Herefordshire
Community Safety Partnership

EXECUTIVE SUMMARY

A REVIEW

Into the circumstances
of the death of a woman aged 84 years
in April 2014

Case HDHR 03

Under Section 9 of the Domestic Violence Crime and Victims Act (2004)

Independent Author:
Malcolm Ross M.Sc.

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LIST OF ABBREVIATIONS

ASC - Adult Social Care

CCG - Clinical Commissioning Group

CSP - Community Safety Partnership

CKD - Chronic Kidney Disease

DNACPR - Do Not Attempt Cardiac Pulmonary Resuscitation

DMHOP - Department of Mental Health for Older People

GP - General Practitioner

HCSP - Herefordshire Community Safety Partnership

HMC - Her Majesty's Coroner

MAPPA - Multi Agency Public Protection Arrangement

MARAC - Multi Agency Risk Assessment Conference

PIPOT - Person in a Position of Trust (Health)

SIO - Senior Investigating Officer (Police)

UTI - Urinary Tract Infection

Introduction

This Review examines the circumstances surrounding the death of an 84 year old woman in April 2014. The woman's youngest daughter was interviewed under caution on suspicion of causing the death of her mother and papers were been sent by the Police to the Crown Prosecution Service for a decision. In December 2015, the Crown Prosecution Service decided that there was insufficient evidence to support a prosecution against any one in relation to the death of the Deceased.

Details of the Review process, the terms of reference, panel members and agencies that contributed to the review are contained in an appendix to this report.

For the purpose of this executive Summary of the Overview Report, the Deceased, the youngest daughter, family members and other that were involved with the review process will be anonymised. A key is provided for ease of reading.

Deceased	84 year old Mother of D1,D2,and D3
D1	Oldest daughter of Deceased
D2	Middle daughter of Deceased – Qualified Nurse
D3	Youngest daughter of Deceased
Carer	Privately funded carer for Deceased

Summary of Events

This Review concerns the death of an 84 year old woman in April 2014.

The Deceased was a mother of 3 adult daughters, the middle of which was a state registered nurse.

The Deceased had a significant history of serious medical problems including chronic kidney disease and interstitial cystitis. She also suffered with oedema and age related dementia. Her medical care needs were significant and the daughters took it in turns to care for their mother but their mother regularly suffered with severe urinary tract infections for which she was prescribed antibiotics but this particular illness caused her to visit the toilet every few minutes day and night. On occasions whilst she had the infection she would become delirious and on 22nd November 2013 she threatened the middle daughter with what turned out to be a kitchen paring knife. The Police were called and she was taken to hospital and detained. She was on 'End of Life Medication' at the time..

The youngest daughter gave up her job to be the constant carer for the Deceased and care for her mainly during the night.

In September 2012 the Deceased demanded a catheter that had been fitted to be removed. She was talking at that stage about suicide and her Consultant Urologist arranged for the catheter to be removed but this didn't happen for nearly 2 weeks.

The Deceased's GP was spoken to by the daughter about palliative care referral and pain relief and the GP suggested a more appropriate referral to the Department of Mental Health Older Persons which the Deceased declined.

In February 2013, she was assessed by her GP using the Cognitive Impairment Test which showed an underlying dementia type illness.

In March 2013, the Deceased expressed a wish to discuss an advanced directive with her GP. An advanced directive is sometimes known as a 'living will' and is a decision patients can

make to refuse specific types of treatment. She was told that she could not discuss this at an emergency appointment with the GP and needed to see a solicitor.

In April 2013, a referral was made to Adult Social Care.

In June 2013, after consultation with the GP, a 'do not attempt CPR' for was completed as the GP and the Deceased felt it would not be in her best interest to be resuscitated.

In August 2013, Adult Social Care was requested by the family to conduct an assessment of need and care package for their mother. By November 2013, the Deceased's medical and mental conditions had deteriorated but she was adamant she did not want to be admitted to hospital. All of the daughters felt that an admission to hospital would increase the risk to their mother as she was likely to wander off.

