AN EXECUTIVE SUMMARY

OF

REVIEW

DHR 04

into the death of

Margaret aged 85 years

on 28th July 2016

Report produced by Malcolm Ross M.Sc.
Independent Chair and Author

List of Abbreviations

C&VUHB	Cardiff and Vale University Health Board
CCC	Cardiff City Council
PSB	Public Services Board
CSP	Community Safety Partnership
CPET	Cardiff (& Vale University Health Board) Protected Education Time
DASH	Domestic Abuse Stalking and Harassment Risk Assessment
GP	General Practitioner
IMR	Individual Management Report
MARAC	Multi Agency Risk Assessment Conference
MAPPA	Multi Agency Public Protection Arrangements
SIO	Senior Investigating Officer (Police)
WAST NHS Trust	Welsh Ambulance Service Trust (National Health Service Trust)

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(The family of the two deceased, who are the subject of this review, have given the Review Chair and Author written permission to refer to themselves and their parents by their first names.)

Introduction

This is a review into the death of Margaret who was 85 years of age when she was killed by her husband Angus, who was 86 years of age at the time.

Margaret died at her home on 28th July 2016. She died of injuries to her head inflicted by Angus. Following her death, Angus travelled to a nearby railway station and jumped in front of a moving train, seriously injuring his legs. He was taken to hospital where, after a series of operations, he died on 11th September 2016 from complications arising from his injuries.

The circumstances of the death of Margaret were reported to the Community Safety Partnership and a review under the Domestic Violence, Crimes and Victim's Act 2004 was commissioned.

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

Margaret and Angus had been married since 1952 and had six children, Ann, Sheena, Stuart, Catherine, Ian and Andrew, all of whom are now adults ranging from 55 years to 63 years old.

According to the children, Margaret and Angus were devoted to each other. They had years of active pastimes. Margaret was an accomplished bridge player. Angus enjoyed his allotment and sea fishing. Both loved entertaining and of course were proud parents and grandparents. Two of the children, Ann and Sheena, lived close by; Stuart, Catherine and Andrew had moved to different parts of England; and Ian lives and works in Scandinavia.

Angus had traditional views about many things especially his duty to care for Margaret when she started to show signs of a dementia-type of illness. On 26th March 2013 Margaret was diagnosed with early-onset dementia and Angus took on the role as her full-time carer. However, as Margaret's illness progressed, the two oldest daughters took an increasing part in looking after both Margaret and Angus.

The children say that as Margaret's symptoms became worse and she was less able to manage day-to-day activities, they tried to help with Margaret's needs to a greater degree. Angus found managing Margaret's incontinence difficult, especially during the night time and even though various aids such as a rubber mattress and an alarm to indicate when she was trying to get out of bed were provided, often Margaret would not make use of them.

Social Services made offers of help and indeed installed a 'walk-in shower' at the family home. However, Angus often declined Social Services' offers of help insisting that Margaret's condition was manageable and not as advanced as it was.

Social Services arranged for Margaret to attend a Day Centre twice a week, but after attending a few times, she began asking to leave early, as she wanted to be with Angus. Staff at the Day Centre said that she would usually lose interest and want to leave during the afternoon.

The two daughters did all they could within their own respective abilities. Ann was not well herself and Sheena had mobility problems but she could take her mother out in her car. The provision of a home help was discussed, but Angus refused to have a stranger in his home. So between Angus and his two daughters, the care for Margaret slowly became a practical problem.

Angus and Margaret found that as her condition advanced, they lost their circle of friends, they stopped playing bridge and Angus stopped working on his allotment. Angus was caring full time for Margaret and became exhausted through sleepless nights tending to Margaret's toilet needs. During the day he did what he could for her but her increasing inability to understand what was going on around her and her constant needs made Angus irritable and even more tired. Sheena described how Angus would put Margaret to bed during the early evening even though she may not have been tired enough to go to bed, just for some respite from caring for her.

A short time before the date of her death, Angus had told her that he could not cope anymore and he was going to look for a home for her, something he had promised her that he would never do. Such was his frustration and exhaustion.

