known why. When she did call the ambulance on 1st June 2014, Mr F was seriously ill, and was taken to hospital. The records and reports don't give a clear picture about how long Mr F may have been on the floor following his fall. The Wexham Park chronology mentions his wife being vague about this; the safeguarding Strategy Meeting notes state "he was on the floor for a day according to his wife"; the ambulance service call log reports that "Mr F had not been eating or drinking for the last couple of days". The report of his very neglected state when the ambulance crew moved him (covered in faeces and urine) suggested a significant time lapse, as did the extent of his tissue damage and other symptoms, but no definitive statement has been offered of the likely duration. Mr F was treated in hospital but died on 6th June.

2.12. The Terms of Reference for the review were agreed by the Panel at its first meeting and can be found in full at Appendix 2. In addition to the original membership of the Review Panel, at the point when the transition was made from SAR to DHR, a representative of the Community Safety Partnership joined the panel. Contact was also made with the Probation Service which confirmed that Mr F was not known to them.

2.13. The Independent Chair is a freelance social care consultant with extensive senior management experience in social services. She has chaired two safeguarding adults boards and chaired/authored several Serious Case Reviews. She has no connection with the agencies involved in this case.

2.14. The process began with the first Panel meeting on 11th February 2015. The full membership of the Panel and the agencies that were asked to provide Individual Management Reviews are shown in the Terms of Reference above. All Panel members except the South Central Ambulance Service were present at the first meeting.

2.15. The review has been conducted using the standard methodology commonly used both for SARs and DHRs: the appointment of a panel with an independent chair; scoping the review to create terms of reference; commissioning Individual Management Reviews from all the relevant agencies and producing an Overview Report.

2.16. Each contributing agency was asked to provide a chronology of their involvement with Mr and Mrs F and an Individual Management Review, for which a template was provided. All agencies provided chronologies and reports. The two residential care homes, which are less familiar with review processes, offered a much lower level of detailed analysis, particularly Burnham House. The chronologies were collated by the Independent Chair so that all the relevant activity could be tracked in a single document.

2.17. All the health and social care agencies had significant levels of involvement. The police and ambulance services had a lower frequency of contact but were involved at some significant points in the sequence of the case. The police report records six contacts about Mr and Mrs F, but none of them relate to allegations of crime, and two resulted in Adult Protection reports concerning Mrs F's welfare during the time that Mr F was in hospital.

3. SUMMARY OF EVENTS

3.1. Mr F was born on 7th April 1932, so was 82 at the time of his death. He and his wife, who is about ten years younger than him, lived in the home they owned at Manor Park, Slough, and they had been married for fifty years. They have two daughters, one of whom lives in Great Yarmouth and one in Hemel Hempstead, though it appears there had recently been little contact with the latter. The relationship between Mrs F and her daughters was described in adult social care records as poor, and Mrs F is reported to have said that her daughter in Hemel Hempstead would not want to be involved in Mr F's care.

3.2. There are several references in the reports to the space in Mr and Mrs F's home being very limited because of the quantity of items collected by Mrs F. This was thought to increase the risk of Mr F falling, so discussions with Mrs F about reducing the amount of things in the house were attempted but she was unwilling to participate.

3.3. The full collated chronology for the period of the review (January 2012 – June 2014) runs to some 100 pages because of the extensive contact with Mr and Mrs F from various social and health care agencies in response to Mr F's care and support needs. The key stages are those outlined in Section 2 above.

3.4. At the time of his final discharge home on 15th April 2014 Mr F had Parkinson's disease, a history of postural hypertension, dysphasia, risk of falls, deafness in both ears and swelling of his left leg. He had had a number

of serious pressure ulcers and at this time had a pressure area on his left heel. He needed support with all the activities of daily living, which included personal care, toileting, continence management, medication, mobilising and domestic tasks. In addition he had swallowing difficulties and needed a soft diet.

3.5. A package of care consisting of four visits, seven days a week had been agreed in order to support Mr F's care at home. This would be considered a heavy package of care so indicates that he had been assessed as requiring a very significant level of support to him and his wife. However, this support was cancelled on the day after his return. The records show conversations about this taking place with Mrs F but it is not clear whether Mr F expressed his views.

3.6. On Sunday 1st June 2014 a phone call was made to Thames Valley Police by South Central Ambulance Service (SCAS) saying that an Accident and Emergency Doctor at Wexham Park Hospital had requested police attendance after Mr F had arrived at the hospital (brought by ambulance) in a state of neglect. SCAS had been called to Mr and Mrs F's home address that morning by Mrs F because Mr F had not been eating or drinking for the last couple of days.

3.7. The ambulance crew arrived at 9.45 and found Mr F lying on the living room floor and very unwell. Mrs F was vague about how long it was since Mr F had fallen, and he was unable to communicate with the crew in any way. They took him to hospital and raised a safeguarding alert as they considered his condition to be the worst state of neglect they had ever encountered.

3.8. The hospital found Mr F to be suffering from sepsis and multiple pressure sores and it seemed likely that he had been on the floor for a considerable time. His condition continued to deteriorate despite intervention to treat the sepsis and he went on to develop pneumonia and renal failure. He died on 6th June.

3.9. A post mortem was carried out on 10th June 2014 which gave the causes of death as: 1A – Multi organ failure; B – Sepsis and acute renal failure; C – Multiple pressure sores and associated complications, Peripheral vascular disease.

3.10. A criminal investigation was started by Thames Valley Police on 6th June 2014. Mrs F was charged on 1st June 2015 with manslaughter through gross neglect and appeared at the Magistrates Court on 18th June and at Crown Court on 21st July for a Plea and Case Management Hearing.

4. ANALYSIS – KEY THEMES FOR LEARNING

4.1. IMR authors were asked to analyse their organisation's activity under the specific areas of enquiry in sections 4.2 – 4.10 of the Safeguarding Adults

Review Terms of Reference. From the material in the reports and the panel's discussion of them, five of these of areas of enquiry emerged as key themes and the following sections therefore focus on those themes. Learning also comes from examples of good practice, and those that were highlighted in the reports are outlined in Section 12.

4.2. When the transition was made to a Domestic Homicide Review the original IMR authors were contacted again with the DHR Terms of Reference. They were asked to review their reports with the issues of domestic violence and abuse in mind and report to the Panel any points they wanted to add or change given that additional context. The issues emerging from the reports and these additional contributions are covered in section 10.

4.3. In their discussions the Panel was conscious that, viewed together and with hindsight, actions or events which at the time were not individually of serious concern may seem more obviously demanding of a strong response than was evident at the time. The clearer pattern that is available from that vantage point is necessary for the identification of strengths or gaps in service responses and the learning that can result, but commentary needs to recognise that those involved at the time may not have had access to full information.

5. The appropriateness and co-ordination of Mr F's support, care and treatment, and the quality of inter-agency communications

5.1. From the detailed accounts provided in the chronology, there is no doubt that a great deal of appropriate, and often high quality care and support, was offered to Mr F both from community based services such as specialist out-patient clinics, and from in-patient hospital services and residential care. There was also evidence of extensive inter-agency communication, particularly around the arrangements for Mr F's various moves: from hospital to his daughter's home, into residential care in Norfolk and then in Slough and finally back to his own home.

5.2. There are two areas of co-ordination that concerned the Panel and which might have improved the overall response to Mr F and his family.

Co-ordination of medical care

5.3. From a medical perspective Mr F would have benefited from a comprehensive geriatric/frailty assessment so that the knowledge of all his conditions and the appropriate responses to them could be managed together. Guidance on this topic was issued by NHS England in February 2014[1], so part way through the period under review, though the evidence and principles had been developing for some time. The guidance provides

[1] Safe, Compassionate Care for Frail Older People using an Integrated Care Pathway; *NHS England February 2014*

the definition of comprehensive assessment as a 'multi-dimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long-term follow-up'.

5.4. In Mr F's case, such an assessment would have had the potential both to highlight his overall level of need more clearly and, as a result, prompt an earlier and clearer focus on what levels of support he and his primary carer needed for him to live safely at home. The use of the comprehensive geriatric assessment has progressed further since this time and its continued implementation is one of the recommendations in the IMR from the GP practice. However the panel noted that role of the GP was limited as allied health professionals were leading Mr F's care.

5.5. The Panel identified a number of unusual features in Mr F's care which might have been differently handled with a more comprehensive approach:

- he was in hospital for much longer than would usually be expected
- rehabilitation care took place in hospital rather than at home
- no step-down arrangement was used in support of his rehabilitation and transition back to community care

Co-ordination of case activity as a whole

5.6. In the broader sense of co-ordination, the Panel identified a pattern of extensive activity which was not effective because it didn't result in well-structured action. Examples of this will be highlighted in this section. What was missing from the activity was any sense of a single individual who took responsibility for the co-ordination of all the services involved in order to get an overview of Mr F's care and support needs and make effective plans. This gap was particularly acute at the points of planned transition: from Slough to Great Yarmouth; from Great Yarmouth to Slough residential care; from residential care to his own home. It may have influenced the length of time it took to achieve these moves and may have contributed to the need for an unplanned move from his family in Great Yarmouth into local residential care there.

5.7. The context for this concern is the established understanding that changes in living environment potentially have a significant impact on frail older people, whether that frailty is physical or mental, particularly if the change is unplanned. Taking the period from his first admission to hospital in March 2013 through to his return home in April 2014, Mr F had five moves in just over twelve months, which was likely to affect him to some degree each time. We noted that by the time he returned home in April 2014 he was assessed as needing a greater degree of support equipment and care than

the previous year, but it is not possible to know how much of that deterioration would have occurred in any case.

5.8. Looking at these processes in more detail, Mr F was admitted to hospital on 25th March 2013. Discharge planning started to be discussed in mid-April and included discussions about arranging home rehabilitation, but the physical conditions and Mrs F's attitude precluded this, so his rehabilitation took place in hospital. The possibility of discharge to his daughter's home was raised in the early discussions but the plan for his discharge was not finally agreed until the case conference on 3rd June 2013, with a target date of 20th June but the final discharge took place on 16th July.

5.9. The conference took its decision before there had been any assessment of the suitability of the proposed accommodation or the availability of the support that Mr F would need. It would have been more appropriate to have made a conditional decision and then reconvened the conference when this work had taken place so that there was multi-agency confirmation in discussion with Mr and Mrs F that the decision was still the right one. The Panel was struck by the apparent lack of exploration with Mr F about his rationale for wanting to leave his marital home and be cared for by his daughter. Nothing has emerged in the reports provided to indicate that this was discussed with him in any detail and there seemed to be no curiosity on the part of staff or managers about this. This point will be referred to again in section 6 below.

5.10. The period from case conference to discharge shows much detailed activity and communication taking place first of all to discuss the options and then to put all the necessary care and financial arrangements in place in Norfolk. However, it appears very episodic, without the sense that it was a priority activity for a lead person throughout the period. All the contact was by phone and email and the assessment of the suitability of the family home was done by the Norfolk social worker rather than by someone with direct experience of Mr F's abilities and needs.

5.11. There are contradictory accounts of the family home and plans for Mr F's care. It's appropriate to cover these in some detail as they affected the decisions that led to Mr F having so many moves in a short period.

