

**Domestic Homicide Review**  
**Pauline/2016**  
**Overview Report**

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Commissioned by:  
Kent Community Safety Partnership  
Medway Community Safety Partnership

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# Domestic Homicide Review

## Pauline Matthews

### Purpose

The key purpose of a Domestic Homicide Review (DHR) is to:

- a) 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;
- b) 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;
- c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) Contribute to a better understanding of the nature of domestic violence and abuse; and
- f) Highlight good practice.

### Scope

This DHR examines the contact and involvement that organisations had with Pauline Matthews between 1<sup>st</sup> of November 2014 and her death on either the evening of the 3<sup>rd</sup> of February 2016 or the early hours of the 4<sup>th</sup> February 2016, at the hands of her husband, Marcus Matthews.

In order to meet its purpose, this DHR also examines the contact and involvement that organisations had with the perpetrator, Marcus Matthews.

### Terms of Reference

The terms of reference for the DHR are set out in [Appendix A](#) to this report.

## Timescales

This review began on 4<sup>th</sup> of March 2016 following the decision that the case met the criteria for conducting a DHR. Marcus Matthews was arrested on suspicion of Pauline's murder on the 5<sup>th</sup> of February 2016 and was subsequently charged with murder. He later pleaded guilty receiving a mandatory life sentence (to receive a minimum of 15 years); he also received a five year prison sentence for theft which related to a sum of £180,000 he had stolen from his Father in Law, Brendan Flowers.

The review was submitted as concluded on the 23<sup>rd</sup> of November 2016. In December 2016 new guidance issued by the Home Office borne out of findings and best practice from submitted DHRs, caused a review of this DHR. It was decided that the new guidance and advice provided be applied to this report. This has caused a delay in submission, but it was felt that the time delay was appropriate in ensuring this report was submitted in line with the current best practice expected.

# Terms of Reference

## 1. Methodology

- 1.1 This Overview Report is an anthology of information gathered from Independent Management Reports (IMRs) prepared by representatives of the organisations that had contact and involvement with Pauline Matthews and/or Marcus Matthews between 1<sup>st</sup> of November 2014 and Pauline's death on either the 3<sup>rd</sup> or 4<sup>th</sup> of February 2016. In addition to this, representative organisations were asked to report upon their involvement with Pauline's father Brendan Flowers and any of their children. It also addressed the nine protected characteristics under the Equality Act 2010 and if relevant to the review.
- 1.2 An IMR is a detailed examination of an organisation's contact and involvement with Pauline and/or Marcus. It is a written document submitted using a template. The IMR is written by a member of staff from the organisation subject to review, who has no involvement with anyone who is a subject of the review. It is signed off by a senior manager of that organisation before being submitted to the DHR review panel.
- 1.3 Each of the following organisations completed an IMR for this DHR:
  - Kent and Medway NHS and Social Care Partnership Trust (KMPT)
  - NHS West Kent Clinical Commissioning Group (WKCCG)
  - Kent Police
  - Kent County Council Adult Social Services
- 1.4 The private care provider who provided care for Brendan Flowers in Pauline's home was interviewed. This was with regard to the level of care and interaction with Brendan Flowers and also the rest of Pauline's family. Following this a report was completed.
- 1.5 A report was commissioned from Education and Young Peoples Services (Safeguarding in Education) to examine whether any issues had arisen within the school environment regarding the youngest daughter, Olivia Matthews, in respect of her home and school life.
- 1.6 Pauline was a teacher in two primary schools. Both her employers were contacted and invited to provide information relevant to the review. This is contained within the Education and Young Persons Services report.
- 1.7 In addition, requests were made to the work place of Marcus Matthews, Pauline's sister, and the church that Pauline attended. All either declined or stated that they had no information to offer.

1.8 In each of the different Agencies' Independent Management Reports, relating to their dealings with both Pauline and Marcus Matthews, a low level of interaction with either individual was reported. They did not find any evidence to suggest that there were any concerns about domestic abuse, nor were any issues reported. However, the panel did feel that other factors within their lives, in particular the care of Pauline's father Brendan Flowers, played a significant part in the circumstances that led to Pauline's murder. It was felt by the panel that although these were not issues directly linked to Domestic Abuse, and more related to Adult Safeguarding, they provided valuable lessons that should be contained within this report.

## 2. The Review Process

### 2.1 Contributors to the Review

2.1.1 The review panel consisted of an Independent Chair and senior representatives of the organisations that had relevant contact with Pauline Matthews and/or Marcus Matthews. It also included the Kent and Medway Domestic Abuse Coordinator and a senior member of Kent County Council Community Safety team. In addition a senior member of a Domestic Abuse Charity in West Kent (DAVSS) was invited to sit on the board.

2.1.2 The members of the panel were:

Alison Gilmour	Kent & Medway Domestic Abuse Coordinator
Jessica Willans	Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)
Carol McKeough	Kent County Council Adult Social Services
Andrew Rabey	Independent Chair
Shafick Peerbux	Kent County Council Community Safety
Andy Pritchard	Kent Police
Tracey Creaton	NHS West Kent Clinical Commissioning Group
Sue Dunn	Domestic Abuse Volunteer Support Service (DAVSS)
Cecelia Wigley	Kent & Medway NHS and Social Care Partnership Trust (KMPT)

2.1.3 The Independent Chair of the review panel is a retired senior Police Officer He has experience and knowledge of domestic abuse issues and legislation, along with a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse. He has a background in serious crime investigation, reviews, multi-agency panel working groups, and the chairing of strategic and multi-agency meetings. The Independent Chair retired from Kent Police in 2014 since retiring he has had no links or connections with Kent Police or the Community Safety Partnership. He is a trustee for two local charities one of which is a Domestic Abuse Charity.

### 2.2 Review Meetings

2.2.1 The review panel initially met on 20<sup>th</sup> April 2016 to discuss the terms of reference, which were then agreed by correspondence. The review panel then met on 19<sup>th</sup> of July 2016 to consider the IMRs, and again on the 26<sup>th</sup> of September 2016 when the draft Overview Report was considered, and amendments agreed.

## 2.3 Family and Friends Involvement

2.3.1 The review panel considered which family members, friends, and members of the community should be consulted and involved in the review process. The panel was made aware of the following family members and friends. All of the names of family and friends have been anonymised.

<b>Name</b>	<b>Relationship with Pauline Matthews</b>
Peter Matthews	Son
Colin Matthews	Son
Deborah Matthews	Daughter
Olivia Matthews	Daughter
Jane Matthews*	Sister of Pauline Matthews
Mary Fletcher	Friend of Pauline Matthews

\*Jane Matthews is married to Marcus Matthews' brother.

2.3.2 The Independent Chair made contact with the family via the Kent Police Family Liaison Officer. Following this he wrote to the family members on 27<sup>th</sup> of April 2016. He offered to meet with them to discuss the DHR process and listen to any views and concerns they had. The letters were sent by recorded delivery.

2.3.3 Not all of the family members wished to meet, and as a result the Independent Chair met with two members of Pauline's family. They were able to provide background information about her, including aspects of her relationship with Marcus which was not recorded by agencies. Where relevant to the terms of reference, this information has been included within the report. The Chair and panel members were extremely grateful to family members and friends for their contributions to this report. It was acknowledged how difficult this was for all who offered help in learning lessons from Pauline's death and the panel wished to put on record their condolences to the family and all those affected by this tragic incident.

