DOMESTIC HOMICIDE REVIEW

The London Borough of Islington

Anthony Wills
September 2013

Contents

Domestic Homicide Review – WX
London Borough of Islington

Executive Summary

Outline of the incident

1. On Monday 30th July 2012 at approximately 11:30pm the London Ambulance Service and Police were called to an address in Islington where the subject of this review, WX, had been living with his ex-partner and primary carer, YZ. Police and paramedics found WX unconscious as a result of YZ strangling and asphyxiating him with a plastic bag. WX was taken to hospital and died the next day as a result of his injuries.

2. YZ and WX had formerly been in a long-term relationship although this had ended in 2006/7 prior to WX's diagnosis of cirrhosis of the liver in October 2011. Following his diagnosis, WX moved into YZ's flat so that she could provide him with care.

3. YZ was arrested and charged with WX's murder and was remanded in custody. In May 2013 YZ was found guilty of manslaughter and having served the equivalent to a 19-month jail sentence on remand, YZ was given a 12-month jail sentence, suspended for two years, along with three years' supervision. YZ was released from custody on 13 May 2013.

The review process

4. These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Safer Islington Partnership (SIP) in Islington. The initial meeting was held on 22nd January 2013 and there have been two subsequent meetings of the DHR panel to consider the circumstances leading up to WX's death.

5. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004. The purpose of these reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims

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

6. This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Terms of Reference

7. The full terms of reference are included in Appendix 1 in the overview report. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

Methodology

8. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with YZ or WX. A list of those agencies and the individuals involved is contained within the main report (See Appendix 2). It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. The IMRs, discussions at DHR panel meetings and additional communications such as emails and telephone calls relating to this case were used to write this Overview Report. All DHR panel members and family members have had the opportunity to review and comment on this report prior to publication.

Independence

9. The independent chair of the DHR is Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the Borough of Islington or any of the agencies involved in this case.

Parallel Reviews

10. There were no reviews conducted contemporaneously that impacted upon this review.

Contact with family and friends

11. WX has surviving relatives; two biological daughters, one stepson and one stepdaughter and an ex-wife (not YZ). One of WX's family members chose to participate in the review, whilst the others have chosen to take no part in this review despite multiple attempts to seek their involvement. It was not possible to identify any friends who could have added value to this review.

12. The perpetrator has not been interviewed for this review despite many and varied attempts to contact YZ.

Summary of the case

13. WX was 66 at the time of the murder and both he and YZ were known to a number of agencies prior to his death. WX was suffering from end-stage liver disease as a result of long-term alcohol misuse and had serious and persistent health issues. In October 2011, he elected to live with YZ and for her to be his primary and only carer.

14. YZ is a 69 year-old woman with a documented history of mental health issues including depression, suicidal ideation and overdosing (including in 2007 and 2010). At trial she was diagnosed with avoidant personality disorder. YZ also had a history of moderate substance misuse involving alcohol consumption. She is of moderate to poor health and is being treated for arthritis. She received intermittent treatment for her mental health issues including prescription medication, psychiatric support and in-patient hospital care. She was prescribed medication through her GP but there is no record of any formal review of her mental health needs except around her inpatient hospitalisations. She had no previous criminal record. There were no previous reported incidents of domestic violence between YZ and WX.

15. WX and YZ's relationship began some time after he separated from his ex-wife in the 1970s and was intermittent until 2003/4. There were no children of the relationship between WX and YZ and they were never married.

16. From 2004 until moving in with YZ in October 2011, so she could be his primary carer after his diagnosis of cirrhosis of the liver, WX lived in New Belvedere House, a hostel for ex-service personnel.

17. From 2010 until the time of his death, WX was treated for a range of medical conditions relating to liver disease by the following services: GP, District Nursing (DN), ELiPSe Palliative Care (Clinical Nurse Specialist, MacMillan Social Worker (MSW), Physiotherapist, Volunteer Welfare Rights Worker) and Whittington Hospital. He received inpatient, in office and at home care from these services, including while he was living with YZ and she was acting as his primary in-home carer. Between 2010 and 2012, WX's health deteriorated as he had terminal liver disease. In the last 6 months of WX's life, both WX and YZ had significant contact from a variety of agencies whose role it was to evaluate and facilitate supportive care for adults who are terminally ill and are being cared for at home by family.

18. Due to WX's increasing care needs and deteriorating health, the DN team referred him for an assessment by the Social Services Access Team in May 2012. The process of assessment was delayed due to issues with clarifying consent for the referral, but an assessment was completed in mid-May 2012. Issues were identified with YZ's physical disabilities and her desire for help with caring for WX's hygiene and personal care needs, however, YZ and WX turned down additional support at this time. Risk of carer relationship breakdown was recorded by the Access Service at this time.

19. By end May 2012, the GP and the Palliative Care Team had also identified that the situation between YZ and WX was strained and a care package was to be initiated. YZ stated that she and WX had never clearly negotiated WX's health and care needs when he had come to stay the previous autumn and WX had not been well enough to return to the hostel. It is apparent that there were increasing tensions in the house. The MSW recorded that she had the impression from YZ that she would soon need a break from caring and respite may be an option. YZ voiced concern that WX's care would be compromised as he needed to be enabled to access a toilet on the lower floor. MSW noted increased tensions between WX and YZ, and that pain exacerbated this. On 30th May 2012 a physiotherapist also conducted a home visit and noted that there appeared to be tension between WX and YZ about his total dependence on her.

