DOMESTIC HOMICIDE REVIEW

ISLE OF WIGHT COMMUNITY SAFETY PARTNERSHIP

Mrs Fleming

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1. INTRODUCTION

1.1. This report of a domestic homicide review examines agency responses and support given to Mrs Fleming, an 83-year-old British female resident of the Isle of Wight, prior to her death on 31st August 2015. When she died she showed signs of severe neglect/ self-neglect.

1.2. In addition to agency involvement, the review examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.3. The subjects of the review are:

Victim	**Name**	Mrs Fleming
	Age at Death	83
	DOD	31/08/2015
Victim's Son	**Name**	Mr Fleming
	Age at Death of MrsFlemming	57
	Relationship to Victim	Son
	Charge(s)	1) Gross Negligence (Involuntary) Manslaughter 2) Causing the death of a vulnerable adult Acquitted of both

1.4. The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 states that a domestic homicide review must be held where the circumstances in which a person aged 16 or over has died and the death had, or appears to have, resulted from violence, abuse or neglect by—

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

1.5. The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

1.6. The initial pathology report into Mrs Fleming's death, in 2015, did not enable the police to regard that the case met the criminal threshold.

1.7. The initial post mortem results identified the cause of death as:

- 1a) Bilateral pulmonary thrombosis
- 1b) Left side deep vein thrombosis
- 1c) Immobility

With coronary artery disease as a contributory factor.

1.8. The pathologist took the view that Mr Fleming had done "a really good job of keeping Mrs Fleming clean" and paid tribute to the level of care he had provided. She concluded that there was no indication of a lack of care.

1.9. In October 2015 the police investigation was concluded and Mr Fleming was informed that no further action would be taken against him in relation to the death of his mother.

1.10. Following contact from the Coroner's office in 2017, in December 2017 the death was reinvestigated by Hampshire Constabulary Major Investigations Team.

1.11. Following the engagement of a second expert, a consultant geriatrician, a further opinion was provided. This said that Mrs Fleming died of a pulmonary embolism caused by prolonged immobility. The geriatrician continued *'The available evidence suggests the patient lacked mental capacity due to chronic medical disease; with likely additional mental disease (such as dementia or depression.)… Post Mortem examination showed evidence of malnutrition, and skin ulceration due to fixed abnormal neck position with underlying deep bone damage. Earlier medical intervention … could have prevented Mrs Fleming's death. In my professional opinion, Mr Fleming should have sought medical support at an earlier stage and by refusing to take this course of action, he severely neglected the welfare of his mother.'*

1.12. This re-investigation has resulted in the CPS decision for charges of Gross Negligence (Involuntary) Manslaughter and Causing the death of a vulnerable adult to be brought against Mr Fleming. In November 2019 he was acquitted of those charges after a trial at Winchester Crown Court.

1.13. This case was referred to the Isle of Wight Safeguarding Adults Review sub group for consideration in January 2018. Due to only health agencies being involved it was

considered that the statutory criteria for a Safeguarding Adults Review[1] was not met. A review of health services involvement has been undertaken by the Named GP for Safeguarding and learning identified.

1.14. This review has been shared with the Community Safety Partnership (CSP) for their information and consideration. Given this case involved an allegation of abuse and neglect by Mr Fleming towards Mrs Fleming, it was rightly understood to fall under the definition of domestic abuse. As Mrs Fleming is believed to have died due to that abuse and neglect, notwithstanding there was only one agency involved, it also fell under the definition for a domestic homicide review.

1.15. The CSP received the referral for a DHR from the police on 31 January 2019, this was considered by the CSP on 13 February 2019 and partners agreed for a DHR to be commissioned.

2. TIMESCALES

2.1. This review began in February 2019 and was concluded in January 2020. The reason for there being so long between Mrs Fleming's death and the commissioning of this review was due to the initial investigation showing no criminal offences disclosed. This position was reviewed following the Coroner's intervention, the police re-investigation and the Crown Prosecution Service's decision that Mr Fleming was to be charged as highlighted above. There then followed the Safeguarding Adults Board considerations and subsequently the CSP.

3. CONFIDENTIALITY

3.1. Whilst key issues have been shared with organisations, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of the report were approved by the Review Panel.

3.2. The IMRs will not be published but the redacted overview DHR report and Executive Summary will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.

3.3. The content of the Overview Report and Executive Summary is anonymised in order to protect the identity of the victim, relevant family members, staff and others, and to comply with the General Data Protection Regulations. All names contained, other than professionals, are pseudonyms.

3.4. Mrs Fleming's family have been given the opportunity to read a draft copy of this report and will be provided a final copy two weeks before publication. They did not wish to review it, saying that they wanted to put the matter behind them.

4. TERMS OF REFERENCE

4.1. The specific terms of reference set for this review to consider are:

- Whilst Mrs Fleming had no known contact with any specialist domestic abuse agencies or services, the review will consider whether there was any history of domestic abuse involving Mrs Fleming and Mr Fleming and therefore whether there were any warning

[1] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

signs.