Later that month a syringe driver for the administering of diamorphine and cyclizine, end of life medication, was fitted but the following day it fell out of her arm and despite attempts of the Carer to re-fit the syringe she was unable to do so. It was replaced in favour of oral medicine.

On 23rd November on the day after the paring knife incident, the Deceased was reviewed in hospital and deemed suitable for both old age and psychiatric referral and a palliative care review. The Palliative Care Team deemed the Deceased's pain to be chronic but not palliative so she was discharged from hospital on 25th November.

By January 2014, the youngest daughter was showing the effects of the stress and anxiety caused by being the full time carer for her mother, and she reported that she needed some respite. She commissioned a family friend as a supplementary carer.

On 7th March 2014, the Deceased suffered another UTI and the DMHOP Team noted that the youngest daughter was suffering fatigue and becoming increasingly distressed with her mother's situation.

The Deceased was referred to the 2gether NHS Foundation Trust and her mental health was assessed. It was thought that the Deceased had become obsessed with wanting to pass urine and this together with her significant history of medical problems resulted in a recommendation that her GP should refer her to the Memory Clinic on her discharge from hospital.

Adult Social Care, who was informed of the Deceased's admission to hospital, considered whether a residential place would be better for the Deceased given that the carer's were struggling emotionally and physically. The daughters considered a short stay in a community hospital would be useful but wanted their mother returned home, and the idea of a placement in residential care was not pursued by the daughters.

On Good Friday, 18th April 2014, a Locum Primary Care GP attended to the Deceased at her home address. The daughters reported that their mother was constipated and not eating. She was not recognising her daughters. The Locum stated he would send a note to the Deceased's GP suggesting that she be seen after the Easter Holiday. D3 was on her own at this stage and she states that the Locum told her that her mother would die imminently, and to stop concentrating on her mother's illness and just make her comfortable. The Locum denies saying anything about this. D3 states that she showed the Locum all of medication they had in a kitchen cabinet, indicating that the Locum possibly did not recognise the significance of stock piling medication and the possible risk involved.

It appears that on 20th April, the youngest daughter attached extra Fentanyl patches (pain relief) to the Deceased's skin and covered these with extra blankets and clothing so the middle sister, D2 would not see them. As the patches dropped off due to the Deceased getting hotter, she would apply more patches to her mother. The youngest daughter later

told Police she could recall 5 patches being on at any one time but she removed them before her sister D2 washed her mother after she had died.

It appears that later on the 20th April, D2 injected the Deceased with 2.5mg of Midazolam and replaced a Fentanyl patch as her mother had become highly agitated, sweating profusely and unable to sleep. She stated the injection calmed her mother down and make her comfortable. She gave the used syringe and the remaining 7.5mg of Midazolam to the youngest daughter who admitted to the Police instead of disposing of it, she hid it and used it again later that evening. Whilst D2 was asleep the youngest daughter injected the Deceased once more with 5mg and 7.5mg of Midazolam. At 4.45 hours the following morning, D2 injected another 2.5mg of Midazolam into her mother completely unaware of the 12.5mg that her sister had injected the previous night. Again D2 gave the syringe and the unused phial of Midazolam to the youngest daughter for disposal, but again the youngest daughter concealed them and later used it to inject another 5mg – 7mg.

During a later interview with the Police, the youngest daughter admitted injecting her mother on more than one occasion that day suggesting it was possible that she had injected in the region of another 30mg of Midazolam over and above the prescribed dose. She stated that she wanted to make her mother comfortable and she didn't understand that the drugs would prove to be fatal. It should be noted that this medication was prescribed to be administered by a syringe driver and under no circumstances by an injection.

The Deceased died at her home during the following afternoon. Her GP attended and 'recognised death' and authorised the Deceased to be removed by an undertaker. HM Coroner's Officers were made aware of the death and a post mortem was arranged. It was then the youngest daughter went to the Police, admitted what she had done and a criminal investigation commenced.

A Home Office post mortem concluded that the medical cause of death was initially established to be

> "Bronchopneumonia on the background of aging changes to the brain, chronic kidney disease, and chronic interstitial cystitis"

The Crown Prosecution Service deliberated for a considerable time and concluded that there was insufficient evidence to prosecute the youngest daughter for any criminal offence.

