

**CARLISLE AND EDEN COMMUNITY SAFETY  
PARTNERSHIP**

**DOMESTIC HOMICIDE REVIEW**

**Under section 9 of the Domestic Violence, Crime and  
Victims Act 2004**

**In respect of the death of a woman**

**DHR Case Reference: DHR/2015**

**Anonymised**

**Report produced by Prudence M Beever  
Independent Chair and Author**

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## **Glossary of abbreviations:**

ASC	Adult Social Care, Cumbria County Council
C&ECSP	Carlisle and Eden Community Safety Partnership
CCG	Clinical Commissioning Group
CHESS	Care Home Education and Support Service
CMHN	Community Mental Health Nurse
CPN	Community Psychiatric Nurse
CPFT	Cumbria Partnership NHS Foundation Trust
CSP	Community Safety Partnership
CQC	Care Quality Commission
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DSS	Dementia Support Services
ECA	Eden Carers Association
EMI	Elderly Mentally Infirm
IAS	Integrated Adult System
IMR	Independent Management Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MHA	Mental Health Act
SW	Social Worker

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# **Section One: Introduction and Background**

## **1.1 Introduction**

This report of the Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Mrs A M, date of birth 22 June 1934, aged 80 years, by her husband Mr B M on 2 September 2014.

Plain English has been used where possible in the production of this report.

## **1.2 Brief History**

Mr and Mrs M were retirees in their 80s. They were both academics and had come to live in an isolated rural spot with only two neighbours, a couple living within the vicinity, who, over time, became their friends and a source of support.

On the morning of 2 September 2014, the police received a call from B M at 6.16am stating that he thought his wife was dead. He informed the call handler that he was ill, he could not talk and was going to sleep. Officers were immediately deployed and arrived at his home address at XXXXXX, Cumbria. Mr M told them that his wife was dead upstairs in the house. He informed the officers that he had tried to kill himself in his car by placing the exhaust pipe inside his vehicle.

Officers found the car with a pipe in the vehicle and a strong smell of fumes within the garage. His wife was located upstairs with a plastic bag and pillow over her head which was weighted down. She was confirmed deceased by paramedics at 6.50pm.

Mr M was arrested and was taken to be medically examined at Cumberland Infirmary. He was later formally charged with the murder of his wife by Cumbria Police. He was remanded in custody with the support of a psychiatric report, until given bail on appeal on 13 October 2014. There were address and reporting conditions imposed at the Crown Court. He was found dead by the River Eden on 11 December 2014.

The death of Mr M is the subject of a separate internal review by Cumbria Partnership Foundation Trust. Evidence from this review has been shared with them to avoid duplication of documentation and interviews of key witnesses.

### **1.3 Purpose of a Domestic Homicide Review**

The Domestic Violence, Crime and Victims Act 2004 establishes at section 9 a statutory basis for a Domestic Homicide Review, which was implemented with due guidance on 13 April 2011. Under this section, a Domestic Homicide Review (DHR):

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

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These matters are for Coroners and criminal courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

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

## **1.4 The Review Process**

Cumbria Constabulary notified Adult Social Care (ASC) electronically on 2 September 2014 at 1.15pm of the death of Mrs A M. An initial meeting was held on 11 September 2014 chaired by DB, Safeguarding Adults Officer.

Other attendees included Mrs M's social worker (SW), and representatives from the Care Home Education and Support Service, Cumbria NHS, Cumbria Partnership Foundation Trust (CPFT), and several members of Cumbria Police. Mrs M's GP had also provided a synopsis of her (the GP's) involvement.

The purpose of the meeting was to gather information surrounding Mrs M's unexpected death and to decide whether further action or investigation was required, and whether or not input was required from Adult Social Care. The outcome could have been a progression towards a serious case review and further investigation, or the necessary answers could have been found at the meeting. It appears that no decision was taken to progress the matter further at that stage.

A second meeting did take place, however, on 1 October 2014, chaired by the Chair of the Carlisle and Eden Community Safety Partnership. Other attendees were also members of the Community Safety Partnership. It was pointed out that section 3 (para 18) of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews states that when a domestic homicide occurs, the relevant police force should inform the relevant Community Safety Partnership (CSP) in writing of the incident. No such letter had been received and the Police representative agreed to forward one. After much discussion, it was agreed by the group that whilst the incident was a domestic homicide, there was no previous history of any involvement by the police or other agencies in relation to domestic violence between Mr and Mrs M; it was therefore felt that it was not necessary to undertake a Domestic Homicide Review. The Group did feel that an internal review would be appropriate to establish what lessons, if any, could be learnt to prevent anything similar occurring in the future. It was agreed to approach the current Chair to assist with the internal review.

On 29 October 2014, the Home Office was notified that a DHR would take place.

The Author was requested to accept the appointment on 21 November 2014.

The Police and Crime Commissioner's Office agreed to fund the DHR.

The initial pre-Panel meeting to discuss the appointment of Panel members took place on 12 December 2014. Panel members were appointed and requests were made by the Chair for basic information to be shared.

The first Panel meeting took place on 21 January 2015, chaired by the Author of this report. The purpose of the meeting was to agree the scope of the review, and it was considered that it might be appropriate to undertake a review into the death of Mr M to avoid some duplication of work. However, it was recognised that it would have to be a separate piece of work as it could not form part of the DHR itself.

The number of statutory agencies involved with the family was quite wide. It was agreed which friends and family members should be approached.

Target dates were agreed for completion of the enquiries and for submission of the report.

Chronologies were requested, and due to the likely number of these it was determined that Independent Management Reviews (IMRs) would be requested after perusal of the chronologies. All of these were received by 25 February 2015 as requested, a total of 13 in all.

The second meeting took place on 27 February 2015. It was agreed that IMRs would be requested from:

- Cumbria County Council Adult Social Care
- Cumbria CCG - Brampton Medical Practice
- JK House Care Home
- Cumbria Partnership Foundation Trust
- Cumbria Constabulary
- Alzheimer's Society

Further clarification from some or all of the other agencies would be requested thereafter if required.

## 1.5 Independent Chair

The Home Office Guidance requires that:

“The Review Panel should appoint an Independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRs and any other evidence the Review Panel decides is relevant.”

and

“The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review.”

Mrs Prudence Beever was appointed on or about the end of November 2014. She is a Barrister-at-Law with over 30 years' experience. She has extensive knowledge of domestic violence and abuse, honour killings and abduction and forced marriages.

She has experience in many other areas of abuse, including serious and sometimes fatal abuse of children. As this was her first Domestic Homicide Review, Home Office online training took place, and study and research into the subject of DHRs, and in particular suicide/homicide cases and studies, were undertaken before taking the first meeting. In addition, voluntary mentoring was requested and undertaken with an experienced Chair of DHRs throughout the process.

Mrs Beever has had no involvement either directly or indirectly with members of the family concerned, or the delivery or management of services by any of the agencies. She has attended and chaired the meetings of the Panel, the members of which have contributed to the process of the preparation of this report and have helpfully commented upon it. All information was received in a timely manner from the agencies.

Unfortunately the review was delayed by just over a month, due to a bereavement in the Chair's immediate family.



## **1.6 DHR Panel and Terms of Reference**

In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mrs Beever chaired the Panel and is also the author of the Overview Report. Other members of the Panel and their professional responsibilities were:

- Safeguarding Adults Service Manager, Health and Care Services, Cumbria County Council
- Detective Inspector for North Cumbria Constabulary
- Development Officer for Mentally Disordered Offenders (Cumbria), Cumbria Partnership NHS Foundation Trust
- Head of Lancashire and Cumbria Crown Court Prosecutions Unit, CPS (extended leave prior to completion of the review)
- Communities Director Eden District Council
- GP Safeguarding Lead for Adults in Cumbria, NHS Commissioning Group
- NHS England, Quality and Safety Manager, Cumbria, Northumberland, Tyne and Wear Area Team. Later replaced by:
- Senior Quality and Safety Manager, Cumbria Partnership NHS Foundation Trust

The Community Safety Manager Cumbria County Council, was originally a member of the Panel but had been offered a post elsewhere and was unable to attend further meetings.

### **Terms of reference were to:**

- Establish whether it was known, or could have been suspected, that the perpetrator posed a serious risk of harm to his wife, the victim, and whether any action could have been taken to prevent the homicide. To establish whether the domestic homicide was predictable or preventable.
- Identify how effective agencies were in identifying the victim's vulnerability to domestic abuse/homicide and whether the risks were identified and appropriately managed.
- Identify how effective agencies were in identifying the risks that the perpetrator posed to the victim (or himself), and how such risks were managed.
- Establish how agencies work together and to identify any gaps and/or changes that are required to strengthen inter-agency working, practice, policies or procedures to improve the identification of people who may be subject to the risk of abuse and homicide within Cumbria and beyond.

### **1.7 Parallel Proceedings**

The first Panel meeting took place after the death of the perpetrator. It became clear after the death of Mr B M that a review of his death (suspected suicide) would also have to be undertaken. The Panel members were keen to avoid any duplication of work, but recognised that it was outwith the scope of the DHR to cover the circumstances surrounding Mr M's death. However, there is considerable scope for the sharing of information gathered in this review with CPFT, which is to carry out the internal review.

The Chair advised the Coroner that a DHR was taking place and requested sharing of his reports and enquiries. The DHR and the Coroner's Office did exchange information. The Coroner's Regulation 28 report was also provided on request.

## 1.8 Chronologies

The process began with an initial scoping exercise prior to the first Panel meeting. This was confirmed at a pre-Panel meeting chaired by the Panel Chair. The agencies involved or likely to have been involved with the victim and perpetrator were identified further at the first Panel Meeting, as well as those agencies and charitable organisations to which the couple were referred.

Thirteen agencies responded that they had recorded contact with Mr and/or Mrs M and/or held information that was relevant to the scope of the review. They submitted to the Panel with chronologies:

- Cumbria Partnership Foundation Trust (Mrs M)
- Cumbria Partnership Foundation Trust (Mr M)
- North Cumbria University Hospital
- Crown Prosecution Service
- Adult Social Care, Cumbria County Council
- Alzheimer's Society
- Cumbria Constabulary
- Mr M's GP, Brampton Medical Practice
- Mrs M's GP, Brampton Medical Practice
- JK House Care Home
- North West Ambulance Service
- Penrith Mountain Rescue Team
- Durham Prison

The following agencies/organisations indicated that they either had no recorded contact with the victim or Mr M, or that any contact was out of scope and was not of relevance to the review, or that the information they provided was of minimal assistance to the review:

- Eden Carers Association
- Crossroads Care

Agencies were asked to give chronological accounts of their contacts with the victim and the perpetrator prior to the homicide.

Where agencies had no involvement or insignificant involvement, they informed the review accordingly.

In line with the terms of reference, the DHR has covered in detail the period from February 2012 to the date of Mrs M's death. A comprehensive chronology was formulated from all of the chronologies received to assist with the enquiries and place events into context.

The organisations that completed an IMR have responded with information indicating some level of involvement with the family.

A combined chronology was undertaken to assist in the process of more fully understanding the events that occurred and decisions taken up to the date of death.

## **1.9 Time Period**

The review covered the time period from approximately February 2012 until 2 September 2014, when Mr M called the police after killing his wife. The review also considered relevant information from individuals and agencies from their contact with the perpetrator after that time period, in order to gain insight into the state of his mind/thinking processes before he was eventually found dead.

## **1.10 Key Lines of Enquiry**

- **History of events and relationships**

What was known about the perpetrator's relationship with his wife? What was the sequence of events leading up to the date of the homicide?

- **Information and assessments**

How was information about Mr and Mrs M received and addressed by the agencies? What assessments were completed and what was the outcome of these? Were there trigger points or missed opportunities for sharing information that would or could have made a difference? What were the thresholds for decision making?

- **Risk assessments**

What risk assessments were completed to a) assess the risks to the victim and b) to assess the risks posed by the perpetrator? Did the perpetrator have a history of violence and, if so, how was this managed? What were the outcomes of any risk assessments? Were these completed on a single agency basis or jointly with other agencies? What actions were taken?

- **Contact with and support from agencies**

What contact did each agency have with the victim and the perpetrator? What support did each receive and from whom? What processes were followed and what were the key decision points and why? Was there any additional action that could have been taken and would it have made a difference?

- **Adult safeguarding**

Were there any safeguarding issues in respect of the victim and, if so, were these appropriately managed?

- **Awareness of domestic abuse indicators**

To what extent are staff and agencies aware of the indicators of risk in these circumstances? Were these appropriately identified and what action was taken? Does the agency have policies and procedures in place for dealing with concerns about the possibility of the existence of elderly abuse/homicide/suicides?

