STANDING together
against domestic violence

DOMESTIC HOMICIDE REVIEW

The London Borough of Islington

Sections of this Overview Report have been redacted on the basis that the exact details in these sections have no bearing on the report's conclusions. They contained identifiable information and personal medical information. The publication of these details is therefore not necessary for the functions the council in undertaking [per Condition 7(1)(b) of Schedule 3 DPA 1998].

LB Islington's Head of Community Safety

Anthony Wills
September 2013

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Domestic Homicide Review – WX
London Borough of Islington

Executive Summary

Outline of the incident

1. Late in the evening of a date in July 2012, 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 suspended sentence. YZ was released from custody later in 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.. 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 serious mental health issues and 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 a date in 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 the following morning 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. In 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 suspended sentence. YZ was released from custody later in 2013.

32. The trial judge 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 and the date of WX's death 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.

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.


STANDING
together
against domestic violence

Domestic Homicide Review – WX
London Borough of Islington

Overview Report

Anthony Wills

September 2013

Introduction

83. Late in the evening of a date in July 2012, London Ambulance Service and Police were called to the home address of YZ. Police and paramedics found WX unconscious and not breathing 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.

84. YZ and WX had formerly been in a long-term relationship although this had ended sometime between 2004 - 2006 prior to WX's diagnosis of cirrhosis of the liver in October 2011. Following this diagnosis, WX moved into YZ's flat so that she could provide him with care.

85. When Police officers attended her flat on the date of the incident, YZ is noted to have commented that she 'had enough' and 'should have done this 6 weeks ago'. YZ had had a number of alcoholic drinks during that day and police found a practically empty vodka bottle at the scene.

86. During interviews with police YZ stated that WX had previously asked her about what tablets she might have so that he could commit suicide and she stated that they had a conversation about her assisting his suicide.

87. YZ was charged with the murder of WX and pleaded not guilty. YZ was found guilty of manslaughter in 2013. Having served the equivalent to a 19-month jail sentence on remand, YZ was given a suspended sentence n. YZ was released from custody later in 2013.

88. 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 22 January 2013 to consider the circumstances leading up to this death.

89. The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

90. 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

91. 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

92. The full terms of reference are included at Appendix 1. 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.

Independence

93. 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

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

Methodology

95. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with YZ or WX. 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.

96. Contact with family and friends has been attempted and is discussed further below (paragraph 240).

97. Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

Composition of the DHR panel

- London Borough of Islington Community Safety Partnership Unit (CSPU)
- London Borough of Islington Supporting People
- Blenheim CDP (CASA)
- Metropolitan Police (Islington Borough and Critical Incident Advisory Team)

- London Borough of Islington Adult Safeguarding and Adult Social Services
- Elipse Palliative Care Centre
- London Borough of Islington Corporate Customer Service
- Whittington Health
- London Borough of Islington Children's Social Care
- London Borough of Islington Housing Operations
- Camden and Islington NHS Foundation Trust (CANDI)
- Solace Women's Aid
- Central and North West London NHS Foundation Trust (CNWL)
- Nina Murphy Associates (for the relevant GP practice)
- Victim Support Islington.

Facts

98. WX was 66 at the time of the murder and both he and YZ were known to a number of agencies prior to the death. The chronology details the contacts in very great detail. The following is an outline of WX's contact with those agencies and the relevant issues. Where available, details of YZ's contact with agencies are also mentioned.

99. The terms of reference specifically seek information about WX from 1st January 2010 but to assist this DHR some earlier information is included.

Information relating to WX prior to 2010

100. WX was married to his previous wife (not YZ) with two biological children and two stepchildren through this relationship. WX and his ex-wife separated some time in the 1970s and WX had varied contact with his ex-wife and four children until the time of his death. WX and YZ's relationship began some time after he separated from his ex-wife and was similarly intermittent until 2003/4. There were no children of the relationship between WX and YZ.

101. YZ was also married prior to her relationship with WX and had two children with her ex-husband. Both WX and YZ's families know each other and have had interactions over the course of their relationship.

New Belvedere House

102. On 11th October 2004, WX was admitted to New Belvedere House, a hostel for homeless ex-service personnel. Whilst unclear it is thought that he had ended his relationship with YZ and did not have a fixed address and slept rough on occasion, particularly when he had been drinking. It was recorded that he had significant health issues on admission to the hostel, including a painful back injury for which he took increasingly strong prescription painkillers and was less mobile as a result of the pain. WX also drank alcohol, but this was not noted as a problem by hostel staff. Staff noted that WX was a family man with good relationships with his children and had a sunny, warm disposition and was always pleasant to staff and other residents. WX lived in the hostel for seven years and was a well-liked, easy-going man. In relation to living independently, WX was generally not fit enough to manage without support, so re-housing plans were not pursued.

103. In Jan/Feb 2012 WX was absent from the hostel for longer than usual and the unit manager was concerned and checked his file and rang his ex-wife. She told the manager WX was not there but would get a message to him. Two days later, WX returned the call and gave YZ's

house number for future contact, asking that his ex-wife's number be stricken from the file as YZ had been upset by his ex-wife coming to her house. This was the first mention of YZ in seven years of contact with the staff team.

104. At this time, WX began to look quite unwell; his pallor was bad and he had difficulty walking. Staff encouraged him to look after himself, but he spent more time at YZ's house than at the hostel. WX was adamant that he wanted to keep his room at the hostel and that he wanted to be re-housed in Tower Hamlets if he were able to live on his own.

105. In March 2012, YZ rang a couple of times to say WX was okay but staff always followed these calls up with a direct call to WX himself. WX agreed he was fine and maintained that as soon as he could walk better he would be back to live at the hostel. YZ came to the hostel approximately three times to pay WX's service charge and give an update on his condition. YZ was offered support and help if needed by hostel staff. Staff described YZ as 'frail' but very nice.

106. At the end April/beginning of May 2012, YZ came to the hostel with another man in a car to pay WX's service charge. Staff told YZ that now may be the right time for WX to move out but YZ insisted that was not what WX wanted, which matched WX's stated preferences to staff in the past.

107. WX kept the room at the hostel until the time of his death. In July 2012, staff received a call from YZ's daughter to say that WX was dead and her mother had been arrested for murder. One of WX's daughters collected WX's personal effects and spoke to staff for a long time about her father. Three members of staff attended WX's funeral, where many friends and family were in attendance.

London Borough of Islington Housing Operations

108. The area housing office had very little contact with YZ on their files as YZ owned her property and was not someone known to Housing Operations for any reason. They had no record of WX on the files held for YZ. The only notes on file were for entirely unrelated issues.

109. There are no records of home visits or office interviews by Area Housing Office staff.

110. In February 2012 the Home Ownership Unit confirmed that other than the completion of a diversity data form sent to YZ by them and returned on 6th February 2012, they have had no

contact from her. They also sent invoices to YZ and some consultation documents relating to building insurance and energy procurement after this date. YZ paid her service charges by direct debit and the land registry documents indicated there was no mortgage on the property. No others agencies made contact with Housing Operations about YZ.

Whittington Health Alcohol and Drug Services

111. The service has no record of any contact with WX and has a record of a single contact with YZ dated 17th March 2010. On this date, YZ was seen by an Alcohol Liaison Nurse when an inpatient on Victoria Ward. This was a single contact episode and a screening/triage assessment was completed. The reason for hospital admission was recorded as pneumonia following a collapse. Assessment identifies that alcohol detoxification had already commenced as YZ was a hospital inpatient.

