Tendring Community Safety Partnership

DHR Overview Report

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The Tendring
Community Safety
Partnership

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Section One
Introduction and background

1.1 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 Overview 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.

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —*

- *a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'*

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In addition to agency involvement the review also examined the past to identify any relevant background or pattern of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. The review seeks to identify the lessons that may be learned from this case and through its recommendations, assist in making victims and those affected by domestic abuse safer in the future.

1.3 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

1.4 Process of the review

The notification of the homicide to the Tendring Community Safety Partnership (TCSP) was made on 22 August 2017. The decision to hold the DHR was taken by the DHR Core Group and Chair of TCSP on 13 September 2017 having decided that the criteria set out within The Act was met. The Home Office was advised of the decision on 13th September 2017.

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.

1.5 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the TCSP accepts the Overview Report, Executive Summary and Action Plan and it has been reviewed and approved by the Home Office Quality Assurance Panel.

1.6 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.

1.7 Methodology

An initial scoping process was undertaken to establish the agencies and organisations that had contact with Adult A and Adult B. As part of this process a list of agencies and relevant contacts was developed and a timeline was created. This process enabled the gathering of information about types and level of contact and informed the decisions about which agencies and organisations to approach to request Individual Management Reviews.

Individual Management Reviews (IMR) were requested from a range of agencies to establish if there had been contact with Adult A and B and if so the nature of that contact and any services or interventions provided to Adult A and Adult B.

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of any contact and/or service provision by agencies with both Adult A and Adult B.

The IMRs were used to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs were also used to assess the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

IMRs were reviewed by the panel members. IMRs were presented and discussed at a panel meeting. Questions were asked and clarifications sought by the panel regarding specific elements of each of the IMRs. Some IMRs were amended and resubmitted as a result of those discussions.

The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the DHR panel.

This Overview Report is based on IMRs commissioned from local agencies as well as summary reports and scoping information.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review.

1.8 Involvement with 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.

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.

1.9 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

1.11 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.

1.12 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Adult A and Adult B and if this played any part in how services responded to their needs.

"The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

The nine protected characteristics in the Equality Act were considered by the panel and two were found to have direct relevance to the review. These were sex, age and disability. The victim was an older female who was living with dementia. The panel ensured that the review always considered these issues in their thinking about the engagement and involvement of organisations and professionals and where identified, the impact of them on decision making.

Research conducted by the University of Warwick in 2016 found that 45% of UK adults over pensionable age live with a disability, it also found that 15.7% of women with disability experienced domestic abuse in 2015.[3]

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[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty
[3] Disabled women and domestic violence, Thiara, Dr. R. University of Warwick 2016

It is in this context that the panel felt that the three protected characteristics were of direct relevance in this case.

1.13 Dissemination

The Overview Report will be sent to all the organisations that contributed to the DHR. In addition an appropriately anonymised electronic version of the Overview Report will be posted on the SET Domestic Abuse website. A copy will be provided to the Police Crime and Fire Commissioner.

1.14 Chronology

A full combined chronology of agencies contact with both the victim and perpetrator has been compiled as part of the DHR. That chronology is not appended to this report in accordance with Home Office advice. What follows is a narrative chronology of agency and organisational involvement.

Narrative Chronology for victim

In June 2015 a Section 2 Mental Health Act Assessment was undertaken at the home of Adult A. The outcome was detention under Section 2 and she was admitted for further assessment and treatment in a hospital setting. Adult A was discharged from Section 2 and back to her GP with a care coordinator in late July 2015.

In August 2015 carers were commissioned to take Adult A out in to the community. Service noted to be going well.

In October 2015 Adult A's husband was asking for respite to allow him a break from his caring role. Care review undertaken and one week respite requested.

In November 2015 community nursing visited Adult A for a trial without catheter. Noted in full chronology that opportunity to undertake holistic assessment of husbands needs was overlooked at this time.

In January 2016 a memory monitoring process was undertaken. Risk assessment states that husband (Adult D) felt that Adult A was much the same as she was six months before, including requiring prompts for self-care. Adult A was not aware of why she was in the assessment and appeared distant and confused. The husband stated that it takes a while in the mornings for the medication to take effect but she also becomes agitated during the early evening. Advice given to seek support from the helpline to discuss evening issues.

Further calls and discussions took place throughout January 2016 in relation to Adult D's concerns about her restlessness and agitation in the early evenings. The helpline was accessed as were the GP practice and the memory monitoring service for advice and support.

In February 2016 North Essex Partnership University NHS Foundation Trust (NEP) (now part of Essex Partnership University NHS Trust (EPUT)) saw Adult A for a medical review. The outcome was to continue as planned and for the helpline to be used for support. A further review was to be held in six months' time. A letter stating the outcomes of this review was not sent to the GP therefore the recommended actions for the GP were not immediately undertaken. Adult A was sent a letter

following this contact, which did outline actions, including changes to the timing of administration of her medication, which were able to be actioned by Adult D.

In May 2016 Adult A's youngest daughter (Adult C) contacted the dementia helpline to state that in the review in February her mum should have an ongoing nurse to monitor Adult A's situation and medication but this had not happened. She also informed them that Adult A was awaiting an assessment from a continence nurse.

In May 2016 NEP received a referral back from Adult A's daughter due to on-going concerns about Adult A's agitation. The response was further referral to the Dementia Support Team. The outcome was an increase in medication of Mirtazepine and it was for the GP surgery to action this. Although there was some delay in this happening due to the previous issues with non-receipt by the GP of the letter in May, referred to above, this was subsequently actioned.

In June 2016 ACE met with Adult A and daughter to discuss continence issues. Advice given and prescription dispensed. This was identified as an opportunity that was overlooked to undertake an holistic assessment of Adult A's husband.