2.3.4 Following the completion of the draft Overview Report, the Independent Chair wrote again to the family members, offering them a further opportunity to meet to discuss the content, conclusions and recommendations.



### **3. The Death of Pauline Matthews**

#### **3.1 Events Surrounding the Death of Pauline Matthews**

- 3.1.1 Pauline lived with Marcus in rented accommodation, a detached house in the village of A. They lived with two of their children Deborah and Olivia, whilst their two older children Peter and Colin lived independently. In addition, Pauline's father, Brendan Flowers, lived at the home address. He was suffering from a variety of physical and mental impairments including dementia.
- 3.1.2 Marcus was employed as an IT Consultant, but at the time of his wife's murder he was having financial problems. He appeared to be living a 'double life' and spent much of his money financing escorts, prostitutes and gambling. Pauline worked part time as a supply teacher at the local village school and in another school in Town B.
- 3.1.3 From the Police Investigation it was discovered that on the 3<sup>rd</sup> of February 2016 Marcus Matthews travelled to London by train and while there visited a hotel with a woman who appears to have been from an escort agency. Later that day he travelled back to village C's railway station. During the trip there were two exchanged text messages in which Pauline stated that she could no longer trust Marcus. At approximately 9pm Marcus arrived home and that evening neighbours reported hearing raised voices. The following morning Olivia went to school, Marcus having told her that her mother was unwell and could not be disturbed. Marcus drove to village C's railway station with his other daughter, Deborah, and they both travelled to London where they went their separate ways. Prior to leaving home Marcus had left a note stating that he had killed Pauline by mistake, and that 'things had gone too far'. Marcus also sent a text message to a mutual friend, Mary Fletcher, in which he stated that he had killed Pauline. Throughout this period Brendan Flowers was in the house. Police subsequently went to the address where they found Pauline's body in her bedroom. Marcus was arrested and admitted killing his wife. He also admitted stealing £180,000 from his father-in-law Brendan Flowers. A post mortem of Pauline's body showed that her death had been caused by strangulation.

#### **3.2 Trial of Marcus Matthews**

- 3.2.1 At the trial of Marcus Matthews he pleaded guilty to the murder of Pauline Matthews and the Theft of £180,000 from Brendan Flowers.
- 3.2.2 He was sentenced to life imprisonment with a minimum term of 15 years.

## **4. Background Information**

### **4.1 Pauline Matthews**

- 4.1.1 Pauline had been married to Marcus Matthews for approximately 30 years and to all, appeared to have a good and strong relationship. They had lived in the area of West Kent for a number of years. Information obtained from Mary Fletcher a long term friend of Pauline recalled that approximately 7 to 8 years ago they had to take their children out of private education, sell their home, and move into privately rented accommodation due to financial difficulties. Although this information is not disputed it is not corroborated by any other person or family member.
- 4.1.2 Pauline worked as a part time teacher in two local primary schools.
- 4.1.3 Pauline and Marcus had four children. The two eldest children no longer lived in the family home but were regularly in contact. The children described the relationship between their parents as loving, with occasional arguments, and said that they had never witnessed any violence.
- 4.1.4 Pauline was the main carer for her elderly father and the main decision maker regarding his needs, Marcus assisted her and carried out some caring activities. They had been doing this for a number of years. Pauline's father was in poor health, both physically and mentally. His physical conditions meant he was very frail and unable to move around easily, his sight was very poor, and he had a diagnosis of vascular dementia which affected his mental wellbeing and functional ability. All of this made caring for him difficult, and this became increasingly stressful for Pauline.
- 4.1.5 Both Pauline and Marcus held joint Power of Attorney since August 2013 over her father's finances and health and welfare, although Marcus dealt solely with his father-in-law's finances.
- 4.1.6 In early 2015 Pauline's father moved into the family home and was given a separate room within the house.
- 4.1.7 Pauline shared with several different agencies and friends that she was struggling to manage the needs presented by her father's complex needs.
- 4.1.8 The agency care of Pauline's father was arranged through a private care provider, managed by Pauline under a 'self-funded' arrangement. The assets from the sale of her father's home were above the threshold for publicly funded social care support. At the time of Pauline's death the private care team visited 4 times a day, 7 days a week.

- 4.1.9 In the summer of 2015 friends and work colleagues had noticed that Pauline had lost a significant amount of weight. Pauline put this down to healthy living and taking up running.
- 4.1.10 It was believed by a friend that the money from the sale of her father's property was being protected in order to buy a new family home.
- 4.1.11 Pauline was an active member of her local church, and they assisted her on a rotational basis to sit with her father to enable her to go out.
- 4.1.12 There are no reports or any evidence provided to agencies that indicate Pauline was a victim of domestic abuse or engaged with services in relation to domestic abuse.

## 4.2 Marcus Matthews

- 4.2.1 Marcus worked in London in the financial sector, this often meant that he was up early to go to work and home late. His job has been described as stressful.
- 4.2.2 His family describes him as a loving father, who would do anything for them. They also describe how he kept all of his stresses and strains from his family.
- 4.2.3 Marcus visited his GP in January 2015 stating that he was having suicidal thoughts. He shared that he had previously made an attempt at suicide, although the details of when are not known. He undertook treatment for anxiety and depression.
- 4.2.4 Marcus disclosed during his treatment for anxiety and depression that he drank heavily, about 40 units per week.
- 4.2.5 Marcus managed his father-in-law's money on his own, Pauline never dealt with the finances. He was the sole point of contact for all financial issues with the private care provider. In the three months before Pauline's death he had been unable to settle the account for the care of Brendan Flowers.
- 4.2.6 Marcus was stealing money from his father-in-law. He was spending this money on escorts, prostitutes, and gambling. At the time of the sale of his father-in-law's house, a large sum of money was paid into Brendan's account, and by the time of Pauline's death the proceeds of the sale of the house had been spent.

## **5 Chronology**

### **5.1 Introduction**

- 5.1.1 This section considers, in detail, the contact and involvement that Pauline and Marcus had with agencies during the period covered by the terms of reference. The facts are based on IMRs submitted by organisations, interviews with family, friends, employers and other organisations that Pauline and Marcus came into contact with.
- 5.1.2 In addition, some reference and reporting will be made in relation to the care and medical history of Pauline's father, Brendan Flowers. It is the view of the panel that his care had a bearing upon the circumstances that led to Pauline's death.