5.12. At the time of the discharge planning meeting when Mr F made his decision to go to Great Yarmouth, Mrs F raised a number of concerns about this. She stated that her daughter and son-in-law argued; that the home was not in good condition; that her son-in-law was on anti-depressants and that their sons were using drugs. She also said that there were historic differences of opinion between Mr and Mrs F and their daughter and son in law. While Mrs F was understandably unhappy and angry about the discharge plans and her husband's decision, the Panel nevertheless was surprised that these comments didn't lead to more discussion and

exploration with Mr and Mrs F about their relationships with their daughter and her family and the situation there as part of the discharge planning. We were concerned that there was not a sufficiently full understanding both of the family dynamics and the physical circumstances of the daughter's home and thought that the focus may have been too exclusively on Mr F at this stage and insufficient attention given to Mrs F's views and needs.

5.13. Mr F's daughter initially said on 29th May that she would try to manage without care services as her husband was at home and could support Mr F but she would seek care support if necessary. On 3rd June, following the case conference, she said that her home was not perfect, but clean enough and "fine" and that Mr F had easy access. On 5th June she and her husband agreed to an assessment visit and to a care package to support Mr F.

5.14. On 11th June the social worker in Slough received an email from Norfolk social services advising against Mr F going to live with his daughter due to historic incidents involving the children. The Police were said to have been involved, and referrals made to social services. The Slough social worker informed them that an assessment visit had been arranged in the light of the concerns expressed by Mrs F. Similarly, in a discussion on 13th June between the ward staff and the social worker in Norfolk, the social worker stated that the children in the household were under the supervision of social services.

5.15. The report by phone on 17th June from Norfolk County Council (NCC) to Slough Borough Council (SBC) about their assessment visit was that there was room in the property for Mr F and there was no current Social Services involvement with the family. There was no evidence in their view to indicate that Mr F should not move in with his daughter and family. A record on 21st June confirms this, but there is nothing to show whether or not the specific points raised in the conversations noted in 5.14 above were followed up either by the Norfolk social worker or by the Slough worker when the report was received. Further records indicate the commissioning of a care package to support Mr F at his daughter's home.

5.16. On 31st July, i.e. within two weeks of Mr F's discharge, concerns were being expressed by Norfolk social services about the suitability of the placement and the ability of the family to care for Mr F, who was unwell. This resulted in Mr F moving into a care home in Great Yarmouth on 6th August, with a view to that being his long term placement.

5.17. The care home's observations of the family home on their assessment visit add another perspective to the suitability of the home. They considered it totally unsuitable for Mr F as it was very cluttered, making it difficult for him to move. Their understanding was that he was alone in the house all day as his daughter was at work, and he was unable, in their view, to access any

part of the house safely. (This is contrary to the earlier understanding that Mr F's son in law would be at home and able to care for him)

5.18. Mr F's daughter's explanation for the early ending of the arrangements with them related to his increasing level of care needs, his failing memory and the dynamics within her family home. Given the short time that had passed, it seems likely that these factors could all have been identified and, if necessary, addressed during the discharge planning process and the assessment of the family's home.

5.19. The Panel recognises the pressures on staff time in social care, but considers that a well-planned visit to Norfolk could have covered many of the necessary planning issues more quickly and thoroughly than the continued reliance on email and phone contact. It would also have had the major advantage of someone who knew Mr F assessing the environment and the level of care available for his particular needs. The very quick breakdown of the placement suggests that this additional disruption for Mr F could have been avoided with a better co-ordinated approach to its assessment and planning.

5.20. The Panel noted that from June 2013, when the case was closed to the safeguarding team, through to December 2013, when Mr F had returned to Slough from Norfolk, the case was managed by the hospital social worker. This may well have influenced the pace at which it was possible to progress the case because:

- The role of the hospital social work team is primarily to manage timely discharges from acute hospital settings rather than the longer term rehabilitation and planning when the acute episode of health care need is over. The workload of the team is heavy and time-pressured so it would be difficult to give appropriate concentrated attention to a complex longer-term case.
- The team is based at Wexham Park Hospital whereas Mr F was being cared for at Upton Hospital, which will have added to the worker's difficulty in actively managing his case.

5.21. The Panel's view is that the case should have been transferred to a community social worker at a much earlier stage in the discharge planning. It was also completely inappropriate for the hospital social worker to be expected to manage the complex planning between Norfolk and Slough for Mr F's return to Slough.

5.22. Another extended period of discussion and planning followed Mr F's admission to Clarence Lodge which ended with him moving back to Slough to Burnham House residential care home on 27th November 2013. There was again an immense amount of administrative and consultative activity by social services throughout this period but it had the same episodic quality as

the earlier discharge planning. There was no multi-disciplinary discussion or case conference to reflect on the previous decisions and make a comprehensive plan for the next stage of Mr F's life and there was again no visit to Norfolk to have direct contact with the people involved there in this complex care and family situation; for example, the care home staff in Norfolk had four months experience of Mr F's needs and abilities by then.

5.23. The pattern of extensive but not very effective activity is repeated at this stage. The time spent on extended email and phone exchanges could have been reduced and the planning expedited if a more direct and concerted approach had been taken. As noted earlier, at this stage the case was still held by the hospital social work in Slough, which in the Panel's view was not appropriate. Contact with and assessment of Mrs F as a carer are discussed in more detail below, but are a key element at this stage, as they were during the previous discharge planning.

5.24. The final stage of discussion and planning which resulted in Mr F's return home was also lengthy: just under five months. Once again, this stage is characterised by a high volume of individual contacts but no multi-disciplinary planning meeting as far as the records show. Both social care and health professionals were fully engaged with the family (and in social services' case still having to finalise the administrative issues from the Norfolk placement) but no multi-agency comprehensive assessment of Mr F's current care and support needs seems to have been arrived at, and therefore no systematic identification of appropriate options to discuss with him and his wife. The priority at this stage should be bringing all the necessary information together to establish whether and how a safe discharge can be achieved.

5.25. Overall the panel's view is that the wide range of appropriate treatment, care and support that was offered to Mr F could have achieved better outcomes if it had been more effectively and consistently co-ordinated. A lead agency needs to be identified in such a complex case and planning needs to be assertive, with a recognition that investment of time in well-planned multi-disciplinary discussions or direct contact may be more economical and effective than extensive email and phone conversations.

5.26. We question whether:

- the case may not have evolved into such a complex one had good co-ordination been in place from the start
- there was appropriate management oversight to help identify the case's growing complexity and provide appropriate workload management and direction of activity
- Mrs F's own position, such as her health, her isolated position once her husband moved to Norfolk and her ability to care for him safely received

sufficient attention and assessment, notwithstanding her reluctance to engage with services

6. What the expectations and procedures were for ensuring that Mr F's views were central to decision-making and whether these were properly applied, including whether and how his mental capacity to take decisions about his care and support was assessed

6.1. There is clear evidence throughout the reports that Mr F's views were sought throughout his care and during all the decisions about his support and living arrangements. Health staff were all conscientious about seeking his consent to treatment or noting when he was not able to give it, and there were numerous discussions with him about the options for his future care. Some of this work is highlighted in the good practice points identified in the IMRs and summarised in Section 10 below.

6.2. What is less clear in the reporting of these discussions, however, is an understanding of the rationale for Mr F's views at various points. For example, when he was expressing a wish to live with his daughter was his reason for not wanting to go home known to those working with him? It's not clear whether this was discussed and had not been recorded, or whether the reasons were never explored with him. Knowing more about this may have had an important impact on the care planning right through to his eventual return home. As noted at 5.9 above, it is important for staff and managers working with families to be curious about opinions and decisions; to ask "why" all the way through the process. This may have prompted the more complete assessment of the overall family relationships and circumstances that the Panel felt was missing in the discharge planning. (Paragraph 5.12)

6.3. When the placement with his daughter broke down Mr F was interviewed by an Independent Mental Capacity Advocate (see below paragraph 6.7 et seq for further comments on mental capacity issues) who reported that Mr F's preference was to live with his wife but he would also be happy to live in a care home close to her as he recognised that he was "a lot of work". It wasn't the role of that discussion to establish how that view related to the one he expressed earlier in the year, but it is also not clear how that comment was fed into or referred to in the later planning. The practice at this point addressed the technical requirements, and produced a very useful report from the IMCA.

6.4. It is difficult to track how the plan shifted from staying in a care home in Slough to returning to the marital home. The original approval for the placement in Slough was for a short term stay, and on 19th December both Mr and Mrs F expressed a preference for him to be at home, but acknowledged the difficulties of this, particularly because of his frequent

falls. It doesn't appear that the helpful IMCA report was used to inform and influence decisions at this key point. Planning started for Mr F to return home, though there does not seem to have been any multi-agency meeting to consider the risks and benefits of this plan and how to manage any risks that were identified.

6.5. Early in January Mr F was expressing doubts about the viability of a return home, but this did not lead to any change of plan. However, there were numerous difficulties in liaising with Mrs F about the installation of the necessary equipment, including a landline phone, to support Mr F's care which contributed to the long delay in implementing the plan. If there had been a risk assessment in place, these extended difficulties might have been a trigger for further review.

6.6. While there is a clear record of Mr F's views being sought, and him expressing them, there are also some references to him being difficult to understand:

- During the safeguarding enquiry in March/April 2013 the social worker noted that Mr F was difficult to understand and that it had not been possible to gain consent to enquiry because of his limited responses.
- BHFT staff identified at the point of discharge planning that Mr F was having difficulty with verbal communication and his wife was making decisions for him. This led to the Mental Capacity Assessment in April 2013 (see 6.9 below).
- Staff at Burnham House made a referral to the Speech and Language Therapy service in December 2013 as Mr F was having difficulty producing words and making himself understood.
- After Mr F's return home it was noted that all the documented conversations that the district nurses had about Mr F's care were with Mrs F and that 'it was difficult to understand what Mr F was saying but Mrs F seems to understand him'.

It is not clear that any formal arrangements were made to support Mr F's contribution to decision making at those points where his speech was difficult to understand.

Mental Capacity

6.7. Beyond the general issue of seeking Mr F's views, the Panel considered how his mental capacity to participate in decision making had been assessed and responded to.

6.8. It is clear from the various reports that staff involved were alert to the need to establish whether Mr F had the mental capacity to make decisions about where he should live. It is also evident that his capacity fluctuated from time to time throughout the period under review. This inevitably presents a

more complex situation for those supporting him to manage and there is some confusion in the record about formal MCA assessments and their outcome and also whether his capacity was re-assessed at each appropriate point.

6.9. It is reported by Frimley Health that on 16th April 2013 a formal Mental Capacity Act (MCA) assessment was completed by a FY2 doctor at Wexham Park Hospital and recorded on an MCA assessment form. The reason for the assessment was to determine capacity relating to Mr F's discharge planning, and the outcome of the assessment was that he did **not** have capacity to make this decision and the decision should not be delayed as he was not likely to regain capacity. The IMR author considers the assessment was thorough and the documentation fully completed. However, following this assessment there is no evidence of a Best Interest meeting being held in either the acute trust or the rehabilitation ward to which he moved on 18th April in order to inform Mr F's discharge plan.

