BE SAFE BOLTON STRATEGIC PARTNERSHIP

And

BOLTON SAFEGUARDING ADULTS BOARD

DOMESTIC HOMICIDE REVIEW (DHR)

Incorporating

SAFEGUARDING ADULTS REVIEW (SAR)

Margaret

Died March 2019

EXECUTIVE SUMMARY

23rd February 2022

Chair and Author Paul Cheeseman

Supported by Ged McManus

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Be Safe Bolton Strategic Partnership [the statutory Crime and Disorder Partnership] and Bolton Safeguarding Adults Board in reviewing the homicide of Margaret a resident in their area. This report also includes the results of a Safeguarding Adult Review [SAR] conducted in conjunction with the domestic homicide review [DHR].

1.2 The following pseudonyms have been used in this review for the victim, and perpetrator to protect their identities and those of their family members:

Name	Relationship	Age	Ethnicity
Margaret	Victim and wife of Aaron	80	White British
Aaron	Perpetrator and husband of Margaret	88	White British
Mary Ellen	Eldest daughter of Aaron and Margaret	Adult	n/a
Ron	Son of Aaron and Margaret	Adult	n/a
May	Youngest daughter of Aaron and Margaret	Adult	n/a
George	Grandson of Aaron and Margaret	Adult	n/a
Shirley	Granddaughter of Aaron and Margaret	Adult	n/a
Address 1	Home address of Aaron and Margaret and scene of the homicide.	n/a	n/a

1.3 In February 2019 Aaron was admitted to hospital in Bolton. Margaret then disclosed to a community nurse that Aaron had perpetrated domestic abuse on her and she did not feel safe with him and did not want him to come home. Following a hospital discharge planning process Margaret later agreed to Aaron returning home with a package of care. He killed Margaret by use of a knife at their home a few days after his discharge from hospital.

1.4 The DHR panel wish to extend their condolences to the family and friends of Margaret on their tragic loss.

1.5 On 7 May 2019 Be Safe Bolton Strategic Partnership [Core Screening Panel] determined the death of Margaret met the criteria for a domestic homicide review [DHR]. The panel also agreed that a recommendation should be made

to Bolton Safeguarding Adults Board to hold a SAR which would run in parallel with the DHR. The Home Office were informed, and an independent domestic homicide review was commissioned. All agencies that potentially had contact with Margaret and Aaron prior to the homicide were asked to secure their files.

1.6 The first meeting of the DHR panel was held on 14 October 2019 followed by a further two meetings after which the DHR/SAR process was significantly delayed by the Covid19 crisis. The panel resumed work in August 2020 and then held two further on-line meetings during which they refined the covering report and met members of Margaret's family. The DHR process was completed on 23 March 2021 when Bolton Be Safe and Bolton Adult Safeguarding Board received the covering report after which it was sent to the Home Office Quality Assurance Panel.

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Agency	IMR[1]	Chronology	Report
Greater Manchester Police [GMP]			√
Greater Manchester Fire and Rescue Service [GMFRS]			√
Bolton Council Adult Services	√	√	
Bolton NHS Foundation Trust	√	√	
NHS Bolton CCG	√	√	
Greater Manchester Mental Health NHS Foundation Trust	√	√	
Bolton Housing Options			√

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review which includes a chronology.

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Review Panel Members

Name	**Job Title**	**Organisation**
Sharon Boardman	Deputy Adult Safeguarding Lead	Greater Manchester Mental Health NHS Foundation Trust
Paul Cheeseman	Chair and Author	Independent
Zylla Graham	Det. Inspector	GMP Serious Case Review Team
Suzanne Hilton	Chief Executive	Age UK
Tony Kenyon	DHR Lead	Be Safe Bolton
Martina Kingscott	Assistant Director of Nursing	Bolton NHS Foundation Trust
Paul Lee	Director of Operations	Integrated Care Partnership Bolton Council[2]
Ged McManus	Support to Chair	Independent
Mike Robinson	Associate Director of Governance and Safety	Bolton CCG
Gill Smallwood	Chief Executive	Fortalice [Providing front line services for women, families and children affected by domestic abuse and violence]
Rachel Tanner	Managing Director	Integrated Care Partnership Bolton Council
Charlotte Thaker	Manager	Bolton Adult Safeguarding Board
Michelle Tynan	Advisor on Adult Social Care	Co-optee

3.2 The panel met five times[3] and the review chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny.

[2] Paul Lee replaced Rachel Tanner as the Integrated Care Partnership panel member from January 2021.

[3] The final two panel meeting were conducted remotely using Microsoft Teams as face-to-face contact was not possible because of Government restrictions.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 Paul Cheeseman was appointed as the Independent Chair and Author. He was supported by Ged McManus. Both are independent practitioners who have chaired and/or written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. Neither has been employed by any of the agencies involved with this review nor are they connected to Be Safe Bolton or Bolton Safeguarding Adults Board both of which judged they had the necessary experience, skills and independence to undertake the review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The Panel settled on the following terms of reference and agreed the review should cover the period from 1 November 2018 to a day in Spring 2019 when the homicide occurred.

1. Did your agency identify that either Margaret and/or Aaron were adults needing care and support? How and when were their needs identified and what services did your agency provide to them both?

2. Did your agency have any information that indicated Margaret and/or Aaron might be at risk of either neglect or abuse including the risk of domestic abuse? What did your agency do in response to such information?