- How opportunities to 'routinely enquire' as to any domestic abuse, neglect, self-neglect, sexual violence or carer stress experienced by the victim or family of were, or were not, identified and taken by professionals and what was the outcome.
- Whether professionals took opportunities to consider the health and wellbeing of **both** Mrs Fleming and Mr Fleming and whether either needed carer support in their role towards the other.
- Whether there were opportunities for professionals to refer any reports of domestic abuse, neglect, self-neglect or sexual violence experienced by the victim to other agencies and whether those opportunities were taken.
- Whether there were opportunities for agency intervention in relation to domestic abuse, neglect or self-neglect regarding Mrs Fleming or Mr Fleming that were missed or could have been improved.
- Whether either Mrs Fleming or Mr Fleming had care and support needs, whether as a consequence of those care and support needs either suffered abuse or neglect (including self-neglect) and if so the nature and quality of the single and/ or multi agency response to that, including how their wishes and feelings were taken into consideration.
- Whether there were any barriers or disincentives experienced or perceived by Mrs Fleming, Mr Fleming or their family/ friends/colleagues in reporting any abuse, neglect or self-neglect, including whether they knew how to report abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.
- Whether family, friends or colleagues were aware of any abuse, neglect or self-neglect, relating to Mrs Fleming or Mr Fleming, prior to the homicide and what they did or did not do as a consequence.
- Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, neglect or self-neglect, their families, friends or perpetrators.

Additional lines of enquiry

- The review will consider any equality and diversity issues that appear pertinent to the victim, victim's family and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
- The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services on the Isle of Wight.

4.2. The time period to be reviewed was agreed as being 31st August 2012 to 31st August 2015.

5. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

5.1. Mrs Fleming had no social contact with anyone other than her son. When spoken to by the police following these events, some neighbours believed she had already died. However, her cousin who lives nearby, her niece and a local gardener were interviewed.

5.2. Mrs Fleming's cousin was provided with the Home Office leaflet, offered specialist and expert advocacy, specifically Advocacy After Fatal Domestic Abuse – she declined -, and updated regularly including the sharing of the Terms of Reference.

5.3. It is important to understand that Mrs Fleming was not close to any family member, except her son, and even her cousin said that she did not see her for months at a time. There were no other family members therefore, other than the cousin, with whom the review could consult, and she was clear that she was not close to her.

5.4. A decision was taken by the panel not to interview Mr Fleming until after the trial. This decision was taken on the basis that the police had provided the extensive record of his interview which took place immediately after his mother died and this is comprehensive enough to understand his perspectives. Once acquitted, Mr Fleming was contacted twice through his solicitor to ascertain whether he wished to contribute to this review. The review received no reply to either contacts so took the view that he did not wish to.

6. CONTRIBUTORS TO THE REVIEW

6.1. Initially, the following agencies were required to submit Summaries of Involvement to allow the panel an opportunity to understand the nature and scope of their involvement with Mrs Fleming and/ or Mr Fleming during the time period under review.

- Age UK Isle of Wight
- Department of Work and Pensions
- Hampshire Constabulary
- Isle of Wight Council – Adult Social Care
- Isle of Wight Council – Housing
- Isle of Wight Fire and Rescue Service
- Isle of Wight NHS Trust – Hospital Services
- Isle of Wight NHS Trust – Mental Health Services
- Red Cross
- Primary Care 'Practice Q'

6.2. Having reviewed the summaries of involvement at the initial panel meeting on the 13th March 2019, it was established that the only agencies to have had any involvement with either Mrs Fleming or Mr Fleming during the period were Primary Care 'Practice Q' and St Mary's Hospital. Both of these providers had been subject to the review undertaken by the Named GP for Safeguarding and that report served as the IMR.

6.3. The lead reviewer interviewed Mrs Fleming's named and accountable GP, her cousin, niece and her gardener. The police provided the review with statements from medical staff at Practice Q as well as those from her cousin and gardener. Efforts were made to establish whether any local service providers such as refuse collectors or post-delivery staff held any relevant knowledge but they had nothing to add.

7. THE REVIEW PANEL

7.1. Mr Graham Bartlett was appointed to chair the Domestic Homicide Review panel and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd. He Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards and, until recently, was the Independent Chair of

Brighton and Hove Local Safeguarding Children Board. He has completed the Home Office online training for independent chairs of Domestic Homicide Reviews and the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing six Domestic Homicide Reviews and is currently lead reviewer for a serious case review and a safeguarding adults multi agency review. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight.

7.2. The panel comprised the following members:

- Graham Bartlett - Independent Chair
- Amanda Gregory - Isle of Wight Council (IOWC) Chair of Community Safety Partnership
- Helen Turner - IOWC Community Safety
- Christine Charnley - IOWC Safeguarding
- Jeff Walls - Isle of Wight (IOW) Fire and Rescue
- Mandy Tyson – IOW Clinical Commissioning Group
- Lucy Slaterpartridge – IOWC Domestic Abuse Project Officer
- Emma Coleman - IOW Local Safeguarding Adults' Board
- Rosie Price - IOW NHS Trust Safeguarding
- Maria Blazeckova - IOWC Safeguarding
- Dr. Alison Robins - Named GP IOW Clinical Commissioning Group (now no longer in that role.)
- Mark O'Sullivan - Age UK Isle of Wight
- Ruth Attfield - Hampshire Constabulary
- Tracey Webb - IOW Fire and Rescue Community Safety

7.3. Whilst all represent their own agencies, none were directly involved in the services provided or the supervision of those providing services to any of the subjects of the review.