6.10. The IMR takes the view that as formal re-assessment of his capacity should have been carried out in the rehabilitation ward. The next reference to a MCA assessment is on 28th May when the social work record states that in a telephone call with the Matron at Upton Hospital "social worker informed that a MCA has been completed" and Mr F was able to make informed choices. It is not clear who completed this assessment or when, nor is there any reference to the apparent changed position from the assessment carried out at Wexham Park. However, it was this assessment that was relied on in the subsequent discussions about Mr F's move to Norfolk.

6.11. A further MCA assessment was carried out on 30th July 2013 when the care arrangements with Mr F's daughter were breaking down. This found that he lacked capacity to make informed choices and an Independent Mental Capacity Advocate (IMCA) was appointed to work with him in the decision making process. The IMCA report has some of the clearest statements of Mr and Mrs F's preferences that occur in the whole record and also suggests that consideration should be given to IMCA involvement in any future care review. The service remained involved until his return to Slough.

6.12. Finally, there is a confusing sequence of records of conversations on 15th November 2013 where he is referred to both as lacking and having capacity. Again, it is not evident that these different statements are based on a fresh assessment or are referring back to an earlier one.

6.13. The IMR from Adult Social Care recognises the difficulties presented in working with an adult who has fluctuating capacity and the impact this can have in creating hesitancy and uncertainty in decision making. The Panel also recognises this difficulty and the clear evidence of thoughtful practice in the assessments that were undertaken.

6.14. However, the Panel had two concerns about the responses to Mr F's capacity. Firstly, it has to be a matter for concern that there was a lack of clarity about Mr F's ability to contribute independently to decision making at two key points: his discharge planning during April – July 2013 and when he was about to return to Slough. It is not clear why the outcome of the MCA assessment in April 2013, which found Mr F not to have capacity at that point to make informed decisions, was not acted on. Nor is it clear how the opposite outcome came to be reported into the discharge planning discussions, with the result that the whole of that process took place on the basis of Mr F being able to make informed decisions himself about his care and support.

6.15. When Mr F was about to return to Slough, given the passage of time since the previous assessment, a new assessment at this point would have been appropriate to ensure he was properly supported in decision-making. By this point it was known that Mr F's capacity was not stable and it would have been appropriate to recognise this in more regular assessments at key decision points.

6.16. Secondly, the Panel thought in particular that it was a serious omission that no new MCA assessment was carried out when the plan was being developed for him to return home from the Slough care home in April 2014. This was a crucial decision point and not without risk, and confirmation of his capacity or otherwise to make that decision should have been an important component of the process. Reference to the IMCA report from the previous July, and recognition of his fluctuating capacity, would have prompted this discussion and provided important information to support the assessment.

6.17. The issues of decision making and consent in this case were sufficiently complex that it would have been helpful to seek legal advice at the key decision points: in planning Mr F's move to Norfolk, in view of the significant disagreement between him and his wife about this plan; then most particularly when planning his final discharge home. The advisability of seeking legal advice in such complex cases is identified in the IMR from Slough Borough Council adult social care. Legal advice would have enabled a more complete discussion to take place of the options available to achieve an appropriate balance between Mr F's capacity, decisions and choices, Mrs F's views and the safe management of his care, considering the range of risks involved.

6.18. The Panel concluded that it would be important to carry out an assessment of the competency of staff and managers about mental capacity and the responsibilities related to it. Most will have completed training, but there will only be confidence about its effectiveness if it is followed up to see what

the outcomes are as applied in staff understanding and confidence and therefore their practice and skills.

7. How arrangements for carer assessments and support for Mr F's family were applied before and during care activity and after Mr F's death

7.1. The issue of carer assessment and support applies primarily in this case to Mrs F, but also to a lesser extent to Mr and Mrs F's daughter, with whom he lived for a short time. In relation to Mrs F the SAR had identified two related issues to be addressed:

- her role as a carer and the assessment and support she was entitled to receive in that capacity
- indications that she had needs in her own right which may have required a service response

7.2. The decision to charge Mrs F with manslaughter of Mr F through gross negligence and the commissioning of the DHR means that this section also needs to address what indications there were in contact with Mrs F of any risk of abuse.

Support offered to Mrs F as a carer

7.3. A review of the range of interactions with Mrs F over the period of this DHR shows a consistent pattern of reluctance or refusal to accept support either on her own or Mr F's behalf. This was particularly the case if the support was to be offered in their home. As early as June 2012 following Mr F's hospital admission after a fall, Mrs F declined offers of social care support. After the first of his falls in March 2013 the Occupational Therapist noted in their contact with social care that Mrs F had refused to agree to Mr F receiving in-patient rehabilitation.

7.4. At the time of Mr F's second fall in March 2013, the ambulance crew reported that Mrs F had not accepted help and did not appear to be coping. Following Mr F's admission to hospital, as the picture emerged of the difficulties in the home situation, on 4th April 2013 Mrs F was offered a carer's assessment and also contact with Carer's Support, but she declined both of these. She was subsequently sent carer's information, but there is no evidence that the reasons for her declining support were explored at the time.

7.5. As the discharge planning proceeded it was reported that Mrs F was not receptive to having a care package in place. The safeguarding social worker also noted that Mrs F is reluctant to allow carers into the home.

7.6. The issue of support next arose when plans were being made for Mr F's return to Slough and then discussions taking place about his possible return home. On two occasions Mrs F refused to complete the financial assessment form for Mr F's care and was verbally abusive in the phone calls

with the social worker. On an unexpected visit to the care home in Norfolk, when she wanted to bring Mr F home with her straight away, Mrs F was said to be agreeable to accepting formal help in the home to care for Mr F. However, as planning developed for his return home there were continual difficulties about getting the necessary arrangements in place and communication directly with Mrs F by phone or visit was very difficult.

7.7. Eventually all the necessary support was arranged and Mr F returned home but, as noted earlier, Mrs F immediately refused access to the care agency that was to provide the substantial support agreed. Mrs F repeated this refusal the following day on the grounds that she would have to pay for it, and also refused non-chargeable reablement support and assistive technology.

7.8. The reports do not identify any full discussion with Mrs F about the reasons for her reluctance to accept support in her care for Mr F. This is despite the fact that the chronology records several occasions when staff were concerned that Mrs F did not really grasp what she was being told about his care needs. From around September 2013 there is an emerging picture of concern by Mrs F about the costs of care:

- she refused social care support to fill in the financial assessment for Mr F's residential care, saying she would get Age Concern support to do it
- she then refused to complete it at all as she thought his care should be publicly funded the council
- Mrs F refused to pay the invoice from the Norfolk care home
- Following Mr F's return home she refused the care agency support because she had to pay for it
- Mrs F talked to the District Nurse on her final visit in May 2014 about her financial concerns and the BHFT IMR suggests that the conversation with the District Nurse was an opportunity to open up the issue of support from other sources such as voluntary sector organisations.

7.9. Despite the earlier refusals to be assessed for or to pay for care, the issue of the costs of care and Mrs F's willingness or otherwise to accept it for her husband on that basis do not appear to have been specifically discussed with her. If Mrs F's reluctance to talk to social care staff prevented then getting a better understanding of her financial concerns then an alternative source of advice may have been able to either reassure her or establish more definitively what the basis for the concerns was and their likely impact on her behaviour.

7.10. In the light of all Mrs F's previous refusals of support, the Panel found it difficult to understand why her apparent acceptance of it in March/April 2014 was relied on. In the Panel's view, taken in conjunction with the

concerns about Mrs F's own welfare (see below), the lack of support available to/accepted by her in her caring role for Mr F either from family or formal carer support should have been considered an additional risk in his return home. There was a clear indication from the history that a contingency plan was needed before Mr F's discharge home that would respond to a further refusal of care support by Mrs F.

Mrs F's own needs

7.11. There are many references in the reports submitted to Mrs F's own possible needs for assessment and support:

- She was described as "aggressive and confused" by the ambulance crew in March 2013
- Police visiting on 14th April 2013 in response to Mrs F's daughter's concerns found Mrs F "very confused and erratic in her thoughts and conversation", thought that she was struggling to cope with Mr F (though he was in hospital at that time) and wondered whether she was suffering from dementia or mental illness. They raised an adult protection referral.
- She was angry and distressed about Mr F's proposed move to Great Yarmouth
- The safeguarding closure/transfer notes on 19th June 2013 state "it is suspected Mrs F may have a mental health need" though nothing is said about action being taken on that.
- Contact with the GP on 21st June noted that Mrs F was waiting for a mental health review, but there is no information about the outcome
- Similar concerns were identified by police at a visit on 22nd August 2013 in response to concern from a neighbour, and a further adult protection referral was made.
- In an unusually positive and open discussion with a social worker the day after that police visit Mrs F talked about her concerns about her ill health, the condition of the house and fractured family relationship as well as her wish for Mr F to return to Slough.
- When Mrs F was verbally abusive in October 2013 to the social worker following up the financial assessment, that worker checked whether Mrs F was known to any of the voluntary mental health services, but she was not. There is no further information about follow up to this concern.
- The ambulance crew that attended in June 2014 referred both Mr and Mrs F for safeguarding consideration.

7.12. This information presents a vulnerable woman, anxious about her circumstances, not in good physical health at times and with repeated concerns being expressed about her mental health. There is no evidence

that any discussion took place during the planning for Mr F's discharge from hospital in 2013 about the impact on his wife if he moved to live in Great Yarmouth. Whatever the nature of their life together, this was a potentially traumatic separation for Mrs F from all of her family for which the reasons, as noted earlier, are not at all clear.

Mrs F's behaviour

7.13. There are some reports of Mrs F being verbally hostile or abusive to professional staff. She was hostile to a community physiotherapist in July 2012, who noted that this was unusual behaviour, and was sufficiently aggressive to occupational therapy staff in March 2013 to prompt them to document a safeguarding concern, but not to report it as a referral. No explanation is suggested for Mrs F's attitude on these occasions, so it is not possible to know whether it was an indicator of a more general problem in her health

7.14. There were two incidents of verbal aggression to staff on the ward during the discharge planning process in 2013, when Mrs F was angry that the decision did not simply rest with her and was suspicious of the motives of community staff visiting the house to assess for equipment and support needs. As noted above, she also became angry and distressed about the plan for Mr F to go to his daughter's rather than come home to her, but this seems quite a natural reaction to such a significant decision. The panel noted that in most of the incidents of "hostile" or "aggressive" behaviour we don't have a specific description of this behaviour and what the words imply in the circumstances at each point.

7.15. Mr F himself, in expressing a wish to go to live with his daughter, referred to his wife as sometimes shouting and him and walking away. It doesn't appear that this was explored any further with him or with Mrs F. The BHFT IMR reports that the ward matron commented that Mrs F showed great kindness towards her husband. She visited him regularly, had meals with him, and provided clean clothes and treats for him. There are no directly observed reports of Mrs F behaving with hostility, rejection or malice towards Mr F. The matter of her ability to care for him safely will be addressed in Section 9 below.