### **5.2 Agency Involvement with Pauline Matthews**

- 5.2.1 On the 24<sup>th</sup> August 2013 Pauline Matthews and her husband Marcus Matthews were granted lasting Power of Attorney for; Property and Financial Affairs; and Health and Welfare, they were also registered with the Office of the Public Guardian for Mr. Brendan Flowers.
- 5.2.2 On the 23<sup>rd</sup> of March 2015 Pauline met with the Community Psychiatric Nurse as requested by Brendan Flowers' Doctor. A memory assessment was carried out on her father, and a care plan was developed to address his needs. This plan considered the benefit of day care and some one-to-one care in the home.
- 5.2.3 On the 5<sup>th</sup> of May 2015 a call was taken by the Community Psychiatric Nurse from the Alzheimer's Society, who were concerned that Brendan Flowers was 'locked in the house and the family leave him on his own at times'. The Community Psychiatric Nurse contacted Pauline to discuss this concern. The Community Psychiatric Nurse suggested that he should not be left on his own and more care was required for him, and if this was done a safeguarding alert would not be raised.
- 5.2.4 On the 6<sup>th</sup> of May 2015 the Community Psychiatric Nurse had a follow up conversation with Pauline to discuss further, the need for care and outlined additional options to assist in caring for her father. Pauline was keen to ensure that her father remained in the family home, and felt that he would be very unhappy in residential care. On the 21<sup>st</sup> of May 2015 another call was made to Pauline to discuss further options for care. Pauline reported that she was feeling very upset and unsupported by being told that her father could not be left on his own, and felt she was being criticised.

- 5.2.5 On the 16<sup>th</sup> of July 2015 Pauline attended her GP surgery and saw the nurse. This was in relation to her weight loss. This is disputed by Peter Matthews, Pauline's son, who said that his mother was pleased with regard to her weight loss, putting it down to healthy eating and exercise. He said that it was his belief that his mother had attended for another issue and the matter of her weight loss had been raised as an aside. The Independent Chair checked this information; both in the records recorded in the chronology; and with the provider of the information and have found no discrepancy in the information originally provided.
- 5.2.6 Pauline was responsible for informing the private care providers of any changes to the care of Brendan Flowers, this included changes to medication. The private care provider, when interviewed, stated that they had never been contacted by, nor had they felt the need to contact; social services, KMPT, or the local GP over any concerns or issues regarding Brendan Flowers.
- 5.2.7 Pauline met regularly with her friend Mary Fletcher. She had known Mary for 42 years having attended the same school as young girls. Mary had become concerned in relation to Pauline's ability to continue caring for her father. Pauline would ask her advice on caring for her father and due to Mary's experience as an Occupational Therapist, she gave advice when sought. Mary was becoming increasingly concerned about Pauline's weight loss and was worried that she was developing anorexia.

### 5.3 Agency Involvement with Marcus Matthews

- 5.3.1 On the 24<sup>th</sup> of August 2013 Marcus Matthews, together with his wife Pauline, was granted lasting Power of Attorney for; Property and Financial Affairs; and Health and Welfare for Brendan Flowers, and registered with the Office of the Public Guardian. Marcus managed all the financial aspects of the Power of Attorney.
- 5.3.2 On the 14<sup>th</sup> of January 2015 Marcus attended, together with Pauline, his GP. This was to report that he was having stress related problems. He stated that he was depressed and was having financial problems, although he still had a good income from his job. He said that work was all consuming and that he had very few outlets from work. He stated that he had considered self-harming to get an insurance pay out, but had now spoken to his wife, she had persuaded him that this was not in the best interests of him or any of the family. The GP advised counselling and Marcus said that he would self-refer through his private health care insurance. Peter Matthews disputes this account of the attendance to the GP as he does not believe that his Mother would have attended together with his Father. He felt that his Father would have kept this from her, not wishing her to be troubled by his difficulties. The Independent Chair checked the source of this information and can find no discrepancy with the account

originally provided in the chronology.

- 5.3.3 On the 22<sup>nd</sup> of January 2015 a report from Marcus's treatment provider was sent to his GP. It stated that he presented with mild symptoms of depression and mild anxiety, and describes him as having negative thoughts about himself. Marcus had recently shared his feelings with Pauline and as a result his suicidal thoughts had lessened. However, for the past 6 years he had been thinking about suicide, and 6 years ago he planned to take his own life but something had stopped him. At the time of the consultation he had no suicidal intent, he reported no episodes of self-harming and was assessed as not posing a risk to himself or others. He stated that he realised his family would not want him to take his own life and had 4 children that he was able to care for. Marcus reported that he had been drinking 40 units a week, but had reduced this to between 15 and 20 units. He was provided with information on the risks to mental health and heavy drinking, and offered guided self-help, based on cognitive behavioral therapy, to support him.
- 5.3.4 On the 31<sup>st</sup> of March 2015 a discharge letter was received by his GP from the treatment provider. This stated that Marcus had three treatment sessions where he was helped to challenge his negative self-critical thoughts that he had been having. He had engaged well and progress had been made focusing upon his sleep quality. He stated that he had reduced his alcohol consumption to only drinking 2 glasses of wine 3 days a week.
- 5.3.5 On the 6<sup>th</sup> May 2015 Marcus made a call to the Community Psychiatric Nurse to discuss and seek further advice about on-going care for his father-in-law, Brendan Flowers. He requested information on charities and care providers, so that he would not be left alone in the house. He was given details of relevant care providers.
- 5.3.6 On the 21<sup>st</sup> May 2015 the Community Psychiatric Nurse visited Brendan Flowers to update his assessment. The community Psychiatric Nurse also met with Marcus and Pauline at the family home to discuss the ongoing care of Pauline's father. They reported that neighbours and friends from the church had been very supportive in helping care for Brendan. Peter Matthews questions the use of the word 'very' when describing the impact of this support on his mother. He acknowledged that their support was helpful but felt this statement does not correctly reflect the support given.
- 5.3.7 The Community Psychiatric Nurse reported contact with Marcus on the 11<sup>th</sup> of June and the 20<sup>th</sup> of July 2015 to discuss the introduction of and best use of medication for Brendan Flowers.
- 5.3.8 On the 24<sup>th</sup> of September 2015 Marcus contacted The Mental Health Trust to notify them that Brendan Flowers had been admitted into hospital with a chest

infection and that following discharge he may need additional care.

- 5.3.9 On the 24<sup>th</sup> of December 2015 the National Crime Agency received a suspicious activity report (SAR) as a result of very large sums of money being withdrawn over a period of 12 months from Brendan Flowers' accounts. It showed that just over £180,000 had been made payable to Marcus Matthews' own account. This detail was sent to Kent Police.
- 5.3.10 On the 6<sup>th</sup> of January 2016 Kent Police tasked a patrol to speak with Brendan Flowers in regards to the withdrawal of monies from his accounts. The patrol attended his previous address and found that he had moved and was now living with Pauline and Marcus Matthews.
- 5.3.11 The decision was taken to file the SAR with no further action, this was following a review by a supervisory officer.
- 5.3.12 The accounts management team from the private care provider, contracted to provide care for Brendan Flowers, reported that three months prior to Pauline's death, Marcus had been unable to settle his accounts, however they were still continuing to provide the same level of care.