7.4. The panel met twice on 13 March 2019 and 12 September 2019 and contributed virtually to the review as well.

8. BACKGROUND INFORMATION

8.1. Mrs Fleming was found dead in her home on 31st of August 2015. She was white, British and was 83 at the time of her death and lived with and was cared for by her son, Mr Fleming, also white British.

8.2. The Ambulance crew found Mrs Fleming extremely malnourished and emaciated. She weighed just 38kg. As a result of concerns regarding the condition in which she was living and her physical state, police were contacted and Mr Fleming was arrested on suspicion of neglect.

8.3. Mrs Fleming was skeletal in appearance with multiple scabs and scars apparent on her skin. She also had several ulcerated areas on her body which were weeping and in need of medical attention. She was dressed in clothes which were too big for her and were stained with fluid from the weeping sores on the left side of her neck and wet with urine. Her hair was unkempt and had clearly not been brushed or washed. There were no signs of any physical injury consistent with physical abuse but there were concerns about neglect and whether this contributed or hastened her death.

8.4. It was identified that Mr Fleming had not attempted to get any services to help him with Mrs Fleming's care, or seek medical assistance when her condition deteriorated. In the last few years of her life, Mrs Fleming was incontinent and there was an overpowering smell of ammonia in her room. Mr Fleming said during the police interview that he tried to cope with his mother's ill health but it was all too much for him and he felt unable to seek help. There was no suggestion of intent, malice or any financial abuse.

8.5. The house was very poorly maintained and severely neglected. The property was extremely filthy and the walls were brown with mould with the wallpaper peeling off. The house looked very unkempt and smelled of mouldy dirt mixed with urine, faeces and parts of it were rotting. The whole property was in a state of disrepair with a leaking roof and extremely overgrown garden. The house appeared to be infested by vermin.

8.6. Neighbours did not see Mrs Fleming for over two years and some presumed she died some time ago. A cousin, who lives nearby, had not seen Mrs Fleming for some months and had raised concerns with the GP regarding Mr Fleming`s capacity to deal with his mother's ill health on three occasions. A gardener did attend the house more recently and noted that Mrs Fleming was in the same chair and believed that she may not have left it for over a year. He attended the GP surgery along with Mrs Fleming's cousin to voice his concerns twice.

8.7. Mrs Fleming was registered with Primary Care 'Practice Q' since 1967. She was last seen by the practice nurse in 2010, however, as she suffered with chronic ulceration of her lower legs, migraines and high blood pressure, she continued to be prescribed Pizotifen and Bendroflumethiazide (the prescription being picked up by her son), this was issued regularly without review.

9. CHRONOLOGY AND OVERVIEW

9.1. Mrs Fleming was 83 years old when she died. Her husband had died in the property from a heart attack twenty years prior to her death and she had continued to live with her only child Mr Fleming who had been born and raised there. Neither were known to any services except their GP where they were both registered with the same doctor.

9.2. Mr Fleming had not worked since 2004 when a shop, where he worked, closed. He said he was Mrs Fleming's carer although he was not claiming carers allowance and did not appear to access any medical attention for her during this period.

9.3. Externally the house stands out in its road, being very poorly maintained and, despite Mrs Fleming having a gardener, the front garden is overgrown to the extent that the house is almost inaccessible. There have been no reports or concerns raised by any neighbour, professional or passer-by regarding the house and its occupants highlighting a potential need for help or support.

9.4. The house was heated with small stand-alone heaters. The wall paper was peeling off the walls, which were mouldy, and there was evidence of damp, a lot of dust and multiple cobwebs. There were buckets upstairs outside the bathroom catching water from a hole in the ceiling.

9.5. The rooms were cluttered, several disused white goods were in the hallway and there

were signs of items being hoarded. In one room there was a sofa and a chair which were clean and useable. The kitchen was in a very poor state and there was a bottle of rat poison on the floor. There were clean plates on the draining board. The fridge contained food wrapped in foil parcels, yoghurts and bottles of milk. It had evidence of mould on the door. The freezer was also stocked with food. There was a gas cooker, washing machine and tumble drier which had white bed sheets inside which appeared to be clean. There was one toilet in the property which was situated upstairs. This contained only male toiletries and only male clothes were in the process of drying.

9.6. There was evidence that Mr Fleming had made some efforts to care for his mother in that there were:

- Recently purchased toiletries
- Cutlery, dinner plate, a cup of tea and a teapot under a cosy next to Mrs Fleming
- Some clean clothes and towels in the room
- Up to date medication
- Food in the fridge and freezer.