Views of the family

At an early stage of this review process the Overview Author wrote to all the daughters including the youngest daughter inviting them to indicate if they wished to participate with this review process. A letter was also sent to the youngest daughter's solicitor. No reply has been received from any of the people written to at this stage.

Following the decision by Crown Prosecution Service to take no further action, the daughters were again written to seeking their willingness to participate in the review process.

The youngest of the daughters replied to the letter stating that she wished to contribute to the review process. She was seen by the Report Author on 27th January 2016 at her home address. She explained that life with her mother as her mother's illness deteriorated became increasingly difficult to such an extent that she had to give up work to look after her mother. She described how she was not able to seek medical assistance for her own anxiety and depression as she could not spend time waiting on the telephone to speak to various medical professionals as her mother's demands for assistance were constant.

The youngest daughter was told that there could be no respite care at night time to allow her to sleep while someone looked after her mother's constant toilet needs and to achieve that level of care her mother would have to go into a care home, something that the family had promised the deceased would not happen.

She describes how a social worker visited her mother and spoke to her whilst she was using the toilet. The social worker came to the conclusion that the deceased was bright and communicative and she did not reach the threshold for extra care. D3 is aware that the Social Worker was not fuily trained and thought that her actions could have been more robust.

It appears that the physical wellbeing of the youngest daughter was not addressed and her own health deteriorated during this period of caring for her mother.

Analysis and Recommendations

None of the IMR's submitted in relation to this review indicate that there was any domestic abuse towards the Deceased from the daughters. It therefore follows there was no suggestion of the Deceased being referred to MARAC,

It was not until the youngest daughter surrendered to the Police that there was any suggestion that anything out of the ordinary had occurred.

The Overview Author of this report is tasked to make recommendations that are overarching and affect more than one agency or are particular to a particular agency if that issue has not been identified in the agency IMR. It is not proposed to make recommendations within the Overview Report about issues that are adequately contained within individual IMR's.

West Mercia Police IMR identifies that the incident with the paring knife in November 2013 could have resulted in the Officer recognising this as a domestic incident albeit the Deceased of this report was the aggressor at that time. The IMR however correctly points out that even if the incident had been recorded as a domestic abuse incident, it would have had no impact on the way the Police dealt with the incident. The Police IMR makes recommendations about the recording of such incidents which adequately deals with this issue.

Herefordshire Adult Social Care IMR recognises that no formal assessments were completed in respect of the Deceased and considers that the Deceased's voice was not heard. It appears that the Deceased's views were always youngest daughter may well have been entitled to assessments and advice earlier despite being told that the Deceased was over the capital limit for assistance under the NHS Capitals Community Care Act. The IMR points out that whilst the carer's assessment was carried out in January 2014, there was no Deceased assessment. Also identified in the IMR was the fact that the stress and anxiety being caused to the youngest daughter in caring for her mother was not recognised as a risk to herself or the Deceased.

Adult Social IMR makes 11 recommendations that adequately cover all the points raised. The Primary Care IMR points out that an assessment could have been made by Adult Social Care as to whether the Deceased met the criteria for Continuing Healthcare Funding and even as a self-funder the Deceased may have been entitled to assessment and support services from the local authority. A continuing healthcare assessment was not completed. Had it been completed the family would probably have been eligible for a fast track package of care, funded by the NHS which in turn may have resulted from an external professional over sight into the nursing and care the Deceased was receiving.

The main area of concern expressed by the Review panel was regard to the prescribed 'end of life' medication. This at one time came under the guidance called the Liverpool Pathway but that has since been rescinded. Once end of life medication is prescribed, it remains the property of the patient, whether or not it is used.

End of life medication should only be administered by a district nurse through a syringe driver, but as in this case, the medication being left in the family home, it was open to abuse by family, patient or anyone else. There appears to be little governance of the medication once it has been prescribed.

Recommendation number 1 is for the Chair of the Community Safety Partnership to write to the Department of Health explaining the circumstances of this case and expressing the panel's views and the lack of governance around end of life medication.