In August 2016 Adult A spent a three week period in respite care. She was seen by GPs in regard to a query about a stroke and at A&E about a muscle strain. In September 2016 a referral was received for a continence assessment which took place and a plan was put in to place and shared with GP and family.

Throughout the period of October 2016 and March 2017 Adult A was seen by ACE service on several occasions after referrals requested by the GP. These visits included some personal care (podiatry), assessments of Adult A in line with her care plan, and contact with GP relating to blood results and episodes of diarrhoea. Concerns raised by the family relating to weight loss in Adult A.

In late March 2017 Adult A returned home from a stay with her youngest daughter. She had had a fall and was badly bruised as a result of this. No concerns were raised regarding the situation and previous falls on record.

Throughout the month of April 2017 Adult A was visited by the memory monitoring service once and by the ACE service on ten occasions. Each visit included a basic assessment of her general health, mobility and pressure care. A Mental Capacity Act (MCA) assessment was undertaken in relation to wound care (pressure ulcer) and a referral was made to the dietician service due to concerns around weight loss.

In May of 2017 Adult A was seen by the ACE service fourteen times. This was for pressure area care and general assessments. Again mental capacity assessment was completed regarding wound care. A follow up referral was also undertaken to the dietician as no response had been received to the initial referral. Adult A's

husband and youngest daughter also spoke with the GP and ACE service about their concerns relating to weight loss as well as increasing levels of confusion being shown by Adult A.

June 2017 saw Adult A being discharged in relation to wound care as the wound had healed. The ACE service conducted three visits throughout the month of which one outcome was the discharge from ulcer care as well as undertaking assessments of Adult A's general wellbeing including monitoring her weight, activity, mobility, nutrition and Body Mass Index (BMI).

Towards the end of June 2017 Adult A's husband spoke with the GP and supported Adult A in attending the GP practice. Husband was concerned Adult A was off colour and appeared lethargic. GP treated for potential Urinary Tract Infection (UTI) though no sample could be obtained. Other medications were reviewed after discussion about Adult A's difficulties in swallowing tablets. All medications changed to orodispersible or solutions.

In July 2017 a referral was made relating to pressure area care as there was concern that the wound had re-opened. Two visits from the ACE team were recorded for the month of July.

One visit was made by the ACE team in the month of August 2017 where an assessment was completed.

Adult A died at an address in South Essex in August 2017.

Narrative Chronology for Adult B

In August 2013 a report of domestic abuse was received by Essex Police relating to an incident where Adult B had confronted her son about moving her car and that the row had resulted in Adult B being pushed causing her to fall. The incident occurred whilst both were intoxicated. No further action taken as once sober, no allegations of assault were made and no other offences were disclosed.

In July 2015 the Ambulance service attended Adult B’s address on two occasions. On the first occasion assessment by the ambulance crew was refused by Adult B. On the second occasion their attendance was due to suspected overdose, police attendance was also requested due to concern that Adult B was armed with a knife and reported as being violent. It was noted that aggression was being shown by Adult B to her husband. Both parties were intoxicated. Adult B was conveyed to hospital. At hospital she received an assessment from a Registered Mental Health Nurse. Adult B stated her actions were impulsive and as a result of an argument with her husband. A copy of the assessment was sent to the GP which included the suggestion of referral to the Improving Access to Psychological Therapies service

(IAPT) and continuation of engagement with Open Road to address her alcohol misuse.

After this incident the GP referred Adult B to NEP. Their assessment highlighted concern that whilst engaging with Open Road regarding alcohol dependency there was a question about whether there may be an underlying depressive disorder which exacerbated the alcohol misuse.

Medication (fluoxetine) previously prescribed was stopped after three weeks as although this had some impact on Adult B's mood it also caused her extreme agitation and anxiety. The multi-disciplinary team noted that assessment of mental state would be difficult due to the heavy use of alcohol.

In April 2016 a full assessment was completed by Essex Specialist Treatment and Recovery Service (Essex STaRS). The potential pathway was discussed and a plan formulated with Adult B in relation to the risk of alcohol related withdrawal. Subsequently there was no engagement with Open Road so Adult B was discharged back to the care of GP.

In March 2017 Adult B took an overdose and was threatening to kill herself and feeling at crisis point. Police attended with the Ambulance service as Adult B was being physically violent and verbally abusive. She attempted to abscond prior to being conveyed to hospital. The Access and Assessment team completed an assessment after which it was agreed to discharge her back home with advice to contact GP for review of anti-depressant medication and to request medication to help with anxiety and poor sleep. Advice was given to utilise the crisis team for support when required. Adult B was also seen by the drug and alcohol liaison team.

In May 2017 a referral was made for Adult B to Essex STaRS after she stated she wanted to work with them. However, Adult B did not engage and made no response to telephone calls when contacted. An appointment letter for July was sent out but Adult B did not attend the appointment. She was discharged back to the GP.

At the end of May the GP notes show that discussion regarding alcohol intake and engagement with Open Road took place. It was noted that Adult B was engaging well and had reduced her intake of alcohol but this had then increased due to relationship issues impacting upon her life.

In mid July 2017 the Ambulance service was called to attend to Adult B after she collapsed, there was a query about overdose, she was conveyed to hospital. No outcome was recorded.

In July 2017 police received a non-emergency abandoned call from Adult B’s home address. On attendance it was believed that Adult B had had argument with her son and that she was arguing with her husband about this. There were no reports of assault or injury but Adult B refused to be interviewed only speaking to the police over the telephone about this. No further action was taken in respect of this incident. A risk assessment was completed and it was deemed this incident be classed as a standard risk, meaning that the evidence did not indicate likelihood of causing serious harm.

In August 2017 there was a GP appointment with Adult B to discuss alcohol intake and commencement of anti-depressants to help with problems with mood and sleep. This is the last professional contact recorded prior to Adult B's arrest.