20. Due to the above concerns, the Social Service Access Team were asked to re-assess WX and YZ at the end of May 2012, and this was completed by mid-June. Despite the records indicating 'Mr WX is reliant on others for activities of daily living. Family are struggling to cope with Mr WX's needs', WX again refused services at this time. It was noted in the records that YZ received help from friends and her daughter and that WX had 'substantial needs that were being currently met by family'. They were offered the Linkline service as well, which they initially agreed to but later declined. There were issues with communication

between agencies around this referral. Additionally, YZ consented to a referral to the Islington Carers' Hub at this time, but the referral was never completed.

21. In early July 2012, records from the Access Team Notes stated that although YZ was clearly proving considerable support to WX, there was a low risk to the sustainability of the caring role. WX decided against receiving formal support, preferring to accept assistance from YZ, family and neighbours. YZ would have preferred WX to accept formal support. Risks were identified as: YZ at risk of carer fatigue, especially as WX's health deteriorated; YZ had her own pre-existing health problems. Protective factors were recorded as: YZ had a car and was able to access the community; YZ had a supportive daughter and neighbours.

22. On 18th July 2012 ELiPSe conducted a joint visit with the MSW and CSN. During this visit YZ said she could do with a break and the possibilities of this were discussed, including hospice for an inpatient stay for WX. MSW identified that YZ and WX had previously turned down social services care. MSW strongly recommended that YZ accept input to relieve YZ from providing all personal care. The MSW enquired about wider family issues; YZ said that her daughter was now pregnant and YZ was concerned about childcare as her daughter worked full time. MSW encouraged YZ to see her GP about her own needs as she mentioned joint pain. This was the last contact recorded by the ELiPSE Team.

23. On 30th July 2012, YZ took the action which led to the death of WX and made admissions to this effect to both neighbours and the police.

24. The London Ambulance Service (LAS) upon being called, alerted police to the incident and both attended. WX was found lying on the floor unconscious and not breathing.

25. At 23:38 hours YZ was arrested and conveyed to Islington Police Station Custody Office where she made further comments, "I'll put my hands up to it", 'I'll put my hands up to it, I did it" and "I put a bag over his head".

26. WX was resuscitated by the LAS and transported to the Intensive Treatment Unit at Whittington Hospital for treatment. Subsequently, at 06:46 hours on 31st July 2012 his life was pronounced extinct.

27. YZ was interviewed by police. She confirmed that their relationship broke down in 2006/2007 due to WX's alcoholism. She reported that there had not been any violence between them.

She advised that she was WX's full time carer and that she did this voluntarily without payment. She added that he could be difficult and on occasions shouted at her.

28. When asked what had happened she stated that WX asked to go to the toilet. She agreed to take him. She entered the living room and found him on the floor. She approached him and said, "Let me help you, do you want me to do this?" He did not answer and appeared to be suffering. YZ then went to the kitchen, picked up two plastic bags, returned to WX, knelt beside him, slipped one of the bags over his head and held it for about 6 seconds. She then removed the bag.

29. Samples taken from YZ were tested and showed high toxicology tests for alcohol, which were in contrast to WX'S tests, which were negative for alcohol.

30. A post mortem concluded that the cause of death was compression of the neck and plastic bag asphyxia.

31. YZ was charged with murder and a trial date was set for 18th March 2013 at the Central Criminal Court. In May 2013 YZ was cleared of WX's murder but found guilty of manslaughter. Having served the equivalent to a 19-month jail sentence on remand, YZ was given a 12-month jail sentence, suspended for two years, along with three years' supervision. YZ was released from custody on 13 May 2013.

32. At trial Judge Gerald Gordon, said, when passing sentence: "You had to provide constant and arduous care in increasingly difficult circumstances. With the enormous benefit of hindsight and knowledge, far more active intervention was necessary to get you out of the situation you were in. But it has to be said that the main reason that did not happen was that you never really revealed the scale of the problem to others."

Key issues arising from the review

33. What is shown within the IMRs and through discussions within the DHR panel is that communication amongst the agencies involved with WX and YZ could have been better, especially during the last few months of his life. The DHR panel generally agreed that had one or more of the agencies involved raised concerns about this case and spoken to Adult Safeguarding this may have led to inter-agency discussion and better outcomes especially bearing in mind YZ's ability to cope with WX's care in the context of her significant and well-recorded mental health and substance misuse issues. Had YZ also been offered carer

support at an earlier stage, this along with other factors, could have led to an increased level of support.

34. It was also evident was that although this case was not a straightforward or easily identifiable situation of domestic violence, the DHR process has given agencies an opportunity to review their responses to this issue; in some cases this has highlighted gaps in service provision around domestic violence. It is also evident that practice regarding safeguarding, carers' support and inter-agency communication must continue to develop.

Broad themes identified throughout the review are summarised below:

Equality and diversity

35. The panel highlighted that gender and mental health (disability) potentially played a role in the circumstances of this case.

36. As more women are killed by their partners and ex-partners than men, the Panel considered whether signs of potential aggression or violence were overlooked in this case because YZ was female. This appears not to be the case as there were no records of previous violence cited in any of the organisations IMRs. However, it would seem the potential existed for professionals to make assumptions about not looking for domestic violence between YZ and WX as no record of asking WX or YZ about potential abuse from the other was recorded anywhere. Gender could have also played a role in professionals' acceptance of YZ's role as WX's carer as a 'natural' one because YZ was a woman.