The youngest daughter is of the opinion that she and her mother were let down by the health agencies and adult social care also failed to meet her mother's needs.

Conclusions

The Deceased, in this case, was 84 years of age, with chronic illnesses and the onset of dementia. It is clear she required 24 hour care but neither her or any of her 3 daughters would agree for the Deceased to go into hospital or the care arrangements.

Other than the incident with the paring knife, at which the Deceased was the aggressor, there was nothing to indicate any suggestion of domestic abuse.

The Deceased had significant health interventions and many offers of support, most of which were not considered appropriate by the Deceased or the daughters in that the care offered was not in line with the family's ability to take the offer up. There was nothing offered in place.

Following the Deceased's death, had there not been a post mortem there is no doubt that the truth behind the circumstances surrounding the Deceased's death would not have been known. It was only the youngest daughter surrendering herself to the Police that alerted agencies that something out of the ordinary had occurred.

There is nothing to indicate prior to her death that anyone, especially her daughters wanted to harm the Deceased. It is the youngest daughter's case that no one else knew what she was doing. In these circumstances the manner in which the Deceased died could not have been predicted or prevented.

Recommendations

Overview Report Recommendation

Recommendation 1

The Chair of the Community Safety Partnership to write to the Department of Health explaining the details of this Review and expressing the concerns of the Review Panel about the End of Life medication, which was left in the Deceased's household according to guidance but later abused by a family member to the detriment of the Deceased.

Individual Management Review Recommendations

Warwickshire and West Mercia Police

Recommendation 1

West Mercia Police Officers and those staff involved in conducting referrals, to receive additional guidance on considerations to be made when recording incidents where vulnerability and domestic abuse concerns overlap.

Hereford CCG

Recommendation 1

Map of Medicine to include the care pathway for domestic abuse.

Recommendation 2

The CCG to include a link to the document 'Managing Pain in Dementia' in their next GP newsletter.

Recommendation 3

The CCG to include information regarding PRN Oramorph Charts in their next GP newsletter

[2]gether NHS Foundation Trust

Recommendation 1

To ensure that all patients receiving a service from [2]gether have a risk assessment as outlined in the [2]gether Foundation Trust Assessment and Core Policy. This would ensure that any identified risks are identified and incorporated into a risk management plan for that person.

Recommendation 2

To ensure that considerations of issues of capacity and consent are routinely explicitly recorded in patients records where appropriate and as outlined in Mental Capacity Act 2005. This will ensure that an accurate record of a person's capacity to make specific decision and for consent to treatment and information sharing will be made.

Wye Valley Trust

All nursing staff involved in the completion of Continuing Healthcare Assessments to have appropriate training.

HFD Older Person Services

Recommendation No.1.

Deliver a learning event to the teams involved in this episode of care delivery. This will provide staff with the learning from this review and give education on the actions.

Recommendation No 2

Provide a Trust wide briefing on this case, detailing the observations, learning and recommendations from this individual management report. This will be communicated and Team managers will be directed to discuss in Team meetings.

Recommendation No 3.

SBARD training will be delivered to the teams involved in this case and will also be made available to other Trust services in Herefordshire.

Recommendation No 4

Conduct an audit of carer's assessments completion and review dates will be completed for the Herefordshire Memory Assessment Service and Older Person Services.

Recommendation No 5

Conduct an audit of completion of care plans, risk assessments and crisis contingency plans for the Herefordshire Memory Assessment Service and Older Person Services.

Recommendation No 6

Development work on better liaison and promotion of careers support services linked with wider Trust work in this area. This will include the development and communication of strategies to be used when reasonable support is being refused

Recommendation No 7

Review the interface between the Memory Services, Primary Mental Health Teams and Older Adults Community Mental Health Teams utilising the learning from this review.

Recommendation No 8

Review the Herefordshire Memory Assessment and Older Person Services sharing of information with clinicians, patients and carers, including the practice of copying or addressing letters to patients. This will also consider the sharing of information regarding medication and care planning.

Recommendation No 9

Provide clear guidance to ensure that patients and carers are offered and consistently reminded of a clear single point of contact at whatever level they are engaged, and that appropriate supporting information is given regarding planned interventions and indications for contacting services before crisis.