7.16. Overall, the period under review was a distressing and complicated time in Mrs F's life and the picture is of a woman under stress for whom an acceptable source of support needed to be identified. She did not make this easy to do, but the Panel was surprised that it appeared no one had asked her asked about her more difficult behaviour nor offered her any feedback about the impact of that behaviour on planning and risk assessment. It seemed, from the more positive discussion with a social worker in August 2013 (paragraph 7.11 above) that she was not completely closed to contact, but we don't know why that discussion wasn't able to be pursued further.

We were also concerned about the limited activity to address her own situation and, if she continued to resist support, to recognise the risks that resistance involved for her and her husband.

8. The adequacy of operational policies and procedures applicable: whether they were complied with – in particular the application of safeguarding procedures

8.1. The IMRs mostly reported a full range of relevant procedures in place, though this was less clear in the residential care homes' reports. IMRs also provided clear analyses of the various organisations' awareness and use of safeguarding adults procedures. In the case of the NHS organisations and the police, these identified some good practice and some areas for improvement. The review of adult social care raised a wider range of significant concerns, which reflect the views that Panel members developed as we considered the events in this case and responses to them.

NHS and Police

8.2. Thames Valley Police were called out to the family home on a number of occasions because of family or neighbours' concern about Mr and Mrs F and on two occasions because of flooding risk in the neighbourhood. The IMR carried out a careful analysis of compliance with all expected procedures and practice including safeguarding procedures. It confirmed that the generally all the appropriate actions and responses were carried out but identified two areas for clarification of practice which resulted in recommendations (see Section 14 below):

- clarification of risk thresholds for alerting the Emergency Duty Team (EDT) outside Multi-Agency Safeguarding Hub (MASH) working hours, to complete checks
- the need to for all agencies to record the justification for asking the police to carry out welfare checks

8.3. The IMR also confirmed that decisions made by police about whether or not a safeguarding referral was required on each occasion they were involved were correct. A referral was made about Mr and Mrs F following a welfare concern in August 2013, though at that time only Mrs F was resident at the house and the report suggests that additional detail about the cluttered state of the house should have been included in that referral. On other occasions no referral was necessary.

8.4. South Central Ambulance Service's IMR confirmed that appropriate procedures, including safeguarding procedures are in place in the organisation. It finds that on the occasions when crews were called to the house after Mr F's falls, they could have explored more fully how Mr F

usually mobilised around the house, the reasons for his falls on each occasion, and included this information in their reports.

8.5. The IMR also identified that safeguarding referrals should have been made following their crew's attendance in May 2012 and on 25th March 2013 and on the latter date particularly in respect of Mrs F. On 25th March a referral was made by Wexham Park Hospital (see below) so the concern was picked up through another route. Their final attendance on 1st June 2014 did result in an appropriate safeguarding referral in the light of the very poor condition in which they found Mr F and the general state of the home at that time. The report makes a recommendation to respond to this finding.

8.6. Berkshire Health Foundation Trust generally found good compliance with the range of policies that are in place relevant to this case. It did identify two learning points which are the subject of recommendations:

- the need for guidance that supports staff in managing patients with complex physical health conditions who do not engage with other supporting agencies in the community
- the development of recording systems so that recording of clinical care is all held in one place

8.7. The report also identified two occasions when staff should at least have considered and sought advice about action within the safeguarding procedures. The first was in March 2013 when a community Occupational Therapist was concerned about Mrs F's verbal aggression to the OT and that she answered for her husband during the contact. The OT raised this concern but not as a safeguarding issue.

8.8. The second occasion was during the discharge planning process for Mr F when arrangements were being made for him to go and live with his daughter. Mrs F raised a number of concerns about the suitability of this arrangement and the review author thought these should have been identified as potential safeguarding issues and that advice should have been sought from the Borough Council safeguarding team about this.

8.9. The Frimley Health IMR reported general compliance with procedures. Wexham Park Hospital staff made safeguarding referrals about Mr F on the two occasions of his in-patient admissions: 25th March 2013 and 1st June 2014. On both occasions this was because of serious pressure ulcers and his general state of neglect which was particularly severe on his final admission. This was appropriate action in both cases.

Slough Borough Council

8.10. The IMR from Slough Borough Council adult social care provided a full critical analysis of responses to contacts and referrals and, in particular, how safeguarding procedures were used. It also linked the application of these

procedures to the use of legal advice to support the decision making process in complex cases such as this one. The account raises a number of concerns about how policies and procedures were applied.

8.11. The report author considers that the Berkshire Safeguarding Adults Policy is easily accessible to staff and is, in itself, a valuable resource for information and advice in addition to the advice and direction available from the safeguarding team. The IMR describes as a "significant omission" that neither the written nor the team resource was sufficiently used in assessing this case. Some examples of this follow.

8.12. On 14th March 2013 a phone call was received from the hospital OT expressing concern about Mr F's poor mobility and about Mrs F refusing to give consent for him to have in-patient rehabilitation. Although the OT was not referring it as a safeguarding case, the IMR considers that the information should have triggered a safeguarding strategy meeting. It also notes that it would have been useful to understand more at this stage about Mrs F's reasons for refusing this care for Mr F. Action under safeguarding procedures might have led to a better understanding of the home circumstances and of Mrs F's abilities as well as Mr F's needs.

8.13. A key problem point is identified about the one safeguarding incident that was pursued: the referral from the hospital that was made on 25th March. The procedure was appropriately applied but moved very slowly because of the delay in being able to discuss with Mr F his consent to the enquiry being pursued. (He was often asleep or not well enough to have the discussion). His view was finally obtained on 16th April at a meeting that also included Mrs F. It's worth noting that this is the same point at which the MCA assessment had been carried out that found Mr F to lack capacity to make informed choices, but this does not seem to have been known to the social worker carrying out the safeguarding enquiry.

8.14. The record then shows that the enquiry was discontinued as it was not possible to get Mr F's consent because of his "limited responses". This was not the right action in this situation. A strategy meeting could still have been called to consider the risks and get legal advice about Mr F's ability to consent. Again, this would have been an opportunity for a multi-agency assessment and overview of the situation, and might have linked the work to the MCA assessment outcome.

8.15. The safeguarding policy includes a definition of neglect, and offers examples to illustrate this. The IMR identifies issues and events in Mr F's case that should have prompted a safeguarding discussion on these grounds. These included:

- inadequate physical care from Mrs F such as the failure to deal with the cluttered environment in the home

- Mr F's poor physical state on his admission to hospital
- neglect of Mr F's needs through failure to provide access to social and domiciliary care services such as the refusal of domiciliary care following his return home in April 2014

8.16. In addition, there were several risk factors identifiable during the course of the case for Mrs F herself including stress, financial difficulties, problematic living conditions and isolation. As she was Mr F's main carer, these all contributed to a scenario where Mr F was potentially at risk.

8.17. The IMR concludes that the risk involved in the discharge home in April 2014 would have been significantly better managed with the use of safeguarding procedures and processes. This would have put a stronger multi-agency structure around the transition, including an agreed plan for appropriate care and support to Mr and Mrs F and would have identified what circumstances might require further actions in both their interests.

8.18. The Panel agrees with the report's overall assessment and shares the view that the insufficient use of safeguarding procedures had been a serious omission. Even if a particular event or concern was found not to meet the safeguarding threshold, the process would have brought the relevant people together to get a better overview of Mr and Mrs F's situation and needs. This would have been another way of achieving the better co-ordination discussed earlier in this section and shared understanding of the risks involved in the decisions being taken.

8.19. At the key point of Mr F's return home in April 2014, a very extensive package of care was considered necessary to enable his safe care and support in that environment. This, taken with the experience over the previous year of difficulties in working consistently with Mrs F, should have meant that the immediate refusal of that care prompted a safeguarding concern or at least some other reconvened multi-agency meeting. It should have been seen as a sign of increased risk, particularly as Mr F's own view about refusing care was not clear, rather than leading to withdrawal by adult social care.

8.20. This issue links to the council's policy on case closure. Reference to the most recent handbook for staff shows that the section on case de-allocation, closure and transfer seems exclusively focussed on the process of the closure and doesn't make any links to the possible circumstances of the closure and other actions that may be necessary or desirable to ensure a safe completion of work. This includes the need for agencies to inform each other when they are considering closing a case so that any impact from that decision can be identified and managed safely.

8.21. The Panel therefore concluded that a number of actions need to be taken to ensure that safeguarding policy and procedures are effectively and consistently applied in adult social care.

9. Management and assessment of risks

9.1. This theme has already been referred to in earlier sections, as the management and assessment of risks should have been a key component of decision making about the health, care and support of Mr F and support to Mrs F. While a varied picture emerged from the reports, what struck the Panel most forcibly was the lack of risk assessment apparent at the key decision points in this case and therefore the lack of related contingency planning.

9.2. The NHS Trusts both reported risk assessments on specific issues (such as falls, swallowing, medication review, pressure areas and malnutrition) being appropriately completed and actions taken in response to the findings at each stage of Mr F's care in hospital or the community. Frimley Health also reported discussion with Mr F about the relative risks of community rather than inpatient rehabilitation following his 13th March 2013 hospital treatment to ensure that he understood the possible risks of his choice.

9.3. BHFT's report made a helpful distinction between the specific condition-related risk assessments and awareness of the more general risks in Mr F's situation. The one omission it notes on specific points is that the falls risk assessments would appropriately have included a home assessment, so that the specific conditions there were taken into account in his care. The Slough home also notes the full range of risk assessments carried out on his specific conditions when he was admitted there in 2014.

9.4. The Panel noted that, with hindsight, the sequence of falls between 2011 and 2013 leading to hospital attendance and, in some cases, admission look like a developing pattern. The SCAS report notes that crews should have completed Falls Risk Assessment Forms following their attendances in May and June 2012. What it is difficult to track is whether anyone at the time could have seen the developing picture from, for example:

- It not being considered on 11th May 2012 safe to discharge Mr F home straight away because of his risk of falls, though after transfer to Heatherwood Hospital and an OT and physiotherapy assessment he was deemed only three days later that he was safe to return home. The reports don't detail what the assessment involved that had enabled this change of view
- The next fall coming only a month later and the offer of social care support in June 2012, which was declined by Mrs F

- Mr F's report in of a high number of falls at his Parkinson's Disease Clinic appointment in October of that year
- The series of ambulance call outs as a result of falls
- The Norfolk care home specifically refers to Mr F's risk of falling and how that was managed.

9.5. Being able to see this whole picture might have led, at various points, to more detailed follow up of the causes, impact and frequency of his falls and the way in which that needed to be managed. The Panel could not find any indication that discussion of Mr F's falls ever led to advice or information being offered both to Mr and Mrs F about what to do when he fell, whether it was likely to be possible for them to get him up without external help and therefore what to do each time.

9.6. In relation to general risk management points identified in the IMRs, in addition to the specific point noted earlier in relation to Mrs F's concerns about Mr F's move to Great Yarmouth, the BHFT report identifies gaps in the discharge planning for that move: that there was no overall risk assessment carried out and Mr F's capacity to consent was not reviewed at this point. This reinforces the Panel's concerns described in Section 5 and summarised in paragraph 5.26 about the co-ordination of work with Mr and Mrs F, including the discharge process.

