THE CONTENT OF THIS REPORT IS RESTRICTED UNTIL PUBLICATION

SUNDERLAND DOMESTIC HOMICIDE REVIEW

CONCLUDING REPORT INTO THE DEATH OF Mrs X

Final Report produced by Kath Albiston

Date: 08/01/15

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PREFACE

This Domestic Homicide Review (DHR) was carried out following the death of Mrs X on Friday 11th April 2014. This was the second statutory homicide review carried out in Sunderland. It was carried out in accordance with Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

We would like to express our profound sympathy to the X family and their friends and assure them that in undertaking this review we are seeking to learn lessons from this tragedy and to improve the response of agencies. We would also like to thank them for their time and cooperation throughout this review process.

We would also like to thank staff within all agencies that have contributed to this review, and express gratitude to the Safer Sunderland Partnership for their support with the process.

1. INTRODUCTION

1.1 Background to the Review

1.1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Mrs X and her family prior to the point of her death on 11th April 2014.

1.1.2 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed by a family member or someone with whom they are in an intimate relationship. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1.3 On 14th April 2014 Northumbria Police notified the Safer Sunderland Partnership of the deaths of Mrs X and her husband Mr X, whose bodies were discovered on Friday 11th April 2014. Initial investigations highlighted that Mr X has possibly administered drugs to his wife and then taken his own life. At an initial case review meeting on 25th April 2014 it was established that the deaths met the criteria for a Domestic Homicide Review under Section 9 of the Domestic Violence Crime and Victims Act. Following this initial meeting, the Safer Sunderland Partnership notified the Home Office that a Domestic Homicide Review would be taking place.

1.2 Purpose of the Review

1.2.1 The purpose of a Domestic Homicide Review, as set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, is to:

- Establish what lessons are to be learned from the domestic homicide

regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.

1.2.2 DHRs are not inquiries into how the victim died or who is culpable; in the case of Mrs X this was a matter for the coroner to determine.

1.2.3 As far as is possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

1.2.4 DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action would be initiated, the established agency disciplinary procedures would be undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently, but separately to, disciplinary action.

1.2.5 The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence, by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, with an aim to avoid future incidents of domestic homicide and violence.

1.2.6 The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which are understood and adhered to by their staff.

1.3 The Review Process

1.3.1 The review process consisted of the following meetings:

25/04/14 – Initial case review where it was established that the case met the criteria for a Domestic Homicide Review.

15/05/14 – Full scoping meeting at which the terms of reference for the review were agreed and the Panel for the review established. This included identification of those agencies that were to undertake Individual Management Reviews (IMRs).

21/05/14 – The Chair and a representative of the Safer Sunderland Partnership met with Mrs and Mr X's two daughters. Their son lives out of the area and therefore could not be present.

28/05/14 – 2nd meeting with Mrs and Mr X's two daughters by the Chair and a representative of the Safer Sunderland Partnership.

14/07/14 – Panel meeting at which the Chronology was reviewed and 1st drafts of Individual Management Review were presented.

31/07/14 – The Chair and a representative of the Safer Sunderland Partnership met with a representative of Parkinson's UK.

06/08/14 – Panel meeting for review of revised IMRs.

19/09/14 – Circulation of 1st draft of the overview report.

15/10/14 – Panel meeting to discuss 1st draft of the overview report.

22/10/14 – Meeting with the Service Manager of Washington MIND by a representative of the Safer Sunderland Partnership.

13/11/14 – Panel meeting for agreement of final overview report.

17/11/14 – Meeting with Mrs and Mr X's two daughters to share the overview report.

Due to sickness the Independent Chair was absent from the review process for a short period including meetings that took place on 15/10/14 and 13/11/14. As a result, an extensive telephone meeting between the Chair and Independent author took place on 19/11/14 at which further amendments to the report were agreed. The report was re-circulated and agreed by all Panel members. The Home Office were notified of the resulting delay to the review process.

1.4 The Review Panel

1.4.1 The review panel consisted of representatives of both statutory and non-statutory agencies, including those agencies that had had contact with Mrs and Mr X, as well as other agencies acting as 'critical friends' in the review process. Other agencies invited to take part in the review process included those who were felt to have specialist knowledge around areas identified as specific to this case; such areas included Mrs X's diagnosis of Parkinson's and Parkinson's related dementia, and the role of Mr X as her main carer.

1.4.2 The panel membership was as follows:

- Independent Chair: Nonnie Crawford – Director of Public Health
- Stuart Douglass – Lead Policy Officer for Community Safety, Sunderland City Council
- Julie Smith – Associate Policy Lead for Community Safety, Sunderland City Council
- Sharon Lowes – Lead Commissioner, Sunderland City Council
- Debbie Cheetham – Lead Nurse Patient Safety, City Hospitals Sunderland NHS Foundation Trust
- Susan Leonard – Practice Development Sister, City Hospitals Sunderland NHS Foundation Trust

- Lesley Schuster – Lead Nurse Safeguarding, South Tyneside NHS Foundation Trust
- Richard Scott – Designated Nurse Safeguarding Adults, Sunderland Clinical Commissioning Group
- Jan Grey – Head of Safeguarding, Northumberland Tyne and Wear NHS Foundation Trust
- Michael Barton – Detective Chief Inspector, Northumbria Police
- Claire Phillipson – Director, Wearside Women in Need
- Alan Patchett – Director, Age UK Sunderland
- Anna Stabler – Quality and Safety Manager, NHS England
- Graham Burt – Chief Executive Officer, Sunderland Carers' Centre
- Michelle Meldrum – Managing Director, Gentoo Operations
- John Hall – District Manager, Tyne and Wear Fire and Rescue Service
- Kath Albiston – Independent Overview Report Author

1.4.3 The Independent Chair has been a Director of Public Health since 2002, undertaking the role in Sunderland since 2008. During this time she has chaired and authored a number of reviews into serious incidents relating to both adults and children, and also chairs South of Tyne and Wear Child Death Overview Panel, which oversees the activity of the three Child Death Review Groups in the Local Authorities. She has also been a member of the Sunderland Children's Safeguarding Board and the Safer Sunderland Partnership since 2008.

1.4.4 The Chair was asked to conduct this DHR as she has worked in the Sunderland area for seven years, and is thus familiar with, but not directly associated with, the agencies involved in the review. The Chair has had no involvement with Mrs or Mr X, or any of the professionals' work being reviewed.

1.4.5 The Independent Overview Report Author has had no involvement with Mrs or Mr X or any of the professionals' work being reviewed. She is a

qualified Probation Officer and prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer for eight years she has undertaken a variety of roles within the domestic violence and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She also currently acts as an 'expert witness', writing domestic abuse risk and vulnerability assessments for family court cases. The author has also been involved as author and/or Chair with a number of Domestic Homicide Reviews within the North East area, including the writing of the overview report for Sunderland's first Domestic Homicide Review.

1.5 Terms of Reference

1.5.1 The specific terms of reference agreed for this review were:

- Subject to family and friends or colleagues wanting to participate in the review, were they (i) aware of Mr X's ability and willingness to take on the caring responsibilities for his wife and (ii) aware of any abusive behaviour from Mr X to Mrs X or vice versa, prior to the homicide
- Was there any domestic abuse or indicators of domestic abuse within Mr X and Mrs X's relationship and was this known to agencies? If so, how was this responded to and were any assessments undertaken?
- Was Mrs X considered an 'adult at risk' in agencies' dealings with her?
- Did Mrs X have capacity and was she capable of making informed decisions about her care in agencies' dealings with her?
- At any point was Mrs X seen alone so that her own wishes and feelings could be expressed about her care?
- Were agency assessments carried out and decisions made about Mrs X done in an informed and professional way? Were appropriate

enquiries made, services offered or services provided given what was known or what should have been known at the time?

- Was the extent of Mr X's and his children's caring responsibilities recognised? Were appropriate enquiries made, services offered or services provided given what was known or what should have been known at the time? Was a carer's needs assessment carried out on Mr X and/or his children and if so, were decisions made in an informed and professional way?
- At any point was Mr X or his children seen alone so that their own wishes and feelings could be expressed about their caring responsibilities?
- Were there any missed opportunities for agency intervention or referrals to support agencies in relation to the family's caring responsibilities? Were agencies sensitive to the needs of the family in their caring responsibilities? Was it reasonable to expect staff, given their level of training and knowledge, to fulfil these expectations?
- Given that Mr X and Mrs X were self-funders, how did this impact on the assessments carried out, enquiries made, services offered or services provided around Mrs X's care and the family's caring responsibilities?
- Were appropriate managers or other agencies and professionals involved at the appropriate points?
- To what degree could the homicide have been accurately predicted and prevented?

1.5.2 The time period to be covered by the review was set from 11/04/12 to 11/04/14. This is based on a time period of two years before the deaths of Mrs and Mr X, and eighteen months before Mrs X's diagnosis of dementia. It was also requested that any significant events or points of contact since 01/12/00, when Mrs X's Parkinson's disease was first

diagnosed, be included where it was felt that this would provide further context for the review.

1.6 Profiles of Agencies Involved and Methodology

1.6.1 As part of the review process Individual Management Review (IMR) reports were completed by five agencies where it was identified that significant contact had taken place with Mrs and Mr X within the specified time period. All IMR authors were independent of the case and had had no contact with Mrs and Mr X, either as a practitioner or through the management of staff involved. IMR reports were received from the following agencies:

- Sunderland Clinical Commissioning Group (CCG)
- South Tyneside NHS Foundation Trust (STNHSFT)
- City Hospitals Sunderland NHS Foundation Trust (CHS)
- Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
- Sunderland City Council covering: Occupational Therapy; Social Work (Adult Services); and Reablement at Home.

1.6.2 **Sunderland Clinical Commissioning Group (CCG)** is the statutory body responsible for planning, purchasing and monitoring the delivery and quality of local NHS healthcare and health services for the people of Sunderland. All 53 GP practices within the Sunderland area are members of the Sunderland CCG. The IMR for Sunderland CCG was undertaken by the Named General Practitioner for Safeguarding Adults in Sunderland. In undertaking the IMR the author reviewed all General Practice records of Mrs and Mr X, as well as undertaking an interview with the lead General Practitioner (GP) involved in the case. The lead GP also produced a report for the practice where the couple were registered, with their analysis of the events surrounding the deaths, and this was referenced where appropriate within the IMR.

1.6.3 The IMR author was supervised by the Designated Nurse for Safeguarding Adults, and the IMR was approved by the Medical Director for Sunderland Clinical Commissioning Group, and the Medical Director for the Local Area team NHS England.

1.6.4 **South Tyneside NHS Foundation Trust (STNHSFT)** provides a wide range of NHS services across Gateshead, South Tyneside and Sunderland. In relation to Mrs and Mr X STNHSFT were involved through the provision of Community Matron Services. The IMR for STNHSFT was prepared by the Lead Nurse for Safeguarding for the Sunderland locality, South Tyneside NHS Foundation Trust. In preparing the IMR the author had access to copies of health records, which are held by the Community Matrons within their office, as well as access to the electronic records. In addition, the author interviewed one Community Matron, who was involved with Mrs and Mr X from November 2011 until the point of their deaths. The purpose of this interview was to clarify issues that required further exploration following the review of the health records. The author also spoke with the wider Community Matron Service to gain clarity regarding team systems and processes prior to November 2011. The author was however unable to access, despite requests to do so, the Community Health Service Records for Mrs X and Mr X, which were held in their home and removed by Northumbria Police as part of their investigation.

1.6.5 The IMR author was supervised, and the report approved, by STNHSFT's Strategic Lead, Safer Care.

1.6.6 **City Hospitals Sunderland (CHS) NHS Foundation Trust** is an acute healthcare provider in Sunderland. City Hospitals Sunderland's IMR was co-authored by the Lead Nurse for Patient Safety and the Practice Development Sister aligned to patient safety. In undertaking the IMR the patient healthcare records for both Mrs and Mr X were reviewed, and nine members of staff interviewed. All staff were based at

Sunderland Royal Hospital and the purpose of the interviews was to seek clarity or more in-depth information regarding the entries made within records by the identified members of staff. Staff were also questioned on the processes, policies and procedures they adhere to in their normal, day-to-day practice.

1.6.7 The IMR authors for CHS were supervised throughout the process by the Head of Nursing and Patient Safety. The IMR was also reviewed and approved by the Executive Director of Nursing and Quality (Executive Lead for Safeguarding), prior to it being submitted to the Domestic Homicide Panel.

1.6.8 **Sunderland City Council** provides Adult Social Care Services across the Washington, Coalfield and Sunderland (North, West and East) areas. Sunderland Council's IMR was undertaken by the Lead Commissioner within the Council's People Directorate. The following services were involved in providing care and support to Mrs X:

- Community Occupational Therapy – this service provides functional assessments to children and adults in order to support independence and continued community living and provide equipment to assist with activities of daily living.
- Community Rehabilitation Service – a part of the Community Occupational Therapy Service which provides support to people in their own homes after a hospital stay, or to prevent a hospital admission, through the provision of both physiotherapy and occupational therapy for up to 12 weeks.
- Independent Living Team – this service provides an assessment, supply and fitting service for a range of equipment in a one-off visit.
- Social Work – this service provides assessment of needs and care management functions for adults aged 18 and over, who are eligible for community care assessments.
- Reablement at Home Service – this service is part of the recently

transferred Local Authority Trading Company, Care and Support Sunderland. The Service provides care and support for up to 6 weeks following hospital discharges, or to avoid hospital admissions, using a reablement approach to maximise an individual's potential to do things for themselves.

1.6.9 In producing the IMR the electronic case notes relating to Mrs X were reviewed, as she was the main customer of the Council. In addition staff from the above teams who have been involved in the provision of care and support to Mrs and Mr X were interviewed, with the exception of one. This member of staff was unavailable and their Line Manager was spoken to instead.

1.6.10 The IMR author was not able to access the paper Service User Held Record, which the Community Support Assistants from the Reablement at Home Service would use to record every visit, as this was removed by Northumbria Police as part of their investigation.

1.6.11 The IMR author for Sunderland City Council's People's Directorate was supervised throughout the preparation of the report by Head of Integrated Commissioning; who also approved the first draft of the report, with final approval being provided from Directorate Management Team.

1.6.12 **Northumberland, Tyne and Wear (NTW) NHS Foundation Trust** is one of the largest mental health and disability trusts in England. It works from several sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington and serves a population of 1.4 million. The IMR was undertaken by the Head of Safeguarding and Public Protection. In order to prepare the report the author reviewed information stored in the Trust's electronic records. One staff member was also interviewed in relation to this case, while another staff member had left the organisation and therefore was unable to be interviewed.

1.6.13 In undertaking the IMR for NTW, the author was supervised by the Nursing Director for Specialist Services, who also approved and quality assured the IMR report.

Additional Information

1.6.14 In addition to the above agencies, it was identified that Mrs and Mr X had contact with both **Parkinson's UK** and **MIND,** and thus the contribution of these organisations was sought to inform the review process and is referenced within this report.

1.6.15 All other agencies on the Panel reviewed their records and were not identified as having had any, or sufficient, contact with the couple to warrant the completion of an IMR.

1.7 Family and Friends Input into the Review

1.7.1 Mrs and Mr X's three children, two daughters and one son, were contacted by the Chair of the review to inform them of the process and invite them to contribute. As a result meetings took place with their two daughters (D1 and D2) on 21/05/14 and 28/05/14. This report was also shared with D1 and D2, and their feedback used to revise the report accordingly prior to its submission to the Safer Sunderland Partnership Board.

1.7.2 After initial attempts to contact Mrs and Mr X's son (S1) were unsuccessful, a representative of the Safer Sunderland Partnership spoke to him by telephone following completion of the report. He confirmed that he was aware of the review process and was happy for his sisters to represent the views of the family.

1.7.3 The Panel also identified that it would have been useful to meet with friends of Mr and Mrs X identified within the review process, however

despite attempts, the contact details of such friends could not be obtained.

1.7.4 Relevant information from family and friends was also taken from the police report supplied to the Coroner.

1.8 Coroner's Inquiry

1.8.1 This review ran parallel to the Coroner's Inquiry. The Chair of the DHR attended the pre-inquest review on 28th May 2014, and the full one day Inquest on 15/10/14 was attended by a representative of the Safer Sunderland Partnership. The conclusion of the Inquest was the unlawful killing of Mrs X by asphyxiation, and the taking of his own life by Mr X. Within the Inquest the Coroner described how Mrs X's health had been in severe decline, and how family and agencies supported the couple throughout this. He referred to evidence of 'mutual despair', and stated that no one could have predicted events.

