SETDAB | Southend, Essex & Thurrock Domestic Abuse Board

Tendring Community Safety Partnership

DHR Overview Report Executive Summary

Prepared by

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The Tendring Community Safety Partnership

1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Adult A in South Essex, in August 2017. The DHR process was centralised across Southend, Essex and Thurrock in July 2017. The case was considered by a central DHR core group on the 13th September 2017 where it was decided that a DHR would be commissioned by the Tendring Community Safety Partnership.

In August 2017 Essex Police received a call from the East of England ambulance service reporting a sudden death of a female at the home address of the youngest daughter of the deceased in South Essex.

An inquest into Adult A's death was opened and adjourned in August 2017. At the time of writing the outcome of the inquest is not known.

Subsequent to the death of the victim, her eldest daughter was arrested and charged with murder. She appeared in court for trial in February 2018 and was found guilty of murder and sentenced to life imprisonment.

The DHR panel wishes to express its condolences to the family of the victim and recognises the distress that the incident and this subsequent review brings. We hope this report will provide them with assurance that the circumstances of the involvement of local agencies has been properly and thoroughly reviewed.

The panel has sought to ensure that the voice of the victim is central to this report. The DHR panel and the Home Office Quality Assurance panel have recognised that this has been challenging, given that family members declined to participate in the review process. However, the DHR panel has strived to focus on the circumstances and needs of the victim, while balancing an appropriate degree of review of service contact with the perpetrator.

The report and Executive Summary use Adult A to denote the victim in this case and Adult B to denote the perpetrator. The decision to adopt this approach was taken after discussion with the panel and was taken to maintain confidentiality. In addition because family members declined to be involved in the review the panel felt unable to use a pseudonym, because without their consent there was an inherent risk of choosing a name that was sensitive to them.

Subjects of the review

Adult A - victim

White British female
Date of Birth: January 1947
Date of Death: August 2017

Adult B - perpetrator
White British female
Date of Birth: January 1966

Others included in the review:

- Adult C – Adult A's younger daughter
- Adult D – Adult A's husband
- Adult E – Adult B's husband
- Adult F – Adult C's husband

2. The DHR process

The DHR has been conducted in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004. It has since been updated and was republished in December 2016. This DHR has used this revised guidance in the development of this Overview Report.

The review has considered agencies contact/involvement with Adult A and Adult B from August 2015 to the date of the homicide.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The DHR began in September 2017 and was completed in June 2018. This report was approved by the DHR panel prior to its submission to the Home Office.

3. Contributors to the review

A number of agencies contributed to the review through the submission of IMRs and the provision of initial scoping information. Those agencies were:

- Anglian Community Enterprise (ACE)
- A GP Practice (involvement with Adult A)
- East of England Ambulance Service (EEAST)
- Essex County Council – Adult Social Care (ASC)
- Essex Police
- Home Instead
- A GP Practice (involvement with perpetrator Adult B)
- Mid-Essex Hospital NHS Trust
- Essex Partnership University NHS Foundation Trust/STARS

1.10 Panel Membership

Steve Appleton	Managing Director Contact Consulting – Independent Chair
Mel Arthey	Essex Partnership University NHS Foundation Trust - Clinical Specialist Safeguarding
Janet Dalrymple	Chief Executive - Safer Places
Sandra Garner	North East Essex CCG – Designated Nurse Safeguarding Children
Helen MacIsaac	Essex County Council – Adult Operations Team Manager
DI Alison Hooper	Essex Police –Public Protection Strategic Centre
Cllr Lynda McWilliams	Tendring DC – Community Safety Partnership (CSP) Chair
Anna Price	East of England Ambulance Service – Named Professional for Safeguarding
Leanne Thornton	Tendring CSP Manager
Michelle Williams	DA Co-ordinator- SET Domestic Abuse Board

5. The Overview Report author

The independent author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He went on to hold operational management roles in local authorities and senior strategic posts in the NHS.

Steve has been Managing Director of Contact Consulting, a consultancy and research practice for 11 years. In that time he has led reviews into a number of high profile serious incidents including mental health homicides, adult safeguarding, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has now chaired over a dozen DHRs for local authority community safety partnerships.

Steve has had no previous involvement with the subjects of the review or the case.

6. Terms of Reference

- Establish the facts that led to the incident in August 2017 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.

- Identify what the lessons are, if any, how they will be acted upon and what is expected to change as a result.

- Establish whether the agencies or inter-agency responses were appropriate within the frameworks in which the organisations operate leading up to and at the time of the incident in August 2017; suggesting changes and/or identifying good practice where appropriate.

- Establish whether agencies have required policy and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

- Contribute to a better understanding of the nature of domestic violence and abuse.

- Highlight good practice.

