DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Roger in September 2015

Report Author

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The Review Panel and the Barking & Dagenham Community Safety Partnership would like to express their sincere condolences to Roger's family for their loss and the very sad circumstances which led to his death.
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DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1 The Review Process:

1.1 This summary outlines the process undertaken by the Barking & Dagenham Community Safety Partnership Domestic Homicide Review Panel in reviewing the murder of a resident in the Barking area in September 2015.

1.2 Following a Police investigation and criminal trial the victim's daughter was found guilty of murder. She was sentenced to life imprisonment with a minimum tariff of 4 years.

1.3 The Review process began when the chair and the Borough divisional director with responsibility for the Community Safety Partnership took the decision in November 2015 that the homicide met the criteria to undertake a Domestic Homicide Review (DHR) and the Home Office was notified accordingly. This was outside the timescales required by statutory guidance. A meeting of the Community Safety Partnership followed on 7 December 2015 to discuss the DHR. The Review was concluded on 17 May 2017. This is over the statutory guidance timescale to complete a Review due to the criminal proceedings, time taken in gathering information from agencies, and questions raised by the Community Safety Partnership Board following the first submission of the Review. These questions required the reconvening of the Panel, additional information and a restructure of the report requested by the Board. Thus further delays in final completion of the Review were unavoidable. The author wishes to apologise to Roger's family for this delay. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

Agencies Participating in the Review:

1.4 Of agencies contacted a total of 8 confirmed contact with the victim and the perpetrator, of which 6 provided Individual Management Reviews (IMRs), 2 provided a chronology, and one provided a report. Agencies participating in this Review and the method of their contributions are:

- The Metropolitan Police - chronology & Individual Management Review (IMR)
- The London Borough of Barking & Dagenham Housing Management Team - chronology & IMR
- The London Borough of Barking & Dagenham Adult Social Care - chronology & IMR
- Barking, Havering & Redbridge University Hospital NHS Trust - chronology & IMR
- North East London Foundation NHS Trust (NELFT) (Community Nursing Services) - chronology & IMR
- Genesis Recruitment Agency Ltd (Care Provider) - chronology, statement & information
- G P Practice for the family - chronology & IMR
- NELFT (Barking Community Mental Health Team) - chronology for background

Family, friends, and the perpetrator have also contributed to this Review.

1.5 To protect the identity and maintain the confidentiality of the victim, perpetrator, and their family pseudonyms have been used throughout the Review. They are:

The victim: Roger aged 67 years at the time of his death.
The perpetrator: Sarah aged 36 years at the time of the homicide.
Both Roger and Sarah are of white British ethnicity.

1.6 **Purpose and Terms of Reference for the Review:**

The purpose of the Review is to:

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

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

**Specific Terms of Reference for the Review:**

1. To review the events and associated actions that occurred which relate to the victim and the perpetrator between the end of March 2012 when the victim was admitted to hospital which instigated the first referral to Adult Social Care and September 2015 when the victim was found dead. Agencies with knowledge of the victim or alleged perpetrator in the years preceding the timescale for detailed review are to provide a brief summary of that involvement, with the exception of Mental Health Services where detail concerning their involvement with the perpetrator from first referral to case closure should be detailed.

2. Agencies which had involvement with the victim and the perpetrator to assess whether the services provided offered appropriate and timely support, resources, and interventions to meet the needs and safeguarding of the victim, and that procedures were followed.

3. Were decisions concerning the victim’s care needs, additional vulnerabilities, living conditions, financial situation, and the services provided informed by:

   a) Full and up to date facts concerning his living situation and who was living with him at the time.

   b) Reviews and risk assessments undertaken which were updated in response to his changing needs and changes in circumstances. If so what risk assessment tools or framework were used and was it fit for purpose?
c) Effective and timely communication and information sharing between individual practitioners and agency systems.

4. Explore what issues if any prevented the victim accessing appointments or support services offered to support him and whether these barriers were recognised and addressed.

5. To assess whether agencies have robust and up to date policies, procedures, and referral pathways in place which are fit for purpose in assisting staff to identify and practice effectively where domestic abuse is suspected or present.

6. What was the level of training and knowledge of the staff who were involved with the victim and perpetrator in relation to the identification of domestic abuse and coercive control, the additional vulnerabilities affecting older people and those with disabilities, and the application and use of appropriate risk assessment tools and referral pathways to support and protect victims?

7. As the victim's main carer did the perpetrator receive a carer assessment and if so how and by whom was this completed and what was the outcome?

8. What assessment and evidence was gained to assess the victim's decision to have the perpetrator as his sole carer and whether this decision was taken freely, with information about risk, and without coercion?

9. Was an assessment of the victim's mental capacity as defined by the Mental Capacity Act 2005 undertaken to inform assessments and decision making, and if so how and by whom was this completed?

10. Was the victim formally identified as a vulnerable adult up to March 2015, or an adult at risk post April 2015? Or was he in need of services under Section 29 of the National Assistance Act 1948:

Over the period of time covered by this Review two criteria applied for assessing an adults' vulnerability. Up to March 2015 a 'vulnerable adult' was defined by the Department of Health ‘No Secrets’ guidance as:

“An adult (a person aged 18 years or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation.” No Secrets, Department of Health 2000

Under the Care Act 2014 which was enacted in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

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1 A local authority may, with the approval of the Secretary of State, and to such extent as he may direct in relation to persons ordinarily resident in the area of the local authority shall make arrangements for promoting the welfare of persons to whom this section applies, that is to say persons aged eighteen or over who are blind, deaf or dumb, or who suffer from mental disorder of any description and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself
against the abuse or neglect or the risk of it.

11. Were there any resource, organisational, or systems of working that affected the
provision of services or the way in which staff were able to perform their role.

1.7 The Overview report author was responsible for contacting family and friends to invite
their contribution to the Review. The family member who has contributed was contacted
with the assistance of the Victim Support Homicide Team support worker, and the family
member facilitated contact with the friends who took part.

1.8 Agencies were asked to give a chronological account of their contact with the
victim and perpetrator prior to the victim's death. Where there was no
involvement or insignificant involvement, agencies advised accordingly. Each
agency's chronology was combined into one narrative chronology covering the
timescale set out in the terms of reference. A summary of agencies contact
follows.