1.9 Other Reviews

1.9.1 As Mrs X was active to services within the six months prior to her death, Northumberland, Tyne and Wear (NTW) NHS Foundation Trust undertook a Serious Untoward Incident Review. No significant issues were identified as a result of this review.

1.10 Confidential Information

1.10.1 Relevant information relating to individuals within this review was shared by agencies in the public interest. Consent was not sought due to both the victim and perpetrator in this case being deceased. In line with Home Office Guidance for the completion of DHRs, full consideration was given to the need to anonymise or redact any necessary information prior to publication.

2 THE FACTS

2.1 Circumstances of Mrs X's death

2.1.1 At the time of her death Mrs X was living in the home she shared with her husband, Mr X, in the Sunderland area. There were no other residents at the address. On 11th April 2014 the bodies of Mrs X and her husband, aged 74 and 76 respectively, were discovered at the home. There was no evidence to suggest any third party involvement and initial investigations indicated that Mr X may have administered drugs to his wife and then taken his own life. As has been previously outlined, the subsequent conclusion of the Coroner's Inquiry was the unlawful killing of Mrs X by asphyxiation, and that Mr X took his own life.

2.2 Family structure and background

2.2.1 Mr and Mrs X were a White British couple. Mrs X was an ex-midwife and Mr X was an ex-merchant navy officer. They had three adult children, two daughters (D1 and D2) and one son (S1).

2.2.2 Agency records indicate that Mrs X was diagnosed in 2000 with Parkinson's disease, although her daughters believe that this diagnosis occurred earlier at some point between 1994 and 1996. Mrs X remained living at home, cared for by her husband Mr X with the support of their daughters. In 2012 she was also diagnosed with Parkinson's related dementia.

2.2.3 Mrs X has ongoing contact with statutory health agencies from the time of her diagnosis, and intermittent contact with social care, and this is outlined in further detail below. In addition both her and her husband were active members of a Parkinson's UK local support group, and Mr X had previously accessed the support of a local MIND group.

2.3 Agencies involvement with the couple

2.3.1 As has been outlined previously, five agencies were identified as having had sufficient contact with Mrs or Mr X to warrant the completion of a chronology and Individual Management review (IMR). A full composite chronology was completed in which each relevant contact with Mrs or Mr X was detailed. Below is a summary of the extent and nature of such contact taken from the agencies' IMRs. This information is divided into contact prior to the review period, which is included to provided context, and that within the review period of 11/04/12 to 11/04/14. This also includes a concentrated period of contact with agencies from 18/03/14, when Mrs X was admitted to hospital, until the time of her death.

Contact prior to the review period

2.3.2 Mrs and Mr X had been attending the same GP practice since 1986, and were well known to the GPs, nursing staff, Community Matrons, and practice administration staff. They were active members of the Patient Participation Group, as well as being regular attenders at the practice for their own healthcare needs.

2.3.3 Following her diagnosis with Parkinson's in 2000 Mrs X regularly attended appointments with her **GP practice and City Hospitals Sunderland (CHS)**, including the outpatient clinic with Consultant Neurologists and the Specialist Parkinson's Nurses, where her medications were reviewed and adjusted. Throughout the period of her illness her symptoms steadily worsened, and she was increasingly troubled with slow and stiff movements, jerky involuntary movements, continence problems, hallucinations, and in the later stages, falls associated with dropping blood pressure.

2.3.4 During this period Mr X was considered to be in good physical health, apart from high blood pressure. He did however have historic issues

with anxiety and insomnia and in the 1980s there is repeated reference within his GP records to trouble sleeping, as well as records of repeated prescriptions issued for benzodiazepines (which can be used to treat both anxiety and insomnia).

2.3.5 During the period from March to July 2008 there were 28 recorded consults with his GP or practice nurse relating to anxiety, low mood, insomnia, and his concerns about Mrs X and her deteriorating physical health. These anxiety symptoms were coupled with somatic symptoms of facial pains and sensations of a foreign body stuck in his throat. During this time Mr X was treated with a variety of antidepressant medications and was also referred to the Older People's Mental Health team in November 2008. According to **Northumberland, Tyne and Wear NHS Trust (NTW)** this referral was received by the Older People's Mental Health Team in respect of symptoms of anxiety/low mood, with reference to possible links to the onset of caring for his wife. Following a request to the GP to supply further information to support the referral, Mr X was assessed by a Community Psychiatric Nurse (CPN) on two occasions (19/01/09 and 11/08/09) and showed evidence of anxiety type symptoms. There is no record of any ongoing contact or support following these assessments. Mr X was then contacted by telephone on 18/11/09 by another CPN, who was taking over the caseload of the original CPN, and Mr X indicated that he did not require any further intervention from the service. The discharge letter from NTW held on the GP file reports that Mr X '*declined further intervention from our service, stating that he had been really well for the last 3 months*'.

2.3.6 In May 2011 the GP practice altered Mr X's antidepressants for the last time to two different types of sedating antidepressants. In July 2011, he was seen by the Practice Nurse and it was noted that there was '*good compliance with meds, sleeping much better…requests 2 months (of these medications) so ties with other meds and on repeat. (GP) agrees'*. This is the last reference to Mr X's mental health within the GP records,

and he is maintained on these two antidepressant medications until his death. The last use of benzodiazepines by Mr X was in the records as a prescription issued in April 2011 for a small supply of a low dose of Diazepam.

2.3.7 During the above period Mrs and Mr X were also involved with **South Tyneside NHS Foundation Trust's (STNHSFT)** Community Matron Service, initiated by a request from Mrs X's GP in 2008. The Community Matrons are experienced senior nurses who work closely with clients who suffer from serious long term conditions or a complex range of conditions. They plan, organise, and deliver care directly to the client at home, acting as a single point of contact for care support and advice.

2.3.8 The referral from the GP to the Community Matron Service highlighted that Mrs X had Parkinson's disease and was being cared for by her husband, who had requested support and guidance with regard to services available across Sunderland. A Single Assessment was completed by the Community Matron on the 12/09/08 and within this Mr X was noted to suffer from stress and anxiety. Records indicated that Mr X was offered a CD to support relaxation, and both Mrs X and Mr X identified they received a lot of support from their local Parkinson's group.

2.3.9 The Community Matron Service had contact with Mrs and Mr X at their home on 7 occasions during 2008. Within this, information documented in the Community Matron records on 18/09/08 indicated that Mr X had major issues with anxiety/depression and would be supported by the Community Matron. Mr X also reported to the Community Matron that he felt anxiety regarding his 'wife's future'. He was noted to have commenced antidepressants during 2008, and to have been referred for Cognitive Behavioural Therapy and to MIND for support; however there is no reference within the chronologies of other agencies to these

referrals. MIND however reported that Mr X self-referred to them and was assessed in October 2008.

2.3.10 Throughout 2009 to the beginning of 2012, Mrs X and Mr X continued to have contact from the Community Matron Service, although much of this appears to have involved telephone contact rather than home visits. Whilst home visits were offered these were often declined, primarily it appears by Mr X, with whom the majority of contact during this time appears to have taken place. Within both the home visits and telephone contacts that took place during this period, Mr X's levels of anxiety are referenced throughout. It appears that in relation to this, information around the support he was receiving came from Mr X himself. He stated he was continuing to use his relaxation tapes, as well as taking his prescribed antidepressants and attending MIND for support when needed. There is no evidence of liaison by the Community Matron with any other professionals involved in the care of Mrs or Mr X to confirm the nature or extent of such support.

2.3.11 For the purpose of this review, MIND supplied information that, following his initial self-referral in October 2008, Mr X attended two one to one sessions, before going on to attend an anxiety peer support group and continuing to access support and information from the service. He also attended the Annual General Meeting and social events with Mrs X, such as the Christmas party in 2009. Mr X's last contact with the service was thought to be in early 2010.

2.3.12 In April 2011, due to the fact that much of Mrs and Mr X's contact was by telephone, the Community Matron suggested that they be discharged from the Service, as it was felt there was a lack of on-going support and contact required by them. Mr X became very distressed at this suggestion and stated he '*wanted to be kept on (their) books*'. During this period it was unclear from the discussions documented within records what was known regarding Mrs X's current health status,

specifically her Parkinson's. There was also no evidence of communication with professionals who may have been able to provide this information. Given the absence of an up to date health assessment, it was unclear as to why discharge for Mrs X was recommended.

2.3.13 While not recorded in STNHSFT's chronology, **Sunderland City Council** recorded a referral from the Community Matron on 26/05/11, as a result of which a home visit took place by the Independent Living Team on 20/06/2011. During the assessment of need it is recorded that Mrs X stated she *'currently has no difficulties getting around the home and declined to be assessed for any equipment or adaptations….she is very proud and in denial that her condition or how her functional ability will deteriorate'* as a consequence of Parkinson's Disease.

2.3.14 In November 2011 a Community Matron Care Plan was completed following a home visit to Mrs and Mr X. This provided an assessment of Mrs X's needs at the time. She was reported to be well and under review by a Consultant for her Parkinson's disease. The Community Matron indicated that Mrs X was well supported by Mr X with all activities for daily living. Mrs X had identified that she had experienced some recent falls, but no injuries. A falls risk assessment was completed and offered Mrs X a referral to the falls clinic for review and support, which she agreed to. Mr X was also reviewed at this contact and reported to be suffering from a bout of depression but to be using diversion techniques to combat this. Mr X declined any additional support. The Community Matron documented that Mr X was the main carer for Mrs X and that this motivated him and his mood.

2.3.15 Throughout the above period Mrs X also received support from **Sunderland City Council** in the form of a range of equipment provisions from 2007 to 2012. These equipment provisions were to

support the continuing independence of Mrs X within the home environment.

Review Period (11/04/12 to 11/04/14)

2.3.16 It would appear that Mrs X's symptoms deteriorated considerably during the last two years of her life. Throughout this time she had regular contact with the Community Matron Service (monthly home visits), her GP practice (6 monthly checks at which Mr X also attended for a blood pressure and medication review), and City Hospitals Sunderland (including regular clinic appointments with the Consultant Neurologist and Specialist Parkinson's Nurse). Within this contact her physical health and symptoms associated with her Parkinson's disease were monitored and reviewed.

2.3.17 In March 2012 at a home visit to Mrs X by the Community Matron Service, Mr X was also reviewed. His mood was noted to still be problematic, however he reported that he continued to attend his GP for support. He indicated that his appetite and sleep pattern had been slightly disrupted but he hoped that this would improve with his mood. The Community Matron highlighted that Mr X still functioned well in caring for Mrs X. It was recognised however that Mr X's mood fluctuated with his wife's condition, with him becoming more anxious and depressed when Mrs X's condition deteriorated.

2.3.18 One of the concerns presenting in early 2012 was in relation to increased falls by Mrs X, which were associated with her blood pressure. She attended the falls clinic in relation to these, and the Community Matron also visited the family home and offered advice regarding making things safe to minimise falls. No Safeguarding concerns were identified in relation to the falls.

2.3.19 Mrs X commenced new medication in July 2012 and informed the Community Matron that she felt it had helped her symptoms. She also spoke of getting out and about more regularly, and there was no evidence of any further falls. Both Mrs X and Mr X reported to the Community Matron that they were both well.

2.3.20 During the remainder of 2012, Community Matron records note that Mrs X continued to be stable with regard to her Parkinson's disease, and that the couple were getting out regularly. Mrs X's shakiness was said to be noticeably reduced, and there were no reports of falls. Mr X was also noted to be well and his anxiety and depressions to be under control.

2013

2.3.21 Throughout 2013 Mrs X's regular contact with the GP, CHS and the Community Matron Service continued.

2.3.22 At some point in late December/early January 2013 Mrs X would appear to have fallen fracturing her left wrist; the exact date is not know as it is only referenced in agency records after the event with no entry relating to her attending hospital for the fracture itself. It is of note that Mrs X's daughters report having no recollection of any fracture having occurred around this time.

2.3.23 During 2013 Mrs X started to suffer from hallucinations. Initially this had been thought to be due to her medication, however these continued when the medication was stopped. In June 2013 the Community Matron contacted the Parkinson's Nurse and Consultant in relation to this, and it was agreed that a referral would be made to the Mental Health Team to assess for Parkinson's related dementia. The Community Matron completed a screening tool for dementia on 13/06/13. Mr X also reported to the Community Matron that his mood

at this time was worse, due to Mrs X's deterioration, but that he was continuing to cope.

2.3.24 Following the agreement that a referral was needed regarding Mrs X's memory loss, on 19/06/13 the Parkinson's Nurse referred her to the Memory Protection Service (NTW) requesting an assessment. The referral also stated that Mrs X and Mr X were both having difficulties managing at home with the symptoms, and that their situation was under review at that time with a Community Matron. Based on the needs identified in the referral letter, the Memory Protection Service redirected the referral to the Older People's Community Mental Health Team (NTW).

2.3.25 On 01/07/13 a Community Psychiatric Nurse (CPN) from NTW visited Mrs X at home for an assessment, which Mr X also participated in. A comprehensive cognitive assessment was undertaken and Mrs X gave permission for the CPN to discuss this with a Psychiatrist and then feedback the care plan to Mrs X. On 10/07/13 the CPN wrote to Mrs X informing her that the Psychiatrist had agreed for investigations of a CT scan and ECG to complete psychiatric formulation. In September 2013 the result of the assessment and investigations undertaken was a diagnosis of Parkinson's disease dementia. Mrs X was offered a trial of medication, commencing at a low dose, to assist symptoms.

2.3.26 At a home contact with the Community Matron in August 2013, Mrs X became quite emotional regarding her memory loss and stated that she felt '*things (were) becoming out of control*'. Records indicate that the Community Matron continued to 'offer support' to both Mrs X and Mr X.

2.3.27 Community Matron Service documentation indicates that in September 2013, an Occupational Therapy assessment was also requested regarding the home bathroom. During this contact the Community Matron had offered Mrs X the opportunity to attend a day hospice,

however she was not keen on this at the time. During discussions for the IMR, the Community Matron highlighted that this had been offered to support Mr X with his caring responsibilities, which the Community Matron recognised had increased over the previous few months.

2.3.28 Following the referral from the Community Matron, a home visit took place by on 05/09/2013 by **Sunderland City Council** to provide support to Mrs X in relation to bathing needs. During this visit, equipment was provided to support access to the toilet and shower. It is noted within the assessment documentation that Mr X was the main carer, and he was offered, but declined, a carer's assessment.

2.3.29 On 17/10/13 a CPN undertook a planned home visit to monitor the introduction of the new medication given to Mrs X four weeks prior. Mrs X had taken the medication with no reported side effects, and both her and Mr X felt that it had helped slightly, and were keen for the medication to be increased. A prescription was provided and the CPN informed the couple that Mrs X would be reviewed by the Psychiatrist in the Memory Management Team and discharged from the CPN. If any issues arose or advice was required, Mrs and Mr X were informed that they could contact the CPN at anytime.

2.3.30 In October 2013 Mrs X reported to the Community Matron Service that she had less confusion and hallucinations since commencing new medication. Both Mrs and Mr X were going on a seven day holiday and were reported to be looking forward to this. In December 2013, Mrs X was noted to be stable and continuing to manage at home. Both Mrs and Mr X managed to get out daily and walk short distances, and Mr X's mood was reported to be stable with no change in his condition.

2.3.31 On 19/12/13 Mr X accompanied Mrs X to an appointment with a Psychiatrist in the Memory Management Clinic. This assessment indicated an improvement in Mrs X's symptoms since commencing

medication, no depressive features, no thoughts of self harm, and Mrs X reported a good appetite and to be sleeping well. Falls were evident at times, although no injuries were reported to the Psychiatrist. Due to progress made, the Psychiatrist discharged Mrs X and requested that the GP continue to prescribe medication. A Dementia Guide handbook, produced by the Alzheimer's society, was provided. The Psychiatrist offered to see Mrs X in the future if the need arose.

2.3.32 Mr X was discharged from the Community Matron's service in December 2013. During discussions with the Community Matron regarding this, she highlighted that the reason for discharge was that Mr X had remained 'stable' for some months and there was nothing to continue to case manage. Mr X was believed to be continuing to access professionals when required with regard to his mental health. He was also said to recognise that his mood changed with regard to Mrs X's health, and he was felt able to seek help from a variety of sources for his mental health as required. The Community Matron also noted that when contact was made with Mrs X, Mr X was present and thus would always be reviewed during these contacts in relation to his caring responsibilities for Mrs X.

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2.3.33 Throughout 2014 Mrs X again continued to have regular contact with her GP practice, CHS and the Community Matron Service.

2.3.34 On 14/01/14 Mrs X was reviewed at her home by the Community Matron Service and was noted to be very dyskinetic (involuntary jerking movements). However, Mrs and Mr X were reported to still '*get out and about daily*'. A further home review then took place on 13/02/14.