112. Alcohol triage assessment identified YZ's alcohol history as problematic to specify. YZ was recorded as initially denying any problem alcohol use and later admitting to consumption of up to 6 units daily. The triage assessment mental health screening checklist recorded a history of depression, suicidality and psychosis. This assessment specified no current mental health service involvement. It also specifies a past history of overdose, other suicide attempts, deliberate self-harm acts and self-neglect. History of violence to others, including use of weapons / threatening behaviour is recorded as "no". The triage assessment does not specify if the patient was in a relationship at the time of contact.

113. The assessment summary records contact as: *66 year old lady with long psychiatric history admitted to hospital with collapse and pneumonia. Is registered at Hornsey Rise Practice and agreed to see* the Primary Care Alcohol and Drug Service (PCADS) GP Liaison Nurse *there. Will need to do some motivational work.* PCADS service coded this episode as a single Tier 2 modality (Advice and Information) and the episode was closed in their records as of 17th March 2010.

114. On 18th March 2010 the triage assessment was presented at the PCADS clinical team meeting. Clinical meeting minutes record summary of above assessment and confirms outcome that patient provided with option for further alcohol service input via PCADS clinic at her GP surgery post hospital discharge.

115. There are no records to indicate that YZ made subsequent contact with PCADS services via her GP surgery. The service has no other records relating to the contact episode dated 17th

March 2010 nor any record of subsequent contact within primary care or as a hospital inpatient.

NHS GP Service, District Nursing Service and Whittington Hospital

116. YZ and WX were registered at the same GP practice. There is no evidence of any domestic violence in either set of records. There is no pattern of injuries in their records that might suggest violence occurred but was not reported.

117. In August 2010 WX was referred to the Whittington Hospital with symptoms of abdominal distension and shortly afterwards alcoholic liver disease was diagnosed. WX was admitted to hospital on 28th September and discharged from the Meyrick Ward on 5th October 2010 after treatment for respiratory problems, pleural effusion, liver disease and alcohol dependence.

118. WX was not a regular attendee at his GP surgery and he did not always attend his hospital appointments. His GP took a role in encouraging him to attend and re-referred him if necessary. On 6th May 2011, the GP received a letter from Whittington Hospital stating WX had failed to arrive for his appointment for admission on at least two occasions and had therefore been removed from the waiting list. It was stated that if the patient still required treatment he would have to be referred as a new patient.

119. By May 2011 WX's condition had deteriorated sufficiently for him to have returned to share a home with YZ as he had no other social or family support. The practice became aware of this situation as YZ wrote to them on 3rd May 2011.

120. In June 2011, WX made two appointments (10th and 14th June) with his GP for medication and a persistent cough. He was emaciated as his weight had dropped to 70kg.

121. On 25th August 2011, WX presented at his GP's office with a very distended abdomen, cough and dyspnoea (shortness of breath). He could only walk short distances, he was sallow but his lungs were clear. He was given a gastroenterological referral and was referred to Whittington Hospital. He was given a chest x-ray at the hospital where a large right-sided pleural effusion extending up to the lung apex was found and WX was referred to the Chest Clinic on 5th September 2011. The GP was advised by the Chest Clinic that WX had missed his appointment on 29th September.

122. On 3rd November 2011, the GP practice received a letter from a consultant physician in Gastroenterology. The letter stated that WX was struggling with his respiratory system, complaining of a cough, shortness of breath, and white sputum. His past history included pleural effusion ascites secondary to chronic liver disease. WX was clearly struggling with his health, particularly effusion, and was offered admittance to hospital. However, he was not keen, and stated that he could cope at home. His dose of Spironolcatone was therefore increased to 200mg od and he was asked to continue with the Frusemide. WX was advised if his condition should worsen that he should check himself in for drainage as this would help with his symptoms.

123. On 23rd January 2011, WX was seen by a Consultant Gastroenterologist because his abdominal swelling had worsened. WX was given medication and YZ (listed as WX's 'wife') was told that if WX did not respond in a week that he should be brought to A&E for further drainage of his lungs.

124. The district nursing team was contacted on 27th February 2012 by a doctor at the Rise Group Practice as WX's condition declined to ensure that some regular clinical oversight was provided as his liver disease had reached a point where he spent most of his time in bed. They were asked to visit and check his bloods.

125. District Nursing visits began on 8th March 2012 when it was noted that "Bloods taken, Noted Waterlow score of 17 and all pressure areas intact; Hospital bed and pressure relieving mattress offered but declined; WX sleeping in chair and didn't want to change this; WX needing help with personal care which daughter helps with; Care package offered and declined; Managing own medication; Admitted to District Nurse (DN) caseload for care and support fortnightly;" The assessing nurse has stated that there was no reason to doubt the patients mental capacity during this assessment; he was able to retain information and repeat it back correctly. WX agreed to the set DN visiting plan, every 2 weeks for pressure area monitoring. The assessing nurse recalls speaking to a social worker during one of the patient visits and he informed her that he was coming to assess WX the following day but she is unsure of the date of that conversation.

126. On 15th March the GP visited WX at home as he was experiencing increased abdominal and ankle swelling and had stopped taking his diuretics as he felt dizzy when standing. WX was advised to restart medication. The GP noted that WX had cold/flu like symptoms, head lice and an earache.

127. On 16th March 2012, the District Nursing Team sent a fax to the GP stating that they visited WX. They checked his blood pressure in a seated position and he felt too dizzy to check standing up. WX complained of dizziness the entire time, and that he had started to feel nauseous. The nurse stated that she would continue to visit '2 weekly' and monitor his skin integrity.

128. On 21st March, the DN visited WX to check if he needed palliative care, to do pressure area checks and bowel monitoring. All pressure areas recorded as being intact and that WX's bowels had not opened for 5 days along with WX's 'wife' stating that WX was experiencing some ear pain and that she would get in touch with the GP in order for him to prescribe eardrops.

129. On 22nd March the GP visited WX and treated him for an earache. An adult musculoskeletal services and podiatry referral was made as WX is housebound and unable to self-care and he 'lives alone'.

130. On 4th April, the DN visited WX for palliative care support, for pressure area checks and bowel monitoring. It was recorded that WX refused to allow check of pressure areas on buttocks and sacrum on this visit. All other pressure checks recorded as being intact. Legs found to be swollen and WX advised to elevate his legs. Hospital bed offered during this visit and accepted by patient. Bed was delivered on 10th April.

131. On 12th April YZ visited the surgery (she was noted on the records as WX's 'partner') requesting WX's medication and stating his condition had worsened. An appointment was booked for 26th April. This visit did not happen as it is noted that patient was in seen in hospital on this date for shortness of breath and abdominal swelling.

132. On 13th April, the DN visited WX to check if he needed palliative care and for pressure area checks. WX was not expecting the DN today as visit plan has been agreed for fortnightly. WX refused pressure area checks to buttocks and sacrum on this visit.

133. On 19th April, the DN visited WX for palliative care support and for pressure area checks. All pressure areas recorded as being intact. 'Wife' was present during visit.

134. On 25th April, the DN visited WX for palliative care support and for pressure area checks. Allocated nurse could not gain access and visit rearranged for 26th April.

135. On 26h April, the DN visited WX for palliative care support and for pressure area checks. DN made a telephone call to locate WX as there was no access when nurse visited. WX had been admitted to hospital.

136. On 2nd May, the DN visited WX for palliative care support and for pressure area checks. All pressure area checks recorded as normal and patient was referred for podiatry visit (which was completed on 24th May).

