Herefordshire
Community Safety Partnership

A REVIEW

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

Case HDHR 3

Independent Author:

Malcolm Ross M.Sc.

June 2017

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

PIOT - Person In a Position of Trust (Health)

SIO - Senior Investigating Officer (Police)

UTI - Urinary Tract Infection

CONTENTS

HEREFORDSHIRE COMMUNITY SAFETY PARTNERSHIP

A REVIEW

into the circumstances

of the death of a woman aged 84 years

in April 2014

1. Introduction

1.1 This Review, constituted under the Domestic Violence, Crimes and Victims Act 2004, examines the circumstances surrounding the death of an 84 year old woman in April 2014 at her family home. Throughout this report the Deceased will be referred to as the Patient and the person who was initially considered to have caused her death is referred to as the Carer following the decision from Crown Prosecution Service as set out below. This is the Patient's youngest daughter and the main carer for her

1.2 The Patient, who was terminally ill with numerous ailments and dementia, was being cared for by her three daughters, the middle one of which is a trained nurse. The youngest daughter was her main carer. The Patient required 24 hour care and supervision. She also required the administration of a number of drugs to assist with pain relief etc. the middle daughter administered drugs subcutaneously to her mother which she faithfully recorded. She would however, give the empty syringe and vials to her younger sister for disposal.

1.3 The Carer, the youngest daughter, however, did not dispose of the used equipment and during the night time used the equipment to administer extra medication over and above the prescribed amount, wanting her mother to be comfortable.

1.4 Following the death of the Patient the Coroner's Officers were informed and it was decided to conduct a post mortem on the body of the Patient At this point, the Carer surrendered to the Police and admitted what she had done. She was arrested and bailed while toxicological tests are completed. A file of evidence was submitted by the Police to the Crown Prosecution Service to determine any criminal responsibility in this case. In December 2015, the Crown Prosecution Service decided that there was insufficient evidence to substantiate any criminal charges.

Purpose of a the Review

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

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

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

(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"

1.2.2 Where the definition set out in this paragraph has been met, then a Review must be undertaken.

1.2.3 It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.2.4 In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[2], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition 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*

1.2.5 These Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of such a Review is to:

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

1.3 Process of the Review

1.3.1 West Mercia Police notified Herefordshire Community Safety Partnership (HCSP) of the death of the Patient on 7th November 2014 HCSP convened a DHR Sub-Group meeting and decided that the circumstances of the death of the Patient as reported at

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

that time, met the definition of a Domestic Homicide Review. A letter was sent to the Home Office to this effect indicating the intention of HCSP to commission a DHR.

1.3.2 An independent person was appointed to chair the DHR panel and to be the author of the overview report.

1.3.3 Home Office Guidance[3] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

1.4 Timescales

1.4.1 Home Office Guidance requires that DHR's should be completed within 6 months of the date of the decision to proceed with the review.

1.5 Independent Chair and Author

1.5.1 Home Office Guidance[4] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

1.5.2 The Independent Chair and Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing over 80 Serious Case Reviews and 13 DHR's chairing those processes and, more recently, performing both functions in relation to Domestic Homicide Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.5 The Review Panel

1.6.1 In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Members of the panel and their professional responsibilities were:

Adrian Turton	Learning and Development Officer, HSCB/HSAB/HCSP
Mandy Appleby	Principal Social Worker, Adult Social Care Herefordshire Council
Lynne Renton	Head of Safeguarding – CCG Quality
Cath Holberry	Lead Nurse Adult Safeguarding, Wye Valley NHS Trust
John Trevains	Deputy Director of Nursing – [2]gether, NHS Foundation Trust
Tom Currie	Assistant Chief Officer, National Probation Service
Jan Frances	Chief Executive, West Mercia Women's Aid
DI Helen Kinrade	West Mercia Police
Josephine Cullen	Safeguarding Lead, Adults Wellbeing, Herefordshire Council

[3] Home Office Guidance 2013 page 15
[4] Home Office Guidance 2013 page 11

Observing: Adele McGuigan, West Mercia Women's Aid
Sue Little, CCG

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

1.6.3 The business of the panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

1.6.4 The full panel met on four occasions.

1.7 Parallel proceedings

1.7.1 The Panel were aware that the following parallel proceedings were being undertaken:

- HM Coroner for Herefordshire opened an inquest adjourned it to a date to be fixed. The Panel Chair advised HM Coroner that a Review will be undertaken and the Coroner has been updated on a regular basis. On 12th May 2016 the Coroner came to the conclusion that the Patient had died from natural causes.
- West Mercia Police continue to investigate the death and enquiries are ongoing. CPS decided that no further action would be taken.
- Wye Valley NHS Trust have held a PIPOT (Person in a Position Of Trust) enquiry into the action of the daughter D2, a qualified nurse, may have contravened protocols regarding the administering medication and the disposal of used and unused equipment.
- The review was commenced in advance of criminal proceedings having been concluded and therefore proceeded with an awareness of the issues of disclosure that may arise.

1.8 Time Period

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

1.9 Scoping the review

1.9.1 The process began with a scoping exercise by the panel to identify agencies that had involvement with the Patient and her family prior to the homicide. Where there was no involvement or significant involvement by agencies the panel were advised accordingly.