2.3.35 On 17/02/14, the practice nurse saw both Mrs and Mr X; an annual dementia review was undertaken in relation to Mrs X, and a general health and medication review undertaken in relation to Mr X. There was no mention within either of these reviews of consideration of home circumstances or the impact of the caring role on Mr X's mood, despite his medication including anti-depressants.

2.3.36 On 13/03/14 Mrs X attended the walk-in centre accompanied by her husband, having had a fall that resulted in a laceration to her left temple. She was referred to A&E, where following treatment she was discharged into the care of her husband.

2.3.37 On 18/03/14 Mr X contacted the Community Matron Service by telephone at 3pm to inform them that Mrs X had previously fallen and sustained an injury to her temple, which had been sutured. Mr X reported that Mrs X had intermittently lost consciousness for short periods over the course of the day. Mr X was advised that he needed to return to hospital with Mrs X for assessment. He then attended A&E again, reporting that Mrs X had had a blackout lasting approximately two minutes. There was reported to be no fall as Mr X had caught her. He also reported an episode from the previous day in which Mrs X lost consciousness for approximately 4-5 minutes. Mrs X had no recollection of this. She was reported to have swelling and pain to her left thumb. Mrs X was admitted to hospital on 18/03/14 and remained there until 28/03/14.

2.3.38 Whilst Mrs X was in hospital, references were made throughout City Hospitals notes to Mr X being present as well as reference to Mrs X's 'daughter', although it is not always clear as to whether these references refer to the same daughter on each occasion.

2.3.39 On 19/03/14 an incident occurred within the hospital when Mr X became 'angry', as Mrs X had not been given her Parkinson's medication. Mr X then gave the medication to his wife and was asked by staff to tell them if he was administering medication. Within the CHS incident report he is said to have '*remained very, very aggressive and threatening in front of other patients and relatives in the bay – he was making comments to them and nursing staff felt this was in-appropriate'*.

2.3.40 On 20/03/14 Mrs X, accompanied by her husband, was seen by the Neurology Support Nurse. Mr X discussed it having been upsetting that his wife's medication had not been given at the correct time. The Nurse also noted that Mr X was 'exhausted' and she advised him to rest. On this date it was also noted within hospital records that Mrs X '*was becoming increasingly difficult to manage at home with (her) husband*'. She was also referred to the physiotherapy department.

2.3.41 On 21/03/14 Mrs X was noted to be unwell, and therefore the undertaking of a mobility assessment was not felt appropriate.

2.3.42 On the ward round on 24/03/14 Mrs X was noted to be well and '*much brighter*' but still have difficulty in standing. She was also seen by the physiotherapist who undertook postural work with her. On this date Mr X also had a telephone consultation with his GP around cough/cold symptoms. During this he reported that Mrs X was in hospital, although it does not appear any exploration took place regarding his emotional well-being in relation to this.

2.3.43 On 25/03/14 Mrs X's husband and daughter were present during an assessment undertaken by the physiotherapist. They are reported to have said that Mrs X had previously mobilised independently, but had been unsteady of late. Mrs X was reported to have managed well on this day but to be low in confidence.

2.3.44 On 26/03/14 one of the nurses noted that there were no plans for discharge at this time. However within a multi-disciplinary team meeting on the same day it is noted that Mr X wanted his wife home, and the physiotherapy department said that Mrs X had been mobile with the help of her husband prior to her admission to hospital. They also reported that Mrs X had managed fine with a standing and turning aid, that they would try and mobilise her, and that with a referral to Occupational Therapy she could then be discharged home.

2.3.45 On 27/03/14 it is recorded within nursing documentation that Mrs X's husband and daughter were spoken to regarding possible discharge home and whether they would need Mrs X referred to Occupational Therapy or the Medical Social Work team. It is reported that they responded that they would like an Occupational Therapy assessment, perhaps for a wheeled commode, but were not keen for Mrs X to stay in over the weekend. They preferred Mrs X to go home the following day and a wheeled commode to be delivered, as well as her being assessed by a Social Worker in the community.

2.3.46 On 28/03/14 Mr X contacted Sunderland City Council Adult Services to inform that Mrs X was being discharged from hospital and requesting an assessment to help in relation to transferring her from chairs and getting her in and out of their house. An Independent Living Team assessment visit was organised for 02/04/2014.

2.3.47 Nursing notes from this day indicate that Mrs X's family were 'unwilling to wait' for Mrs X to be assessed by an Occupational Therapist or Social Worker. A further entry that day from the Occupational Therapist reported:

'*Spoke to ward sister...re patient's family requesting to take patient home today and would like a wheeled commode, OT* (Occupational Therapist) *advised will complete initial interview but cannot provide*

equipment without assessments being complete, (ward sister) fedback physio recommendations and advised patient not transferring well. OT telephoned patients husband, consent gained. Initial interview complete. OT recommended patient remain in hospital until OT assessments complete...OT advised not safe as no care package in place to help (husband)…therefore unsafe discharge. Patient's daughter then took phone, OT fedback recommendations and why. (Daughter) not happy as stated doctor had said her mother was "ready for home yesterday", (daughter) questioned why a doctor would say that if "her mother was not going to cope at home". OT attempted to explain that patient may be MFD (medically fit for discharge) *but physically/socially she is not. (Daughter) said that they have found their mother's full stay and treatment in hospital "distressing" and they wanted to take her home because they feel she is "deteriorating everyday". (Daughter) advised she is going to make complaint OT directed…to PALS (Patient Advice and Liaison Service) and apologised that they felt this way. (Daughter) said she will speak to ward this afternoon as wants clarification on why this has only now been brought to their attention about concerns around discharge today and not when decision was made yesterday by doctor.'*

2.3.48 Following this, within the nursing notes it was recorded by one of the nurses that:

'*since speaking to physio I have been informed that patient is safe to transfer with two but would benefit from an 'eturn' for home, I informed patient's family of this and they are unhappy generally regarding medical care on the ward, and the lack of daily physiotherapy, but are generally happy with nursing care, firstly she has been apparently missing doses of her parkinsons meds which I was not aware of, I apologised for this which they did not accept, they were unhappy at the level of physio that patient had been receiving and that she was not back to her baseline after being in bed for so long, but on the other hand, they were not willing for her to stay any longer, OT explained to*

them that she would recommend that patient stay in hospital for a full assessment of her needs but they declined and also were not willing for her to be seen by MSW and would arrange this in the community, numbers wrote down on patients discharge checklist, they stated to me that they were going to make a formal complaint and to visit PALS, they thanked me for my help, i offered for them to speak to the matron but they declined, stating that she would say nothing that i had not already said….patient escorted to main reception by hca (health care assistant) *who they hugged and thanked for all our care while she has been in hospital*'.

2.3.49 Within the discharge summary it was reported that '*assessed by OT and physio and deemed suitable for discharge home*'.

2.3.50 Later that day (Friday 28/03) it is documented by the physiotherapy department that one of their physiotherapists received a call from Mr X who reported that he could not manage Mrs X at home. He reported that she was not mobile and he could not stand her to get her from the chair to the toilet or commode. A home visit was then made to Mrs X, with Mr X and their daughter reported to be present. Mrs X was reported to demonstrate mobility with the support of one person, although was unsteady at times. It was noted that her husband was happy to provide support to mobilise, and that both her husband and daughter were providing support within the home. A referral to the Community Rehabilitation Team was suggested and the family were reported to be happy with this, they also further stated that they had not been happy with the care Mrs X had received whilst in hospital.

2.3.51 The physiotherapist also called the couple's GP practice the same day and reported they were not coping at home due to mobility issues, and that they had made a referral for assessment for further services.

2.3.52 On 30/03/14 a further visit was undertaken by an occupational therapist who reported that Mr X '*reports chronic hypotension is still causing some dizziness, patient is wearing her stockings but standing blood pressures very hard to obtain. Treatment: assisted trunk flexion and sit to stand practice, gait practice and turning with facilitation, balance work in standing to facilitate awareness of balance and normal weight transfers. Patient tires easily. Husband states unable to use walk in shower due to 2 x internal steps and would like some assistance from reablement to help with bathing therefore advised I would refer to reablement. Patient has a higher toilet and TSF but patient still struggles at times, husband feels wall to floor rails would be more suitable so patient can pull up rather than needing to push up. Husband has input from ILC and is awaiting a ramp, given advice re time scales for ramps etc.*'

2.3.53 On 31/03/14 referrals were made from the Interface Team (City Hospitals Sunderland) to both Sunderland City Council's Community Rehabilitation Services and Reablement at Home Services.

2.3.54 On 01/04/2014, the Reablement at Home service commenced for Mrs X for one visit a day, by one Community Support Assistant. At the first visit, the Community Support Assistant recognised that the package of care prescribed by the Interface Team was not sufficient to meet Mrs X's needs and therefore requested that a further assessment be undertaken and the package amended; an additional Community Support Assistant was added to the package of care.

2.3.55 An Assistant Service Manager from the Reablement at Home Service visited on 02/04/2014 to assess the moving and assisting problems being experienced by Mrs X. They requested an urgent referral for assessment of bathing needs and increased the package of care to four visits per day, with two Community Support Assistants at each visit. Discussions also took place in relation to the purpose of Reablement at

Home Services and the need to look at longer term support arrangements.

2.3.56 The Interface Team had also referred Mrs X for support and intervention from the Community Rehabilitation Service. On 02/04/2014, a Physiotherapist from the team visited Mrs and Mr X at home, undertaking a functional therapy and physiotherapy assessment of Mrs X. During this assessment it was noted by Mr X that '*he had seen a dramatic deterioration in his wife during the 10 days she was in hospital*'. The Physiotherapist put in place a mobility plan with exercises that both Mrs and Mr X agreed to undertake in between visits.

2.3.57 On the same date, the Community Matron also visited the family at home. Mrs X's mobility was noted to have deteriorated. The Community Matron was to complete a review with Mrs X in 1 week. This contact was planned for 11/04/14, the day the couple were found deceased within their home.

2.3.58 A home visit from an Independent Living Officer took place on 03/04/2014, which was originally initiated by Mr X and also picked up as an urgent referral by the Assistant Service Manager from the Reablement at Home Service. The assessment of need concluded with the provision of a shower chair and grab rails to support with the moving and assisting needs. As regards accessing their home, in line with the eligibility criteria the Independent Living Officer declined a request for a ramp; however a grab rail was provided.

2.3.59 Following contact from the Assistant Service Manager from the Reablement at Home Service, indicating that Mrs X had no potential for reablement and therefore required an ongoing care package, a Care Manager visited on 07/04/14 to discuss options for ongoing care and support with Mrs X. Mr X and both their daughters were present at this visit. It was established during the visit that due to the savings the

couple had in the bank, Mrs X would be a self-funding customer. A range of further information was also provided and the Care Manager arranged to revisit the family the following week.

2.3.60 On 08/04/14, a follow up visit took place by a Physiotherapist from the Community Rehabilitation Service, where it was recorded that Mrs X '*participated well in the therapy session; transfer practice with both Mrs X and Mr X – left exercises for undertaking within the home before next visit scheduled for 15/04/2014*'.

2.3.61 On 08/04/14, one of the Community Support Assistants informed their Assistant Service Manager that during one of the visits that day, they had to lower Mrs X to the floor due to mobility issues in order to reduce the risk of fall and injury. The Assistant Service Manager advised the Community Support Assistant to '*risk assess at each visit and inform Mr X that they would not leave them without any support, however if Mrs X's mobility is poor, they would not be able to walk Mrs X at this time*'. The Assistant Service Manager also requested that staff discuss times that Mr X supports Mrs X with her medication, to ensure that this is not reason for the fluctuation in her mobility.

2.3.62 As part of the ongoing involvement from the Community Rehabilitation Team, the Physiotherapist had requested that an Occupational Therapist also visit the home in relation to ongoing equipment needs. The home visit took place on the morning of 10/04/2014. Mrs X slept throughout the majority of the visit and Mr X was present with one of his daughters. Mr X '*advised that he did not think any further support was required regarding equipment provision as he felt the time had come to consider (Mrs X) going into residential care. (Mr X) and his daughter both advised that they wished to arrange some respite and were going to ask their GP. The Occupational Therapist provided contact numbers for social work service contact centre and advised them to request duty social worker if their allocated worker was not*

available. The Occupational Therapist advised she would contact them next week to establish what their longer term plans were.'

2.3.63 At midday on 10/04/2014, one of Mrs X's daughters (D1) contacted the Duty Service (Adult Services) and spoke to a Social Worker, requesting information regarding accessing short break care services for Mrs X. D1 informed the Social Worker that the family were self funding and was thus informed that if required they could access short break care that day, without delays of awaiting approval for Council funding. The Social Worker also provided D1 with information on Care Homes in the local area that could meet Mrs X's needs, their Council Quality Rating for the homes, how to access information from internet about the homes, their vacancy levels, and the prices paid by the Council. The Social Worker informed D1 that they were able to visit that afternoon if required. However D1 confirmed that she had the information she needed and was happy with this.

2.3.64 On 11/04/2014, the Occupational Therapist contacted the Care Manager to see if Mr X or his daughter had made contact regarding the request for short break care. The Care Manager was on leave, however a colleague confirmed that the daughter had spoken with the Social Worker regarding short break care. Tragically, on the same day the Community Support Assistants from the Reablement at Home Service had accessed the home of Mrs and Mr X, using keys from the key safe, and found the couple deceased. As already outlined, initial investigation indicated that Mr X has administered medication to his wife, and then taken his own life.

3 THE PERSPECTIVE OF FAMILY AND FRIENDS

3.1 The daughters of Mrs and Mr X expressed some concern regarding the undertaking of this Domestic Homicide Review, as they did not consider their mother's death to be a homicide. They wished however

to be involved in the process to enable learning for agencies dealing with similar circumstances, and provided valuable information to inform the review.

3.2 The information provided indicated a close and supportive family, caring for an increasingly dependent family member. Whilst their mother's illness had been apparent for many years, her daughters spoke of how she maintained a degree of independence and social interaction. This included her meeting monthly for coffee with former work colleagues, up until around four months prior to her death, as well as social activity with the family, including shopping trips and attendance at football games, until relatively recently. They also reported how until very recently Mrs and Mr X made daily visits to the coast by car for a walk. The whole family had also holidayed together in October 2013 and following this Mrs X had begun to gradually decline. This decline increased significantly in a relatively short period of time prior to her death.

3.3 D1 highlighted that the family had two key areas to bring to the attention of the review, these related to her mother's stay in hospital prior to death, and the discharge and care given following this stay. D1 indicated that the family were very unhappy with aspects of the hospital stay including meal times, care and medication. Within a later meeting for the purpose of this review, both daughters highlighted that this was particularly relevant in relation to the report that their father became 'aggressive' with staff. They felt it was important to understand this within the context of the level of frustration the family were feeling around the care being provided. They provided extensive information regarding their concerns to the Coroner's Inquest and also considered making a formal complaint, although later decided not to pursue this.

3.4 Mrs and Mr X's daughters also indicated that post discharge there had been a care package in place 4 times per day for 6 weeks but that after 2 weeks this service had given notice of being withdrawn. While Sunderland City Council confirmed, within the process of this review, that this was in fact an interim service and would only have stopped after an ongoing care package had been put in place, D1 and D2 felt that there father had not understood this to be the case and that at the meeting with the Care Manager on 07/04/14 he had believed that the care package was to be withdrawn.

3.5 [redacted]

3.6 When asked, Mrs and Mr X's daughters reported that they were not aware of any agency having had a conversation with any family member regarding their caring capabilities and support. They also indicated that they were sure that their father would have discussed this with them had it been the case.

3.7 [redacted]

[1] Paragraphs 3.5, 3.7 and 3.9 paragraphs have been redacted at the request of the family to protect privacy. The paragraphs were valuable to the Home Office and Review Panel and demonstrated the deterioration of Mrs X's health and its impact on Mr X.

[redacted]

3.8 Mrs and Mr X's daughters described April 10th 2014 as a difficult day, as their father was very stressed and tired, and at this point agreed that they could explore respite care, but stated that he could not research it himself. D1 reported that the Duty Social Worker was very helpful in giving assessment scores and contacts for local care homes.

3.9 Further information provided within the police report outlined how on 10th April, the day before Mrs and Mr X's deaths, both their daughters had been in contact with their parents. [redacted]

4 ANALYSIS OF AGENCY INVOLVEMENT AGAINST THE TERMS OF REFERENCE

4.1 In examining agency involvement, focus has been upon how the events and circumstances leading up to the death of Mrs X would have been viewed by individuals involved at the time. While an element of hindsight is difficult to exclude entirely from such a review, and indeed

can sometimes assist in identifying lessons learned, every effort has been made to avoid it where possible.