Section Two

2.1 Introduction

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Adult A and Adult B. The report examines agency responses and support given to Adult A and Adult B in the two years prior to the incident in August 2017.

The DHR has not found any evidence of domestic violence or abuse relating to Adult A in this review, either from the IMRs received or the wider work of the panel. The review has found incidents of domestic violence or abuse in relation to Adult B and these are described in the IMRs and analysis. Despite these incidents, there are no recorded examples of contact between Adult B and domestic violence or abuse support organisations.

2.1.1 Summary of the incident

Adult A was a 70 year old married lady who lived in North Essex with her husband. Adult A had two adult children, to whom her husband was step-father. The eldest daughter, the perpetrator in this case, Adult B, aged 51 at the time of the homicide. Adult B lived with her partner, Adult E in Mid Essex. She has one son. The younger daughter, Adult C, lives in South Essex, with her husband, Adult F.

Adult A had been living with Alzheimer's Disease. Her husband stopped working in 2014 to provide care for her at home with the support of local home care and input from statutory agencies.

It had been their regular practice for Adult A to spend a weekend each month at her daughter Adult C's house. Over a weekend in August 2017 she was staying at Adult C's house and Adult B was also there. Adult B was staying with Adult C and Adult F following the breakdown of her relationship with Adult E.

At around 20.00 on the day prior to the incident, Adult A was assisted to go to bed in the spare room. Later that evening, around 23.30 Adult B joined her mother in the spare room and shared the bed with her.

At 00.03 on the day of the incident East of England Ambulance Service received a call from a man, assumed to be Adult F saying that his mother in law had died. The Ambulance service dispatched a crew to the address and notified the Police who also attended.

On arrival the Ambulance crew administered advanced life support for approximately 20 minutes before recognition of life extinct was declared at 00.32 on the day of the incident. A post mortem was conducted later on that day, which provisionally found that death was caused by compression to the neck.

On the day of the incident, Adult B was arrested and was subsequently charged with murder. Adult B appeared at Crown Court for trial during February 2018. She was found guilty and sentenced to life imprisonment.

2.2 Overview

2.2.1 NHS – General Practice

North Essex GP Practice - GP contact with Adult A

Adult A had been a registered patient at the practice since 2006. Adult A had begun to experience some memory loss in 2011, but her mental health deteriorated in 2013 and by the start of 2014 she was in the care of the Older Adult Psychiatry and Dementia Service, when she was diagnosed with early onset Alzheimer's Disease in September that year.

Following the diagnosis, Adult A's mental health worsened and in June 2015 she was assessed and detained under Section 2 of the Mental Health Act. She was then an inpatient at an Essex mental health hospital for the assessment and treatment of older people with dementia.

A memory medication monitoring review was undertaken in late March 2016 and the surgery received a report of this review. During March 2017 there were concerns about weight loss. Further blood tests were undertaken, the results of which were not of concern.

In June 2017, Adult A received a nurse home visit related to her physical health. At the same time her Mirtazapine[4] mediation was reduced to 30mg per day.

[4] Mirtazapine is a type of anti-depressant medication. It has been used in the treatment of people with dementia who are agitated in their behaviour.

In early July 2017 Adult D phoned the surgery to advise that his wife was '101% better'. There was no further contact between the surgery and Adult A before her death. The surgery was advised of her death in August 2017.

Mid Essex GP contact with Adult B

Adult B was registered with a Mid-Essex GP Practice and generally saw two of the GPs based there. The most significant issue that Adult B had contact with the surgery was about her misuse of alcohol. The surgery were first aware of this during February 2014 when Adult B saw her GP about her own concerns about her excessive use of alcohol. At this time Adult B reported to her GP that she was consuming a bottle of wine every night.

The misuse of alcohol had a negative effect on her relationship with her husband and on her work. She was described as 'a high functioning alcoholic'. The GPs were aware that alcohol was a significant part of her and her husband's relationship, which could be volatile due to their alcohol use.

Adult B did not disclose any domestic violence or abuse incidents to the GPs or to other staff there. There are no domestic abuse notifications on her medical records.

During 2016 and in March 2017, following referral by the GP practice, Adult B did engage with the local alcohol service, Open Road. By May 2017 Adult B had reduced her drinking, however relationship issues were again impacting on her life and she had returned to her previous pattern of excessive drinking.

The last documented contact in relation to alcohol was about a week before the homicide. Adult B reported to her GP that she was 'capping' her alcohol intake.

In March 2017 the mental health team at NEP reviewed Adult B during an attendance at the Emergency Department. They felt that any mental health issues being experienced by her were a result of excessive alcohol use and she was discharged home.

The only risk noted in the records was in March 2017 when the GPs were advised by Mid-Essex Hospital Services NHS Trust of an apparent overdose by Adult B of her anti-depressant medication. This was felt to be reactive in nature and not an on-going risk. Adult B had given up work due to increased stress and her alcohol use and was noted to have been taking less care of herself, this was noticeable to the GPs in her overall appearance and presentation. GP felt that Adult B did not want to stop drinking and she told them she had been lying to her husband about her alcohol use.

2.2.2 Anglia Community Enterprise (ACE)

Anglia Community Enterprise (ACE) provides over 40 adult and children's community healthcare and health and wellbeing services to the population of North Essex. ACE had contact with Adult A through three of its services, Community Nursing, Podiatry and the Urology and Continence Service.

The Community Nursing Service (CNS) provided support to Adult A in managing pressure ulcers. They had been providing this support since April 2017. Treatment and support for the pressure ulcer was provided and when healed, Adult A was discharged from the CNS in June 2017.

The podiatry service assessed Adult A for a service in October 2016. She did not meet the criteria for the service and was discharged.

The Urology and Continence service had contact with Adult A to assess for and provide incontinence pads in May 2016 and this service continued until her death.