9.7. The Adult Social Care report, as already noted at paragraph 8.17, emphasises the role of risk assessment in the context of the planning for Mr F's discharge home in April 2014 and that the risks involved could have been much better managed within the context of safeguarding procedures. It describes the return home as "a clear risk" and makes a number of significant points about this.

9.8. Firstly, the positive risk taking plan, which should have been developed well in advance of Mr F's return home as a focus for safeguarding discussions, was actually completed the day after his return. The Panel noted with concern that, although it was known by the time the plan was written, that the care package arranged to support Mr and Mrs F had now been refused, the Risk Taking Plan does not identify this as an increased risk. (See above paragraph 8.19 re the implications of the heavy package proposed.) It takes an over-optimistic view, in the light of the overall events of the previous year, of the likely safety and success of the return home. It relies very much on Mr and Mrs F's own assertions of their ability to manage, without reference to others' doubts and concerns. It also accepts that Mr F has expressed his own views, though the comments of the District Nurse about his communication ability certainly raise a doubt about whether suggest they were directly expressed by him.

9.9. Secondly, the IMR reinforces this point with reference to the complexity of the case, as discussed earlier, including inconsistent views from Mr and Mrs F about how well they could manage at home. The clear evidence of resistance to support at home was a strong indicator for effective risk assessment and contingency planning in advance of the move taking place. Despite the extensive arrangements made to support that move, the concepts of risk, safety and safeguarding were not prominent in the discussions.

9.10. Thirdly, the IMR points out that a contingency plan would have dealt much more robustly with the inevitable breakdown and the withdrawal by Mrs F from the domiciliary care package. It would have addressed the issues presented including legal processes to deal with the situation if necessary. It takes the view that Mrs F had too powerful a role in decision making about Mr F's care despite reservations from health and care agencies about her ability to care for him safely and understand how to react when he fell.

9.11. Finally, the report states that it is clear that the case was closed by the social care team far too quickly. Given the support that had been considered necessary for Mr F to return home, a multi-disciplinary discussion to agree monitoring arrangements, at least, would have been appropriate. This would have been a further opportunity to consider the different risks and necessary responses. As it was, it doesn't appear that the District Nursing service was informed that they were the only remaining service to the family nor any arrangements for them to report back if they had concerns and when they finished their involvement. In those circumstances they couldn't operate as an effective protection.

9.12. The Panel fully shared theses concerns raised in the adult social care IMR. We would have expected to see a much more focussed discussion of the possible benefits and risks of various decisions throughout the case but particularly as Mr F's return home in April 2014 was planned. We would also have expected to find evidence of greater challenge and exploration of the issues in the social care supervision discussions. Opportunities were missed by all those involved both before his return and afterwards to safeguard the situation through good risk identification and management and contingency planning and action.

10. Domestic violence and abuse

10.1. During the early work on the SAR none of the IMR reports referred to any suspicion on their part or suggestions from others of violence or abuse in the relationship between Mr and Mrs F. There were references to Mrs F struggling to cope at times, which generally led to a concern for her health and welfare and its potential impact on Mr F. While neglect was identified

as a concern this has not been attributed to deliberate action or malice on Mrs F's part.

10.2. The adult social care report states unequivocally that "having unilaterally taken the decision to accept responsibility for the care of her husband Mrs F will also have to accept the consequences of her actions". What's not clear from this comment is how much weight the author gave to the issues identified about Mrs F's own needs and capacity, physically and mentally, and whether this influenced the assessments and decision-making appropriately.

10.3. Following the transition to DHR and the additional Terms of Reference created to support that process, all IMR authors were asked to review their reports with this issue in mind and identify any additional information relevant to the review. A number of authors responded that they had nothing to add, and further comments were received only from the police, BHFT and adult social care IMR authors.

10.4. Thames Valley Police noted that none of their contacts were classified as Domestic incidents, nor did subsequent enquiries suggest that they should have been. There was no previous domestic violence history between the couple. They also observed that, while Mr F's capacity was fluctuating, he was clearly competent at many points to make a disclosure to medical staff, for example about the circumstances of the wrong cream being applied to his leg. Finally, when Mrs F was noticed not to be visiting Mr F in hospital, police completed a welfare check and found her apparently unwell in bed. She had no notice they were going and therefore this seems like a reasonable explanation for not going to see him and would not have raised domestic violence concerns in itself.

10.5. BHFT reviewed their observations about Mrs F's interactions with staff and with Mr F. They noted that the incidents referred to as aggressive or angry had not been considered as an indication of actual or potential domestic abuse at the time and the further review did not suggest any other view. Mrs F's anger on the ward was directed at staff rather than Mr F, to whom she had shown many small kindnesses. The other angry interactions with staff were considered by them to be an expression of Mrs F's frustration with the health delivery system. There was no evidence or concern that she directed any abusive behaviour towards Mr F.

10.6. The adult social care IMR author extended his comments about the availability and use of the policy and procedures available, particularly the safeguarding procedures, to support identification of the risk of abuse, including domestic abuse. He also reiterated the point about the appropriate use of legal advice to support complex decisions and its potential to provide guidance about decisions in the context of the difficulty of engaging Mrs F. He also proposed that case discussions should be

included in future meetings of Designated Safeguarding Managers to promote open learning opportunities about complex situations. He did not identify any points at which he thought domestic violence or abuse concerns would have been raised.

11. VIEWS OF FAMILY, FRIENDS AND NEIGHBOURS

11.1. At the start of the SAR Mrs F and both her daughters were contacted by letter to inform them about the process and offer the opportunity for further discussion with the Independent Chair of the review. The daughters were contacted by the police to inform them of the decision to prosecute Mrs F, and further letters were sent to them about the transition to a DHR offering contact with either the Chair of the Safer Slough Partnership or the review Chair again.

11.2. The only response to the initial letter about the SAR was from Mrs J, the daughter with whom Mr F went to live in Great Yarmouth, who contacted the Chair by phone. Following some further explanation of the purpose of the review she made the following points:

- she thought her father should not have died at that time because he shouldn't have been left without support other than from Mrs F, and that agencies should have insisted on getting access to support him; she felt the outcome was "a disaster"
- she didn't think her mother's understanding of what was needed to care for Mr F was that good and that Mrs F had some mental problems of her own; she gave the example of an occasion when Mr F had fallen from his chair and Mrs F didn't think it was necessary to call the ambulance
- she was unhappy that she was not contacted to inform her of Mr F's admission to hospital in June 2014, and didn't understand why he didn't recover following that admission. She had not been very happy with the quality of his care during his hospital stay from March 2013, but as he had recovered then she thought he would do so again. (It would appear that she was unaware of how ill Mr F was on that final admission.)

11.3. Mrs J did not mention any domestic violence or abuse concerns during that conversation and the police also noted that she had not raised this as an issue. At the time of completion of this report no further contact has come from family members in response to notifying them of the DHR.

11.4. The police also had contact with neighbours when they made welfare checks, as noted in the chronology, and none of them raised any domestic abuse concerns. This included the elderly gentleman who reported a welfare concern on one occasion and appeared to know that Mrs F was having problems with her family.

12. ANALYSIS - GOOD PRACTICE EXAMPLES

12.1. It is usually the case that, whatever concerns and difficulties have been identified in a Safeguarding Adults or Domestic Homicide Review process, that there are also examples of good practice which it is important to note. This case is no exception and IMR authors identified a number of aspects of good practice that were present in Mr F's care and support and in contact with his family. These are shown in more detail below, but included the recording and reporting of welfare and safeguarding concerns, the quality of clinical care from various NHS professionals and of residential care in the two care homes Mr F lived in, confident exercise of professional roles and some good inter-agency communications.

South Central Ambulance Service (SCAS)

12.2. On two occasions SCAS crews documented their concerns on the PCR about the environment that Mr F was in and their concerns about his wife. This shows understanding of good practice requiring all relevant information to be shared, though it's not clear from the record how this information was passed on.

Slough Borough Council

12.3. Although the IMR author for SBC raised a number of concerns (see earlier sections) he also identified several areas of good practice by the council:

- the support, care and treatment commissioned for Mr F in the two different residential homes was appropriate to meet his care needs
- there was clear inter-agency working between health, social care and the provider services during his stays in hospital and residential care
- a mental capacity assessment was appropriately carried out on the 30th July 2013 by Norfolk County Council and found that Mr F lacked capacity to make a decision about his accommodation and support needs and an Independent Mental Capacity Advocate was appointed to represent him.
- there was some careful work with Mr and Mrs F and their daughter, promoting expression of choice and engagement in decision making

Berkshire Health Foundation NHS Trust (BHFT)

12.4. The BHFT provided well-evidenced clinical care in the podiatry service, comprehensive assessment, treatment and review of his condition in the Parkinson's disease clinic and good clinical care while on the rehabilitation ward. His in-patient care included the use of the National Early Warning Score (NEWS) to identify early signs of acute infections or factors which

impact on mobility, cognition and coherency. This would have helped to minimise his risk of acute illness and falling. Identified risks to his physical health were assessed and reviewed regularly and managed appropriately.

12.5. There was good communication with Mr F across all services. This included responding promptly and sympathetically to his concerns, seeking and taking his views into account, discussing changes to his treatment plan with him and keeping him at the centre of the decision making. His family were also involved in his care planning.

12.6. Recording standards were high, including seeking consent from Mr F to examination and/or treatment and communicating results and recommendations to his GP. All significant events were properly documented and when safeguarding issues were identified, these were alerted to the local authority safeguarding team.

Frimley Health Foundation NHS Trust

12.7. The Trust's report highlighted the completion of medications review to reduce Mr F's risk of falls, the appropriate and timely raising of adult safeguarding concerns and resulting referrals and the appropriate use of the Mental Capacity Act in his care.

Thames Valley Police (TVP)

12.8. Police officers responded to a number of reports relating to Mr and Mrs F that mainly related to their general welfare and the IMR identified:

- swift responses to the various incidents
- extensive enquiries to locate Mr and Mrs F when family or neighbours became concerned including appropriate use of S.17 PACE[2] powers to ensure that Mrs F was located and a welfare check completed
- Creation of Adult Protection Referrals when appropriate
- Seeking permission from Mrs F on one occasion to make a referral to Adult Social Care and on one occasion making a referral despite lack of consent from Mrs F which was justified given the circumstances.

13. CONCLUSIONS AND LESSONS LEARNT

13.1. The Panel has drawn a range of conclusions and related learning points from the review process and the analysis above. The following paragraphs identify them in the same order as the themes of Sections 5 – 10 above.

Co-ordination of services

[2] Police and Criminal Evidence Act 1984

13.2. The development of the comprehensive geriatric/frailty assessment has a lot to offer in this kind of case. The use of this approach with Mr F would have brought together knowledge of all his medical conditions and the appropriate responses to them could then have been managed together. It would also have had the potential to highlight his overall level of need more clearly and, as a result, prompt an earlier and clearer focus on what levels of support he and his primary carer needed for him to live safely at home.