7. Views of the family

The panel has sought throughout the review to ensure that the wishes of the surviving family members have informed the DHR Terms of Reference and are reflected in the DHR report.

The Chair of the Panel wrote to the husband of Adult A and to her younger daughter (Adult C) to advise them of the commencement of the review, the process and to invite them to contribute to the review. The family responded to this and declined the invitation to participate and as such the panel has respected their wish. As is usual practice, the family was provided with information about specialist advocacy support when contacted by the Police Family Liaison Officer.

8. Involvement with the perpetrator

The panel has communicated with the perpetrator. The Chair wrote to Adult B to advise her of the commencement of the review, the process and to invite her to contribute to the review. At the time of writing no response had been received from Adult B and as such she has not had any input to the DHR.

The panel identified one friend of the perpetrator who it was felt might have helpful insights and information. The Chair wrote to the individual to advise them of the commencement of the review, the process and to invite her to contribute to the review. At the time of writing no response to that letter had been received.

9. Conclusions

Having reviewed and analysed the information contained within the IMRs, the chronology of events and the information provided by family members, the panel has reached the following conclusions:

Findings and conclusions relating to services provided to Adult A

Adult A and her husband had had a long marriage and there is no evidence that it was anything other than a loving and supportive relationship. Adult D had been a dedicated carer for his wife in the three years prior to her death, giving up work to care for her fulltime. It is clear that Adult C played an active and supportive role in caring for her mother, and spent some time liaising with those agencies and individuals who were providing support.

The panel have given the family the opportunity to participate in the review but have had to respect their decision not to take part in the process. The panel recognises the value family and friends can add to the review, and therefore identify this does leave gaps.

Based on the information available there is no evidence that there was ever any domestic abuse or violence between Adult A and her husband, nor from Adult B toward either of her parents.

The care and support offered to Adult A by her GP surgery was of a good standard. There were no issues relating to access to GP services and the surgery and its staff had a good knowledge of Adult A's health needs and of her home circumstances. Appropriate referrals for other services were made by the GP. In particular the referral to specialist dementia services for assessment was timely. There was no routine enquiry about domestic abuse, but given there was no indication that any such incidents were happening, this was probably reasonable.

The engagement of ACE was appropriate. Their input was delivered in an appropriate way and overall met the standards that would be expected of such a service. In particular there is evidence that the staff from ACE took care to consult Adult D about their interventions with her throughout their involvement. However, there is no evidence that they sought any wider information about the relationship between Adult A and her husband or the wider family.

ACE staff rightly ensured that a Mental Capacity Act assessment was conducted. It is clear that the outcome of this was properly recorded on the appropriate form.

The input from Essex County Council Adult Social Care (ASC) did attempt to meet Adult A's needs. In particular the use of personal budgets to enable Adult D to procure respite support was appropriate. The offering and conducting of a carer's assessment for Adult D was appropriate and in line with standard practice. However, there were some deficits in the contacts between the ASC worker and Adult A and her husband.

However, the oversight of the worker was not sufficient to enable those more senior at the time to have a clear view of the details of case, and thus to guide and supervise the worker.

The tasks that the worker was undertaking were appropriate but the process of doing them was not. This is reflected in the fact that the worker did not keep accurate records of contacts with Adult A, nor did those records set out any detail of the wider family network. In addition there is no evidence that the worker engaged with the wider multi-disciplinary team.

This all resulted in the worker making key decisions alone, with little or no regular oversight or sufficient scrutiny of their work. Although the omissions in

recording and deficits in supervision had no bearing on the eventual outcome, they did result in the lack of an accurate picture of the family and after the incident made it harder to establish the nature of ASC's involvement.

No carer's assessment was offered to Adult C and this should have taken place given that she too had a caring role with her mother.

The involvement of NEP/EPUT with Adult A through its dementia services was appropriate and the assessment process was conducted thoroughly, resulting in a clear diagnosis. Appropriate medication was prescribed and regularly reviewed. Risk assessments and care plans were in place and were properly reviewed during regular clinical meetings.

Overall there was good and regular communication with Adult A's GP about the input of the dementia service with Adult A. However, there was one instance where a letter to the GP which outlined changes to the care plan was not sent. This was not spotted by the service in the first instance. Adult C alerted the service and the oversight was rectified swiftly. However, there was a breakdown in the system for sending the letter that resulted in delays to the implementation of an amended care plan and the resultant actions needed.

Adult D raised his concerns about his wife's increasing agitation with the service on two occasions. He was advised to contact the helpline, which he did. He was told that his concerns would be raised in a clinical meeting which was in line with standard practice. The clinical meetings are multi-disciplinary meetings and it was reasonable that these were the forum for such a discussion. Adult D was advised of the discussions after each clinical meeting.