Comments from Roger's Eldest Daughter:

1.9 The comments below on the Review's findings come from Roger's eldest daughter. They
were presented to the penultimate Review Panel. The chair asked permission to include
them in the final draft of the report to which Roger's daughter kindly gave her consent:
They are given below to give context to the summary which follows:

1. Please express my appreciation to the carers that went beyond the call of duty for my
Dad, e.g. visiting him out of hours to help clean the house, feeding the numerous pets that
were neglected and providing food for him when he had been left on his own and there was
no food left for him. They continually advised other agencies of the condition of the house
and the Safeguarding risks this environment imposed on my Dad.

2. In future it would help vulnerable adults like my Dad if the sharing of information
among agencies and health professionals was more vigorous.

3. The team around my Dad to care and assess his needs fell short.

4. My Dad’s appointments that were missed for the hospital and the doctors should have
been followed up. He was a man with complex needs that fell off the radar of the
professionals who could have supported him and his condition. Instead he became a
statistic, lost in translation with the countless referrals that he was at risk, the house needed
thoroughly cleaning and him being left on his own.

5. When my Dad decided to end his care package he was signed off without his case being
referred for consideration by a senior member of staff. Considering the experiences in the
past where Sarah (pseudonym):-

- Left him without food, medication or a phone nearby.
- The house was a health hazard to my Dad with the condition it was in.
- There was limited space for him to have an opportunity to use his hoist and his
wheelchair.
• Sarah's mental health.
• It surprises me how staff would be happy to cease a care package without it raising major concerns.

6. I think Sarah should have been assessed thoroughly concerning her mental health and how she was coping on a regular basis.

7. I wish agencies had asked my Dad if there were members of the family they could contact to support him or just contacted me so I could have become involved to support him.

8. The people who truly understood the living conditions of my Dad's home and his care were the carers. That is because they were exposed to it in its full horror and experienced it. It was tangible. This naturally moved them to request further support for my Dad. Whereas, other agencies and health professionals saw a name and information on a piece of paper. It is then easy to detach from the true picture of what was going on and dismiss my Dad's appointments as a no show and discharge him.

9. I ask you to think about my Dad's review and the recommendations with care and consideration. To assist in making changes where necessary so this may not happen to someone else. Also to support and monitor family members who are the carer and any changes in behaviour that may put the vulnerable adult at risk. Maybe if concerns are raised a psychiatric evaluation could be made.

10. At the end of the day imagine your loved one was in my Dad's situation and ask yourself:-
Would you be happy with the level of care?
Would you consider the living environment safe, secure and acceptable?
Would you want this type of support and team around the vulnerable adult?

My Dad deserved a person centred approach to his care which sadly was lacking in some areas. In future with the review's recommendations I hope this will no longer be the case.

Summary of Agencies Contact:

1.10 The victim Roger was diagnosed with multiple sclerosis in 2000, and as a consequence of his illness and deteriorating mobility over the years, he had involvement with Adult Social Care and significant contact with Health agencies. This ranged from his GP, district nurses, community out of hours nurses, hospital, and in the early years from a specialist multiple sclerosis nurse. There is evidence from a multiple sclerosis nurse report of 2007 to his GP that Roger's condition was not just affecting him physically, but psychologically and mentally. At this time he was noted as being uncharacteristically irritable and aggressive towards his wife and suffering from low mood. The specialist nurse asked Roger's GP to consider prescribing medication to help resolve this, and an antidepressant was given with good effect. However, the antidepressants were stopped in 2010 by a different GP as Roger's mood was judged to be improved.

1.11 In the autumn of 2008 the Local Authority Housing Department was notified that Roger's wife had died and he became the sole tenant. It was noted in records that he had a disability and the property had a stair lift and a ramp for wheelchair access to the house.
Sarah, her daughter was also living at the property. Sarah was previously known as Simon, Roger's son. From approximately early 2008 Sarah began receiving medical support and psychological assessment for gender reassignment, and later that year she changed her name by deed poll to Sarah. In interview for the Review Sarah stated that her change in gender was accepted and supported by her parents. Sarah identifies herself as transsexual. She is emphatic that she is not homosexual.

1.12 Sarah had supportive friends at this time, one of whom enabled Sarah to do voluntary work in her shop. Sarah did not have paid employment. She had been home educated from the age of 13 years following being bullied and removed from school by her mother. Roger's wife suffered from long term depression and she is reported to have discouraged visitors to the family home, thus the family were socially isolated, and this continued after her death. Sarah was also noted by her GP to have suffered from episodes of agoraphobia and to have received medication for depression and anxiety. She was very close to her mother and for some months after her death Sarah received bereavement counselling.

1.13 On 13 February 2012 Sarah was reviewed by her GP in connection with an aspect of her gender reassignment and she was referred to a hospital. This date was Sarah's last prescription or requested repeat prescription for hormone therapy medication from her GP. Sarah attended the hospital appointment 2 weeks later where no problems were identified. A follow-up appointment for a scan was arranged for May 2012, but Sarah did not attend.

1.14 A fundamental change in Roger's health took place on 29 March 2012 when he was seen in the Accident and Emergency Department of the King George Hospital with an infection and difficulties connected with multiple sclerosis. He was admitted to the hospital and on 12 April a referral was made to Adult Social Care for an assessment of his needs. Roger also had an assessment by an occupational therapist, and saw a physiotherapist on the ward when he explained that he mobilised at home by crawling on his hands and knees. The physiotherapist informed Roger that this would no longer be possible as he now had a long term catheter in place and he would need to use a wheelchair inside and outside the home. During a follow up session in hospital Roger reported to the physiotherapist that money had been going missing from his house. Tradesmen had been in the house, but the only other person with access was his daughter. The physiotherapist tried to pursue this with Roger, but he refused to discuss it.

1.15 Roger was ready to be discharged from hospital on 25 April 2012 with a package of care which included four visits per day by two carers, however this was delayed twice as Sarah was not at home to receive the equipment which needed to be in place for him to return home and she could not be contacted. Roger had been offered residential rehabilitation, but he refused; he said he wanted to return to his home. The Local Authority were informed of the modifications needed, and eventually with a hoist and key safe fitted Roger was discharged on 3 May.