137. On 3rd May the DN Team referred WX for a needs assessment by the Social Services Access Team as YZ was not coping with WX's hygiene needs. On 11th May the DN Team was contacted by the Access Team requesting a phone number for WX and asking whether WX had given permission for Social Services to contact him. The District Nurse who answered call from Access did not know as she did not make the referral. Access followed up with an email on 16 May asking if WX was happy to be contacted. On 17 May another referral by a DN Team Manager was made for help with WX's personal care. Access Team advised manager that a care assessment had already been made and that Access was waiting for confirmation from the original referrer that WX or his family were happy to be contacted by Social Services.

138. On 4th May, the DN visited WX for palliative care support and for pressure area checks. No evidence if all pressure areas were checked as the nurse was from an agency. No issues were recorded during this visit.

139. On 11th May, the DN visited WX for palliative care support and for pressure area checks. All pressure area checks recorded as normal. WX's appetite was recorded as poor. WX refused laxatives as he found it too difficult to get to the toilet especially as his 'wife' provided him with support to get to the toilet.

140. On 14th May 2012, WX was visited by a GP at home. He had been back to the Whittington Hospital for further care. WX appeared very weak, and spent all his time in bed. He used a bottle to pass urine and needed help to get to the toilet when necessary. He was barely eating, and was surviving on Ensure Plus (a food supplement drink). YZ was looking after him. WX complained of abdomen and back pain, which was only partially alleviated by paracetamol. He was using lactulose. Upon examination WX looked sallow, his abdomen was distended, but soft and pain-free. His lungs were clear, and his tongue was dry. He had a sore mouth, but he had Difflam to help his symptoms. The doctor stated that they would speak to the district nurses who were assessing his skin on a weekly basis. WX's condition

had clearly deteriorated and the GP referred him to the Palliative care team. The aim of this referral was to ensure that he was comfortable and well supported.

141. On 21st May 2012 the district nurse advised the Access Team social worker that the nurse who visited WX on 18th May could not gain access as "Mrs X" (YZ) was out at the time; she also advised that she had contacted YZ by phone and asked if she would like to be referred to Social Services as a carer and YZ said that she would.

142. On 23rd May the Access Service called the District Nursing Team after speaking with YZ and encouraged a nurse who had contact with WX and YZ to discuss their options with them and feedback to the social worker once this had been done.

143. On 24th May the GP conducted a home visit and WX was prescribed additional medication.

144. On 25th May, the DN visited WX for palliative care support and for pressure area checks. No notes recorded for this visit.

145. On 28th May another phone call between the District Nurse and Access Teams occurred and the DN told the social worker that she would encourage WX and YZ to contact the Access Team again or they would refer back to the Access Service if requested by the family.

146. On May 31st 2012, GP received a letter from the palliative care team noting that the situation between YZ and WX was strained and a care package was to be initiated. No further detail of this is found in the GP records. A request to supply medication in blister packs was made by the Access Team and received but it is not clear if the practice acted upon this.

147. On 6th June, the DN visited WX for palliative care support and for pressure area checks. WX's appetite recorded as poor, his bowels had not opened for a week and he refused taking other laxatives. GP was informed via telephone requesting a review of laxatives. Pain was recorded as well controlled.

148. On 8th June, the DN visited WX for palliative care support and for pressure area checks. WX refused pressure area checks as this was completed on 6th June. WX started taking laxatives the previous day and his bowels had started opening. It was recorded WX reported he was finding it difficult to manage with personal hygiene needs. This was going to be reported to the Access Team but social services called during the visit and the issues were

discussed. The DN was informed by the social worker that they would come to assess WX the next day.

149. On 13th June, the DN visited WX for palliative care support and for pressure area checks. All pressure area checks recorded as normal. WX reported his skin was dry and that his wife applies moisturiser cream every day for him. His bowels opened 4 days before and the GP was contacted for another review of laxatives. (This area of WX's health was a constant source of worry and possibly a significant factor for YZ.)

150. On 21st June an email was sent to the DN Team from the Access Team about their assessment, during which WX and YZ were receptive to support as YZ was finding it difficult to strip wash WX. After this assessment, YZ contacted Access and said that they did not want formal support with care but would manage with friends and neighbours.

151. On 22nd June there was a clinical consultation in WX's home as WX presented with a cough and was given Amoxicillin.

152. On 27th June, the DN visited WX for palliative care support and for pressure area checks. All pressure area checks recorded as normal. WX complained of abdominal pain but refused to take medicine to relieve the pain.

153. On 16th July GP received a letter from a Consultant physician in Gastroenterology. The letter stated that WX was suffering from decompensated chronic liver disease and the characteristics that accompany this illness. Upon examination WX had signs in his right lower zone, which would be consistent with pleural effusion. WX was offered admission, but he was adamant that he would not come in. It was therefore arranged that WX should have a chest x-ray and some blood tests. He had stopped taking his diuretics and he was asked to restart Spironolactone 200mg od, and Frusemide 80mg od. He was also commenced on propranolol, and discharged for prophylaxis against oesophageal bleeding. It was not clear why WX was no longer taking his medication. The consultant noted that when he reviewed WX in three weeks he would try and commence it again at that stage. The consultant also suggested that if WX's symptoms worsen he should be admitted to A&E.

154. On 17th July a telephone consultation was conducted by the GP with the palliative care nurse who suggested they increase WX's morphine dose to 10mgm to help with pain control. The nurse also confirmed that WX had stopped taking sprionolactone and asked for blister packs.

155. On 18th July, the DN visited WX for palliative care support and for pressure area checks but the visit was not achieved. Nothing is recorded in the DN notes as to why this was.

156. On 25th July, the DN visited WX for palliative care support and for pressure area checks. All pressure area checks recorded as normal. Pain was recorded as being under control and WX was using pressure relieving equipment correctly. WX reported as having had physiotherapy and his mobility had now greatly improved. WX was able to get out of bed independently and use the Zimmer frame to mobilise around the house. WX reported his appetite was improving and he had a well-balanced fluid intake. There was a reference to a dietician review but the referral cannot be located. WX reported that he was experiencing difficulty with his bowel motions but was taking Lactulose as prescribed. Movical was prescribed and available in WX's house but was not administered by WX or family.

157. On 26th July WX was seen by a doctor at the GP practice and it was noted that WX was now under the care of the ELiPSe palliative care team for his terminal liver disease. He had not been compliant with his medication, so blister packs were set up.

Information held regarding YZ

158. [redacted].

159. [redacted].

160. [redacted]

[redacted]

161. [redacted]

162. [redacted]

163. [redacted]

164. [redacted]

[redacted]

165. [redacted]

166. [redacted]

Islington Adult Social Services, The Access Service

167. The Access Service[1] had contact with WX and YZ from 03.05.2012 until 21.06.2012.

168. On 3rd May 2012, a District Nurse raised concerns that YZ was not coping with WX's hygiene needs and requested a needs assessment from Adult Social Services Access Service.

169. On 11th May 2012 a social worker contacted the District Nursing Team to request a phone number for WX and asked whether WX had given permission for Social Services to contact him. The district nurse did not know as she was not the one who had made the referral. The district nurse advised that WX was reported to their service in February 2012 by the GP with end stage liver failure and fluid in his gut and that district nurses currently see him at home once a week. Another district nurse reported that WX is currently bed bound. They were unable to advise on what support was currently provided by family, or whether or not he lives alone. On this date, the Access Service confirmed receipt of the referral in their records and requested confirmation that the referrer from the District Nursing Team discussed this with WX and confirmed that he was happy to be contacted by Social Services.

170. On 14th May 2012, it was noted that the social worker was not certain that the referral to Social Services had been discussed with WX and that she will discuss with a colleague who has met the family to obtain more details.

171. On 16th May 2012, the social worker emailed the district nurse to check if their team had met with WX that week, and whether he was happy to be contacted by Social Services. The

[1] The Access Service is a front door to adult social services providing, information, advice and care support. It is the contact point for all initial enquiries, new and returning referrals. The office is open to the public.

district nurse emailed back advising that the next home visit would take place two days hence (18th May) and she will feed back to Access Team after that.