1.9.2 Agencies were asked to identify any other significant information that may add to an understanding of the quality of dynamics of the relationships within the family before and after the time period.

1.9.3 The purpose of the extended period is to examine and identify what opportunities were available for agencies to intervene or challenge decisions that were made in respect of the Carer where concerns may have been escalated by agencies.

1.10 Individual Management Reviews

1.10.1 The following agencies were requested to prepare chronologies of their involvement with the Patient and her family, carry out individual management reviews and produce a report:

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

and a report from:

Kemble Care

1.11 Summary

1.11.1 This Review concerns the death of an 84 years old woman, who was extremely poorly and being looked after by her three daughters in her home address. There had been significant medical intervention with the Patient by hospitals and GP services and end of life medication had been prescribed by her GP.

1.11.2 Her youngest daughter was the Carer and had given up work to look after her Mother, the Patient, who needed 24 hour care. The middle daughter is a Registered Nurse and was aware of the procedures for administering medication. The Patient had been fitted with a syringe driver to administer her medication. The driver had fallen out and the patient found it distressing for it to be re-inserted so the driver remained out of her arm.

1.11.3 At 04.45 hours on the date of the Patient's death, the, middle daughter administered by injection her Mother's medication, Midazolam, but unbeknown to the middle daughter, her sister, the Carer, injected further medication into the Patient, over and above the prescribed amount, which was acknowledged by the Carer to be to the detriment of the Patient's health.

1.11.4 A Police investigation was commenced as a result of the Carer attending at a local Police Station the following day and admitting what she had done. She stated that she believed that the overdose was the cause of her Mother's death.

1.12 Terms of Reference

1.12.1 The Terms of Reference for this DHR 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.

1.12.2 The generic questions are as follows:

1. Were practitioners sensitive to the needs of the victim and the Carer, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or Carer?
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 Carers (DASH) and were those assessments correctly used in the case of this victim/Carer?

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 victim 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 in what way, were the victim's wishes and feelings ascertained and considered?
12. Is it reasonable to assume that the wishes of the victim should have been known?
13. Was the victim informed of options/choices to make informed decisions?
14. Were they signposted to other agencies?
15. Was anything known about the Carer? For example, were they being managed under MAPPA?
16. Had the victim 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 victim, the Carer 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 Carers? 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 victim and the Carer?
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.

1.13 Individual Needs

1.13.1 Home Office Guidance[5] requires consideration of individual needs and specifically:

[5] Home Office Guidance page 25

- "Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the Carer and their families? Was consideration for vulnerability and disability necessary?"

1.13.2 Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.13.3 The review gave due consideration to all of the Protected Characteristics under the Act. 1.12.4 The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.14 Lessons Learned

1.14.1 The Review will take into account any lessons learned from previous Domestic Homicide Reviews as well as Child Protection and Adult Safeguarding reviews and appropriate and relevant research.

1.15 Media

1.14.1 All media interest at any time during this review process will be directed to and dealt with by the Chair of the Herefordshire Community Safety Board.

1.16 Family Involvement

1.16.1 Home Office Guidance[6] requires that:

> "members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and Carer's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances", and:
>
> "Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

1.16.2 The views of the family members and any family friends identified by the family will be taken into consideration. The family members will be invited to participate in the review process. (See section re Views of the Family)