1.16 When carers arrived on 4 May 2012 they were unable to gain entry. There was a note on the door from Sarah saying there was no need to visit as she was going to settle her father in. However, when Sarah was phoned there was no answer. The carers contacted Roger's social worker who attended with a colleague and the Police and Ambulance Service were called to assist entry. Roger was found in bed watching television and Sarah was away from the home at her voluntary work. The risks of being locked in with no phone and unable to mobilise in an emergency were discussed with Roger. There was no evidence of food for Roger only the remains of a takeaway meal, and there was no medication left for him. The social worker reported afterwards to the care agency that Sarah had been called home from work so that she could put a key in the key safe, and
she was instructed in its use. The poor state of the property was also mentioned in the call.

1.17 On 9 May 2012 the Hospital Social Work Team notes record that Roger's daughter appeared not to be coping with the level of care needed. The agency carers were reporting that there was no food in the house; the house was unkempt, a cat litter tray was overflowing; cat faeces was everywhere, and there were springs protruding from Roger's mattress. The care agency information describes the property as being in a state of disrepair with piles of rubbish everywhere which was not being disposed of. The Hospital Social Work Team records noted that Roger's agency carer and a district nurse said he was at risk. A social work home visit follow up was recorded as being arranged. The case was closed to the Hospital Team and passed to the Reablement Team on 11 May. That day a district nurse phoned a social worker raising concerns about Roger's living conditions, lack of appropriate food, mattress problems, and carers not arriving early enough to empty his catheter which increased the risk of infection, the home phone was also not working.

1.18 On Tuesday 15 May 2012 Adult Social Care began information gathering due to what is recorded as the serious concerns raised by one of Roger's carers and by the district nurse. It was noted that Roger had nowhere to sit even if he was hoisted from his bed. Roger's agency carer reported that Sarah had gone on holiday, and Roger was left in living conditions which caused them concern; there was cat faeces on the floor, Roger was running out of medication, and there was no food in the house. (In interview Sarah maintained that she had left sufficient meals in the freezer for her father before she went away). The carers bought supplies to make sandwiches. Roger was not mobile and was therefore bed bound. Concerns were also raised about Sarah; at the last visit the carer had been told that she was at work, but as the carer was leaving Sarah appeared from upstairs. There were no reported mental health or learning difficulties concerning Sarah on record. Adult Social Care records at 14:41hrs show that the care agency Genesis was to raise a safeguarding alert.

1.19 On Wednesday 16 May 2012 an Adult Social Care support planner and the Care Agency manager made a home visit. A safeguarding concern was raised, however it was not immediately clear from records by whom or to whom this was raised. The Adult Social Care IMR stated it was raised by the support planner. Later in the Review it was said to be a Reablement Team worker. The Housing Department received an email stating that a safeguarding alert had been received, but not from whom. It was reported that 'daughter controls all the money' and there were rent arrears. A direct debit for the rent had been cancelled in March 2012 and there was now a £2,000 debt. Emergency funds were granted by Adult Social Care for a new mattress and bed raisers; Roger had been unable to use an air-flow mattress provided by Occupational Therapy due to the poor condition of his existing mattress, a microwave oven was also purchased for meals to be heated as the cooker was deemed unsafe. An additional hour for two carers was arranged to clean. The Housing Department was contacted with regard to rent arrears and urgent repairs needed to the property were arranged; the Department had previously tried to arrange these repairs, but were unable to gain access.

1.20 On 17 May 2012 a manager in the Assessment and Care Planning Team emailed an officer in the Metropolitan Police Safeguarding section regarding concerns that Sarah had control of Roger's money and that a safeguarding alert had been raised concerning Roger. Included was the fact that Roger's rent was in arrears and a direct debit previously in place had been cancelled. Roger had stated that he did not see his bank statements and did not think he received any, however bank statements had been seen in the house. The matter had not been discussed with Sarah as she had gone away
on holiday on 12 May and it was not known when she would return. It was stated that Roger had mental capacity to make informed decisions. On the basis of the information provided it was asked whether the Police could be involved in the investigation as the manager felt there was potential for financial abuse. The Police responded to this email enquiry on 21 May 2012 that if Roger had mental capacity and had willingly given his daughter control of his money there was no action they could take unless a crime was identified.

1.21 Roger was found not to be in receipt of any benefits therefore support with applying for these was arranged. Threats of eviction due to rent arrears were put on hold. Roger told a member of the Housing Access and Referral Team that Sarah dealt with all his money, but he could not assist them with contacting her. The housing officer recorded that they thought Sarah was living somewhere in Essex. Sarah eventually paid off the arrears in July 2012 and stated that she would rearrange the direct debit, however this was never carried out.

1.22 Between 17 May and mid July 2012 there were a stream of emails from Roger's care agency to managers in the Assessment & Care Planning department of Adult Social Care highlighting the deteriorating environment in the house. A district nurse also contacted Roger's social worker regarding their concerns of 11 May 2012 about the environmental state of the property and requesting Adult Social Care review as soon as possible. Concern was also raised once more that Roger did not have access to a working telephone. The District Nursing Service found no record of nurses being informed of the safeguarding alert.

1.23 Care staff were reporting fleas, cockroaches and bed bugs, and carers were getting bitten. The cats and birds in the house were removed by the RSPCA as Roger was unable to care for them in Sarah's absence; one cat had been locked in Sarah's bedroom for a week and had to be released. Until the cats were removed faeces was everywhere. Staff were on the verge of refusing to carry on. The involvement of Environmental Health was requested and a "blitz" clean as it was too large a job for the care staff. In August 2012 the house was fumigated twice to eradicate fleas. Roger was spoken to regarding tenancy conditions, and later he was sent a letter concerning the overgrown state of the garden. It was not until September that a thorough clean of the property was arranged and carried out.

1.24 On 13 September 2012 the Housing Advice Service received a homeless application from Sarah; it records "claims abusive relationship with father. Homeless application taken/applicant advised she will stay with a friend". However the application was not followed up; Sarah could not be contacted for further details and the case was eventually closed.

1.25 Adult Social Care records of 24 September 2012 note 'Safeguard Closed', and "investigated with no further action but casework was required". A Post Safeguard Review followed on 18 October when it is recorded that there were no concerns and Roger was happy with his care. There was no contact with other agencies before the closure of the safeguarding case. From the point of Roger's return home from hospital in April when concerns started to be expressed safeguarding procedures were not fully followed and timescales were not met.