3. Did your agency consider conducting a Mental Capacity Act assessment on Aaron?. If so, what prompted this and what was the outcome?

4. Did your agency consider whether use of the Mental Health Act may be appropriate with reference to Aaron? If so, what prompted this and what was the outcome?

5. Did your agency have any information that Aaron might present a risk to anyone else other than Margaret? What did your agency do in response to such information?

6. Did your agency document an assessment of any risk Aaron might present to Margaret or any other person? If not, why not?

7. Did your agency share any of the information above with any other agency including making a referral to MARAC? If not, why not?

8. What involvement (if any) did your agency have in relation to the decision not to conduct a S42 safeguarding enquiry in respect of Margaret? Why was that decision made? Was that decision in compliance with the Care Act and/or your multi-agency Safeguarding policy?

9. What involvement (if any) did your agency have in relation to the decision to hold a multi-disciplinary meeting to discuss the concerns that had been raised in respect of Margaret and Aaron? Why did that multi-disciplinary meeting not take place? Did the decision not to hold a multi-disciplinary meeting have an impact upon the risk that Margaret faced?

10. What involvement (if any) did your agency have in relation to the decision to discharge Aaron from hospital on 20 March 2019? Who was involved in the discussions and decisions to discharge Aaron (including any family members)? What assessments were made in relation to that decision and how were they documented?

11. Did any assessments relating to Aaron's discharge from hospital identify that Margaret was at risk from Aaron? If any risk was identified what plans did your agency have to remove, reduce or manage that risk?

12. Were the services your agency offered Margaret and Aaron accessible, appropriate, and sympathetic to their needs? Were there any barriers in your agency that might have stopped Margaret from seeking help for the domestic abuse?

13. What knowledge or concerns did Margaret's family or friends have about her relationship with Aaron? Did they have any information which might have indicated there was any domestic abuse in the relationship? If so, did they know what to do with such information?

14. Was there any evidence that Margaret and/or Aaron had issues with managing debt? If so, to what extent did that impact upon their relationship?

15. What were the circumstances of any housing application that Margaret and/or Aaron made? To what extent were the couple's living arrangements impacting upon their relationship?

16. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Margaret and Aaron?

17. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Margaret and Aaron, or on your agency's ability to work effectively with other agencies?

18. How effective was your agency's supervision and management of practitioners involved with the response to the needs of Margaret and Aaron and did managers have effective oversight and control of the case?

19. Were single and multi-agency policies and procedures, followed; are the procedures embedded in practice and were any gaps identified?

20. What learning has emerged for your agency?

21. Are there any examples of outstanding or innovative practice arising from this case?

22. Does the learning in this review appear in other domestic homicide reviews commissioned by Be Safe Bolton Strategic Partnership?

6. SUMMARY CHRONOLOGY

6.1 Margaret worked as a ward sister at a [now closed] hospital before she retired. She suffered poor health and after retirement was paraplegic and mobilized in an electric wheelchair. Aaron worked in the building trade and as a scaffolder before his retirement. He needed the use of sticks and a scooter. The couple were married for 59 years and had a son Ron, and daughters Mary Ellen and May.

6.2 Ron, Mary Ellen and May engaged with the review and, with other family members, met the panel Chair. Mary Ellen, May, and Shirley spoke to the panel during an on-line meeting after the covering report was drafted. These meetings provided the DHR panel with important background information that helped build a picture of Margaret and Aaron's relationship.

6.3 May recalled that some years ago when she still lived at home she witnessed her parents arguing and Aaron coming home from work drunk. May said that even after Aaron stopped drinking he could be 'massively volatile'. She also witnessed Aaron getting ready to 'go for' Margaret about 4 or 5 times during which May had intervened. Although May did not witness Aaron hitting her mother, she considered it likely he had.

6.4 May spoke about an event some years ago when Aaron assaulted her and put marks around her neck after pushing her against a wall in the house when he had argued with her. After this event May said she tried to persuade Margaret to leave Aaron. Margaret would not leave him and May felt they had been together for so long they just could not separate.

6.5 Ron and Mary Ellen had not witnessed physical aggression by their father. However, they said Margaret and Aaron used to swear at each other and could be verbally abusive. As well as verbal and physically aggressive behaviour to her, May also told the review Aaron was cruel to animals.

6.6 There was no evidence before 2019 that Margaret had reported domestic abuse to any agency. Although they fall outside the timescale of this review, there were two incidents that were noteworthy. In 2008 Margaret was assessed by a psychological therapist. She disclosed a number of issues relating to family dynamics the nature of which are not recorded.

6.7 During the assessment process she became upset. Aaron came in to the session and shouted at her. He also became verbally aggressive to the practitioner. After the session, the therapist contacted Margaret to arrange a further appointment. Margaret told the practitioner tensions between her and Aaron had dissipated and she no longer required input from a psychological therapist.

6.8 In November 2015 a referral was made for Margaret while she was in hospital for a matter not connected to this DHR. She was reported to be in a low mood and as a result of the referral was seen by the Rapid Assessment Interface and Discharge Team [RAID] team. A referral was then made to Age UK.

6.9 In late 2018 and early 2019 Aaron became increasingly forgetful. Following tests he was admitted to Bolton Hospital on 21 February 2019 with acute kidney injury. The family felt Margaret did not want Aaron to return home. They felt she might be holding something back and asked her what she was frightened of. She did not say whether she was frightened of anything. Although the family had no knowledge of physical abuse perpetrated by Aaron on her, they felt Margaret would only tell the family what she thought they wanted to hear.