6 Home Office Guidance page 15

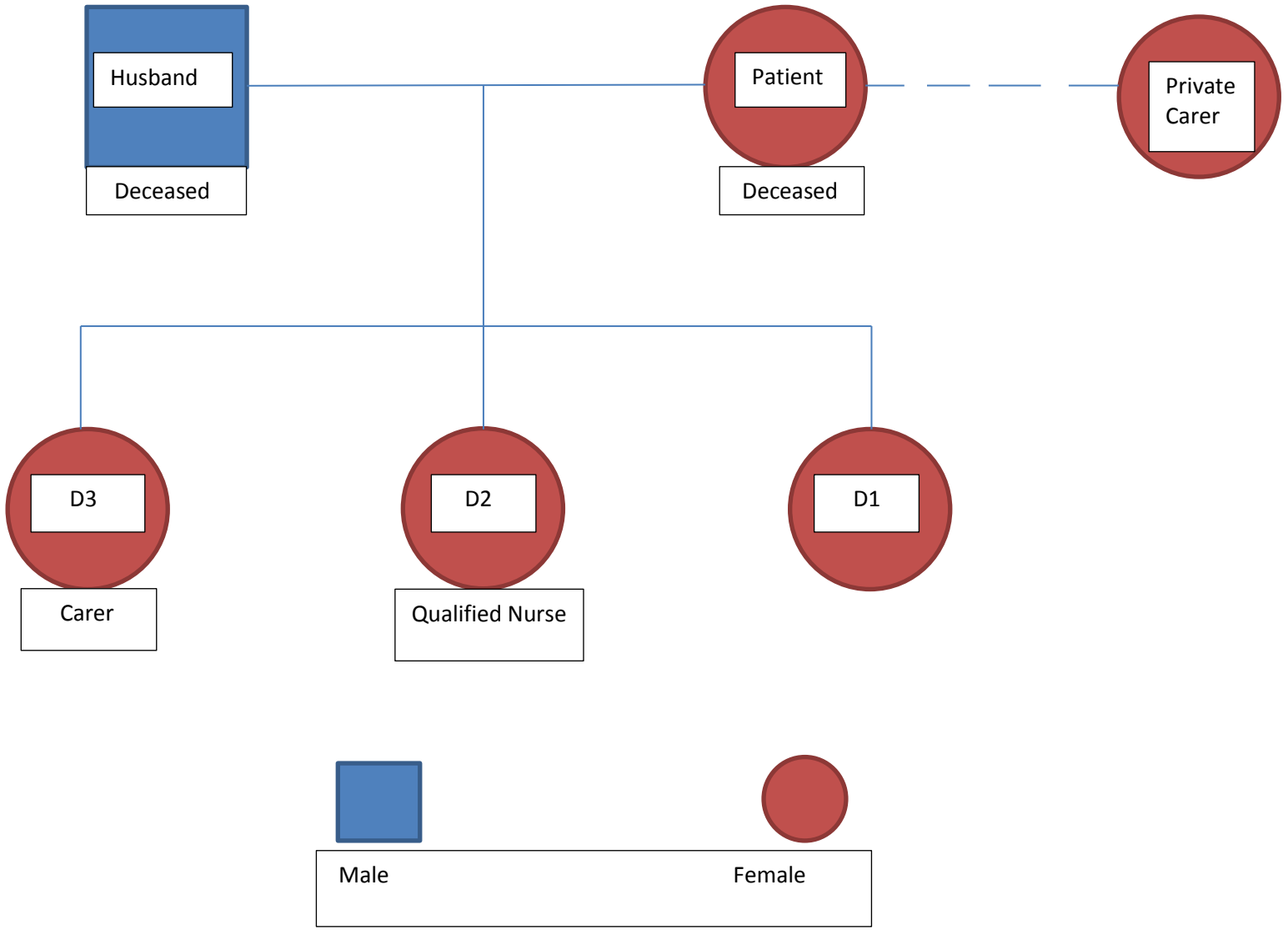
1.16.3 These Terms of reference were considered a standing item on Panel Meetings agendas and will be constantly reviewed and amended according as necessary.

1.17 Individuals involved in the Review Process

1.17.1 The following genogram identifies the family members in this case, as represented by the following key:

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

GENOGRAM


Husband
Deceased
Patient
Deceased
Private Carer
D3
Carer
D2
Qualified Nurse
D1
Male
Female

2. Summary of events

2.1 All members of the family concerned in this review are white, British and English is their first language. There are no known cultural issues.

2.2 The scoping dates for this review begin in September 2012, but it is worthy of mention that none of the parties involved in this Review had come to the notice of the Police or another agency other than health before the start date for this review, except Police have recorded details of minor domestic incidents involving D1 following the breakdown of her marriage in 2009, and the youngest daughter was a witness in several incidents of assaults and disorder by virtue of her then employment as a security guard.

2.3 The Patient's relevant health problems are first recorded in early 2012, when she was diagnosed with Cellulitis in her leg, and the consequent infection caused her confusion and swollen legs. Medical records indicate that the Patient had a long medical history of chronic kidney disease (CKD)[7] and interstitial cystitis[8]. She also suffered with oedema and age related dementia.

2.4 In September 2012, the Patient was fitted with a supra-pubic catheter by a Consultant Urologist at hospital. This was to assist with her frequent nocturia, (passing urine overnight). However, the Patient had trouble managing her catheter and one of her daughters was advised to contact the GP if the Patient was unable to tolerate it.

2.5 On 25th September 2012, the Patient attended at her GP with the Carer. She would usually attend with D2, the qualified nurse, but due to holiday commitments D2 was unable to attend. The Patient requested the catheter to be removed and was quite distressed about having it inserted into her. She was talking about suicide she was so anxious. She was adamant that it was to be removed and the GP attempted to contact the Consultant at the hospital but was unable to do so. GP records indicate that there were no concerns about the Patient's mental state at that time or her capacity to make this decision. The GP emailed the Consultant a letter in which the GP suggested that the decision to remove the catheter should wait until D2 returned from holiday to involve her in the decision making process.

2.6 In any event the GP informed the Patient that the catheter had to be removed at hospital and it was not something that could be done at the GP's surgery.

2.7 The Patient attended at the hospital on 3rd October 2012 and the catheter was removed. The Consultant Urologist documented:

> '[the Patient] would not be a candidate for reinsertion of a further catheter in the future and would need to live with the consequences and discomfort'.

[7] About 1 in 10 people have some degree of chronic kidney disease (CKD). It can develop at any age and various conditions can lead to CKD. It becomes more common with increasing age and is more common in women. About half of people aged 75 or more have some degree of CKD, most of these people do not actually have diseases of their kidneys; they have normal ageing of their kidneys.

[8] Interstitial cystitis is a chronic bladder condition of unknown cause. In the Patient, the condition caused intense pain, pressure or discomfort within the bladder and daytime and night-time increased urinary frequency. The Patient also suffered from regular urinary tract infection for which she was prescribed antibiotics, both prophylactically and for acute episodes.

2.8 In September 2012, Adult Social Care (ASC) became involved following a referral, with the Patient and assisted her in applications for welfare benefits.