1.26 During the latter months of 2012 Roger was on the Integrated Care Pathway which meant he was discussed at Integrated Care meetings due to his complex needs. He remained on this Pathway until July 2013. Activity at this time concentrated on ensuring that he had access to the correct benefits and concerns about his immobility; a wheelchair was
ordered and a hospital bed delivered, plus aids to help him out of bed and sitting up. Roger failed to attend hospital appointments for which he had been referred by his GP on two occasions during 2012.

1.27 Between January and May 2013 the local authority had to resort to court action for rent arrears once more; no direct debit was rearranged as Sarah had stated before. Sarah appeared to be living back with Roger for an eviction letter was served on her on 23 May and she eventually paid the arrears in June 2013. The events in the following paragraphs may give context for what was taking place around this time.

1.28 In January 2013 a friend of Sarah's contacted the Police to report what was reported as a burglary at her home. No items were stolen, but clothing belonging to Sarah was found in the victim's wardrobe. Sarah was interviewed and provided a sample of DNA which matched that found at the scene. The victim of the burglary phoned the Police once more in March to report that she had received a text message from Sarah stating that she was going to commit suicide. The Police made checks to establish her whereabouts. A second call from Sarah to the victim was relayed to Police stating that Sarah was no longer considering taking her own life. Roger was unaware of the events surrounding the Police involvement, but he did call the Police frequently for updates whilst Sarah was missing until she returned home. Sarah was arrested and interviewed in connection with the January report in June 2013. She admitted entering the victim's house and trying on her clothes. Photographs of the victim were also found in her possession. Sarah was charged with criminal damage and pleaded guilty; she was fined with costs. A 5 year restraining order was also imposed not to attend the victim’s property.

1.29 In April 2013 Sarah's GP received a letter from the Gender Identity Clinic informing them that despite efforts to contact her Sarah had not responded, therefore they were discharging her from the clinic. Sarah was copied into this letter.

1.30 In July 2013 a wheelchair was successfully delivered for Roger after 2 previous attempts failed; at the first appointment there was no answer, and for the second the room had not been cleared to allow access for the wheelchair as Sarah had been instructed. It was noted that Roger was keen to get out and about in the wheelchair. However, for the most part reviews by the practice nurse indicate that he was bed-bound and increasingly suffering from leg spasms which made being in a wheelchair, or later attempts to use an electric scooter, difficult and uncomfortable. In November Roger's GP referred him to the Department of Neurology at Barking Hospital; he had not been assessed by the multiple sclerosis nurse since 2009. Roger failed to attend 2 arranged hospital appointments. Roger also experienced regular problems with his catheter which required the attention of the district nurses and out of hours nursing service, and he had prescriptions for antibiotics. In December 2013 an infection required Roger to be admitted to hospital for treatment.

1.31 North East London Foundation Trust Wheelchair Services had a telephone call with Sarah on 14 January 2014 following a referral made by Occupational Therapy for a power chair. Sarah cancelled the assessment appointment stating that her father did not want a power chair. This is counter to Roger's earlier keenness to get out and use the wheelchair which was delivered the previous July. There is no information to confirm that Roger was seen alone to confirm that this was his wish.

1.32 In March and July 2014 Sarah had to be contacted due to rent arrears once more, and two further appointments for the Neurology Clinic were sent to Roger in March and August 2014, both of which he failed to attend or acknowledge. Roger's GP was informed by the hospital each time an appointment was not attended, however, these missed appointments were not followed up, even though the hospital and his GP practice were
aware that he was disabled and might need assistance to reach hospital. An alternative explanation that he may be prevented from attending (by Sarah) was never considered.

1.33 On 24 July 2014 Sarah phoned Adult Social Care and cancelled Roger's personal assistants who had been providing his care as she said she wanted to look after her father herself. A home visit to undertake a reassessment followed on 8 August 2014. The social worker undertaking this visit was recently qualified and was not aware of the extent of Roger's previous care i.e. the need for 2 carers, nor of the safeguarding alert in 2012. Roger confirmed that he did not want to continue with the care package and he was happy for Sarah to provide all his care. Case notes record that Sarah was offered a carer assessment and she was advised about a carer's allowance. It is not recorded whether or not a carer assessment was completed; from the absence of records it is assumed Sarah declined. It is not known whether Roger was seen on his own during this visit to confirm that it was his wish for the care to end, and the outcome of this reassessment was not loaded onto the Social Care database. On 14 August 2014 Roger and Sarah signed the consent for withdrawal of the care package. Case notes recorded on that day confirmed the termination of care had been discussed by the social worker with their manager and closure agreed. No closure summary was on the database. There was no consultation with other agencies involved in Roger's care.

1.34 At a home visit by the practice nurse for the elderly and housebound on 22 September 2014, Sarah was present and it was recorded that she was now Roger's main carer. The missed hospital appointments to attend the Neurology Clinic was raised and it is recorded that no first invitation had been received; a further appointment 3 months from August was to be sent. It is not recorded who said the invitation was not received, but as Roger was bed bound and Sarah dealt with the post it is highly likely that it was her. In interview Sarah reported that her father did not attend the appointments as it was too painful for him to get out of bed and make the journey to the hospital and he felt there was nothing that could be done anyway. Asked why she did not cancel the appointments she admitted that she should have done.

1.35 The next assessment home visit for Roger took place 4 months later on 23 January 2015 by the practice nurse for the elderly and housebound. Sarah was present. There were no catheter problems; the district nurse visited if there were. An assessment for dementia was undertaken, and it was noted that Roger was conversant and slow due to multiple sclerosis. Roger was bed bound and watched television most of the time. This is the last entry in Roger's GP record before he died almost 9 months later. During March, April, May and July 2015 there were seven attendances to treat Roger for a blocked catheter by the out of hours nursing service. District nurses made routine visits in June, July, and August 2015 for catheter care and pressure area monitoring.

1.36 Contact was made with one of Roger's former personal assistants on 10 April 2015 by an Adult Social Care manager requesting that they made a welfare visit to see how Roger and Sarah were coping without formal care. However, the personal assistant was unable to feedback the results of her visit as she was unaware who had contacted her, and the team manager did not call back. The former personal assistant reported in interview for the review that generally everything seemed to be going well.

1.37 There is evidence that the garden of the property had become overgrown and neglected when on 10 April 2015 a Garden Assist Request was made by a local ward panel stating that this had been requested on 10 occasions. Records show this as 'case closed' and 'referred to other department'. No further notes were made. A further contact was made by a neighbour concerning the state of the garden in July 2015 pointing out that the resident was disabled and required assistance. An officer was requested to provide a report, however, there are no records to show that a visit to the property took place. On
24 July 2015 there was a stair lift service and repair visit to Roger's home, although Roger was bed bound by this stage and did not use the stair lift.