37. Many of the professionals involved in this case were aware of YZ's mental health history, which included multiple overdoses and significant depression, which was treated via medication for many years. It appears that the extent of YZ's mental health issues in relation to her ability to be a carer were not fully considered or examined in this case.

Missed opportunities to share information about and understand the potential impact of YZ's history on her ability to care for WX / Missed opportunities to link YZ's past with current ability to care for WX / Should WX have received different care?

38. Due to the underlying issues with YZ, the opportunity for a number of professionals to interpret the situation and consider YZ's ability to care for WX was missed. There seem to be three separate issues: whether YZ had vulnerabilities that should have been explored

more thoroughly when opportunities arose, whether YZ should not have been a carer, and whether WX should have had better or different care.

39. Currently a Carer's Assessment is completed based on what was disclosed by the Carer and there would not be a history check at that point. It does not seem that the question was asked by any service whether YZ was actually capable of providing long term and complex care to WX. There is the clear possibility that the risks presented by YZ's pre-existing physical and mental health problems and substance misuse issues were unclear, unknown and/or underestimated by professionals, despite the fact that research consistently shows that alcohol misuse and mental health issues of carers are significant risk factors in adult abuse and neglect cases.

40. The DHR Panel felt strongly that recognition of the massive stress that carers are under should be emphasised in this report. It is incredibly important that **the circumstances and needs of carers are identified, listened to and emphasised when professionals are considering care plans for the cared for.** The panel agreed that there could have been much more done to support YZ in her role as primary carer for WX.

In this case, various agencies each held significant information about YZ and WX's current situation and historical factors, yet only shared this with each other in small snapshots, if at all. For example, during the whole period of WX and YZ's involvement with the Access Team professionals identified risks and documented these thoroughly, but did not share them holistically across all involved services. The risks identified were not considered sufficiently serious for further action, and there was no evidence that WX was suffering harm at the hands of anyone else. Additionally, the assessment approval on the Access Team's record shows that WX had "substantial care needs" which were currently being met by the family, therefore the Fair Access to Care Services (FACS) eligibility was agreed as "low".

41. There was broad consistency among the Panel that professionals did know the majority of the factors in the case but that they did not feel it merited a safeguarding alert. There was also strong agreement among the group that had a safeguarding alert been triggered it would not necessarily have met the thresholds. Certainly there was agreement that the case would have been borderline since WX had mental capacity and there was no evidence of abuse. However, it was agreed that had an alert been made, that might have triggered more social work support being offered, and that in turn might have triggered agencies to consider YZ's needs as well as WX. The Panel discussed the move towards a safeguarding approach that focuses more on prevention and on vulnerability than on risk, and the group did feel that

the risks that were being considered in relation to WX and YZ were not identifies as risks in relation to abuse and homicide.

42. There was also cross agency discussion regarding WX's care needs between CSN, Social Care Access Team and District Nursing. However, communication and info-sharing across District Nursing, the Social Services' Access Team ,the ELiPSE Palliative Care Team (who were supporting WX and YZ in four different capacities) and the GP and acute services (who each had access to some elements of YZ's substance misuse, psychiatric and physical health history) could have been more coordinated. This case would have benefited from a case conference or a multi-agency approach with all involved parties then able to discuss the known level of risk (which would have increased if all agencies' knowledge was shared) and the suitability of YZ as a carer given the significant needs of WX. Sharing information could have led to a more robust understanding of YZ's ability to care, her needs as a carer, the risks to both WX and YZ and WX's total needs package. This would have been an opportunity for any concerns to be addressed and risks to be mediated in a multi-agency context.

43. The GP surgery saw both WX and YZ on numerous occasions, including in YZ's home and thus were in a position to observe the home care situation and ask YZ and WX about current levels of support. They made appropriate referrals to services, for example the DN Team in February 2012 and the Palliative Care Team in May 2012 but did not take any further action over concerns raised about YZ's inability to care for WX.

44. Speaking with WX's family also highlights the missed opportunity for more holistic consideration of YZ's history and ability to care for WX, across and within agencies. When asked, *'What do you think should have been done for WX or YZ by professionals?',* a member of the family said that:

> One thing maybe is that they could have looked into her [YZ's] history because she was not well herself and couldn't cope because of her issues….Maybe if they had picked it up she could have gotten her help that she needed. At court it was decided that she has avoidance personality disorder. They should have realised she would have shunned help. He [WX] didn't like making decisions and it would have been YZ using more control and he would have allowed that to happen. It was a woman with issues making decisions for him. She was willing to make the decisions.

Clearly this family member was not referring to any specific organisation but felt there was a collective failure to amass the information that was available on YZ, which could have led to a different outcome. However, in terms of earlier substance misuse interventions, it was

thought by a member of the family that as WX never admitted he had a problem with alcohol, he probably would not have taken any help had it been offered earlier.

Risk Assessment

45. Previous case file audits of adult social services cases have identified absent or cursory risk assessments. Although there were 3 risk assessments in this case, the quality of them could have been improved.

46. The practitioners followed good practice by considering and listing the risks and protective factors both for WX (14 June 2012 and 21 June 2012) and for YZ (22 June 2012) before closing the case. However, it is noted that both of the risk assessments conducted were simplistic and did not take into account all of the actual risks involved in the case. Research studies have identified clear associations between mental health needs of carers and severe physical abuse of adults at risk. Another example is that the risk assessment did not take into account the possible fragility of WX's and YZ's relationship given that WX had only moved in fairly recently. Similarly, the risk assessment did not take into account the suggestion of conflict between WX, who didn't want care support, and YZ, who did. Therefore, it seems that the risk assessment in this case underestimated the situation by not considering all the risks and not giving the appropriate weighting to individual risk factors.