9.7. Their reclusive lifestyle provided very few opportunities for outsiders to know and understand what life was like for Mrs Fleming. The only person who saw them with any degree of regularity was their gardener Mr Barry.

9.8. He had known them since just before Mrs Fleming's husband died. He said the house conditions had been the same ever since in that it was cluttered and in need of total redecoration and modernisation.

9.9. He had been helping with the front garden for up to fifteen years, attending roughly once a fortnight to cut the grass but also twice a year to cut the front hedge. He did this on a voluntary basis.

9.10. He described Mrs Fleming as completely lucid up until the last four years of her life, her health gradually deteriorating since then. He said she had arthritis in her knees and struggled to get up the stairs so slept downstairs in her fireside chair for the last 2 years.

9.11. He described Mr Fleming as being not entirely capable as Mrs Fleming's carer. He said he was fanatical about cleanliness and bathed every day. He and his mother would both watch television most nights and he would get too tired to go to bed so would sleep in the chair opposite Mrs Fleming. Some days he would not get up until late afternoon and Mr Barry would have to bang the door hard if he wanted to work on the garden before 3pm.

9.12. He said that Mrs Fleming became chair-bound and believed that, in the time up to her death, Mr Fleming would place her on a commode. Towards the end of her life the smell inside the house had started to become quite pungent but it was not like that all the time. Mr Fleming tried to feed Mrs Fleming for the last few months and she did not always respond so he would cut up the food.

9.13. Mr Barry said Mr Fleming would get Mrs Fleming's repeat prescriptions from the local chemist but struggled to understand how she could be issued these without being seen by the GP.

9.14. Mrs Fleming's cousin, Mrs Curtis, saw her rarely but in October 2011, whilst attending the Medical Centre for a routine visit, she took the opportunity to raise her concerns regarding Mrs Fleming's deteriorating health with a nurse. She told the nurse she was worried that while Mr Fleming was living at home, he kept himself to himself and was spending much of the day in bed. Neither would open the door, there was no landline to the property and neither had a mobile phone (although later Mr Fleming acquired one but only turned it on when he wanted to make a call.) Mrs Curtis said there had been a

recent incident a few weeks previously when Mrs Fleming had got stuck on the stairs and Mr Fleming had not known how to get her up or down.

9.15. The nurse (who has no recollection of this encounter) is said to have told Mrs Curtis that if Mrs Fleming needed help she would ask for it and not to get involved. However, the concerns were added as an administrative note to her records and the nurse sent an e mail to the GP on the same day. There is no evidence that anything happened as a consequence of this concern, certainly no contact was made with Mr Fleming or any attempt to explore the situation further.

9.16. In April 2013 Mr Barry and Mrs Curtis went to Primary Care Practice Q again as they were still concerned about Mrs Fleming's ill health and Mr Fleming's ability to cope with the situation. They spoke to a member of staff and Mr Barry recalls her stating that they would arrange for someone from the practice to attend and check on Mrs Fleming's health. Later Mrs Curtis went back to the Medical Centre because no one had been to see Mrs Fleming and was told not to interfere because she could get into trouble. Mrs Curtis says she was told that if they called round to see Mrs Fleming they could be refused entry. There is no evidence that anyone actually tried to do this until much later on. There is also no evidence that a safeguarding alert (this was before the Care Act 2014) was raised with Adult Social Care or any other agency.

9.17. In November 2013, Mrs Curtis managed to procure a walking Frame from the Red Cross and, early the following year, bought some clothes from local charity shops as she noticed that Mrs Fleming's clothing was in very poor condition. That was the last time she saw her.

9.18. General practice should play a pivotal role in the delivery of high-quality care to people with long-term conditions. Isle of Wight GP practices are contracted to use READ coding. This is where all significant information is to be coded including clinical conditions, medical procedures, social circumstances and administrative details including **all** communications regarding patients. It stipulates that all communication regarding patients is to be coded in a manner from which essential information can be easily identified and shared. READ codes in Mrs Fleming's notes identified Chronic bilateral leg ulcers, Bilateral oedema, Varicose Veins (bilateral and prominent), Migraine, Hypertension and Osteoarthritis. Mr Fleming had been diagnosed with chronic conditions which were included in the Quality Outcomes Framework (QOF) chronic disease registers.

9.19. Inclusion in these registers carries an expectation that the individual will have an annual review of their conditions as set out in the QoF guidance which is evidence-based best practice; this would include a review of their medication.

9.20. Mrs Fleming's Hypertension and Mr Fleming's chronic conditions fell within primary care's additional monitoring requirements for Long-Term Condition (LTC) groups. None of the requirements appear to have been completed for Mrs Fleming but all were documented for Mr Fleming. However, it would appear that many of the observations recorded for Mr Fleming were those carried out during his regular secondary care reviews, which were shared following outpatient appointments.

9.21. Mrs Fleming was sent three letters in the second half of 2013 which were documented *as Lifestyle advice regarding hypertension - Leaflet and advice given on Risk of CVD. Hypertension Treatment - Lifestyles Changes*, to which there was no response. After this, Mrs Fleming was "exemption reported" stating she had "informed dissent" because she had failed to respond to three invites.