13.3. The Panel finds that it was a significant factor in the events of this case that the wide range of appropriate treatment, care and support offered to Mr F could have achieved better outcomes if it had been more effectively and consistently co-ordinated. A lead agency needs to be identified in such a complex case and planning needs to be assertive, with a recognition that investment of time in well-planned multi-disciplinary discussions or direct contact may be more economical and effective than extensive email and phone conversations.

13.4. Multi-agency meetings were not used sufficiently in this case to ensure a shared understanding of the planned action, its intentions and risks. A structured framework for discussion has better potential to identify all the possible options and track the decisions being made between them. It seemed not to be considered outside the context of safeguarding, but needs to be used equally in general care management work and must be strongly emphasised in policy and guidance. Social services as the lead agency in care management and safeguarding must ensure that front line staff and their managers are aware of and implementing this approach.

13.5. The related learning that emerged in discussion of the co-ordination of the case was the need for effective management oversight, workload management and direction of activity. It was not appropriate for the medium and long-term work on this case to be done by the hospital social worker for the reasons shown at paragraph 5.20, but this does not appear to have been picked up at any point. Whoever was holding the case, their supervisor should have enabled them to manage their workload and their approach to the case to gather comprehensive information on which to base decisions and achieve timely actions.

Ensuring Mr F's views were sought and applied in decision-making; his mental capacity

13.6. There is plenty of evidence in this case that Mr F's views were sought and acted on. However, the case presented a number of difficulties about effective communication, which are likely to arise in other cases and so present significant learning points. The key ones are:

- The need for discussion of the views expressed and decisions proposed; for curiosity on the part of professional staff about the reasons for those

views; for exploration of the issues with the individual to enable a fully informed decision.

- How to ensure that the views of a person who has a physical communication difficulty are directly conveyed in the decision-making process
- The need for stronger awareness and application of the requirements of the Mental Capacity Act

13.7. It is important that the voice of the service user (and their carer) is a meaningful one i.e. that it is not only heard but respected by being questioned and developed in discussion, and supported in its expression when necessary. At times in this case Mrs F's voice seemed to dominate but at other times was not heard. At other points Mr and/or Mrs F's views seemed to be adopted without considering sufficiently the balance of risks and benefits and the statutory agencies' own responsibilities in the situation.

13.8. There was a worrying lack of clarity at times about the use of the Mental Capacity Act, the times when a new assessment would have been appropriate and the implications of the results of the assessments that were carried out. This continues to be a demanding area of work for many people and so needs refreshing regularly and good supervision.

Arrangements for carer assessment and support

13.9. This was already a significant factor in the SAR and became more important when Mrs F was charged with manslaughter and the DHR was established. Section 7 above examines this theme in detail and from that the Panel identified the following learning points.

13.10. Greater confidence and persistence is needed in working with a carer who consistently refuses support on either their own or their relative's behalf. While it was recognised as an issue in this case, there was no evidence of attempts to establish the reasons for refusal, which might have enabled some negotiation to take place, or to enable Mr and Mrs F to understand the possible consequences of that refusal.

13.11. Even when a carer has refused an assessment, proper attention needs to be given to their needs and concerns and to the impact on them of the decisions being taken. There were a number of missed opportunities in this case to follow up Mrs F's own needs or concerns about her raised by others, including the one occasion noted when she had a more positive and confiding discussion with the social worker.

13.12. These activities are important contributors to the risk assessment of a case, particularly when the service user is going to be dependent on the carer. Carer assessment and support are not only a service to the carer

and service user but part of the assurance for agencies involved that the plans being made are safe and achievable.

Operational policies and procedures, particularly including safeguarding

13.13. The main shared learning from this theme concerns safeguarding procedures, as others were generally found to be sound and well-applied, with individual agencies making their own recommendations for action on minor improvements. As noted in section 8, the Panel concluded overall that the lack of use of the safeguarding procedures in this case was a serious omission. Even if the case was not found to meet the safeguarding threshold, the use of that framework would have brought the relevant people together to get a better overview of Mr and Mrs F's situation.

13.14. It appears that awareness needs to be significantly improved about:

- the opportunity to seek advice from the safeguarding team when concerns are raised
- the range of issues that contribute to safeguarding risks and should therefore prompt consideration of action within those procedures
- the need to use legal advice appropriately

13.15. Linked to this theme (and also to that of risk assessment) was the issue of case closure. The refusal of service when Mr F returned home should have triggered increased concern rather than withdrawal. The council's policy needs to be strengthened to address the circumstances of the proposed closure rather than simply the process.

Management and assessment of risks

13.16. The Panel found good evidence of the identification and management of specific risks mainly related to Mr F's medical conditions. However, we also found a notable lack of reference to the concepts and language of risk management in the care and support planning for Mr F. Understanding of these points needs to be much more developed in adult social care in particular, but possibly in other agencies as well.

13.17. The other area of learning relates specifically to how the risk of falls is managed, especially with frail older people and their carers. A number of points emerge from this case that have more general application:

- the need, when planning care, support or rehabilitation, to be able to see the full history of the person's falls, the impact on them and what response their primary carer made
- the importance of an assessment of the home situation and a realistic appraisal of whether the risk of falls can be reduced there

- the need to discuss specifically with the person and their carer what happens when they fall, how they can and should respond to that, including what is safe for both of them to do

Domestic violence and abuse

13.18. As described in Section 10 above, when this review was transferred to the Domestic Homicide Review process, the Panel itself and the IMR authors reconsidered the information they had already provided with the issues of domestic violence and abuse specifically in mind. From that discussion, while recognising the requirement for a DHR, the Panel has not found anything in the history of the case that would have prompted those involved to raise domestic violence or abuse concerns.

13.19. We were conscious that the focus on a single dramatic event can risk overshadowing awareness of a pattern of cumulative neglect. In this case there was evidence of Mrs F not coping with Mr F's care and support needs, and a cumulative pattern of events and information was available by the time of his return home. However, the evidence did not suggest that any shortfalls were deliberate or malicious on Mrs F's part.

14. RECOMMENDATIONS OF DOMESTIC HOMICIDE REVIEW

We recommend the following actions to the Safer Slough Partnership and recognise that they will need to implement them in liaison with the Slough Safeguarding Adults Partnership Board.

14.1. To seek the full implementation of the NHS England frailty assessment framework in the Partnerships' area, accompanied by awareness raising activity across all the relevant professional groups.

14.2. To promote the development of a joint protocol that sets out clear requirements for the co-ordination of complex cases, whether or not they are identified as safeguarding matters, and the provision of care to those who are refusing support. This should include the identification of a lead person, the role and impact of multi-agency discussions in that process and the circumstances that should lead to the calling of such a discussion.

14.3. To ask Slough Borough Council to review:

i. its policy for transfer of cases between hospital and community social workers to ensure that the right focus on medium and long-term planning can be provided

ii. its policy and expectations about supervision of casework to ensure that complex cases are identified, that staff are supported to manage them effectively and that key decisions are based on full expert advice, and escalated where necessary

iii. its guidance to staff about carer assessment and support to ensure that it highlights that this is a crucial factor in care and support planning and risk assessment, and includes escalation arrangements when support is refused

iv. its policy on case closure in order to address the issues set out in paragraph 8.20

14.4. To seek assurance from partner agencies on:

i. their policy and guidance on service user/patient and carer involvement; that it is clear about both formal and informal aspects of this work and that it is effective in practice

ii. how they assess the competency of staff and managers in mental capacity assessments and the actions that result from them; that they have robust systems in place for evaluating the impact of MCA training

14.5. To discuss risk assessment and management as part of safeguarding prevention and how that can be integrated into policy and practice across partner agencies.

14.6. To take appropriate action to assure the Board that falls risks are well understood and well-managed.

14.7. To oversee the development of a "dashboard" of indicators to be available to supervisors and managers so that they can easily see when an individual is featuring across a range of potential risk factors and follow this up in supervision and decision making.

14.8. To ensure that there are clear links between the Domestic Abuse procedures and the Safeguarding Adults procedures.

14.9. To establish that the Safeguarding Board's Workforce Development Strategy can assure the Board that both inter-agency and single organisation training is:

- delivered in a range of ways that reflects different learning styles and organisational needs
- embedded in practice
- evaluated regularly

This should enable the gaps in safeguarding awareness identified in this review to be addressed.

15. RECOMMENDATIONS FROM INDIVIDUAL MANAGEMENT REVIEWS

15.1. Each of the Individual Management Reviews identified recommended actions for their own organisations and these are noted below without further commentary

15.2. Thames Valley Police

Recommendation 1: Thames Valley Police to liaise with Local Safeguarding Adult Boards through the Heads of Adult Social Care meeting regarding the clarification of risk thresholds when considering whether officers should contact EDT outside of MASH working hours to complete checks.

Recommendation 2: When Adult or Children's Social Care or any other statutory body request Police welfare checks, CR&ED should be reminded to record all information shared by the partner agency with justification for Police attendance and a level of defined risk; also to specify exactly what is required of the Police during the welfare

Also Proposed roll out of a new Customer Relationship Management (CRM) solution which will provide an improved level of information to Call Takers and Control Room Operators.

15.3. GP Surgery

Recommendation 1: Implementation of the NHS England frailty work

Recommendation 2: When a person has been discharged from a service to inform the GP of this discharge and any risks identified.

15.4. Slough Borough Council – Adult Social Care

Recommendation 1: Social work teams' recognition, familiarity and understanding with the safeguarding procedures

Recommendation 2: Risk Management training for social work teams and other professional agencies including the decision making in closing active cases and those service users deemed at risk

Recommendation 3: Providing social work teams and other professionals with access to training in a multi-agency approach to working with service users' relatives who are not engaging

Recommendation 4: Consider and identify opportunities for closer working relationships between adult health and social care services similar to those within Community Mental Health Teams and Community Teams for People with Learning Disabilities

15.5. Frimley Health

To review the process for referral to falls clinics for all specialities to ensure future referrals are made when concerns are first identified so that appropriate action and treatment can take place

15.6. Berkshire Health Foundation NHS Trust

Recommendation 1: that current risk management guidance is reviewed to reflect the increasing need for guidance for practitioners who support patients with complex physical health needs living in the community

Recommendation 2: that where it is possible to do so, the recording of clinical care is held on one recording site. This practice will ensure that clinical staff who are involved in patient care have access to a comprehensive picture of a patient's holistic needs for the purpose of safe clinical decision making and compliance with best practice guidance for record keeping.

15.7. Clarence Lodge

Recommendation 1: Ensure other agencies and past history are seriously taken into account prior to a person being allowed home

Recommendation 2: Ensure that emergency measures are provided as a back up in the event that agencies are not let in to complete tasks that are required, and prompter action if this situation occurs

15.8. Burnham House

Recommendation 1: More information prior to admission to residential care

Recommendation 2: More robust discharge arrangements

15.9. South Central Ambulance Service

Further extensive training for patient-facing staff to make sure they are aware of their duty to report any concerns they may have regarding safeguarding issues and the implications that it may have on them as individuals.