4.2 **Subject to family and friends or colleagues wanting to participate in the review, were they (i) aware of Mr X's ability and willingness to take on the caring responsibilities for his wife and (ii) aware of any abusive behaviour from Mr X to Mrs X or vice versa, prior to the homicide.**

4.2.1 As regards the issue of whether family or friends were aware of any abusive behaviour from Mr X to Mrs X, all those spoken to as part of this review process were adamant that they did not believe this to be the case. The couple's daughters were clear in stating that their parents relationship was not abusive, and that their father provided support and care to their mother as her illness progressed.

4.2.2 Those organisations with which Mrs and Mr X had contact with for support also reflected such a picture. The representative from MIND spoke of a 'happy, loving couple' and answered definitively 'no' in relation to whether there was any abusive behaviour. Similarly, Parkinson's UK spoke of a 'delightful' and 'perfect' couple and reported that there had been no indicators suggestive of abuse.

4.2.3 In relation to Mr X's ability and willingness to taking on the caring responsibilities for his wife, both his daughters were aware of this and themselves offered a high level of support to both their parents. As outlined, they commented on their father's initial reluctance to consider any kind of respite care for Mrs X, and their mother's wish to be cared for at home.

4.3 **Was there any domestic abuse or indicators of domestic abuse within Mr X and Mrs X's relationship and was this known to**

agencies? If so, how was this responded to and were any assessments undertaken?

4.3.1 None of the agencies identified within their IMRs, any indicators, disclosures or allegations of domestic abuse within Mrs and Mr X's relationship. As indicated above, this was also the view of their children, MIND and Parkinson's UK. As a result of this no assessments were undertaken in relation to domestic abuse, or further services around this. Neither were any domestic abuse or Safeguarding policies or procedures enacted.

4.3.2 Within the IMR undertaken for the Sunderland Clinical Commissioning Group, it is stated that there were no concerns from the practice, either documented or during interview for the purpose of the IMR, in relation to domestic abuse within Mrs and Mr X's relationship. Their GP stated they were a '*delightful couple', 'always together' and 'absolutely dedicated to each other'.* Within their written report provided in relation to the incident the GP also said that Mr X '*had always appeared utterly devoted and highly attentive to his wife's needs and they were generally seen together and appeared inseparable'.*

4.3.3 The practice team also never asked directly regarding domestic abuse, and the GP for the practice reported that to do so had never occurred to any of the team. The practice group also hold bi-monthly meetings at which issues around domestic abuse and Safeguarding Adults are addressed, and Mrs and Mr X were never considered for discussion at such a meeting due to the lack of concerns, as outlined above.

4.3.4 The IMRs for the Community Matron Service (STNHSFT) and City Hospitals Sunderland highlighted there were never any concerns, disclosures or allegations of domestic abuse in relation to either Mrs or

Mr X. The Community Matron involved in the care of Mrs X from 2011, commented during interview for the IMR that they were a 'devoted, loving and caring couple', and all CHS staff interviewed commented on the 'loving and caring relationship' between Mrs and Mr X.

4.3.5 The only incident of concern in relation to Mr X's behaviour was on 19/03/14 within the hospital setting when he was described as becoming 'angry', as Mrs X had not been given her Parkinson's medication. While the incident report cited that he became 'very, very aggressive' with staff, no further action was deemed to be necessary following report of the incident. The IMR author identified that other than on this occasion, Mr X was considered by staff to be friendly in his interactions with them, and there was never any indication of such behaviour directed towards Mrs X. Furthermore it was recognised that Mr X's behaviour could likely have been a reaction towards the stressful circumstances.

4.3.6 Had there been any evidence of abuse, the above could be seen as an attempt by Mr X to reassert control, as he was the one who usually dealt with Mrs X's medication. However, in the case of Mr X it could have been that his actions were those of a man frustrated, as he believed his wife was not getting appropriate care. Therefore it was not unreasonable that staff did not perceive this to be a concern or indicator of domestic abuse. It could perhaps have acted as a prompt for further investigation in terms of speaking to Mrs X alone to clarify if she had any concerns, even if only in relation to Mr X's ability to care and the impact this may be having upon him.

4.3.7 Similar to the other agencies, NTW and Sunderland City Council identified no known domestic abuse, indicators, or concerns within their staff's contact with Mrs and Mr X.

4.3.8 The lack of any indicators around domestic abuse in the case of Mrs X also meant that selective enquiry did not take place. The very nature of selective enquiry is such that it is focused on those perceived as being within a high risk group, such a pregnant women, or prompted by the presence of concerns. It is of note that when Mrs X is reported to have fallen fracturing her left wrist in January 2013 (although this has been queried by her daughters), and lacerated her left temple by falling and hitting her head on 13/03/14, this did not prompt any further enquiry. While such falls and injuries were consistent with her medical condition, it does raise the question as to whether injuries in themselves, and not just those inconsistent with their explanation, should prompt enquiry regarding domestic abuse. Should people be living in an abusive situation, their medical conditions could be used to mask any abuse that may be occurring, making those in such situations highly vulnerable. However it should be noted that there is no evidence to suggest this was the case in relation to Mrs X.

4.3.9 In light therefore of the difficulties associated with selective enquiry, if routine enquiry (enquiry undertaken as a standard question within all assessments) with all service users were part of agencies' practice, this would provide greater opportunity for disclosure of any abuse or concerns, and remove the element of 'judgement calls' from the hands of practitioners. While nothing has come to light during this review that indicates any history of abuse, had there been hidden abuse, Mrs X would have had very limited opportunity to disclose this, despite the high levels of agency involvement. This is strongly related to the fact that she was rarely seen alone, a point that is discussed in more detail later within the report.

4.4 Was Mrs X considered an 'adult at risk' in agencies' dealings with her?

4.4.1 The IMRs completed by agencies highlighted two different aspects in relation to the question of whether Mrs X was considered an 'adult at risk'. It was recognised that as someone over 18, who was in receipt of services due to her Parkinson's disease and the associated dementia, Mrs X could be classified as a 'vulnerable' adult. However, in their dealings with Mrs X none of the agencies had identified any safeguarding concerns suggesting her to be 'at risk'.

4.4.2 The GP practice identified that they have monthly Multi Disciplinary Team meetings to discuss all new Cancer diagnoses, all deaths, all Palliative care patients, and any patient deemed to be 'risk' or 'of concern'. Mrs and Mr X never met the threshold for being discussed at the meetings, as they were deemed by those within the practice who knew them, as stable and not at high risk.

4.4.3 Similarly the Community Matron Service and CHS highlighted that Mr X was seen as a 'devoted carer' who provided 'excellent support' for his wife thus managing risk linked to her illness, as opposed to someone who may pose a risk to her.

4.4.4 As with other agencies, Sunderland City Council's practitioners did not identify any Safeguarding concerns in relation to Mrs X, either within documentation completed at the time of their contact, or retrospectively in interview for the IMR. During interventions relating to moving and assisting, it was noted by staff that Mr X would potentially place his wife at risk if he continued to transfer in a way that was unsafe. As a result at a home visit on 02/04/14 Mr X was provided with education on how to undertake a safe technique, and was felt to be very supportive and welcoming of this advice.

4.4.5 NTW also highlighted that Mrs X had insight into her health problems and was able to independently decide her care and treatment options, therefore not considered 'at risk' in relation to this area of her care either.

4.4.6 Once more, as with the question of whether agencies had any concerns regarding domestic abuse or violence, none of the agencies identified any indicators of any safeguarding concerns. However it should be noted that Mrs X having rarely being seen alone, and the lack of further exploration and management of the the impact of Mr X's caring responsibility, may have limited the opportunities for any risk to be fully identified and addressed. These issues are discussed further below.

4.5 Did Mrs X have capacity and was she capable of making informed decisions about her care in agencies' dealings with her?

4.5.1 The Mental Capacity Act 2005 states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. The starting assumption should always be that a person has capacity, and where it is thought that this is lacking this must be formally assessed and documented. Such assessment should be decision specific, and is in two stages. Firstly, does the person have an impairment, or a disturbance in the functioning, of their mind or brain? This can include, for example, conditions associated with mental illness, concussion, or symptoms of drug or alcohol abuse. Secondly, does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? Appropriate support to achieve this should be offered before applying this stage of the test.

4.5.2 In the case of Mrs X no formal capacity assessments were undertaken by any agencies, as there were no indicators that this was required in relation to any specific decisions. This is with the exception of the GP, where, as is explored further below, the IMR author for the CCG identified that an assessment should have been undertaken. IMRs completed by other agencies also gave consideration to the issue of capacity in the case of Mrs X, to thus demonstrate why no formal assessments were considered necessary.

4.5.3 The IMR for Sunderland CCG identified that Mrs X's capacity, during the time period covered by the review, could be inferred from some of her interactions with agencies that are referenced in correspondence with the GP practice. These include on 06/06/12 when the Parkinson's Specialist Nurse undertook a mini mental state examination with Mrs X, and her score was recorded as 27/30. Although this isn't a direct measure of capacity, it gave some insight into her cognitive function as being mildly impaired, and from this information the IMR author felt that it was reasonable to infer that she had capacity at this point. Similarly Mrs X was seen by the Parkinson's Nurse again on 25/07/12, and correspondence from this consultation stated that she could be '*forgetful, but no major confusion*'.

4.5.4 Following Mrs X's diagnosis with dementia in September 2013 she attended an appointment on 20/12/13 with the Consultant in Elderly Care Psychiatry. In the correspondence to the GP following this consultation it is written that Mrs X had '*good insight into (her) visual hallucinations…she was alert...able to give a good account of herself*'. The IMR author felt that these observations, although not formally assessing Mental Capacity, would suggest that Mrs X had some limited capacity despite her memory loss and visual hallucinations.

4.5.5 Subsequent to this, on 17/02/14, during a follow up with the Practice

Nurse regarding her dementia, there is a record of Mrs X's mini mental state examination being assessed with a score of 24/30. The original score sheet is in the GP records and it records that Mrs X had '*perfect orientation in time, space and person, with good immediate recall, but poor attention, and impaired delayed recall*'.

4.5.6 The IMR author for the CCG concluded however that, despite the inference that can be taken from the above, it was impossible to say with accuracy if Mrs X was able to make informed decisions about her care using the information gathered from the GP records. Indeed, in interview for the IMR, the GP themselves identified that they felt it was likely that Mrs X didn't have capacity. It is of note that when attending the GP practice she was often in the presence of her husband, who the IMR author noted seemed to do a lot of the talking and decision making. This does not appear to have been questioned by practitioners despite the fact that there was no formal assessment to indicate that Mrs X could not take such decisions herself.

4.5.7 While formally assessing and documenting mental capacity in Primary Care is not routine practice, the IMR author for the CCG concluded that, in the case of Mrs X, a formal Mental Capacity Act assessment should have been carried out by a clinician involved in her care. In interview however the GP suggested that they thought that undertaking a formal assessment would be more within the remit of the Psychiatric Services than Primary Care.

4.5.8 In relation to the above, training about the Mental Capacity Act was delivered directly to the majority of GPs in Sunderland in a half day learning event on the 09/04/14. The event covered learning relating to previous Serious Case Reviews as well as Sunderland's first DHR, with issues around the Mental Capacity Act arising specifically from a previous Serious Case Review. After this learning event, GPs should

have been equipped to have more understanding of the Mental Capacity Act; be able to perform an assessment; understand that capacity is decision specific; understand in what circumstances an Independent Mental Capacity Advocate is needed; and be able to appropriately document and code the decision regarding mental capacity. To aid this, a comprehensive template exists on the computer system that the vast majority of Sunderland GPs use. This 'Elderly Health Assessment and Dementia' template is easily accessed and includes prompts and questions around an array of issues, including specific questions about the Mental Capacity of the patient.

4.5.9 In contrast to the GP's feeling that it was likely that Mrs X didn't have capacity, other services' contact with Mrs X suggested that she did have capacity, which is more in line with the information taken from the review of the GP practice's records. The Community Matron Service indicated that there was nothing to suggest that Mrs X did not have capacity and as a result of this formal capacity assessments were not undertaken. The Community Matron informed the IMR author for STNHSFT that this included their contact with Mrs X just over one week before her death on 02/04/14, when there were no concerns regarding her capacity to make informed decisions around her own care.

4.5.10 NTW also reported Mrs X to have capacity when seen by the CPN and Psychiatrist, and as a result she made decisions regarding all investigations and treatment options. In all three appointments Mrs X was reported to give a good account of herself, and to have made a choice regarding her medication. Mrs X was also described by the CPN who saw her, as an independent lady with insight into her disability, who was able to discuss freely her opinion regarding her care.

4.5.11 City Hospitals Sunderland also identified that no formal capacity assessment had been undertaken. However the IMR author went on to identify that Mrs X would appear to have had capacity, as she understood what was said to her, and was compliant with that which was required of her. The IMR author also however identified that staff reported that Mr X would speak for Mrs X with her 'best interests at heart'. As with other agencies, the lack of a formal capacity assessment, combined with staff's belief that Mrs X did have capacity, brings into question the acceptance of Mr X speaking on her behalf. It is also of note that in relation to Mrs X's discharge from hospital in March 2014, there is much reference made in records to her husband and daughters' wishes for her to be discharged. However there is limited reference to Mrs X's opinion in relation to this, other than that during personal care she responded 'yes' when asked if she wanted to go home.

4.5.12 In the case of Sunderland City Council's Adult Services it is documented within the assessments undertaken on 05/09/13 and 03/04/14 that Mrs X had capacity to consent to the assessments being undertaken and the intervention proposed (equipment in both cases). There were also a number of home visits by a variety of other Adult Services staff following Mrs X discharge from hospital in March 2014. In interviewing these staff the IMR author for Sunderland City Council identified that practitioners who had seen Mrs X felt that she had had the capacity to understand the assessment and interventions taking place. The Community Support Assistants who provided care and support four times a day reported that Mrs X had capacity to understand the tasks being undertaken by the care team and required only verbal prompting in relation to mobilising to the bathroom. In considering evidence of capacity, one Community Support Assistant (CSA) recalled a time when Mrs X had been '*a little rude*' to a fellow CSA; when the CSA returned the next day, Mrs X '*apologised for her behaviour and hoped she hadn't upset her*'.

4.5.13 In reviewing agencies' practice around capacity assessment in the case of Mrs X, while in the case of most agencies no formal assessments of capacity were required, there is evidence of capacity having been actively considered and recorded, as in the case of Adult Services and NTW. In the case of the GP however, there would appears to be a retrospective lack of clarity as to whether Mrs X had capacity and this thus demonstrates that a formal assessment would have been useful. Furthermore in the case of both the GP and CHS, both agencies directly identified that Mr X often appeared to talk for Mrs X and make decisions on her behalf. While it is good practice for staff to be sensitive to someone within a caring role, and thus to involve them through seeking and considering their opinion in relation to the person for whom they are caring, it is important that this does replace the views of the individual themselves, where such individual is deemed to have capacity.

4.5.14 While in this case there had been no concerns identified indicating abuse within the relationship, in cases where abuse is present such practice would unknowingly result in collusion with the abuser, and their abuse, through allowing them to speak for the victim and make choices on their behalf. It would also decrease opportunities for the victim to disclose. This once again links to the issue of Mrs X having been seen alone on limited occasions, which is discussed further below.

4.6 **At any point was Mrs X seen alone so that her own wishes and feelings could be expressed about her care?**

4.6.1 Mrs X was seen alone by health and care professionals on extremely limited occasions; this occurred primarily during the undertaking of

personal care tasks during her in-patient stay at hospital, or during visits from the Reablement at Home Service following her discharge.

4.6.2 Within GP practice notes there is no documentation specifically indicating that she was seen alone, and the GP stated that her and Mr X were generally seen together and '*appeared inseparable'*. Similarly, Mrs and Mr X were always together for home contacts with the Community Matron, who reported that while there was opportunity to speak with Mrs X or Mr X on their own, they had never felt the need to do so. The Community Matron was aware that Mr X could at times speak on behalf of Mrs X, however did not have any concerns that this was a control measure by Mr X, and perceived it as the result of him being a caring husband.

4.6.3 This was also the case with Sunderland City Council's services, and throughout all assessments and home visits, with the exception of personal care, Mrs X was always seen with her husband. At no stage during interventions did any staff from SCC feel they needed to see Mrs X alone. When interviewed, all staff stated that they had experience of situations where they had requested to see a customer by themselves, due to either conflicting opinions being shared or dominating behaviours by another member within the household; however, this was not felt to be the case with Mrs and Mr X. One of the Independent Living Officers recalled that Mr X was involved during an assessment that took place in 2013, and did not dominate the assessment, with Mrs X answering the assessment questions without interference from her husband. Similarly, one of the physiotherapists who undertook a home visit to Mrs X said that though she presented with communication difficulties (very quiet voice) linked to her Parkinson's disease, Mr X did not answer questions for his wife. He did 'correct' information when Mrs X was drowsy during the initial part of the visit, however the Physiotherapist saw this as supporting the

assessment process, in order that accurate information was shared.