172. On 17th May 2012, the Access Team received a second referral from the District Nursing Service's Team Manager for an assessment for help with WX's personal care. The social worker emailed back advising that the Access Service had already received a referral regarding WX, and explained that she was awaiting confirmation from the original referrer that WX or his family were happy to be contacted by Social Services.

173. On 21st May 2012, the district nurse emailed the social worker advising that the nurse who visited WX on 18th May 2012 could not gain access as "Mrs X" (YZ) was out at the time. The district nurse also advised that she had contacted YZ and asked if she would like to be referred to Social Services as a carer and YZ said that she would.

174. On 22nd May 2012, the district nurse emailed the social worked again to reiterate that the nurse visiting on 18th May had not gained access and advised that another visit was booked for the next Monday (28th May 2012) and that she will contact the social worker with the outcome then.

175. On 23rd May 2012, a social worker called YZ seeking to gather further information about the situation. The social worker spoke to YZ who advised her that WX had cirrhosis of the liver and the GP had not advised her of his prognosis. YZ said she had her own physical disabilities (pain in legs) and had depression. YZ said she did all the cleaning, laundry and meal preparation and that her neighbour and daughter supported her occasionally with shopping. She said she would like support to give WX a wash a few times a week. She said that she and WX manage finances between them. YZ said that WX spent all his time in bed apart from occasionally getting up to use the toilet. She said he had a hospital bed and was very thin and had lost weight recently and had nutritional drinks prescribed by GP. YZ and social worker had a discussion about some equipment that could help and what benefits WX received. YZ said she was not worried about money but just wanted support with WX's personal care needs. The social worker advised about the financial assessment process and the importance of WX receiving maximum benefit entitlements. YZ said it sounded too overwhelming. YZ then stated that WX had started new medication the previous day and she hoped it would make a difference to his health and improve his independence. The discussion ended with YZ saying it would be better to call back in a few weeks to see how things are then. The social worker agreed to send details about how support could be provided in the meantime.

176. Later on 23rd May 2012, the social worker called the district nursing team and spoke to the allocated nurse for WX. The social worker advised the nurse that she had spoken to YZ and how things had been left. The social worker requested that a district nurse who knew the family well would discuss things with them further and feed back to her once this had been done. The social worker left her contact number and agreed to call back early the next week if she had heard nothing.

177. On 28th May 2012, the social worker called the allocated district nurse to follow up on the previous week's discussions. The nurse advised that last week WX was not at home and agreed that someone would discuss this with him further the next Friday. The social worker advised she would send a letter to WX and YZ with further information about the assessment process, both for services and finances and explain that support was available for this. The nurse said they would encourage WX and YZ to contact Access again or they would refer back if requested by the family.

178. On 29th May the social worker completed a file note which summarised events to date. Evaluation of the risks were recorded as: 1) WX at risk of further physical decline 2) Risk of carer relationship breakdown. Evaluation of the protective factors were recorded as: 1) Access contact details sent 2) Carer's assessment sent to YZ to complete 3) Assessment process information sent 4) Ongoing support and weekly visit from District Nurses. Note also summarised contact with YZ as: Contact made with YZ once agreed by the family when YZ identified that she would benefit from increased support. After discussing things at length, YZ advised that WX had just started new medication, and she would therefore rather wait and see how the medication takes effect to see if it enhances his ability to do things for himself. YZ also advised that she felt a little overwhelmed by everything going on at present. The social worker agreed to forward some information for her to look through and get back in touch when they were ready. Allocated district nurse has advised they will attempt to discuss things further with the family and support them to get back in touch.

179. On 30th May 2012, a note was entered by the Access Team Manager stating that there was no further action at this time and that the district nurse will re-refer when/if required.

180. On 31st May the Access Team received a referral for a care/needs assessment for WX from the Islington ELiPSe Palliative Care Team. The referral advised that WX had alcoholic liver disease and would like assistance with the minimum of a morning visit for assistance with personal care. The referral advised that WX lived with his ex-partner YZ.

181. On 7th June 2012, the case was tasked to a Support Adviser from ELiPSe by a Senior Practitioner to contact WX and YZ and complete an assessment.

182. On 8th June 2012, the support advisor called WX/YZ and spoke to YZ who advised that WX was now more receptive to accepting support with personal care and that the district nurse confirmed this. A home visit was arranged for 14th June 2012.

183. On 14th June 2012, a carer's assessment was completed by a Support Adviser with YZ and social services support was declined. The needs assessment included a section on safety and risks, with a prompt to consider safeguarding issues. The following was recorded: 'Mr WX is reliant on others for activities of daily living. Family are struggling to cope with Mr WX's needs'…. 'Mr WX has decided against receiving support from Social Services'.

184. On 14th June 2012, copies of the assessment for WX and the carer's assessment for YZ were logged on to the Access Service's system. WX's assessment shows that both he and YZ were present at the assessment. YZ reported knowing WX for over 36 years and that WX had moved in with YZ and relied upon her for shopping, housework, laundry and meal preparation. The assessment records that WX had his own property in Limehouse. He was cared for in the lounge area at YZ's property as he was unable to manage the stairs. WX's diagnosis was end stage liver failure. He regularly attended Whittington Hospital for fluid to be drained from his lungs. WX reported being often low in mood and having sleep problems, with continuous coughing making him tired and irritable. He mentioned being depressed with his condition. The assessment referred to WX having a supportive family and neighbours. He received support from the ELiPSe Team as well as help with his benefit maximisation from ELiPSe, and mentioned that he was trying to cash in his shares and pension and was frustrated at the time this was taking. Actions agreed: WX and YZ gave consent for a referral to be made for Linkline (a pendant connected via telephone for summoning help). A referral was made to the Reach Team (to assess ways of improving mobility).

185. YZ's carer's self-assessment questionnaire (SAQ) from 14th June 2012 shows that YZ provided considerable support to WX and that initially they were receptive to having support with personal care as YZ was finding it difficult to strip wash WX. In the SAQ YZ rated her general health and wellbeing as "not very good" and rates her quality of life as "not very good". She described WX as her ex-partner. It sets out that YZ sometimes helped WX with washing/bathing, dressing, meal preparation, getting in or out of bed, and toileting, and she

did all the shopping, laundry, cleaning, money management/paperwork, driving and arranging transport, medication and appointments. She stated that her daughter helps her to look after WX, and neighbours also help her. YZ described that she was WX's registered carer and that she received Carers Allowance. Action agreed: To refer YZ to Islington Carers Centre (or other voluntary agency), although there were no specific outcomes YZ wanted from this action. In YZ's carer's SAQ, there is a section where the assessor records whether the carer's view matches their own. In this section, the assessor records that both WX and YZ were initially receptive to having support for personal care as YZ was finding it difficult to strip wash WX but that they changed their mind the day after the assessment.

186. On 14th June the social worker made the referral to Telecare for Linkline to be installed at YZ's property.

187. On 20th June 2012, the Access Records stated that WX has substantial needs that are currently being met by family.

188. On 21st June 2012, a Senior Practitioner within the Access Service summarised the completion of the assessment, including events and evaluation of risks: Elipse & the Hornsey Rise DN Team both referred for support with WX's personal care. Initially, both WX and his ex-partner YZ were receptive to having support with personal care, however following the assessment they decided not to have formal support with personal care, and stated they would manage with the assistance of family and neighbours. Risks were listed as: 1) WX is at risk of further physical decline 2) Risk of carer fatigue. Protective factors recorded as: 1) WX lives with his ex-partner 2) WX has supportive family and neighbours 3) WX is being supported by health professionals. A decision of no further action for Access was taken at this time.