2.9 On 12th December 2012, the Patient was called to the GP's surgery for a review of her medication and a plan for any worsening of swelling of her ankles was made.

2.10 On 29th January 2013, the Patient was again seen by her GP. The Carer, daughter 3, was concerned about her pain control and the Patient's deteriorating memory. Her medication of Gabapentin was stopped and the Carer asked about a palliative care referral for pain relief for the Patient. The GP suggested a referral to Department of Mental Health Older Person (DMHOP) to be more appropriate and blood was taken to rule out any organic illness. The Patient wanted to discuss the possible referral with her family before she made a decision and following a discussion she declined to be referred to DMHOP. She wanted help but the DMHOP declined to make a home visit. She was unable to attend anywhere for treatment.

2.11 On 7th February 2013, the Patient's memory was assessed by the GP using the 6 item Cognitive Impairment Test[9], which demonstrated the probability of an underlying dementia type illness. Her medication was changed which showed a slight improvement in her condition.

2.12 On 7th March 2013, the Patient attended the GP' surgery at an emergency appointment and wanted to discuss an advanced directive[10]. She was told that this could not be discussed at an emergency appointment and she needed to see a solicitor.

2.13 During March and April 2013, the Patient was diagnosed with two urinary tract infections (UTI) for which she was prescribed antibiotics. On 8th April 2013, the GP made a referral to Adult Social Care regarding the Patient being treated for UTIs and was becoming increasingly muddled. The referral was for a short term reablement whilst she recovered from the UTI. It was noted that the Carer was caring for the Patient whilst she was not at work. Reablement had no capacity to provide short term care and as it appeared that the Patient was responding to medication there was no care assessment completed and therefore no urgent need for care. The referral was subsequently closed.

2.14 It appears that Wye Valley Intermediate Care Team wrote to the GP in April 2013, stating that following as assessment of the Patient, they would not be offering her a service but they had referred the matter to Adult Social Care.

2.15 On 9th April 2013, the GP conducted a review of the Patient after a suspected UTI. One of the daughters was seen and stated that she was now able to cope and that she would liaise with the Reablement Team.

2.16 On 5th June 2013, the GP had a conversation with one of the daughters about the use of Oromorph, and the Patient's anxiety and dementia making her pain worse especially when she was on her own. It was suggested that she would be prescribed

[9] This is a dementia screening tool developed in 2000 by *The Kingshill Research Centre, Swindon, UK* for use in primary care. The test asks 6 questions which take 3-4 minutes to complete, scoring up to 28. The Patient scored 22, demonstrating the probability of an underlying dementia type illness.

[10] An advance directive (sometimes known as an advance decision to refuse treatment, or a living will) is a decision patients can make to refuse a specific type of treatment at some time in the future. It lets family, carers and health professionals know whether the patient wishes to refuse specific treatments.

antidepressants, which were increased three weeks later. She was also prescribed a Fentanyl patch, a strong opioid painkiller in patch form.

2.17 The GP also completed a 'Do not attempt CPR' form (DNACPR) and this was agreed as the GP was of the view that in the event arising, it would not be in the best interests of the Patient to be resuscitated.[11]

2.18 By 20th August 2013, the daughters were showing the strain of caring for the Patient and they agreed to contact Adult Social Care and request an assessment of need and a care package for the Patient. She was sleeping badly and needed to pass urine frequently during the night.

2.19 On 4th November 2013, the GP made a home visit to the Patient, who was reported as being very confused and troubled by the constant need to pass urine. Her care was being provided by the daughters. The Patient was sure that she did not want to be admitted to hospital. Her daughters felt that an admission would increase the risk for their Mother as she was likely to fall as she had done so during a previous admission to hospital. The following day, the youngest daughter contacted the GP saying that despite using opioids overnight, her Mother was in increased pain and more confused. The GP planned to visit to see if admission to hospital could be avoided. At the visit the GP saw D2 who said that she was able to nurse her Mother at home. The GP considered that the Patient could now be 'end of life care' and prescribed palliative care end of life drugs and completed a handover sheet to inform the out of hours service of the Patient's care plan. The Patient's care was left mainly to her daughter (No 3), as a carer.

2.20 Wye Valley IMR notes indicates that in November 2013, the daughters arranged privately for a care package but the Patient would not allow carers into her house so the three daughters agreed to provide the care needed. Records show that between 7th and 11th November 2013, the Patient received services from an independent Care company from Hereford which consisted of three visits per day totalling 2 hours. This service ceased because the Patient would not tolerate carers. It is noted that a carer's assessment did not take place at that time and was not undertaken until January 2014.

2.21 On 21st November 2013, medication was prescribed that included a syringe driver for the administering of diamorphine and cyclizine as end of life medication. A syringe driver was fitted. Records indicate that the GP visited the Patient just before midnight and remained with the Patient for an hour and a half to ensure that she was comfortable. The following day the District Nurse saw the Patient at her home. The syringe driver fell out and not replaced and oral medicine was prescribed.

2.22 Later that day, 22nd November 2013, West Mercia Police had their first contact with the Patient. Officers responded to a call from D2 saying that the Patient had pulled a sharp kitchen paring knife on her. Her Mother was quite unwell and was outside the house in her night clothes and in freezing weather. She stated her Mother was on end of life medication and was very confused. She did not want to know any of her daughters. Officers treated this call as a concern for safety call and not as a domestic violence incident. On arrival Officers found that neighbours had prevented her wandering off.