4.6.4 In the case of all the four agencies above it can be seen that no attempts were made to see Mrs X alone, due to the lack of any previous safeguarding issues or the presentation of any concerns during their contact with her.

4.6.5 Despite the lack of any concerns, the CPN for NTW noted that they did offer Mrs X the opportunity to be seen alone at the start of the appointments, but that she declined and was happy to be seen with her husband. The CPN reported that Mr X did not at any time interrupt Mrs X within the assessment process, and supported the conversation appropriately when requested. In relation to Mrs X declining to be seen alone when asked directly by the CPN, it is important to note that such questions appear to have been posed in the presence of Mr X. In cases where domestic abuse is taking place, asking the victim in the presence of the perpetrator may well be ineffective, as in such circumstances they are unlikely to identify that they need to be seen alone.

4.6.6 On the limited occasions where Mrs X was seen alone, both CHS and Sunderland City Council's Reablement Service identified that she did not raise any concerns or issues. Whilst in hospital Mrs X was asked on two separate occasions if she wanted to go home by ward staff, when they were assisting her with showering, and on both occasions she said yes. The IMR author for CHS felt this was demonstrative that there was no coercion or control by Mr X. The Parkinson's Nurse also took Mrs X to the bathroom on her own where she had the opportunity to discuss any issues, but none were raised. Sunderland City Council staff from the Reablement at Home Service also spent time alone with Mrs X during their 4 visits a day, and at no stage did Mrs X express any concerns.

4.6.7 It is recognised that there were no safeguarding or domestic abuse indicators present, that would have acted as a 'trigger' for Mrs X to be seen alone. However given the high levels of contact she was having with services it is concerning that so few attempts were made to see her alone, ascertain her feelings about her care, and also create opportunities for any disclosures. As has already been identified, it would appear from information available that Mrs X likely had capacity throughout much of her contact with services. Whilst she is constantly met with in the presence of her husband, there is no indication that this was 'necessary' in order to obtain her views. Therefore should domestic abuse or violence have been present, or should Mrs X have had other concerns such as Mr X's ability to provide care for her, she would have had extremely limited opportunities for such disclosure. While it is noted that she was at times seen alone, this occurred on relatively few occasions and always took place during personal care, which would not necessarily have been the most conducive time for unsolicited disclosure.

4.6.8 In addition to limited attempts being made to explicitly see Mrs X on her own, the lack of any presenting concerns also appear, as discussed previously in relation to selective enquiry, in no direct questions around domestic violence or abuse being posed. As already addressed a lack of direct enquiry results in missed opportunities for possible disclosure by those who may be experiencing abuse. This is also linked to learning that emerged from another recent Domestic Homicide Review, and as such is discussed further in relation to lessons learned.

4.7 **Were agency assessments carried out and decisions made about Mrs X done in an informed and professional way? Were appropriate enquiries made, services offered or services provided given what was known or what should have been known at the**

time?

4.7.1 Throughout the period of the review it has been identified that Mrs X was seen regularly by the Consultant Neurologist, the Parkinson's Specialist Nurse, the Community Matron, and her GP Practice. In addition there is a period of three contacts with NTW between July and December 2013, during her diagnosis with dementia; as well as an increased period of contact with staff from Sunderland City Council following her discharge from hospital in March 2014.

4.7.2 During this time there is evidence of communication between the services at City Hospitals Sunderland and Mrs X's GP with regards to the treatment she is receiving, as well as letters from NTW to the GP regarding Mrs X's diagnosis with dementia. The IMR for Sunderland CCG identified that this correspondence did not note any concerns that would prompt the need for any further assessment of Mrs X in addition to those assessments that were already taking place. However within the Chronology, on 06/06/12 a letter from the Parkinson's nurse to the GP noted Mrs X '*to be worse with anxiety*'. Furthermore, a letter received from a psychologist on 28/02/13, following Mrs X participation in a research study, notes that her mood was assessed as '*anxious and depressed'*. While it is also noted in the latter correspondence that the couple were '*not concerned about her mood or anxiety levels at present*' and were '*aware they could make an appointment should they require further support in the future*', this would appear however to have been an opportunity for further follow up and assessment to ensure that Mrs X's anxiety was being appropriately addressed and managed.

4.7.3 In addition to the above, following a hospital clinic appointment on 29/04/13 a letter was sent to the GP in which it is written that '*husband hasn't been well recently and things seem rather a struggle at present*'.

Similarly, on 19/06/13, in the referral to the Memory Protection Service, the Parkinson's Nurse stated that Mrs X and Mr X were both having difficulties managing at home with the symptoms, and that their situation was under review at that time with a Community Matron, although it is not clear as to what such review consisted of.

4.7.4 It would appear therefore that while references were consistently made to the emotional difficulties Mrs X was experiencing, this does not appear to have prompted individual agencies to undertake any further assessment or referral specifically linking to her emotional well-being. These would therefore appear to be missed opportunities to offer further support. As much of the information was being fed into the GP practice, such concerns could perhaps have acted as a prompt for discussion at the Practice's Multi-Disciplinary Team meeting, or resulted in further exploration with Mrs X of the support services available.

4.7.5 The IMR author for the CCG also noted that on 17/02/14 when the Practice Nurse undertook a 'dementia review' with Mrs X, there was no mention within the notes of home circumstances (bar lives 'independently with spouse'- which is an automatic coding phrase); Mrs X's cognition or Mental Capacity; Mr X's mental health; or the couple's subjective ability to cope at home. Given the proximity of this review to the couple's death the IMR author identified that this was a missed opportunity to explore any issues the couple had with regard to their home circumstances and ability to manage. Such reviews may also have been a point at which to revisit concerns raised in correspondence from other agencies.

4.7.6 In regards to the Community Matron Service, there was significant ongoing contact with Mrs X from 2008 onwards, and the IMR author for STNHSFT did identify that the services offered from 2008 to 2011

required review regarding a number of aspects. This included how visiting patterns were determined given that contact with Mrs and Mr X was often undertaken via telephone; and the lack of health assessments being undertaken despite referrals for equipment made in April and November 2010. A review took place at a Kaizen event (a rapid service improvement exercise) held in 2011 and one of the things this resulted in was the development of a risk assessment tool, which also provided a minimum guide for contact by the service dependent upon the needs of the patient. The IMR author reviewed the current systems and processes within the Community Matron Service, and was assured that many of the issues prior to 2011 had now been addressed with new systems and processes in place to support the team. The author was also able to see this change in practice evidenced by continuity of care offered to the couple, and the quality of documentation, assessments and reviews undertaken from November 2011 onwards.

4.7.7 In relation therefore to the contact by the Community Matron Service that took place from this point, it would appear appropriate assessments and referrals were undertaken in relation to Mrs X's changing health needs and the management of her Parkinson's disease and associated dementia. This included in November 2011 the completion of a Community Matron Care Plan and a falls risk assessment, followed by referral to the falls clinic. As regards Mrs X's falls, at this and later stages, the Community Matron identified during interview for the IMR that there were never any indicators of domestic abuse or safeguarding concerns in relation to such falls. It was noted that the falls were shared with the Community Matron and other professionals, medical explanations were offered and, where necessary, medical treatment was sought.

4.7.8 In relation to the question of whether decisions were carried out in an

'informed' and professional way, the STNHSFT IMR author did identify that throughout the review process they had struggled to clarify if information was shared between the GP practice and the Community Matron Service regarding progress and outcomes. Indeed in looking at Chronology, it would appear that while there is evidence of communication between services provided by CHS and the GP practice, there is little evidence of communication between the Community Matron Service and GP practice. This is of concern given that the Community Matron is identified as a single point of contact for coordinating care. On discussion with the Community Matron team the IMR author concluded that there appeared to be no clear process that facilitates reciprocal sharing of information, and this is addressed within the individual agency recommendations proposed by STNHSFT.

4.7.9 In Mrs X's contact with City Hospitals Sunderland, the IMR completed identified that most assessments and referrals made were done in an informed and professional way. It was recognised however that there was a late referral to the Occupational Therapist, which resulted in a missed opportunity for early intervention prior to Mrs X's discharge from hospital. Ward staff asked D2 on 21/03/2014 if a referral to a Medical Social Worker or Occupational Therapist was required. D2 stated that she would check with her father and let staff know, but ward staff did not follow this up. The Occupational Therapist could have started the assessment one week prior to discharge, and this would have resulted in the home assessment being completed and equipment in place ready for discharge.

4.7.10 It is also of note that the discharge took place on Friday 28/03/14. Discharges on Fridays are not ideal in light of the fact that referrals to other services are not likely to be picked up until the following Monday.

4.7.11 CHS also identified the issue of assessments linked to Mrs X being

'medically fit' but not 'therapy fit' for discharge. The Physiotherapist described the term 'therapy fit' as the patient being able to safely transfer (from bed to chair to toilet etc.) and mobilise in the home. On assessment, the Physiotherapist found that Mrs X had not returned to her baseline in this respect. On admission to hospital Mrs X was able to transfer with the assistance of one person, but on her assessment prior to discharge, she required the assistance of two people and a transfer aid as her physical state had deteriorated significantly. At the present time within CHS the self-discharge process only covers patients who are not deemed medically fit for discharge and there is no process in place for those who are not therapy fit. Therefore while the assessments themselves were informed, the delays that occurred and the lack of process for addressing the inconsistency around medical and therapy fitness contributed to the subsequent difficulties upon Mrs X's discharge, as well as confusion for the family.

4.7.12 The IMR for NTW identified that Mrs X was provided with appropriate services based on her presenting needs. The CPN undertook a comprehensive mental health assessment which included Presenting Problems, Mrs X's Needs, Mental State, a FACE risk assessment, Carer's View and information, Personal History, Social Circumstances including mobility, self care and communication, and Mr X's Caring responsibilities. The care and treatment provided to Mrs X at the time of involvement was seen to improve her wellbeing. The assessment from the Older People's Community Mental Health Service and transfer to the Memory Protection Service was also appropriate based on her presentation and diagnosis.

4.7.13 Following her diagnosis of dementia Mrs X also attended a review with the Psychiatrist who is reported to have provided her with a 'Dementia Guide,' produced by the Alzheimer's Society, and to have offered to see here again in the future should the need arise. There was no

further signposting or contact offered, as at this time the assessment did not highlight any significant concerns regarding her emotional wellbeing. Information about further support services for both patients and carers is contained within the dementia guide.

4.7.14 As regards Sunderland City Council Adult Services' contact with Mrs X, equipment assessments that took place from 2007 - 2013 appear to have been appropriately undertaken, with the whole situation being considered and relevant equipment offered. The assessments and support provided post hospital discharge for Mrs X then commenced on 31/03/14, with a referral for Reablement at Home services by the Interface Team (City Hospitals Sunderland). The package of care commenced on 01/04/14 following agreement by Mrs and Mr X that the proposed time of visit was suitable to them both.

4.7.15 Following the initial assessment on 01/04/14 by the Reablement at Home Service, it was then identified that one Community Support Assistant was not sufficient to meet the needs of Mrs X, and by 02/04/14 an Assistant Service Manager accordingly increased the package of care to four visits per day with two workers. The IMR author noted that the flexibility of the Reablement at Home Service to meet the fluctuating needs of Mrs X should to be noted as good practice in terms of assessment and decision making. This ensured that the risks associated with Mrs X's mobility and inability to access the shower were appropriately and safely managed, which in turn supported Mr X in his caring role.

4.7.16 As part of the referral from the Interface Team, there was also a referral to the Community Rehabilitation Service, which provided physiotherapy and occupational therapy support to assess Mrs X's potential for rehabilitation following her hospital stay. At the time of the referral, there was a 72 hour delay for Community Rehabilitation

Service due to capacity within the service; however the first visit took place as soon as was possible, on 02/04/14, when a Physiotherapist visited Mrs X at home. During the visit by the Physiotherapist, a functional assessment took place in relation to Mrs X's mobility and a mobility plan was put in place with exercises for Mrs X, supported by Mr X, to follow during visits.

4.7.17 On 02/04/14, during visits by both the Reablement at Home Assistant Service Manager and the Physiotherapist, both reminded Mrs and Mr X about the purpose of Telecare (an emergency contact system operated by the Council, whereby people can contact someone 24/7 if they require assistance or support). The Telecare system had been fitted within the Home since 2012 and records showed no calls had ever been made to Telecare Response System from Mrs X or Mr X since installation.

4.7.18 Following information on 01/04/14 from the Reablement at Home Service, that Mrs X did not have reablement potential and required an ongoing care package, a Care Manager visited. There was no urgency to the referral as the Reablement at Home Services were continuing to support Mrs X and meeting her needs; therefore the visit took place 6 days following referral. As this was the first time Mrs and Mr X were seeking ongoing social care support, the visit focussed on providing information and advice on the range of options available to support Mrs X within the home environment. A lot of information was shared and it was noted that D2 was present and taking written notes of the conversation.

4.7.19 At this visit, the Care Manager did not initiate an assessment of need, as there was no urgency to set up an ongoing care package due to the Reablement at Home Service confirming that they would continue to provide four visits a day, by two workers, for at least four weeks.

During the visit, information was provided on the home care agencies within the local area and the wider city, and the Care Manager informed Mrs and Mr X that although they were self-funding the Care Manager could support them in arranging the ongoing care package. D2 also asked about care homes, as she wished to know what would happen if an ongoing care package in the home did not work. The Care Manager informed her that one of the options was short break care, which would allow Mrs X and the family time to consider future options. The conclusion of the visit was that, at this stage, the family were unsure of what decision to take. The Care Manager therefore agreed to revisit the family the following week and provided them with direct contact numbers should they wish to discuss anything in the meantime.

4.7.20 When an Independent Living Officer (ILO) visited on 03/04/14, a shower chair and grab rails to assist with the increased needs of Mrs X were provided. However, a request for a ramp to access outside was declined in relation to the eligibility criteria, and one of the reasons for this was that Mrs X was receiving support from Reablement at Home and Community Rehabilitation Service and therefore it was expected that her mobility could improve. However, in line with process, when a Team Manager reviewed the Independent Living Officer's assessment, and considered the other information known about Mrs X from the records on the system, they requested that the ILO reassess the access issue and an appointment was arranged for 17/04/2014.

4.7.21 Throughout all interactions with Sunderland City Council, it would appear that assessments pertaining to Mrs X were carried out in an informed and professional manner, with appropriate services provided in a timely manner to meet Mrs X's needs.

4.8 **Was the extent of Mr X's and his children's caring responsibilities**

recognised? Were appropriate enquiries made, services offered or services provided given what was known or what should have been known at the time? Was a carer's needs assessment carried out on Mr X and/or his children and if so, were decisions made in an informed and professional way?

4.8.1 At no point during his contact with agencies was a carer's assessment carried out in relation to Mr X. Despite this it appeared that all agencies recognised his role as Mrs X's main carer, and varying attempts were made by agencies to address this. The role of her children was less well documented however, with their involvement becoming more apparent within recording during, and following, Mrs X's period in hospital. It is clear however from discussion with the couple's daughters as part of this review process, and from brief references within records to the support of Mrs X's family, that they were present in Mrs X's life and involved in her care.

4.8.2 In relation to the GP practice, it was outlined in the IMR for Sunderland CCG that the couple were 'well known' to the practice and were on the 'Patient Participation Group' (a group made up of patients that meet regularly to discuss relevant practice issues). The GP specifically reported in relation to Mr X that '*we all knew him*', and he was '*an active fit chap*', who was '*a bit fussy if things weren't right*'. The couple therefore appear to have had regular contact with the practice in a variety of different forms that weren't routinely documented in the GP records. The IMR author identified that this resulted in an assumption of shared knowledge throughout the practice team that the couple were managing together, and that this included Mr X managing his anxiety and his caring responsibilities.

4.8.3 Despite this apparent awareness of Mr X as Mrs X's main carer, there was no specific coding in the practice records to document this.

Sunderland CCG have rolled out a 'Carers' Improvement Scheme' in Primary care which aims to offer support and signposting to those patients who care for people in the community. There is also financial incentive for GP practices attached to the scheme and it is well known about in Primary Care. The GP for Mrs and Mr X stated during interview that their practice was signed up to the scheme, and they therefore did not know why Mr X wasn't coded as a carer. If he had been, then a computer search may have identified him and he would have been offered a carer's assessment, a health check, and onward referrals to both Sunderland Carers' Centre and Adult Social Services.