6.10 After a period of assessment Aaron was transferred to a medical ward at Bolton Hospital. He was reviewed by a consultant who noted Aaron was experiencing delirium and was pleasantly confused. A scan of his head was conducted that disclosed small vessel disease[4] with no acute pathology. On 28 February 2019 Aaron was reviewed by a consultant who noted the kidney injury had resolved, however he remained confused.

6.11 In view of Aaron's history of deteriorating memory and cognition, the ongoing delirium was assumed to be related to undiagnosed dementia. Aaron was assessed as medically fit for discharge while requiring social and therapy assessment and the hospital ward made a referral to Adult Services for an assessment in readiness for discharge planning.

6.12 In text messages sent by Margaret to her daughter Mary Ellen, Margaret said she could not take Aaron home. Margaret also told a social worker [SW1] she did not want Aaron home during a conversation at the hospital. SW1 felt a mental capacity assessment should be undertaken on Aaron because he declined help and support. This action was agreed by SW1's deputy manager as well as the allocation of the case to a qualified social worker [SW2] for complex planning.

6.13 On 6 March 2019, while at Bolton Hospital, Aaron became wandersome, aggressive and assaulted a nurse and a health care assistant. The assaults were not reported to the police. By 12 March, Aaron was reported as being

[4] Small vessel disease, or SVD, is a major cause of dementia and can also worsen the symptoms of Alzheimer's disease. It is responsible for almost half of all dementia cases in the UK and is a major cause of stroke, accounting for around one in five cases. Patients with SVD are diagnosed from brain scans, which detect damage to white matter a key component of the brain's wiring.
https://www.sciencedaily.com/releases/2018/07/180704161504.htm

settled and 'oriented to place and person'. On 13 March SW2 met with Aaron during which time Mary Ellen also visited. SW2 had a conversation with her and noted, among other things, that Aaron should be referred to the memory clinic post discharge by a doctor on the ward.

6.14 On 14 March 2019 a community nurse visited Margaret at address one. During the visit Margaret disclosed that Aaron was volatile and aggressive when carers were not present and she felt unsafe. She also requested that his discharge from hospital should be postponed as she felt a discharge planning meeting was required so she could highlight her concerns. The community nurse passed this information to SW3 the duty social worker in Bolton Council who agreed to notify the allocated social worker [SW2]. Later the same day Margaret contacted the hospital ward by telephone and said that she did not want Aaron home.

6.15 The following day a social worker from the Adult Safeguarding team [SG SW] spoke to the community nurse. The community nurse informed SG SW that Aaron had presented as violent towards Margaret and to nursing staff on the ward. The community nurse said that Margaret had indicated she did not want him to return home even with a care package: she could not cope.

6.16 SG SW then spoke to SW2 and told SW2 what Margaret had said about being unable to cope with Aaron because of his violent episodes. SW2 explained to SG SW that Aaron had delirium and, since he had been in the ward, he had not been violent. SW2 was to arrange a multi-disciplinary meeting [MDT] to address the issues in more detail so that SW2 could confirm the most appropriate discharge destination for Aaron.

6.17 SG SW noted the concerns expressed by Margaret did not require progression to a s42 safeguarding enquiry under the Care Act 2014[5] due to the following rationale.

(i) [Margaret] Is independent with all her support needs except for her catheter care.

(ii) [Margaret] Has experienced aggression and violence by Aaron. It would appear he is not fully aware of his actions and aggressive outburst due to his health needs of dementia and delirium. He is currently in hospital and requires a needs assessment with consultation with Margaret to identify the appropriate discharge destination.

[5]The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

(iii) [Margaret] Is able to protect herself as she has voiced her wishes and views about M1 not returning home.

6.18 SG SW then spoke with Margaret and she repeated to SG SW what she had told the community nurse: that she could not cope with Aaron returning home from hospital and would like alternative care arrangements for him. The same day SG SW spoke with the Deputy Safeguarding Team Manager who confirmed the episode did not require progression to a section 42 enquiry and agreed with the actions and advice that had been given. The Safeguarding Team manager then closed the contact document for Margaret as 'signposted to other services'.

6.19 On 15 March 2019 a request was made from the ward at Bolton Hospital for a dementia/mental health assessment. A consultant psychiatrist advised that it was not appropriate at that time to assess Aaron for dementia on a background of a resolving delirium as it would be difficult to assess the severity.

6.20 The same day SW2 spoke to Margaret by telephone. Among other things, Margaret told SW2 she was wheelchair bound and vulnerable and said Aaron had tried to hit her previously and displayed aggressive behaviour towards her. Margaret said Aaron was not safe at home. She said she did not feel safe living with him. Margaret requested Aaron should go into Wilfred Geere[6] House for further assessment. Alternatively, she wanted a planning meeting before Aaron was discharged from hospital.

6.21 SW2 then spoke to Aaron and he explained that he did not try to hit Margaret and would not do that. He said he wanted to go home. SW2 noted Aaron had good insight and seemed to have capacity about his discharge destination. Therefore SW2 did not carry out a formal mental capacity assessment.

6.22 Adult Services notes from 15 March 2019 record a telephone conversation between Margaret and SW2 in which she agreed Aaron could be discharged home with a care package of support by the reablement team. Margaret was asked if she still wanted a discharge planning meeting. She declined and felt that Aaron should be discharged home to see if they could manage. This occurred on 20 March 2019.