#### 5.4 Agency Involvement with Brendan Flowers

- 5.4.1 In September 2011, Brendan Flowers was diagnosed as having Vascular Dementia.
- 5.4.2 On 24<sup>th</sup> of August 2013 a Lasting Power of Attorney was granted to his daughter Pauline Matthews and her husband Marcus.
- 5.4.3 On 12<sup>th</sup> October 2014 Brendan was taken to A&E following fall at home and was admitted to hospital.
- 5.4.4 On the 17<sup>th</sup> of October 2014 an Occupational Therapist discussed Brendan's needs with Pauline on the ward. It was discussed that Brendan continuing to live at home alone was a risk. However, Pauline stated that this risk could be mitigated by a care package, and this was preferable to him going into a care home, which she said Brendan would hate. Peter Matthews said that his mother had felt strongly against placing her father into a care home, due in part to a previous negative experience and her belief that he would have better quality of life living with her at the family home.
- 5.4.5 On the 22<sup>nd</sup> of October 2014 Pauline again spoke with the Occupational Therapy team and reiterated her point that Brendan would not be happy in a care home, evidenced by a previous experience, and would rather be at risk but in his own home. She asked that physiotherapy be continued. On the 29<sup>th</sup> of October 2014 further concerns were raised regarding the discharge destination,

and further consideration for rehabilitation discussed to support Brendan returning to his own home. On the 14<sup>th</sup> of November 2014 Brendan was transferred to a rehabilitation ward.

- 5.4.6 On the 2<sup>nd</sup> of December 2014 a visit was made to the home address of Brendan where a needs assessment meeting was held with Pauline. It was agreed Brendan could be discharged back to his home with support services once therapeutic equipment was in place. Brendan was discharged back home on the 18<sup>th</sup> of December 2014.
- 5.4.7 On the 26<sup>th</sup> of December 2014 Brendan was admitted to A&E from his home. He had not been taking his antibiotic medication and was unaware that he was supposed to since his discharge from hospital. Again issues of residential care were considered and discussed with Pauline, she felt that his quality of life is greater when at his home. On 18<sup>th</sup> of January 2015 Brendan was discharged from hospital to Pauline and Marcus's home address.
- 5.4.8 Brendan was admitted to hospital again on the 24<sup>th</sup> of January 2015 following a fall, and was discharged on the 15<sup>th</sup> of February 2015.
- 5.4.9 On the 12<sup>th</sup> of March 2015 it was reported to the family Doctor that Brendan was now living with Pauline and Marcus due to the increasing number of falls. He was having difficulties settling in and was disturbing the household overnight. A care package was in place 4 times a day, but Brendan had refused to attend a day centre. The family were around on and off during the day and Brendan's constant activity and night wandering had put an increased strain on the family.
- 5.4.10 On 23<sup>rd</sup> of March 2015 a visit by the Community Mental Health Nurse was carried out and a needs assessment completed together with Pauline. Brendan was assessed as having a severe level of dementia and presented with night time disturbance, agitation and severe confusion. Changes to medication were made, together with recommendation to request external support from the Alzheimer's Society.
- 5.4.11 On the 1<sup>st</sup> of May 2015 Brendan was taken to A&E due to him pulling out his catheter.
- 5.4.12 On the 5<sup>th</sup> of May 2015 the Alzheimer's Society made a referral to KMPT because of their concerns that Brendan was being left alone at home during the day.
- 5.4.13 On the 26<sup>th</sup> of May 2015 the Community Mental Health Nurse reviewed Brendan's medication and a new medication was introduced to help with night time disturbances.



- 5.4.14 On the 27<sup>th</sup> of July 2015 Pauline called her GP practice to say that she was concerned that Brendan was having a stroke. Pauline was reluctant to take him to hospital as Brendan found visits to the hospital too traumatic, and requested that the Doctor attend the home address which he did.
- 5.4.15 On the 3<sup>rd</sup> of August 2015 Pauline contacted her GP practice to tell them that the private care providers were unable to cope with Brendan's moving and handling needs. A referral was made to Rapid Response, a service whose aim is to prevent the need of hospitalisation, but due to the care package being privately funded they were not able to assist. Pauline was advised to contact Kent County Council Social Care. Social Care could also only advise her and she was told any equipment required would need to be privately funded.
- 5.4.16 On the 5<sup>th</sup> of September 2015 a Doctor's note highlighted that Brendan was drinking but not eating. On the 11<sup>th</sup> of September 2015 following a home visit Pauline was offered to have Brendan admitted to hospital but she declined due to her concerns about the impact this would have on his anxiety.
- 5.4.17 On the 12<sup>th</sup> of September 2015 Pauline called the out of hours service as Brendan was found unconscious. Brendan was taken to A&E with a query chest infection and admitted to hospital.
- 5.4.18 On the 13<sup>th</sup> of September 2015 a discharge plan for Brendan outlined the need for new equipment at home for his care and comfort, including full hoist, hospital bed and increased care package, the health records also stated that Brendan would benefit from a social services input for discharge planning.
- 5.4.19 On the 29<sup>th</sup> of September 2015 a Doctor's report highlighted that a face to face meeting would be needed with Brendan's daughter Pauline, this was to offer her the opportunity to discuss her ability to cope with the increased care regime. On the 15<sup>th</sup> of October Brendan was discharged home with a changed care package which provided two carers for each visit.
- 5.4.20 Following all Hospital discharges, Brendan Flowers was referred to Social Services for an assessment of his needs. However, due to his financial circumstances, which meant he did not qualify for publicly funded services, these assessments were not carried out. In speaking to the private care provider they reported that information and care planning was discussed and agreed solely with Pauline Matthews.

## 6. Analysis

- 6.1 There is no evidence or information available to the review panel from agency contacts, family or friends that would indicate that Pauline was a victim of domestic abuse at the hands of Marcus prior to the event that led to her death. Similarly, there is no evidence or information to suggest that Marcus had been a domestic abuse perpetrator prior to the actions which caused Pauline's death. The circumstances presented in this report relating to the mismanagement of finances, the pressures of caring and managing a relative with complex needs, the stress and pressures both Pauline and Marcus reported to their Doctor which others had noticed and reported, are all considered to be contributing factors. However, the discovery by Pauline of the mismanagement of her father's funds by Marcus and the likelihood of his arrest led to circumstances whereby a violent argument took place between them and this subsequently led to the death of Pauline.
- 6.2 The review panel looked carefully at the changes within the Care Act 2014, in particular the opportunity to carry out a needs assessment for carers. Pauline had, on a number of occasions, raised concerns with agencies about her ability to cope with caring for her father, The Alzheimer's Society in raising a safe guarding concern alerted agencies to the fact that the family were experiencing difficulties in their coping. While it is acknowledged that at times an offer of support was presented to Pauline, there was not a clear recommendation or adherence with the guidance as set out within the *'Supporting Carers Policy and Practise guidance'* (published in April 2015, revised October 2015) Appendix B.
- 6.3 A Lasting Power of Attorney was granted to Pauline and Marcus in October 2013, this related to the care and financial management for her father Brendan Flowers. In understanding the extent of the financial abuse suffered at the hands of Marcus, and looking back, it appears that statutory agencies did not challenge or have a clear understanding of how a Lasting Power of Attorney operated and the responsibilities it requires. When reviewing the care and needs of Brendan throughout this period it was noted that no review of the Power of attorney was carried out, there were no questions asked of the fitness of either Pauline or Marcus to continue in the role following significant episodes of mental health problems, or suspicions of financial mismanagement of Brendan Flowers' funds. Nor was there sharing of information or concerns relating to these suspicions with other agencies charged with the care and welfare of Brendan Flowers, who in his own right was a vulnerable person, and a victim in this instance of domestic abuse. This could have provided an opportunity to explore further not only the financial management of Brendan Flowers' affairs, but the wider context of the family's circumstances.
- 6.4 Between the 15<sup>th</sup> of November 2011 and the 13<sup>th</sup> of September 2015 Brendan Flowers had multiple admissions to hospital. Upon discharge NHS staff

referred him to the Social Care team for a needs assessment. On each occasion assessments were not undertaken due to the fact that Brendan Flowers was self-funding his care. This appears to be a matter of routine and demonstrates a clear gap between statutory support and care and privately funded care.

