Nottingham Crime & Drugs Partnership

Working together to reduce Crime, Disorder and the misuse of Drugs

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Executive Summary: A domestic homicide review into the death of Adult A (Operation Hornpipe)

A report for the Nottingham Crime and Drugs Partnership

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1. **Executive Summary**

The review process

This summary outlines the process undertaken by the Nottingham Crime and Drugs partnership Domestic Homicide Review panel in reviewing the murder of Adult A. Adult A was cared for by her son, Adult B, at the time of her death and he has been convicted of her manslaughter.

The process began with an initial meeting on 30th April 2012 of all agencies that potentially had contact with Adult A prior to the point of death.

Agencies participating in this Review and commissioned to prepare Individual Management Reviews are:

- *Nottinghamshire Police*
- *Nottingham University Hospitals NHS Trust*
- *East Midlands Ambulance Service*
- *Nottinghamshire Health Care Trust*
- *NHS Nottingham City - Clinical Commissioning Group (within General Practice)*
- *Nottingham CityCare Partnership*
- *Nottingham City Council Adult Services – Provider Services*
- *Nottingham City Council Adult Assessment*
- *Sevacare*

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report was asked to consider whether internal procedures were followed; and draw conclusions and recommendations.

Key issues arising from the review

A number of themes have arisen from the overview of this case. These are:

- *Awareness of and referral for Carers Assessments*
- *DNA in mental health services*
- *Mental health assessments for carers and patients*
- *Care Coordination and Review Arrangements*
- *Recording and notification*

Throughout the chronology there are several points at which a referral for a Carers Assessment could have been made and a Carers Assessment offered and undertaken. The rationale for not completing such is unclear. On the one occasion where a Carers Assessment was completed, when Adult A was about to be discharged from hospital in June 2011, this was of her daughter as the main carer despite her son Adult B moving to live with Adult A.

It is of note however, and significant to this case, that Carers Assessments are assessments of need as opposed to assessment of ability to care. Most carers have a legal right to an assessment of their own needs and what help they need with caring. This includes help that would maintain the carer's own health and help balance caring with other aspects of their life, such as work and family. It is clear that Adult B met the criteria for a Carers Assessment in his own right. This was never completed and it is unlikely that Adult B was aware of his right to ask for such an assessment.

A Carers Assessment could have examined Adult Bs role as a carer; how being a carer affected him; and how much caring he could realistically do. This may well have then elicited information regarding his mental health issues. That said, the overall purpose of the carers assessment is to establish the needs of carers and determine with the carers how to meet those needs. If the carer is unsuitable, this would not generally form part of the assessment, unless the carers themselves volunteered that they felt unsuited to it. The Review has found that this is a significant gap. The Carers Act does not currently provide the legislative framework to enable suitability and capability to become part of the assessment process to ensure that the needs of vulnerable individuals are met and that the strategic priority to support carers to remain mentally and physically well is achieved.

It has been identified within this Review that a far more robust and creative approach should have been developed in order to engage Adult B with mental health services. Despite it being known to agencies that he was not opening his mail, appointment letters continued to be sent to him and therefore it is not surprising that he did not attend appointments. Adult B asked that he be contacted by letter or phone, although there is little evidence of the latter. The GP continued to re-refer Adult B to a service with which he had demonstrated a disinclination to engage. The Mental Health and Wellbeing Team continued to discharge Adult B when he failed to attend appointments, despite the number of and frequency of referrals made by the GP to the service. It may have been advisable for the GP to have discussed with Adult B why he was not engaging with mental health services, and explore alternative options. The IMR for Nottinghamshire Heath Care Trust has found that the Trust's Did Not Attend (DNA) Policy in place at the time was not complied with.

During Adult B's involvement with mental health services, 3 no access visits were undertaken. When no further contact was made, no attempt was made to ascertain Adult B's whereabouts. A duty of care to patients would be to ensure that their safety and wellbeing is known. Checks could have been made with family members, health care providers and indeed the Police but there is no evidence to suggest that this occurred.

Adult B had a number of assessments in respect of his mental health. It is highly likely that at the time of these assessments, he did not have caring responsibilities for Adult A. It is evident however that this question was not asked of him. The Care Programme Approach (CPA) documentation used for mental health assessments that was introduced in 2009 asks staff to consider

as part of their assessment whether a client has caring responsibilities. In the case of Adult B, this was not considered as the worker did not use the correct assessment documentation. This Review has found that there is merit in ensuring such routine enquiries are embedded within mental health assessments in order to firstly, determine whether a person with mental health difficulties has caring responsibilities, and secondly to ensure that those responsible for coordinating the care are aware of the carers mental ill-health. This is of course totally dependent upon the Carer's decision to disclose such information.