4.8.4 Within his contact with the GP practice Mr X also had a review every 6 months for his blood pressure medication. During these reviews by the nursing staff at the practice, his antidepressant medication was also automatically reviewed. Despite this there is no written notes that his mood had been enquired about, nor any reference to the caring role he was undertaking. This would have been good practice given both the nature of his medication and his known home circumstances, and as such is a missed opportunity to offer further assessment or support.

4.8.5 Staff working with City Hospitals Sunderland, who were interviewed for the purpose of the IMR, also recognised Mr X's caring role, however no carer's assessment was undertaken during their contact with him. The Consultant and Parkinson's Nurse had regularly documented that Mr X was Mrs X's main carer, but also that he reported to be coping and that he had a good support mechanism within the Parkinson's group. On 14/01/13 at a CHS clinic appointment with the Parkinson's Nurse, the nurse also noted that there was no 'social services intervention but good support from daughter'.

4.8.6 Following a clinic appointment on 29/04/13, as referred to earlier, a letter is written to the GP from the Consultant who *reports that Mr X is*

'not well recently and things seem rather a struggle. They do not feel MDT support is needed at present'. As discussed previously, in light of the concerns which are obviously present, and which presumably had been discussed resulting in the couple declining additional support, this perhaps should have warranted further consideration, possibly within an MDT setting. Similarly, on 03/09/13, the GP received a letter from the Consultant following Mrs X attendance at the clinic stating that as a result of her emerging dementia '*Mrs X has become more unpleasant at* home', but again there is no evidence of this prompting any further assessment of the support needs for Mr X in relation to the impact of this upon his caring role.

4.8.7 Overall in his contact with CHS, Mr X was seen as a fit and active man who was adequately coping with caring for his wife. During Mrs X's time as an inpatient he had disclosed to an Occupational Therapist that he had suffered from depression but inferred that it was not a problem. One of the Parkinson's Nurses also recognised that Mr X was exhausted during his wife's last admission to hospital and recommended that he go home to have some rest. Mr X had also told an Occupational Therapist that he and Mrs X had a good support network and that he would manage Mrs X's needs on discharge with the help of family and friends. However, all the above, combined with the discharge needs of Mrs X, and the incident during her stay in hospital, where Mr X had become 'angry' and 'aggressive' with staff when he perceived Mrs X's medication was not being administered correctly, should have perhaps prompted the offering of a more formal carer's assessment, or discussion around additional support available such as the Sunderland Carers' Centre or Age UK Sunderland.

4.8.8 Within Mr X's contact with the Community Matron Service, his difficulties linking to anxiety and depression are acknowledged throughout, as well as his role as main carer for Mrs X and the impact

of this upon his own mental health difficulties. As a result of this in 2008 he was added in his own right to the Community Matrons' caseload. This resulted in ongoing review of Mr X and an example of this is in March 2012, when during review his mood was noted to '*still be problematic; however (Mr X) still reported to be attending the GP for support, although as noted above, Mr X indicated his appetite and sleep pattern had been slightly disrupted but he hoped this would improve when his mood improves*'. It was recognised that his mood fluctuated with Mrs X's condition, and documented that he became more anxious and depressed when Mrs X's condition deteriorates. However it was also noted that Mr X still functioned well in caring for his wife.

4.8.9 While the link between his caring role and his own anxiety are well documented by the Community Matron Service, as regards management of this it appears that this was based primarily on the self-report of Mr X. It is noted that in 2008 Mr X was given a CD to help with relaxation and continuing reference is made to his use of this, as well as contact with his GP, CPN, MIND and the Parkinson's Support group. Such support is referenced throughout the review period in relation to Mr X's management of his anxiety and the demands of his caring role. However the IMR author for STNHSFT noted there is no evidence of liaison with other professionals to clarify the support being received by Mr X. This is highlighted in relation to Mr X's reference to support from his CPN, although NTW records indicate that this consisted solely of two assessments seven months apart, and a follow up call three months later.

4.8.10 Throughout 2013 as Mrs X's condition declined Mr X reported his mood at this time to be worse, however he continued to state to the Community Matron that he was coping. During discussions the Community Matron indicated to the IMR author that she was aware of

the increasing caring responsibilities for Mr X and continued at most contacts to discuss additional support, however both Mrs and Mr X always declined this. One example of this was in September 2013 when the Community Matron had offered Mrs X the opportunity to attend a day hospice in order to support Mr X with his caring responsibilities, which the Community Matron recognised had increased over the previous months. Throughout this time the Community Matron reported that she remained concerned regarding the sustainability of the caring role for Mr X, however felt that Mrs and Mr X continued to refuse any additional support offered.

4.8.11 Mr X was subsequently discharged from the Community Matron's service in December 2013. During discussions the Community Matron highlighted that the reason for discharge was that Mr X had remained stable for some months and there was nothing to case manage. Mr X was said to have recognised himself that his mood changed with regard to Mrs X's health, that he was anxious regarding Mrs X's future, and on numerous occasions stated to the Community Matron '*I don't know what I would do if anything happened to (her)*'. Despite the Community Matron's concerns regarding the sustainability of his caring role, as indicated previously, Mr X reported that he was seeking help from a variety of sources regarding his mental health and continued to decline additional support offered. The Community Matron also noted that when contact was made with Mrs X, Mr X was present and as such he would continue to be reviewed during these contacts in relation to his caring responsibilities for Mrs X. The Community Matron was clearly aware of Mr X's own mental health needs however highlighted to the IMR author that she never saw this impact upon the level of care he provided to Mrs X. In relation to Mr X's discharge from services however, the IMR author for STNHSFT identified that prior to this, clarification should have been sought regarding the support he reported receiving from other services, especially in light of his caring responsibilities.

4.8.12 Within the IMR for NTW it was identified that the caring role was fully explored with Mr X during Mrs X's contact with the Service in 2013, and he was thought to be managing well. Both Mrs and Mr X were reported to have felt that a referral to Adult Care Social Services for support was not necessary at this point in time. Furthermore the CPN confirmed that in her contact on 1st July 2013 she had offered, as routine with all carers, a carer's assessment, but that this was declined by Mr X. At the two further appointments subsequent to this no further issues were identified that would prompt further assessment or support being offered.

4.8.13 Throughout all of Mrs and Mr X's contact with Sunderland City Council, Mr X was recognised as the main carer for Mrs X. In 2013, at the home visit by an Independent Living Officer, Mr X was offered a carer's assessment and an emergency plan, and declined both. Mrs and Mr X informed that '*family offer and provide support they need*'. The Independent Living Officer also recalled that during interview they offered information regarding organisations that could support Mrs X and Mr X, and that they responded that they had support from Parkinson's UK.

4.8.14 On 02/04/14, when undertaking assessment of Mrs X the Physiotherapist noted '*Mr X's role (had) changed since wife was discharged from hospital*'. The Physiotherapist had a discussion with Mr X in relation to his caring role including information around the Parkinson Disease Society's (PDS) support group and Alzheimer Society's 'memory cafes'. It was noted that Mr X already had information on both of these and informed that he '*aims to get back to the PDS meetings*'. Mr X therefore indicated that he had support, presented as knowledgeable regarding services, and declined any other support. During the home visit, the Physiotherapist also

discussed health implications of caring roles and Mr X reported that he had no physical health problems, although did state '*he was taking medication for anxiety*'. Mr X also stated that since the start of the Reablement at Home service, him and Mrs X were managing much better since her discharge from hospital.

4.8.15 The Community Support Assistants from the Reablement at Home Service also recognised Mr X as a carer; in so much as it was one of the reasons their service was in place, in order to provide support to Mr X in his caring role. During interview they recalled that Mr X would like to provide practical support whilst they were undertaking their visits. As they believed that one of the outcomes of their intervention was to support Mr X, they would encourage him instead to read his newspaper or make a cup of tea. Mr X reportedly always listened to the Community Support Assistants and would take a rest from undertaking practical support for Mrs X whilst they were visiting.

4.8.16 When the Care Manager visited to provide information and advice to support Mrs X's ongoing needs, a formal assessment of need did not take place; however the Care Manager was cognisant of Mr X as a carer. They provided information regarding support services available from Sunderland Carers' Centre – including leaving information and the contact phone number. The Care Manager also noted that D1 and D2 were present at this home visit, with D2 taking written notes of all information being shared.

4.8.17 It should also be noted that on 10/04/14, the day prior to the death of Mrs X, an Occupational Therapist visited the home in relation to ongoing equipment needs. Mr X, and one of his daughters, informed them that further support regarding equipment provision was no longer needed, as the time had come to consider Mrs X going into residential care. There were no indicators within this of the actions Mr X took the

following day, and the request was responded to appropriately by the Occupational Therapist through the provision of contact numbers for social services. This was then followed up by D1 contacting social services regarding short break care for Mrs X, which was once again responded to appropriately.

4.8.18 Throughout agencies contact with Mr X, it has been demonstrated that all recognised him as a carer for Mrs X. The extent to which the impact of this was explored and recognised with agencies varied however. The GP practice and CHS believed that the couple were managing their situation and no formal assessment or further support was offered. In the case of the GP practice a failure to do so was also due to the fact that Mr X had not been appropriately coded on the system as a carer. Similarly, while NTW had limited contact with the couple, due to a lack any concerns reported by Mr X, he was viewed as adequately coping with the situation. A carer's assessment was offered but declined and a dementia guide given with support services listed within, however no further signposting appears to have occurred.

4.8.19 STNHSFT were aware of Mr X's caring role and the significant impact this was having in terms of his own mood and anxiety was considered and documented. However Mr X's own report that he was managing this and accessing support from other sources was accepted and no further clarification was sought, or additional support information supplied. Within contact with Sunderland Council's Services Mr X's role as a carer was recognised and explored with him, including discussions and information provision around support services available.

4.8.20 Within the above, a number of issues can be identified. There was an absence of any formal carer's assessment, although there were occasions where this was offered, but declined by Mr X who asserted

that he was coping. It does not appear however that this was always followed up in terms of discussing with Mr X what other more informal support might have been available. Furthermore it is often referenced that he declined further support but it is not always clear to what extent this was explored with him to ascertain what he perceived as 'support' and if he was fully aware of what may be available. In feedback to the Panel, it was raised by the representative of Sunderland Carers' Centre as to whether Mr X was involved in discussions about how support could be given without taking away his caring role and dedication to his wife. It should be noted that there is evidence of this being undertaken in his contact with Adult Social Services, and this includes him being given the details of Sunderland Carers' Centre. No other agency gave information around this service, which could have offered support to Mr X through less formal pathways.

4.8.21 Finally, lack of further action by agencies is often based on Mr X's own report that he was accessing other sources of support. There is no evidence however of liaison, either across or within agencies (statutory and third sector), to clarify these support avenues. Furthermore when information is shared between agencies regarding increased stresses, or changes in Mrs X condition, there is no evidence of any coordinated approach being taken to address the potential impact of these upon Mr X as a carer. Also, the fact that Mr X was already receiving support, such as that offered by the Parkinson's group this should not in itself have excluded referral to others services such as Sunderland Carers' Centre, Age UK Sunderland or other care and support services.

4.8.22 As regards the role of Mrs X's children in terms of caring there is a distinct lack of agency information relating to this, which is perhaps reflective of no formal assessments being undertaken regarding care. Any information relating to this is therefore gained solely through the children being present during visits, through them contacting services

directly on behalf of their parents, or through references to them by Mrs and Mr X. Within this Mrs X's children do not appear to have been offered any formal assessment or supplied with information around informal support, such as that which could be offered by the Sunderland Carers' Centre or Age UK Sunderland. The point at which Mrs X was in hospital and during her plans for discharge would appear to have been a significant opportunity to consider the role of her children as carers, and to engage them in exploring support that may be available.

4.9 **At any point was Mr X or his children seen alone so that their own wishes and feelings could be expressed about their caring responsibilities?**

4.9.1 It has already been identified that Mr X was present at much of his wife's contact with agencies. In relation to him being seen alone, the GP practice identified that this occurred during a number of appointments in relation to minor dermatology issues. Furthermore a phone consultation on the 24th March 2014 was conducted by the GP when Mr X had a cough and was given antibiotics. Within this it was documented that Mr X reported that his wife was '*currently in hospital following a fall*', but there is no mention of any resulting enquiry around his emotional wellbeing at this time. There is also no documentation of specific questioning during these times about Mr X's thoughts about his caring role and responsibilities, despite the fact that he was recognised as a carer by staff within the practice, and was also being prescribed medication for mental health issues.

4.9.2 As has already been outlined, Mr X also discussed his caring role with staff from the Community Matron Service. While some of this contact took place within the home, it also on occasion took place by phone. While this could be perceived as Mr X being 'alone' it should also be

noted that his wife may have been present in the room, and this may have impacted on the extent to which he was willing to disclose any difficulties he was having.

4.9.3 Within CHS, the Parkinson's Nurse regularly had telephone conversations with Mr X regarding treatment/medication but he never asked to speak to her in confidence, in relation to any concerns/issues; as above, this may have been impacted upon by Mrs X's presence in the room. Mr X also regularly spoke to ward staff by himself but this was always regarding his wife's treatment/progress. The Occupational Therapist had a telephone conversation with both Mr X and D2 around Mrs X's discharge. D2 said that Mrs X could stay in hospital if the Occupational Therapist could promise her that her mother would receive physiotherapy and Occupational Therapy daily over the weekend. However this could not be promised and D2 insisted that her mother should come home as her condition had deteriorated since coming into hospital. There is no evidence of any issues around caring responsibilities being discussed within this call.

4.9.4 As regards NTW, it has already been outlined that Mr X was seen with Mrs X during her appointments, and as such not on his own. In addition, no contact was had with other family members, although routine invite letters do offer the opportunity for family or friends to attend appointments.

4.9.5 Finally, in relation to Sunderland Council's contact, when the Reablement at Home Assistant Service Manager visited on 02/04/2014, to review the package of care, they had the opportunity to see Mr X alone whilst staff provided support to Mrs X. The Assistant Service Manager took Mr X into the kitchen to discuss support that he could access when the workers were not there, including reminding him about the purpose of the Telecare Service. They also discussed

the possibility of short break care if Mrs X did not improve. At this stage Mr X informed the Assistant Service Manager that he was coping and had all the support he needed. Similarly during the home visit by a Physiotherapist on the same day, they also had the opportunity to see Mr X alone and discuss his caring role, although Mr X reported that he had no issues.

4.9.6 Throughout the time that Reablement at Home Service were visiting, staff often spent time with Mr X alone whilst Mrs X was being supported. During these times, he did not express any concerns about his caring responsibilities.

4.9.7 When the Occupational Therapist visited on 10/04/2014, Mrs X was asleep and Mr X was still in his nightwear (the visit took place at lunchtime). D1 was also present, having been requested by Mr X to visit due to him having had a difficult night and feeling tired. It was during this visit that Mr X '*stated he didn't need any further help; as he was considering permanent care*.' The Occupational Therapist took the opportunity to explain about the benefits of short break care to consider any longer term plans. During this conversation with the Occupational Therapist Mr X did not express any urgent concerns about his caring responsibilities.

4.9.8 It can be seen throughout the above that Mr X had more opportunities than Mrs X to be seen alone and discuss any concerns he may have regarding his caring role. However, it should also be noted that such contact was often in the context of him engaging with agencies about Mrs X and her treatment, which again may have influenced the extent to which he was willing to disclose any concerns regarding himself. At the GP practice reviews that did take place of his own medication, no specific questions were asked about the impact of his caring role on his emotional well-being, and furthermore this was carried out in the

presence of Mrs X.

4.9.9 As has already been addressed, there was limited recorded contact with the children of Mrs X prior to her admission to hospital in the latter part of her life. Little is therefore know about their involvement in her level of care or support they may have wished for in relation to this, and there is no indication that they were spoken to alone.

4.10 **Were there any missed opportunities for agency intervention or referrals to support agencies in relation to the family's caring responsibilities? Were agencies sensitive to the needs of the family in their caring responsibilities? Was it reasonable to expect staff, given their level of training and knowledge, to fulfil these expectations?**

4.10.1 The question of whether there were any missed opportunities for agency intervention, or referrals to support agencies in relation to the family's caring responsibilities, has been addressed previously in response to whether the extent of Mr X's and his children's caring responsibilities were recognised, and whether appropriate enquiries were made, and services offered or provided. Within this it was demonstrated that staff were aware of Mr X's caring role and there is also evidence of some good practice in responding to this, and offering further assessment and support. However it was also recognised that the nature of the support offered varied and there were opportunities when steps could perhaps have been taken to explore further the extent of his support needs and consider alternative ways in which to address these, such as referral to Sunderland Carers' centre. The role and extent of the couple's children also appears to have been unclear within agencies records and as a result there is no evidence of any formal or informal support or services being offered to them as carers.