## **1.11 Contact with Family and Friends**

Two members of the immediate family and the M's immediate neighbours were interviewed by the Panel Chair after permission was sought from them directly or through their solicitors. They were provided with a sensitively worded explanatory leaflet and introductory letter. Their statements were sent to them for approval.

A meeting was arranged by the Chair with the District Coroner. He kindly provided a full bundle of Inquest documents which was due to be heard in July 2015, strictly for consideration only by Panel members.

## 1.12 Summary of Key Events

This history has been taken from a wide number of different sources, including ASC, GP records, JK House Care Home, the police and other emergency services, and family and friends. The combined chronology assisted in the process.

Mr and Mrs M were both intellectual retirees in their 80s. They had been married for over 50 years. They lived alone in a fairly remote part of the Eden Valley in Cumbria, and their only immediate neighbours were Mr and Mrs K. They saw little of their family, who lived in the USA and Australia. There had been some visits now and then. All the evidence suggests that they were individuals who were independent-minded and devoted to one another.

Concerns over the victim's mental health were first raised in March 2012 when Mrs M's memory was noted to be poor. She was eventually diagnosed with Alzheimer's-type dementia on 7 June 2012. There is some reference on 20 March 2012 from the perpetrator's son to the GP to his father having a history of depression. It became clear from the GP records that depression had been a long-standing issue for Mr M.

Mrs M was prescribed medication to slow down the onset of her condition by her GP, but it seems both Mr and Mrs M were resistant to her taking any medication and, indeed, it appears that the victim did not take her prescribed medication. Mrs M had begun wandering away from her home and getting lost. The first reference to this was in April 2013. There were other incidents recorded by the emergency services in June 2013, but it is unlikely that these were the only incidents with which Mr M had to cope, as is indicated from a note of a telephone conversation Mr M had with the social worker on 30 July 2015 when his wife had climbed out of a window. She did return, however, later that day.

Mrs M's condition deteriorated until it reached crisis point for Mr M at the end of July 2014, when he himself became quite ill. He believed initially that he had developed cancer, but in fact it turned out to be far less serious, but debilitating nonetheless, and very painful; he was greatly reassured after a hospital assessment on 4 August 2014.

In September 2014, Mr M was due to be admitted to hospital for a gall bladder operation. He was keen to find a care home for his wife to enable him to sort out his own health problems, and a search for a suitable home began in earnest in June/July 2014.

One major issue was the sort of home that would be suitable for Mrs M. Mr and Mrs M were 'self-funders' in that the care home was to be paid for by themselves, as their capital was such that no contribution was to be offered by the Local Authority. In such a case, the choice was therefore entirely with Mr M, as his wife was not able to make her own choice or even offer an opinion by this stage in the development of her disease.

It seems to have been the case that Mr M was beginning to realise that he was not coping with his wife and that her admission into a home was likely to become permanent.

There is some evidence to assume, by the nature of the search for a home and the conversations he had with agencies, that Mr M was well aware that Mrs M required a **secure** home. The Local Authority social worker and Mr M's GP also appear to have been aware of this need.

Mr M did make several enquiries of different homes, but either a suitable place was not available within his timescales, or he felt it would not be suitable for his wife.

Adult Social Care became more heavily involved with the couple at this stage, particularly after the incidents of Mrs M being found after being missing overnight. However, although an assessment had been completed in 2013, this was not updated and no care plan had been devised for her.

The social worker, who worked only 2 days a week, sought advice from her manager on more than one occasion, but it was made clear that, as self-funders, the M's alone had the choice of home, and the home itself could apply for an order under the Mental Health Act (MHA) if they needed to do so.

For reasons known only to Mr M, he decided upon JK House Care Home as his preferred choice, which was not in fact a secure home. It was within a village known to Mrs M and him, and it was within a reasonable distance of his own home, but there were other care homes within the vicinity. Whether cost came into the equation it is difficult to surmise. He clearly felt that one particular secure unit he visited was not suitable, and another secure home had no vacancies.

Mr M mentioned his choice to his GP. His GP recalls enquiring of Mrs XY, the manager of JK House Care Home, as to whether she felt it was the right home for Mrs M, as Mrs M was fit and active and prone to wandering. The GP was informed that

there would be an assessment of Mrs M before she could be admitted on a permanent basis. Mrs XY does not recall the conversation in this way, but recalls that she was told Mrs M was quite active.

Initially there was no bed available for Mrs M. Mr M was informed in August 2014 that a bed had become available, but that Mrs XY, the manager and owner, was on leave until 1 September and she wished to be present to settle Mrs M into her room and to undertake an assessment of her.

Mrs K, his neighbour, describes how Mr M stitched name tags into all his wife's clothes, even into her underclothes, days before she was admitted.

Mr M took over some of his wife's belongings to JK House Care Home on 30 August, and arranged to take Mrs M there on the morning of 1 September 2014. The manager, Mrs XY, told him that she would see them about 1.45pm so that she could be present to settle Mrs M into the home. A short risk assessment seems to have been undertaken, but this is handwritten and does not mention Mrs M's tendency to 'wander'.

Mr M and his neighbour both took Mrs M into JK House and were clearly expected by them. Mrs M was left in the charge of Mrs XY and her staff after a short time, and Mr M and Mrs K returned home.

Mrs XY left JK House and returned to her own home that afternoon. It is not clear how long she spent with Mrs M, but soon after she left for home, Mrs M herself left the home unobserved at around 5 to 5.30pm and was soon found unharmed by staff about 300 yards away towards the village of Brampton. She was returned by the staff, and Mrs XY had been alerted by between 5.30 and 6.15pm. By the time Mrs XY returned to JK House, Mrs M had been found and returned to the care home.

Mrs M was bathed by staff and made ready for bed. Mr M was called by telephone by Mrs XY at between 6 and 6.15pm to ask if he could collect his wife, as they could not keep her as they were not a secure home. His neighbour reported Mr M describing Mrs XY as saying to him, "she's not for us."

According to a conversation Mr M had with Mrs K later, Mr M said he could not collect his wife, as he was ill and tired and had had something alcoholic to drink.

Mrs M was returned home by both Mr and Mrs XY at about 8 or 9pm, having got lost on the way. Mrs M's belongings had been packed into bin liners and left in the porch.



It is reported that Mr M made a joke of it. He said to Mrs M, "you've done it again", and drew his finger across his throat in what Mr XY suggests was a jokey way to say he could "do himself in." However, it is known from the reports from various care homes he called and the message received by the social worker that he was in fact very distressed, and at the "end of his tether."

The evidence is that sometime between the time that Mrs M was brought home and the early hours of 2 September 2015 Mr M killed his wife. He did so by mixing sleeping medication in with her milky drink. He placed a plastic bag over her head, then a pillow and weighted this down. He then attempted unsuccessfully to take his own life by piping the exhaust fumes from his car into his vehicle to asphyxiate himself. When he was unsuccessful in his suicide attempt, he called the police at 6.16pm.

When the police arrived at the scene, Mr M admitted immediately what he had done, and said that he did not regret it. He was arrested and taken to hospital in an ambulance for a medical check-up with his hands in plastic bags and handcuffed. He told the police that he did not regret what he had done.

It is clear that the homicide was deliberate and carefully planned that evening. Mr M did leave a suicide note dated 1 September 2014 addressed to 'The Coroner' with a copy for his brother-in-law, S T-W. He explained in the letter that due to his own failing health, he was unable to care for his wife. They had promised each other, when of sound mind, that they would not allow themselves to go into care suffering from dementia and that events had pushed him into having the courage to keep his promise. He thanked all who had encouraged and supported them in recent years. His message included an apology, but he wrote that life had become impossible. The one home he could find to take her returned her to him after half a day.

After his arrest, Mr M was initially kept in custody and refused bail. However, on the strength of a psychiatric report, and on appeal, he obtained bail with restrictions on 13 October 2014, and was allowed to live in a hostel. He did return to his own home to visit from time to time. He was found dead by the River Eden on 11 December 2014. There was a finding by the Coroner that this was suicide.

As a result of this, of course, the criminal proceedings were ended, and the DHR could then proceed without awaiting their outcome. The inquests into the deaths of Mr and Mrs M commenced on 1 July 2015, with an estimated length of hearing of 4 days, with Mrs M's inquest first, to be closely followed by Mr M's. A regulation 28 report was

delivered by the Assistant Coroner for the County of Cumbria, which identified issues of failure of communication and arrangements for the wellbeing of Mrs M on the part of both Adult Services and the managers of JK House, irrespective of whether or not this was a privately funded arrangement.

### **1.13 Individual Management Reviews**

All of the chronologies were received in a timely manner, and a combined chronology was produced.

After careful perusal of these, it was determined that Individual Management Reviews would be desirable from a number of agencies as follows:

- Cumbria County Council Adult Social Care
- Cumbria CCG - Brampton Medical Practice
- JK House Care Home
- Cumbria Partnership Foundation Trust
- Cumbria Constabulary
- Alzheimer's Society

The IMRs were received by 15 May 2015. The contents of these were discussed in detail at the Panel Meeting on 1 June 2015. The Panel members requested further information from all agencies and asked for further clarification on some issues.

Two of the IMRs were substandard, by JK House Care Home and by ASC.

The IMR from JK House Care Home was in the correct format but lacked much relevant or useful detail. It did not contain reference to the risk assessment apparently undertaken by them. Additional information had been obtained via an interview with them by a nominated Panel member, but as this was a small organisation, with no previous experience of IMRs, it was felt that the best solution would be for the Chair to have a further meeting with them to obtain clarity on a number of questions that specifically arose from the Panel meeting.

The initial IMR from Adult Services was not in the correct format and did not address the pertinent issues. The Panel requested that the IMR be reviewed and rewritten, with guidance from the Chair and the Panel member for Adult Services, to which ASC readily agreed. The Chair was informed the following day by the relevant Panel member that she had been assured that a new officer was to be appointed to

undertake the new IMR. The Chair made her own enquiries, and it was found that the same officer was to undertake the work but that a new supervisor had been appointed to oversee it. As a result of this, the Chair arranged an urgent meeting with the officers concerned to ensure that the format and the relevant issues would be addressed fully. Detailed guidance was given to them to enable them to complete their report in a timely manner. Their second report, dated 23 June 2015, was considered by the Panel to be of excellent quality and covered all areas of concern comprehensively.

The Chair also agreed to meet with some of the authors of the IMRs to discuss any matters raised by Panel members. Unfortunately this was interrupted by unforeseen events due to a bereavement in the Chair's immediate family.

Brampton Medical Practice and the CPFT were each able to identify areas of concern and where improvements could be made. The police identified no areas of concern and no need for action as they felt that they had dealt with matters as best as they were able to do so. It was felt by the Panel, after discussion, that the police were unlikely to be able to do very much more than they had done. They relied on medical experts to determine whether a vulnerable adult should be sent home or sent to hospital, and they had on each occasion of their involvement reported Mrs M as a vulnerable adult to ASC.

## **Section Two: Key Events and Analysis of Agency and Other Interventions**

### **2.1 Cumbria County Council Adult Social Care**

The initial IMR submitted was rejected as inadequate on a number of levels. However, this was supplemented in a timely manner by a very comprehensive document after further discussions.

The author of the Individual Management Review report was the County Manager Social Care Operations South Cumbria, with contributions from the Development Manager within the Council's Adult and Local Services. Neither manager was directly involved in this case.

The contents of this IMR are so pivotal that a detailed description of this agency's involvement and analysis is contained within this section.

#### **(A) Summary of Involvement**

This IMR was a crucial piece of work and highlighted some important recommendations for best practice in the future. The history of involvement by the service commences on 26 April 2013 and continues to the date of Mrs M's death on 2 September 2014. The IMR is divided into three distinct periods of time, and sets out in considerable detail the work undertaken in each period and key events, and offers an analysis of both the good and substandard practices and missed opportunities.

The initial referral was received from Cumbria Police on 26 April 2013 to report their response to a missing person. The referral was passed on to the Community Mental Health Team and ASC for follow-up action.

Cumbria Adult Social Care followed up the referral on 29 April 2013 and spoke to Mr M to ask if he wanted a social work visit. Mr M explained that his wife's physical condition was not a problem, but he had concerns for her mental condition.

The record also details the risk indicators associated with this referral as follows:

“Does the vulnerable adult suffer with any physical disability or mental disorder?” Answer recorded is “Yes. Mild Alzheimer's, not currently taking any medication.”

In response to the police referral on 26 April 2013 and follow-up call on 29 April 2013, the case was allocated to Adult Social Care (ASC), Eden Team.