1.38 On Thursday 10th September 2015, uniformed police officers attended Roger's home to conduct a welfare check in response to a call from a concerned neighbour. The neighbour reported that Roger was an unwell man who required constant care and that his daughter was his carer. In interview for the Review the neighbour described how Sarah was seen very little, she tended to have takeaway meals and shopping delivered. Their neighbour would put out the bins to ensure they were emptied. Their neighbour reported that they did not visit Roger in the home due to the unhygienic state of the house.

1.39 Officers forced entry and discovered Roger's body. Three pages of handwritten notes were found which stated that the writer had killed the male who was referred to as Dad. It was evident that Sarah had written the notes. There were further references to Roger suffering, and Sarah referring to killing herself now her father had died. Following extensive enquiries Sarah was traced to a hostel in a town in the south of England where she was arrested. The post mortem gave cause of death as 'consistent with plastic bag asphyxia'. The Police investigation identified that a text had been sent from Sarah's mobile phone to the District Nursing Service on 2 September requesting them to visit the patient that night. There is no record or action to suggest this text was read, otherwise Roger's body could have been discovered 8 days earlier. The District Nursing Service confirmed to the Review Panel that the text was missed. The nurses have small mobile phones which indicate a text by displaying a small envelope icon and as it is unusual to receive texts this was missed. This problem was identified as early learning from the Review and a new procedure was introduced following the fatal incident to address this. A need to review the 'Did Not Attend' policy by the hospital and Roger's GP practice also identified as early learning due to Roger's failure to attend hospital appointments without this being followed up.

1.40 When the Local Authority regained possession of Roger's home it was found to be extremely cluttered and squalid. It cost a significant amount to clear and to bring the property back into a habitable condition. The condition of the home suggested evidence of hoarding. Roger's equipment such as the hoist and wheelchairs were clearly unused and his bedroom was cluttered to the extent that there was little room around the bed and elsewhere in the room.

2 Key Issues Arising from the Review:

2.1 The key issues outlined here as learning from the Review are an overview from a strategic position rather than drawing out individual agency learning. Readers are advised to see the Analysis section of the Overview Report in which individual agencies' learning and recommendations are described.

Key Issues Concerning Roger's Care:

2.2 The care of those with life limiting long term illness should aim to be the best it can be. Roger had experienced a number of significant losses including the death of his wife and the loss of an active able life, but this and the psychological impact of his illness appears to have been missed. In such cases the whole person needs to be taken into account not just the physical being. This did not feel to be the case for Roger. Even the exceedingly cluttered and squalid environment in which he was living appears to have become accepted and invisible over time. Care plans should take account of the latest research,
developments, and best practice and utilise all resources necessary for the mental as well as the physical wellbeing of a person with such life limiting illness.

2.3 There is no evidence that effective risk assessment for domestic abuse or the potential for such abuse took place other than for each agency's particular area concerning Roger's care. The FACE² assessment for example contains little to encourage effective risk assessment for domestic abuse within family or carer relationships. There are two boxes entitled 'risk of abuse/neglect by others' and 'risk to relationships'. These are the only questions likely to engender such discussion among the many other questions in this assessment, and if these assessments are undertaken with a carer in the room, those questions are unlikely to be asked. This is a difficult and sensitive area of work and staff need the support of clearer risk assessment tools to fit such cases as Roger's and adequate training and managerial support and supervision to do this commensurate with their experience.

2.4 The level of training in domestic abuse by those with responsibility for assessments and/or treating people in their homes was either basic awareness or minimal as part of safeguarding training. Professionals need to be more aware of the prevalence of domestic homicides involving adult children as carers for parents with additional needs such as disabilities or mental ill-health, and to be able to think the unthinkable when undertaking assessments. In order to do this they need in-depth specialist domestic abuse training which includes abuse by partners and family carers including high risk groups such as those with disabilities and mental illness. For those expected to assess and support this client group the training should be mandatory.

2.5 It is understood that the Borough has now adopted the new London Multi-Agency Safeguarding Policies and procedures which includes domestic abuse. Other agencies also include domestic abuse as part of safeguarding policies. The power dynamics around domestic abuse and the specific safety needs of victims warrant a separate referral pathway to assist practitioners. Staff must also be given adequate training in procedures and be supported by management supervision to avoid the pitfalls of the 2012 safeguarding alert and there was a disappointing lack of inter-agency communication and joint working to protect Roger from neglect.

2.6 The unilateral decision to close the safeguarding case, and to end Roger's package of care, both without consultation, showed a disregard for the importance of inter-agency communication and a disrespect for the views of fellow professionals who knew Roger and his circumstances better than Adult Social Care. This does not dismiss the value of a 'fresh pair of eyes' on a situation, but a single pair of eyes will not gain the full picture in such cases. Those who feel uninformed, or who are aware they are not fully informed regarding a safeguarding case, need to be knowledgeable about procedures and confident to challenge partners when they are unsure or believe that procedures are not being followed. Again feedback and communication are key.

2.7 This Review has highlighted the importance of the need to follow up when a patient with serious health problems fails to attend numerous hospital appointments, especially when they have a physical disability as Roger did. Roger appeared to be unaware of his appointments which suggests that Sarah was either not opening the letters or not

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²FACE assessment tools are nationally-accredited by the Department of Health and used throughout the UK and Ireland by NHS, social care and independent sector organisations. The FACE toolsets are a complete documentation system tailored to the needs of the relevant care group. The toolsets include both generic and specialist tools covering a range of support needs.
informing him of hospital correspondence, thus impeding his treatment. That such scenarios may be preventing a patient attending appointments needs to be recognised.

**Key Issues Relating to Sarah:**

2.8 There is a need to make the carer less invisible and to see them as a person in their own right, to identify any tensions caused by the caring role or shortcomings in the care provided, and to assess the suitability of the person to be a carer. It is arguable that Sarah's frequent absences from the home when Roger was discharged from hospital in 2012 should have raised concerns about neglect and her ability and preparedness to be her father's carer. Her suitability for this role should have formed part of the safeguarding assessment before it was closed. Had Sarah been living alone in the cluttered and squalid conditions in the home, attention to her social anxiety and other issues might have attracted a different response.