Failure to explore non-engagement thoroughly

47. During the Panel discussion it was cited that currently, resources to support people who are caring for those with chronic substance misuse issues are a very scarce resource. However, even when confronted with stretched resources, professionals must query and challenge situations of potentially inappropriate care rather than accepting them in place of more costly or complicated solutions.

48. Almost all professionals involved with this case, including the physiotherapist, District Nurses, the Access Team and the MSW and CDN, did recognise that there was tension between YZ and WX because YZ was feeling overwhelmed with the situation and needed a break from caring. However when WX was offered daily help with personal care by social care this was declined.

49. Both YZ and WX refused additional care on two occasions but the reasons for their refusal were not queried or followed up by the Access Service, District Nursing, the GP Service or

ELiPSe Palliative Care. In the case of the Access Team, as the social worker assessed the situation at low risk in terms of the sustainability of YZ's caring role, the Team would not pursue this further especially as both WX and YZ appeared to have the mental capacity to refuse services.

50. Given that YZ stated that she would have preferred WX to have accepted some formal help with personal care, and made reference to her own health needs in her carer's assessment, there may have been an opportunity to make further attempts to offer support from Adult Social Services through the Access Team. However the decision to close the case to Access at this time was reasonable given the absence of a case conference and that there was regular support going in from both the palliative care and district nursing teams. Both YZ and WX had been given contact details for Access if they wanted to explore further support. The acceptance then refusal of social services support for both YZ and WX was not sufficiently discussed or queried amongst the organisations involved. There is the possibility that because YZ and WX often started by saying yes to services and then later said no, they may not have triggered organisational processes around non-engagement. As YZ's mental health diagnosis was not recognised or known to services this did not play a factor in them querying why she might not want or be able to engage with services despite not feeling able to cope with caring for WX on her own.

Following a standard protocol to speak to YZ and WX separately to give both an opportunity to express how they felt about the care situation and to disclose any abuse.

51. In certain situations it was unclear whether agencies interviewed the parties separately. It is worth noting the good practice of New Belvedere House, who rang back to speak to WX directly each time when YZ called on his behalf to check in.

52. Alternatively, both YZ and WX were present at WX's care assessment by the Access Service, when this should have been done separately. The ELiPSe Team noted that because of the layout of the home it was sometimes difficult having discussions because YZ and WX could only be spoken to in different parts of the same room. It is unclear if anyone from the ELiPSe team ever spoke to WX on his own.

Domestic violence policies not in place or not followed.

53. Some agencies cited that they have robust and frequently utilised domestic violence policies and procedures in place: Victim Support, Islington Adult Social Services (covering the

Access Team) and Family Services. It is unclear if the ELiPSe Team has a domestic violence policy although staff are aware of referral pathways to domestic violence services.

54. Belvedere House, the PCT and the GP Practice cited that they have policies relating to vulnerable adults but neither has a policy relating to domestic violence identification and referral.

55. The Access Team does not have a procedure of routine enquiry for domestic violence. it is important that agencies in contact with and responsible for service users have an adequate domestic violence policy in place, which is a living document, utilised by all members of staff. Despite the fact that a history of domestic violence was not noted in this case, opportunities for domestic violence screening across all agencies involved with WX and YZ were missed.

56. For most agencies, failure to routinely screen for domestic violence means that if there was a past history of domestic violence in the relationship between WX and YZ, they are unlikely to have become aware of it unless WX, YZ or a third party had shared the information with them.

Information sharing and communication difficulties led to delay in actions

57. The District Nursing Service initially referred WX to the Access Team for a needs assessment on 2 May 2012. The referral contained very little detail, stating only that 'One of our nurses reported that the family are not copying [sic] with managing his personal hygiene needs'. It would have been helpful to the Access Team to have more detail in this referral. The subsequent re-referral by the Palliative Care Team was similarly brief.

58. During the period between the initial referral from the District Nursing Service until after the Access Service completed their assessments, records show that information about both WX and YZ was shared appropriately, albeit slowly, between the involved agencies.

Failure to follow through with actions regarding support for YZ and WX

59. Two actions in particular were not completed as a result of the Access Service care assessments: the non-installation of the Linkline by the Telecare Team and YZ's referral to the Carers' Hub.

60. The Access Team Support Advisor made the referral to Linkline, however WX and YZ declined the service as there was no landline in the property and YZ did not have plans to install one. There is some confusion about the process in place for Linkline to report this back to the referring agency, in this case the Access Team, who did not have any record of WX's refusal of the service and were told subsequently that this was not something the Linkline team did routinely.

61. The Access Team agreed to refer YZ to Islington Carers' Hub, but somehow this was never actioned and the reasons for this remain unclear. As a result YZ lost the opportunity to alleviate her carer stress through accessing respite and meeting and networking with others in a similar situation. Carer isolation is a well-known risk factor for adult abuse and/or neglect. Had she been referred to the Islington Carer's Hub, YZ may have been able to share her feelings of being 'overwhelmed' and may have been encouraged by other carers to accept services. Greater social support, such as that offered by Islington Carer's Hub, has been shown to be associated with better adjustment outcomes in carers. It would also have provided another set of professionals the opportunity to interact with YZ and possibly even to spot signs of escalating carer stress. However, it must be noted that carer support services such as the Islington Carers' Hub tend to be more effective at reducing carer stress in the longer-term and are generally not a 'quick-fix'. In this case, the interval between YZ agreeing to a referral to the Islington Carers hub (14 June 2012) and the date of WX's death (31 July 2012) was only 6 weeks. Islington Carers Hub does aim to respond to all carer referrals with a personal telephone call within 48 hours. Therefore, there may have been some, albeit limited, opportunity for intervention.