4.10.2 It has also been highlighted that in the case of the GP practice, a failure to code Mr X as a carer on the system resulting in assessment and services that would otherwise been offered, not taking place. No explanation could be offered however as to why this did not occur. As a result Sunderland CCG have included within their IMR a recommendation around the recognition of carers and action that should be taken as a result of this.

4.10.3 As regards the level of training of staff it has been noted that no significant failures in practice have been identified. However, as is summarised subsequently within lessons learned, there are a number of areas for improvement linked to addressing the role of carers, and ensuring robust steps are taken to offer appropriate assessment and support. As noted within the IMRs completed, due to Mrs and Mr X being seen as a 'doting' and 'loving' couple then there were no concerns around safeguarding or domestic violence or abuse issues identified. Whilst this would not appear unreasonable in light of the presenting information, it has been identified that further pro-active steps could have been taken, such as seeing Mrs X alone, in order to maximise opportunities for disclosure. This is therefore an area to consider in relation to the training needs of staff.

4.10.4 The IMR author for STNHSFT also raised the need to consider issues around people taking their own life, and the links to or homicide, in the elderly. They felt that it was evident in their discussion with staff involved with Mrs and Mr X, that they had not considered such acts as a possibility. Yet as demonstrated in this case, this is an important area for consideration, particularly when one partner is in the caring role and the other reliant upon them for this. The IMR author for STNHSFT identified that this area receives little focus within training or supervision and therefore professionals have limited awareness of this

issue. Staff were reported to have highlighted that the thought of an elderly person taking their own life is not something that they would have considered in their daily practice.

4.11 **Given that Mr X and Mrs X F were self-funders, how did this impact on the assessments carried out, enquiries made, services offered or services provided around Mrs X's care and the family's caring responsibilities?**

4.11.1 Sunderland CCG, STNHSFT, CHS and NTW did not identify any ways in which self-funding impacted on decision making, assessments or services offered and provided.

4.11.2 In expanding upon this further Sunderland City Council identified that it was not known that Mrs X would be self-funding until 07/04/14, as the services accessed up until this stage did not incur social care charges. Following her discharge from hospital, Mrs X accessed both Community Rehabilitation Service and Reablement at Home Service, which are time-limited services with no cost to the customer. Following this on 07/04/2014, the Care Manager ascertained that the savings held by Mrs X and Mr X exceeded the cap of £23,500, which means that in line with the Council's Contribution Policy, Mrs X would have been a fully self-funding customer, until savings dropped below the threshold of £23,500.

4.11.3 The phone call by D1 to the Social Worker on 10/04/2014 discussed the self-funding aspect of ongoing care and support. D1 was requesting information on how to access short break care for her mother and, in this instance, being self-funding would have quickened the process for accessing the service. D1 could have arranged short break care on the same day as a self-funding customer, and the Social

Worker informed her of this fact. If the Council had had to fund the short break care, there would have been internal Council processes to go through to agree funding and eligibility for the service (unless in an emergency situation). The Social Worker would have followed up this phone call with a visit, however this was not required as D1 confirmed that she was happy with information that had been provided regarding accessing short break care. The Social Worker reaffirmed that if they wanted to access short break care, it could be arranged on the same day due to self-funding.

4.12 **Were appropriate managers or other agencies and professionals involved at the appropriate points?**

4.12.1 None of the agencies involved identified that there were any safeguarding concerns or domestic abuse concerns that would have warranted involvement of a line manager, or other agencies or professionals, in relation the level of risk. An example of this is that there was nothing to warrant referral to processes such as Safeguarding or MARAC (Multi-Agency Risk Assessment Conferences). Similarly all assessments undertaken appear to have been done so with appropriate management involvement.

4.12.2 As has already been outlined throughout this report however there have been a number of opportunities identified where further exploration could have taken place in relation to wider referral or consideration of Mrs X or Mr X in relation to their situation, the stresses they were experiencing, and the care Mr X was providing. This could have included referrals to Sunderland Carers' Centre or consideration of a Multi-Agency approach to addressing the situation, such as through the GP practice's Multi-Disciplinary Team meetings.

4.13 **Is there good practice to highlight as well as ways in which practice can be improved?**

4.13.1 In identifying lessons that can be learned as part of this review, a number of areas for improvement have been identified, however it should also be highlighted that areas of good practice have also be seen. The Community Matron Service offered a high level of contact and support to both Mrs and Mr X, and were aware throughout of the difficulties related to managing the deterioration in Mrs X's condition. There was also good liaison between the Community Matron Service, CHS and NTW to ensure appropriate assessment took place when Mrs X's symptoms of dementia began to present. Within the IMR for NTW the author also identified that the CPN was thorough in ensuring that medical interventions was undertaken and followed up to assist the diagnosis and treatment.

4.13.2 The IMR for CHS also identified that in terms of Mrs X's outpatient medical care the Consultant coordinated this in such a way as to reduce the number of appointments that she had to attend, and another Consultant highly commended the care and compassion shown to Mrs and Mr X by one of the Parkinson's Nurses with whom they had regular contact. Indeed, Mrs X received regular monitoring of her health needs through monthly attendance at the clinic, and there is also evidence of regular feedback from CHS to the GP practice regarding this. Regular health checks were also provided to Mrs X and Mr X at their GP practice.

4.13.3 In relation to the needs relating to the management of her illness and her physical health needs, Mrs X appears to have received a high level of care, with the exception of omissions that occurred around her last

admission and discharge from hospital. Following the discharge however, a responsive and comprehensive service was provided by the Interface team at CHS, and Sunderland City Council (SCC). Within SCC, a pro-active approach to identifying and seeking to address any additional support needs Mr X may have as a carer can also be seen.

5 LESSONS LEARNED AND CONCLUSIONS

5.1 The IMRs of all agencies involved in the case of Mrs and Mr X present a picture of a devoted and loving couple; a picture which makes the tragic and untimely death of Mrs X difficult to reconcile. Even with the benefit of hindsight, nothing has emerged in the review of the couple's contact with agencies that suggests indicators of abuse or violence that were missed by staff working with them. Mr X presented as a man attempting to care for his wife at home as her illness progressed and her symptoms worsened.

5.2 Despite this however, what has also emerged is a picture of Mrs and Mr X's contact with agencies during the period of this review where Mr X was the more prominent partner, who often spoke in the interest of his wife. Mrs X's voice was at times noticeably absent, or secondary to her husband's, around her own care needs. During their participation in the review process Mrs and Mr X daughter's confirmed that prior to the advanced stages of her illness their mother as independent with her own thoughts and actions and that she would express her own views. As she advanced in illness she became quieter, which would accord with the observations of agencies, however this had not always been the case.

5.3 In addition, Mr X emerges as a man who himself had long term issues in relation to anxiety and depression, that were unsurprisingly impacted upon by the deteriorating health of his wife. While some agencies viewed him as adequately coping with the stresses of being a carer,

others were aware of the impact of this upon him, and varying levels of support were offered, which Mr X was often seen to decline. At no stage however did agencies feel that Mr X's own difficulties impacted upon the level of care he was able to provide for Mrs X.

5.4 While no significant failures have emerged as a result of this review, a number of areas for improvement in practice have been identified that may have assisted in supporting Mr X in his role as carer, provided greater opportunity for the voice of Mrs X to be heard, and also provided increased monitoring and opportunities for disclosure if there had been hidden domestic violence or abuse. These lessons learned are summarised below.

5.5 **Limited occasions in which Mrs X was seen alone in order for enquires to be undertaken with her regarding her care needs or any other concerns.**

5.5.1 It has been identified throughout this report that Mrs X was rarely seen alone by agencies providing services to her. This appears to have occurred solely when she was receiving personal care during her admission to hospital, and following her discharge home in March 2013. Within all other contact agencies identified that there had been no concerns that made it 'necessary' for Mrs X to be seen alone; with the exception of NTW who did offer her this opportunity, although it would seem this occurred in the presence of Mr X.

5.5.2 This lack of contact with Mrs X alone reduced opportunities in which she would have been able to disclose any abuse had it existed, or indeed to comment upon any concerns she may have had in relation to her husband's ability to care for her. While it has been highlighted that Mr X declined additional support, there are limited occasions evidence when Mrs X's opinion in relation to this appears to have been solicited. A similar issue was identified in the first Domestic Homicide Review that was undertaken in the Sunderland area, in which, albeit in different

circumstances, a failure to seek the views of the victim was highlighted.

5.5.3 The lack of any presenting concerns that resulted in it being felt unnecessary to see Mrs X alone, can also be seen to be a factor in relation to no direct questions being asked around domestic abuse. Most agencies work with an approach of selective enquiry where questions about domestic abuse are posed either with perceived high risk groups, or when there are concerns or indicators that are picked up by staff. While no evidence has emerged from this review to indicate that there was a history of abuse, it does nevertheless highlight that in cases where abuse may be hidden the lack of routine enquiry potentially results in missed opportunities for disclosure.

Recommendation 1: All statutory health and social care agencies to ensure that service users are offered the opportunity to be spoken to alone, in order to seek their views independent from carers and family members, and that this is incorporated into relevant policy and procedures. Agencies should also consider whether this should include routine enquiry around domestic abuse. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

5.5.4 Within the previous DHR it was also highlighted that the victim's age may have impacted upon indicators of domestic abuse being identified, as staff potentially considered this less likely to be an issue when working with the older population. Despite the different circumstances of this case, this raised the questions of whether the age of Mrs X may have played any part in staff's belief that it was not necessary to see her alone. As a result of the first DHR action is currently being taken to address perceptions in relation to working with older people. Thus the

Safer Sunderland Partnership, in conjunction with the Sunderland Safeguarding Adults Board, are working on a City wide approach to promote awareness around issues relating to older people and domestic abuse, including details of referral routes to domestic violence services. In addition a briefing document was produced by the Safer Sunderland Partnership outlining the key learning points from the review, including background information in relation to older people and domestic violence.

5.5.5 Linking to the above point, STNHSFT highlighted within their IMR that in the case of Mrs and Mr X, staff did not necessarily have awareness around issues of people taking their own life, and links to unlawful killing or homicide, within the older population. They recommended within their IMR that awareness among their staff needed to be raised in relation to this. Similarly, Sunderland City Council recommended that they needed to raise awareness of the potential amongst older people of taking their own lives, by accessing training for the Reablement at Home Service. In order to support this, and to ensure that this is achieved across all agencies, a general recommendation has also been included.

Recommendation 2: Safer Sunderland Partnership to produce a briefing document outlining the key learning points from this review, including background information on people taking their own life, and links to unlawful killing or homicide, within the older population. All partnership agencies to provide feedback, within one month of the briefing document being produced and circulated, as to how the briefing document has been disseminated among staff.

5.5.6 Locally, a programme of suicide prevention training, 'A Life Worth Living', has been developed by Washington Mind, originally as an integral part of the NHS South of Tyne and Wear Emotional Health and Well-being Strategy 2010-2020. This half-day training event is available to frontline workers, volunteers and employers within

Sunderland.

5.6 **Lack of a formal assessment of Mrs X's mental capacity.**

5.6.1 It has been identified that no formal Mental Capacity Act (MCA) assessment took place in relation to Mrs X, despite it having been identified that this should of taken place in relation to her contact with her GP practice. Furthermore, while Sunderland City Council and NTW did record that consideration of this had taken place and no formal assessment was considered necessary, other agencies such as the GP practice and CHS were only able to address this in hindsight, as no direct consideration of this was present in records. This is of particular importance given the evidence to indicate that Mr X did at times appear to speak on behalf of his wife and, as outlined above, limited attempts were made to speak to her alone.

5.6.2 As a result of this learning both the CCG and CHS included recommendations within their IMRs to address this. In relation to the CCG it was identified that training around the Mental Capacity Act had already been delivered directly to the majority of GPs in Sunderland. In order therefore to ensure that such learning is incorporated into practice, it has been recommended that any appropriate capacity assessments be considered as part of annual dementia reviews, which are a part of GP contracts. In the case of CHS it has been recommended that awareness raising and understanding of the Mental Capacity Act and Best Interest Assessments amongst Trust staff be achieved through CHS's ongoing participation in the Regional Mental Capacity Act Project Implementation Group. This group is looking at having MCA "champions" on each ward/department to be able to advise and assess patients' capacity (16yrs and over). The issue will also be addressed through including the subject of the MCA/Capacity Assessments within the Trust's Annual Safeguarding Symposium in March 2015. A Sunderland and South Tyneside Mental Capacity Act Assessment Conference will also be held in February 2015.

5.6.3 In the case of Mrs X, other than the above issues in relation to the GP practice and CHS, the question of capacity appears to have been dealt with appropriately. However during the review process, discussion of this raised the question of whether staff in all agencies were always clear about under what circumstances a capacity assessment should be undertaken and who can undertake it. As a result of such discussion, a further recommendation was agreed.

Recommendation 3: All health and social care agencies to ensure that relevant staff are suitably trained regarding the Mental Capacity Act, including processes for when and how to undertake formal Mental Capacity Act assessments; the recording of any decisions in relation to capacity; and the need to ensure that where a person has capacity their view regarding their treatment and engagement are directly sought.

5.7 **The need to fully explore the caring role of family members, and to ensure sufficient steps have been taken to offer appropriate support.**

5.7.1 One of the key issues identified within this review was the role of Mr X as a main carer for Mrs X. The impact of this cannot fail to be seen as significant, given the tragic outcome of Mrs X's death shortly after her discharge from hospital, and Mr X's report the day before her death that he felt the time had come for long term care for Mrs X to be considered.

5.7.2 It has been recognised that all agencies recognised to some degree the caring role being undertaken by Mr X in relation to his wife. However it has also been highlighted that the extent to which he was seen to be coping with this varied between agencies. A number of agencies, including CHS, STNHSFT, NTW and Sunderland City Council offered carer's assessments, additional support or, in the case of Sunderland Council, explored other services available; however Mr

X was seen to decline these on most occasions. What has also been identified however is that it was not always clear to what extent these options were fully explored with Mr X, in terms of his perception of the impact they would have on his caring role and whether he fully understood the support available. Furthermore, Mr X's assertions that he was receiving support from other sources appears to have been accepted with little follow up to verify this, or to explore if other services may compliment this. In addition, there were a number of opportunities in Mr X's reviews with his GP, where further exploration could have been undertaken regarding his own emotional well-being and the impact on this of his role as a carer.

5.7.3 Despite the above, it should be noted that this review has not identified any significant indicators missed by staff to suggest that the stress caused by his caring role was in any way impacting on his ability to care for his wife, or thus placing her at risk. However the link to safeguarding issues and carer stress should be acknowledged, and staff need to be cognisant of this when working with carers, as supporting them appropriately may assist in managing and reducing such risks.

5.7.4 It has also been highlighted that the role of Mrs X's children in relation to her care was relatively unknown to services and as a result no further support or assessment of this was offered.

5.7.5 As a result of the above all agencies identified within their IMRs ways in which their services to carers could be improved. In the case of Sunderland CCG it was recommended that the role of the carer be explored at each dementia review, and appropriate support and information offered. In addition is was recommended that any mental health reviews taking place for patients on long term psychotropic medication should be carried out by an appropriately trained clinician, which would include a GP, CPN or psychiatrist.

5.7.6 As regards, STNHSFT, it was recommended within their IMR that all health professionals across STNHSFT should provide known carers with contact details of Sunderland Carers' Centre; and that it will be essential that STNHSFT raise awareness with such health professionals of the support Sunderland Carers' Centre can provide to carers. CHS also identified that they need to be proactive in the use of the Sunderland Carers' Centre and Age UK Sunderland.

5.7.7 Sunderland City Council recommended within their IMR that all social care staff should access training on supporting carers and that it be mandatory to attend; and that assessment documentation of the Community Rehabilitation Service should be reviewed to ensure the voice of carers is evident.

5.7.8 Finally NTW highlighted that learning from this review is incorporated into induction training for all staff.

5.7.9 In order to support and build upon these individual agency recommendations, some further general recommendations have also been identified.

Recommendation 4: Safer Sunderland Partnership to encourage partners to promote awareness among staff of the role of the Sunderland Carers' Centre, Age UK Sunderland and other care and support agencies.