9.22. The registered practice has a key role in ensuring their Long Term Condition (LTC) patients are given every opportunity to engage with services as there could be a high clinical risk if they do not attend (DNA) for scheduled appointments. Disengagement is a strong feature in domestic abuse, serious neglect and physical abuse so all practices should be aware and be able to provide an appropriate response when patients fail to attend for appointments; this is a key component to ensuring safe and effective care and involves a comprehensive process of risk assessment and proactive follow up which could be in the form of telephone contact or home visiting. This would ensure those who no longer have decision making ability, like Mrs Fleming, are being safeguarded.

9.23. Mr Fleming was proactively called for his annual chronic condition review and attended the surgery five times between 2007 and 2014. He was also under the care of the specialist team, being seen approximately every six months between April 2009 and April 2012. However, he was discharged from specialist follow up after that because he failed to attend on three occasions.

9.24. His chronic condition control was never optimal, and he had early disease complications. There is no evidence that this was proactively managed in the GP practice as, whilst his blood monitoring was organised regularly, it did not appear to have been actively followed up with advice and guidance or resulted in any medication alterations. Each result was marked as "*No action required."*

9.25. A medication review is a *'Structured critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste.*

9.26. The groups normally prioritised for reviews are:

a) adults, children and young people taking multiple medicines (polypharmacy)
b) adults, children and young people with chronic or long-term conditions
c) older people.
d) residents in Care Homes
e) individuals recently discharged from hospital

9.27. Mrs Fleming fitted category b and c and Mr Fleming fitted category a and b.

9.28. There is no evidence that medicines were proactively managed for either Mrs Fleming or Mr Fleming There is also no clear documentation that their Long Term Conditions were proactively managed in primary care. Mr Fleming had medications recorded in January 2009, February 2011 and March 2012 when he was attending for review of his swollen legs. There are no details of what was discussed and if compliance or side effects were checked. The records suggest the majority of Mr Fleming's disease and blood pressure management were coordinated by secondary care. A number of blood tests (31/03/10, 07/09/10, 08/04/11, 01/11/11, 06/04/12 and 01/05/14) were organised which indicated poor disease control. These were reported as *"No Action Required"* the administrative team were advised that it was not necessary to contact the patient.

9.29. Mrs Fleming had no medication reviews documented in the review period. The last one was when she was seen acutely in June 2010 and an opportunistic medication review was documented with her blood pressure. There is no evidence that any systems review or clinical assessment was undertaken; this is the last time Mrs Fleming was seen in

surgery. In March 2015, Mrs Fleming was sent a reminder letter to say she needed a medication review before any more medication would be issued but there is no documentation to say she or her carer replied. Mrs Fleming's medication continued to be reauthorised and prescribed despite her never being seen.

9.30. Medication reviews can be carried out face to face, by phone or with family / carers if appropriate (e.g. when a patient lacks mental capacity). There is no record to support that this was done (although it is READ coded) and a monthly prescription was issued every month during the review period. No mental capacity assessment was carried out or deemed necessary during the period.

9.31. The review has learned that the most recent Primary Care Network contract includes Structured Medication Reviews for priority groups as a new national metric. The frail elderly is one of these groups. With 10% of hospital admissions in the elderly being medicine related and compliance being an issue in up to 50% of patients the objective is to stop, reduce or advise on alternatives for those taking non-effective medicines, over-medicating or inappropriately using antibiotics.[2] The duty to promote wellbeing applies equally to those who do not have eligible needs but come into contact with the system in some other way. As individuals age, there is an increased risk of developing conditions such as hypertension, heart disease and type 2 diabetes. The NHS Health Check is a health check for adults aged 40 – 74 designed to identify the early signs of long term conditions and help prevent the development of these diseases and their complications. Individuals are also given advice to help lower their risk of a stroke, kidney disease, heart disease, diabetes or dementia, and maintain or improve health.

9.32. In 2014/15 over 75s were assigned a Named Accountable GP to provide oversight and co-ordination of their care. The GP had a responsibility to:

- Ensure that all appropriate GMS services are delivered to the patient.
- Where required, work with health and social care professionals to deliver multidisciplinary care that meets the needs of the patient.
- Ensure that the patient's needs are recognised and responded to by the relevant clinicians in the practice
- Ensure that the patient has access to a health check, if requested.

9.33. This should be a full physical assessment and holistic review of the care requirements

9.34. There is no record of a full physical health or wellbeing check being done for either Mrs Fleming or Mr Fleming in primary care during the review period.

9.35. These Health Checks are an opportunity to consider the patient holistically by also enquiring and discussing their social and environmental circumstances, their diagnosis and prognosis of any medical conditions and their impact on their health and emotional wellbeing. There is no evidence of any formal assessment of either Mrs Fleming or Mr Fleming's mental capacity in primary care, nor was there any carer's assessment carried out in respect of Mr Fleming.