6.23 The Reablement Service, who were then responsible for delivering the package of care to Aaron, completed a service risk assessment which stated the following.

[6] Wilfred Geere House offers accommodation for persons who require nursing or personal care, Dementia, Caring for adults over 65 years.

i. The doctor suggested delirium and a referral to the memory clinic is to be made.

ii. Aaron has shown aggression at one time on the ward towards staff, carers to be mindful of this.

iii. Margaret has stated that she would telephone the police if Aaron presents with any signs of aggression towards her.

iv. Staff should report any concerns to the office (reablement).

6.24 Over the following days the Reablement Service continued to visit address 1 and provide care and support to Aaron. No concerns were reported and it appeared that limited support was required by Aaron. The night before Aaron killed Margaret, Ron described how he had received two missed calls from his mother. He sent her a text message asking if she was OK. In response Margaret sent a text message to Ron in which she said.

'if he raises his sticks to me it is 999'.

6.25 At 08:12 hours the following morning North West Ambulance Service [NWAS] reported to GMP they had received a call from address 1. Aaron told NWAS he had argued with Margaret and stabbed her in the stomach. Police officers and paramedics attended and at 08:19 hours found Margaret deceased at address 1 with stab wounds.

6.26 Aaron was arrested and charged with Margaret's murder. After his arrest and before he could stand trial Aaron was assessed as suffering from dementia. He was therefore unfit to enter a plea or stand trial. Consequently, in late 2019 a finding of fact hearing was held before a jury at a Crown Court. The jury found Aaron had committed the act he was accused of. The judge imposed a hospital order[7] on Aaron.

[7] Under S37 of the Mental Health Act 1983 is an alternative to a prison sentence and a court can make an order that a person is detained in hospital if it thinks this is the most appropriate way of dealing with them.

7. FINDINGS

7.1 Although Margaret and Aaron had health issues, the panel found no evidence either of them was at risk of neglect nor had unmet needs for care and support before Aaron was admitted to hospital. Before Margaret made a disclosure to a community nurse on 14 March 2019, the review panel found no evidence that agencies had any direct knowledge she was at risk of domestic abuse from Aaron.

7.2 There were two occasions outside the timescale of this review when domestic abuse might have been an issue between Aaron and Margaret. The first of these related to the incident in February 2008 when Aaron was verbally aggressive to her in the presence of a professional. Although Margaret gave assurances that tensions had dissipated, the panel felt there was a lost opportunity here to consider whether carer fatigue had manifested into domestic abuse and to ask Margaret's GP to explore this at her next appointment.

7.3 The second historic occasion was in 2015 when, during an unrelated hospital stay, Margaret disclosed she was lonely at home. Because there were no other indicators, the review panel felt it was reasonable on this occasion that professionals did not consider domestic abuse. However, while they found no evidence this was the case here, the panel feel it is important to recognise that isolation is something that many victims of domestic abuse can experience and may be deliberately engineered by perpetrators.

7.4 Although members of the family had different recollections, it is clear there were aspects of Aaron's behaviour going back some years that would now be recognised by professionals as indicators of domestic abuse. This included Aaron being ready to 'have a go' at Margaret and May suffering physical abuse from him when he put his hands around her throat. Information provided by May, that Aaron was cruel to animals, was significant because of the well-established connections between such behaviour and domestic abuse.

7.5 The panel's professional backgrounds and access to material for this review mean they recognise Aaron's behaviour amounted to domestic abuse. The family did not and could not reasonably have been expected to have reached such a conclusion before these events. A significant lesson from many other reviews of domestic homicides is that families often hold pieces of information which, if known to professionals, might help them identify a pattern of domestic abuse.

7.6 Text messages between Margaret and Mary Ellen illustrate Margaret did not feel able to cope if Aaron returned home from hospital. She repeated this position when she spoke to SW1 and also gave that social worker information

about his disorientated behaviour. SW1 felt there might be some cognitive defect and hence a mental capacity assessment should be undertaken.

7.7 The responsibility for that assessment rested with SW2 who took over the case from SW1. SW2 did not undertake a mental capacity assessment despite a clear action having been agreed with SW1 for this to happen. The review panel believe that was an inappropriate decision. However, they also recognised other professionals could have assessed Aaron's mental capacity while he was in hospital. There is no record to indicate whether that happened. If Aaron had been assessed as lacking capacity, then a 'best-interests decision' might have led to a meeting between professionals, Margaret, and her family to consider the safe discharge of Aaron.

7.8 Although a consultant psychiatrist gave advice about Aaron's mental health following a request from the hospital, it is clear from what the family says that it was not passed on to them. While the panel recognise there are data protection considerations, they feel it is disappointing the family were not given a sufficient level of feedback to help them fully understand what was happening in respect of Aaron's mental health.

7.9 There are a number of references within agency records of the need to refer Aaron to the memory clinic after his discharge from hospital. The family were given assurances a referral had been made. It was only when this review panel specifically asked for the facts to be checked that it was found no referral for Aaron had ever been recorded. The panel feel it is disappointing for the family that did not happen. All the agencies that had a part to play in Aaron's care could have made a referral to the memory clinic or checked to establish if a referral had been made.