The children say that Angus could lose his patience with Margaret, especially when she constantly changed her mind as to which pair of shoes she wanted to wear or which dress she preferred that day. They also described how during the night, Angus would get Margaret up every couple of hours to use the toilet and said that perhaps she actually didn't need the toilet and wanted to sleep. It is easy to see how frustration on both sides could erupt in the middle of the night.

On 27th July 2016, the day before her death, most of the children had gathered at the family home. It was intended that the family, including Margaret and Angus, would travel to West Wales where the family had a boat and caravan. They had an evening meal together and the following morning they had a breakfast together. Angus decided that he and Margaret would drive to the caravan a few days later and the children dispersed, either to their homes in Cardiff or 'down west'.

Ann went home and a few hours later decided to return to her parents' house to do some odd jobs. On arrival she found uniformed police officers at the door. The officers broke the news that Margaret had died of injuries to her head inflicted by Angus . Angus had then travelled to the local mainline railway station and had jumped in front of a moving train. He had suffered serious injuries to his legs and had been taken to hospital He died in hospital from his injuries some weeks later.

HM Coroner for Cardiff concluded that Margaret had been unlawfully killed. Angus died of natural causes.

Summary of events and recommendations

Home Office Guidance requires the report to contain the views and opinions of members of the family and in this case the Author has had significant contact with all of the six children of Margaret and Angus. Their views paint a picture of a loving elderly couple, who, after marrying 65 years ago, spent their life together raising their children and enjoying an active social life. They each had hobbies, Margaret an accomplished bridge player and cook. She loved entertaining friends and family at home. Angus had an allotment and also a boat in West Wales, where the family had a caravan. Angus loved sea fishing and the family have many photographs of Angus and his grandsons fishing from his boat off the coast.

Margaret and Angus had lived in the same house for almost all of their married life and were popular members of the local community. Angus would say that he intended to live until he was 100 years old.

Their life changed considerably when Margaret developed the symptoms of Alzheimer's disease. She attended the Memory Clinic in March 2013 due to a noticeable loss of her memory.

As time passed by, Margaret became more dependent on Angus for day-to-day things and this was of concern to their children.

The children describe Angus as being a very traditional, strong-willed man who was determined to look after Margaret and he did not feel that he required assistance from any outside agency.

In August 2013, Margaret and Angus were visited by a specialist nurse who gave them advice about Alzheimer's disease and the support that was available, but the family declined the support at that stage. Angus also expressed the view that he did not feel there was need to consider a Lasting Power of Attorney, which was also suggested by the specialist nurse.

Margaret's condition slowly got worse, but Angus persevered in looking after her and despite his diabetic condition, Angus would describe himself as being 'as fit as a flea'. Ann and Sheena did what they could to assist on a daily basis.

Margaret became incontinent, which put Angus under a great deal of pressure especially during the night time. He would wake Margaret up every few hours to take her to the toilet to prevent her wetting the bedsheets. According to Ian and Catherine, sometimes they suspected Angus did this even though Margaret did not need to use the toilet. This, in the opinion and experience of Ian, caused friction between Margaret and Angus. Angus would get frustrated and often exhausted due to lack of sleep. Ian described how Angus would often put Margaret to bed in the early evening stating it was her bedtime, sometimes when she was not tired.

The deterioration in Margaret's condition did not appear to trigger a review of support by the family GP or Adult Social Services and the significance of the incontinency linked to the stigma, embarrassment and difficulty for Angus in dealing with these issues was not recognised.

Therefore recommendations No 1 is made:

Recommendation No 1

Where a person with dementia who is being cared for at home displays additional or increased needs that may lead to an increase in the carer's stress, then Social Services should consider if a review is required.

All of the children describe their father as being totally exhausted, but still determined to manage without assistance from any agency.

Social Services did manage to persuade Angus to have a walk-in shower fitted in their bathroom making it easier for Margaret to shower. Margaret was also allocated a place at a Day Centre two days per week, but she would become agitated after lunch and request to be taken home. This clearly impacted upon Angus' respite time and the ability to have a few hours on his own.