9.36. Since 2015/16 There is a contractual requirement to provide a named and accountable GP for ALL patients. The contract requires the named accountable GP to take responsibility for the co-ordination of all appropriate services required under the contract and ensure they are delivered to each of their patients where required (based on their clinical judgement.)

9.37. Mrs Fleming had her blood pressure measured when she attended in 2010 but no routine screening or review in the last 5 years of her life as would be expected for

[2] https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-guidance-2019-20-v2.pdf

someone with a diagnosis of Hypertension. Mrs Fleming had a number of the hypertension READ codes added to her record but there is no evidence that any lifestyle assessment was undertaken which could have highlighted her care needs, or those of Mr Fleming as her carer. Mr Fleming's record was not READ coded to show he was a carer, as it should have been.

9.38. Mrs Fleming had not been seen in the practice in the 5 years prior to her death. Where a registered patient between the ages of 16 and 75 who has not attended the surgery for three years requests a consultation, the GP practice must take advantage of this opportunity to *"make such inquiries and undertake such examinations as appear to be appropriate in all the circumstances."* The duty only arises if the patient requests a consultation. The time period of non-attendance that needs to elapse in relation to patients over 75 is twelve months yet it is still contingent on them making the contact.

9.39. If Mrs Fleming had decided to disengage the practice, the practice team still continued to prescribe medication for her without the appropriate reviews.

9.40. Mrs Fleming's named and accountable GP joined the practice in July 2014, so subsequent to the concerns being raised by Mr Barry and Mrs Curtis. He inherited around 2000 patients from practitioners who had left. He said a letter was sent to each patient informing them he was their GP. He said patients over 75 are invited to see a Health Care Assistant for an annual Well Check. If they did not reply to the invitation it was assumed they have declined, unless they have serious conditions such as cancer or heart problems, in which case the practice would follow up. Mrs Fleming had hypertension and should ideally have had an annual blood pressure test, which she would be invited for but, as there were no concerns about her capacity and she was not on the "*in need*" register she would not have been followed up. There were no risks or vulnerabilities identified for Mrs Fleming.

9.41. The GP had never met Mrs Fleming and has no recollection of her. He said the medication she was prescribed was mild and common for a woman of her age and her medical history was 'light,' her having seen a doctor no more than 'three or four times in her life.

9.42. From her records Mrs Fleming was seen in the surgery at least twice a year until 2005 and was included in the influenza, and later pneumococcal, vaccination program till 2012. She was referred for specialist investigation and intervention for a damaged toe (amputated) post-menopausal bleeding and change in bowels (Barium Enema). She attended for a number leg dressings in 2004 and 2009.

9.43. The Named and Accountable GP maintained that there was no guidance to suggest that patients should be seen for a medication review; that it is a clinical decision which varies per patient, per GP and per practice. He never personally authorised Mrs Fleming's medication, but the practice checked that she was collecting the prescription and, with each issued, sent a notification to the chemist to ask her to come to surgery for a blood pressure test. The practice held no phone numbers for Mrs Fleming but sent similar letters to her address by registered post.

9.44. The NICE Guidelines (updated 2004) advise that clinicians provide an annual review of care for adults with hypertension to monitor blood pressure, provide people with support, and discuss their lifestyle, symptoms and medication People with hypertension should also be offered a review of risk factors for cardiovascular disease annually.

9.45. The GP said that he saw Mr Fleming after Mrs Fleming's death and had made personal efforts to call at the address given what had happened but received no reply. He maintains that Mr Fleming was appropriately checked during the period as part of his condition management.

9.46. Mr Fleming had told Mr Barry, and later the police, that he regarded himself as Mrs

Fleming's carer and it was his responsibility to provide that care. He knew he was struggling but was disinclined to ask for help. He did not want to burden anyone.

9.47. Mr Barry said that, since Mrs Fleming had been in hospital for a toe amputation (2001), she had developed a phobia of hospitals and doctors. He says that Mr Fleming, in not accessing help, was respecting her wishes to die at home. He told the police that she did not want to visit the doctor but accepts that he should have sought more help. He couldn't explain why he did not but did say that he did not know who to turn to.

Improvements since Mrs Fleming's Death

9.48. There has been a long period of time between Mrs Fleming's death and this report. This has provided the practice opportunities to review their own arrangements to not only meet their contractual obligations but also to safeguard their most vulnerable patients.

9.49. The practice has since developed and embedded a robust Long Term Condition QOF register monthly monitoring and recall system. A dedicated administrative team now invite the patient in for their annual review arranging the necessary baseline bloods tests and an appointment with the most appropriate practitioner when they respond. Three letters are sent at regular intervals and if the patient does not engage they (or family/ carer with their permission) are contacted by phone. If these patients still do not respond, a READ code is added to their individual patient records to ensure that if they attend the surgery in the interim then they are reminded opportunistically of their outstanding review and the monitoring tests and a follow up appointment are booked.