2.2.3 Adult Social Care

Essex County Council Adult Social Care (ASC) had contact with Adult A, her husband and Adult A's daughter Adult C. The first principle contact came in 2014 when Adult A was referred to the team and support was provided by a Community Psychiatric Nurse.

Three reviews were completed in 2015 in response to contact from Adult A's husband reporting changes to her situation, and in response to Adult A being an inpatient in April 2015.

In August 2015 Adult D was assessed for and provided with a personal budget that would enable him to purchase care support for his wife. This took the form of the provision of companionship visits to Adult A that would enable her husband to have a break from his caring role. These visits were undertaken by Home Instead.

In October 2015 a carer's assessment was conducted in relation to Adult D as a result of this, respite care was considered as a current need. Day services were in place from April 2015 until October 2016. In addition domiciliary home care was provided from October 2016.

Most contact was from an unqualified social care worker. The case was active intermittently from 2014 until Aug 2017, however it was not always allocated to the worker during this time. Adult D or Adult C would contact the worker if there was a change in circumstances and the worker would then respond.

The worker confirmed that she had a lot of contact and intervention with Adult A and her family but the IMR finds that this is not reflected in the recording keeping in the case notes.

2.2.4 Home Instead

Home Instead Senior Care offer three types of care: personal care, home help and companionship Home Instead provided input to Adult A from August 2015 to August 2017. The main point of contact throughout for Home Instead was Adult D and also Adult A's social care worker from ASC.

Initially the service was provided for two hours per day, Monday to Friday and the visits from Home Instead were for companionship. Care givers often took Adult A out in the car, for walks or for coffee. This enabled her husband to have a break from his caring responsibilities. In October 2015 the number of contacts was reduced to four times a week. Carer givers did notice that over time Adult A had lost a lot of weight and they were aware that her husband had consulted the GP about this.

No safeguarding concerns were raised by Home Instead staff. They were made aware in March 2017 that Adult A had suffered a fall and had bruised her hip, but because they did not provide personal care to her they did not see the bruising.

There is no record that Home Instead staff had any contact with other members of the family.

2.2.5 EPUT/Open Road

Essex Partnership University NHS Foundation Trust (EPUT) was formed in April 2017 following the merger of North Essex Partnership University NHS Foundation Trust (NEP) and South Essex Partnership University NHS Foundation Trust. Prior to the merger, NEP had provided mental health service input to Adult B and had provided dementia care services to Adult A. Following the merger there were no changes to the pattern of services.

Open Road is a drug and alcohol service, and staff there act as the service users primary worker. The service is provided in partnership with the Essex Specialist Treatment and Recovery Service (Essex STaRS) which is a specialist prescribing service.

Involvement with Adult A

Adult A had contact with the dementia services provided previously by NEP and now by EPUT. She was first given a diagnosis of Alzheimer's Disease in September 2014 and had continued to receive services since then.

She has been prescribed medication to slow the decline of her cognitive functions. Adult A was referred to the Dementia Access Team, which completes all urgent work, such as on call assessments, home treatment and routine work such as information meetings, occupational therapy and group work.

Adult A had a meeting with the service to discuss welfare benefits and a referral to social care services and the offer of a Cognitive Stimulation Therapy Group. She was supported by a care coordinator in the Dementia Support team to review medications, their effectiveness and side effects, and a mini mental state examination.

In August 2015 Adult A was discharged and she was transferred to the Memory Monitoring Service. This service is for anyone prescribed medication for their dementia. This service does not provide care co-ordination.

In January 2016 Adult A was seen for a routine medication review. She was still experiencing confusion and agitation. Adult D was advised to contact the helpline to discuss this. A further review was scheduled for six months' time. Adult D did contact the helpline and was advised that the issues of agitation would be discussed at the next clinical meeting. In January 2016 a clinical meeting was held and no changes were made to the medication. Adult D was still concerned about Adult A's restlessness. It was agreed that this would be discussed further at another clinical meeting.

An outpatient appointment to discuss medication took place in the first week of February 2016. Adult D again expressed concerns about his wife's agitation. The outcome was that the GP would be advised of the need to make an increase in medication. As a contingency if this did not prove effective, Adult D was advised to change the time of one of Adult A's already prescribed medications to help with the agitation and this was set out in a letter that was sent to Adult A following the appointment.

A further review was scheduled for six months' time. As described in the narrative chronology, the letter regarding this did not reach the GP and so this change in medication was not immediately actioned. Following enquiry by Adult C it was confirmed that the letter to the GP had not been sent. This was discussed at the next clinical meeting and Adult C was contacted by the nurse and assured that the GP would be asked to action the existing plan.

In March 2017 the last contact with Adult A by the team took place. She was seen with her husband for a medication review. A mini mental state examination did not take place due to her cognitive decline. The plan was to continue with the medication and a further review was due to take place after six months.

Involvement with Adult B

Adult B presented at the Emergency Department on two occasions, firstly in 2015 and then in March 2017. Both of these incidents involved excessive use of alcohol. On each occasion specialist mental health service staff assessed her and she was encouraged to seek help from Open Road. Adult B was assessed as not requiring ongoing mental health service input. She did not meet the criteria for service, as she did not have a severe and enduring mental illness. She was provided with a Crisis Card with information about where to seek help when in crisis.

Adult B did access the Open Road service (as evidenced by the GP IMR) but disengaged quickly on each occasion.

2.2.6 East of England Ambulance Service NHS Trust (EEAST)

Involvement with Adult A

East of England Ambulance Service NHS Trust (EEAST) had previous contact with Adult A. In August 2014 they attended to her following reports of shortness of breath and the expression of anxiety following an injury to her shin.

The next contact with Adult A was in June 2015 when the ambulance service conveyed her to hospital. This was following an assessment of her mental health. Adult A was subsequently detained under Section 2 of the Mental Health Act.