Recommendation 5: All statutory health and social care agencies to ensure that a carers' assessments is always offered to any one identified as having a caring role. Where declined, further exploration should take place as to any additional support that is being provided and by whom, and information provided as to alternative support that is available. All steps undertaken should be documented. Feedback to be provided to be the Safer Sunderland Partnership as to how this has

been achieved and how staff have been made aware of any changes in practice.[2]

5.7.10 **Information sharing and a coordinated response.**

5.7.11 As will be apparent in the reading of this report, Mrs and Mr X had high levels of contact with a range of agencies within the last two years of their lives. Within this, differing levels of insight and information can be seen to have been possessed, particularly around the extent to which Mr X was acting as a carer and the difficulties he had in dealing with this.

5.7.12 In relation to Mrs X's health care, there was evidence of good liaison between the GP and CHS around her attendance at appointments with the Consultant Neurologist and the Parkinson's Nurse. However both the CCG and STNHSFT identified an issue around information sharing between the GP and the Community Matron Service. The GP stated on interview that the Community Matron visited the couple regularly and this is alluded to in letters from outpatient appointments. However there is no formal recording of these visits in general practice records, which could have provided a valuable source of information. Community Matrons are not part of the 'staff' in the General Practice and are employed separately. Because of this they have no direct access to General Practice records, and do not input into the same system of clinical notes. This point was also raised by STNHSFT who highlighted the limited information sharing between the GP practice and the Community Matron Service.

5.7.13 In order to address this Sunderland CCG identified that improvements

[2] The Implementation of the Care Act 2014 will give local authorities a responsibility to assess a carer's need for support, where the carer appears to have such needs. This replaces the existing law, which says that the carer must be providing 'a substantial amount of care on a regular basis' in order to qualify for assessment. This will mean that more carers are able to have an assessment, comparable to the right of the people they care for.

could be made to the documentation in Primary Care clinical records from the Community Matrons. They recognised that shared records would be an ideal, but that this, in practice, is an enormous undertaking as it involves many areas of difficulties, including integrating IT services and confidentiality issues. Sunderland Clinical Commissioning Group is currently engaging in promoting an 'Integrated Working' model, in which multi-disciplinary team working is the norm, and this ideally would include shared records. It was noted however that this model is in its early stages at present.

5.7.14 From the perspective of the Community Matrons it was identified that as a starting point to improving the process of information sharing, Community Matrons could share a copy of the holistic health assessment with the GP practice. This would include the initial assessment and any subsequent assessments undertaken when new health needs are identified. Discussions will also be undertaken with the CCG to clarify how the Community Matrons would gain information from GP practices with regard to clients and carers they are currently working with. Again it was identified that this would ideally be through accessing IT systems.

5.7.15 In addition to the specific issue above, it appears that outside of Mrs X physical health needs, there was little coordinated approach in addressing the emotional well-being of both her and Mr X in dealing with her illness and its progression. As has been discussed, while letters between agencies such as STNHSFT, CHS and the GP highlighted concerns about how the couple were coping, or that they were 'struggling', no action appears to be have been taken in response to the sharing of such information. This links back to the lesson learned around responding to carers' needs, and the need for individual agencies to ensure support is explored to address any concerns identified. In addition however it highlights the lack of any coordinated response to such concerns. Sunderland CCG highlighted that the practice held Multi-Disciplinary Team meetings for patients that were

deemed to be at high-risk or 'of concern'. While Mrs X was not deemed to meet the threshold for this, the correspondence received was indicative that the couple were having difficulties in coping. Given the risk linked to carer stress, this raises the question of whether this should perhaps have prompted consideration for discussion at the MDT meetings.

Recommendation 6: Sunderland CCG to explore with GP practices the criteria for discussion of cases at MDT meetings and consider if this needs to be amended to fully recognise potential indicators of carer stress and the risks linked to these.

5.7.16 In addition to the above it has also been highlighted that staff tended to rely on the self-report of Mr X that he was receiving support from other sources, without this being followed up.

Recommendation 7: All statutory health and social care agencies to ensure that staff are aware of the need to liaise, where possible and with consent, with agencies who are identified by service users and their carers, as providing additional support, especially in cases where this is identified as a way by which concerns are being managed. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 8: Sunderland Safeguarding Adults Board to highlight the benefits of closer liaison with both statutory and third sector organisations and share these, and the key findings of this review, with third sector organisation.

5.8 **Mrs X's last admission to hospital and subsequent discharge home.**

5.8.1 During their participation in this review, the daughters of Mrs and Mr X highlighted that they had concerns regarding a number of aspects of Mrs X's hospital admission including the administration of her medication. This is something that was discussed with them and they were aware of the opportunities to take these concerns further should they decide to do so. The impact of their concerns can also be seen in relation to their decision to take Mrs X home from hospital as they believed they could provide a better level of care than that which she was receiving. Furthermore such concerns, and the accompanying decisions, need to be considered in the context of an already stressful situation in which Mr X and his family were trying to care for Mrs X.

5.8.2 Within the IMR of CHS it was identified that there were a number of issues arising in relation to Mrs X's discharge home from hospital. The IMR author concluded that poor discharge planning was evident. It was highlighted that a referral could have been made to the Occupational Therapist days prior to Mrs X's actual discharge, and ward staff did not follow up the request made to D2 regarding the input of the Medical Social Worker and the Occupational Therapist. This would have given the Occupational Therapist enough time to complete a home assessment and arrange for equipment to be in place ready for discharge. The Physiotherapist was also asked to assess Mrs X on her ability to transfer 90 minutes prior to her discharge, and subsequently reported that Mrs X would be unsafe to transfer with one person. They recommended turning equipment that would assist Mrs and Mr X once she was home, and recommended that Mrs X stay in hospital until all assessments were completed and the equipment was in place. However both Mr X and D2 insisted on taking Mrs X home, which was not challenged by the ward staff.

5.8.3 The above also highlighted the difficulties around the fact that while patients may be classed as 'Medically Fit' for discharge they may not be 'Therapy Fit'. The Trust has an agreed process for patients who wish to self-discharge when they are not deemed medically fit, in the

form of self-discharge forms that patients must sign. However, there is no similar process for patients who are not deemed 'Therapy Fit' and wish to go home / self discharge.

5.8.4 In order to address these issues CHS made specific recommendations within their IMR. These included review of the discharge planning policy and process within CHS, in order to ensure that this included referrals to other professionals and comprehensive documentation. In addition, consideration is to be given as to whether it would be feasible to consider a similar process of self-discharge for patients who are 'Therapy Fit', as that used for patients who are 'Medically Fit'.

6 TO WHAT DEGREE COULD THE HOMICIDE HAVE BEEN ACCURATELY PREDICTED AND/OR PREVENTED?

6.1 None of the agencies that undertook IMRs felt that the tragic death of Mrs X could have been predicted or prevented. Even with the benefit of hindsight there have been no indicators of domestic violence or abuse revealed, or any risks relating to Mr X's behaviour that could have predicted the actions he took. While there is one incident within the hospital when he is reported to have become 'aggressive' and 'angry' towards staff, it was recognised that this could likely have been a reaction to concern regarding the care his wife was receiving, and as such indicative of his level of stress as a carer. While it has been recognised throughout the review that the extent of Mr X's stress in his role of carer was not always fully acknowledged or acted upon, there were no significant behavioural indicators that can be seen to be predictive of Mr X's ultimate actions leading to the death of his wife and himself.

6.2 As regards prevention, it has been identified within this review process that there are a number of lessons that can be learned. These include the need to increase opportunities for victims to be spoken to alone and for their voices to be heard; for practitioners to fully understand

capacity and to make assessments appropriately; for the needs of carers to be fully assessed and explored and for appropriate signposting to take place; for the impact of carer stress in terms of risk to be recognised; and for a more coordinated approach to the management of such cases. In addition specific issues related to Mrs X's stay in hospital and subsequent discharge have been identified. Had the above occurred it may have created greater opportunities to address Mrs and Mr X's situation, offer increased support, and should there have been hidden abuse or violence, for this to have been disclosed or identified. However while these are areas for improvement there have been no occasions identified when it can be said that a different course of action would have definitively prevented the tragic death of Mrs X.

7 RECOMMENDATIONS

7.1 Summary of the General Recommendations arising from this Review

7.1.1 A number of general recommendations from this review have been identified in relation to the lessons learned and these are summarised below. In addition, Recommendation 9 outlines action to be taken to ensure that learning from this review is embedded into future training.

Recommendation 1: All statutory health and social care agencies to ensure that service users are offered the opportunity to be spoken to alone, in order to seek their views independent from carers and family members, and that this is incorporated into relevant policy and procedures. Agencies should also consider whether this should include routine enquiry around domestic abuse. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 2: Safer Sunderland Partnership to produce a briefing document outlining the key learning points from this review, including background information on people taking their own life, and links to unlawful killing or homicide, within the older population. All partnership agencies to provide feedback, within one month of the briefing document being produced and circulated, as to how the briefing document has been disseminated among staff.

Recommendation 3: All health and social care agencies to ensure that relevant staff are suitably trained regarding the Mental Capacity Act, including processes for when and how to undertake formal Mental Capacity Act assessments; the recording of any decisions in relation to capacity; and the need to ensure that where a person has capacity their view regarding their treatment and engagement are directly sought.

Recommendation 4: Safer Sunderland Partnership to encourage partners to promote awareness among staff of the role of the Sunderland Carers' Centre, Age UK Sunderland and other care and support agencies.

Recommendation 5: All statutory health and social care agencies to ensure that a carers' assessments is always offered to any one identified as having a caring role. Where declined, further exploration should take place as to any additional support that is being provided and by whom, and information provided as to alternative support that is available. All steps undertaken should be documented. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 6: Sunderland CCG to explore with GP practices the criteria for discussion of cases at MDT meetings and consider if this needs to be amended to fully recognise potential indicators of carer stress and the risks linked to these.

Recommendation 7: All statutory health and social care agencies to ensure that staff are aware of the need to liaise, where possible and with consent, with agencies who are identified by service users and their carers, as providing additional support, especially in cases where this is identified as a way by which concerns are being managed. Feedback to be provided to be the Safer Sunderland Partnership as to how this has been achieved and how staff have been made aware of any changes in practice.

Recommendation 8: Sunderland Safeguarding Adults Board to highlight the benefits of closer liaison with both statutory and third sector organisations and share these, and the key findings of this review, with third sector organisation.

Recommendation 9: The Safer Sunderland Partnership to ensure that the minimum standard training specification developed for all agencies (in response to a previous DHR) incorporates the lessons learned from this review.

7.2 Single Agency Recommendations

7.2.1 In addition to the general recommendations arising from this review agencies identified a number of single agency recommendations within their IMRs to address specific points raised or to improve general practice. These are detailed below:

Sunderland Clinical Commissioning Group (CCG)

- Dementia Reviews

Dementia annual reviews are a part of the GP contract. This means that GPs have to ensure that several baseline tests are performed on their population of dementia patients, and GPs are paid if they reach a given target. This is a national standard, and the indices carrying a payment attached are essentially very clinical- being blood test based. This review

has to occur annually for GPs to receive payment, and in itself it is a fairly basic requirement, but it does necessitate clinical contact with the patient and ideally extra information should be sought as follows:

a) Capacity assessments

Any appropriate capacity assessments be considered as part of annual dementia reviews.

A very comprehensive Template exists on Emis Web- which is the computer system that the vast majority of Sunderland GPs use. This 'Elderly Health Assessment and Dementia' Template is easily accessed and includes prompts and questions around an array of issues, and does, specifically prompt questions about the Mental Capacity of the patient.

b) Carers

Information about the carer supporting the patient with Dementia should be sought on each Dementia review. When the carer is identified, appropriate support and information can then be offered, and this pathway is already clearly defined and reimbursed by Sunderland Clinical Commissioning Group. Again, the 'Elderly Health Assessment and Dementia' Template accessed via Emis Web offers prompts and coding for this.

- Mental Health Reviews at Encompass

Reviewing a patient's mental health who is on long term psychotropic medication should be carried out by an appropriately trained clinician, which would include a GP, CPN or psychiatrist.

- Multi-Disciplinary working and documentation

The importance of information sharing is a common theme in many reviews of this nature. In this case it would seem improvements could have been made to the documentation in Primary Care Clinical records from the Community Matrons. Shared records would be an ideal, but this, in practice, is an enormous undertaking. It involves many areas of difficulties, not least of which include integrating IT services and

confidentiality issues. Sunderland Clinical Commissioning Group are currently engaging in promoting an 'Integrated Working' model, in which multi-disciplinary team working is the norm, and this ideally would include shared records. This model is in its early stages at present.

South Tyneside NHS Foundation Trust (STNHSFT)

- Standard Operating Procedures should be developed for the Community Matron Service to ensure consistent delivery of standards of care to clients with complex long term health conditions. This will support the developments which were initiated with the Community Matron Service in 2011.

- Health Professionals across STNHSFT should provide known carers with contact details of Sunderland Carers' Centre. It will be essential STNHSFT should raise awareness with their health professionals of the support Sunderland Carers' Centre can provide to carers.

- There is need to improve the process of information sharing between the Community Matron Service and GP practices. As a starting point would be the Community Matron could share a copy of the holistic health assessment with the GP practice. This should include the initial assessment and any subsequent assessments undertaken when new health needs are identified. Discussions will be required with GP colleagues to clarify how the Community Matrons would gain information from GP practices with regard to clients and carers they are currently working with. Ideally this would be through accessing IT systems, however the author is aware this would require further discussion.

- There is a need to improve the feedback provided to health professionals who refer to Sunderland fall's clinic. This will ensure continuity of recommendations made and improve client outcomes.

- Awareness must be raised with health professionals regarding people taking their own life, and the links to unlawful killing or homicide, in the elderly by promotion through STNHSFT IT systems, training at Safeguarding Champion events and incorporating this into training programmes as appropriate.

City Hospitals Sunderland (CHS)

- CHS are part of the Regional Mental Capacity Act Project Implementation Group. This group is looking at having MCA "champions" on each ward/department to be able to advise and assess patients' capacity (16yrs and over). There is a need to generally raise awareness and understanding of the MCA and Best Interest Assessments (BIAs) amongst Trust staff. This will be addressed by the aforementioned project and by including the subject of MCA/Capacity Assessments within the Trust's Annual Safeguarding Symposium (November 2014).

- A review of the discharge planning policy and process within CHS is required, to include referrals to other professionals and comprehensive documentation.

- This case review has highlighted the fact that although patients may be classed as being "Medically Fit" for discharge they may not be "Therapy Fit". The Trust has an agreed process for patients who wish to self-discharge when they are not deemed medically fit for discharge, in the form of self-discharge forms that patients must sign. However, there is no process for patients who are not deemed "therapy fit and want to go home / self discharge. Consideration should be given to whether such a process would be feasible.

- The use of abbreviations in documentation needs to decrease. The

Trust held a Safety Awareness Month in September (called "*Safetember*") which included a conference called "*Communicate, Mitigate, or Litigate*" focusing on correct documentation. All health care professionals were encouraged to attend this conference and it was ver well attended. Additionally, all health care professionals need to be reminded of the need to ensure accurate, contemporaneous documentation in accordance with the Trust's policy on Record Keeping.

- There is a need for stronger partnership working and information sharing between CHS and NTW. In order to address this, the Trust Lead for Mental Health (Executive Director of Nursing & Quality) and Lead Nurse Patient Safety will raise staff awareness about the Psychiatric Liaison Team within CHS, to facilitate the sharing of information between CHS & NTW.

- CHS to be more proactive in the use of the Sunderland Carers' Centre and Age UK Sunderland.

- Whilst this case review did not reveal any concerns or suspicions of domestic abuse/violence between Mrs X and Mr X, the authors consider the need to review Trust guidance, policies and procedures for dealing with concerns about domestic abuse/violence and for the risk assessment and risk management for victims or perpetrators.

Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

1. The learning from this DHR to be included in the trust induction training.

Sunderland City Council

2. Access training on supporting carers for all social care staff – ensuring

it is mandatory to attend.

3. Review assessment documentation of the Community Rehabilitation Service to ensure voice of carers is evident.

4. Raise awareness of the potential for suicide amongst older people by accessing training for Reablement at Home Service.

5. Reablement at Home staff access the ‘Life Worth Living’ training.

Abbreviations Key

A&E	Accident and Emergency
BIA	Best Interest Assessment
CAADA	Coordinated Action Against Domestic Abuse
CPN	Community Psychiatric Nurse
CHS	City Hospitals Sunderland
CCG	Clinical Commissioning Group
DHR	Domestic Homicide Review
EMIS	Egton Medical Information Systems
GP	General Practitioner
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conferences
MCA	Mental Capacity Act
MSW	Medial Social Worker
NTW	Northumberland, Tyne and Wear (NHS Foundation Trust)
OT	Occupational Therapist
IMR	Individual Management Review
SCC	Sunderland City Council
STNHSFT	South Tyneside NHS Foundation Trust