62. The Access Team were not the only professionals who could have referred YZ to the Islington Carer's Hub. Other services could have referred YZ at a much earlier stage. For example, the District Nursing Service had a longer-standing involvement with YZ (since February 2012) and could have made that referral prior to 14 June 2012. Although Islington Carer's Hub would not have been able to support YZ with the full range of their carer services and would not have been able to offer respite without a needs assessment, YZ would have been able to access at least some of the carer services, such as training events and social support. Had this happened, it is possible that YZ would have felt less isolated, been more connected to other carers and begun to explore 'benefit finding' (that is finding benefits in adversity), which research shows has been associated with positive adjustment outcomes for carers. Where caregivers adjust better to their caregiving role, they are less likely to abuse the person they care for.

Conclusion / Preventability

63. It is clear that as WX's condition worsened YZ found it increasingly difficult to cope with his care needs alone. A number of organisations intervened on both WX and YZ's behalf and despite YZ expressing her desire for support to multiple professionals, both she and WX refused additional help with care in the home. The reasons for these refusals were not explored in great depth by organisations involved which may be common in situations where the family is the sole carer.

64. Despite a number of interventions by organisations and some level of communication amongst them, no full understanding of the situation, especially regarding YZ's historic and current mental health and substance misuse issues and their impact on her ability to care for WX, was held by any or all of the agencies involved (as the result of a lack of a multi-agency case conference, safeguarding hub meeting or risk assessment forum). Without this, it would have been difficult for each agency to respond differently than found in this review.

65. Had the information regarding each agency's concerns about WX and YZ, her history and current ability to care been shared holistically and appropriately amongst all organisations, perhaps the level of risk assigned by professionals would have been higher and therefore would have triggered additional levels of support for WX and YZ although thresholds for safeguarding would not have been met. Had additional professional support been given to supplement YZ's sole daily care of WX the circumstances of this case could have been different. Additionally the fact that YZ's vulnerability was not sufficiently recognised is also worthy of consideration when assessing how change must be delivered in the future.

66. When the issue of preventability is considered more clearly the concerns expressed in the preceding paragraphs indicate that this death could have been prevented if information-sharing structures had been effectively instituted. However, as there was no forum or institutional system for bringing together concerns and sharing information regarding a carers' setting, this was not an option in this case, except by stepping out of the policies by which the agencies operated. This case highlights the collective failure of agencies to ascertain and respond to YZ's needs and ability to act as a carer for WX, which left her in a vulnerable position in which she killed WX. It is to be hoped that the recommendations will make such an event in the future much less likely.

Recommendations

67. Some of the agencies involved in this DHR process had identified changes to their internal processes and approaches. These are indicated in the full report. The following

recommendations are based on what should happen now, beyond what has taken place. The action plan that relates to these recommendations is shown at Appendix 2.

Recommendation 1

68. Islington CSPU will develop minimum standards around DV definition/policies that will be distributed for adoption by all partners locally, so to ensure a consistent approach and understanding of the issue.

Recommendation 2

69. At a strategic level, Islington Adult Social Care should review how effectively it works with domestic violence agencies and MARAC and the MARAC Steering Group. Joint working may help to raise awareness of the specific risks relating to domestic violence for adults at risk and ensure better adjustment outcomes for their family carers.

Recommendation 3

70. For all agencies who do not conduct periodic reviews of their processes and policies they must conduct a review of all safeguarding adult and domestic violence processes and policies and explicitly consider the overlap of the dynamic of domestic violence in its broadest sense and the response to safeguarding adults at risk. (The review process should be overseen by the Islington Safeguarding Adults Board in addition to the Safer Islington Partnership.) All agencies will be required and expected to implement policies and procedures in this area and report on their progress. These processes and policies to be reviewed annually and reported back to both strategic boards.

Recommendation 4

71. Organisations to consider implementing separate interview and screening procedures for carers and patients to ensure both parties have the ability to speak freely and openly about their needs and concerns. This is particularly important in case of potential abuse and domestic violence, but a relevant screening tool for all cases.

Recommendation 5

72. Adult Social Care to adopt an integrated whole systems infrastructure which will better facilitate and support multi-agency working. Adult Social Care to identify a lead organisation with case management responsibility and a lead local authority with co-ordination responsibility. Local authorities have the lead role in coordinating the multi-

agency approach to safeguarding adults at risk. This includes the coordination of the application of this policy and procedures, coordination of activity between organisations, review of practice, facilitation of joint training, dissemination of information and monitoring and review of progress within the local authority area. This could be addressed in Islington by the launch of the 2013 Plan for Whole System Integration. The objective of this approach is to optimise multi agency expertise and resource to deliver effective seamless multi agency preventive services, treatment and care closer to home and will include other public services in addition to health and social care. Carers at Risk - Greater multi agency and think family interventions incorporated in a whole systems approach as described above in working with carers to identify risk where the carer has unmet or unrecognised low level needs, are vulnerable themselves and have little personal or private space or life outside the caring environment.