Appendix 1

Terms of Reference for Domestic Homicide Review re Mr F

July 2015

1. The purpose of the Domestic Homicide Review is to:

1.1. 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;

1.2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

1.3. Apply those lessons to service responses including changes to policies and procedures as appropriate; and

1.4. Prevent domestic violence homicide and improve service response for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

2. **Guiding Principles of the Domestic Homicide Review:**

To be objective, unbiased and independent
To be open and transparent
To conduct the Review with compassion
To respect the confidentiality of all persons affected by the Review
To be thorough, accurate and meticulous

3. Scoping of the Review:

3.1. The circumstances of Mr F's death were already the subject of a Safeguarding Adults Review (SAR) before further information confirmed that a Domestic Homicide Review (DHR) was indicated and commissioned by the Safer Slough Partnership (the Slough Community Safety Partnership) The Review Panel will therefore work mainly by using the information already gathered through the Terms of Reference of the SAR, which broadly meet the requirements of the DHR, and by building on the work already completed. Additional information will be sought as necessary to fill all identified potential gaps and to ensure a full DHR

3.2. The Review will examine events and agency involvement, where relevant, with Mr and Mrs F between January 2012 and June 2014. However, this may vary depending on information received during the DHR process.

4. Confidentiality and Anonymity:

All documents will remain confidential and distributed either through secure email and/or password protected. Individual names will be anonymised and for the purposes of the Review the deceased will be called Mr F.

5. Methodology:

5.1. As noted above, to take up the work already completed by the SAR and adapt it as necessary to meet the requirements of the DHR.

5.2. Individual Management Reviews (IMRs) were commissioned, reviewed and analysed

5.3. To seek involvement of the family members, neighbours, friends and other contacts where relevant, to ensure that a robust analysis takes place of the full circumstances surrounding the homicide.

5.4. To prepare an Overview Report identifying the lessons that can be learnt from the homicide, what action will be taken as a result and what needs to change.

6. Reports

The following areas will be addressed in the IMRs and Overview Report:

6.1. Examine the events leading up to the incident, including a chronology of the events in question

6.2. The specific issues identified in the Terms of Reference of the Safeguarding Adults Review

6.3. Consider which agencies did not come into contact with Mr or Mrs F but might have been expected to do so, and what could have been done to maximise the opportunity for engagement and/or disclosure

6.4. Consider which agencies were in contact with Mr and Mrs F where there was no reporting of a disclosure or signs of domestic violence/abuse and what could have been done to maximise the opportunity for disclosure or recognising domestic violence/abuse.

6.5. Form a view on practice and procedural issues that emerge in considering the circumstances of this case and any lessons from this engagement that can be applied to other situations where domestic violence/abuse is known of or suspected.

6.6. Seek the views of family, friends, neighbours and other contacts where relevant on how agencies could improve identifying and raising awareness of the risks associated with domestic violence/abuse, provide effective interventions and access to support.

6.7. To determine if there were any missed opportunities for agency intervention in relation to Mr or Mrs F

6.8. Any other matters that the review considers arise out of the matters above

7. Family Involvement:

To involve the family, friends, and neighbours of Mr and Mrs F to give them the opportunity to participate in and inform the Review

8. Equality and Diversity:

8.1. The Review will give due regard and consideration to any equality and diversity issues that are relevant to Mr and Mrs F, for example age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation[3]

8.2. To seek independent expert advice if the Panel is agreed that such a contribution to the DHR is necessary

9. Parallel Processes:

Work with the criminal justice process to prevent any evidential compromise or similar and share any disclosure that may impact on the trail with the Crown Prosecution Service and Defence where applicable

10. Reporting and feedback processes:

10.1. To provide the Safer Slough Partnership and the Slough Safeguarding Adults Partnership Board with updates when requested on how the Review is progressing in relation to predicted timescales and full explanation for any unforeseen delays that may occur

10.2. To prepare a written report that includes recommendations so that as far as is possible, in similar circumstances in the future, learning is taken forward and care is effective and efficient

10.3. To explain the findings and recommendations as well as share the draft Overview Report with family and friends for their comment

10.4. To explain the findings and recommendations as well as share the draft Overview Report with Mrs F if she agrees to being involved

10.5. To prepare an anonymised Overview Report, Executive Summary that will be made public and remain the responsibility of the Safer Slough Partnership. The documents will be restricted until published

10.6. To prepare a SMART action plan addressing the DHR's recommendations to be presented to Safer Slough Partnership

10.7. To consider media arrangements for the publication of the DHR

11. Purpose of the Overview Report:

11.1. To summarise the circumstances that led to this Review

11.2. To state the terms of reference for this Review

[3] Equality Act 2010

11.3. To list the contributions to this Review and the nature of these contributions

11.4. To compile a chronology

11.5. To meet the requirements of the Home Office *Multi-Agency Statutory Guidance of the Conduct of Domestic Homicide Reviews*

11.6. To seek to answer the question 'why' at each critical juncture. It should summarise all relevant information and consider whether different decisions or actions may have led to an alternative course of events

11.7. To determine if Mr F's death was preventable or predictable and if there were opportunities to do things differently

11.8. To summarise the lessons to be drawn, including good practice, from this case and how these lessons should be translated into recommendations for action.

12. Timescales:

It is intended that the Overview Report will be published by the end of 2015. This timescale may be delayed due to a number of factors including but not limited to:

12.1. The completion of the Criminal Justice Process

12.2. Sensitivity to the concerns and wishes of the family

12.3. The need to avoid compromising other formal activity

12.4. Delays outside of the control of the Review Panel and IC in the quality assurance process

12.5. The potential for identifying matters which will expand the scope of the Review

Appendix 2

Terms of Reference for Safeguarding Adults Review into the care of Mr F

This Safeguarding Adults Review (SAR) is commissioned by the Slough Safeguarding Adults Partnership Board. The Terms of Reference were finalised in February 2015.

1. Timescales

The review started its work in February 2015 and aims to provide a report and recommendations to the SSAPB for its meeting in September 2015.

2. Purpose of the Review

To examine the support, care and treatment provided to Mr F between January 2012 and his death in June 2014. The purpose of a SAR is neither to reinvestigate a case nor to apportion blame. It is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk;
- To review the effectiveness of procedures, both multi-agency and those of individual organisations;
- To inform and improve local practice;
- To prepare an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

The SAR process is based on Guidance for Multi-agency Safeguarding Adults Reviews of serious cases (West of Berkshire) as used across Berkshire adult procedures.

The SAR will conduct its work in private but will engage any relatives of Mr F as appropriate.

3. Agencies involved

Agencies contributing to the Review and the services for which they have responsibility.

Slough Borough Council	Adult Social Care
Berkshire Healthcare NHS Foundation Trust	District Nursing Parkinson's Nurse Tissue Viability Service
GP practice Dr Lama Farnham Road Surgery	Primary care services
Thames Valley Police	
South Central Ambulance Service NHS Foundation Trust	Emergency health care

Frimley Health (Wexham site) NHS Foundation Trust	Acute hospital care
Clarence Lodge Care Home, Great Yarmouth	Residential care
Burnham House Care Home, Slough	Residential care

4. Terms of Reference

4.1. To review and analyse the agencies' Individual Management Reviews.

4.2. To examine the support, care and treatment of Mr F from January 2012 to the time of his death in June 2014 and in particular whether his support was appropriate and co-ordinated between the relevant agencies, including the quality of inter-agency communications.

4.3. To examine expectations and procedures for ensuring that the views of the adult being assessed/ offered support are central to decision-making processes and whether these were properly applied in this case.

4.4. To consider the adequacy of the operational policies and procedures applicable to his support and whether they were complied with.

4.5. To establish how known risks were assessed and managed; for example, falls.

4.6. To identify what guidance is available to staff when a service user/ patient or their carer refuses support, care or treatment and, in particular, whether appropriate arrangements for escalating concerns are in place and if so, whether they were used.

4.7. To examine whether and how the mental capacity of Mr F to take decisions about his support and care was assessed; how strong the systems and guidance to support good practice are in this respect and how confident the relevant practitioners felt in applying them.

4.8. To consider the relevance to this case of systems and processes in response to self-neglect

4.9. To examine how arrangements for carer assessments and support for Mr F's family were applied before and during care activity and after Mr F's death.

4.10. To identify any good practice and recommend areas for improvement and learning in relation to multi-agency safeguarding procedures and practice

4.11. To prepare a report identifying recommendations so that learning is acted on by all relevant agencies; and to prepare a suitable Executive Summary that can be made public.

5. Agency Reports

Each agency preparing an IMR will:

5.1. Provide a chronology of its involvement with Mr F and his family

5.2. Address all the issues set out in 4.2 to 4.9 above in relation to each service for which it holds responsibility.

5.3. Identify any further issues or concerns arising from their review that they think the Serious Case Review should address.
5.4. Propose recommendations that the SCR should consider including in its findings
5.5. Identify the sources of evidence used for the report

6. Review Panel Membership

Frimley Health NHS Foundation Trust	Jo Barnett
South Central Ambulance Service	Alan Heselton
Thames Valley Police	DCI Nigel Doak
Berkshire Healthcare Foundation Trust	Peter Oldham
Clinical Commissioning Group	Debbie Hartrick
Slough Borough Council Adult Social Care	Daryl Reading
Slough Safeguarding Adults Partnership Board	Helen Buckland
Slough Community Safety Partnership (from July 2015)	Ginny de Haan
Independent Chair and Author	Margaret Sheather

Appendix 3

Letter from the Home office DHR Quality Assurance panel

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Garry Tallett
Community Safety Partnership Manager
Consumer Protection/Business Compliance & Wellbeing
Slough Borough Council

11 10 2016

Dear Mr Tallett,

Thank you for submitting the Domestic Homicide Review report for Slough to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 2 September 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel felt the report contained a good level of detail and was clearly written. The Panel found this to be an honest and transparent report that has challenged appropriately.