On 14 May 2013, a home visit was conducted by a social worker to the home of Mrs M. Mr M was also present for this visit, and a formal social care assessment was conducted along with a quality of life assessment. During this assessment, consideration was given to maintaining Mrs M's safety, the use of mobile telephones, and the provision of a GPS tracking device and use of assistive technology equipment. During the visit, Mr M advised that he would be undergoing a medical intervention in the near future and would require support to keep his wife safe during this time. He ruled out respite or any form of residential care. Mr and Mrs M were offered a range of support options that included respite care, day care and support at home. Mr M stated at this time that he did not require a break from his caring role, but would consider day care as a possible future option. During the visit, SW discussed a referral being made to Eden Carers Association (ECA). Mr M did not want a referral to be made. Records show that Mr M had already obtained information about ECA and would contact them himself in the future to make a contingency plan. Mr M also stated to SW that he did not feel he needed a break from his caring role. It was agreed that he would contact ASC when the date of his operation was known. At this meeting, SW clarified with Mr M that they would be self-funding their own support.

Records show that no support plan was completed at this time. Records also show that no carer's assessment was undertaken.

The analysis shows:

- (i) The social worker's response was swift, in accordance with policy and procedure, and was supportive of Mrs M and her partner. The social worker considered the needs of Mrs M and responded appropriately with a suggested range of possible interventions, all of which would have been sufficient to meet the identified needs. The social worker followed standard procedure to conduct both a 'Your Assessment' and a 'Quality Of Life' assessment.
- (ii) The social worker also considered the needs of Mr M by recognising his needs as the main carer. She demonstrated this by recommending a referral to ECA, which is in accordance with procedure. The social worker respected the decision of Mr M and accepted his choice to make the contact himself.
- (iii) However, practice procedures were not followed to agree a support plan at the time of assessment. She apparently intended to finalise support interventions once a hospital date was known. A completed support plan would have detailed

the arrangements and support to be put in place to enable support and care to be provided to Mr M during his medical operation.

- (iv) During the assessment visit an offer to undertake a carer's assessment with Mr M was not made. She offered to refer to ECA for this agency to complete a carer's assessment. Practice procedures were not complied with, in that the carer should be offered an independent carer's assessment. It is not clear whether the social worker gave this any consideration. A completed carer's assessment would have detailed the needs of Mr M. This assessment would have resulted in a carer's contingency plan being created, which is a useful tool as it would indicate to the social worker which support and care arrangements would need to be put in place in the urgent event of the carer being unable to fulfil their caring duties. As Mr M was waiting for a date to undergo surgery, it would have been appropriate for the social worker to have offered this to make effective plans in preparation for this surgery.
- (v) The social worker did determine Mrs M's ability in making decisions. During the assessment process, SW asked Mrs M if she was able to make decisions. The response was, "Yes, I can make all decisions with the help and guidance of friends and family."
- (vi) Mr M clarified that this was only in the context of everyday decisions. He confirmed that he would make the important decisions. The social worker acted appropriately by not assuming that Mrs M did not have capacity. As no care was being arranged at the time of assessment, the social worker acted in accordance with procedure, which states that "if the decision does not need to be made at this time, then an assessment of capacity would not need to be made."
- (vii) Mr M, as her decision-maker, did have authority to fully influence such decisions if working in Mrs M's best interests. There was no concern raised or communicated that Mr M was not doing so, and so it was appropriate for the social worker to act on Mrs M's decision and to consider Mr M as the decision-maker.

A follow-up phone call on 12 June 2013 by Mr M to the social worker is recorded in the case notes. In this note, Mr M informs the social worker that no date has been set for him to go into hospital. This discussion details that he expects the minor operation

would result in him staying in hospital as a day patient. The social worker discussed the possibility of a care agency providing support on this day, but Mr M concluded that he could call on a neighbour if needed. Mr M did enquire about the possibility of residential care for the day. The social worker agreed to send him a list of residential care homes, but advised that Mrs M would require elderly mentally infirm (EMI) care. It was agreed that Mr M would contact SW once a date was known so that there would be enough time to arrange care, although SW also concluded that Mr M could arrange the residential care himself as he was a self-funder.

**Analysis:**

The social worker demonstrated persistence by repeating the range of interventions available to Mrs M during a conversation with Mr M on 12 June. As Mrs M was a self-funder for residential care and Mr M was willing and able to make arrangements himself, it was appropriate social work practice to provide Mr M with information of services available for the carer to make their own arrangements.

However, an opportunity to check whether Mr M had made contact with Eden Carers Association was overlooked. The social worker did not determine whether Mr M was receiving support from other agencies. She also did not seek third party information or alternative professional perspectives on both Mr and Mrs M.

During a home visit on 7 February 2014 to Mr M by the social worker, agreement was reached that a referral could be made to Eden Carers Association. Case records show a referral being made to ECA on 18 March 2014 by SW, but the case notes do not show a conversation between ECA and SW, or any record of any further conversations between ECA and SW during this time period. The records do not explain how this referral was made and what information was shared. The referral to ECA was not timely. However, the social worker did show some persistence in pursuing with Mr M the need to have a carer's assessment undertaken. Unfortunately, a second opportunity was missed to undertake this assessment and to complete a contingency plan.

Having made the referral, the social worker did not follow up the referral to ECA to find out whether the assessment took place. The social worker did not record a conversation with ECA. ECA notes detail the conversation with the social worker on 18 March 2014, and confirm that they did inform SW that Mr M had made contact the previous year but an assessment had not been completed. The notes also detail that

the reason for the referral was to undertake an emergency (contingency) plan. Up to date social worker records were not kept. The social worker overlooked an opportunity to ensure that Mr M's needs as a carer were being addressed.

During the home visit on 7 February 2014, consent was also obtained to refer Mrs M to Dementia Support Services (DSS). Case records show a referral being made to Dementia Support Services on 18 March 2014.

On 24 March 2014, the social worker was contacted over the telephone by Dementia Support Services. They informed the social worker that they had had contact with Mr M on 20 March 2014, but he had turned down the offer of support. This contact makes clear that Mr M stated that he and his wife were okay and that he knew how to make contact if need be. Dementia Support told the social worker that information was given to Mr M regarding benefit entitlement and which groups were available in Penrith that were suitable for Mrs M to attend. Contact details were also left for Mr M to contact Dementia Support, if required.

The records do not show how this referral was made and what information was shared. Opportunities were missed to:

- Proactively support Mr M to establish a support network.
- Address with Mr M why he did not want to pursue support.
- Ensure that Mr M's needs as a carer were being addressed.

During the home visit on 7 February 2014, the social worker recorded that Mr and Mrs M did not feel that any home care support was currently required, and Mr M confirmed that no support was required from ASC. Agreement was reached for Mr M to contact ASC should support be required in the future and that the case would be closed.

On 18 March 2014, following referrals on the same day to ECA and Dementia Support Services, the social worker recorded that "no further support is required from ASC. Case to be closed."

The social worker acted in accordance with procedures in seeking to close the case when Mr M and Mrs M were not seeking services. Closing the case at this point resulted in no further contact being made between the social worker and Mr and Mrs M from 7 February 2014 until the end of June 2014. The social work involvement in the case was heavily focused on options in seeking service interventions to meet needs. In closing the case, opportunities were missed to provide therapeutic social



work interventions and support to Mr M and to put in place an established network of support agencies. It is widely understood in caring for people with dementia that support services for carers can be an essential source of emotional and practical support, and empower the carer to care for the person with dementia.

### **30 June 2014 to 2 September 2014**

On 30 June 2014, a police referral was received by ASC regarding Mrs M being reported missing on 26 June 2014. Following the police referral, the case was reallocated on 2 July 2014 to the social worker.

On 4 July 2014, the social worker made a phone call to Mr M in response to the recent referral. Records show that Mr M had come to the conclusion that his wife would require a care home. Mr M confirmed that he had visited JK House Care Home in Brampton and believed this to be suitable following initial contact with the home. He was awaiting a call back from them. The social worker agreed to call the following week to arrange a visit to discuss this further. She advised Mr M to contact the Adult Services Duty Officer should he need any further help or advice in the meantime. The response in reallocating the case to the social worker already known to Mr and Mrs M was appropriate, as the social worker was known to the family and professional consistency would be maintained.

However, the social worker's response to Mr M was not timely given the nature of the referral from the police. A referral of this nature should have prompted an earlier call, given that the incident occurred on 26 June. However, the social worker, worked part time and the referral was not received until Monday 30 June. ASC should have had an opportunity to arrange alternative provision to cover the period in which the SW did not work. If this had been in place Mr M may have felt able to access the services available. Once contact was made, the opportunity to agree a home visit appointment with Mr M and to offer a reassessment of Mrs M's needs was not provided.

On 10 July 2014, a professional case discussion was held between the social worker and her line manager. During this discussion, the social worker raised concerns regarding Mrs M's capacity and how she might feel regarding Mr M's plan to find a care home. The social worker was advised by her line manager that as Mrs M would be a self-funder for residential care, Adult Social Care should not interfere in Mr M's decision made on behalf of his wife. It was considered that Mr M would know best how to meet his wife's needs. This advice was based upon the 'framework' in the Mental

Capacity Act that Adult Social Care should not interfere in this situation unless there is evidence of abuse.

The advice given by the line manager was in part correct. Mental Capacity guidance does make clear that:

“more routine, less significant decisions are to be made by carers on behalf of someone who lacks capacity. Any actions must still be in the person’s best interests and carers should be able to justify them. Decisions like these could be noted in a care plan. The care plan should also document the assessment of capacity.”

Whilst Mr M could be considered to be in the best position to make this decision, the social worker and her line manager missed an opportunity to challenge the situation further to determine if the decision was being made by Mr M in his wife’s best interests.

As the social worker had raised concerns regarding Mrs M’s capacity and the decision being made in relation to considering a residential care home, the social worker and her line manager overlooked an opportunity to work with Mr M to determine the steps he had taken to determine that his wife now lacked the capacity to make this decision. Opportunities were missed to follow the Local Authority’s MCA Practice Guide to undertake a best interest checklist. The best interest checklist considers the appropriateness of the intervention and determines whether the proposed decision, as in this case, residential care, was in Mrs M’s best interests.

Telephone exchanges between the social worker and Mr M were held on 11 July, 14 July and 17 July 2014. Discussions were held referencing a list of care homes sent by SW to Mr M, whether GPS tracking would be a suitable intervention, and the possibility of day care. A home visit was planned for 17 July by the social worker and telecare equipment provider; however, this was subsequently cancelled by Mr M. There was a telephone discussion initiated by the social worker to Mr M on 30 July 2014 in which they discussed the potential of a home visit planned for 6 August to consider the installation of a GPS tracking system. Mr M was initially not open to the suggestion of GPS tracking or day care, but he had reconsidered these as possible interventions. From the case records, the onus of making these arrangements rested on Mr M as a self-funder, although support and advice were being provided by the SW in relation to residential care, GPS tracking and day care arrangements.

## **Analysis:**

There is currently no **legal** requirement on ASC to arrange residential care for someone who intends to pay for this by private arrangement. It is, however, appropriate for a social worker to offer advice and support, and only provide assistance if there is no one else who can do this on behalf of the person. The IMR concluded that the social worker acted in accordance with procedures.

There was a telephone discussion initiated by the social worker to Mr M on 30 July 2014 in which they discussed the potential of a home visit planned for 6 August to consider the installation of a GPS tracking system. The SW writes in the notes that Mr M appeared “agitated” on the phone and confirmed he no longer wished to pursue GPS tracking until he had read the brochure. He also referred to a couple of failed visits to potential residential care homes. This discussion resulted in a later call from Mr M and a return call from the social worker. During this conversation, Mr M again appeared “snappy and agitated.” Discussion was held regarding possible respite units, and also a referral to the Community Mental Health Team being made by the social worker. Mr M responded by stating that he was “tired of assessments” and had a feeling of being “under siege.” Mr M also stated that it was “soul destroying and impossible” with “so many jobs to do.” The social worker offered home care to help him, but this was also dismissed, with Mr M saying that it would create more work for him. The social worker agreed with Mr M to contact a respite unit.

During this conversation, Mr M informed the social worker that his wife had gone out by getting out of a window, and was currently not in the house.

The social worker did not record that safeguarding procedures were considered, or whether the situation warranted a safeguarding referral on the issue of Mrs M “getting out of a window.” The ‘Safeguarding Adults Procedure’ makes clear that risks arising from self-neglect or a person’s own behaviour are not covered by these procedures. Good practice was not followed to consider bringing agencies together to discuss her concerns at a multi-agency meeting.

In addition, it was recognised that an urgent home visit was not provided to support Mr M during a breakdown of the current arrangements. This would have given the SW an opportunity to support Mr and Mrs M, and to assess the situation and determine whether a multi-agency meeting would be beneficial.