Recommendation 6

73. MSW and ELiPSe team to review referral pathways, especially around how information about referrals to family services is communicated to clients and how referral outcomes are fed back to them.

Recommendation 7

74. Organisations to review/develop their policies on non-engagement and refusal of services, with an emphasis placed on the importance of focussing on the whole family including cared for and carer in terms of refusal or non-engagement. (There may be scope for additional work looking at ways of supporting carers where the cared-for person refuses to accept care from anyone else, as this is a common tension within informal care relationships.)

Recommendation 8

75. District Nursing team to continue to seek consent from service users and/or have discussion with them before referring to social services. This consent needs to be documented clearly in case files as not to delay referral processes. Additionally, as it is standard procedure to share notes with clients and keep them at the client's property, **on a national level**, District Nursing should develop a central electronic back-up system (attached to health records) of home notes so professionals can access these records at any time and that in the case of loss or destruction there remains a copy of all patients' records.

Recommendation 9

76. Telecare Service should review their procedures relating to service users who refuse services to ensure this information is captured and systematically fed back to the referrer. To this end, the Telecare Service will work with Adult Social Care to further develop the IAS system to capture and report issues of non-engagement by service users and/or their carers. This will ensure risk assessments are based upon accurate information and processes and procedures are managed in line with the guidance published by the Islington Safeguarding Adults Unit on 'Complex Cases including persons who refuse to engage and persons who self-neglect' (November 2010).

Recommendation 10

77. All organisations to explore ways of implementing best practice to identify carers and their support needs and refer them at the earliest stage possible to the Islington Carers Hub for advice, support and opportunities to be with a potentially supportive peer group of other carers. The Islington Carers Hub is open to all carers, even if a formal Needs Assessment has not been completed, and referral should take place at the earliest opportunity. Carers' should be Red coded in the GP clinical computer system thus allowing easy identification of them by a simple search.

Recommendation 11

78. As this case has some similarities with other serious cases involving family carers, the Islington Safeguarding Adults Partnership Board should examine together all such cases in the last 24 months to identify any areas for development or concern.

Recommendation 12

79. To deliver training to ensure all practitioners have a good understanding of the dynamics of domestic violence and appropriate responses. This case must be used as part of the development of an enhanced training package for practitioners which addresses safeguarding issues and includes domestic violence and abuse in its broadest sense.

Recommendation 13

80. Islington CCG should develop a more consistent approach to domestic violence that includes training, identification and appropriate responses.

Recommendation 14

81. The Islington Safeguarding Adults Partnership Board to look into the issues of carer support and domestic violence and the overlap with safeguarding adults (perhaps by conducting a review with Domestic Violence agencies to raise awareness among professionals and the

public about the risks and vulnerabilities). For example, no widely-used risk evaluation tool exists which reliably predicts which family carers are likely to abuse the person they look after. (The ISAPB could look to develop such a tool to facilitate weighting of various risk factors, decision-making and thresholds for intervention in this area if deemed appropriate.)

Recommendation 15

82. Agencies to review the use of, and triggers for, risk assessments. Appropriate training to be commissioned to support staff to use risk assessments as a robust tool to manage risk and inform actions and outcomes, particularly where carers are involved or where domestic violence is suspected.

Appendix 3 DHR - WX

Action Plan

All recommendations will be overseen by the Safer Islington Partnership, and will be delivered by a task and finish sub-group of that partnership

Colour Key:

All **CSPU** **District Nursing**

ELiPSe **Telecare** **Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 1 – Local partnership					
Recommendation 1 Islington CSPU will develop minimum standards around DV definition/policies that will be distributed for adoption by all partners locally, so to ensure a consistent approach and understanding of the issue.	Produce minimum standards Distribute minimum standards	**CSPU**	Minimum standards produced Minimum standards distributed to all local partners	June 2014 September 2014	
Recommendation 2 At a strategic level, Islington Adult Social Care should review how effectively it works with domestic violence agencies and MARAC and the MARAC Steering Group. Joint working may help to raise awareness of the specific risks relating to domestic violence for adults	Senior Management Team has received feedback from MARAC steering group about areas for development within Adult Social Care. Adult Social Care will identify a representative	**Adult Social Care**	SMT have received presentations and feedback from Community Safety re: MARAC and its steering group. Representative to attend next Complex Needs Working	Completed Summer 2013. Feb 2014	

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All **CSPU** **District Nursing**

ELiPSe **Telecare** **Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
at risk and ensure better adjustment outcomes for their family carers.	to attend the complex needs working group. Team managers from across Adult Social Care are attending the MARAC each month to raise awareness. The SAPB will oversee progress of awareness raising about MARAC via the SCR sub group. DV coordinator to be invited to attend the Leaders in Safeguarding professional group to promote MARAC and DV awareness to ASC staff.		Group. All managers to have attended one MARAC meeting Referrals to be higher in 2013 than 2012. Report to SAPB by the SCR sub group. DV Coordinator to deliver MARAC and DV awareness raising to ASC staff via Leaders in Safeguarding.	 September 2014 April 2014 End March 2014 April 2014	
Theme 2 – Processes/systems /audits					
Recommendation 3 For all agencies who do not conduct periodic reviews of their processes and policies they must conduct a review	Services review safeguarding adults policies and processes and domestic violence policies and processes,	**ALL**	Policy and process reviews conducted and report on reviews submitted to ISAPB or SIP as appropriate.	June 2014	