[11] The British Medical Association (BMA), the Resuscitation Council (UK), and the Royal College of Nursing RCN) issue guidance regarding anticipatory decisions about whether or not to attempt resuscitation in a person when their heart stops or they stop breathing. A DNARCPR does not equate to not treating a person's health needs or offering them a poorer quality service. This process is an integral part of good clinical practice. It is important to involve people (or their representatives if they are unable to make decisions for themselves) in the decision making process.

An ambulance had been called and the Patient handed over kitchen paring knife to the Officers, who accompanied her to hospital in the ambulance. She was detained on a medical ward for ongoing treatment.

2.23 The Police made a referral to Adult Social Care but the case was closed as it was described as the Patient was in a confused state due to a UTI. Instead a referral was made for a Community Care Assessment and package of care. The assessment was not completed for support as it was deemed that the Patient was over the capital limit for services and was able to purchase her own care as opposed to the Local Authority providing care for her. The decision involved the family however it was potentially a missed opportunity in that if Adult Social Care had provided a full assessment it could have provided by doing so a wider source of support and coordination for the individual and her carers. This decision was made in the context that practice at the time was that full assessments were not routinely provided to individuals who were considered self-funders.

2.24 On 23rd November 2013, the Patient was reviewed in hospital and deemed appropriate for both old age and psychiatric referral and a palliative care review. The palliative Care Team review deemed the Patient's pain to be chronic and not palliative. She was discharged home on 25th November 2013.

2.25 On 26th November 2013, there was a request made by a Physiotherapist from Wye Valle NHST for a Carers Assessment but this was not completed due to the Patient not being able to tolerate agency carers and also that she was over the capital limit for carers. There had previously been another request for a carer's assessment in April 2013, but this had not been done due to the Patient recovering from an ITU at the time.

2.2 In January 2014, the carer's assessment, (mentioned above) was completed. The Carer stated that she had to take unpaid leave from work to care for the Patient and although she felt that caring for the Patient was a positive experience, she was feeling stressed at being a full time carer and needed a break. An application for carers allowance was successful and payment commenced in February 2014. By this time the family had privately commissioned a family friend as a supplementary private carer (as shown on the Genogram)

2.27 On 7th March 2014, the Patient attended the hospital again with another UTI and she was admitted to a medical ward. The opinion of the DMHOP Team was sought and it was noted that the carer, the Carer, was suffering fatigue and becoming increasingly distressed by the situation with the Patient.

2.28 The Patient was referred to the 2gether NHS Foundation Trust (2gft) and her mental health was assessed in the context of her physical health needs. It has determined that she had become obsessed with wanting to pass urine, which was understandable with her UTI problems. It was noted that she had increasing mood changes and loss of memory and a significant history of medical problems. It was recommended that the GP should refer her to the Memory Clinic once she was discharged from hospital. The Consultant was able to meet the carer commissioned by the daughters, who described the Patient as being 'back to her usual self'. It is also recorded that there was a delirium present and it was recommended that guidelines for the management of delirium should be followed.

2.29 On 12th March 2014, Adult Social Care were informed of the Patient's admission into hospital and a discussion took place with hospital staff as to whether a residential placement would be better for the Patient and the daughters, who were having trouble coping. Information about residential care was given to the daughters, but they stated that they wanted only a short stay in a community hospital and then for her to return

home once she was discharged. The placement in residential care was not followed up by the daughters and on 31st March 2014, the Patient was discharged home, albeit concerns were raised as to how the Carer, daughter 3, and her sisters would cope.

2.30 On the 9th of April, 2014 a continuing health care assessment was arranged and attempted with both a social worker from ASC and a continuing health care nurse specialist (CCG) on discharge home. This assessment was started but not completed before the Patient's death.

2.31 On 18th April 2014, (Good Friday) a Prime Care (locum) GP attended at the home address of the Patient as the daughters were concerned that the Patient was constipated. She was not eating and did not recognise her daughters. The Locum Doctor, referring to his notes when seen as part of this review, stated that he sent a note to her GP's surgery suggesting that she be seen after the Bank Holiday and he denies mentioning anything about the Patient dying imminently, although the Carer says he told her to stop concentrating on the Patient's illness and just make her comfortable. The Carer says that the Locum Doctor gave her and her sisters the impression that their Mother would die either that day or the following day.

2.32 Following the death of the Patient and the Carer surrendering herself to the Police, the following details of events unfolded.

2.33 It appears that during the 20th April 2014, the Carer attached extra Fentanyl patches to the Patient's skin and disguised these with extra blanket and clothing so her sister, D2 would not see them. As the patches dropped off due to the Patient becoming hotter, more patches would be applied to her. According to the Police IMR she recalled that there were five patches on the Patient at some stage over the weekend and she removed them before her sister washed her Mother after the Patient had died.

2.34 At 18.15 hours on 20th April 2014, it is recorded in the medicine register kept by D2 that a Fentanyl patch was replaced and at 21.55 hours she injected the Patient with 2.5mg of Midazolam. D2 noticed that the Patient was highly agitated, sweating profusely and unable to sleep. The Carer will say that the injection calmed the Patient down into a more relaxed and peaceful state.