The next and final contact was in relation to the homicide. Shortly after midnight on the night of the incident in August 2017 EEAST were called via the 999 service. A paramedic was dispatched and Essex Police were contacted and asked to attend the scene. The paramedic crew arrived on scene first and were subsequently joined by an Emergency Medical Technician and a two person ambulance crew, who were accompanied by a student paramedic. Life extinct was pronounced at 00.32.

Involvement with Adult B

EEAST had previous contact with Adult B. In July 2015 they attended to her at her home. She has been complaining of chest pain, had been vomiting and was experiencing dizziness. The symptoms appeared to the crew to be the result of intoxication by alcohol. Whilst there the attendance of the crew was cancelled by Adult B and they were asked to leave before completing a full assessment. It was reported to them while there that she was under stress as a result of her mother's recent detention under the Mental Health Act.

5 days later EEAST were called to attend to Adult B following a suspected overdose. She was reported as being potentially violent. It was reported that Adult B was in possession of a carving knife and was intoxicated. The police were called to attend. Although Adult B left the house during the initial call to EEAST she did return. She was noted to be displaying aggression towards her husband. She was conveyed to Broomfield Hospital. The ambulance crew advised need for assessment of Adult B's mental health as a matter of urgency.

In March 2017, Adult B, who stated she had taken an overdose and was threatening to take her own life called EEAST. She described feeling at crisis point, suicidal and unable to cope. During assessment, at which Police were also present, she denied overdose but had consumed alcohol and was not compliant with prescribed medication. She was conveyed to Broomfield Hospital.

In July 2017 EEAST attended Adult B who had collapsed. It was thought this may be due to an overdose. When assessed she complained of frontal headache and said this was her second collapse that day. She stated she was alcohol dependent. The ambulance crew found her to be orientated and not short of breath. She was taken to Broomfield Hospital. This was the last contact to Adult B before the homicide.

2.2.7 Essex Police

Between 2011 and 2017 Essex Police had four contacts with Adult B.

In 2013 Adult B reported a domestic incident between herself and her son. This related to an argument about the moving of her car and it was alleged that her son had pushed her. There were no allegations of assault and the police took no further action.

On 17 July 2015 Essex Police received a call from EEAST. They advised that they were attending the home of Adult B, following a report of a female who had taken an overdose and was in possession of a knife.

Two officers, who were supported by a further third officer attended the incident. After speaking with Adult B and her husband they established that she had recently been experiencing mental health issues and had been prescribed medication by her GP. During the argument Adult B had taken a knife and threatened to harm herself and threatened her husband with the knife. She said she had also taken an overdose. She was taken to hospital by ambulance.

Her husband declined to make a formal complaint about the threats his wife had made to him with the knife but was willing to speak with the police to ensure his wife received appropriate help.

Adult B was discharged from hospital on the same day as her ED attendance and was visited by an officer at home, who also spoke with her husband. The officer completed a Domestic Abuse Investigation (Non Crime) on ATHENA[5] along with an DASH Risk Assessment grading the incident as Medium Risk, meaning that there were identifiable indicators of risk of serious harm.

(ATHENA is a single platform used to manage investigations, intelligence and custody) An appropriately trained officer reviewed this assessment on 20 July 2015 and the matter was filed as a Domestic Abuse Investigation with no offences having been committed.

The Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model is used by all Police forces in England and Wales. Use of this model enables the Police to grade an incident as standard, medium or high risk against a set of criteria described in national guidance.

The next contact was later in July 2017 when Essex Police received a non-emergency abandoned call from the telephone number attributed to the home address of Adult B. She had had an argument with her son and had at some point argued with her husband concerning this. All parties appeared to be well with no reports of assault and/or injury. An appointment was made for officers to visit Adult B to complete a DASH in respect of the incident but she refused to be interviewed and would only speak to officers over the telephone.

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[5] ATHENA a single platform used to manage investigations, intelligence and custody. It should be noted that investigations are recorded in two ways on ATHENA. The first is as an ATHENA Investigation (Crime). In these cases following an initial report to the police an investigation is commenced during which it is identified that a specific crime has been committed. A criminal investigation is conducted and the outcomes recorded within the record. The second is an ATHENA Investigation (Non Crime). In these cases following an initial report to the police an investigation is commenced but no specific crime has been identified. Such matters can include referrals made to the police from partner agencies concerning child protection issues or domestic incidents reported to the police where specific crimes have not been identified but there is a requirement to record details of the incident and the subsequent action taken by the police. Investigations involving domestic abuse are allocated to various teams dependent on the identified risk resulting from an ATHENA DASH Risk Assessment initially conducted by the first investigator.

The account obtained from Adult B was recorded on the incident log and the incident was transferred to the Crime Bureau (staffed 24/7 with a team of Investigators the Crime Bureau provides the crime recording function for both police staff and members of the public directly inputting crime onto ATHENA) for the purposes of creating an ATHENA Domestic Abuse Investigation (Non Crime). The incident was graded as standard risk and then filed as a Domestic Abuse investigation with no offences having been committed.

The sixth and final contact was the homicide when the police received a call from EEAST reporting the sudden death of Adult A at the home of her younger daughter. On arrival the police found the ambulance crew in attendance. Once Adult A was pronounced dead by the ambulance crew officers gathered information at the scene and declared the death as suspicious. Adult B was subsequently arrested and then charged with the murder of Adult A.

2.2.8 Broomfield Hospital

Broomfield Hospital is the general hospital for Chelmsford and is part of Mid-Essex Hospital Service NHS Trust (MEHT). The DHR did not request an IMR from Broomfield Hospital as the contacts with Adult B that took place there were conducted by staff from the mental health services (as set out in Section 2.2.5). However, a chronology was requested and supplied. Having reviewed the chronology the DHR panel asked two questions of the hospital in relation to the procedures used during Adult B's 2015 admission. Those questions are set out here along with the responses received.