7.10 There were missed opportunities after Aaron was admitted to hospital for agencies to identify, document and assess the risk of domestic abuse to Margaret. While the review panel feel the community nurse who received the first direct report from Margaret on 14 March 2019 acted correctly in referring that disclosure to SW SG, an opportunity was missed to record more information from Margaret about the nature of her abuse.

7.11 Margaret made a further disclosure of domestic abuse when she spoke to SW2 who did not appear to recognise what Margaret was describing was actually domestic abuse. Neither SW SG nor SW2 completed a DASH risk assessment. They should have followed guidance and done so. The fact they did not, meant an opportunity was missed to record, assess and formulate the risk that Margaret faced from Aaron.

7.12 The review panel also found SW2 had no justification nor consent from Margaret for sharing with Aaron the information she had given about the

domestic abuse she suffered. Disclosing information without justification about domestic abuse to perpetrators can increase the risk victims face.

7.13 Domestic abuse is often mistakenly believed to be something that does not involve nor impact upon the elderly, both as victims and perpetrators. That is a perception or belief that is wrong as illustrated by this and an increasing number of other cases nationally. However, that was not the reason the domestic abuse was missed in this case. The panel are clear, the core lesson here is that professionals simply did not recognise what they were being told about was domestic abuse. It appears professionals may have mistakenly treated Aaron's abusive behaviour as connected to, and a manifestation of, his underlying medical condition.

7.14 Although the information provided by the community nurse to SW SG amounted to domestic abuse and should have been recognised and recorded as such, it also met the criteria for a S42 safeguarding enquiry. The decision not to progress in this direction was inappropriate and meant there was no formal investigation to establish the extent of the disclosure and the outcomes and support that could be offered to Margaret. Several assumptions, some incorrect or inappropriate, appear to have led to the decision not to progress to a S42 enquiry.

7.15 There is variance between the accounts the family have given and the recollections and notes of SW2 concerning the hospital discharge planning process. The review has not been able to establish what led Margaret to apparently change her mind, consent to Aaron returning home and decline the offer of a discharge planning meeting. While the panel have not been able to reconcile the variance in accounts they recognise that, even if that planning meeting had been held, it may not have led to another outcome. Aaron may still have been discharged home with a package of care.

7.16 However, this was a complex case. Margaret had told professionals she was a victim of domestic abuse. Those concerns were never properly addressed, because a decision was made not to hold a S42 enquiry. They should still have been recognised as significant issues that had a bearing upon the discharge planning decision. They were not, and that was a missed opportunity to assess the risk to Margaret. A discharge planning meeting, rather than a series of telephone calls between SW2 and the family, would have been a much more appropriate and effective way of fully exploring those issues.

7.17 When he was discharged from hospital, the review panel concludes that the Bolton Council Social Care Service User Risk Assessment [while it may have been appropriate for a simple discharge from hospital with an underlying health condition] did not adequately identify and formulate the risk of domestic abuse that Margaret faced from Aaron. Neither was the plan to

protect Margaret appropriately robust relying almost entirely upon Margaret using her own initiative to contact the police.

8. LEARNING

8.1 Agencies Lessons

8.1.1 Bolton NHS Foundation Trust

- Exploration as to who is responsible for initiating MARAC/Domestic Abuse assessments.
- The need to make more detailed explorations of domestic abuse disclosures particularly as to the degree of violence used.
- The need for further training on 'making safeguarding personal'.
- The need to complete mental capacity assessments.
- The need for professionals to feel confident about challenging decisions.

Bolton Council Adult Services

- The use of language in notes can be interpreted in different ways.
- The safeguarding referral was managed within the set timescales.
- A number of assumptions were made about the time the alleged abuse occurred and that this was directly related to Aaron's period of ill health. A section 42 enquiry should have been undertaken to formally investigate and establish the extent of alleged aggression from Aaron.
- The MARAC process was not considered and there needs to be further clarity about the referral process and who is responsible for referring once a concern for domestic abuse has identified.
- A Mental Capacity Act assessment should have been carried out.
- An MDT meeting could have been established and subsequently recorded as to whether an assessment was appropriate prior to discharge and if not a clear rationale.
- Further discussion is required when any discharge to assess bed is identified.

Bolton Clinical Commissioning Group

- This case demonstrates that domestic abuse or violence can and does occur with all age groups throughout life and specifically to older people.
- Vulnerability and frailty can be more than physical and clinical and consideration needs to be taken from a safeguarding adult point of view if a person is vulnerable, who is an adult at risk, with care and support needs and agencies need to establish if a person has capacity or not to protect him or herself from harm or exploitation.

8.2 The Domestic Homicide Review Panel's Lessons

8.2.1 The DHR panel identified the following lessons. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson One-Panel Recommendation Two Applies
Narrative Margaret disclosed to a community nurse that Aaron was violent and aggressive. She said she did not feel safe. Margaret also told a social worker she was vulnerable and that Aaron had tried to hit her and displayed aggressive behaviour towards her. The behaviour Margaret described fits the government definition of domestic abuse. Professionals did not record nor deal with Margaret's disclosures as domestic abuse and did not follow multi-agency policies and procedures for handling disclosures of domestic abuse. Instead they appeared to treat Aaron's abusive behaviour as a manifestation of his medical condition.
Professionals should be able to recognise when information they receive is a disclosure of domestic abuse. They should understand how to handle and record this information in accordance with multi-agency policy and procedures on domestic abuse.