9.50. A similar process is followed for medication reviews and if they fail to respond to the initial request, a reducing quantity of medication is issued until the patient attends, Reminders are sent initially which allows the patient the opportunity to attend before they run out of medication and mitigates against the risk of withdrawing from medication.

9.51. When electronic prescriptions are being generated and indicate a review is required, the authorising clinician should now document a records review to ensure the appropriate monitoring has been undertaken and then issue the medication as an 'acute' with proactive communication the level of which is determined by the documented risks and vulnerabilities. The practice is not yet using the nationally agreed READ codes to identify risks and vulnerabilities in adults but are now aware of them and plan to utilise them to trigger pro-active follow up and exploration of DNA's and failures to engage.

9.52. The expectations in 2012 were for the practice to pick up Mr Fleming's care following his failure to attend for three appointments. *Making Time in General Practice*[3] and *The Five Year Forward View*[4] highlighted the need to reduce the administrative burden generated by secondary care on practices chasing appointments, delays in discharge summaries and changes in medications, release time and access for patient care. This was to be achieved by ensuring closer working relationships, greater communication and sharing of information between the two providers and should actually reduce workload for both parties as this would reduce the likelihood of A&E attendances and admissions. A new NHS standard contract for secondary care trusts came into force on 1 April 2016 to address this. Whilst this is a positive step, the new contract standards are inconsistently met by the hospital and the interface between primary and secondary care on the island remains an area for focused improvement.

9.53. Enquiries regarding carer status are now made at Practice Q during Long Term Condition reviews, at new patient registrations and checks to facilitate a regular assessment of the care needs of the carer and those receiving care. There are posters in reception asking for carers to make themselves known and advertisements of local support groups and network for care givers. Carers are allocated a READ code which

[3] Making time in General Practice Primary Care Foundation NHS Alliance October 2015
[4] NHSE Five Year Forward View October 2014

identifies them as care givers immediately on accessing their records, this now triggers an annual Carer review. This is an opportunity to check carer individual support needs as well as any risks and vulnerabilities to both the carer and those they are caring for.

10. Conclusion

10.1. This review was unusual as it showed just one agency had opportunities to recognise that Mrs Fleming's health and living conditions were deteriorating and that her sole close relative, Mr Fleming, either could not or would not seek support to provide her with effective care or to access medical provision.

10.2. Exploration and analysis of each of the Terms of Reference point to primary care having had multiple opportunities to, either react to the specific alerts / concerns raised on three separate occasions or proactively consider Mrs Fleming's health and wellbeing holistically in discharging their contractual obligations. This is particularly important as the NHS is in a time of transitioning to an out of hospital model of care which is based on primary care coordinating all care in the community around an individual based on their specific needs. This requires the Named GP to be considering the social determinants of health and their impact on the individual to ensure they are afforded the most appropriate intervention and support.

10.3. Mr Barry and Mrs Curtis were as diligent as any lay person could be expected to be in highlighting their concerns to Mrs Fleming's own GP practice. On each occasion they were effectively told that it was none of their concern and that if Mrs Fleming wanted help she would ask for it. There seemed to be a culture that services could not be offered unless they were requested by the intended recipient, in case they in some way offended or imposed on them. There was no evidence that anyone at the practice had either assessed Mrs Fleming or knew her well enough to presuppose she would reject offers of support or that, with capacity, she had knowingly dissented.

10.4. It may be the case that the practice did not have the resources to carry out a home visit themselves but it is unfathomable why they did not raise a safeguarding alert to Adults Social Care, or at least seek advice. Instead they did nothing and the situation perpetuated unchecked. Doctors and other healthcare professionals have a duty to be alert to signs of domestic abuse. This includes elder abuse and this duty was not discharged in respect of Mrs Fleming.

Recommendation 1

Isle of Wight CCG should work with all Primary Care Practices to ensure that all communications and contacts regarding a patient and their carer are documented in patient records using the appropriate READ codes.

Recommendation 2

The Isle of Wight CCG should also assure itself that, where there are concerns regarding a patient having unmet care and support needs, the record is brought to the attention of the Named and Accountable GP for them to coordinate services and using, the Decision Support Guidance[5], raise a safeguarding concern with the local authority.

[5] https://www.iowsab.org.uk/wp-content/uploads/2019/05/IOWSAB-Decision-Making-Guidance-and-Tools-Version-2.pdf

Recommendation 3

The Isle of Wight CCG should assure itself that each primary care practice has an effective and up to date safeguarding policy which all staff are familiar with and which guides them on what to do if they have a safeguarding concern.

10.5. Primary Care Practice Q had several opportunities through their contractual arrangements to proactively assure themselves that Mrs Fleming's health and wellbeing needs were being met. Had they carried out medication reviews or NHS Health Checks these may have highlighted risk factors and opportunities for support and intervention, either for Mrs Fleming or for Mr Fleming, for himself or as a carer.

10.6. Had they taken any of these opportunities and ensured that either they, or another professional, actually visited Mrs Fleming they would have seen her situation for what it was. It would have been very apparent to anyone seeing the house, that Mrs Fleming was being neglected and Mr Fleming, as her carer, was the person neglecting her – whether he realised that or not – and that he was also self-neglecting.