In January 2016, Andrew contacted Social Services stating that Angus was exhausted looking after Margaret. Various services that may have helped Angus and Margaret were discussed

with Andrew but he was told that Angus must give his consent to such services being allocated. Angus, being a very proud man, was reluctant to accept any assistance, being sure he was able to look after Margaret himself.

The following month, Andrew again contacted Social Services stating that the situation was sometimes becoming volatile and on occasions Angus was losing his temper with Margaret and would 'fly into a rage'. He asked that his father was not told that this had been disclosed as Andrew thought it would make the situation worse. A home visit was arranged for 17 days later but Andrew asked that it be done sooner 'before it was too late and dad had a crisis'.

The assessment took place 17 days later and the Day Centre mentioned above was arranged. A Care and Support Assessment together with a Care and Support Plan were also completed. A Carer's Assessment had been offered to Angus but he had declined. The family are of the view that despite his refusal, the Carer's Assessment should have progressed as it may have identified that fact that Angus was unable to cope albeit he was saying he could cope. In fact a Carer's Assessment could have been offered to another member of the family and not just to Angus.

The advice from an experienced Alzheimer's Society representative who, assisted this review process, was that both Margaret and Angus could have been allocated a 'Key Worker' to support both of them and listen to the voice of Margaret, which was not heard throughout this period of time.

Two further recommendations are made:

Recommendation No 2

Where a Carer's Assessment is refused by a husband or wife deemed to be the main care giver, the assessment should routinely be offered to additional family members who are also undertaking care giving tasks.

Recommendation No 3

All social care staff should ensure that the voice of the individual at the heart of the assessment is heard. This should ensure that they are interviewed in their own right, and also alone if felt to be appropriate or necessary.

Telecare sensors were provided and Margaret could call for assistance by pressing a button on a sensor that resulted in help being despatched or carers being notified. Angus thought the sensors were too intrusive and after two weeks he removed them. There was no record of the alarm company being aware that Angus had removed the system. If there had been such notification, the company would have alerted Social Services as a matter of course.

In July 2016 Catherine contacted Social Services expressing her concerns about Angus being able to cope with Margaret and that she had witnessed Angus lose his temper with Margaret on a couple of occasions. It was left to Catherine to seek consent from Angus before a home visit could take place. The Social Services IMR recognises that Margaret could have been considered a vulnerable adult and a potential safeguarding concern could have been raised.

Catherine stated that the family were concerned and she thought that extra support was needed but appreciated that Angus had not and would not give his consent to this taking place.

The manager of the Review Team for Adult Social Services accepts that more positive action could have been taken with regard to the refusal by Angus to undergo a Carer's Assessment and further attempts to persuade him should have been made. However the manager is of the opinion that in the circumstances, there was nothing to trigger a different intervention and the

service delivered was appropriate given the information received from the family and the home visits. The family would disagree with this statement.

The family feel that their concerns were not listened to and that no action was taken because Angus refused assistance. They question if Angus should have been listened to over and above the concerns of the family and whether Angus was able to make such an important decision in his state of exhaustion.

A recommendation is made:

Recommendation No 4

Adult Social Care Services to ensure that concerns expressed by family members, and/or others, regarding any potential safeguarding concerns as regards an adult, when the adult in question is deemed and assessed to be an Adult at Risk, are acted upon in accordance with the guidance in Part 7 (Vols. 1 and 6) of the Social Services and Well-being (Wales) Act 2014.

The Cardiff & Vale University Health Board indicate that the care and treatment for Margaret during her declining health was appropriate and her attendances to her GP were necessary to deal with her dementia.

However, Angus' attendance at the same GP surgery (but with a different GP) usually concentrated on his physical requirements, being anxious, losing weight and being exhausted. It appears that there was no connection made between these symptoms and his role as carer for Margaret. In June 2016, the GP told family members to contact the Memory Clinic as Margaret was becoming increasingly dependent on her family for support. Both Margaret's and Angus' symptoms could have triggered a referral to Adult Social Services by the GP; however the GP suggested the family make contact with support agencies themselves.