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ELiPSe	**Telecare**	**Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**			
Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
of all safeguarding adult and domestic violence processes and policies and explicitly consider the overlap of the dynamic of domestic violence in its broadest sense and the response to safeguarding adults at risk. (The review process should be overseen by the Islington Safeguarding Adults Board in addition to the Safer Islington Partnership.) All agencies will be required and expected to implement policies and procedures in this area and report on their progress. These processes and policies to be reviewed annually and reported back to both strategic boards.	considering overlap between the two. Services update policies and processes to ensure the dynamics of domestic violence are fully considered. Policies and processes reviewed annually **ELiPSe** Team: AS and BN to discuss with team and the CNWL Trust Safeguarding Group on the 10th December 2013. AS and BN will meet with **ELiPSe** Team on the December 19th 2013 and will adhere to above timescales.		Updated policies and processes produced and reviewed by ISAPB/SIP as appropriate. Annual review deadlines set for these policies and processes, including report back to ISAPB/SIP.	November 2014 Oct/Nov 2015 onwards	
Recommendation 4 Organisations to consider implementing separate interview and screening procedures for carers and patients to ensure both parties have the ability to	**ELiPSe Team**: AS and BN to discuss with team recommendations, particularly screening carers separately to cared for, and giving them the opportunity to	**ELiPSe** **District Nursing** **Adult Social Care**		Date to visit team December 19th 2013.	

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ELiPSe	**Telecare**	**Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**			
Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
speak freely and openly about their needs and concerns. This is particularly important in case of potential abuse and domestic violence, but a relevant screening tool for all cases.	discuss concerns and worries. AS and BN will discuss at CNWL safeguarding adults group and CNWL safeguarding committee key themes in case and recommendations. **District Nursing:** Where carer's assessment is undertaken as part of the patient assessment, if highlighted the opportunity to be interviewed independently is offered. If risks are highlighted then a list of 'patients of concern' is kept ASC to create a Developing Professional Practice Forum for social workers and support		Best practice clarified and improvements in practice will be implemented in screening and assessing carers.	April 2014	

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ELiPSe	**Telecare**	**Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**			
Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
	advisors. Issues about screening and assessing carers will be discussed at the forum. Practice issues/challenges/advice relating to assessing and screening carers will be raised at the Leaders in Safeguarding group		Improvements in practice will be implemented in relation to assessing and screening carers in safeguarding cases.	Feb 2014	
Recommendation 5 Adult Social Care to adopt an integrated whole systems infrastructure which will better facilitate and support multi-agency working. Adult Social Care to identify a lead organisation with case management responsibility and a lead local authority with co-ordination responsibility. This could be addressed in Islington by the launch of the 2013 Plan for Whole System Integration. The objective of this approach is to optimise multi	Work is underway on a transformation programme for ASC and its integration with Health.	**Adult Social Care**	Learning from this DHR will be integrated into the transformation programme.	Dec 2014	

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Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
agency expertise and resource to deliver effective seamless multi agency preventive services, treatment and care closer to home and will include other public services in addition to health and social care. Carers at Risk - Greater multi agency and think family interventions incorporated in a whole systems approach as described above in working with carers to identify risk where the carer has unmet or unrecognised low level needs, are vulnerable themselves and have little personal or private space or life outside the caring environment.					
Recommendation 6 MSW and ELiPSe team to review referral pathways, especially around how information about referrals to family services is communicated to clients and how referral outcomes are fed back to them.	BN and AS will work with the team on its referral pathways and on how outcomes of referrals are communicated with users and families/carers	**Elipse**	Improved referral pathways and communication processes	February 2014	

Colour Key:

All **CSPU** **District Nursing**

ELiPSe **Telecare** **Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Recommendation 7 Organisations to review/develop their policies on non-engagement and refusal of services, with an emphasis placed on the importance of focussing on the whole family including cared for and carer in terms of refusal or non-engagement. (There may be scope for additional work looking at ways of supporting carers where the cared-for person refuses to accept care from anyone else, as this is a common tension within informal care relationships.)	Services to review non-engagement and refusal policies with a particular focus on whole family including carer and cared-for person. ISAPB and SIP to monitor progress in reviewing these policies	**ALL**	Non-engagement and refusal policies reviewed and updated Report made to SIP/ISAPB on the review of these policies	October 2014 Jan 2015	
Recommendation 8 District Nursing team to continue to seek consent from service users and/or have discussion with them before referring to social services. This consent needs to be documented clearly in case files as not to delay referral processes.	Already in operation unless there is a major safeguarding issue when patients' best interests are considered and then the system reverts to national guidelines.	**District Nursing**			

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ELiPSe	**Telecare**	**Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**			
Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
Additionally, as it is standard procedure to share notes with clients and keep them at the client's property, **on a national level**, District Nursing should develop a central electronic back-up system (attached to health records) of home notes so professionals can access these records at any time and that in the case of loss or destruction there remains a copy of all patients' records.					
Recommendation 9 Telecare Service should review their procedures relating to service users who refuse services to ensure this information is captured and systematically fed back to the referrer. To this end, the Telecare Service will work with Adult Social Care to further develop the IAS system to capture and report issues of non-engagement by service users and/or their carers. This will ensure risk assessments are based upon	Islington Telecare and ASS to design new referral process in line with the guidance published by the Islington Safeguarding Adults Unit, including new procedures to capture and report issues of non-engagement. IAS to be updated with new referral pathway.	**Telecare Team**	New referral process completed	Feb 2014	