- 6.5 The private care provider reported that the company had been providing care for Brendan Flowers for approximately 5 years. Carers initially attended 3 times a day when he was living in his own home, but when he moved in with Pauline and Marcus this increased to 4 visits a day, reflecting the increasing level and complexity of his needs and advancing dementia. All discussions about Brendan's care needs and medicine changes sat with Pauline, placing increasing pressure on her to ensure the right information was appropriately shared. The private care agency reported that Brendan was left on his own between visits and that they never saw any family members during their visits. This detail is hard to evaluate, and was disputed by Peter Matthews who stated this was not his understanding, nor was it a true reflection of the situation as his family were often home. He acknowledged this support was in place to alleviate some of the pressure on his mother, and would therefore not have spoken to the carers on every visit. Additionally other evidence presented indicates that Brendan was regularly visited by members of the church and other voluntary groups. However, greater communication and information sharing would have provided an opportunity to explore this situation further. The private care agency was not aware of the safeguarding concern made by the Alzheimer's Society which identified this as an area of concern. It was the view of the private care agency that older people visited by them are often left alone for many hours in between visits, which suggests, supported by the fact that they did not raise this as a safeguarding concern, that Brendan being left alone was not an issue of concern to them. The Private care provider is registered and regulated by the Care Quality Commission (CQC).
- 6.6 The Proceeds of Crime Act 2002 (POCA) sets out money laundering offences for which individuals can be prosecuted. The National Crime Agency receives Suspicious Activity Reports (SAR's) submitted by the 'reporting sector' i.e.: Financial Institutions, the Legal Sector, and Accountants. These reports are made available to Law Enforcement Agencies for investigation. The reports are not crime reports in the normal sense but are information reports for investigation, this is a process defined and outlined in the '*Proceeds of Crime Act 2002*'. However, details of who provides the information are strictly confidential and are not open to public disclosure. Nor is it available for sharing outside the NCA and their accredited staff within the Law Enforcement Agencies. Only in certain circumstances as defined in the '*Criminal Procedure and investigation act 1996*' can the details of the originator be disclosed. Kent Police received a SAR with regards to concerns that Marcus Matthews may be

misusing funds and diverting them to his own personal account. The SAR was reviewed and allocated for investigation. Police Officers attended the previous address given for Brendan Flowers and found that he had moved from there to live with Pauline and Marcus Matthews. They learned of his illness and that he was suffering from Alzheimer's disease. Further enquiries were made with the Office of Public Guardian (OPG) establishing that Marcus and Pauline shared jointly a Power of Attorney for Brendan Flowers covering both welfare and financial needs. In addition it was discovered that another person Jane Matthews, Pauline's sister was aware of the Power of Attorney. Due to this information, Police believed that this diminished the risk towards Brendan Flowers. There was also concern that any further action in speaking to Marcus Matthews would have disclosed and breached the confidentiality of the SAR. As a result of their investigation the report was filed without further action required. It is clear now that offences were being committed and the provision of this information could have led to the arrest of Marcus Matthews. Although the source of the information cannot be shared, the content, once sanitised, can. An opportunity was missed to share the information with Police Officers and other agencies that specialise in Adult Safeguarding. This could have led to a fuller investigation being undertaken by a specialist team experienced in dealing with Adult Safeguarding matters. Such processes already exist for dealing with other offence types and could form the basis of an improved approach in such cases in the future.

- 6.7 In the year leading up to Pauline's murder, both she and Marcus had attended their GP surgery with issues relating to personal stress, increased pressure, and a sense of not coping. In addition, the escalating care needs of Pauline's father and the reported strains this was placing upon the whole family by other professionals was not linked because in the main, they were utilising private services outside of the statutory framework of services provided. The panel felt that this was an opportunity missed, and if the issues had been flagged and discussed collectively, rather than dealt with in isolation within the practise, this could have led to an escalation of concerns and provided the opportunity for a different approach.
- 6.8 It was identified within the review that the staff and Doctors within Pauline and Marcus Matthews' GP practice had not received any level of domestic abuse training. While it is not evident that this lack of training led to any break down of care to any of the family members, a better understanding of the circumstances that can identify domestic abuse are essential. Specifically that it is not always violence based, but includes controlling and behaviour and financial abuse. This will improve the knowledge base of all staff and enhance the service provided by the practice.

## **7. Conclusions**

- 7.1 There is no evidence or information available to the review panel from agency contacts, family or friends that Pauline was a victim of Domestic Abuse and before the actions that led to her death neither was Marcus a perpetrator of abuse against her. However, it is important to acknowledge that financial abuse can be domestic abuse and in this context Marcus was a perpetrator against his father in law. It was a combination of these factors together with the discovery of financial abuse towards his father in law that led to the murder of Pauline Matthews.
- 7.2 Agencies who had raised concerns that Pauline was struggling to cope with the care of her father did not fully comply with the Care Act 2014.
- 7.3 Statutory Agencies did not challenge or have a clear understanding of how a Lasting Power of Attorney operated or the responsibility it required.
- 7.4 Information Sharing protocols are well established between statutory agencies, however, there was a lack of information sharing between statutory and private agencies providing care to Brendan Flowers.
- 7.5 The Suspicious Activity Report (SAR) provided to the Police was not fully investigated considering the vulnerability of the victim. An opportunity to share the sanitised information with relevantly trained departments or agencies was not considered.
- 7.6 All family members attended the same GP surgery. The complexity of issues they were individually experiencing were all looked at independently of each other. If consideration had been given to the connection and interplay between all parties this may have flagged concerns for the family as a whole and led to an intervention.
- 7.7 The staff at the GP surgery had not received any level of Domestic Abuse training. This training would improve awareness and the ability of the staff to identify signs that a patient may be a victim of Domestic Abuse.