The Health IMR contains several relevant observations which are contained in detail in the Overview Report.

The Alzheimer's Society[1] expert, who assisted this review process, makes a valid observation about the comparison between the awareness of Alzheimer's disease and domestic violence within GP surgeries.

In 2011, the General Practice guidance to GPs demanded three specific elements for raising awareness of domestic abuse among patients. First, a more proactive approach by GPs to seek information from patients about the possibility of domestic abuse in their relationships. Secondly, to have a 'Single Point of Contact' within the surgery where patients can obtain information about domestic abuse and be signposted to relevant support agencies and thirdly that all medical and non-medical staff receive training on domestic abuse.

At present there is nothing of a similar nature for the subject of Alzheimer's disease or dementia. The expert's wish is for GP surgeries to become 'Dementia Friendly'.

In view of this the following recommendations are made:

Recommendation No 5

In line with Cardiff & Vale Dementia Strategy, Cardiff & Vale University Health Board will encourage GP surgeries in Cardiff and the Vale of Glamorgan to

[1] www.alzheimers.org.uk

become designated "dementia friendly" and provide literature, awareness and guidance on dementia to patients and members of the public.

Recommendation No 6

Cardiff & Vale University Health Board to encourage GPs to undertake dementia training in Cardiff and the Vale of Glamorgan in line with Cardiff & Vale Dementia Strategy. Dementia training should also be provided as part of the CPET programme for GP Education.

Conclusions

Margaret and Angus were part of a close family unit. They had provided their children with a very happy fulfilled life. They both enjoyed their long marriage together. They had an active social life with many long-term friendships. They both had hobbies and interests. Angus had said that he wanted to live to be 100 years old. However Margaret was struck down with a progressive dementia illness that changed their life plans.

Angus was left caring for his wife whose memory was deteriorating. He found it frustrating and found it hard to cope with her worsening condition. He admitted losing his temper. Angus told his family that he could not cope. The Health Service and Adult Social Care did all they could do within due bounds of guidance. Angus' dogged independence and strong will to look after Margaret himself meant that he did not accept the offer of additional help. He refused to be assessed as a carer which may have made a difference. He admitted he told Margaret that he was going to put her in a home. He also admitted whilst he was terribly injured, that he had told her what he intended to do to himself.

Angus was desperate to prevent Margaret suffering and took a course of action that he thought was the best way for her and then, himself.

The children have views about what could have been done better. So too have the IMR authors of both the Cardiff & Vale University Health Board and Social Services. IMR recommendations are made by both agencies in an attempt to improve responses to similar situations in the future.

No-one knew or could have suspected that the end of their lives would happen the way it did.

Malcolm Ross M.Sc

Recommendations

Overview Report Recommendations

Recommendation No 1

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Recommendation No 2

Where a Carer's Assessment is refused by a husband or wife deemed to be the main care giver, the assessment should routinely be offered to additional family members who are also undertaking care giving tasks

Recommendation No 3

All social care staff should ensure that the voice of the individual at the heart of the assessment should be heard. This should ensure that they are interviewed in their own right, and also alone if felt to be appropriate or necessary.

Recommendation No 4

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Recommendations from Individual Management Reviews

Recommendations from Adult Social Services IMR

Recommendation No 1
That an appropriately phased programme of training be developed to ensure that Social Work Assistants who will be required to undertake assessments and reviews have a relevant social care qualification at Level 4 or above.

Recommendation No 2
As an extension of the recent 'Better Conversations' training, all relevant staff undertake additional carer awareness training to further enhance a proactive approach in supporting carers and providing them with information

Recommendation No 3
Day Centres to ensure proportionate follow-up and further consideration where the "Getting to know you forms" are not completed and returned by the family.