It was not considered Mrs M climbing out of a window to go for a walk could be a result of unnecessary restraint.

The Panel also makes the observation that it may have been a failure not to recognise that the care being provided by Mr M was not such that he could keep Mrs M safe.

The situation that the social worker became aware of during this conversation should have given her just cause to consider whether a safeguarding alert should be raised.

The social worker sought advice regarding her concerns for Mr and Mrs M from her line manager. The advice given by the line manager was to “leave Mr M to his own pace for 24 hours but inform CMHT and GP of concerns.” Advice was also given for SW to give information of support available, but that she “cannot force Mr M to accept.”

It was acknowledged in the IMR that the line manager did not fully recognise the concerns being raised by SW in relation to the potential breakdown of the family situation. The line manager’s solution to this situation was to “do nothing for 24 hours, provide some information to Mr M and refer the case on to other agencies.” The social worker did follow the direction of her line manager and referred the case to CMHT. The social worker assessed the situation appropriately and did convey to the CMHT worker that the situation was reaching a “crisis point.”

The IMR accepts that appropriate advice by the line manager at this stage would have been to follow staffing procedure on ‘Risk taking for positive outcomes’. The procedure states:

“Positive risk-taking is weighing up the potential benefits and harms of exercising one choice of action over another, identifying the potential risks involved, and developing plans and actions that reflect the positive potential and stated priorities of the individual.”

This procedure would have been appropriate, as it considers “Risks to the individual - including abuse and neglect.” This procedure forms part of the authority’s wider safeguarding agenda and procedures.

It also accepts that an appropriate course of action should have concluded with the social worker offering Mr M a home visit on that day, or near to it, offering a review of the assessment and a ‘working with risk’ review as detailed in the procedure. This procedure gives social workers an opportunity to:

- Provide close monitoring of the individuals they are working with, including their own therapeutic interventions and their indirect contact with informal supports, ensuring the individual's views on treatment and support are heard and acted upon.
- Co-ordinate the input of the multidisciplinary team and wider network of support.
- Demonstrate good practice in assessment interventions, decision-making and information sharing through good recording.
- Clearly record interventions and outcomes.
- Ensure that adequate review of progress happens in line with good practice guidelines.

The recorded SW response and interventions do demonstrate that the social worker was working to some of the principles set out in this procedure, but was not actively using the procedure as no support plan was in place and no risk review plan was formulated. The responses, therefore, remained reactive and lacked a clear professional appraisal of the situation and resultant coordination.

ASC supervision, training and workload management may have been relevant factors in the decisions that were taken.

The social worker did provide support to Mr M in arranging support services on his behalf. The social worker displayed insight into the needs of Mr M by providing him with support to make arrangements to ease the burden on him. However, this was reactive and not part of an agreed plan of intervention.

On 30 July 2014 there was a further call to Mr M by the social worker confirming the outcome of the previous calls.

During this call the social worker reports that Mr M seemed "more relaxed" and confirmed that Mrs M had returned from her walk. Contact details were shared with Mr M regarding local day care and sitting service providers, and he was advised to contact the provider direct. Home care services were also raised by the social worker and Mr M appeared more willing to accept this intervention. Again, contact details were given by the social worker to Mr M for a local care agency for him to follow up. The social worker also informed Mr M that CMHT had been informed of the situation.

The social worker showed professional responsibility in following up a call to Mr M later in the day to determine the current situation. The social worker acted appropriately by briefing Mr M on the outcome of previous calls.

A message was received from CPN1 (Community Psychiatric Nurse) on 31 July 2014, informing that Mrs M was not open to their team. Following this call, the social worker telephoned CMHT Older Adults Team, Carlisle, and spoke with CPN2. An urgent referral was made for Mrs M which detailed the situation and that the social worker was concerned that Mr M was struggling to cope. CPN2 agreed to make contact with Mr M that day.

The social worker clearly acted responsibly in making a new referral to the correct team.

On 1 August 2014, SW telephoned Mr M to provide contact details for care homes with EMI vacancies. The list of homes did not include JK House. Mr M confirmed that CMHT had contacted him, but he had declined a visit as he wanted to leave things until his own health issues were sorted out on the coming Monday. Mr M confirmed that he was now considering his wife moving into a long-term care home. In the meantime, he stated that he felt that support with bathing for his wife was a good idea and would be helpful to him, and he intended to follow up by contacting a care agency. Mr M also confirmed that he had spoken with a day care provider who could offer help. Mr M also reconsidered a GPS tracker. The social worker offered additional help, but Mr M declined this. The social worker gave him the ASC contact number and her mobile phone number, and made him aware of her part-time working hours. Mr M confirmed that no further support was required, but agreed for the social worker to make a follow-up call in one week's time.

The Panel agrees with the IMR author's analysis that the social worker missed an opportunity to provide support for Mr M in making suitable care arrangements for his wife. It is appropriate for a social worker to withdraw support to a self-funder if the person does not want or need assistance. The social worker respected the decision of Mr M, and attempted to maintain contact with him by offering to make a follow-up call in a week's time. However, given the recent concerns, the social worker missed an opportunity to arrange a home visit to check and confirm that Mrs M was being cared for appropriately. The social worker based her decision to disengage on phone discussions with Mr M. She also failed to follow up with CMHT in response to Mr M

declining a visit. The social worker did provide him with appropriate advice regarding the type of care home available.

The SW received a call from Mrs M's GP on 4 August 2014. In this call, the GP confirmed that Mr M was seeking residential care. The GP also commented on the relationship between Mr and Mrs M, and confirmed that Mr M was going to contact JK House Care Home, as follows:

“Mr M has always been very independent, refusing help, and is very loyal to his wife. GP spoke with Mr M on Friday and said she has agreed to contact JK House Care Home in Brampton to check whether this home will be able to meet Mrs M's needs and to check how long waiting list is to see if it is feasible option - as this is the home that Mr M is waiting for.”

This shows that the social worker did at this point receive a wider understanding regarding the relationship between Mr and Mrs M. The social worker also received confirmation that Mr M was considering JK House Care Home.

On 8 August, the social worker telephoned Mr M, as agreed, following his recent hospital assessment. Mr M informed the social worker that the hospital assessment had had a “positive outcome”, and that he had made contact with a residential care home for possible respite for his wife if he were to need a hospital stay. He confirmed that he was feeling “more relaxed now, since his health check, and will be better able to consider options already suggested to him by the social worker and to look at care homes also.” The social worker informed Mr M that she was to be on leave for 2 weeks from the next week, but that he could phone the office if he needed any further advice or support. Agreement was made by the social worker to call him on her return from leave. The social worker was scheduled to return from leave on 26 August 2014.

The social worker showed good practice in checking in with Mr M as agreed. The social worker received an appraisal of the current situation from the perspective of Mr M. She confirmed what the contact arrangements would be whilst she was on leave.

Unfortunately, an opportunity was missed to discuss the suitability of JK House Care Home for Mrs M. There are no records that show that the social worker made a further call to Mr M on her return from leave.

On 2 September 2014, ASC received an electronic referral from Cumbria Constabulary in relation to the death of Mrs M. The police referral details that they

received a call from Mr M on 2 September 2014 at 6.16am, stating that he thought his wife was dead.

Case records on IAS detail a phone message left by Mr M for the social worker on her work mobile phone on Monday 1 September 2014 at 7.06pm. In this call, Mr M confirmed that he was aware that the social worker was not on duty but that she might check her messages. Mr M went on to inform SW of his latest difficulties with Mrs M. He explained that a residential placement for Mrs M had that day broken down. Mr M detailed his desperation and need for help to identify a suitable placement for his wife, pending his operation on the coming Thursday. This phone message was picked up by the social worker whilst off duty on the 2 September 2014 at about 6.30pm.

The social worker was not on duty at the time of the phone call, and there is no procedure in place that requires her to check phone messages when off duty. The social worker is required to leave a recorded message when not on duty advising the caller what arrangements are in place should the caller need to contact someone. It has not been established whether the SW had left a recorded message to this effect. The social worker had recorded that Mr M had contact details for ASC in her absence; it is not clear whether the social worker made absolutely sure that Mr M did have the correct numbers to call. In the event, Mr M did not call Adult Social Care when he could not speak with the social worker.

#### **(B) Agency List of Lessons Learnt and Recommendations**

- There is a need to focus on Mrs M as an individual. This was missing in this case. There should not be assumptions made by professionals that her lack of capacity precludes her from making any decisions, and every effort should be made to include her in the decision making process.
- Following on from above, there is no substitute for face to face meetings with the adult with care and support needs.
- There is a need for professionals to recognise when they are faced with a complex problem involving dementia, capacity, best interests and potential carer breakdown. These elements were missing in this case.
- Professionals must not work in 'silos' and only respond to events in a reactive way. Rather, they should identify and tackle the underlying causes and consider



the most appropriate multi-agency intervention through comprehensive assessment and support planning.

- 'Joined-up' working was absent in this case. It is not enough just to refer people on to other agencies without further engagement and scrutiny to ensure that there is follow-through with resulting actions.
- An enquiring mind is essential to achieving the above; in this case it was largely missing.
- It has become apparent within this review process that the three main agencies involved in the support of Mr and Mrs M did not engage in an effective multi-agency process to ensure that regular and focused information sharing took place. Risk procedures were not used.

- SW practitioners must use tools available to them to evaluate risk.

- **Working with Self-Funders:**

Engagement between the social worker and Mr M was predicated in the main on the pursuit of service interventions and the way in which the department works with self-funders. Mrs M was considered to be a self-funder early on in the social work relationship, along with Mr M stating that he was prepared to make care arrangements himself. This review highlights a weakness in the way the department engages with self-funders. Whilst the department and the SW acted in accordance with legislation and known practice on the role and responsibility for self-funding customers, the social work engagement placed an overreliance on support being about service options and availability of such services from care providers. The social worker in this review did not adequately consider their own role as a Social Worker and the different ranges of therapeutic interventions or emotional support they could have offered to Mr M. The social worker looked to meet this responsibility by referring to other agencies, for example ECA or Alzheimer's Society.

- Practitioners must look wider than service-specific interventions to the type of therapeutic social work support a person may need, irrespective of the person's financial circumstances.

- **Working with carers making best interest decisions:**

The MCA Code of Practice is clear that carers do not have to be experts in assessing capacity. However, to have protection from liability when providing care, they must have a 'reasonable belief' that the person they care for lacks capacity to make relevant decisions about their care. A carer is not required to follow a formal process; however, if somebody "challenges their assessment" they must be able to describe the steps they have taken. No attempt was made by SW to work with Mr M to determine the steps he was taking to ensure his wife did lack capacity, which could have been addressed had a best interest checklist been used, as detailed in the authority's procedures.

- Social workers must be trained to apply the MCA Code of Practice.

- **Home visits during a crisis:**

Throughout the relationship between the SW and Mr and Mrs M, there are only two recorded home visits: at the point of assessment on 14 May 2013, and 7 February 2014. Although there are numerous telephone contacts initiated by both SW and Mr M, this is not a reasonable substitute to home visits during a crisis situation. During the key events on 30 July 2014 and reported concerns by the social worker, it would have been appropriate for a home visit to have been conducted.

- Social Workers should pursue face-to-face contact with a service user during a crisis.

### **(C) Conclusions**

In this case, it seems that the social worker looked to try and support Mr and Mrs M at least as much as Mr M was willing to allow. Mr M appeared able to arrange services and willingly pursued this responsibility. The social worker looked to refer to various other agencies to seek wider support for both Mr and Mrs M, but on many occasions Mr M did not pursue this support. Many opportunities were missed to address this with Mr M, or determine whether the agencies had followed up the referral. The reasons for this remain unclear. However, the issue of being a self-funder was ever-prevalent in many of the communications between the social worker and Mr M. It is possible that this not only set the context for their communication and relationship, but also influenced the decision-making of the social worker and line management regarding the terms of the authority's interaction and engagement with both Mrs M and Mr M.

These terms of engagement heavily influenced decision-making at many of the key events, and in particular the key episode on 30 July 2014.

Engagement with Mr and Mrs M was perhaps biased because of this agenda, and possibly got in the way of the social worker needing to engage on a more therapeutic level. Interaction was always about what services were available and not about good social work disciplines. Could the social worker have done more when Mr M repeatedly turned down offers of support or assessments from the agencies involved? This in itself should have been a trigger to the social worker that Mr M was isolating himself from support networks and seemingly 'going it alone' to make all of the arrangements for his wife. There seems to have been an overreliance placed upon Mr M and his ability to make decisions in his wife's best interests. Perhaps more could have been done by the social worker to break this barrier down; telephone contacts are no substitute for face-to-face contact.