2.9 The state of Roger's house both inside and out was almost a manifestation of the inability to cope that was taking place inside. Whether we believe that Sarah killed her father at his request or not, either Roger was not coping with his life, or Sarah was not coping with caring for him any longer; the two may be interlinked. There are lessons to be drawn that all is not right in someone's world to live in that way and tolerating squalid conditions, hoarding, or excessively cluttered interiors and overgrown neglected exteriors is not an option. The conditions which existed should have triggered assessment and support for Sarah in line with practice recommended by the British Psychological Society Hoarding Guidance referenced in this Review. If she resisted such agency support, as previous experience suggests may have been the case given Sarah's tendency to hold agencies at arm's length, then when a vulnerable adult's life is also affected, safeguarding procedures may have to be considered.

2.10 A carer's assessment should have been offered as a positive service to Sarah from the beginning. Those with a caring role should be recognised within their GP practice so that they are aware of that role and any additional stress this might bring. The NICE guidelines on assessing carers ability and willingness to care prior to transition from hospital discharge to home needs to be widely adopted and the recommended review process put in place.

2.11 In common with Roger, Sarah too did not attend clinic or hospital appointments made for her despite three reminder letters, the final of which informed her that her case would be closed. Her GP was copied into this letter and was also aware of her failure to attend. This meant the family GP practice who were aware of both Sarah and Roger's health needs knew of their persistent failure to attend hospital appointments. Given the complexity of their situation further enquiries could have been made.

**Other Key Issues for Agencies:**

2.12 In common with so many DHRs and Serious Case Reviews communication and information sharing is a key issue in this Review. When silo working takes hold lines of communication suffer and professional relationships become weakened or fractured. Cases where there are complex and multiple needs such as Roger's warrant a multi-disciplinary coordinated approach to facilitate communication, assessments and joint work.

2.13 This case demonstrates the importance of effective tools for the job and that they are used. There were examples of databases not having data entered which then caused a break in working processes and the sharing of information. Also of a database which was
not user friendly and which did not facilitate the sharing of vital information such as safeguarding alerts in a fast and visible format, and which impeded access to information which should have been clearly and easily visible. The social worker who undertook the reassessment to end Roger’s package care, was relatively newly qualified and did not know about the previous safeguarding alert or that he needed two carers. This was put down in part to the difficulty in finding such information on the database.

3. Conclusions

3.1 Despite the concerns raised in 2012 and the state of the property, no one could have predicted that Sarah would kill her father. She had no previous history of violence and in later years she was seen as caring for her father adequately, for example she acted promptly when her father’s catheter was blocked.

3.2 However, although concerns about the unhygienic condition of the property was raised by some practitioners in 2012 who recognised the risk to Roger, some did not appreciate the risk or the implications. It took too long for the relevant organisations to whom a referral was made to address the problem. For example despite a stream of emails between May and July 2012 it was not until late August that the first fumigation for pests commenced. In the latter years before Roger’s death professionals’ tolerance of the very unkempt and excessively cluttered state of the home suggests an acceptance and normalisation of this environment despite the risks to Roger. That the state of the property may indicate an inability of Sarah to cope adequately, or that the large amount of clutter was of a nature which represented hoarding was not recognised.

3.3 The British Psychological Society Division of Clinical Psychology is now recognising hoarding as a distinct mental health difficulty in its own right, with specific issues affecting access to services and psychological intervention. However, Sarah’s mental wellbeing was not questioned by those with whom she had contact. It is not possible to say whether her reclusive way of living in later years was due to the effects her upbringing, or whether her transgender identity with which she herself identified impacted upon the way she lived. Transgender has been described as a mismatch between the biological sex a person is born with and the gender identity that a person ‘identifies’ with or feels themselves to be. This can lead to distressing and uncomfortable feelings called gender dysphoria. Gender dysphoria is a recognised medical condition for which treatment is sometimes appropriate; there is evidence that Sarah felt this was the best option for her as she did access treatment, although she did not maintain contact with health professionals following treatment. However, gender dysphoria is not seen as a mental illness.

3.4 One way that Roger’s death might have been prevented could have been if he had been in residential care, but from his expressed wish to return home from hospital in 2012 instead of going to residential rehabilitation for a period of time, it might be reasonably assumed that his wish to live at home would have remained the same. However, there is no evidence that a reassessment of his wish to remain at home as his condition deteriorated was undertaken; holistic reviews did not take place after 2012. Alternatively, had there been:

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http://www.bps.org.uk/system/files/Public%20files/a_psychological_perspective_on_hoarding.pdf

4 Source: http://www.nhs.uk/conditions/gender-dysphoria/Pages/Introduction.aspx accessed on 26.6.16
a. a more robust carer’s assessment and recognition that Sarah was not coping;
b. more holistic treatment of Roger’s physical and psychological health needs;
c. better living conditions arranged for him;
d. a fully informed decision made to continue with his carers

An intervention including some or all of these components may have led to a different outcome and Roger may not have died a violent death.

3.5 Inter-agency working was mostly reasonable at the start of the safeguarding alert in 2012, however there appears, on paper and from interviews, some confusion about the alert being raised and for what reason. It appears to be on suspicion of financial abuse, but there is evidence of Roger being neglected and put at risk by omission of care, and yet neglect was not explicitly raised and named in any records. There were shortcomings in following procedures, and in clear and open communication about the nature and outcome of the alert, there is also no evidence that the alert closure was shared with the relevant partner agencies who had been a party to the various concerns raised. A serious omission was not to inform Roger’s GP practice of the concerns and the safeguarding alert.

3.6 All agencies are responsible for following procedures around safeguarding, and whilst Social Care may be the hub and receiver of alerts others too have a role. It is good practice for Adult Social Care staff as the receiver of a referral to provide feedback to a referrer; it is also the responsibility of the referrer to follow-up if they have not received an update. If an alert has been raised and partner professionals realise they have not received the appropriate feedback they must have the confidence to follow up, and if necessary to challenge processes that are not working as they should.

3.7 The lack of inter-agency consultation over the termination of the care package for Roger is another episode of practice which demonstrated a lack of appreciation for multi-agency working. It is all too easy when resources become stretched or caseloads increase to retreat into silos. However, for cases such as Roger and Sarah’s the lack of coordination and information sharing can result in missing the whole picture as was the case here.