189. On 7th July 2012 a note was entered by the social worker from the Access Team Note which stated that the Carers SAQ was complete and that although YZ is clearly proving considerable support to WX, there is a low risk to the sustainability of the caring role. WX has decided against receiving formal support, preferring to accept assistance from YZ, family and neighbours. YZ would prefer WX to accept formal support. Risks were identified as: YZ is at risk of carer fatigue, especially as WX's health deteriorated; YZ has her own pre-existing health problems. Protective factors were recorded as: YZ has a car and is able to access the community; YZ has a supportive daughter and neighbours. No further action for Access was recorded.

Islington Corporate Customer Services, Telecare Team

190. On 21st June 2012, a Community Alarm Service application form was received for WX. This had been completed and sent through to the Telecare team by the Support Advisor for the Adult Social Care Access team. The form requested the installation of a personal Telecare alarm in WX's property. The reason given for this was because WX had end stage liver failure. The form also gave YZ, WX's ex-partner, as the main contact.

191. The purpose of these personal alarms is to allow the client to summon help in case of an emergency, such as a fall at home. A pendent is worn around the neck and when activated, sends a signal to a receiver box connected to a telephone line. This then automatically calls the Islington Telecare control room. A controller can then speak directly to the client to access the situation and ensure an appropriate response. The exact response will depend on the nature of the problem, so for example, if the client indicates they have fallen and are unable to get up, one of the Telecare team will be dispatched to the clients' home to offer assistance.

192. The Emergency Response Officer recorded details of the referral onto the Islington Telecare PNC database and on the same day, contacted YZ to discuss the installation of the alarm. The notes show that the installation did not go ahead however, as the officer was informed by YZ that the client did not have a landline, a fundamental requirement for the installation of an alarm, nor would he be getting one. The inability to install the equipment was reported back to the referrer as standard procedure although the referrer has no record of this.

ELiPSE Team (End of Life and Palliative Care Service)

193. During the period 15th May – 18th July 2012, Islington ELiPSe provided varied support to WX including a Clinical Nurse Specialist (CNS), a MacMillan Social Worker (MSW), a Physiotherapist and a Volunteer Welfare Rights worker. ELiPSe is the palliative care team for Camden Provider Services (CPS), which is part of CNWL.

194. On 15th May 2012, the ELiPSe Team received a referral for pain control and end of life care from WX's GP, which stated that WX suffered from alcoholic cirrhosis with terminal liver failure.

195. On 18th May 2012, a palliative care initial assessment form was completed by a Clinical Nurse Specialist (CNS) with YZ present. Assessment noted that WX had a hostel bed but had plans to give it up. It was confirmed that WX lived with an ex-partner in her flat, which he

stated he wanted to be his place of death and that WX had support from his ex-partner YZ. The CNS made a referral to an Occupational Therapist.

196. On 21st May the CNS referred WX to a physiotherapist as he was passing urine into an old juice bottle.

197. On 22nd May 2012, a Palliative care nurse spoke with WX's GP via a telephone consultation and suggested a small dose of morphine for WX.

198. On 24th May 2012 a home visit was made to conduct a benefit assessment by a Volunteer Welfare Rights Officer who noted that YZ and WX had a joint account into which his pension was paid. The Officer completed an Attendance Allowance form.

199. On 30th May 2012 ELiPSe conducted a joint visit with a MacMillan Social Worker (MSW) and Clinical Specialist Nurse (CSN) to YZ's property. The MSW saw YZ and the CSN saw WX.

200. YZ described significant pressure on her to the MSW. YZ stated that she and WX had never clearly negotiated WX's health and care needs when he had come to stay last autumn and as WX has not been well enough to return to the hostel there had been increasing tensions in the house. YZ became tearful and told the MSW that YZ's and WX's break up was due to WX's severe dependency on alcohol. YZ stated her ideal situation would be if WX could go elsewhere, but knew that he was not yet at the stage that he would go into a hospice. [redacted]. MSW wrote 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.

201. The CSN met with WX who said that his new pain medication was helping as he was able to get out of bed and into a chair for the first time. The CSN suggested a blister pack, which WX agreed to, along with a care package. CSN agreed to contact the Access Team to have this set up.

202. 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.

203. On 31st May the CSN specialist referred WX to the Access Team for a care assessment, advising that WX had alcoholic liver disease and would like assistance with daily living including as a minimum a morning visit for assistance with personal care. In the referral the CSN also advised that WX lived with his ex-partner YZ. It was noted by the Access Team that this referral did not include any detail about what hygiene needs were not being met and to the degree to which they were not being met.

204. On 31st May the CSN wrote to WX's GP stating that the CSN had visited WX and reassessed his pain. WX seemed to be responding to medication and that his pain was 80% better. CSN suggested an increased dose. WX also asked if his medication could be placed in a blister pack for ease. The CSN noted that things in the house had been a little strained between WX and YZ. The CSN also noted that he had requested that a care package be started by the Access Team.

205. [redacted].

206. On 6th June 2012, the Physiotherapist had a telephone conversation with YZ who confirmed the Zimmer frame had arrived, which enabled WX to get to the toilet. Physio stated that he would chase up the order for a urinal.

207. On 12th June 2012, the CSN called and spoke to YZ who stated WX was moving around the flat more, his pain was more controlled and they had an appointment for a care package assessment on Friday 15th June.

208. On 21st June 2012, the CSN and District Nursing Team received an email from the Access Team which stated that during the Access Team's assessment WX and YZ were receptive to support with personal care as YZ was finding it difficult to strip wash WX. Following the assessment YZ contacted the support advisor within the Access Team to inform that WX and YZ had decided that they do not want formal support with personal care but would

manage with friends and neighbours. The Support Advisor completed a carer's assessment for YZ at this time.

209. On 21st June the physio conducted a home visit and noted that WX's cough kept YZ awake at night.

210. On 29th June the physio had telephone contact with YZ who reported that WX was much better after having antibiotics and that YZ was going to have a few days away at her brothers while a neighbour looked in on WX to make sure he was managing.

211. On 18th July 2012 ELiPSe conducted another 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. YZ responded 'yes' but said she would feel guilty if she left WX somewhere and went away herself. MSW discussed the importance of self-care, also the need to be more realistic about the boundaries of their relationship and communicating this more directly with 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. YZ was worried that WX would not take his medication consistently. YZ had discussed it with WX's Consultant but felt rebuffed as no further advice was forthcoming. CSN and MSW provided reassurance that WX remained able to make his own decisions about medication and that YZ should not feel pressured to take responsibility for his medication. The MSW enquired about wider family issues; [redacted]. 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.

212. On 19th July WX's GP spoke to a palliative care nurse who suggested that they increased WX's dose of morphine to help with pain control. The CSN also confirmed that WX had stopped spironolactone and had asked for blister packs.

Islington Council Safeguarding Adults Unit

213. During the period under review there was no referral to or involvement from the Safeguarding Adults Unit and the relevant safeguarding adults policies and procedures were therefore not invoked in relation to WX or YZ.

Metropolitan Police

214. There is no history within MPS records of domestic issues in relation to WX or YZ. The following information has been gleaned from the investigation following the homicide.

215. [redacted].

216. In October 2011 WX moved back in with YZ at her property. She invited him to live with her and voluntarily agreed to provide him with full time care following his diagnosis of chronic cirrhosis of the liver.