Tools available to support social work practice were not utilised, namely support plans, risk assessment and a 'best interest' checklist. Social work engagement was on a superficial level, regarding the types of services that could be available from care providers rather than providing emotional support and risk management.

The Panel observed that It would be helpful if ASC could **review whether cover arrangements are effective enough** during social worker's leave or 'out of hours' service, and improve the information offered to service users about continuity of care during these times.

## **2.2 Cumbria CCG - Brampton Medical Practice**

The report was undertaken by Dr CD, GP Safeguarding for Carlisle Locality, Cumbria CCG.

The GP's Practice, Brampton Medical Practice, covers Brampton itself and the surrounding large rural area. There are 11 GPs. The practice has a slightly larger than average number of elderly patients over the age of 75 years, and there are currently 121 patients on their dementia register.

The practice has adopted the Safeguarding Adults Policy drawn up by the Cumbria Safeguarding lead in 2013. This is stored on the practice intranet and staff know where to find it. There are two GP Safeguarding leads. Learning events are held twice a year.

There is a trained practice nurse to improve the care of dementia patients. She visits patients with dementia in their own homes for an annual review. This includes an assessment of the patient's mental and physical health. There is also an open door policy for patients who need help between visits which is a link between patients and other dementia services.

#### **(A) Summary of Involvement**

Both Mr and Mrs M were patients of the practice, albeit registered with two separate GPs. They are both described by the practice as highly educated, Mrs M as "reserved, intelligent and smiley and anxious to please." She liked to make her own mind up.

Mr M made it clear on several occasions that he did not want strangers involved in his wife's care.

Neither liked visiting the practice, and rarely did so until Mrs M's memory began to fail in March 2012. She had never been kept on medication, and when she became ill she declined medication either for her dementia or for her underactive thyroid.

It is noted however that the Community Support Worker spoke to Mr M on 15 October 2012; Mr M stated that he had no intention of giving Mrs M the medication (Donepezil) because he did not think it would be of any benefit to her.

The couple had two sons: one they did not have any contact with and was not disclosed to professionals, and one who lived in New Jersey, USA, but they were described as "not particularly close." However, his son did make a call in March 2012 to discuss his mother's health. He confirmed he did not think his mother would comply with medications. He had also called the surgery to advise them that his father had a history of depression. Indeed, the first occasion Mr M was diagnosed with a depressive disorder was in 1975. He attended the surgery with insomnia in 2002; in 2007 he attended once again suffering from a depressive disorder; and again in 2009 he complained of insomnia.

A CT scan of Mrs M's brain confirmed general atrophy, and her brain function had declined - more obviously in July 2014 when Mr M also became unwell.

Nothing unusual was noted in the couple's relationship. There were no signs that Mrs M was unhappy or unsettled. Mr M was always caring and behaved appropriately. The Consultant Psychiatrist had not noted Mr M appearing depressed.

There were long gaps between consultations. Many contacts were third party contacts. There were telephone contacts by her son, the social worker and Mr M. Calls were returned.

The practice nurse did make a home visit and was made to feel welcome on 22 February 2013.

Dr AF urged Mr M to contact Adult Social Care urgently about his wife when he himself became unwell on 17 July 2014. On 31 July 2014, Dr JR strongly encouraged Mr M to pursue a residential placement for his wife. Dr JR also spoke to the social worker about this on 4 August 2014.

On 31 July 2014 a CPN called Mr M intending to undertake an assessment. He seemed angry and stressed. He seemed angry at "the services." He informed her that he had a permanent place for his wife in JK House.

Once the surgery was aware that Adult Social Care were involved with the family, their expectation was that the social worker was the most appropriate person to advise on the most appropriate care for Mrs M. Indeed, this appears to be the impression that the practice nurse was given by Mr M when she spoke to him by telephone on 18 July 2014.

Dr JR was concerned that JK House was not the best place for Mrs M because of her dementia and history of wandering. Dr JR spoke to Mr M on 22 August 2014 questioning his choice of JK House, as she had previously suggested another home as they had a purpose-built unit there for dementia patients. Dr JR also spoke to Mrs XY, the manager at JK House, about this when visiting another patient. She recalls informing Mrs XY that A was fit and prone to wandering. The reported response was that, due to this, she (Mrs XY) was arranging for A to be admitted after 1 September, when she would have returned from her holiday, so that she could personally supervise her settling in.

**(B) Areas for Improvement**

- Not all the record-keeping, albeit adequate, was as detailed as it could have been.
- Not all phone calls to Mr M were documented.

- The informal conversation with the JK House manager was unfortunately not documented. (This took place when Dr JR was visiting another resident).
- No records were made of when some of the earlier letters received by the practice were viewed or actioned. (This has now changed).
- Not all relevant information was documented on both Mr and Mrs M's records.

There were some missed opportunities. For example:

- i) Mr M's son spoke to Dr JR in March 2012, when he commented upon his father's history of depression; someone with such a history might find it more difficult to cope with looking after a loved one with dementia.
- ii) When Mrs M was found after wandering on 13 April 2013, the GP was informed by letter by A&E, Cumberland Infirmary. This was not considered unusual for someone with dementia and no action was taken. The police had been involved and therefore the GP felt that appropriate action would have been taken. However, there was no mention of what action, if any, had been taken, or if ASC had been informed.

The IMR highlights that the practice receives a high level of correspondence, and it can be difficult to “look behind what is on the page” when dealing with this high level of correspondence.

There was an administration error on 12 April 2014 in which an appointment was made mistakenly when the practice was closed. This led to a complaint against the practice by Mr M on his wife's behalf. Mr M was clearly very upset. He became “rude and unpleasant” and shouted at the practice manager for about 15 minutes. Dr JR was not aware of this until she wrote the chronology for the IMR. The CPN had written in Mr M's records at that time that Mr M was “not under strain”; yet his demeanour towards the manager suggested he was clearly under more strain than he admitted to the CPN.

### **(C) Agency Recommendations**

It was an error to take no action when receiving information about Mrs M's admission to A&E after being rescued from wandering and subsequently getting lost. This was considered in the IMR to be a mistake, and Dr JR herself feels that with additional safeguarding experience and training, she would react differently to this letter. She would consider:

- Contacting the family.
- Asking for further information from A&E.
- Informing the Elderly Psychiatric Team.
- Informing Adult Social Care.

The Panel agrees with this analysis.

Whilst the Panel has some sympathy with the level of correspondence received at a busy practice, the GP needs to build in 'thinking time' in dealing with correspondence, and not just give cursory treatment to letters which could contain vital information about a vulnerable patient's health and wellbeing.

It is important that all relevant details that may provide insight or impinge on the wellbeing of patients are brought to the attention of their GP.

Although it is fairly predictable that a mental health assessment of Mr M would have been refused and it is most unlikely he would readily cooperate, it is noted that this was not suggested at any stage by the CPN or his GP.

#### **(D) Conclusions**

It is not possible to know what motivated Mr M to kill his wife, and whether her death could have been prevented. No formal or informal assessment of Mr M's state of mental health was ever undertaken. Knowing what is known about Mr M's personality, it would have been difficult to engage him in conversation about his mental health.

The couple's reluctance to accept help and advice was an issue that the surgery felt could not be changed.

An analysis was made in considering whether there were any elements of domestic abuse, and the conclusion was that, although there were elements of controlling behaviour, there was nothing in his history to suggest that the practice should have had any concerns about domestic abuse.

The practice did have evidence that Mr M was under strain and may have been depressed. There was some evidence that he was drinking more than he should.

He was very worried about his wife being left on her own now that he was unwell himself. He was, however, a private man and lived "on his own terms".

The care home he chose himself was unsuitable for Mrs M.

## **(E) Lessons to be Learnt**

The practice identified the need:

- To pay more attention to the cared-for person's health needs.
- To consider the needs of carers more carefully and document vulnerable carers.
- For care to be tailored to individual families.
- To systematically review patients with dementia.
- To review carers of dementia patients, considering both mental and physical health.
- To recognise wandering as a significant risk. Do not assume that because police and the social services are involved the problem has been solved.
- For better communication with Adult Social Care. The practice was not aware that Mrs M was known to ASC until Mr M became unwell.
- For careful record-keeping in both sets of notes where appropriate.
- To record all telephone calls.

It has to be noted that the practice was not kept fully informed of significant and important events by other agencies, and examples were given of this.

It is recognised that difficulty with the flow of information is a common thread in safeguarding cases which end in tragedy.

## **(F) Recommendations**

1. To ensure the safeguarding training for GPs includes the implications for dementia patients.
2. To use this DHR as a means of raising awareness amongst GPs about the needs of dementia patients and their carers.
3. To encourage other practices to improve their dementia care. Target payments to be received by GP practices from April 2015 include a payment for annual face-to-face reviews for patients with dementia and their carers. This is a good opportunity for practices to reconsider the care they provide for dementia patients.



4. GP practices should be encouraged to flag the records of patients who are carers for vulnerable adults, particularly those with dementia. This will allow clinicians to consider the effect of their caring role on the carer's physical and mental health.

The Panel notes that there are many positives about this practice:

- The home visits were well documented.
- The practice is well ahead in terms of provision for the elderly and in particular patients with dementia.
- The nurses are readily available to offer help and advice to patients and their carers.
- Attempts were made to engage Mr M in discussions about his wife's needs and appropriate care homes for her.
- Most records, albeit brief and to the point, were accurate and adequate.

Brampton medical practice is commended for its insightful approach to this review.

### **2.3 JK House Care Home**

This is described in the IMR as a “small organisation.” The IMR author was Mr XY, who is a director of the care home. Mrs XY, his wife, is the registered manager.

Mr XY states that he consulted the staff who had contact with Mrs M for the purposes of the IMR.

#### **(A) Summary of Involvement**

A chronology was provided which was very sparse and which made no reference to any contact with Mr or Mrs M prior to 1 September 2014.

Mr M had made arrangements to bring in Mrs M at 10am on 1 September 2014, but Mrs XY called him by telephone to say that this was not “as planned” as an assessment had not been carried out. Clearly there had been some prior contact.

Observations on the chronology provided and the IMR made by Panel members were as follows:

- There was no mention of any earlier conversation with the GP.

- It was agreed that Mrs M could be admitted that afternoon for a “trial stay.” However, there is evidence that Mr M was looking for a permanent home.
- No mention was made of any documents completed, or information taken from Mr M.
- There was no record of the times that Mrs. M was found to be missing and when she was last seen, of how long she was missing, or of who recovered her or how she appeared when returned to the home.
- There was no indication as to which of the staff were involved in her care, or which cares were afforded to her.
- There were no details of the conversation with Mr M by telephone, other than that it was agreed that she should be returned “for her own safety”.
- There was no mention of anyone from either ASC, GP or CPFT being alerted.
- The time of the later decision to return Mrs M was not recorded, and neither was which of the staff returned her or what time she arrived at her own home.
- Within the IMR it was stated that there was an admission procedure in place. However, no formal pre-admission assessment was undertaken, although “several conversations” between Mrs XY and Mr XY had taken place where “areas of assessment had been discussed”, and that Mr M had “not disclosed” some relevant information. No mention of any documented note of these conversations was made.

The admission procedure refers to an assessment taking place within 48 hours of admission if a pre-admission assessment is not possible. However, the evidence is that the assessment undertaken was inadequate.

Unfortunately, the relevant information taken from Mr M and the nature of the policies and procedures were not shared or offered to be shared with the DHR Panel.

However, after obtaining the agreement of Mr and Mrs XY, the police did agree to disclose copies of the documents they took from JK House immediately after Mrs M’s death.

These appear to be documents completed by Mrs XY, although the date of completion is not recorded. The admission therein is described as “planned respite”.

The documents reveal the following:

- There is a diary entry of 1 September 2014, recorded only as “pm.” This records Mr M leaving the care home and Mrs M's demeanour as “tearful”. She was reassured by staff that she was staying with them whilst her husband had hospital treatment. There are no further entries.
- A letter from Mr M, including important information regarding Mrs M's health etc, was included within the documents provided by the police, together with a separate document containing contact details. These appear to be handwritten by Mr M. Some reference to Mrs M's refusals to attend various health appointments was made, but there was no mention of 'wandering'.

Due to the lack of information provided to the Panel, a meeting was agreed to take place between a member of the DHR Panel and Mr and Mrs XY on 28 April 2015.

The following is a summary of the information given at that meeting:

It was confirmed that Mr M visited the home in spring 2014. He had explained the reasons for seeking a care home for his wife. On 27 June 2014, Mrs M was placed on the waiting list. It was explained that an assessment would need to be done in their own home prior to the admission. Mr M rang on a few occasions over the summer anxious to secure a room. A vacancy arose on the 20 August 2014, and Mr M was advised. Mrs XY explained by telephone that the room needed to be prepared and that she was going on holiday. She would ring on her return to arrange the assessment. Whilst she was away, Mr M brought in some clothes and they were placed in the vacant room. He was described as insistent and a little odd.

