Domestic Homicide Review
Pauline/2016
Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review Completed:

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1. Introduction

(*In this report the real names of all persons involved have been anonymised)*

This domestic homicide review (DHR) examines the circumstances surrounding the death of Pauline Matthews in Kent on either the 3rd or 4th of February 2016. She died as a result of an act committed by Marcus Matthews, her husband, and man she had been married to for 30 years. Pauline was a mother of 4 children and together with Marcus cared for her father Brendan Flowers who lived with them.

At Maidstone Crown Court Marcus Matthews pleaded guilty to the murder of Pauline Matthews and the theft of £180,000 from Brendan Flowers.

2. The Review Panel

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. The panel met three times during the course of the review. Each panel member is selected due to their independence from all aspects of the review.

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

The Independent Chair of the review panel is a retired senior Police Officer having retired in 2014. 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. He is also a trustee of a domestic abuse charity. The Independent Chair has no connection with the Community Safety Partnership.

3. The Review Process

At an initial meeting of the review panel on 20th April 2016, the terms of reference were agreed to cover the involvement that agencies had with Pauline and/or Marcus from 1st November 2014 to her death on either the 3rd or 4th of February 2016. In addition organisations were asked to report upon their involvement with Pauline's father Brendan Flowers and any of their children. The following organisations were requested to provide Individual Management Reviews (IMRs):

- 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

IMRs include the following:

- a chronology of interaction with Pauline, Marcus and Brendan Flowers;
- what was done or agreed;
- whether internal procedures were followed; and
- conclusions and recommendations from the agency's perspective

Additional reports and interviews were conducted with the following:

- Private care providers to Brendan Flowers
- Education and Young Persons Services
- A close friend of Pauline
- Peter and Olivia Matthews two of Pauline's children

In addition, requests were made to the work place of Marcus Matthews, Pauline's sister, and the church where Pauline attended. All either declined or stated that they had no information to offer.

4. Terms of Reference for the DHR

Summary Chronology

On the 4th of February 2016 as a result of information the Police had received they attended the home address of Pauline and Marcus Matthews. There they found the body of Pauline Matthews. Subsequently Marcus was arrested and admitted to killing Pauline. He was charged with her murder and remanded in custody.

It was agreed by the Kent and Medway Domestic Homicide Review (DHR) core panel, at a meeting held on 4th March 2016, that the criteria for a DHR were met in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

The agreement was ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office was informed.

The Purpose of the DHR

The purpose of this review 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.

The Focus of the 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.

The initial research taken from agency contacts, family and friends, does not suggest that Pauline was a victim of domestic abuse at the hands of Marcus, prior to the incident resulting in her death. However, it is clear from the review that there were significant pressures being placed upon both of them prior to Pauline's death. These revolved around, the care of Pauline's father Brendan Flowers. Financial pressures within the family, in the main caused by Marcus who was using his Father in law's money for prostitutes, escorts and gambling, although it seems that this was not known by any family members.

The review will examine in detail:

- The pressures placed upon Pauline in managing the care of her very ill Father. Her interactions with care services, and the impact upon her own health and wellbeing. In addition the use of the Care Act 2015 in assessing her needs as a carer.
- The process for the investigation of a Suspicious Activity Report (SAR) provided in terms of the management of Brendan Flowers' finances.
- The Lasting Power of Attorney granted to Pauline and Marcus Matthews to manage the financial and health needs of Brendan Flowers.
- Information sharing protocols
- The learning from this incident and any recommendations to prevent such future incidents

DHR Methodology

Independent Management Reviews (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 and/or Marcus 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 had any direct involvement with Pauline or Marcus, and who is not 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 and/or Marcus from 1st November 2014 to 4th February 2016. If any information relating to Pauline being a victim, or Marcus being a perpetrator, of domestic abuse before 1st November 2014 comes to light, that should also be included in the IMR.

Information relevant to the homicide which is held by an agency required to complete an IMR 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 and/or Marcus. 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 2010, 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 has done 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 Community Safety Partnership.

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 and Marcus 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 and/or Marcus (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 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 and Marcus (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 and promote her welfare, or the way it identified, assessed, and managed the risks posed by Marcus Matthews? Are any such lessons 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, or for working in partnership with other agencies and resources?

x. How accessible were the services to Pauline and Marcus (as applicable)?

xi. To what degree could the death of Pauline have been accurately predicted and prevented?

5. Key issues arising from the Domestic Homicide Review

Pauline had been married to Marcus for approximately 30 years and to all, appeared to have a good and strong relationship.

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.

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.

Pauline shared with several different agencies and friends that she was struggling to manage the needs presented by her father's illness.

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.

The private care team visited 4 times a day, 7 days a week.

In the summer of 2015 friends and work colleagues noticed that Pauline had lost a significant amount of weight. Pauline put this down to healthy living and taking up running.

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.

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 is not known. He undertook treatment for anxiety and depression.

Marcus disclosed during his treatment for anxiety and depression that he drank heavily, about 40 units per week.

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 3 months before Pauline's death he had been unable to settle the account for the care of Brendan Flowers.

Marcus was stealing money from his father-in-law. He was spending this money on escorts, prostitutes, and gambling.

6. Conclusions, Lessons Learned and Recommendations from the Review

Conclusions

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 available to suggest that Marcus had been a domestic abuse perpetrator prior to the actions which caused Pauline's death. However, the circumstances presented in this report relating to the pressures of caring and managing a relative with complex needs, the stress and pressures both Pauline and Marcus reported to their Doctor and other people had seen and had 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.

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 safeguarding concern alerted agencies to the fact that the family were experiencing difficulties in their coping. While it is acknowledged that at times offers of support were presented to Pauline, there was not a clear recommendation or adherence with the guidance as

set out within the ‘Supporting Carers Policy and Practice guidance' (published in April 2015, revised October 2015)

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. Neither was there a 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.

Between 15th of November 2011 and 13th of September 2015 Brendan Flowers had multiple admissions to hospital. Following all Hospital discharges, Brendan 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 and reviews were discussed and agreed solely with Pauline Matthews.

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 is disputed by Pauline’s son, Peter Matthews, whose view was that family members would certainly have been at the house. These details are hard to evaluate, additional evidence presented indicates that Brendan was regularly visited by members of the church and other voluntary groups. 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 to them. The Private care provider is register and regulated by the Care Quality Commission (CQC).

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. 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 that offences were being committed and the provision of 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 offences and could form the basis of an improved approach in such cases in the future.

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 strain this was placing upon the whole family by other professionals was not linked. 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 practice, this could have led to an escalation of concerns and provided the opportunity for a different approach.

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 signals that can lead to domestic abuse are essential. That it is not always violence based, but includes controlling behaviour. This will improve the skill base of all staff and enhance the service provided by the practice.

Lessons to be learnt

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 or information available from agency contacts, family or friends that 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.

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.

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.

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.

The panel has outlined six recommendations based upon the findings of the IMRs and reports submitted.

Recommendations

The review panel makes the following recommendations from this DHR:

	Recommendation	Organisation
1	All member agencies of the Kent & Medway Safeguarding Adults Board to ensure staff awareness of carer's stress and the need to offer 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 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 with partner agencies. *(In line with the Kent and Medway information sharing protocols)*	Kent Police
4	To ensure effective training is provided to all 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 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