10.7. In terms of the efforts to contact Mrs Fleming and Mr Fleming, they were administrative rather than patient-centred. The letters regarding hypertension, sent in 2013, received no response and were marked "exemption reported" stating Mrs Fleming had "informed dissent" because she had failed to respond. This assumed Mrs Fleming received the letter, was able to read and understand it, process it and formulate a response which she was then able to communicate with a full understanding of the potential consequences of opting out. Rather than filing this as, effectively, no further action, a discussion regarding her living situation may have triggered concerns and not following this up was a missed opportunity to assess her care needs and identify potential risks and vulnerabilities.

10.8. When Mr Fleming disengaged from the specialist services this does not appear to have been proactively followed up or the reasons explored with him and thus was a missed opportunity. It may have triggered a more holistic review of his lifestyle and highlighted his role as a carer for his mother.

10.9. His blood monitoring was organised regularly but did not appear to have been actively followed up with advice and guidance or resulted in any medication alterations. Each result was marked as "*No action required."* This was possibly a missed opportunity to assess Mr Fleming's general health and wellbeing and may have been an indication that he was not coping or was self-neglecting. *Mr Fleming told the police that when he once made an appointment to have his prescription reviewed he was told it was not necessary as they would just keep issuing them.*

10.10. Primary Care Practice Q has put in measures to rectify these shortfalls now but it is not clear whether their impact on outcomes has been assessed.

Recommendation 4

Isle of Wight CCG should seek assurance in the form of an audit of primary care providers to demonstrate their alignment with best practice and guidance so as to safeguard against vulnerable patients, especially those with care and support needs, becoming invisible or not receiving the treatment and care they require. This includes all adults who have disengaged from LTC monitoring or medication reviews to have contact with a professional to document (signed) their informed dissent.

10.11. There was an assumption that Mrs Fleming had capacity to dissent or disengage from

primary care services, even though she continued to be issued prescriptions. Whilst mental capacity should always be assumed, the complete absence of contact from her and the information provided to Primary Care Practice Q by Mr Barry and Mrs Curtis suggested she might need a care or mental capacity assessment. As she was never seen by any service this could not happen but, in line with the improvements made to ensure more robust follow up for annual health checks, these should include mental capacity assessments where appropriate, especially if the patient has a history of non-engagement and unmet care and support needs.

Recommendation 5

Isle of Wight CCG should seek assurance from Primary Care services that mental capacity assessments are completed where patients have disengaged or dissented from services, especially if those patients have unmet care and support needs as a consequence of disengagement.

10.12. The staff at Primary Care Practice Q have all received on line training in Safeguarding Adults, but there are concerns this is not up to date and does not include any updates on local policy and procedures. They have not, however, received training in Domestic Abuse. Primary Care is one of the services most likely to receive a first report of domestic abuse[6]. This therefore presents a risk of not spotting signs and symptoms and/ or understand pathways when patients display such indications.

Recommendation 6

That Isle of Wight Clinical Commissioning Group supported by NHS England, develop mandatory workforce development measures aimed specifically towards Primary Care to ensure that the knowledge and understanding of the prevalence and risk factors around domestic abuse are fully understood enabling them to embed the NICE Quality Standards on Domestic Violence and Abuse[7] into practice.

10.13. While Mr Barry and Mrs Curtis were proactive in raising their concerns with Primary Care Practice Q they may also have considered raising a safeguarding alert (now a Safeguarding Concern) with the Local Authority Adult Social Care. They did not know to do this and equally did not know how to escalate their report when it was clear nothing had happened. It's possible Mr Fleming did not know either. It is unknown why the practice did not explore or escalate the concerns raised and if there was, and is now, the understating of their roles and responsibilities in identifying and safeguarding vulnerable adults.

10.14. The Isle of Wight Safeguarding Adults Board (SAB) has clear guidance on its website[8] so the public can learn what to do if they are concerned. Other agencies and services, such as Adults Social Care and Health and Primary Care should replicate this guidance and include where carers can access support. The reach of this message can never be to saturation point but the SAB and agencies may wish to promote the advice in ways that reach as many population groups as possible.

Recommendation 7

The Isle of Wight Safeguarding Adults Board, and its constituent members, should review the spread and reach of messaging aimed at the public regarding what to do if they are concerned about an adult and around support available for carers.

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215635/dh_125938.pdf
[7] https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-75545301469381
[8] https://www.iowsab.org.uk/

They should assure themselves that its reach is as broad and accessible to as many population groups as possible.

10.15. This was an unusual case involving one agency with a number of missed opportunities to recognise domestic violence. Mr Fleming was acquitted of any criminal responsibility for Mrs Fleming's death. However, a greater awareness and adherence to the GP contractual and best practice guidance and the roles and responsibilities of primary care practitioners in identifying DVA and escalating concerns could have resulted in a more proactive holistic assessment of both Mrs Fleming's and Mr Fleming's needs. This in turn may have ensured their individual care needs were met and the appropriate care and support provided.