Upon Mrs XY's return, she found a letter addressed to her stating that Mr M was bringing Mrs M in that morning. This was not what she thought had been arranged, as she had intended to carry out an assessment. He wanted to come in that day because he had hospital appointments and had someone to accompany them. He asked if Mrs M could be brought in that day on a trial basis. This was accepted.

Mrs XY stated that she had informed Mr M that the home was not a secure unit, but he responded by stating that if his wife had company she would be content and he did not feel she would try to leave.

Mrs M was “settled in”, but after Mrs XY had left at 5pm she received a call from a member of her staff that Mrs M was missing. She was found by members of staff very quickly. Mrs XY commented that it was as if Mrs M had waited until carers were not looking to make her exit.

Mrs XY said she was not aware at that time that Mrs M had wandered off before and had had to be rescued by Mountain Rescue. She thought that the GP had not known either.

She and others assessed the situation and decided that Mrs M would not be safe at JK as it was not secure. She called Mr M and explained the situation to him and that he would have to find a secure care home, but he said that his social worker worked only part-time and he would be glad of any help from herself. He said he was tired and could not collect her. Mrs XY offered to bring her home. Mrs M was bathed, got ready for bed in her nightdress and dressing gown and taken home. Mr M joked, when they eventually found his home, “I can’t get rid of you.” He complained about the lack of services, that his social worker was nice but only worked two days a week. He had called other homes, but only one was secure and he had to call back the next day.

She heard what had happened when the police came the following day to take statements. The documents and records held were given to the police.

She recalled a conversation with Mrs M's GP before admission, when she was told that Mrs M “was quite mobile”. She understood that the GP had recommended JK House to Mr M.

Mrs XY stated that she was a qualified nurse and the registered manager, having completed all necessary training. Contact with Adult Social Care is minimal: there is no advice given and no support offered. The home is a member of the Independent Care Alliance Sector, and this is a source of access to training for all staff.

There is some contact with CHESS at the CPFT, who visit regularly to provide a clinic and give advice to herself and carers about handling and caring for those with memory loss and dementia.

A Care Quality Commission (CQC) inspection took place in 2013. The last one took place on the 4 August 2015. Mr XY stated that they have informed the CQC of this incident. A copy of the report was provided to the Chair on her visit on the 15 September 2015. The overall score was ‘Good’.

Mrs XY was adamant that there was nothing that made them think Mr M was desperate, and had genuinely thought that returning Mrs M home was the safest option. They have placed alarms on the external doors and a camera on the back door, but they do not offer their service as a secure unit.

### **(B) Areas for Improvement**

The areas identified by Mr XY of effective practice and lessons learnt were:

- Any failed admission will be discussed with either a named or duty social worker before a person is discharged.
- The JK Care Home Users Guide will be updated to clearly state that the home is not a secure unit. This has now been undertaken and a copy of the User's Guide supplied to the Panel.
- It was identified that security needed improvement. Alarms have been fitted to doors to alert members of staff if doors are opened. As discussed with the Panel member, it is understood that a CCTV camera has been fitted.
- New procedures and protocols are required which must be accessible by all staff, who should be trained in their application. These need to be updated regularly. It is understood that these have since been purchased over the internet and regular 'updates' are provided as part of the package.

### **(C) Conclusions**

As there were no clear conclusions provided by JK House Care Home, the Panel has itself identified in these conclusions a number of concerns that could or should have been considered in the IMR by JK House.

JK House did not appear to analyse what may have gone wrong, or how inadequacies could be addressed, nor did they draw any conclusions. The Panel have had significant concerns about the practices and procedures of JK House Care Home and the modern management of the home generally. Some of these concerns are now being addressed.

The Local Authority no longer inspects homes at all, although in previous years it inspected them on a biennial basis.

Other than as appears on a handwritten form, a comprehensive pre-admission assessment of Mrs M was not undertaken by staff at JK House Care Home. There are

no computerised records kept at the home. It was clarified with Mrs XY that all records are kept manually in individual files in a secure office.

On a more positive note, the 'missing person procedure' was followed by care staff and Mrs M was quickly found.

Other concerns highlighted by the Panel are as follows:

- JK House Care Home was independent of the Local Authority and had little or no connection with, nor engaged on a regular basis with Adult Services.
- In respect of Mrs M, JK House undertook only a cursory and inadequate pre-admission assessment system, so they were not able to determine whether they had the ability to meet Mrs M's individual needs.
- The management of JK House did not have a risk assessment policy before a decision, unilateral or otherwise, to discharge a resident.
- In this instance, the management of JK House did not keep adequate records of Mrs M's admission, and could not evidence adequate and current training for management and staff.
- At the time of Mrs M's death, JK House did not have adequate security in place to safeguard residents, whether or not they wished to leave the home by themselves.
- There was no detailed note recorded by the manager of the conversation with Mrs M's GP regarding important information.

#### **(D) Lessons Learnt and Recommendations**

As JK House did not highlight any lessons learnt, other than practical security improvements, the Panel felt that although the CQC inspected the home in 2013, it was clear that there were several issues that needed addressing quite urgently:

1. As the documentation evidencing the processes for admission and care given to Mrs M were of very poor quality, it is important that the files of all their residents are checked to ensure they contain sufficient information and are kept up-to-date.
2. The policies and procedures need inspecting for currency and, if they do not exist, they need to be drafted and followed. It is understood that standard

policies and procedures have recently been accessed off the internet. All staff should be conversant with these and if not undertaken already, appropriate training arranged as a matter of urgency.

3. A full pre-admission assessment for new residents or, for existing residents, a detailed post-admission assessment together with a risk assessment needs to be undertaken in respect of each resident by a fully trained and senior member of staff, with support and assistance to be offered where required by other relevant agencies.
4. Close working relationships need to be developed between care homes, Adult Social Care and health workers, including GPs and other relevant professionals. Shortcomings in sharing information between all relevant agencies is a common and recognised threat to safeguarding vulnerable people. Permissions should be sought to enable staff to speak to, and share information with the resident's Social Worker, GP and other health workers.
5. Careful and detailed records need to be kept of the key conversations with relatives and residents, of residents' health, all 'cares' and activities given to residents, and staff training and development.
6. The Local Authority should consider the reinstatement of at least biennial face-to-face meetings between management of local care homes and an identified and suitably qualified professional member of Adult Services, who should be permitted to check that procedures are in place and to speak to staff and residents.
7. Documented policies and procedures should be put in place to ensure that no discharge takes place without:
  - a) fully considering the short and longer term care provisions for those residents to be discharged; and
  - b) notifying other agencies, including GPs and ASC, where appropriate.

The positives identified are that management of JK House recognises that the home is not suitable for residents who require a secure placement, and that security has already been improved as detailed above. It also recognises that there should be contact details for JK House to liaise with Adult Services in an emergency.

On 28 July 2015, the Coroners Regulation 28 Report helpfully recommended action as follows:

1. "The Local Authority should provide general guidance to residential homes when considering discharging a resident. They should seek advice from Social Services so that Adult Social Care can be satisfied that there are appropriate arrangements in place for the safety and wellbeing of the resident after discharge, and the appropriate time for that discharge. This would apply if the Social Services had been responsible for placing the resident within the residential home, and also if they had been placed privately without any Social Services direct involvement."
2. "JK House should provide to Cumbria Social Services confirmation that your procedures have been changed so that you follow the guidance set out above. You should send me a copy of your confirmation that you send to the Social Services."

It is pleasing to note that as a result of the Regulation 28 Report, the County Manager, Cumbria ASC circulated a letter to all care homes dated 4th August 2015 containing guidance on procedures to follow in the event of discharge of a resident in an emergency or crisis situation.

It is important that this guidance is followed in every case, and that each Care home ensures that it is incorporated into their own procedures, and all staff are fully aware of what is expected in the event of an emergency discharge.

## **2.4 Cumbria Partnership Foundation Trust**

### **(A) Summary of Involvement**

The timeline of involvement was from 23 February 2012 until 2 September 2014.

There were four recorded contacts with the couple, two face-to-face and two via telephone. The first was on 23 February 2012 when Mrs M was referred for a Memory Assessment. The couple were noted to be reluctant as they did not want home visits, but they agreed to be seen at the surgery. An appointment was given within 15 working days. On 5 April 2012, a home visit was conducted. An initial assessment was undertaken which includes the identification of risk to self and others. No risk was identified, except concerning Mrs M's continuing to drive. A health and wellbeing



check was done. A decline was noted in Mrs M's memory, but at that time she was still functioning at a high level.

A 'carer strain' questionnaire was undertaken with Mr M. None was evident at that time. Both Mr and Mrs M were seen together and individually. Both were described as having mental capacity; however, the Panel noted that this evaluation needed to be 'situation specific', as Mrs M was not considered to have the capacity to drive at that stage.

On 7 June 2012, Mr and Mrs M declined further services or treatment. They were seen together. Mrs M was described as having capacity at this stage and was in the early stages of Alzheimer's. They appeared happier to engage with social care than with mental health services.

On 31 July 2014, the allocated social worker re-referred Mr and Mrs M to the memory service following an incident of Mrs M wandering and missing from home. She had been found and returned home.

The Panel notes that Mrs M had been reported missing prior to this date, but had not been referred to the service. A telephone call was made to Mr M by the CPN; however, Mr M declined a visit, declined help but said he would contact them again when he came out of hospital.

It was not clear from the records what discussion took place regarding plans for Mrs M whilst her husband was in hospital. This was recognised as a potential omission.

Mr M had not made further contact with CPFT by 28 August 2014, and the CPN therefore made contact with him by phone. He informed the CPN that he had found a home for Mrs M at JK House, that she was moving there and that no input was required. Further support was offered to Mrs M after she was admitted into the care home, but this was declined. Mrs M was discharged from the service.

The records do not indicate: how Mrs M was functioning and if there had been a deterioration in her mental capacity and wellbeing; Mr M's reasoning regarding the need for a care home; or any information about Mrs M's feelings and wishes concerning her husband's decision.

Mr M was spoken to by a CPN after Mrs M's death and when he was released on bail. He described his wife's condition as "stropy Alzheimer's". He was tired and in pain at the time she went into JK House. The point at which Mrs M was returned from the

care home and her clothes left in the conservatory was the “tipping point” for him. He appeared to be a “broken man”, and was described as a proud man, who expressed little faith in services.

### **(B) Areas for Improvement**

On 31 July 2014, it is unclear what arrangements had been agreed with regards to Mr M’s stay in hospital.

On 31 July 2014, there was an opportunity to complete a further carer questionnaire with Mr M, and this could have helped to identify the level of strain and thereby instigate referral for additional support and any risk assessments required.

CPFT contacts on 31 July 2014 and 28 August 2014 do not provide sufficient information with regards to Mrs M’s capacity and functioning, and her wishes and feelings were not ascertained.

### **(C) Agency Recommendations**

A mental capacity advocate could have been considered, especially in relation to a person’s change of accommodation, to obtain the wishes and feelings of the person lacking capacity. This is in line with Mental Capacity Act Policy - CPFT 2011 (the Panel note that this may not have met the criteria in the circumstances of this case).

### **(D) Conclusions**

This was generally thought to be a thorough piece of work and appreciated by members of the Panel. However, there are a few areas that require further reflection:

1. The description of both Mr and Mrs M as having mental capacity was too vague. Capacity is ‘situation specific’ and should specify the areas in which the patient does not have capacity. Clarification of this would be helpful in the future.
2. The refusal by Mr and Mrs M to accept treatment/services was a potential training issue, and more training should be considered around the subject of ‘difficult to engage’ patients and carers.
3. Referral to a GP should always be made if patients and/or carers do not engage. Timely communication with a GP is essential. It was questioned whether email could be used, but the issue of confidentiality was the perceived

problem. However, this can be overcome with passwords or other means used by many organisations, without substantial difficulty.

4. An Independent Mental Capacity Advocate could have been considered. The opinion of the Panel was that this was not possible because Mrs M did not meet the criteria, having a caring close relative as next friend.
5. The Panel found the CPFT's use and cognisance of statistics helpful.

## **2.5 Cumbria Constabulary**

This was completed by Detective Inspector RV. Unfortunately, DI RV is a member of this Panel and this should have been carried out by a different Senior Officer.

However, he has had no involvement in the line management of the case, and it was felt by the Panel that his report should be accepted.

### **(A) Summary of Involvement**

The involvement of the police was limited to two incidents of 'Missing from Home' on 24 April 2013 and 26-27 June 2014. On both occasions the Vulnerable Adult Abuse and Safeguarding Vulnerable Adults Procedures were followed.