217. On the date of the incident, YZ was decorating her flat. Throughout the day she received visits from a friend, the friend's son and her own daughter. At about 20:00 hours YZ left her flat and visited a neighbour where she consumed two alcoholic drinks of vodka and orange. Upon her return home YZ requested that her friend's son go out to the shop and purchase a bottle of vodka and some beer. When he returned with the drinks YZ had a further alcoholic drink of vodka and orange.

218. At about 22:00 hours the friend and son left the flat and returned home nearby, leaving YZ alone with WX. Approximately 45 minutes later YZ 'pounded' on her friend's front door, which was answered by the friend's son. YZ stated, "I think I've killed WX, he was getting on my nerves". The son checked on WX and discovered him lying on the floor. He returned home and requested that his mother call an ambulance. He then went back to YZ's house and found YZ sat astride WX stroking his face whilst saying, "don't worry, go to sleep, you're better off like this". A further witness reported seeing YZ kneeling beside WX and cradling him whilst saying, "don't worry babe, go to sleep".

219. 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. On arrival of police, YZ was asked what had happened. She stated, "I killed him", "I held a bag over his head". Police found a practically empty vodka bottle at the scene. On arrival, the LAS attended to WX. YZ stated, "Leave him alone! He's dead! He's gone!"; "I've had to wipe his

shit up. I wish I'd done it six weeks ago" and "Tonight I just had enough. He kept asking do this for me, wipe my shitty arse, I just lost it".

220. 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".

221. WX was resuscitated by LAS and transported to the Intensive Treatment Unit at Whittington Hospital for treatment. Subsequently, at 06:46 hours the next morning his life was pronounced extinct.

222. 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.

223. When asked what had happened she stated that after her friend and son left her address, 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.

224. Witnesses spoke fondly of both YZ and WX and reported never having seen them argue.

225. 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.

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

227. YZ was charged with murder and a trial date was set. In 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 later in 2013.

The North Islington Crisis Resolution & Home Treatment Team (NICRT) (now called the Islington Crisis Resolution & Home Treatment Team) and the Drayton Park Women's Crisis House

228. [redacted].

229. [redacted].

230. [redacted].

231. [redacted].

232. [redacted].

233. [redacted].

234. [redacted].

Victim Support Islington

235. Victim Support had two previous and separate referrals for YZ and WX, unrelated to domestic violence. On 22 May 2007, YZ was referred to and was contacted by Victim Support as a result of a dog bite that occurred in 2006. YZ pursued a CICA award application and was notified by Victim Support on 11th November 2009 of a nil award. On 5th July 2010 Victim Support received a referral from the police for WX which related to an incident of false imprisonment by a member of the public wielding a knife whilst WX was riding the DLR. Victim Support attempted to contact WX but was unable to reach him and the case was closed.

Islington Targeted and Specialist Children and Families Services

236. This service did not have any contact with YZ or WX but with their family members. There was no involvement with WX or YZ either during the period pertinent to this review or historically.

237. There was longstanding involvement of Targeted and Specialist Children and Families services with one WX's daughters (NB) and her family. From 1988, the time of the initial referral until 2002 there is one mention of WX, detailing that he is an alcoholic. Between 2002 and 2006 WX's daughter advised her children's social worker that WX was an alcoholic/ street drinker, this was not explored further and there was no reference to any contact between this daughter and her father, WX.

238. With regards to the more recent intervention both core assessments explore the wider family and make reference to WX. In 2010 the Core Assessment stated NB advised that WX was living in a hostel in Elephant and Castle and that he visited occasionally.

239. In 2011 the Core Assessment stated that NB advised that her father has liver cancer, is an alcoholic and living in a hostel and that he did not like to be visited as he did not like a fuss to be made. SB told the social worker that she was scared of her grandfather as he had threatened to eat her rabbit when she was little.

Islington Community Alcohol Service (CASA)

240. This service did not have any contact with YZ or WX but with their family members. Records produced were not relevant to the murder of WX by YZ.

Contact with family or friends

241. 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 attempts to seek involvement. It appears they have indicated frustration with the outcome of the criminal case. It was not possible to identify any friends who could have added value to this review.

242. WX's family member indicated that WX left his family when she was 11, but after he left, he would still visit the family every week. His family member knew he was ill but had not seen him for a while before his death.

243. WX's family member described him as 'laid back' and a person who did not like making decisions for himself. In terms of his alcohol consumption, once he had a drink, he couldn't stop and drinking was his way of socialising. WX was very quiet and let other people make decisions for him and was not very confident in himself.

244. The family knew and saw he was deteriorating before he went to live with YZ but once he went to live with YZ, the family had less contact with him. WX's family member stated that YZ could have let them take WX into one of their homes and care for him but felt YZ would not allow it. WX's family member suspected that because he was not always there for them as a father, he did not expect he could come to his family once he became ill. The family member also stated that he was a very private person and perhaps did not want his family to see him in that condition or care for him in that way. One of WX's other children had weekly phone contact with WX and got the impression YZ was able to cope with caring for WX and

that she did not want anyone to help. [redacted].

245. WX's family member stated that WX and YZ were together on and off for 30 years and that YZ appeared to be jealous and WX gave the impression of her controlling him. WX slept rough many nights when YZ took exception to his drinking. In 2004 he separated from YZ and moved to the hostel but kept in touch with YZ after moving out. WX's family member did not know if YZ collected him from the hostel when he got sick or if WX came to YZ.

246. WX's family member stated that WX was definitely fearful of YZ if he did not abide by her wishes. During his illness WXs son called and spoke to WX but he could hear YZ in the background. He believed WX could not talk because YZ was there and then her brother heard significant noise in the background and WX put the phone down. After that the only communication with the family from WX was through texts. WX and YZ also had a joint bank account which apparently held approximately £6000.

247. The perpetrator has not been interviewed as attempts to speak with her have not been successful despite various attempts to contact her.

Analysis and Conclusions

248. YZ is a 69 year old woman with a long history of serious mental health issues. 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.

249. It may be helpful to note that the judge 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."

250. 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.

251. 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.

252. 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.

253. 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.

Equality and diversity

254. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The panel highlighted that gender and mental health (disability) potentially played a role in the circumstances of this case.

255. 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.

256. 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.

Conclusion (and preventability)

257. 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.

258. 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 indicated in this review.

Preventability

259. 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.

260. When the issue of preventability is considered more clearly the concerns expressed in the preceding paragraph 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.

Areas of Practice to Highlight in relation to the above

- **Missed opportunities to share information about and understand 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**
- **Whether WX should have received different care**

261. Due to the underlying issues with YZ discussed above, the opportunity for a number of professionals to interpret the situation and consider YZ's ability to care for WX was missed. There was not an identifiable crisis point within the period of this review, because the situation was chronic and was dealt with accordingly. 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.

262. 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 care to WX. The Panel discussed what the other options would have been if YZ had not been available and queried whether other options were really explored. There is the clear possibility that the risks presented by YZ's pre-existing 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.

263. The DHR Panel felt strongly that recognition of the massive stress that carers are under should be emphasised in this report. One panel member described a meeting with a group of carers that had made her acutely aware of the stress they are under and a number of them disclosed that they verbally abuse the person they are caring for and that maybe professionals do not always have the time to consider the stress carers experience. This is in line with the facts of this DHR. It is incredibly important that **the circumstances and needs 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.

264. 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". This would mean that, without the family support WX's needs were substantial.

265. There was broad consistency among the Panel that professionals did know the majority of the factors in the case but that they didn't 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 might have triggered agencies to look more closely at YZ 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 risks in relation to abuse and homicide.