The respite service offered by Home Instead was helpful and appropriate, in that it enabled Adult D to have a much needed break from his caring responsibilities. The service appears to have been valued by him and there was a good rapport between him, Adult A and the carers that visited.

Findings and conclusions relating to services provided to Adult B

The care and treatment provided by the Mid-Essex GP practice was of a good standard and followed appropriate clinical practice. The GPs that saw Adult B had built a good relationship with her and there was continuity of care throughout. Standards of record keeping within the Surgery were good.

The GP practice made appropriate referrals to other specialist services, including Open Road.

Although they knew there were difficulties in Adult B's relationship with her husband, it does not seem that the GPs were fully aware of the incidents of domestic abuse with her husband or with her son. They did not make any routine enquiry about domestic abuse. Had they done so, and given their good relationship with her, they might have become aware of the incident in 2015 and in 2017. Given her misuse of alcohol and episodes of low mood, it would have been helpful to make such a routine enquiry in order to build a wider picture of the circumstances in which Adult B found herself and the relationship between her alcohol use and her behaviour.

Following presentation at the Emergency Department at Broomfield Hospital, Adult B was referred to Open Road for help with her alcohol issues. Open Road responded quickly to those referrals, but Adult B's engagement with the service was limited. Given the nature of the service, Adult B could not be compelled to engage and her withdrawal from the service was perhaps not unusual in the context of her continuing dependence on alcohol.

The response of the Mental Health Team whilst in the Emergency Department at Broomfield Hospital was appropriate and swift. They conducted assessments of her mental health and of her risk to herself and others. These were appropriately communicated the outcome of those assessments to Adult B's GP surgery. There was no evidence at the time that there was an ongoing risk of harm to others, and that the incident in 2015 occurred in the context of her excessive use of alcohol. There is no evidence that threats were made by Adult B to her husband again.

It is clear that Adult B, although experiencing periods of low mood, did not exhibit a severe or enduring mental illness, and as such did not meet the criteria for specialist secondary mental health care services.

EEAST responded swiftly and appropriately to calls for assistance from Adult B and her husband. They also contacted the Police to attend with them and this was appropriate. It may have been helpful to raise a safeguarding alert, but there is no evidence that not doing so had any bearing on the eventual incident.

Essex Police had contact with Adult B in 2015 and 2017 and on each of the occasions that they attended her home they did so appropriately and in a timely way. However there were gaps in practice during the attendances that took place (not including the attendance at Adult A's death). In particular there were gaps in recording that affected the risk grading of the incidents in question. This resulted in other agencies not being alerted and as such other supports and interventions were not considered. Having said that, these issues related to issues in Adult B's relationship with her husband and son,

not with her mother. It is therefore reasonable to conclude that there was no direct impact on the eventual homicide.

There was no evidence in the information made available to the panel that Adult B posed any risk of harm to her mother.

General conclusions

Services provided to Adult A were generally of a good standard and she and her husband were well supported in living with the challenges of her failing cognitive abilities.

There were gaps in the recording of contacts, assessments and interventions that although having no direct bearing on the eventual homicide itself, they do represent deficits in practice that need to be addressed.

There were challenges in the relationship between Adult B and her husband and to some extent with her son. These appear to have largely been related to her excessive use of alcohol. This had also led to her leaving her job. Although she experienced low mood and was under stress, she did not have a severe and enduring mental illness.

Little was known by agencies about the wider family relationships. It is not clear that if more had been known this would have made any difference to the way in which they responded or the eventual incident.

From the information reviewed there is no evidence that Adult B posed any risk or threat to Adult A and that the incident occurred without warning.

10. DHR recommendations

This section of the Overview Report sets out the recommendations made in each of the IMR reports that are revelant to the DHR and then the recommendations of the DHR panel.

DHR recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs.

The DHR panel has made four recommendations for action:

1. Ensure Domestic Abuse is included within the Training received by Essex GPs including consideration of the use of routine enquiry. The panel recognises that due to the presence of a standard National Contract there is only so far CCGs can go in delivering such a recommendation. The panel therefore also directs this recommendation to NHS England. The independent chair of the panel will write to NHS England's safeguarding lead to raise this issue and recommend guidance be issued by NHS England.

2. Essex ASC should ensure that allocation processes are robust and that case work is undertaken by appropriately qualified staff including the regular supervision of unqualified staff.

3. Essex ASC and EPUT ensure that joint working between their respective staff takes place and that information about cases is regularly and appropriately shared between practitioners including holding multi-disciplinary team meetings where appropriate.

4. An audit of the levels of satisfaction following advice given, and actions resulting, from a carer phoning the dementia helpline should be conducted by EPUT.