This Review has found that Mental Capacity Act assessments of Adult A were not always completed and Best Interests Decisions were not always recorded. This is a gap when considering the vulnerability of her circumstances given her diagnosis and her care needs. Whether Adult A's views were sought or not are rarely recorded and even if she did not have capacity to make decisions that were in her own best interests, her views should have been recorded nonetheless. Mental Capacity Act paperwork is standardised within Adult Assessment and this Review seeks assurance that this is embedded and subsequently audited within the service.

Adult A had a comprehensive and intensive care package. Despite this, the evidence presented to this Review indicates that there was a lack of care coordination and review. There is ample evidence of liaison between agencies yet the review process for Adult A's package of care is less clear.

Recording of family demographics is an area of concern in this case. It is not often clear from the records who is caring for Adult A and who lives in her home. It is imperative that full names and addresses are sought for family members and that household composition is reviewed at each significant contact.

Not all agencies were notified of Adult A's death. Indeed, a health professional contacted her daughter to arrange an appointment with Adult A some 5 months after her death. The Review has explored the possible routes for notification, and it has become apparent that this is a gap in service delivery for which there is no local solution. The DHR Panel consider that this may require a national response, such as the expansion of the remit of the Tell Us Once Service to include notification of deaths to health agencies.

It is evident that this was a tragic case and one where Adult B felt that he was acting in the best interests of his mother. This has been echoed within the criminal trial. Adult B had decided that his mother would not die naturally as a consequence of her illness. He knew and planned to end her life.

Although the outcome could not have been prevented, it is clear that agencies responsible for Adult A's care were not aware of Adult B's history of mental health difficulties. Carer stress was evident and it is not clear that Adult B's support needs were fully understood.

There were indicators that Adult B was feeling under pressure and he spoke of feeling isolated and anxious. Had his mental health difficulties been known, these factors may have been viewed differently by the professionals involved in Adult A's care. Although Adult B did not disclose his mental health difficulties, a robust exploration of his needs may have elicited this information.

Adult B was not offered a Carer's Assessment. It is clear that the referral pathway for Carers Assessment needs to be better understood and embedded, and that the support needs for carers, in particular their mental health needs, are a strategic and operational priority.

Significant changes have taken place in the design and provision of services since the death of Adult A. Assessment forms in the Adult Assessment service have been changed to ensure that any risks that caring responsibilities may have upon the ability of the carer to care are documented; with triggers to offer a Carers Assessment being included at various points of an assessment. The implementation in 2013 of the Carers Hub with a single referral point now makes it easier for carers to independently seek advice. The hub will also raise awareness of Carers and the support the Hub offers, which may enhance agencies' understanding and identification of carers and how to refer them for a Carers Assessment.

The DHR panel, after thorough consideration, believes that under the circumstances, agency intervention would not have prevented the victim's death, given the information that has come to light through the Review. Adult B found living with his mother with advanced dementia intolerable, and chose to take the course of action that he did as a way to end her suffering. The information available to the DHR panel suggests that there were no recorded incidences of domestic violence between Adult A and her son Adult B and that the homicide could not have been predicted.

<u>Recommendations</u>

Since the writing of this report a number of changes in policy and practice have taken place, most notably the Nottingham City Joint Carers Strategy 2012 – 2017, which arose as a result of a review of carers' provision and support. One aspect of the strategy is to ensure that agencies, including the third sector, understand the referral pathway for Carers Assessments.

The Review endorses the recommendations of the IMRs. In addition, the Review makes the following recommendations:

- *All relevant Adult Assessment staff have the knowledge and skills to a) enable them to record on the citizen assessment any risks relating to the carer's ability to care and a plan to mitigate that and b) the Carers Assessment is strengthened to specifically explore the impact to the carer of them assuming caring responsibilities*

- *In Complex cases, Adult Assessment, Citycare and General Practitioners need to determine how Multi-agency reviews are initiated and conducted and agree a procedure for such.*

- *That agencies provide assurance that they have a clear bespoke process for the recording of assessment of mental capacity.*

- *The Relative Stress assessment process and documentation is reviewed to ensure that it considers a referral for a Carers Assessment.*

- *That action is taken to ensure robust recording of family demographics, such as household composition and details of carers, by all agencies working with vulnerable adults.*

- *That agencies provide assurance that their DNA policies ensure that appropriate risk assessment and action is taken, including processes of escalation, in cases of concern.*

- *That the Home Office considers what action may be required to address the issue of notification of deaths to health agencies, especially when those deaths occur in the community.*

The above recommendations have formed the action plan at Appendix B and will be monitored via the Domestic Homicide Review Implementation Group which reports to the Crime and Drugs Partnership Board annually.