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Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
accurate information and processes and procedures are managed in line with the guidance published by the Islington Safeguarding Adults Unit on 'Complex Cases including persons who refuse to engage and persons who self-neglect' (November 2010).	Islington Telecare to be given full access to IAS to allow all referrals to be made, received and actioned through IAS.				
Recommendation 10 All organisations to explore ways of implementing best practice to identify carers and their support needs and refer them at the earliest stage possible to the Islington Carers Hub for advice, support and opportunities to be with a potentially supportive peer group of other carers. The Islington Carers Hub is open to all carers, even if a formal Needs Assessment has not been completed, and referral should take place at the earliest opportunity. Carers' should be Red coded in the GP clinical computer system	Services review how their teams identify carers and refer them for support. Where appropriate services improve/implement referral pathways to Carers Hub. SIP/ISAPB monitor progress in reviewing these processes. Discuss with **ELiPSe** team identification of carers, and once identified how to record on RIO, and the next	**ALL**	Review of identification of carers completed Improvements implemented for identification of carers and their support needs. Report made to SIP/ISAPB of progress in improving identification and support of carers	June 2014 October 2014 Jan 2015 March 2014	

Colour Key:

All **CSPU** **District Nursing**

ELiPSe **Telecare** **Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
thus allowing easy identification of them by a simple search.	steps to take i.e. referral to local carer support organisation. Camden PS to release prompt tool for identification for staff. Camden PS to have carer strategy, and identify a process within this to interview carers separately from cared for				
Recommendation 11 As this case has some similarities with other serious cases involving family carers, the Islington Safeguarding Adults Partnership Board should examine together all such cases in the last 24 months to identify any areas for development or concern.	SCR sub group to review similar cases and report to SAPB.	**ISAPB**	• Paper to SAPB • Update to SIP	Feb 2014	
Theme 3 – Training					
Recommendation 12 To deliver training to ensure all practitioners have a good	Review training attendance in last 3 years	**CSPU**	Report on training attendance completed	Oct 2013	This was completed before Oct 2013.

Colour Key:

All **CSPU** **District Nursing**

ELiPSe **Telecare** **Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
understanding of the dynamics of domestic violence and appropriate responses. This case must be used as part of the development of an enhanced training package for practitioners which addresses safeguarding issues and includes domestic violence and abuse in its broadest sense.	Devise training plan for 2013-14 Continue to monitor attendance at DV and MARAC training Hold VAWG Network on theme of adult safeguarding and DV to share learning from this process and other cases.		2013-14 training plan finalised Training attendance monitored on a rolling basis DV/Adult safeguarding VAWG Network completed	Oct 2013 Ongoing March 2014	Completed before Oct 2013.
Recommendation 13 Islington CCG should develop a more consistent approach to domestic violence that includes training, identification and appropriate responses.	VAWG team to present to CCG on DV/VAWG issues. VAWG team to engage CCG with IRIS and write a proposal to institute the IRIS system for Islington GPs. CCG to fund and support implementation of IRIS.	**CCG and CSPU**	Presentation to CCG completed. IRIS bid completed IRIS implemented	Jun-Jul 2013 September 2013 April 2014	A number of presentations and discussions took place with the CCG in summer 2013 The IRIS bid was completed and submitted in Sep 2013

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Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
	VAWG team to support CCG to produce their own DV action plan covering a range of actions around commissioning requirements, training for front line staff etc.		Action plan produced	August 2013	This action plan was completed in Aug 2013 and the implementation of it is ongoing.
Theme 4 –Risk Assessment					
Recommendation 14 The Islington Safeguarding Adults Partnership Board to look into the issues of carer support and domestic violence and the overlap with safeguarding adults (perhaps by conducting a review with Domestic Violence agencies to raise awareness among professionals and the public about the risks and vulnerabilities). For example, no widely-used risk evaluation tool exists which reliably predicts which family carers are likely to abuse the person they look after. (The ISAPB could look to develop such a tool to	SCR sub group to review awareness of MARAC SAU to explore potential of a weighted risk indicator with teams and consider alternatives if appropriate and report to SAPB SAU to review DV toolkit contained within Safeguarding Adults appendix and amend/improve where appropriate	**ISAPB**	Report produced for SAPB New tool approved by Leaders in Safeguarding and SMT and circulated for staff use. Updated toolkit to be re-launched at Leaders in Safeguarding and SMT	April 2014 October 2014 August 2014	

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Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Date of completion and outcome**
facilitate weighting of various risk factors, decision-making and thresholds for intervention in this area if deemed appropriate.)	SAU to link with DV co-ordinator to identify appropriate means to review and raise awareness of DV with staff and the public		Comms plan agreed and put into place. Outcomes of awareness raising/review evaluated	April 2014 July 2014	
Recommendation 15 Agencies to review the use of, and triggers for, risk assessments. Appropriate training to be commissioned to support staff to use risk assessments as a robust tool to manage risk and inform actions and outcomes, particularly where carers are involved or where domestic violence is suspected.	**ELiPSe:** AS and BN are to ensure that DV training is available for staff to access. Ensure that staff are aware of DV policy and know how to find it on trust net should they need it. Ensure that carers identification is released to all staff. BN will find out about local carer support organisation and will request training be available for all staff. ASC to explore development of a risk screening tool which	**ALL**	DV training completed by all Improvements in practice will be implemented	Feb – April 2014 November 2014	

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ELiPSe	**Telecare**	**Adult Social Care (ASC) and Safeguarding Adults Partnership Board (SAPB)**

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
	could trigger a more in depth risk assessment within the IAS workflow				