266. There were some examples of good practice regarding joint working and info-sharing such as communication between healthcare professionals within the ELiPSe team and health care professionals with different specialities undertaking joint visits. However, the MSW spoke to YZ on 30th May and noted that there were increased concerns about YZ's ability to care. The physiotherapist also noted tension between WX and YZ and all members of the same team noted the same thing but this was not followed up when WX changed his mind about care.

267. There was also cross agency discussion regarding WX's care needs between CSN, Social Care Access Team and District Nursing. However, communication and information 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, and would have been an opportunity for any concerns to be addressed and risks to be mediated in a multi-agency context.

268. New Belvedere House, who had significant interactions with WX 2004-2011 as his landlord in a supported living hostel, and understood his care needs to a degree, were clearly supportive of WX and did demonstrate a caring approach as he was increasingly looked after by YZ. They are a "low support" hostel but could have made further enquires about the care he was receiving once he moved in with YZ and asked WX further questions to verify if he was comfortable and safe in her care. It is accepted that this would require the development of their policies but it is felt that this would be a positive addition to their approach given the circumstances discovered within this review.

269. It was also unclear if the information about YZ's mental health history from The North Islington Crisis Resolution & Home Treatment Team (now called the Islington Crisis Resolution & Home Treatment Team) and the Drayton Park Women's Crisis House was held by the GP and if this information could have been requested by any other parties, in terms of assessing how pertinent it was to YZ's ability to be a carer, especially during her care assessment by the Access Team.

270. 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 service, 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.

271. The GP practice does not have a system of "personalised lists" and therefore patients may see any GP. This is often seen to aid access but may not promote continuity of care. This does mean that record keeping practice needs to be exemplary to ensure that all consideration of the patient's case is captured. In addition it is more important in these circumstances to fully record all responses to requests for action so that all practitioners are completely clear about who is doing what.

272. The Quality and Outcomes Framework (QoF) rewards practices for identifying and creating a register of patients in receipt of palliative care. In addition a second indicator requires practices to take part in multi-disciplinary meetings where all patients in receipt of palliative care are discussed. The practice confirmed that both of these statements applied to WX but does not appear that they participated in any multi-agency meetings where information in particular about YZ's historic mental health issues was shared.

273. In addition there is a locally enhanced service run by the Primary Care Trust (PCT) which requires a comprehensive audit of care provided to patients with palliative care. The practice where WX was registered take part in this service.

274. The practice also uses the "Gold Standard Framework", which is a structured approach to managing care for patients who have a terminal disease. This would require a clinician to discuss a variety of matters with WX including his view on where he wished to be in the final stages of illness. This discussion had not occurred with the GP as the view was that in his judgment, when WX was seen in May, it was not an appropriate time to have the

conversation. Much of the care provided in the last two months came from the palliative care team. WX expressed to them that he wished to die in YZ's home.

275. 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

276. 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.

277. 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. For example, the risk assessment for YZ identified that she had her 'own pre-existing health conditions', but failed to separate out those health conditions. In fact, YZ had reported that her quality of life was 'not good' and that she had 3 separate health conditions, namely: arthritis, a history of clinical depression and had been experiencing anxiety since WX had moved in (Carer's Self-Assessment Questionnaire dated 22 June 2012). 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

278. During the Panel discussion it was cited that currently, resources to support people who are caring for those with chronic substance use 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.

279. 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.

280. 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.

281. Islington's Social Services staff guidance also states that an assessment should take account of the wishes of the individual and the carer, the carer's ability to provide care and where possible, should involve their active participation and offer choices. It is clear from the Access Service records that YZ was involved in WX's assessment, and also had her own carer's assessment. The decision not to accept formal care was WX's, and records show that YZ expressed the view that she would have preferred to have had some help, but this was not explored further. Social Services notes that this situation is not unusual, however, and Social Services cannot force people to accept care, and the closing summary takes into account the fact that health professionals were continuing to visit WX, and therefore there was an ongoing opportunity for a further referral should circumstances change.

282. The Panel highlighted a potential issue of the social worker not necessarily hearing what YZ was actually concerned about and offering advice on money when the concern raised had been about personal care. This was possibly a missed opportunity to discuss YZ's needs as a carer beyond financial matters.

283. 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, and both YZ and WX had been given contact details for Access if they wanted to explore further support.

284. An issue that also arose was WX and YZ's engagement with non-specific health related services. Generally both WX and YZ engaged well with the GP, District Nursing and Hospital services, though on occasion WX would not attend hospital appointments. However, their 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 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.

285. 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.

286. 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. Sometimes service-users express a wish that their carer to be present during assessments and best practice is that service-users and Carers are both given the option to be seen alone or with other people to support

them. However, in situations where domestic abuse is present, the service-user and/or Carer might not be in a position to voice their preference to be seen separately for safety reasons, and professionals should take this into account.

Domestic violence policies not in place or not followed.

287. 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.

288. 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.

289. 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.

290. 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 unless WX, YZ or a third party had shared the information with them.

Information sharing and communication difficulties led to delay in actions

291. 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.

292. The District Nursing Team made a referral to the Access Team within Adult Social Services on 3rd May for a needs assessment as at this time the case did not meet their threshold of actual or potential significant harm to justify a safeguarding alert. When an initial phone call was made by the Access Service after receipt of the referral it did not contain contact phone

numbers for WX or YZ so the District Nursing staff could not tell them immediately why WX had been referred, the current level of need or who he was living with/who was caring for him. It was also unclear at this time if they had discussed the referral to social services with WX and/or sought his consent. As it is standard procedure to not proceed without consent/knowledge in non-safe guarding cases, this delayed the needs assessment by over 2 weeks as both agencies sought to clarify this issue. During this time it was noted that the Social Worker was particularly tenacious in following up with the District Nurses. This Social Worker did make contact with YZ quickly once she had obtained confirmation of her agreement, and it was in fact YZ who requested a delay in further action. The Social Worker recorded an evaluation of risks and protective factors before ceasing involvement at that time.

293. 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

294. 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.

295. 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.

296. The Panel discussed the inconsistency over whether the referring agency had been informed of the outcome (i.e. non-installation) and also what the reason was for the non-installation (i.e. was it refusal or lack of landline?) but without achieving clarity about what actually took place.

297. According to Linkline, it is not unusual for staff to be informed that a client does not have a telephone line and so cannot have an alarm installed. As such, no concerns were noted during the course of the team's involvement and there was no further contact with WX or YZ. At first it was unclear if this info had been fed back to the referring agency, but Linkline

states that it is standard procedure by the Telecare team to do this. However, who this was fed back to and when was not recorded. Therefore better recording of contacts and communication is necessary to document these conversations and provide an audit trail in Telecare team records. Also, the Access Team did not have a record of this conversation, so communication between teams seems to be an issue. Although it may not have made a difference to the outcome in this case, it is important that refusal of services is recorded and noted by Social Services as it helps to build a picture of 'non-engagement' and associated risks.

298. 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 and the date of WX's death 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.

299. 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.

300. There is no record of a direct referral for YZ to the Whittington A&E Mental Health Liaison Service; nor is there an account of a direct referral to another Mental Health team within CANDI. This would support the CANDI account that no referral was received from Whittington Health to any of the CANDI mental health services during, or in the weeks following, JE's stay in the Whittington in 2010. No referral was made to any CANDI service from the GP in 2010. This is potential missed opportunity to link YZ with more significant support for her documented mental health issues.

301. There is also a minor issue as to whether the GP Service acted upon the original request to change medication delivery into blister packs after the first request by the Palliative Care Team but it is impossible to be definitive about this.