Lesson Two-Panel Recommendation One Applies
Narrative Margaret and Aaron were elderly residents of Bolton [aged 80 and 88 respectively]. The way in which Margaret's disclosures of domestic abuse were handled was not appropriate [as set out in lesson 1]. While age is not the reason domestic abuse was missed in this case, professionals might not always recognise that elderly people can be both victims and perpetrators of domestic abuse.
Lesson Professionals need to recognise the false assumption that domestic abuse ends after a certain age. Policies and procedures need to acknowledge that the experiences of older victims of domestic abuse may be markedly different from those in other age groups.

Lesson Three-Panel Recommendation Two Applies
Narrative When the disclosure of domestic abuse was made by Margaret insufficient detail was obtained. This meant assumptions were made about when and how the abuse occurred. Those assumptions led to opportunities being missed to formulate and assess risk and hence protect the victim.
Lesson When receiving disclosures of domestic abuse it is important professionals obtain sufficient information from the victim and do not make assumptions so the opportunity to formulate risk is not missed.

Lesson Four-Panel Recommendation Two Applies
Narrative Although a safeguarding alert was submitted it was decided not to proceed to a S42 enquiry. That decision was inappropriate and was based upon incomplete information and assumptions that were incorrect. Margaret met the criteria for a S42 enquiry and not proceeding with one meant there was no formal investigation to establish the extent of the disclosure by Margaret and hence the opportunity to protect Margaret from further harm. The decision not to proceed with a S42 enquiry was not shared with all agencies and professionals concerned with the care of Aaron.
Lesson In order to make appropriate decisions and prepare plans to ensure victims are protected, professionals should have a thorough understanding of relevant legislation and policy and as much accurate information as is available.

Lesson Five-Panel Recommendation Two and Three apply
Narrative Margaret made an initial disclosure of domestic abuse and then shared the same information with other professionals involved in the discharge from hospital process. Margaret told professionals she did not want Aaron to come home and did not feel safe. She requested a planning meeting before he was discharged. The risk to Margaret was not documented and assumptions were made about the nature of the abuse and it was assumed his behaviour was linked to Aaron's temporary confusion.

Lesson

It is important that, when victims of domestic abuse make disclosures, risk is documented and assessed. It is important that decisions are not made about the protection of victims solely on the assumption they are no longer at risk or are able to protect themselves from such risk.

Lesson Six-Panel Recommendation Three and Six apply

Narrative

The professional responsible for discharge planning spoke to Margaret by telephone who [they said] then agreed Aaron could be discharged home and she no longer needed the discharge planning meeting. The family have provided a different perspective. The review panel have not been able to reconcile the different accounts.

Lesson

The failure to hold a discharge planning meeting was the result of inappropriate decision making. The discharge policy was not followed in this case. Better communication is needed in the future so that the views of patients, carers and families are understood and considered and they understand what is happening.

Lesson Seven-Panel Recommendation Two Applies

Narrative

When Aaron was discharged, needs assessment documentation was completed. This contained a reference that Aaron had been physically aggressive to staff but did not contain any information about the disclosure of domestic abuse he had perpetrated upon Margaret. That information was then repeated within a service user risk assessment document that also did not record the risk of domestic abuse [although it did refer to Margaret telephoning the police if he presented with any signs of aggression towards her]. This meant the plan to protect Margaret when Aaron returned home was weak and relied solely upon the reablement workers feeding any concerns back and Margaret protecting herself by making a telephone call to the police if she felt threatened.

Lesson

Professionals should ensure the risk of domestic abuse is recorded, that risk is formulated and shared with other professionals who may have a role in protecting the victim and robust plans developed to protect the victim. This will ensure all professionals fully understand the risk, the plan to protect the victim and their roles in it.

Lesson Eight-Panel Recommendation Two applies
Narrative Margaret disclosed to a professional that she had been abused by Aaron. The same professional revealed that disclosure to Aaron. The professional did not seek the consent of Margaret and it did not appear the circumstances were such that a disclosure was necessary without first seeking consent.
Lesson Professionals should ensure they follow the principles of making safeguarding personal and do not reveal to perpetrators disclosures by victims except in very exceptional circumstances. Failure to follow these principles can increase the risk to victims.

Lesson Nine-Panel Recommendation Four applies
Narrative The family of Margaret had different historic experiences concerning Aaron and his behaviour. While there were happy times in childhood, some aspects of Aaron's behaviour were either direct instances of domestic abuse or indicators that might have led to further enquiry if disclosed to a professional [For example, May's recollections of his behaviour towards her mother, placing hands around May's throat and Aaron's cruelty towards animals].
Lesson In many cases of domestic homicide, reviews find that families hold information, like pieces of a jigsaw, that if disclosed or reported to professionals might have allowed them to identify and assess the risk of domestic abuse. As in this case, families very often do not recognise the significance of the information they hold or if they do, for many reasons they do not consider sharing it with professionals or feel uncomfortable or disloyal for doing so.