## **8. Lessons to be learnt**

- 8.1 This DHR does not identify any lessons that relate specifically to domestic abuse or the prevention of domestic homicides. This is primarily because there was no evidence Pauline was a victim of domestic abuse during the period covered by the review, nor was Marcus a perpetrator against her. The only incidence of domestic abuse was the act that led to Pauline's death. However, the panel felt it important to acknowledge that financial abuse can be domestic abuse, and in this context Marcus was a perpetrator against his Father-in-Law.
- 8.2 The factors outlined within this investigation provide opportunities to improve overall services and review practices and procedures. It is clear that no one single thing could have stopped the murder of Pauline Matthews, but a combination of factors may have provided the opportunity to intervene in the relationship of Pauline and Marcus Matthews and their care of Brendan Flowers.
- 8.3 An important element of this review is within the area of information sharing. There was evidence that there was an over emphasis of simply recording information. A more proactive approach to practice would have resulted in better information sharing. The working environment for all statutory agencies means dealing with increasing volumes of referrals, volume of cases, and repeat clients. It is a challenge for all agencies to assess risk without lessening services due to this volume, and to identify signs that should alert professionals to potential risk.
- 8.4 In the management of the care of Brendan Flowers, many differing agencies were involved. In general when the interaction between agencies is within the Public Sector the information sharing protocols are sufficient for ensuring the flow of important information. In this case, due to the fact that Brendan Flowers was financially independent and did not qualify for funded care and support from the Local Authority, his care was coordinated and managed by the family and a private care agency. The emphasis for sharing important information was placed solely upon Pauline Matthews, and there was no requirement and no evidence that the Private and Public Sector liaised. It is clear from the information and evidence provided that Pauline was feeling under considerable pressure and was struggling to cope with the increasing demands of coordinating the care for her father and his complex needs. As a direct result the pressure placed on Pauline was increased and had a detrimental impact on her wellbeing.
- 8.5 The panel has outlined six recommendations based upon the findings of the IMRs and reports submitted.

## 9. Recommendations

9.1 The review panel makes the following recommendations from this DHR:

	<b>Recommendation</b>	<b>Organisation</b>
1	All member agencies of the Kent & Medway Safeguarding Adults Board to ensure staff awareness of carer's stress and the need for carer assessments where appropriate, including for those who are privately funded.	Kent & Medway Safeguarding Adults board
2	All member agencies of the Kent & Medway Safeguarding Adults Board to ensure staff awareness of regulations and responsibilities governing Lasting Power of Attorney, so that safeguarding concerns are raised and challenges are made where appropriate.	Kent & Medway Safeguarding Adults board
3	A review of the Suspicious Activity Reports (SAR) process is required by Kent Police. The review to consider: The level of experience required for the investigation, in line with the vulnerability, The process to be followed for the sharing of information within the SAR process with partner agencies. <i>(In line with the Kent and Medway information sharing protocols)</i>	Kent Police
4	To ensure effective training is provided to all GP practice staff and policy implemented regarding safeguarding. GP commissioners to check/seek assurance that all practice staff are completing DA training.	NHS England & West Kent CCG
5	To consider introducing a flagging system to GP practices records, designed to link associated persons and provide information that highlights an overarching risk to them individually or by association.	Department of Health
6	To review the support offered to families/carers where self-funded care arrangements are in place, and come to the attention of statutory agencies. Consider options for the provision of information and where necessary practical support to assist and coordinate complex arrangements.	Kent & Medway Safeguarding Adults Board

## DHR Terms of Reference

### The Purpose of DHR

The purpose of this review is to:

- i. Establish what lessons are to be learned from the death of Pauline Matthews in terms of the way in which professionals and organisations work individually and together to safeguard victims.
- ii. Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.
- iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.
- iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

### The Focus of DHR

- This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Pauline Matthews.
- If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.
- If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

### DHR Methodology

- Independent Management Reports (IMRs) must be submitted using the templates current at the time of completion.



- This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Pauline Matthews in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Pauline Matthews, Marcus Matthews, or any of their Children and including Brendan Flowers, Pauline's father. The reviewer cannot be an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.
- Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.
- Each agency required to complete an IMR must include all information held about Pauline or Marcus Matthews, from 1<sup>st</sup> of November 2014 to 3<sup>rd</sup> of February 2016. If any information relating to Pauline Matthews being a victim(s), or Marcus Matthews being a perpetrator, of domestic abuse before the 1<sup>st</sup> of November 2014 comes to light, that should also be included in the IMR.
- Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Pauline Matthews and/or Marcus Matthews. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2015, X was cautioned for an offence of shoplifting).
- The nine protected characteristics under the Equality Act 2010 must be considered and applied to every aspect of this review. The authors of the IMR should consider whether access to services, or the delivery of services was impacted upon, and if any adverse inference could be drawn from the negligence of services towards persons to whom the characteristics are relevant. If none are relevant, a statement to the effect that these have been considered must be included.
- When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR panel and an overview report will then be drafted by the chair of the panel. The draft overview report will be considered at a further meeting of the DHR panel and a final, agreed version will be submitted to the Chair of Kent CSP.

## Specific Issues to be Addressed

- Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:
  - i. Were practitioners sensitive to the needs of Pauline Matthews and knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
  - ii. Did the agency have policies and procedures for the ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Pauline Matthews and Marcus Matthews. (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Pauline Matthews subject to a Multi-agency risk assessment conference (MARAC)?
  - iii. Did the agency comply with information sharing protocols?
  - iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
  - v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
  - vi. Were procedures and practice sensitive to the ethnic, cultural, linguistic, religious and gender identity of Pauline Matthews. (if these factors were relevant)? Was consideration of vulnerability and disability necessary (if relevant)?
  - vii. Were senior managers or other agencies and professionals involved at the appropriate points?
  - viii. Are there ways of working effectively that could be passed on to other organisations or individuals?
  - ix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Pauline Matthews and promote their welfare, or the way it identified, assessed and managed the risks posed by Marcus Matthews? Are any such lessons

- x. case specific or do they apply to systems, processes and policies?  
Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- xi. How accessible were the services to Pauline Matthews (as applicable)?
- xii. To what degree could the death of Pauline Matthews have been accurately predicted and prevented?

*An extract from the Kent Policy for Care needs assessments.*

## **Social Care, Health and Wellbeing OP/PD and DC/LD/MH**

### **“Supporting Carers”**

## **Policy and practice guidance**

### **1. Legislative framework**

This policy and guidance is based on:

- The Care Act 2014
- The Care and Support (Assessment) Regulations 2014
- The Care and Support (Eligibility Criteria) Regulations 2014
- The Care and Support (Charging and Assessment of Resources) Regulations 2014
- The Care and Support (Preventing Needs for Care and Support) Regulations 2014
- The Care and Support (Independent Advocacy Support) Regulations 2014
- The Young Carers (Needs Assessment) Regulations 2015
- The Care and Support Statutory Guidance October 2014

### **2. Statutory duties**

Kent County Council has the following statutory duties towards carers:

- Promote wellbeing: all decisions taken about an individual in relation to their care and support must promote their wellbeing.
- Responsibilities for prevention, reduction or delay of needs (this includes carers who may be about to take on a caring role; carers who do not currently have any needs for support and carers with needs for support which are not being met by Kent County Council or other organisation).

- Establish and maintain an information and advice service relating to support for carers.
- Provide independent advocacy to represent and support carers, if needed, to support their involvement in assessments and support plans.
- Assessment of carer if it appears that the carer may have any level of need for support (whether they currently provide or intend to provide care for another adult). We can delegate this duty to an external organisation.
- Apply the National Eligibility Criteria for carers: Under the Care Act 2014, there is a national eligibility criteria for carers which introduces a minimum threshold establishing what level of needs must be met by local authorities.
- Provide a support plan to meet a carer's eligible needs.
- Work out a Personal Budget that enables the carer to meet their eligible needs.
- Offer a direct payment.
- Ensure reviews of the support plan support occur on a regular basis.
- Carry out transition assessment for young carers at a time when Kent County Council can be reasonably confident about what the young carer's needs for support will be after they turn 18.
- Carry out transition assessment for parent carers at a point when Kent County Council can be reasonably confident what the carer's needs for support will be after the young person for whom they provide care turns 18.