Joint assessment, decision-making, intervention and monitoring

302. The Access Team's decision-making and assessments are very clearly recorded. The first contact with the household was by a qualified Social Worker who spoke at length to YZ, and evaluated the information provided and recorded an evaluation of risks and protective factors. The Support Advisor who carried out both the assessment of WX and the carer's assessment of YZ identified appropriate interventions with both individuals. The ending of the involvement, which was WX's choice, also included an evaluation of risks and protective factors, and took into account the ongoing support being provided by health professionals.

Professional standards

303. The Access Team works in line with the principles set out in "A vision for Adult social care; Capable Communities and Active Citizens" which was launched in 2010, and builds on the vision set out in the Department of Health's 2007 document "Putting People First". Islington's Self Directed Support Staff Guidance of May 2012 sets out principles as follows, "The disabled person and the local authority have a responsibility to each other to explain their decisions, account for money spent and share what they have learnt." In this case, WX made the decision not to take up any formal care services. Although this was his right (as WX and YZ had capacity to make decisions), this was not explored with him by the Access Team..

Safeguarding Concerns

304. Apart from the stress relating to YZ caring for WX she also had concerns regarding a young relative, which she started to disclose to the MacMillan Social Worker, however, when YZ was told by MSW that she is legally bound to share any information regarding the safety of children with social services she refused to share any further information. MSW spoke to appropriate professionals for advice, and informed her manager. It is unclear if the referral to Children Services was fully explained to YZ and the outcome fed back to her. It is possible that this lack of communication could have impacted on WX and YZ choosing to withdraw from continued care support by adult social services following the care assessment.

Remaining gaps in information

305. There seems to have been some confusion in the GP records regarding the relationship between WX and YZ. YZ is described as WX's wife and the practice thought that they were no longer married and she was not legally his next of kin, especially in the District Nursing notes. The practice thought that YZ and WX had been married and were divorced. The names of their spouses are not included in the records. The records do not identify the next of kin of either YZ or WX or their marital status. There are no "fields" to enter this data in the medical records.

Recommendations

306. Some of the agencies involved in this DHR process had identified changes to their internal processes and approaches. For completeness these are shown below.

Islington Adult Social Services, the Access Team

307. Some of these actions have been repeated as general actions for all agencies in the following section:

- Consider establishing a protocol with Linkline whereby they report back on the outcome of an assessment so that if a vulnerable adult declines a Linkline, there is an opportunity to re-evaluate the risks and take action if needed.
- Consider whether carers' services are appropriately linking carers' depression (and other mental health needs) to ensure that carers suffering depression are not placing themselves and the cared-for person at risk as a result.
- Access to look at how agreed actions can be checked before sign-off to avoid a referral (as in the case of the Carer's Centre referral for Joyce Evans) being delayed or overlooked.

PCT, the GP Practice and District Nursing

308. Some of these actions have been repeated as general actions for all agencies in the following section:

- Palliative care meetings should be informed with the full health and social history of a patient to ensure that the total picture of an individual's circumstances are assessed.
- The practice should reflect on chronologies attached to this report to ensure that the record keeping practice and systems for keeping records provide all clinicians with sufficient easily accessible information about a patient.
- The practice and the palliative care team should hold a joint discussion about this case (unless this has already occurred) with a view to ensuring that their information sharing systems are as full and robust as they can be. This might include a simple weekly electronic update which can be included in the patient's record.
- No review occurred until June and there are no details of the substance of the review.
- YZ was seen at the GP surgery at various points after WX had come to stay with her, including on 6th October 2011 when she stated she had not been sleeping at night and that she had recently fallen down the stairs and had chest pain. On this occasion the GP discussed her stopping smoking and she enquired about tablets but with her

history of depression this was counter-indicated. None of the consultations suggest that she was experiencing stress. The medical records do not make clear if there was any formal review of JB's depression. She continued to receive medication, which related to this, and had done so for many years. Could have screened her here about living situation, domestic violence and stress.

309. The following recommendations are based on what should happen now, beyond what has taken place. It is to the credit of the agencies involved that they have taken action to remedy the problems discovered during this process. However if the likelihood of further incidents of this type are to be avoided additional activity is necessary.

Recommendation 1

310. 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

311. 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

312. 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

313. 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

314. 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

315. 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

316. 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

317. 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

318. 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

319. 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

320. 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

321. 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

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

Recommendation 14

323. 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

324. 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.

Glossary of acronyms	
MPS	Metropolitan Police Service
DHR	Domestic Homicide Review
SIP	Safer Islington Partnership
IMR	Individual Management Review
CNWL	Central North West London NHS Foundation Trust
GP	General Practitioner
NHS	National Health Service
DV	Domestic violence
DN	District Nursing
ELiPSe	End of Life Palliative Care Service
MSW	Macmillan Social Worker
CSN	Clinical Specialist Nurse
PCT	Primary Care Trust

Appendix 1

Domestic Homicide Review Terms of Reference for WX

This Domestic Homicide Review is being completed to consider agency involvement with WX, and WX's ex-partner, YZ, following the death of WX on 30th July 2012. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

To consider:

1. Each agency's involvement with the following people between January 2010 and the death of WX in July 2012:
   (a) WX (dob XXX) of XXX
   (b) YZ (dob XXX) of XXX

2. Whether an improvement in any of the following might have led to a different outcome for WX:
   (a) Communication between services and, in particular, between services in Islington;
   (b) Information sharing between services and, in particular, between services in Islington;
   (c) Joint assessment, decision-making, intervention and monitoring.

3. Whether the work undertaken by services in this case was consistent with each organisation's:
   (a) Professional standards;
   (b) Domestic violence policy, procedures and protocols; and
   (c) Whether these standards, policies, procedures and protocols are consistent with current best practice and what more could have be done to increase access and take up.

4. The response of the relevant agencies to any referrals relating to WX or YZ, during the period covered by this Review concerning domestic violence or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   (a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact within the period covered by this review onwards.
   (b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   (c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
   (d) The quality of the risk assessments undertaken by each agency in respect of WX and YZ.

5. The training provided to child focussed services to ensure that, when the focus is on meeting the needs of a child, the welfare of adults is also a significant consideration.

6. Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of those involved and whether any special needs were explored, shared appropriately and recorded.

8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

10. Whether there are lessons for the further development of the Multi Agency Safeguarding Hub (MASH) and information sharing with the diversity of service providers.

TERMS OF REFERENCE FOR THE CHILD'S ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

11. The primary role of this element of the Review in relation to children is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence experienced by the parents or guardians of children at risk.

12. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in this case. It should also highlight any good practice that can be built upon.

Appendix Two: Letter from Home Office Quality Assurance Panel

Home Office

Safeguarding & Vulnerable People Unit
2 Marsham Street
London
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Ms Katie Furniss
Violence Against Women and Girls Project Officer
Community Safety Partnership Unit
Islington Council
Room G04/05 Islington Town Hall
Upper Street
N1 2UD

23 May 2014

Dear Ms Furniss,

Thank you for submitting the Domestic Homicide Review (DHR) overview report for Islington to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in March.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report and I am pleased to tell you that it has been judged as adequate by the QA Panel.

There were some issues that the Panel felt might benefit from some amendment, or detail, and which you may wish to consider before you publish the final report:

- The QA Panel thought the review cold benefit from a more succinct Executive Summary;
- Further text to clarify the circumstances behind the delay in starting this review;
- Inclusion of the information on the scope of the review and independence of the panel in the main body of the report, to make it more accessible to the reader;
- Some identifiable information is contained in the report such as the exact time and date of the death, and personal medical information. Please ensure all

identifiable references are removed and the Executive Summary, the Overview Report, and Action Plan are fully anonymised before publication, in accordance with paragraph 73 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews.

The Panel does not need to see another version of the report, but we would ask you to include our letter as an appendix to the report when it is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding & Vulnerable People Unit