Recommendation No 10

Provide clear guidance on the process for ascertaining that a carer's assessment has been requested, and undertaken or refused, should be reviewed, including its documentation and reference to actions in RIO.

Recommendation No 11

Provide additional training and guidance for the Herefordshire Memory Assessment Service and Older Persons Services regarding safeguarding information on older person's abuse issues.

Recommendation No 12

Meet with Wye Valley Trust nursing lead to discuss methods for improving communication between services in light of the learning from this IMR.

Appendix No 1

EXECUTIVE SUMMARY

A REVIEW

into the circumstances

of the death of a woman aged 84 years

on April 2014

Case HDRH 03

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for this Review, which was implemented with due guidance[1] on 13th April 2011. Under this section, a review means a review "*of the circumstances in which the death of a person aged 16 or over has, or **appears** to have, resulted from violence, abuse or neglect by—*

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

In March 2013, the Government introduced a new definition of domestic violence and abuse[2], that states that domestic violence and abuse is:

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

In accordance with the statutory guidance, a Review Panel was established to oversee the process of the review. The members of the panel consisted of senior professionals from:

- Learning and Development Officer, HSCB/HSAB/HCSP
- Principal Social Worker, Adult Social Care Herefordshire Council
- Head of Safeguarding – CCG Quality
- Lead Nurse Adult Safeguarding, Wye Valley NHS Trust
- Deputy Director of Nursing – 2gether, NHS Foundation Trust
- Assistant Chief Officer, National Probation Service
- Chief Executive, West Mercia Women's Aid
- West Mercia Police
- Safeguarding Lead, Adults Wellbeing, Herefordshire Council

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

- Observing members from West Mercia Women's Aid and Hereford CCG.

The CSP appointed an independent author and chair to be responsible for writing the report and chairing the panel meetings.

None of the panel members or the independent author had direct involvement in the case, nor had any line management responsibility for any of those involved.

It was decided that the review should focus on the period 29th September 2012, (when the Deceased was first referred to Adult Social Care) to 23rd April 2014, two days after the Deceased's death.

The following agencies were requested to prepare chronologies of their involvement with the Deceased and her family, and to prepare individual management reviews and produce reports:

- West Mercia Police
- Health – Wye Valley Trust, GP's, Herefordshire CCG and 2gether NHS Trust
- Adult Social Care Herefordshire County Council

and a report from:

- Kemble Care

Terms of Reference

The Terms of Reference for this Review are divided into two categories i.e.:

- the generic questions that must be clearly addressed in all IMRs; and
- specific questions which need only be answered by the agency to which they are directed.

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the Deceased and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a Deceased or perpetrator?
2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse Victims or perpetrators (DASH) and were those assessments correctly used in the case of this Deceased/perpetrator?
4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?
5. Were these assessments tools, procedures and policies professionally accepted as being effective? Was the Deceased subject to a MARAC?
6. Did the agency comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?
7. What were the key points or opportunities for assessment and decision making in this case?
8. Do assessments and decisions appear to have been reached in an informed and professional way?
9. Did actions or risk management plans fit with the assessment and the decisions made?

10. Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
11. When, and iPerpetratorn what way, were the Deceased's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the Deceased should have been known?
13. Was the Deceased informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the perpetrator? For example, were they being managed under MAPPA?
16. Had the Deceased disclosed to anyone and if so, was the response appropriate?
17. Was this information recorded and shared, where appropriate?
18. Were procedures sensitive to the ethnic, cultural, linguistic and religious identities of the Deceased, the perpetrator and their families?
19. Was consideration for vulnerability and disability necessary?
20. Were Senior Managers or agencies and professionals involved at the appropriate points?
21. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
22. Are there ways of working effectively that could be passed on to other organisations or individuals?
23. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard Victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
24. How accessible were the services for the Deceased and the perpetrator?
25. To what degree could the homicide have been accurately predicted and prevented?

In addition to the above, some agencies will asked to respond specifically to individual questions once they are identified following the submission of IMR's.