2.35 The Carer was given the used syringe and the remaining 7.5mg of Midazolam by D2 to dispose of, but instead she hid it to use it again later that evening. Whilst D2 was asleep later that night, the Carer injected the Patient again with between 5gm and 7.5mg of Midazolam. She made no record of this and did not tell her sister D2.

2.36 At 04.45 hours the following morning, D2 injected another 2.5 mg of Midazolam into her Mother, not knowing about the extra injections given by the Carer during the night. Again D2 asked the Carer to dispose of the syringe and the unused Midazolam, but again the Carer concealed them and later injected another 5mg to 7.5mg into the Patient. The Carer went on to admit to injecting the Patient on one more occasion that day, making it possible that she had injected somewhere in the region of an extra 30 mg of Midazolam into the Patient, over and above the prescribed dose. It should be noted that this medication was only prescribed to be administered via a syringe driver and not under any circumstances by an injection.[12]

2.37 The Patient died during the afternoon of a Monday in April 2014. A Primecare GP was called to the house at 1814 hours and was told by the daughters that their Mother had died about an hour before they had called 'Primecare'. They said that the death was expected. As a result the GP 'recognised death' and estimated the death to have

[12] End of Life medication is only to be administered by a District Nurse who will use a syringe driver.

occurred at about 15.10hours that day. He authorised the Patient to be removed by an undertaker on the assumption that a Doctor would issue a medical certificate confirming the cause of death.

2.38 Once HM Coroners Officers were made aware of the death of the Patient, which at first view appeared to be natural causes, a Post Mortem was arranged. It was then that the Carer went to the Police and a criminal investigation commenced. A Home Office Post Morten was conducted and the medical cause of death initially established to be:

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

2.39 The Officer in Charge of the criminal investigation submitted papers to the Crown Prosecution Service for their advice about the culpability of the Carer and decided in December 2015, there was insufficient evidence to prosecute.

3 Views of the family

3.1 At a very early stage of this review, the Author wrote to all of the daughters, including the Carer, inviting them to indicate if they wished to participate with this review process. A letter was also sent to the Carer's Solicitor. Following the Crown Prosecution Service decision about proceedings, another attempt was made to contact the daughters by a letter from the Author.

3.2 An additional letter was sent to the other daughters in February 2016 but no reply was received.

3.3 A reply was received from the Carer, daughter 3, who wished to see the author and contribute to the review process. On 27th January 2016, the author met with the Carer at her home address. She explained that as the Patient's illnesses became worse the more she became exhausted looking after her. The knife incident resulted in her older sister giving less time to their mother so she felt that all of her mother's care fell to her.

3.4 The Carer explained that she was sleeping on the floor of the Patient's bedroom so she could tend to her when she get out of bed to use the toilet during the night which was every few minutes. She asked Social Services for help in providing assistance overnight but was told that would not be possible. She could have 24 hour assistance but her mother would have to go into a care home which the family had promised would not happen. The Carer explained that she was visited by a Social Worker who she found out later was 'only a trainee', who came to conduct a Carer Assessment. Apparently the Social Worker saw the Patient on the toilet and stated that she thought the Patient was friendly and as the offer of a care home placement had been refused, she left saying that there was no money in the budget for overnight assistance. The Carer broke down and the social worker stated she could help but it never came to fruition. The Carer did not ask for help again.

3.5 The Carer was asked if she had sought medical help regarding her own needs. She stated that she didn't have time and explained that she would call the Doctor or the hospital to make an appointment and she would be kept holding on to the call, during which time her mother needed help going to the toilet so she had to put the phone down. She tried to make arrangements for her GP to ring her on a specific day and a specific time but that did not work.

3.6 She described the Patient as frail, tiny woman but with a big heart.

3.7 The Carer asked a work colleague to help look after her mother for payment as her mother was becoming increasingly confused especially about taking her medication. Her mother would ring the Carer at work all of the time to such an extent that she had to resign from her work to cope with her mother's demands.

3.8 Regarding the end of life medication give to the Patient the Carer stated that the syringe fell out of her mother's arm and it took four hours for someone to attend to replace it. The Carer tried for hours to replace it. During that time, the Patient became agitated and physically aggressive pushing her daughters, not knowing what she was doing.

3.9 A locum GP prescribed the end of life medication and the Carer had problems getting the prescription at various chemists. She explained that she had told the GP that she didn't agree with giving her mother all of these drugs.

3.10 When the Patient was taken to hospital by ambulance assisted by the police, the Carer stated that she the Patient was without mediation for hours and becoming more and more agitated. The Carer had to beg the hospital staff to give her an injection to calm her down. However as they tried to give the injection the Patient objected and the staff stopped trying. The Carer stated that she had to insist they the staff continued to administer the injection despite the Patient protesting in order to calm her down.

3.11 The Carer, daughter 3, described how the Patient was stuck on the toilet for what seemed like hours without anyone coming to her assistance and although the Patient was a small frail lady she was still too heavy for the Carer to lift or move about the hospital.

3.12 The Carer is of the opinion that the Patient's palliative care assessment did not take into account her needs. She stated that no one watched her or assessed her properly and hence the conclusion of the assessment that her mother's pain was chronic and not palliative.