Recommendation No 4
That Adult Social Care Services re-visit the overall review related risk assessment process to maximise safeguarding and escalation measures. In effect, this would aim to improve the capacity of the reviewing role to recognise when it would be more appropriate to conduct reviews in person and where service users should be interviewed on their own.

Recommendation No 5
That Adult Social Care Services consider how to assess the risks in a case prior to being transferred into review.

Recommendations from Cardiff and Vale University Health Board IMR

Recommendation No 1
General Practitioners to be encouraged to develop systems to be able to identify when a patient has caring responsibilities associated with a relative who has a diagnosis of dementia

Recommendation No 2
General Practitioners should make any referral onto appropriate services and should not expect family to make contact with services themselves.

Recommendation No 3
General Practitioners to consider signposting carers of a relative with dementia to third sector for support and advice when they are presenting with stress-related symptoms associated with a caring role.

Recommendation No 4
Further strengthen partnership working between the memory team and third sector to further develop support that is provided to family members involved in a caring role.

Recommendation No 5
A capacity assessment should be considered at each contact following a diagnosis of cognitive impairment in relation to having the ability to accept care and support.

Bibliography

Multi-Agency Statutory Guidance For the Conduct of Domestic Homicide Reviews - Home Office 2011 as amended by Home Office Guidance December 2016 www.homeoffice.gov.uk/publications/crime/DHR-guidance

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

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016 www.homeoffice.gov.uk/publications/crime/DHR-guidance

Appendix No 1

Terms of Reference

Purpose of the Review

The Domestic Violence, Crimes and Victims Act 2004 establishes at Section 9(3) a statutory basis for a Review, which was implemented with due guidance[2] on 13th April 2011 and reviewed in December 2016[3]. 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
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death"

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

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.

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[4], 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*

These Reviews are not inquiries into how Margaret 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 a DHR[5] is to:

- Establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations worked individually and together to safeguard Margaret;
- 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;

[2] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 as amended by Home Office Guidance December 2016 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[3] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2016
[4] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance
[5] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Home Office 2016

- Apply these lessons to service responses including changes to the policies and procedures as appropriate;
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

Terms of Reference for the Review

The generic questions are as follows:

1. Were practitioners sensitive to the needs of the Margaret and Angus, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about them?

2. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3. Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (DASH) and were those assessments correctly used in the case of this victim/perpetrator?

4. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

5. Were these assessments, tools, procedures and policies professionally accepted as being effective? Was Margaret 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 Margaret's wishes and feelings ascertained and considered?

12. Is it reasonable to assume that the wishes of Margaret should have been known?

13. Was Margaret informed of options/choices to make informed decisions?

14. Were they signposted to other agencies?

15. Was anything known about Angus? For example, were they being managed under MAPPA?

16. Had Margaret 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 Margaret, Angus and their family?

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 Margaret and promote her welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

24. How accessible were the services for Margaret and Angus?

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 IMRs.

Process of the Review

South Wales Police notified Cardiff's Public Services Board (PSB) of the homicide on 15th September 2016, PSB reviewed the circumstances of this case against the criteria set out in Government Guidance[6] and decided that a Domestic Homicide Review should be undertaken.

The Home Office was notified of the intention to conduct a DHR on 24th October 2016. An independent company, Winston Ltd, was commissioned and appointed a chair for the DHR Panel and an author for the Overview Report. At the first review panel terms of reference were drafted. On 16th January 2018, the Public Services Board approved the final version of the Overview Report and its recommendations.

Home Office Guidance[7] recommends that reviews should be completed within 6 months of the date of the decision to proceed with the review. However there have been a number of

[6] Home Office Guidance 2016 Page 9
[7] Home Office Guidance 2016 pages 16 and 35

contributing factors that has meant this deadline has not been met in this case. Contributing factors include the necessity to:

- Establishing a new multi-agency process for conducting Domestic Homicide Reviews, that is distinct from Serious Case Reviews and which required approval from Cardiff's Public Services Board
- Developing a commissioning framework to recruit Independent Chairs/Authors to facilitate Domestic Homicide Reviews

In addition there has also been a delay between the completion of the Overview Report, Action Plans, and submission to the Home Office Quality Assurance Panel. This has been hampered by periods of long-term sickness of key members of staff contribution to Action Plans and the Local Authority Officer who co-ordinates Domestic Homicide Review on behalf of Cardiff Council. However, Cardiff Council has provided regular updates on progress to the Home Office.