3.8 A relatively inexperienced social worker was given the case to carry out the termination of care assessment for what has been termed a complex case by the professionals that knew the family. This may not have been the wisest allocation on behalf of the manager. The lack of background research before the visit meant the social worker was ill equipped to fully appreciate the dynamics of the case; this was exacerbated by a database which was difficult to navigate. Given that case notes indicate that there was discussion with the manager following the visit it is surprising and disappointing that the social worker was not guided by their manager to consult the other professionals involved with the family. To seek their views and to let them know that the care was to end and Sarah would be sole carer would have been good practice.

3.9 Sarah avoided professionals and Roger’s carers for the most part, but this behaviour only raised a question once from the first care agency. Her behaviour raised no concerns. She had become increasingly reclusive and whereas Roger would go out in his mobility scooter before 2012 this ceased afterwards as he was not helped to do this. Sarah was undoubtedly the hoarder in the family, but her behaviour and anxieties were invisible to professionals as they were subsumed by caring for her father with a concentration on her father’s physical wellbeing. The clutter in the house would have made it impossible for Roger to mobilise at home, therefore this contributed to him being bed bound. It is recognised that the premise that hoarding is a mental health condition which can justify mental health and social care support and intervention is contentious, nevertheless
whether Sarah would ever have accessed such support is debatable, but this was never offered as hoarding was ignored. The local authority now has a hoarding policy which has the potential to make this problem more visible.

3. 10 There was no effective follow up to the missed hospital appointments to which Roger had been referred by his GP and which could have alleviated some of the adverse impact of his illness. Nurses and his GP knew he was disabled and would have found it difficult to reach the hospital, but no transport was arranged nor was it checked that this was the reason for non-attendance. The idea that Sarah had not informed her father of his hospital appointments and therefore possibly controlled his ability to attend was never considered. All the staff involved had received safeguarding training which includes a component on domestic abuse, however the lack of consideration of domestic abuse suggests this is not sufficient to give practitioners the skills they need.

3. 11 Roger had complex needs, of which his physical needs appear to have been well catered for by the district nurses and the practice nurse during his final year. Roger had experienced many losses in his life; the death of his wife; the loss of his health and mobility; his independence, and even his pet animals had to be removed by the RSPCA. Any reasonable person in such a situation would find this difficult to cope with. Whilst his physical needs were being tended to, the impact of these losses on his mental wellbeing do not seem to have been recognised. He clearly had psychological and emotional needs which were not met, but the isolated lifestyle he and Sarah lived did not facilitate him accessing the services and support which could have helped. Roger relied on Sarah to contact health professionals, and whilst she did this with regard to catheter care, she did not contact his GP concerning his low mood. It is of concern that, if as she said, her father wanted to end his life, that she did not seek help for his suicidal thoughts from his GP and mental health services who could have helped to improve his state of mind.

3. 12 When viewed in total, on occasions Sarah's behaviour and the range of incidents described in this review, present a picture of neglect. Whether this was by omission due to lack of understanding, or Sarah putting her own needs first and deliberately manipulating professionals to keep them at arm's length it is not possible to judge. However, had all these individual actions been assessed together the risk to Roger would have been clearer.

4. Recommendations:

4.1. The following recommendations arise from agency's IMRs, lessons learnt during the review and Panel discussions. Discussions with Roger's eldest daughter when sharing the report and her comments on the contents and findings have also informed a number of the multi-agency recommendations. Two Safeguarding Adult Board and one Clinical Commissioning Group recommendations do not appear in the Analysis/Lessons Learnt section; they are added with the intention of strengthening systems with the aim of providing strategic 'back up' to the recommendations which follow.

4.2. The recommendations below are grouped according to their relevance to Roger the victim and Sarah the perpetrator. Actions and timescales for the recommendations to be achieved appear in the DHR Action Plan. Responsibility for the recommendations in the Action Plan are grouped under multi-agency and individual agency headings and are not in the same order as they appear below.

Recommendations Arising from Roger's Contact with Agencies:
All agencies working with those with long-term illnesses should ensure that each review routinely considers a person's psychological and mental resilience and wellbeing, the up to date management of any adverse symptoms, onward referral and information about informal sources of specialist support.

All agencies must ensure their staff are fully trained and compliant with safeguarding procedures and that concerns and alerts are fully and accurately recorded including time, date, who made the contact and name of person contacted, discussions with managers and actions agreed. Consultation with all involved agencies must take place before Adult Social Care closure of the safeguarding alert and be recorded by all agencies before closure of the safeguarding alert. Auditing of staff training, compliance with procedures, and impact on practice to be built into supervision, and annual staff development plans.

The formation of a multidisciplinary team as recommended by NICE Guidance (NG27) December 2015 should be put in place for those with complex needs and life limiting illness who are living at home to ensure an holistic approach is taken to risk assessment and their needs, which includes the identification of a named coordinator, and a structure of regular multi-disciplinary reviews. It is recommended that the Camden High Risk model is investigated.

Taking into account the learning from the review, assessment and review templates should be reviewed to ensure that their design triggers questions to examine risk to service users with additional needs which includes seeing the person alone, and assessing carers who are family members.

Assumptions or not of mental capacity must be clearly recorded as well as the reasoning behind the assumption. Where capacity is doubted then formal assessment should take place and be recorded.

All staff to have regular training with regards to safeguarding, risk assessment and issues of mental capacity. LBBD to consider setting a mandatory timescale for refresher courses.

The new electronic data base needs to have the functionality that enables key information, current or previous safeguarding alerts, and risks to be identified quickly by social workers not familiar with the case.

Checks with all professionals involved with a service user should be part of all case closure processes as standard, recorded clearly, and checked for completion before management sign-off. Auditing of this process to be build into management supervision and an annual compliance audit implemented.

Reassessments at the time of case closure must be fully entered onto the Adult Social Care database ensuring that the rationale for closure is recorded, risk assessed and how any risks will be managed in future. Procedures should be updated and auditing of this process to be build into management supervision and an annual compliance audit implemented.

Where a vulnerable tenant has been identified by the housing officer they should discuss this with their manager as to the required frequency of the next tenancy audit. Discussion should focus upon annual visits unless evidence suggest that this is not required.
Advice notes to be loaded by housing officers with details of tenants disability as per the new 2016 procedure.

A record of all services with whom a patient is in engaged (i.e. MS society, other specialist voluntary services, Integrated Care Team, Social Services, etc) must be routinely recorded on the patient's medical record. Where a GP practice has been given the code if the patient's home has a key safe, all agencies should be informed that the key safe code lies with the GP.