3.13 The Carer stated that the family had no clear guidance how to administer their mother's medication and who was responsible for administering the end of life medication. She is of the opinion that the Patient's mental capacity assessment was wrong and that she did not have the capacity to make decisions about her care.

3.14 She feels that the health care for the Patient and her failed. She said her mother wanted help but she was not offered the correct kind of support.

4. Analysis and Recommendations.

4.1 Throughout all of the IMR in this review, the IMR Author's state that at no time during their dealings with the Patient or the daughters was there any suggestion whatsoever that there was Domestic Violence against the Patient. It follows then that there was no suggestion of the Patient being referred to MARAC.

4.2 It was not until the Carer, daughter 3, surrendered to the Police and admitted her actions that there was anything to suggest something out of the ordinary had happened.

4.3 It is the responsibility of the Overview Author to make recommendations that are overarching and affect more than one agency or are particular to a single agency if the recommendation has not been identified by that agency throughout the review process.

It is not proposed to make recommendations within the Overview Report that are adequately contained within individual IMRs.

4.4 West Mercia Police IMR points out that in relation to the incident of 22nd November 2013, when Officers to the Patient who had threatened D2 with a knife, the Officer attending should have recognised this as a Domestic Abuse incident, albeit the Patient in their review was the aggressor on that occasion. The IMR correctly points out that even if this incident had been recorded as a domestic abuse incident, it would have had no impact on the way the Police dealt with the circumstances of the Patient's death. The Police IMR makes a recommendation regarding the recording of such incidents which adequately deals with any omission.

4.5 Herefordshire Adult Social Care IMR makes the point that no formal assessments were completed of the Patient and that her voice was not heard. Her thoughts were always voiced by one or more of her daughters. Likewise there is nothing to indicate that her capacity had been assessed.

4.6 It is of interest to note that the Adult Social Care IMR indicates that both the Patient and the Carer may have been entitled to benefit from formalised assessments. Advice and guidance was provided at various points for the carer. The decisions were made in consultation with the carer, daughter 3. The Patient was over the capital limit for assistance, under the NHS and Community Care Act 1990 at the time appears to have been a factor towards some of the decision making. The IMR points out that the carer's assessment was carried out in January 2014, but a formal assessment on the Patient was never completed

4.7 It is clear throughout this review that, as the Patient became increasingly ill and thereby more dependent upon her daughters, particularly the Carer, for constant and 24 hour care that took its toll on her as well as the other two sisters, (although there is not much said about D1 within any of the IMRs). The Adult Social Care IMR points out that the stress being caused to the Carer was not recognised as a potential risk of harm to the Patient or herself.

4.8 The safeguarding alert following the incident with the knife was not followed up with an assessment. This together with the Patient's deteriorating mental and physical state provided indicators of the Patient's increasing complex needs and the care being provided by the Carer. While advice and support was noted as being provided as well as the context of family carers being seen as actively caring for the Patient and the Patient's documented objections to unfamiliar carers the IIMR states:

> 'The decision not to progress an assessment of the need in this context is questionable'.

4.9 The Adult Social Care IMR makes a total of 11 recommendations that adequately cover all of the points raised as well as necessary 'administration' issues that need addressing.

4.10 Primary Care IMR indicates that when the Patient was prescribed Oromorph, the use of a PRN Oromorph could be introduced for patients to record their usage of the drug. This is contained in an IMR recommendation.

4.11 On the subject of financial assistance for the Patient and the Carer this IMR states that an assessment could have been ,made by Adult Social Care as to whether the Patient met the criteria for Continuing Healthcare Funding and even as a self-funder the Patient may have been entitled to assessment and support services from the Local Authority. It points out that all Local Authorities in collaboration with their local partners have a legal obligation to promote the health and wellbeing of their entire population.

4.12 A Continuing Health Care assessment was not completed. Had it been completed and at an earlier stage the family would have probably been eligible for a fast track package of care, funded by the NHS. This in turn, may have resulted in an external professional oversight into the nursing and care the Patient was receiving.

4.13 In addition the IMR identifies that there was a lack of joined up communication between health departments such as the GP and Wye Valley NHS trust.

4.13 The panel expressed concerns about the 'End of Life' medication that was prescribed for the Patient. This, at one time, fell under the Liverpool Pathway Guidance, but that guidance has since been rescinded. It appears that once End of Life medication is prescribed for a patient, it remains the property of the patients, whether it is used or not and is kept with the patient. In this case it was kept in the Patient's home.

4.14 End of Life medication can only be administered by a District Nurse through a syringe driver, but the concerns of the panel in this review, were that this medication was available at any time to be abused, by the patient, carer or anyone else. There appears to be no governance of the medication once it has been prescribed and collected by or for the Patient

4.15 In this case the medication was used to relieve pain for the Patient, but over and above her normal prescribe medication by the Carer, knowing or believing that the extra dosage of medication may been to the detriment of her mother's health.

Recommendation No 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 Patient's household according to guidance but later abused by a family member to the detriment of the Patient.

5. Conclusions

5.1 The Patient in this case was desperately ill and in the latter months of her life, she was cared for by three daughters, particularly the carer, daughter 3. All daughters were devoted to her care.