There is a statement dated 19 September 2014 which indicates that there was a visit by the police to Mr M at home on the 27 June by a Police Sergeant. At this time, Mr M reminisced about the time his wife was well and about her successful career as a teacher. He talked about how saddened he was by his wife's illness and how it had "taken her away". He felt overwhelmed about the cruelty of the disease and became tearful when she made him a cup of tea, saying it was a long time since anyone had done that for him. He indicated that she did not want to go into a care home; he was tearful and distressed and said she was becoming harder to deal with. Advice was given to him and he was encouraged to look for some help and speak to his GP. When his wife returned, he was immediately attentive and checked her for injuries.

A Vulnerable Adult report was submitted the following day on both occasions and a referral made to Adult Social Care.

Both cases were reviewed and no further action was taken.

### **(B) Areas for Improvement**

None could be identified.

### **(C) Agency Recommendations**

The police felt that they could make no recommendations for improvement.

### **(D) Conclusions**

Cumbria Constabulary could not identify any areas of improvement. The IMR established that they had followed and adhered to all practices and procedures and no lessons could be learnt from this review.

The Panel's overall view was that the police followed procedures and that there was probably little more that they could have done at that time. It is very clear that Mr M and his wife were very vulnerable; it may have been best practice to have taken details of the M's GPs' practice and informed the practice directly, rather than leaving this to ASC.

The Panel agreed that due to the number of Vulnerable Adult referrals to ASC, this procedure may require reviewing in order to highlight those who may require specific services as a matter of urgency.

The panel commended the police for the sensitive way in which the situation was handled by them on the two incidents in which they were involved.

## **2.6 Alzheimer's Society**

### **(A) Summary of Involvement**

The Alzheimer's Society's involvement was limited to a referral from a social worker, which was taken by its administrator and in turn passed on to the Dementia Support Worker. Mr M was contacted but declined its services. The social worker was then contacted to advise her of the outcome.

The referral and the outcome were not logged on to the database. This should have been done in every case.

### **(B) Areas for Improvement**

The logging of information in every case, even if services are declined.

### **(C) Agency Recommendations**

As a result of this inquiry, the Governance Manager has reviewed its procedures against its internal guidance. All staff have been reminded of the relevant policies and procedures, and asked to revisit the mandatory data protection and record-management training to refresh their knowledge.

The Alzheimer's Society will ensure that all staff have attended the Local Authority's safeguarding training, if they have not already done so by 31 August 2015.

#### **(D) Conclusions**

This Agency is considering the possibility of a partial data-sharing protocol with the Local Authority to enable them to share information regarding a potential client and their circumstances automatically, and whether any existing safeguarding alerts could be flagged up as part of the process.

It is recognised by the Panel that there are some complex data protection and privacy issues that will need to be discussed if this is to be achieved.

It was pointed out by the ASC representative on the Panel that the Local Authority no longer employs an Adults Safeguarding Training Officer and no longer provides other agencies with adult safeguarding basic awareness training.

This training is an E learning Package for local authority staff. Other agencies are expected to provide their staff with appropriate training. This issue is addressed in the Panel's recommendations.

### **2.7 Views and Opinions of Friends and Family**

The Chair made contact with the family's solicitor, who was able to pass on information regarding the review to the known family members. Information leaflets explaining the purpose of the review and the procedure were also provided prior to direct contact being made.

Mr and Mrs M had two sons, but only one, Mr B M Jnr, was contactable. He lived in New York and offered his view by telephone to the Chair.

In addition, Mr S T-W, the brother of Mrs M, contributed to the review.

Finally, Mr and Mrs K, the M's immediate neighbours, were spoken to and they also agreed to contribute to the review. The following are shortened versions of these discussions; as Mr K concurred with his wife, only one statement, from Mrs K, has been included here.

### **Mr B M Jnr, 5 March 2015**

After confirming the confidentiality of the information, and that he had received the explanatory leaflet, Mr M agreed to speak to the Chair about his parents.

He confirmed that he and his wife and children visited his parents on occasion, and that the last time he saw them was in 2014. He spoke to his father once every 2 weeks or thereabouts.

He confirmed that his father was a very private person, who neither sought nor wanted any advice; his mother had been more gregarious, and he very much “ran the show”.

He saw his mother during her deterioration; her memory was clearly poor - she could not always remember names or where she was - but she was in good spirits. She appeared to have some insight into her difficulties.

His parents were very fond of each other. However, his father could be volatile with others and take “umbridge” at something. He might not contact his son for several weeks. He was very much in control, and very touchy about personal matters. His father shared very little with him, but with the benefit of hindsight he was clearly not coping. He knew he was looking into placing his mother into a care home. When he asked if there was anything he and his wife could do to help his father’s response was always, “No.”

Mr M Jnr would have been willing to talk to professionals on a confidential basis to see if he could help. The situation was very shocking. His parents were middle class law-abiding academics. There was no domestic violence in their relationship. His father missed his mother after she was gone, and spoke about his memories of her when she was younger.

He was concerned about the way JK House had returned his mother to his father’s care apparently without informing anyone, or offering any alternative.

### **Mr S T-W, 5 March 2015**

Mr S T-W lives in Australia. He confirmed his agreement to discuss the circumstances of his sister’s death with the Chair by telephone. He had received the explanatory leaflet and understood the purpose of the review. He had not seen his sister or Mr M for over 5 years, but had kept in contact fairly frequently.

He had been asked to be an executor of the will of Mr M, along with other younger members of the family. He recalls his sister's memory fading over the last few years. Both his sister and Mr M were very private people. Mr M was not good at asking for help. They were happily married, although he described them as "isolationist".

Mr M was worried about his own health; he was vomiting, and it was thought at one time that he might have cancer. He became desperate to find a home for Mrs M. He had been thinking about JK House for months beforehand. He thought that the doctor had given him a leaflet about JK House. He was reluctant to place her in there, but had no choice.

Whilst in the care home, they cut her toenails and gave her a bath; this was surprising as she was very strong and could scale a 5-bar gate. They called Mr M to take her back at about 7pm, but he refused as he was exhausted. That night he tried about 5 alternative homes, but with no success.

When Mr T-W saw Mr M, he was still in the police station. Mr M said that he wasn't clear why they had brought Mrs M back, and that they dumped all her stuff in garbage bags in the porch. He said that he then sat down in his chair to think, and realised that there was no future for either of them, and that Mrs M couldn't go into a nursing home - that's when "he did it". He explained in detail how he had killed Mrs M. He missed her dreadfully, but he did talk about his plans for the future.

He believed that the social workers were "useless" young girls straight out of university. "They didn't know anything." He felt abandoned by his friends and felt that Mrs M's friends had also abandoned her.

He had been to see a secure care home, but the residents who needed it to be secure were all on the third floor and he didn't see this as appropriate for his wife. The advantage of JK House was that he could visit her easily and she could see her own friend, S, who lived in the village.

Mr T-W was angry with Mrs XY from JK House and told her so. His impression was that the regulation of the care home was not very good, that it was an emergency that needed coordination between all the relevant agencies. However, if she had insisted on going home, it may have been the case that they could not have legally kept her there.

## **Mrs NK**

This interview is recorded here in full.

"I live next door to where Mr and Mrs M lived. Me and my husband were their only close neighbours. The Ms were a close couple who enjoyed spending time together and going on long walks. They were not a sociable couple, having no real social life. Mrs M had a friend called S, who is a retired vicar living in Brampton (S conducted Mrs M's funeral service at Carlisle Crematorium). On occasion, we did have a cup of tea together. Once we were invited to the M's for drinks. We could tell then that something was not right with Mrs M - the dementia was starting to show. After that we would often see her in the garden just staring, not really doing anything, and she began to wander off frequently on long walks by herself. Mr M had trouble keeping her inside.

Mr M was very self-sufficient and when he came to ask us for help it must have taken a great effort. He was going to go in and have a hernia operation and Crossroads (a care company) were going to come and care for her in her home, but Mr P wanted us to keep an eye out because she would get out and wander off.

Mrs M worked for Age Concern in Penrith, but it became difficult as she forgot where she had parked her car on occasion, and then began to forget the way home.

We did think Mr M was a good carer, he did all the cooking, catering for a vegetarian diet (he grew wonderful vegetables).

They were professional people, well educated, he a philosopher and she a history teacher. His use of Crossroads was a one-off to help out when he had the operation. We have no idea if social services were involved at all but we can imagine that Mr M would not have wanted that.

We didn't really meet the family much, we saw the son BM Jnr and the daughter-in-law.

When Mrs M went missing, Mr M was terribly embarrassed about it, as well as worried, there were helicopters overhead. She had climbed out of a window, she was very fit and agile and could leap over gates. She felt he was imprisoning her when he tried to stop her going out.

We became worried about him around that time, as he lost two stone in weight through illness. He thought he had cancer but it was gallstones.



Regarding the time leading up to her going to JK House, Mr M was worried about what would happen to his wife as he needed the operation and would also need time to recuperate. I said to him "You can't go on like this." The GP recommended JK House and by chance they had a vacancy two days before he went to hospital. Mr M said that it was suitable for Mrs M as it was secure. He snapped the bed up as respite care and I said I was a bit cross as he really needed permanent care for Mrs M. Later it was agreed that it would be a permanent bed for Mrs M.

Unbeknown to us he went out and bought new clothes and new underwear and had sewn name tags in all her clothes so that she could be admitted to JK House. I only know because he asked for help with her favourite dressing gown as the button holes were frayed, and he asked if I could help mend it so that he could sew a name tag on and Mrs M could take it with her. He even sewed name tags on her tights.

It had got to the stage Mrs M wouldn't do a lot of things she needed to like get in the car to go for appointments: chiropodist and hairdresser. I agreed to go in the car with them to help with Mrs M and because she was more likely to get in the car with me there and be charming.

On the morning we knew what time she should be at the home. She was expected. It seemed clear that Mr M felt guilty and was reluctant but knew she had to go somewhere to be cared for. A member of staff said "Bring Mrs M in, the manageress will be with you shortly, we have a nice room ready for you Mrs M."

The manageress arrived after ten minutes and was not surprised to see us and Mr and Mrs M went to another room to talk to her. Mr M and I left after about half an hour or so. Her belongings were left there in a suitcase and another bag. When we left Mrs M was polite, as she was with strangers. Mr M was distressed but relieved that she was somewhere safe. He also said that he was utterly exhausted, once home he declined a cup of tea and said he was going to have a drink and then go to bed. He looked terrible.

The first we knew she had been returned by the home was the next morning when we saw police cars and sirens outside and a policeman informed us that Mrs M was dead, there had been an incident and we said "but she's not here she is in a home in Brampton."

We saw quite a bit after he was bailed. He came back to the house frequently although he was living in Penrith. He came over to our house, he was angry, he told us about the night Mrs M was returned from the home. He said the home had rang him and said that she had got out and they couldn't keep her secure and that she was "not for us" and asked could he come and collect her. Mr M said that he told the manageress from the home "No I can't I am exhausted (also he had had a drink) and can you keep her until morning?" Instead, somebody from the home brought Mrs M back to their house that evening.

He didn't go into details of how he had killed her. We understand from others he had given her crushed-up sleeping tablets and then tried and failed to kill himself.

He told us that he had tried "all through the night" to get her another place in a home.

After he was out on bail he seemed better, he even started eating meat as he had done so in prison.

He was living in a flat in Penrith and seemed to be settling and planning for the future. He was going out and had found a place that sold real ale in Penrith and had visited there. He even said to us "you must come over to my flat for dinner sometime." We don't think it was helpful that he kept coming back to the house. It was being cleared of its contents (some of it going to the saleroom) and each time he came more had gone until at last it was completely empty.

He resented the involvement of CPN (Community Psychiatric Nurse) and of social workers and said he felt smothered by them and that they "always need everything in triplicate", although he had appreciated help in the early stages of Mrs M's dementia.

When he came back and saw the house empty he looked very sad that day and it was not long after that he was found dead.

Generally in describing Mr M, he was a logical person, he had a good, dry sense of humour. Was he controlling of Mrs M? - no I wouldn't say so. He tried to do everything he could for her but it was all a struggle.

The morning he died he must have come to the house early - we didn't see him as there is a separate entrance - and he let the chickens out (we were looking after them) before we were up.

We wonder whether there was a mental health assessment of Mrs M when they were finding her difficult at JK House, and if not why not?”