### **3. Scope of the policy**

This policy applies to:

- Practitioners in OPPD/ LDMH with responsibility for case management work
- Commissioners with responsibility for carers services
- Staff within the commissioned organisations who carry out carers assessments
- Mental Health Practitioners with responsibility for carrying out carers assessments

### **4. Definitions: carer / young carer / child's carer**

**Definition of "carer":**

From the Care Act 2014, Part 1, section 10, subsection (3):

**"Carer" means an adult who provides or intends to provide care for another adult (an adult "needing care")**

Subsection (9) clarifies who is not to be considered a carer:

"an adult is not to be regarded as a carer if the adult provides or intends to provide care a) under or by virtue of a contract, or (b) as voluntary work."

### **Definition of “young carer”:**

Section 96 of the Children and Families Act 2014 defines a young carer as:

**“...a person under 18 who provides or intends to provide care for another person (of any age, except where that care is provided for payment, pursuant to a contract or as voluntary work).”**

### **Definition of “child’s carer”:**

From the Care Act 2014, Part 1, section 60, subsection (7):

**(7) “Carer”, in relation to a child, means an adult (including one who is a parent of the child) who provides or intends to provide care for the child (but see subsection 8).**

**(8) An adult is not a carer for the purposes of this section if the adult provides or intends to provide care:**

- (a) under or by virtue of a contract, or**
- (b) as voluntary work.**

Child’s carers also have a right to an assessment under section 6 of the carers and Disabled Children Act 2000 and support would normally be provided under the Children Act 1989, as part of a whole-family approach. A child’s carer is the responsibility of Children Services/ Education and Young People’s services.

## **5. Principles underpinning the policy**

- The underpinning principle which applies in all cases where Kent County Council is carrying out any of their care and support functions in respect of a person is “promoting wellbeing”. This applies equally to carers and the adults they care for.
- “Wellbeing” is a broad concept, and it is described as relating to the following areas in particular:
  - personal dignity (including treatment of the individual with respect);
  - physical and mental health and emotional wellbeing;
  - protection from abuse and neglect;
  - control by the individual over day-to-day life (including over care and support provided and the way it is provided);
  - participation in work, education, training or recreation;
  - social and economic wellbeing;
  - domestic, family and personal relationships;
  - suitability of living accommodation;
  - the individual’s contribution to society.
- There is no hierarchy. All should be considered of equal importance when considering “wellbeing” in the round.

- It is important to begin with the assumption that the carer is best-placed to judge their own wellbeing.
- We must consider the carer's views, wishes, feelings and beliefs
- We must provide information, advice and signpost to interventions that may prevent or delay the development of needs for support and reduce needs that already exist.
- We must ensure that decisions are made with regards to all the individual's circumstances.
- The presence of a young carer in a family should always constitute an appearance of need and should trigger the offer of an assessment to the adult person needing care and support.

## **6. Duty of Prevention**

The Care Act 2014 provides a duty to contribute towards preventing or delaying the development of adults and carers' needs. This applies to all adults whether or not they meet the eligibility criteria. There are 3 levels of preventative activity:

1. Primary intervention, which involves wellbeing (i.e. healthy lifestyles promotions)
2. Secondary intervention, which involves early intervention ( i.e. falls prevention clinics)
3. Tertiary prevention, which involves maximising independence (i.e. respite care for carers)

Preventative measures should be considered in all interventions with individuals and carers:

- At contact point
- During the assessment
- During the creation of a Care and Support Plan for the cared for and Support Plan for the carer
- During the review

This should focus on all aspects of wellbeing so that we support people to take measures to prevent needs escalating to the point where people need a service.

The local authority's responsibilities for prevention apply to all adults, including carers who:

- may be about to take on a caring role
- do not currently have any needs for support
- have needs for support which may not be being met by the local authority or other organisation.

## **B. PRACTICE GUIDANCE FOR ADULT CARERS**

**1. Identifying a carer** (This could include a young carer. For specific information about all types of young carers and parent carers of children in transition, please go to pages 28-31.)

Carers may be identified in a number of ways, including:

- a) During a needs assessment (for the cared-for person)
- b) By a friend, neighbour or relative
- c) By a partner organisation, such as Health or the voluntary sector
- d) By the carer themselves
- e) During a safeguarding enquiry
- f) Following a complaint investigation
- g) During transition from Children to Adult Services (this means both young carers in transition and the parents of a disabled child in transition)

Referrals b, c and d may be received via different media, including by:

- a) Telephone, using the Area Management Service system (ARMS)
- b) By sending an email to ARMS
- c) Via a Gateway
- d) Where partnership arrangements exist, via the first contact point for these services

On receipt of a referral, information, advice and guidance are provided, including the carer's right to have a needs assessment on the basis that:

- a) The carer provides or intends to provide care for another adult, and
- b) It appears that the carer may have any level of needs for support.

Please note that a carer does not need to live with the cared for to qualify as a carer.



**The carer may choose to:**

- a) Have an assessment on their own via a KCC commissioned carers' organisation.** Carers organisations are a specialist independent resource with a lot of experience and knowledge and are best placed to provide independent carers assessments. For MH practitioners, see 1.2 of this policy.
- b) Have a combined assessment with the adult needing care as long as the cared for agrees to this.**
- c) Decline an assessment.**

**1.1 Considering whether the carer may need an Independent Advocate** to help them through a face to face assessment.

- The contact assessor (e.g. ARMS) should consider whether the carer would have **substantial difficulty** in being involved in the assessment process, this means having substantial difficulty in any of these 4 areas:
  - understanding the information provided
  - retaining the information
  - using or weighing up the information as part of the process of being involved
  - communicating their views, wishes or feelings.
- Where a carer has substantial difficulty in any of these 4 areas, then they need assistance and if so, consider the possibility of asking a family member or friend to support them if the following conditions are met:
  - The family member or friend is willing and able to facilitate the person's involvement effectively
  - The family member or friend is acceptable to the individual
  - The family member or friend is deemed appropriate by the local authority
- Where there is no one thought to be appropriate for this role either because there is no family member or friend willing and available or if the carer does not want them to be part of the assessment, we **must** appoint an independent advocate.

In practice:

- If a carer needs an independent advocate, they will be considered to be a “complex case” (this also includes a carer who has their own care needs, or where there are safeguarding issues) and as such, will not be passed on to the commissioned organisation but will be assessed by a SCHW practitioner.
- Commissioned organisations will transfer a “complex case” to the SCHW cared for’s case manager or to ARMS if the cared for is not known. The responsibility for booking an independent advocate and scheduling an appointment will rest with the cared for’s case manager or ARMS.

## 1.2 Checks with KMPT

Where the cared for has mental health needs and the carer has been identified by, or referred to, a carer organisation for assessment, the carer organisation will contact the locality mental health team in Kent and Medway NHS & Social Care Partnership Trust (KMPT) and request they check the RIO system (an IT system that holds mental health records) or the SWIFT system to see if the cared for person is known.