> Bearing in mind Adult B had been carrying a knife prior to hospital admission and that EPUT discharged Adult B following assessment did Broomfield Hospital make the Police aware of Adult B's discharge to ensure public safety:
>
> The hospital stated that they *'would assume the knife had been removed from the Adult B as she attended the department under police escort. The responsibility to ensure public safety ought to have commenced prior to arrival at MEHT not after discharge*
> *(i.e. risk to public and MEHT staff in the Emergency Department). If there were a perceived ongoing risk to the public we would have expected the police to remain in attendance. There is no documented record of the police or paramedics highlighting no risk or instruction to identify further communication.'*
>
> Were EPUT made aware by Broomfield Hospital that Adult B was armed with a knife prior to hospital admission?

> The hospital stated that: *The Emergency Department records state that Adult B had been threatening her husband and holding a knife. This entry was made prior to mental health review and would have been accessible to the mental health nurse who has documented in the same record. The mental health entry does not comment on risk to others. From an Emergency Department perspective, staff would expect the mental health team to explore this issue and instruct MEHT staff and others accordingly. The final entry from MH nurse states that the patient can go home.*

The specialist mental health assessment was conducted while Adult B was a patient at ED, and as MEHT state, the assumption was that the knife would have been removed. The police did not say or hand over directly to MEHT /mental health staff that the risk was high.

2.3 Analysis from the review of the IMRs

This section of the report provides an analysis of the information received by the panel. Any issues or concerns identified are a reflection of the evidence made available. In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. It is important to note that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

The panel's view is that the North Essex GP practice provided appropriate care and treatment for Adult A. They responded to calls from her husband swiftly and sensitively. All necessary tests and medications were undertaken and prescribed in accordance with national guidance and best practice.

From the information provided the panel finds no evidence that the needs of Adult A's husband were ever explicitly explored with him when he contacted or attended the surgery. The surgery was also not always aware of the input of other agencies or organisations.

The information reviewed by the panel demonstrates that there was (and remains) a need for closer liaison and communication with other agencies involved in patient care.

The panel is aware that the surgery intend to conduct an audit of vulnerable patients and their records to ensure they do not have gaps in relevant information and that appropriate and relevant information is shared to aid care and treatment provision.

The care and treatment provided for Adult B by the Mid Essex GP practice was appropriate and timely. The GPs in particular worked hard to build up a rapport with Adult B and to support her effectively. During consultations the GPs were able to build up a greater insight into Adult B and her lifestyle. They became aware that alcohol was a significant part of her and her husband's relationship, which it appears could be volatile due to their alcohol use.

The GPs had developed a trusting relationship with Adult B and she was comfortable to talk to them about her use of alcohol and to engage with them throughout her contact with them. There was good continuity of care. The GPs retained concerns about her mood throughout her contact with them. They felt her mood was secondary to her alcohol excess.

The record keeping of the Mid-Essex GP practice was of a high standard.

There is no evidence that the GPs or staff at the practice were aware of any other areas of Adult B's life and although they knew there were difficulties in her relationship with her husband, these were usually placed in the context of her alcohol misuse. The GPs were not aware of the incidents of domestic abuse/violence that Adult B and her husband had engaged in and that involved the police.

The practice made appropriate referrals to secondary health care services, more relevantly in relation to her alcohol misuse. There appears to have been information exchange between those services and the surgery but the extent to which this was regular and thus informed the GPs in relation to their own interactions is less clear.

The use of routine or direct enquiry about domestic abuse might have revealed other relevant information about Adult B's relationships, but it is not clear that knowledge of these would have had any direct bearing on her later actions.

ACE staff interacted with Adult A in a caring and supportive way. Staff took care to consult Adult D throughout their input but it is not clear that they sought any further history or background information about the wider family.

ACE staff correctly and appropriately ensured the undertaking of a Mental Capacity Assessment.

The panel could find no evidence that concerns expressed by Adult D about his wife's weight loss were directly acted upon by ACE in follow up visits in September 2016 or in November 2016. It was subsequently picked up in April 2017 following the referral to the CNS and a comprehensive assessment was conducted including the issues of weight loss as well as the management of pressure ulcers.

ACE staff were appropriately trained in safeguarding and they found no evidence to support the need to make a safeguarding adults referral.

In relation to the continence service, it appears that there was a missed opportunity to undertake an holistic assessment of Adult A in June 2016. It is suggested that this is due to systems not being in place to prompt the practitioner to do this. If it had been done then it is possible that the need for pressure relieving equipment may have prevented the development of a pressure ulcer.

Adult Social Care found no evidence of, or suggestion of, any domestic abuse within the family and Adult C and Adult D appeared to be very supportive.

The record keeping in this case was not sufficiently detailed to enable appropriate scrutiny of the documentation or to build a fully accurate picture of the nature of ASCs contact with Adult A. There is no depth to the assessment documentation in relation to Adult A's life, her wider family or circumstances.

The case recording does not consider this wider network of support and as such there is not a link to the family beyond Adult D. In addition, there are gaps in the recording of interventions and contacts.

Adult C was involved in her mother's care and at times this input appears to have been extensive. Although a carer's assessment was conducted for her step-father, no such assessment was offered to her.

There is evidence of prompt and effective response from the service to requests for input or contacts from Adult D. The views of Adult A are limited, largely due to her cognitive deficits.

There is no evidence of any communication with the wider multi-disciplinary team, such as the Mental Health Trust and how their professional expertise may have supported with crisis intervention.

The intermittent nature of the contact with Adult A and her husband seems to have meant that the case was not discussed in supervision with the worker. There was insufficient scrutiny and supervision of the case, and poor recording was not identified. The panel is of the view that there was a lack of oversight of the social care worker's practice.