## **Section Three: Recommendations**

### **3.1 DHR Overview**

Over the course of this review, it became increasingly clear upon consideration of the IMRs and in considering all of the evidence, including the statements of family and neighbours, that there has been some lack of coordination and concerted action by the various agencies trying to help the family achieve the correct and desirable outcomes, and which ultimately may have contributed to Mr M feeling overwhelmed and desperate. The tipping point was the unexpected return of his wife at a point when he was tired, in pain and awaiting surgery. He clearly considered carefully what he was going to do and how he was going to kill his wife to whom, according to the vast majority of the evidence, he was devoted, caring and attentive.

The lack of proper assessment procedures in place at JK House Care Home, lack of referral to social workers or for medical advice before discharging Mrs M, and lack of adult service response to a crisis situation, were the main but not the only factors which played some part in the situation arising. Mr and Mrs M were described as very independent-minded and intelligent individuals who did not take kindly to an overabundance of attention from professionals.

The fact that the JK House placement was self-funding appears to have played a large part in the lack of direct intervention by the Agencies in the choice of care home.

However, Mr M's independent and sometimes seemingly stubborn character also played a part in how the various agencies worked with him and what advice/interventions would have been appropriate in the lives of this couple. In the opinion of the Panel, this in itself should have served as a warning to professionals of possible risk. Mr and Mrs XY were adamant that they were not alerted to the risk that Mrs M might leave the home unattended.

By the time of her death, Mr M was making all the decisions on his wife's behalf and was the only point of contact with professionals.

Little effort was made by the various agencies to see Mrs M personally and within her own home. It was assumed that Mr M knew what was best for his wife and himself, and that should be left well alone. His demeanour could be abrupt and at times difficult, but this should not have been an insurmountable issue for professionals used to dealing with elderly adults with serious health issues. The fact that Mr M had

suffered from depression in the past was not adequately shared by his GP, and the degree of his anxiety at the point of crisis was not taken sufficiently seriously. The tipping point for Mr M appears to have been the return of his wife by JK House Care Home management; however, this was after a considerable build-up of tension, and the Panel's view is that a broader and contextual picture needs to be taken.

### **3.2 Risk Factors Affecting the Couple**

**Was it, or could it have been known or suspected, that Mr M posed a serious risk of harm to his wife?** The answer is probably not. There was no evidence that domestic violence was a feature in the couple's relationship. There is every indication that Mr M loved his wife and was very caring and attentive towards her. However, he could, at times, be irritable and short-tempered with professionals who were trying to help. However, there were a number of risk factors identified by the Panel affecting this couple:

1. They lived in isolation in a rural area, and away from support networks of family and friends.
2. Mrs M was suffering from a diagnosis of Alzheimer's disease.
3. The carer was ill and in pain, with the prospect that this would not be alleviated by an operation if appropriate care for his wife could not be found.
4. Notwithstanding his strengths, it is clear that Mr M was experiencing high anxiety about what would become of his wife should he become hospitalised or die first.
5. Mr M demonstrated 'self-sufficiency', and at times he was difficult to engage and oppositional in accepting help and support. He was not welcoming of follow-up by professionals.
6. Mrs M was reluctant to take prescribed medication.
7. Mr M's depression was not picked up adequately by mental health services and the GP.
8. Mrs M had a propensity to wander, and she was active and agile - this was likely to be a source of extra strain on her husband.

### **3.3 Examination of Why and How Events Occurred**

Was the homicide preventable? Were the risks adequately managed?

There were clearly a number of inadequacies in managing the risks identified above as set out in the IMRs produced by the Agencies. In an ideal world and with the benefit of hindsight, these would not have occurred.

To highlight a number of these:

- ASC did not appear to have arrangements for covering part time staff caseloads adequately.
- There was a lack of proactive social work and appropriate support from line management.
- There was a lack of thorough risk assessments by agencies of either Mr M or Mrs M.
- There was an overreliance on communication with Mr M, and little or no direct contact with Mrs M.
- There was a high level of correspondence into the busy GP surgery - this contributed to not all relevant and important correspondence, and documentation of conversations and phone calls, being treated with sufficient care and attention.
- Inadequate assessments were undertaken by the staff at JK House.
- Although details of out of hours contacts were given to Mr M in the case of an emergency, for unknown reasons he did not utilise this service, and possible reasons need to be explored and addressed by ASC.
- There was no recognition that Mr M was struggling to the extent that he was and that he was desperate for help.
- There was no contingency plan in place or even discussed should the residential placement fail.
- The Panel is not satisfied that there was sufficient inter-agency communication and information sharing. What communication there was appears to have been cursory and reactive rather than proactive.

- A great deal of reliance was placed upon the fact that the Ms were self-funders. The interaction between ASC, the GP and JK House was inadequate, particularly in relation to the suitability of the care home to meet Mrs M's individual needs.
- There was insufficient intra-practice cross-referencing of relevant information on the GP records of Mr and Mrs M.

It is the Panel's view that it is impossible to predict whether the homicide could have been prevented if none of the inadequacies highlighted (and, in the main, recognised by the participating agencies) existed. Mr M stated clearly in his suicide note that he and his wife had an agreement that they would not allow themselves to go into care suffering from dementia.

Whilst recognising that it is difficult to draw a line between respecting the elderly couple's autonomy and breaking confidences by information sharing, nonetheless offering sufficient and appropriate care to vulnerable adults is crucial to minimize the risk of a similar scenario occurring in the future.

### **3.4 Lessons to be Learnt**

The Panel accepts that some lessons have already been learnt by the agencies by taking part in this very vigorous exercise. Additional suggestions of improvements have been highlighted in the above comments on the IMRs made by the Panel.

It is also suggested by the Panel that it would be helpful if permission from carers and clients/patients is sought at an early stage in order to share information between agencies involved with vulnerable adults and to make them aware that information will be shared.

The policy of leaving self-funders to determine what is best for the vulnerable adult is clearly not adequate and leaves the care home itself to undertake the assessment. If that assessment either does not take place or is inadequate, as in this case, this can clearly lead to serious difficulties.

There were many issues in the circumstances of the lives of Mr and Mrs M that may have contributed to this tragic homicide, but it is extremely difficult to conclude that it would have been avoided altogether if the improvements had already been implemented to address the shortcomings as identified by the agencies and by this Panel.

The personality of Mr M was a factor in itself. He was at times difficult to engage, and the evidence is that he was a determined, independent and intelligent gentleman, and had clearly put considerable planning into his actions. However, he was not coping as well as he might have suggested, being saddened and overwhelmed by his wife's illness, and he too was vulnerable, in spite of his outward appearance.

Most of the participating agencies which provided IMRs gave insightful analyses of the failings within their agency. Changes clearly need to be made to improve services, and some have been acknowledged and already implemented.

Providing care to a person with dementia can be highly stressful for carers, and has been shown in many cases to be highly predictive of mistreatment and abuse on the part of the carer. There is considerable evidence that carer stress is related to levels of support, and that greater understanding about Alzheimer's and other forms of dementia and ways of working with people with these conditions can reduce carer stress.

Abuse occurring in families can be considered from two perspectives: abuse that is perpetrated deliberately, and abuse that is not. Sometimes the perpetrator is doing his or her best but cannot provide the level of care and support that is needed, sometimes because they don't know what care and support is available and sometimes because the necessary support is not available. Abuse which is not deliberate can include a wide range of actions, including neglect or the unnecessary restraint of a person with dementia.

Elderly abuse and homicide/suicide cases may sadly become a phenomenon that is likely to become more common as the population ages and more of the population suffers from Alzheimer's or other forms of dementia. It is crucial that all professionals are aware of the risks that exist.

It is the Panel's view that it is imperative that all professionals who are involved or likely to be involved with the affected families have training in understanding the social, psychological and emotional effects of Alzheimer's disease and dementia on both the sufferers and their carers, and that training is kept up-to-date.



### **3.5 SMART Recommendations**

These recommendations are made with the sole purpose of suggesting improvements in:

- (a) identifying people, and in particular the elderly, who may be subject to the risk of abuse and homicide within Cumbria and beyond.
- (b) how agencies could work better together.
- (c) strengthening inter-agency working practices, policies and procedures, and services.

The Panel's SMART recommendations are set out below:

#### **All Agencies (excluding JK Care Home)**

1. All agencies to put in place processes that ensure that significant information concerning a service user, patient/carer is shared with other relevant agencies.
2. All agencies to recognise the need for multi-agency planning meetings to consider potential high risk cases, and to develop a coordinated 'one-stop' response to needs of vulnerable adults.
3. Carers should have their own file if assessed as requiring services. This should be retained on the social care file and the health file. If services are declined, the reasons for this should be carefully documented together with the reasons why.
4. Obtain consent early from carers and vulnerable adults in order to share information between key agencies to improve lines of communication.
5. Put in place procedures and monitoring arrangements to ensure that a carer's assessment is always offered (and encouraged) where a significant other is a caring role; if it is refused, this should be recorded and a note provided and placed. Further assessments offered subsequently when appropriate.

#### **Adult Social Care**

6. Monitoring arrangements to be put in place to ensure that all health, risk and carers assessments are regularly reviewed and updated, at least annually.
7. Clear guidelines to be put in place to highlight the need for the vulnerable adult to be seen on their own during their involvement.

8. To consider revisiting and revising their policy of 'no care plan' for those who are self-funded, and to offer an assessment to the service user in order to provide such a plan. Put in place processes to ensure that care plans are monitored.
9. To ensure that contingency plan is available to identify what support and care arrangements would need to be put in place in the urgent event of the carer being unable to fulfil their caring duties.
10. To consider reinstating regular audits (at least biennially) of care homes and their procedures and policies by Local Authority Adult Services, and to offer advice and support.
11. ASC and the Police,(PPU) to arrange multi-agency review of the Vulnerable Adult Process in order to look in particular at more effective gatekeeping of referrals from the police to ASC and to request a multi-agency response if appropriate.
12. The panel recommends that the Cumbria Safeguarding Adults Board:
  - (a) reviews the adequacy of training across agencies on how to better understand and meet the needs of the carer of those working with adults with Dementia, particularly those who are difficult to engage.
  - (b) requests that the learning and development sub-group considers how training can be improved and shared, utilising a combined package of e-learning and face-to-face training sessions, the latter of which would enable the participants to meet peers and share ideas and experiences.
13. To circulate relevant recommendations in this report to all Care Homes in the county together with the DHR summary report.

### **GP Surgery**

14. GP practices to be encouraged to reconsider and improve their dementia care. Records should ensure that they are all cross-referenced between carer and vulnerable adult and markers of significant events highlighted. All significant conversations regarding the wellbeing of a patient to be documented and also cross-referred where relevant.

15. All correspondence received by the practice to be marked as read and all actions taken properly documented.

### **Care Homes**

16. All practices and procedures of residential care homes to be documented and brought to the attention of all staff, and easily accessible to them. They should be kept up-to-date.
17. If standard procedures and policies are 'downloaded' by the care home, these should be customised and made relevant to the individual care home.
18. Management is advised to invest in sufficient support and training to ensure staff are trained to acceptable standards and to enable them to sustain and improve those standards. Training records to be kept up-to-date.
19. A full and detailed pre assessment to be undertaken for each new resident, and records kept during the post-admission assessment to monitor that the residential home is meeting the resident's needs.
20. Key conversations with relatives, residents and carers to be carefully recorded within the resident's records.
21. ASC guidelines dated 4 August 2015 (circulated to care homes under coroners recommendation) followed and to form part of the care homes' procedures.
22. Documented policies and procedures to be put in place in all residential care homes to ensure that no discharge takes place without:
  - a) Fully considering the short and longer term care provisions for those residents to be discharged; and
  - b) Notifying other agencies of discharge, including GP and ASC, where appropriate.

### **CPFT and Cumbria Police**

23. The Police Protection Unit and Mental Health services should ensure that there is a good line of communication to ensure the most effective method of protection, and that risks are properly managed.

## **Section Four: Conclusion**

This is a tragic case that has deeply affected the family of Mr and Mrs M, the wider community and the agencies who worked with them. Mr M had reached a point of crisis at which he made a decision to end the life of his wife and himself. According to Mr M's suicide note, he and his wife had made an earlier joint decision that neither of them wished to end their lives in a care home, although it is clear he did attempt to place Mrs M in such a home. It was only when he thought this had failed that he took the steps that he did.

It is not possible to know whether this awful tragedy could have been avoided altogether, but it has served to highlight the need for improvements as set out above. The death of Mrs M was not predictable, there was no history to suggest that Mrs M was at risk. Mr M was seen as a caring and attentive husband, but it is now very clear that he was not able to cope with his wife's condition whilst suffering from pain and worry about his own health.

Caring agencies and services, working together, need to be even more supportive of those carers, particularly the elderly, for whom the stress and anxiety endured in caring for a loved one suffering with a degenerative condition such as dementia, often compounded by fears for their own health, may become overwhelming.

Prudence M Beever

Chair