9. RECOMMENDATIONS

9.1 Agencies Recommendations

9.1.1 The agencies recommendations are set out within tables at Appendix A.

Appendix A

Agency Action Plans

Review Panel

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board will seek assurances from the relevant partner agencies that they have reviewed current policy and practice to ensure that it recognises older people can be victims and perpetrators of domestic abuse and there are appropriate pathways in place for handling disclosures of domestic abuse from older people.	1.1 Focussed monitoring of the relevant recommendations within the Bolton Council Adult Social Care, Bolton NHS Foundation Trust and Bolton CCG single agency action plans which already address this learning. 1.2 Chairs of Bolton Strategic Partnership and Bolton Safeguarding Adults Board to write to relevant agencies and request responses to provide the relevant assurances and responses will be monitored. 1.3 Create a learning summary addressing this aspect of learning and	• Monitoring reports for single agency action plans • Reports and responses from agencies. • Learning Summary • Report on Safeguarding Adults Week	Professionals always recognise that elderly people can be both victims and perpetrators of domestic abuse. Policies and procedures acknowledge that experiences of older victims of domestic abuse may be markedly different from those in other age groups.	Bolton Council Head of Service for Adults Bolton Council Head of Community Safety LOCAL SCOPE REGIONAL SCOPE

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
		circulate to agencies being asked to respond. 1.4 Safeguarding Adults week focussing on domestic abuse targeted at staff across the partnership to access training, pod casts, 'Eyes Wide Open Campaign' and Evergreen Training which covers DA provision for over 55's.			
2.	Be Safe Strategic Partnership and Bolton Safeguarding Adults Board to review multi-agency training for Domestic Abuse and Safeguarding Adults to ensure that it addresses the learning from this review, particularly relating to domestic abuse in older people, including; how to receive disclosures about	2.1 Be Safe and BASB to review the training offer to the workforce, ensuring that the training includes all the learning themes set out in the recommendation and that professionals have clarity regarding how adult safeguarding, domestic abuse and health policies and procedure are interrelated. 2.2 A learning summary will be prepared covering	• Reports on review of training offer to the workforce. • Changes to learning objectives. • Amended DAV handbook	When following policies, protocols and procedures, professionals will be able to make the connections between adult safeguarding and domestic abuse, how they are interrelated and how they can be operated separately and in parallel. Professionals will have a thorough understanding of relevant legislation and	Bolton Council Head of Service for Adults Bolton Council Head of Community Safety LOCAL SCOPE REGIONAL SCOPE

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	domestic abuse, how to complete DASH risk assessments and the levels of detail professionals should seek, identifying when an enquiry under section 42 of the Care Act 2014 might be triggered and understanding the principles of Making Safeguarding Personal.	the events of the case and how they relate to training. 2.3 To review the DAV handbook to ensure that the information is assessable and comprehensive and reflects any changes process made following this review.		policy and as much accurate information as is available.	
3.	Bolton Safeguarding Adults Board will seek assurances from Bolton NHS Foundation Trust and Bolton Council that a review of hospital discharges procedures will be undertaken to ensure where appropriate, voices of the next of kin and carers are included in discharge planning giving consideration to	3.1 Multi- agency task and finish group to explore learning from recommendation and review relevant Hospital Discharge procedures 3.2 Findings of the review and any changes to procedures to be reported back to Bolton Adult Safeguarding Board and shared with Be Safe Bolton Strategic Partnership (CSP)	Report of findings and recommendations of Task & Finish Group	Policies ensure that the views of next of kin and carers are considered and that the risks they may face as a consequence of someone being discharged from hospital are always recognised, formulated and managed.	Bolton Council Head of Service for Adults

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	complexity and/or safeguarding issues.				
4.	Be Safe Bolton Strategic Partnership and Bolton Safeguarding Adults Board reviews the information it produces and distributes to the community about domestic abuse and ensures it informs families about the need to report concerns about domestic abuse and the pathways a family can take when they hold such information.	4.1 As part of the review of the DAV strategy and DAV business plan we will ensure that information which is shared with the public is pitched at the appropriate level for the different community groups in Bolton. Taking account of older people, BME groups and people who may have a learning disability. 4.2 Where appropriate revise content of existing public awareness materials to amalgamate learning from this review.	• DAV strategy and business plan • Revised public awareness materials. • Evidence of campaigns to promote awareness	Enhanced awareness amongst families and friends' networks in respect of older people, BAMER and marginalised communities about recognising domestic abuse and violence and how to access the appropriate support services.	Bolton Council Head of Service for Adults Bolton Council Head of Community Safety LOCAL SCOPE
5.	Be Safe Bolton Strategic Partnership to provide periodic briefings to Bolton Safeguarding Adults	5.1 Be Safe to monitor action plans through progress reports.	• Monitoring reports	Both partnerships will be able to exercise joint monitoring of the progress of all single agency action plans	Bolton Council Head of Community Safety

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	Board as to the progress and delivery of recommendations arising from this review.	5.2 Briefings to be provided to quarterly Board meetings.			LOCAL SCOPE
6	Bolton Safeguarding Adults Board to be given assurances by partner agencies that they have reviewed their processes regarding information sharing when they have contact with individuals, family members, significant others. This should include reviewing how and when advice or conversations concerning care and support plans is given, to who and when.	6.1 Partner agencies to review their current processes.	• Report findings, any recommendations and actions.	Staff to have a clear understanding of when and how information is shared with individuals, family members, significant others.	Bolton Council Head of Service for Adults. LOCAL SCOPE