There were some aspects of the report which the Panel felt could be revised, which you will wish to consider before you publish the final report:

- The Panel felt more information and exploration is needed around the part the family GP played;
- The Action Plan needs completing and updating. Actions need to be SMART and have tangible target dates;
- The Executive Summary is succinct but does not follow the guidance layout e.g. there are no list of participating agencies;

- The Panel felt there could be a recommendation on the provision of care to those who are refusing support;
- Please ensure the victim's daughter has sight of the report before publication;

Subsequently it has been brought to my attention that the perpetrator in this case has been found not guilty. Therefore, it would be helpful if you can clarify in the report the terms under which you are analysing this case.
The Panel does not need to see 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 PCC for Thames Valley information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Appendix 4 **Domestic Homicide Review re Mr F – Action Plan**

Recommendation	Action to take	Lead Agency	Date of completion and outcome
1. To seek the full implementation of the NHS England frailty assessment framework in the Partnerships' area, accompanied by awareness raising activity across all the relevant professional groups.	• Awareness raising of frailty assessment across the health economy as part of Vision of Care Planning • Phase one: Frimley Health to undertake the assessment and ensure appropriate patients for assessment are flagged and the assessment is undertaken. • Phase two: To roll this out to primary care • Phase three: Development of a discharge protocol incorporating safe transfers of care.	CCG FPH CCG/Primary care/other community providers CCG and other providers	All completed by May 2016  EB SToC principles protocolv0.4.docx The New Vision of care model has been developed and agreed by the system leaders. This model of care will transform the care for people with complex needs. Wide awareness raising of Vision of Care across each CCG East of Berkshire; including public workshops with updated newsletter published on CCG websites quarterly. Frailty assessments commenced within Frimley Park Hospital (Wexham Park site) 2015. The frailty score has been adopted by Wexham Park Hospital and is being shared with Primary Care in Slough May 2016. If the frailty score hits a certain level then this instigates the sending of the comprehensive geriatric assessment to the GP. There has been the development of a protocol for discharge which has been

			agreed by the system resilience group.
2. To promote the development of a joint protocol that sets out clear requirements for the co-ordination of complex cases, whether or not they are identified as safeguarding matters. This should include the identification of a lead person, the role and impact of multi-agency discussions in that process and the circumstances that should lead to the calling of such a discussion.	• Development of multi-agency guidance regarding working with people who do not engage • Multi agency agreement and sign up • Wide dissemination and communication within all agencies • Clear governance structures including policy monitoring	SAB	June 2016 - The SAB has produced "Multi-agency Guidance: Working with those at risk who do not engage with services". This has been widely disseminated amongst agencies represented at the Board and has been used by several agencies to address cases which have proved to be difficult; this includes GP practices through the CCG, Neighbourhood Services and Thames Valley Police.
3. To ask Slough Borough Council to review: 3.1. its policy for transfer of cases between hospital and community social workers to ensure that the right focus on medium and long-term planning can be provided	Review Staff Handbook to ensure that case transfers between all teams are safe and effective	ASC	The ASC Staff handbook is a working document available to all staff through PC`s and is currently being reviewed through the ASC Change Control Forum that meets fortnightly. Guidance for transfer of cases and case closures for all teams has now been agreed by all operational managers and will be written into the handbook by the end of December 2016.
3.2. its policy and expectations about supervision of casework to ensure that complex cases are identified, that staff are supported to manage them effectively and that key decisions are based on full expert advice, and escalated where necessary	Review Supervision Policy and ensure cross reference with Staff Handbook guidance	ASC	Following the DHR all Supervisors were reminded of their responsibilities regarding supporting staff with complex cases in supervision. We have also reviewed the Supervision policy and this will be launched in February 2017.
3.3. its guidance to staff about carer assessment and support to ensure that it highlights that this is a crucial factor in care and support planning and risk assessment, and includes escalation arrangements when	Review Carer assessment section of Staff Handbook	ASC	Reviewed guidance for staff regarding carer assessment particularly when cares are refusing support either for themselves or on behalf of the person they care for will be written into the staff handbook in March 2017.

support is refused			
3.4. its policy on case closure in order to address the issues set out in paragraph 8.20. This reinforces a point made in the EE review.	Review case closure section of Staff Handbook	ASC	The ASC Staff handbook is a working document available to all staff through PC`s and is currently being reviewed through the ASC Change Control Forum that meets fortnightly. Guidance for transfer of cases and case closures for all teams has now been agreed by all operational managers and will be written into the handbook by the end of December 2016.
4. To seek assurance from partner agencies on: 4.1. their policy and guidance on service user/patient and carer involvement in their care planning; that it is clear about both formal and informal aspects of this work and that it is effective in practice	See separate document	ALL AGENCIES	See separate document
4.2. how they assess the competency of staff and managers in mental capacity assessments and the actions that result from them; that they have robust systems in place for evaluating the impact of MCA training	See separate document	ALL AGENCIES	See separate document
5. To discuss risk assessment and management as part of safeguarding prevention and how that can be integrated into policy and practice across partner agencies.	Risk assessment and management is a strategic objective in the SSAB's business plan , and as part of the development and monitoring of each agency's contribution the SSAB will seek assurance that this is contained in agency policies and reflected in practice audits.	SAB	The SAB has multi-agency risk guidance which sets out the expectations of all agencies in terms of risk management. The application of these principles is being considered as part of the current Performance Group audit on self-neglect, and will be considered as part of all future SAB audits.

6. To take appropriate action to assure the Board that falls risks are well understood and well-managed.	The SSAB will seek assurance as part of the development and monitoring of each agency's contribution the SSAB business plan and that this is reflected in practice audits.	SAB	The SARP, on behalf of the board, confirmed that acute and community health services have robust falls policies and risk assessments as part of 2017/18 planning the SARP has recommended to the SAB that the Performance Group undertake a multiagency falls risk audit.
7. To oversee the development of indicators to be available to supervisors and managers so that they can easily see when an individual is featuring across a range of potential risk factors and follow this up in supervision and decision making.	Review risk assessment and management section of Staff Handbook	ASC	A small task and finish group are currently working reviewing risk assessment, management, supervision and monitoring. A Quality Assurance Framework which will be implemented across all work within ASC to ensure that we continually review and ensure best practice. All developmental work will be ratified by the ASC Change Control Forum after which implementation will begin.
8. To ensure that there are clear links between the Domestic Abuse procedures and the Safeguarding Adults procedures.	Invite the Safeguarding Board Chair to join the Safer Slough Partnership Board, and ensure Community Safety representation at the Safeguarding Adults board	SSP	There is now mutual representation on both Boards.
9. To establish that the Safeguarding Board's Workforce Development Strategy can assure the Board that both inter-agency and single organisation training is: • delivered in a range of ways that reflects different learning styles and organisational needs • embedded in practice • evaluated regularly	To ensure that these areas are contained within the East Berkshire Safeguarding Adults Workforce Development Strategy. East Berkshire sub-group has a monitoring role to ensure these actions are complied with.	East Berks Safeguarding Workforce Development Group	Actions currently exist within the Strategy 2014-17. Strategy to be refreshed by 31st March 2017 and will be ratified by SAB Slough Safeguarding training evaluation report to be completed by September 2017; this will also be included within the SAB Annual Report

This should enable the gaps in safeguarding awareness identified in this review to be addressed.			

Domestic Homicide Review re Mr F – Action 4 – all agencies

To seek assurance from partner agencies on:

their policy and guidance on service user/patient and carer involvement in their care planning; that it is clear about both formal and informal aspects of this work and that it is effective in practice

AND

how they assess the competency of staff and managers in mental capacity assessments and the actions that result from them; that they have robust systems in place for evaluating the impact of MCA training

NB: The Safeguarding Adult Board, Clinical Commissioning Group and Safer Slough Partnership were not required to complete this action as it relates to frontline staff

The Trust uses a range of methods to seek patient feedback including the use of patient stories as a way of involving the people who actually use the services. All feedback is closely monitored with any lessons learned identified and cascaded across the organisation A patient story is presented to the Trust Board each month. This is a compelling way of illustrating the patient's experience and enables the Board to gain a meaningful understanding of how people feel about using our services. The Trust has a Patient Experience Group to provide assurance that the planning and implementation of improvements in the patient experience are being delivered across the Trust. • The Trust has a multi-agency safeguarding group in place in Frimley Park Hospital and Wexham Park Hospital which meet bi-monthly and is chaired by the Deputy Director of Nursing. These groups have the responsibility for : • raising awareness and ensuring staff within the organisation understands the full scope of their responsibilities within the reporting processes for safeguarding adults, Mental Capacity Act, and Deprivation of Liberty Safeguards (DOLs) • ensuring the Trust complies with the Mental Capacity Act 2005; • preventing inappropriate deprivation of liberty of all patient throughout the Trust and ensuring that where it is relevant for some patients, the appropriate legislative framework has been used to apply for DOLs; ensuring appropriate use of the Mental Capacity Act 2005 and accurate assessment by the clinicians in order to ensure inappropriate	FHFT

deprivation of liberty is applied; • ensuring the Trust complies with legislation of the Mental Health Act 2005. • agreeing quality standards, developing audit tools and developing and implementing a training strategy which supports safeguarding adults, Mental Capacity Act 2005 and DOLs	
BHFT Policy CCR001 Care Programme Approach was Extensively updated to reflect current processes and has been updated to reflect the requirements of The Care Act 2014, Mental Capacity Act including changes to legislation with regard to Carers BHFT Policy CCR003 Risk assessment/management in mental health and learning disability services contains a section on user/carer involvement Across CMHT's there is a monthly risk audit to ensure that family involvement is detailed in care plans. As well as the policies in place there are a number of initiatives across the organisation that aim to improve both service user and carer involvement, not only in relation to care planning but also service delivery and improvement. These include patient questionnaires, user feedback groups. The friends and family test. The trust are implementing a Mental Capacity Act training strategy. This is underway and the aim is to bring all identified staff to the same level of knowledge and competence. Once this is completed work will begin to ensure that knowledge is embedded and competency will be measured.	BHFT
Whilst fast-time decisions regarding mental capacity may be made when dealing with operational incidents (S.136), formal mental capacity assessments are not undertaken by TVP staff and therefore this recommendation has very limited relevance to TVP. It is difficult to test whether an officer's assessment of mental capacity is correct as capacity can fluctuate according to the type of decision and a range of other factors. Where a formal assessment is required, a Force Medical Examiner (FME) would be used. However, the following updates are provided in relation to relevant training programme by Thames Valley Police: • The Mental Capacity Act has been included in foundation training for several years. It was also covered in the Mental Ill Health and Learning Disability Awareness College of Policing e-learning package for both new staff and those in post. • Officers and staff (including Control Rooms & Enquiries Department (CR&ED) and Station Duty Office) have received both classroom and e-learning training in the Mental Health Act and Mental Capacity Act during 2015/6. • Over the years it has also been included in other Continuing Personal Development (CPD) packages such as Streetcraft Module 7 (2011) and Protecting Vulnerable People (Safeguarding, Vulnerability & Exploitation) 2016. • There is also MHA and MCA information available on the 'Knowzone', accessed on TVP Intranet. This training and on the Knowzone covers attendance on behalf of other organisations to "fear for welfare" reports relating to mental illness. • TVP should also now work to Approved Policing Practice (APP) from the College of Policing for Mental Health and Mental Capacity. • Joint agency training is occurring in most areas as a partnership initiative addressing local need.	TVP

• New processes within the Safeguarding, Vulnerability & Exploitation (SaVE) programme have streamlined the recording of mental capacity considerations onto an Adult Protection template. • Any changes in Mental Health Act legislation brought about by the Police and Crime Act are being considered by the Inspector, Mental Health Lead in conjunction with the Learning & Development Training & Design Manager. TVP has a MH steering group together with an action plan that addresses any force level strategic direction. Locally LPAs have mental health champions and each County has a senior officer strategic lead. Areas of concern are brought to the steering group which would include where there is concern over levels of training and awareness in any area.	
SCAS do not undertake this type of planning. All we do is record any ACP or safeguarding information from outside agencies attached to the patients address as a special situation note if we are informed of them.	SCAS
All SCAS staff patient facing staff undertakes MCA training face to face and are capable of completing a MC assessment. These are also documented on the patients clinical record. This record will be used in any audits completed on patient clinical records.	SCAS
Review service user/carer involvement section of Staff Handbook. Refreshed and Reviewed handbook Audit tool already in place; framework still needs to be developed. Develop a framework for the auditing of MCA assessments within adult social care casefiles	ASC