Where a patient known to have a debilitating or life limiting illness fails to attend hospital appointments more than once a follow up contact with the patient themselves should be undertaken which may include a home visit to ensure that the patient knows they have an appointment, has the means to attend, and are not being prevented from attending for any reason.

In addition to ensuring all patients with multiple sclerosis are referred to the community multiple sclerosis specialist nurse, the practice should ensure that patients are referred to suitable support agencies such as the MS Society and MS Trust UK, or other relevant organisation according to their needs.

The practice should put in place a clear strategy for managing patients with multiple sclerosis in line with best practice which includes multidisciplinary reviews of their mental wellbeing as well as their physical symptoms, and consideration of how their carer is coping. The strategy to include:

- A review by the practice manager of important case activity once a quarter.
- A health care assistant to visit all MS patients once in 8 weeks on a routine basis and to report any concerns.
- A designated nurse representing the vulnerable and safeguarding services included in the care pathway.
- Adopting clinical management of the patient as recommended in the GP practice IMR.

A system of regular updates for patients with long term illness should be established between the practice and the NELFT District Nursing Service and Community Treatment Team.

An IMR recommendation for the North East London Foundation Trust concerning the large number of callouts to Roger for catheter care relates to clinical decision making and is not included here. NELFT are requested to note and act on this recommendation.

The Trust should publicise the Community Specialist Multiple Sclerosis Nursing Service within Barking & Dagenham among GPs, district nurses, Adult Social Care, allied professionals, and patients and families affected by the disease as soon as possible. This should be completed no later than December 2016. (This recommendation has been completed)

Details of the allocated MS Nurse for each Directorate within NELFT should be identified to the relevant District Nursing teams to ensure timely referrals may be made when additional support may be required to an individual patient.

**Recommendations Arising from Sarah's Contact with Agencies:**
The Safeguarding Adult Board Training Sub Group should note the findings of this review and ensure that learning is disseminated and included in future safeguarding training and that staff receive separate training on domestic abuse, and assessment and support of carers.

It is recommended that a review takes place of the current hoarding policy and practice guidance which takes into account the London Fire Brigade Clutter Rating Guide and the British Psychological Society (2015) A Psychological Perspective on Hoarding DCP Good Practice Guidelines to ensure the policy represents up to date best practice.

Agencies should ensure that staff are aware of the local authority safeguarding policy section dealing with hoarding, and have a greater awareness of the impact of hoarding including on mental health and day to day functioning, home safety, and the steps to take where hoarding is identified.

Training should be provided to enhance the skills of all staff involved in undertaking carer assessments to ensure the willingness and ability of a potential carer and to encourage the uptake of carer training as recommended by NICE Guidelines [NG27] December 2015. The staff must have previously undertaken domestic abuse training to qualify for this.

The GP practice should ensure that they hold a register of patients who have caring responsibilities to inform any need for additional support. The register should be reviewed annually to ensure its accuracy. Each carer should have an annual review as a minimum to assess their needs.

**Recommendations Relevant to both Roger and Sarah’s Agency Contact:**

The Clinical Commissioning Group should note the findings and recommendations within this review and ensure that their commissioning processes and procedures set robust requirements of providers which address the concerns raised which are relevant to the service sector. This should include 'Did Not Attend' policies, staff training in respect of safeguarding, and domestic abuse.

All staff who have responsibility for adult assessments or visiting patients/service users in their own homes must have domestic abuse training suitable for their role which also includes elder abuse by partners and family carers, and high risk groups such as those with disabilities and/or mental illness. It is recommended that this training is mandatory.

Where a request for Garden Cultivation is requested the housing officer should complete the application form with the tenant at their property to ensure that the home is also inspected.

At the time contractors carrying out repairs or at the annual inspection made by the gas engineer the housing officer should be updated within 24 hours where a property is found to be in an unacceptable condition.

There should be a strengthening of the Think Family approach when caring for adults with care and support needs. Staff should use professional curiosity regarding carers,

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5 The Local Authority may wish to consider Carrying Out Assessments Under the Care Act training course provided by Carers UK: [http://www.carersuk.org/for-professionals/training/upcoming-courses/trusted-assessor-carrying-out-assessments-under-the-care-act-16-nov](http://www.carersuk.org/for-professionals/training/upcoming-courses/trusted-assessor-carrying-out-assessments-under-the-care-act-16-nov)
being aware of the carer’s needs assessment and outcome as this affects patient care.

• Taking the learning from this Review, Barking, Havering & Redbridge University Hospitals NHS Trust should strengthen their Patient Access Policy ‘Did Not Attend’ section with the addition of issues to consider when vulnerable adults do not attend, and guidance to staff of steps to take when they have concerns.

Recommendations Arising from Agency Processes and Practice:

• The Safeguarding Adult Board Learning and Development Board sub group should examine supervision templates used by agencies to ensure that safeguarding is a routinely discussed topic, and on completion any relevant changes required made.

• All practitioners should ensure that their case recording is detailed and clear and all assessments are reflective and state reasons for assessment decisions backed up by examples which provide evidence for professional judgement. Quality should be addressed by management in supervision and via annual file audits.

• Up to date and easily accessible information and resources available for front line practitioners around hoarding, domestic abuse, and coercive and controlling behaviour should be reissued and publicised to staff.

• There should be regular audits of staff training to ensure that all safeguarding training is completed and up to date and that staff are confident in the execution of procedures and in the ability to challenge partners when necessary.

• A scanned copy of all service user signed documents should be uploaded onto their electronic record within 7 days of signing to ensure clarity and confirmation of agreements and provision of services.

• All Housing Department staff should complete Adult Safeguarding Training and Domestic Abuse Training.

• Social Worker and other support worker’s details to be recorded on the Housing Department contact screen by housing officers and rents officers within 24 hours of capturing this information.

• All first Tenancy Audits to be completed for all Council properties by the existing deadline of 30th November 2016. (At the time the Review was completed this recommendation was partly completed).

• The District Nursing Service should review their recording system to ensure that there is electronic back-up to handheld patient notes which can be shared by nurses prior to and after visiting patients and to record any safeguarding concerns or alerts.

• To continue the roll-out across all NELFT directorates, of agile working to allow staff to remotely access electronic patient records and update accordingly.