Bolton Council

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	Review of application of Safeguarding Adult Section 42 enquiry criteria.	Review safeguarding training offered to adult social work staff.	Evidence of training sessions.	Increase in number of Section 42 enquires from contact to enquiry. Specifically, in relation to DAV.	Head of Safeguarding
2.	Review of what training is offered to adult social care staff in identifying signs of domestic abuse and violence and how to ask direct questions to gain further information to develop an appropriate risk management plan with a particular focus on Older Adults.	Embed the Bolton MARAC Domestic Abuse and Assessment and referral in practice by ensuring that staff attend briefings and training events.	Increased awareness across adult social work teams and multi agencies.	Quicker access to appropriate services. Increased awareness of the Bolton Domestic and Abuse Strategy across all Social Work Teams, not solely the Safeguarding Adults Team and across the Safeguarding Board Partnership.	Bolton Safeguarding Adults Board Partners
		Identity key staff and then roll out an ongoing programme for Social Work and Social Care staff.			Head of Safeguarding

3.	Identify staff who have not had refresher or undertaken Mental Capacity training across Adult Social Work Teams.	Mandatory Mental Capacity training.	Ensure that staff continue to be legally illiterate and apply the MCA principles.	High quality and proportionate assessments and outcomes, support plans for people who lack capacity.	Principle Social Worker / Head of Services – Social Work Teams.
4.	Reinforce the offer to complete Carers Assessments to highlight any risks of carer fatigue, stress and offer of advice, information, and services.	Ongoing Care Act assessment training, case discussion with managers.	Numbers of Carers Assessment remain stable and/or increase.	Carers feel supported in continue in their caring role.	Head of Service – Social Work Teams. Commissioning Team.

Bolton CCG

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	The IMR Authors felt that domestic abuse does not just apply to adults with children or of working age adults but domestic abuse does and can occur in older adults / or across all age groups. There is a need to raise	**Specific:** CCG Domestic Abuse Lead to meet with IRIS Project and review and re-evaluate the training delivered to General Practice staff. **Measurable:** This would be done by training	• PowerPoint slides • Agenda • Pictures of the event • Staff evaluation forms	To increase the awareness of domestic abuse in older adults across General Practice and for General Practice staff to know which services to signpost people too locally.	CCG Head of Safeguarding Adults will have oversight of the action plan. GP Lead for Safeguarding

	awareness of older people (elder abuse) domestic abuse in General Practice.	evaluation forms, General Practice staff, Feedback from General Practice Staff, at the GP event in February 2020. **Achievable:** CCG Domestic Abuse Lead will work with the head of Safeguarding Adults to raise this awareness across General Practice. **Realistic:** The CCG Safeguarding Team run regular training sessions for GP Practices. Therefore this recommendation is realistic. Timed: December 2020			Adults, Bolton CCG. Deputy Designated Nurse for Safeguarding Children and Looked after Children, Bolton CCG (Who is also the lead for domestic abuse)
2.	The Named GP for Safeguarding Adults felt there is a need to update GP's in General Practice for people who are at risk of delirium	**Specific:** With current GP education for safeguarding adults, delirium and older people is not a stand-alone training subject for GP safeguarding leads. It's an opportunity to build this into	• GP education • PowerPoint slides • Agenda	To increase the awareness of delirium in older people and the impact on carers and self for GP safeguarding leads in general practice.	CCG Head of Safeguarding Adults will have oversight of the action plan.

	exacerbating harm to carers or self.	the existing safeguarding training that the CCG safeguarding team deliver. **Measurable:** This would be done by training evaluation forms, Feedback from GP safeguarding leads at the annual GP safeguarding adult. **Achievable:** The Named GP will work prepare and design the training slides for this specific issue and deliver as core business with existing GP training programmes. **Realistic:** December 2020	• Pictures of the event • Staff evaluation forms • GP safeguarding newsletter		GP Lead for Safeguarding Adults, Bolton CCG.

Bolton NHS Foundation Trust

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1.	To continue to ensure comprehensive assessment of mental capacity following episodes/incidents of violence and aggression	1. Identify cohorts of learners requiring additional training via BOSCA accreditation. 2. (audit)	1. New protocol with associated flow chart now developed which prompts action to be taken following	1. Ability to identify patients with potential for violence and aggression to aid improved risk management.	Lead Nurse Safeguarding Adults Enhanced Care Coordinator

	or where capacity is in doubt when significant decisions have to be made e.g. discharge planning.	3. Continue rolling programme of training provision. 4. Reinforce Violence and Aggression policy and requirement to complete mental capacity assessments. 5. Review of Enhanced Care assessment tools.	episodes of violence and aggression. 2. All wards assessed in respect of completion of MCA training. All wards/Trust achieving >95% of designated cohorts. 3. All staff within Integrated Discharge Team have received training from Trust's MCA lead.	2. Completion of mental capacity assessments by the appropriate professionals.	Manager Integrated Discharge Team
2.	Ensure all agencies aware of how to respond to/escalate disclosure of Domestic Abuse and Violence (DVA)	1. Review information available for all staff on variety of platforms. 2. Provide multi-agency training for all senior staff. 3. Implement Trust wide new Bolton DAV Protocol devised by DAV partnership.	1. Bolton FT DAV training included in L1/L2 and Level 3 training packages. 2. Police now delivering DAV training to senior staff on a monthly basis as part of Level 3 training package provided by Bolton NHS Foundation Trust. Managers/Team Leaders from Safeguarding Board partners invited to access.	To raise awareness and improve response to DAV and the fact that it can affect any age group including older people. Training to improve multi-agency working.	Trust Safeguarding Leads- Adults/Children Safeguarding Adults Board Children's Community Partnership