Although the omissions and deficits in practice did not have any direct bearing on the eventual incident itself, the lack of a clearer overview of the family, the lack of a multi-disciplinary approach, lack of supervision and poor recording in particular meant that the service did not have an accurate picture of the wider family, including not identifying the younger daughter as a carer.

Home Instead provided a companionship service to Adult A for two years and were still providing the service at the time of her death. The input provided was of an appropriate standard and it met the need it was intended to address, specifically to give Adult D respite from his caring role. The service appears to have been valued by Adult D and the staff developed a good relationship with him and Adult A.

There were no concerns expressed by Home Instead staff during the period in which they provided a service. Home Instead had appropriate policies and procedures in place including those in relation to recording and to safeguarding.

EPUT risk assessments and care plans were properly completed and communication with the GP was good. There was one instance when a letter was not sent and this meant an agreed plan was not carried out. The GP also did not receive an update on Adult A's mental health at the time. Once this had been highlighted by Adult C, NEP (now part of EPUT) acted swiftly to address the issue.

Although this did not have an impact on the eventual incident it is a lapse in process that should not have occurred.

It is not clear what lead this to happen and it should not have been left to Adult A's daughter to raise the matter with the Trust. This suggests that there was not a robust system in place for checking that GP letters had been sent and resulted in a gap in the care plan delivery.

There was good collaboration between NEP (now part of EPUT) with social care in arranging for carers to be provided to give Adult D respite.

Adult D was able to contact the helpline to raise the issues relating to his wife's increasing agitation, it was agreed that the matter would be discussed at clinical meetings. Although the correct course of action, this was not initially sufficient to allay his concerns, and did not immediately address the agitation that Adult A was experiencing. The advice given does appear to have been appropriate. Following the first clinical meeting a second clinical meeting was arranged, following input from helpline staff. This resulted in recommended changes in medication.

The response of mental health services to Adult B during her Emergency Department (ED) attendances was appropriate and timely. The outcome of the assessments of her mental health and assessments of risk were completed and properly communicated to Adult B's GP.

Prior to her attendance at Broomfield Hospital Adult B had been in possession of a knife. Staff at the hospital were aware of this prior to the assessment being undertaken by mental health staff. This was important information in enabling them to consider issues of risk to others and to Adult B herself in the context of that assessment.

The specialist mental health assessment was conducted while Adult B was a patient at ED, and as MEHT state, the assumption was that the knife would have been removed. The police did not say or hand over directly to MEHT /mental health staff that the risk was high.

Broomfield Hospital staff made an assumption that the knife that had been in Adult B's possession prior to her admission had been removed from her. They operated on the assumption that as she had arrived with the Police, that the weapon had been removed. What appears to be lacking in the documentation is any confirmation that these facts were checked with the Police on arrival at hospital.

There was a swift response from Open Road to the referrals in 2015 and 2017. Although support was offered Adult B's engagement was minimal and she disengaged on both occasions. It is common for drug and alcohol services to be

offered but that those wishing to use them cannot be compelled to attend or receive treatment. On that basis there is nothing unusual about the approach to service delivery by the Open Road team.

EEAST staff responded promptly and appropriately to the calls in relation to both Adult A and Adult B. They acted within current clinical guidelines and correctly clinically assessed and treated both on each occasion that they attended.

The EEAST has safeguarding policies in place and staff were aware of these. At no stage did they believe there was the necessity to make a safeguarding referral for either Adult A or Adult B.

Drawing on the information about the contact with Adult B and the pattern of calls which related to misuse of alcohol, attempts at self-harm and potential violence to others, in particular her husband, there may have been merit in considering a safeguarding referral for Adult B. Although this did not happen, there is no indication that had it been done, it would have had any direct bearing on whether the homicide occurred or not.

The two domestic incidents in 2016 and 2017 were the focus of the police IMR. The panels view is that in both cases, the police responded promptly and that officers were able to gather information from both Adult B and Adult E about the two incidents.

In respect of the incident in 2015, the attending officers did not complete an ATHENA investigation or ATHENA DASH risk assessment. The ATHENA records do not accurately reflect the facts as they were initially reported to the police. The ATHENA investigation summary does not record that Adult B threatened her husband with a knife but does mention her mental health issues at the time of the incident.

In relation to risk grading, the supervising officer did not have all the relevant information when coming to a judgment about endorsing the application of a Medium Risk grading as a result of the inaccurate recording. The panel also considered whether the grading reflected any difference in approach in relation to male victims of domestic abuse, though there was no evidence to come to a conclusion about this.

Given that a threat had been made towards another with a knife, there were threats of self-harm with an overarching issue concerning mental health, the panel agrees with the IMR authors judgment that this incident should have been initially graded as High Risk.

Grading the incident as High Risk would have ensured the appropriate oversight of the incident within the LPA and an automatic referral to the Central Referral Unit. This in turn would have led to the relevant partner agencies being advised through appropriate referrals including a MARAC referral. As such this review considers that this was a missed opportunity to engage with partner agencies, which may have resulted in the family receiving appropriate support with a view to reducing any potential future risk.

In relation to the incident later in July 2017 the police did not attend the incident. There is no record about the fact that Adult B refused to engage or allow police attendance. It has been established that the resulting Investigation Record and ATHENA Risk Assessment were not the subject of a Secondary Risk Assessment and supervision until nearly a month after the incident and four days after the homicide for which Adult B was found guilty.

Section Three
Conclusions

This section sets out the findings and conclusions of the DHR panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The chair of the DHR is satisfied that the review has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

3.1 Conclusions

The conclusions presented in this section are based on the evidence and information contained in the IMRs and the panel's analysis.

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 full time. 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.

As per usual DHR processes, the family were contacted and were offered the opportunity to contribute to the review and/or to meet with the Independent Chair/Author of the DHR. The family responded that they did not wish to be involved in the process.