5.2 They were offered respite care but chose not to take that opportunity. Indeed the Patient was adamant that she would not go into hospital, nor would she tolerate private carers until a family friend was commissioned to provide limited care.

5.3 The majority of care was provided by two daughters, one a qualified nurse and the other who gave up her work to provide 24 hours care for her Mother. It was noticed during the significant amount of health intervention with the Patient, that caring for their Mother was having and detrimental effect on the daughters.

5.4 The Patient was prescribed 'End of Life' medication which was kept in the Patient's home. The qualified nurse D2 took responsibility for administering medication by injection and completed a strict diary of administration. The Carer took it upon herself to administer significant amounts of Midazolam covertly and unbeknown to her sisters. Once a post mortem was arranged after the death of the Patient, the Carer , daughter 3, surrendered to the Police and admitted what she had done. The motive for her actions is not yet clear, but what she did was totally secret to herself and did not involve

anyone else. She was asked by D2 to destroy the used paraphernalia which she failed to do. She secreted it away to be used again when D2 was asleep.

5.5 It is clear that the death of the Patient was unpredictable and unpreventable in these circumstances, especially given that the End of Life medication was not controlled and left as a possession of the Patient and/or the family members.

Recommendations and IMR recommendations

Recommendation No 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 Patient's household according to guidance but later abused by a family member to the detriment of the Patient.

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.

Bibliography

Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011
www.homeoffice.gov.uk/publications/crime/DHR-guidance

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office

Herefordshire

Community Safety Partnership

A REVIEW CASE HDHR 3

OVERVIEW REPORT ACTION PLAN

Recommendation	DHR	Action	Lead	Timescales	Evidence
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 Patient's household according to guidance but later abused by a family member to the detriment of the Patient.	**HDHR Case 3**	**AT to draft on behalf of the CSP Chair the letter to the Department of Health expressing the concerns. Support to be given from Health Colleagues**	Chair Community Safety Partnership	February 2016	

INDIVIDUAL MANAGEMENT REVIEW REPORT RECOMMENDATIONS

Herefordshire CCG

Review Action Plan

In Respect of HDHR 3

Recommendation	DHR	Action	Lead	Timescales	Evidence
Map of Medicine to include the care pathway for domestic abuse	**HDHR Case 3**	Post HSCB/HSAB/CSP sign off of domestic abuse care pathway upload the pathway onto Map of Medicine	SC	March 2016	Evidence Domestic abuse care pathway updated, awaiting final version to include in GP processes
The CCG to include a link to the document managing pain in dementia in their next GP newsletter	**HDHR Case 3**	SB to include link in GP newsletter	SB	November 2015	Completed Info included in pharmacy newsletter to GP practices
The CCG to include information regarding	**HDHR Case 3**	SB to include information in next GP newsletter	SB	November 2015	As above

PRN Oramorph charts in their next GP newsletter					

Wye Valley Trust Action Plan HDHR 3

Action /Objective	Outcome	Evidence	Lead/s	Timescale	RAG Rating
All nursing staff involved in the completion of Continuing Healthcare Assessments to have appropriate training.	To ensure all appropriate staff are competent with the assessment process.	E-mail trail Training records	Lead Nurse Urgent Care	June 2016	

Warwickshire and West Mercia Police

Recommendation	DHR	Action	Lead	Timescales	Evidence
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.	**HDHR Case 3**	**1) Harm Assessment Units / Vulnerable Adult teams to ensure appropriate referrals submitted irrespective of which Crime header is used to record an incident.** **2) Officer understanding of risk & professional curiosity across incidents to be improved.**	PVP – Supt Eccleston	May 2015	**1) Since Nov 2013 when the incident arose which gave rise to this action, there have been significant changes in procedure, most notably regarding the creation of a Harm Assessment Unit to conduct referrals across agencies irrespective of recording. MASH are also under development to ensure both adult & child services are represented, with Vulnerable Adult Teams continuing to have some involvement in referrals processes in the meantime. The specific issue of how an incident is recorded not**

					dictating the type of referral has been raised in both HAU's to ensure referrals are not missed. **2) Significant work is being undertaken to broaden the understanding of staff around vulnerability & risk. This is focussed around Public Protection and professional curiosity, including a number of strands including domestic abuse. This programme of training is being rolled out across all frontline staff & specialists.**

[2]gether NHS Foundation Trust

Recommendation	DHR	Action	Lead	Timescales	Evidence
1. To ensure that all patients receiving a service from [2]gether have a risk assessment as	**HDHR3**	**All frontline staff to undertake Risk Assessment and management training and**	**Di Topham**	**January 2016**	**There is a data quality action plan in place and compliance is monitored via**

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.		**refresher (every three years)**			**monthly data quality audits.** **As of 23/5/16 - Current recorded compliance for patients having a risk summary is 73%.**
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.	**HDHR3**	**For all frontline staff to undertake Mental Capacity Act training, to include formal documentation/recording.**	**Di Topham**	**January 2016**	**Compliance monitored via monthly data quality audit.**
3.To remind all staff in [2]gether NHS Foundation Trust of the definition of domestic violence	**HDHR3**	**Newsletter to all staff**	**Safeguarding Lead – Alison Feher**	**May 2015**	**Safeguarding newsletter – topic Domestic Abuse.**

and abuse and who it may effect.					