If the cared for person has needs which have been assessed as complex, the carer should be referred for carer’s assessment with KMPT.

Where the cared for person has needs which have been assessed as appropriate for a Primary Care Service response and there are no additional complexities (e.g. safeguarding concerns) the Carer organisation will provide a carer’s assessment.

## 2. Assessment

For a fuller description of the Assessment process, please refer to the [Assessment policy](#).

### 2.1 Assessment documents

Carer’s assessments undertaken by Kent County Council and commissioned services practitioners are carried out using the Carers FACE assessment. KMPT staff will complete the RIO Carers Assessment.

**2.2** We have a **duty to carry out a carer's assessment** regardless of the level of the carer's needs for support or the level of the carer's financial resources or of those of the adult needing care. This means we have a duty to assess a carer even if the person they care for does not meet the eligibility criteria.

**Example:**

A carer may provide care and support to 3 different individuals:

1. Daughter with mental health needs who is currently well but needs ongoing emotional and motivational support.
2. Husband who is recovering at home from an accident at work and relies on his wife to undertake most activities in the home for the next few weeks.
3. Elderly neighbour with some degree of memory loss, who needs help with shopping and looking after her home.

Individually the 3 people may have been assessed as not meeting the national eligibility criteria but this does not stop the carer being entitled to an assessment which would explore the impact of multiple caring on the carer.

**2.3 A carer's assessment must include an assessment of:**

- a. Whether the carer is able, and is likely to continue to be able, to provide care for the adult needing care,
- b. whether the carer is willing, and is likely to continue to be willing, to provide care for the adult needing care,
- c. the impact of the carer's needs for support,
- d. a consideration of the carer's potential future needs for support,
- e. the outcomes that the carer wishes to achieve in day-to-day life,
- f. their activities beyond their caring responsibilities and the impact of caring upon those activities,
- g. the impact of caring responsibilities (both short-term and long-term) on a carer's desire to work and to partake in education, training or recreational activities, such as having time to themselves, and
- h. whether, and if so to what extent, the provision of support could contribute to the achievement of those outcomes.

We must also consider:

- whether, and if so to what extent, something other than the provision of support could contribute to the achievement of the outcomes that the carer wishes to achieve in day-to-day life (for example, a piece of equipment )
- whether the carer would benefit from the provision of anything which might be available in the community.

When assessing a carer where the cared for person is not eligible, the practitioner should double check with the carer whether:

- the carer is actually doing “necessary care”. (If the carer is providing care and support needs which the adult is capable of meeting themselves, the carer may not be providing necessary support. In such cases, we should provide information and advice to the adult and carer about how the adult can use their own strengths or services available in the community to meet their needs.)
- The carer’s needs or problems are the result of something other than their caring role.

## 2.4 Fluctuating needs

We must consider a carer’s support needs over a sufficient period of time to get a complete picture of any fluctuating needs. The carer’s support needs could also fluctuate based on the adult receiving care needs.

**For example:** If the adult’s needs fluctuate, the carer might need additional care at different times of the year and this must be taken into account when determining the carer’s eligibility.

The level of a carer’s needs can also fluctuate irrespective of whether the needs of the adult for whom they care, fluctuate.

**For example:** if the carer is a parent of school children, they may not have the same level of need for support during term time as during school holidays.

## 2.5 Declining an assessment

A carer may choose to decline an assessment, and in such circumstances we are not required to carry out an assessment but the assessor should explain that we would like to identify the level of support provided to ensure that:

- we recognise their contribution to care
- we could support the individual being cared for should the carer no longer be able to continue to provide that level of support for any reason.

When a carer has declined an assessment, they can still have one if and when they change their mind.

## GLOSSARY

Abbreviation/Acronym	Explanation
KMPT	Kent and Medway NHS and Social Care Partnership Trust (Mental Health)
CQC	Care Quality Commission
DHR	Domestic Homicide Review
IMR	Independent Management Review
MARAC	Multi-agency Risk Assessment Conference
LPA	Lasting Power of Attorney
NHS	National Health Service
NCA	National Crime Agency
SAR	Suspicious Activity Report
WKCCG	West Kent Clinical Commissioning Group
DAVSS	Domestic Abuse Volunteer Support Service
IT	Information Technology
A&E	Accident and Emergency
MH	Mental Health
POCA	Proceeds of Crime Act 2002
CPIA	Criminal Procedures and investigations act 1996
OPG	Office of the Public Guardian

The following is an explanation of terms that are used in the main body of the Overview Report.

### **Force Control Room (FCR)**

The FCR is a call center where Kent Police receives emergency (999) and non-emergency telephone calls from the public and other organisations. It is also a dispatch center from which police officers and staff are deployed, usually by radio, in response to those calls. All telephone calls made to or from the FCR, including those made on Kent Police's internal telephone system, are recorded. Radio messages both to and from the FCR are also recorded.

The members of staff who receive telephone calls are referred to as call handlers. Those who deploy police officers and staff, and who otherwise manage the calls received, are referred to as dispatchers.

### **Domestic Abuse Volunteer Support Service (DAVSS)**

DAVSS is a community based charity offering vital and practical support to anyone experiencing Domestic Abuse.

### **Office of the Public Guardian**

The office of the Public Guardian (OPG) protects people in England and Wales who may not have the mental capacity to make certain decisions for themselves, such as about their health and finance.

### **Alzheimer's Society**

The Alzheimer's Society is a united Kingdom care and research charity for people with dementia and their carers. It is a membership organisation, which works to improve the quality of life of people affected by dementia in the UK. Many of the 25,000 members have personal experience of dementia, as carers, health professionals or people with dementia themselves.

### **Alzheimer's Dementia**

Dementia also known as senility is a broad category of brain disease that causes long term and often gradual decrease in the ability to think and remember that is great enough to affect a person's daily functioning. The most common type of dementia is Alzheimer's disease which makes up 50% to 70% of cases. Another common type is vascular dementia that makes up 25% of cases. Vascular dementia is caused by problems in the supply of blood to the brain, typically a series of minor strokes, leading to worsening cognitive decline that occurs step by step.

## **Proceeds of Crime Act 2002**

The proceeds of crime act 2002 (POCA) is an act of Parliament of the United Kingdom which provides confiscation or civil recovery of proceeds from crime.

## **Criminal Procedure and Investigation act 1996**

The Criminal Procedure and Investigation Act 1996 is a piece of legislation in the United Kingdom that regulates the procedure of investigating and prosecution of criminal offences.

## **Information Sharing Protocols**

The Kent and Medway information sharing agreement was introduced in recognition of the need for agencies to share information to ensure services are effectively delivered. Individual Chief Executives representing various organisations (this does not currently include Health providers who are not signatories) formally undertake to ensure protocols and procedures to share information accord with the agreement. The agreement has been developed to:

Provide a framework for embedding best practice with regard to the exchanging of information.

Acknowledge the need for partners to share information proactively. Set out the legal gateway through which information is shared.

Describe the security procedures necessary to ensure compliance with legal and regulatory responsibilities.

Provide a generic standard to be applied for the various specific purposes.

Clarify the understanding between signatories.

Describes the roles and structures that will support the exchange of information between parties.

Ensure compliance with individual partners' policies, legal duties and obligations.