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.

Section Four
Recommendations

4.1 Recommendations

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

4.1.1 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.

4.1.2 Individual Agency Recommendations made in the IMRs

Anglia Community Enterprise

1. Care is integrated with clear and effective communication between members of the multi-disciplinary team.

2. Staff across the organisations should have a fit for purpose tool that promotes holistic assessment of service users.

Essex County Council Adult Social Care

1. Improve communication with health colleagues to support good practice and outcomes. This will initially be completed by meeting with colleagues in the mental health Trust to update on key roles, remits and responsibilities. In addition it has been agreed that we will discuss new and active adults on our caseloads to determine how we can work jointly, and share relevant and appropriate information.

2. Support development of a shift from care management approaches to the principles of the Care Act. This is an internal action to support the team's development. We will be viewing key practice learning information by using resources available such as the Social Care Institute for Excellence to enhance team members' understanding and to support the implementation of law in practice. This is an ongoing development need that will need to be achieved through practice learning workshops, one to one supervision sessions and peer group meetings, all of which are available.

North Essex Surgery

1. Improve liaison and joint working with other agencies to safeguard vulnerable patients and families.

2. Review management of information provided to the surgery.

3. Enhance awareness of the types of domestic abuse that can affect vulnerable adults and support required/available for carers.

4. Improve on existing patient awareness/information.

EPUT

1. Processes be put in place to ensure letters from clinics are sent to GP and patient. A trial of new processes is needed.

Essex Police

1. Ensure that Local Demand and Risk Management Team (LDRM) has the appropriate processes in place to manage domestic abuse incidents where appointments are deemed appropriate.

2. Ensure that processes within the centralised LDRM are in line with and reflected within Force policy.

3. All Essex Police staff to be reminded of the process for finalising domestic abuse incidents where there is no attendance, to include full risk assessment recording on both STORM and ATHENA.

Mid- Essex GP Surgery

1. All agencies and organisations to be reminded of the importance of sharing health information with GPs so that they can make fully informed decisions regarding he care and treatment required by the individual.

2. Multi-agency partnership to consider how best to share information regarding domestic abuse in situations where no children are present.

GLOSSARY

ACE	Anglia Community Enterprise	
ASC	Adult Social Care	
	ATHENA	ATHENA a single platform used by the Police to manage investigations, intelligence and custody.
BMI	Body Mass Index	The body mass index is a measure that uses height and weight to determine if an individuals weight is healthy.
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence	The Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model.
DHR	Domestic Homicide Review	A Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.
ED	Emergency Department	Emergency Depart at acute hospital, sometimes also known as Accident & Emergency.
EEAST	East of England Ambulance Service NHS Trust	
EPUT	Essex Partnership University NHS Foundation Trust	

IAPT	Improving Access to Psychological Therapies	IAPT services provide evidence-based psychological therapies to people with anxiety disorders and depression.
IMR	Individual Management Review	An IMR is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation. The IMR process is not designed for identifying gaps in the actions/activities of other organisations. The aim of IMR's should be to look openly and critically at individual and organisational practice and at the context within which people were working.
LPA	Local Police Area	
LDRM	Local Demand and Risk Management Team	
MARAC	Multi-Agency Risk Assessment Conference	MARAC is a meeting where agencies talk about the risk of future harm to people experiencing domestic abuse and if necessary their children, and draw up an action plan to help manage that risk.
MCA	Mental Capacity Act	The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.
MEHT	Mid-Essex Hospital Service NHS Trust	
OASys	Offender Assessment System	Developed by the Prison and Probation Services definitions of what constitutes standard, medium, high risk. *Standard:* Current evidence does not indicate likelihood of causing serious harm.

		Medium: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. *High:* There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. *Risk of serious harm (Home Office 2002 and OASys 2006): 'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.*
Essex STaRS	Specialist Treatment and Recovery Service	Provides help and advice as well as structured interventions for individuals over the age of 18 who have issues with substance misuse
UTI	Urinary Tract Infection	Urinary tract infections (UTIs) are common infections that can affect the bladder, the kidneys and the tubes connected to them. Anyone can get them, but they're particularly common in women. Some women experience them regularly (called recurrent UTIs).

APPENDIX

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Michelle Williams
Domestic Abuse Coordinator
Southend, Essex and Thurrock Domestic Abuse Board

22 November 2018

Dear Michelle,

Thank you for submitting the Domestic Homicide Review (DHR) report for Tendring to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 26 September. I am sorry for the delay in providing the Panel's feedback.

The Panel was grateful to you and the review chair, Steve Appleton, for attending the meeting and clarifying queries they raised on some of the detail in the report. The Panel concluded this is a good, sensitive report which is well-presented and identifies learning as well as good practice. The Panel noted the challenges in reflecting the victim's voice in the report given the family declined the invitation to participate in the review.

As identified at the meeting, there were some aspects of the report which the Panel felt may benefit from additional comment, further analysis, or be revised, which you will wish to consider before publication:

- The report mentions a secondary risk assessment undertaken by the police, however the Panel noted that this practice is not commented upon or discussed further in the review;

- The Panel felt it would be helpful if sex could also be identified as being directly relevant to the review within the diversity section of the report;

- The action plan should also include single agency recommendations;

- For completeness, it would be helpful if the report could include narrative on the coronial process, the official cause of death and the sentence tariff given by the court;

- The Panel noted that the findings in relation to the police appear in the overview report but not the executive summary;
- It would be helpful if the report could confirm whether specialist advocacy support was offered to the family when they were invited to participate in the review;
- You will wish to spell out acronyms in full the first time they are used, e.g., "ACE" appears several times in the report before it is explained in paragraph 2.2.2.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Hannah Buckley
Chair of the Home Office DHR Quality Assurance Panel