Independent Chair and Author

Home Office Guidance[8] 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."

Executive Public Services Board decided that in this case to appoint an independent chair and an independent author as commissioned by Winston Ltd.

The Independent 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 since retiring he has 18 years' experience in writing over 80 Serious Case Reviews and chairing that process and, more recently, performing both functions in relation to over 28 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.

DHR Panel
In accordance with the statutory guidance, a Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

Name	Designation
Sue Hurley	Independent Protecting Vulnerable Person Manager
Nikki Harvey	WAST NHS Trust, Head of Safeguarding
Donna Newell	Safeguarding Nurse Advisor, Cardiff and Vale UHB
Alys Jones	Operations Manager Safeguarding Cardiff Council
Stephanie Kendrick - Doyle	Community Safety Manager Cardiff Council
Sue Phelps	Director for Wales Alzheimer's Society Cymru
Linda Hughes-Jones	Senior Nurse Safeguarding Adults Cardiff and Vale UHB

[8] Home Office Guidance 2016 page 12

Bruce McLernon	Independent Consultant Social Services
Gail Weaver	Housing Policy Officer City of Cardiff Council (Administrative Support)
Natalie Southgate	Policy and Development Manager Cardiff Council
Nicola Jones	Domestic Abuse Co-ordinator Cardiff Council
Martyn Jones	Independent Author Winston
Malcolm Ross	Independent Author and Chair

Parallel proceedings

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

- CPB advised HM Coroner on 11th January 2016 that a DHR was being undertaken.
- A Criminal investigation was commenced and a report has been submitted to HM Coroner. HM Coroner concluded that Margaret was unlawfully killed. Angus died from his injuries whilst in hospital so no inquest was held.

Time Period

It was decided that the review should focus on the period from 2011, when Margaret was first diagnosed with dementia, until the time of Angus' death, 11th September 2016. It is appreciated that the scope and timescales for the reviews is usually until the time of death of the victim, Margaret, however in this case Angus died six weeks later and it is thought that lessons learned may be identified during that period of time.

Scoping the Review

The process began with an initial scoping exercise prior to the first Panel meeting. The scoping exercise was completed by the Executive Public Services Board to identify agencies that had involvement with the Margaret and Angus prior to the homicide. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report.

Individual Management Reports

Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- Cardiff Council Adult Social Services
- Cardiff & Vale University Health Board

As agreed reports for information were received from:

- South Wales Police
- WAST NHS Trust
- Cardiff Council Housing & Communities – Security and Alarms Monitoring Service

Guidance[9] was provided to IMR authors through local and statutory guidance and through an author's briefing. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.

[9] Home Office Guidance 2016 Page 20

- To identify examples of good practice within agencies.

Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the Reports. The recommendations are supported by the Overview Author and the Panel.

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

The aim of the DHR 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 these lessons to service responses including changes to the policies and procedures as appropriate; and

- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

Individual Needs

Home Office Guidance[10] requires consideration of individual needs and specifically:

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

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, harrassment, 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.

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

[10] Home Office Guidance 2016 page 36

There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

In view of Margaret's dementia, the Panel requested the assistance of a dementia/Alzheimer's expert to attend a Panel meeting. On 10th July 2017, Mrs. Sue Phelps from the Alzheimer's Society attended a Panel meeting and enlightened the Panel about the illness and the effects the disease would have on patients such as Margaret. She also explained the effects and consequences the illness would have on Angus and his relationship with Margaret as her condition deteriorated. Mrs Phelps was able to help with details of support and assistance that would have been open to both Margaret and Angus. Mrs Phelps' contribution was extremely valuable and the panel are grateful for her time and expert opinions. Her views are contained within the Overview Report.