Executive Report of the Domestic Homicide Review and Safeguarding Adult Review Joint Panel into the death of Walter

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1.0 Executive summary

In order to ensure anonymity, the following pseudonyms have been used to identify persons referred to in the report. Mother, father, child, neighbour have the normal meaning associated with them.

Name	Age at time of the fatal fire	Relationship
Walter	78	Victim
Sarah	43	Perpetrator
Tom		Partner of perpetrator

Address 1 is the address of Walter where the fatal fire ended his life
Address 2 is the address of premises owned by Sarah. This is where she lived with Tom prior to moving in with Walter.

2.0 The Review Process

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

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

b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency work.

e) It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximized both locally and nationally.

2.1 This review arose from a fatal fire caused by an arson attack. The victim died at the scene of the fire. A Post Mortem examination concluded that the victim's death had been due to the inhalation of fire fumes. The perpetrator lived with the victim and has since been convicted of intentionally causing the fire with an intent to endanger the victim's life.

2.2 The circumstances of the death of the victim fulfil the criteria of Section 9 (3)(b) of the Domestic Violence, Crime and Victims Act 2004 in that the violence appeared to be perpetrated by a member of the same household as himself.

2.3 This Domestic Homicide Review (DHR) has been conducted in accordance with statutory guidance under section 9(1) of the Domestic Violence, Crime and Victims Act 2004. The review examines the period from 6th August 2014 to the time of Walter's death. The panel has determined that there were no ethnicity, culture, faith, sexual orientation, disability, gender or other diversity issues that had a bearing on agency involvement in respect of this Review.

2.4 The key reason for undertaking a domestic homicide review (DHR) is to facilitate lessons to be learned when a person is killed as a result of domestic violence. To enable 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 these tragedies happening in the future.

2.5 The Essex Safeguarding Adults Board found that this case also met the criteria for a Safeguarding Adult Review under The Care Act 2014. The Care Act Statutory Guidance states that 'Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult dies as a result of abuse or neglect, whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult.' The definition of abuse in this guidance includes domestic violence, psychological abuse and financial or material abuse. It applies to people with care and support needs. Both the victim, and the perpetrator were in need of care and support services.

2.6 The purpose of a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and applied to prevent similar harm occurring again. The Care Act does not require the SAR report to be published but it must be referred to in the SAB annual report.

2.7 It was agreed by the review panel that the DHR and SAR would be combined as a single review. Following this recommendation, a decision was made to appoint a different independent overview report writer with a safeguarding adults background who had the relevant experience in carrying out SAR's. The chair of the panel had a background in carrying out DHR's.

2.8 The panel would like to express their sincere condolences to the family and friends of Walter. We would like to thank all of the panel members and their respective agencies who participated in this review process for their contribution to the formulation of this report. Particular thanks go to the family of Sarah, for sharing their recollection of how agencies worked together to support Sarah. In doing so, they have supported the learning and development by agencies working with other adults at risk in Essex.

2.9 **Panel membership**

Name	Position/organisation
Adam Waller-Toyne Team manager	One Housing
Chief Inspector Ian Cummings	Essex Police
Kim Spain	Essex County Council
David Williams	Essex County Council
Jane Whitington Safeguarding adult lead	North East Essex Clinical Commissioning Group (NEE CCG)
Lisa Hobson DHR Support	Colchester Borough Council
Lisa Poynter Lead for adult safeguarding	Anglian Community Enterprise (ACE
Mel Arthey Clinical specialist safeguarding	Essex Partnership University NHS Foundation Trust
Melanie Rundle Community safety manager	Colchester Borough Council
Michelle Williams Domestic Abuse Co-ordinator	Essex County Council
Paul Bedwell ESAB Board Manager	Essex County Council
Liz Varcoe	Essex County Council
Ruth Cherry-Galal	Colchester Women's Refuge[1]
Val Degiorgio Team manager	Essex County Council Adult Social Care
Liz Hanlon	Independent Chair
Deborah Klèe	Independent Overview Report Writer
Amanda Canham	Essex STaRS substance misuse services within Essex Partnership

2.10 Circumstances leading to the review

2.11 Essex Police received a call from Essex Fire and Rescue service reporting a fire with persons trapped at address 1. A police patrol car was passing this address at the time of the call and so the police were the first emergency service at the scene. Police officers were informed by members of the public that a person was trapped within the premises – a one-bedroomed ground floor flat. Police officers attempted to enter the premises but were beaten back by flames. Fire fighters then arrived and using breathing apparatus entered the premises by the front door. Walter was discovered on the floor of the living room, which he had been using as his bedroom. Walter was rescued from the premises by the fire crew and CPR and treatment commenced at the scene. Sadly, despite the best efforts of paramedics and the fire crews Walter was declared dead at the scene.

2.12 At the time of Walter's death it was identified that he had been living with a female, Sarah, who was described by people as his Grandaughter. During the Police investigation it became apparent that Walter and Sarah were not related but that they had been living together. Walter had told several agencies that he was looking after Sarah as a result of his dead wife's wishes, however this does not appear to be the case. It appears that Walter and Sarah became friends after she moved in with neighbours and was introduced to him.

2.13 Enquiries made by police officers during the course of that morning established that Sarah had been in the premises at the time of the fire and as a result of initial findings at the scene the fire was declared as suspicious. Sarah was arrested the same day and was later convicted of Murder and Arson with intent to endanger life.

2.14 Both Walter and Sarah were actively being supported by care and support services over a substantial period of time. Walter had Diabetes, Macular Degeneration, and a heart condition. Sarah was being treated for substance misuse.

2.15 Scope of the review

2.16 On 6th February 2016 the Panel considered draft Terms of Reference prepared by the Chair and Overview report writer and after revision, adopted the following Terms of Reference:

(1) In conducting the Domestic Homicide Review into the death of Walter, the Panel shall have to regard to:-

(a) The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews and the recommended Home Office security provisions; and

(b) The Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance.

(2) The Panel would conduct the review on the basis that Walter was murdered at the victim's home address of address 1. A family friend Sarah has been charged with the murder. Sarah was introduced to people by both Walter and Sarah herself as his granddaughter, however there does not seem to be a family link.

(3) The Panel was asked to establish the nature of the relationship between Walter and Sarah prior to his death, and the manner of Walter's death would be confirmed. The panel would establish the relationship between Tom who has been identified as Sarah's boyfriend and what his relationship was with Walter.

(4) The Panel would review the Scoping Exercise and chronologies in order to determine which agencies, organisations and individuals should be requested to submit an IMR.

(5) In the light of information arising from (4) above, the Panel was asked to consider whether such practitioners or agencies, including public service and commercial agencies;

- need to increase their own levels of awareness and information gathering across agencies to assess risk and provide a coordinated response;
- were appreciative of and sensitive to the needs of Walter; and
- were knowledgeable about potential indicators of domestic abuse, including financial abuse, and aware of actions they could take if such concerns had arisen.
- The Panel will; gain an understanding of what domestic abuse, either physical, emotional or financially Walter suffered, if any, within his home environment;
- establish the appropriateness of agency responses to Walter - both historically and immediately prior to his death;
- understand if and how agencies assessed risks within the family household settings;
- understand how intelligence and information is shared across safeguarding children and young persons, adults and domestic abuse to assess and respond to risk;
- determine if and how agencies assessed needs for care and support;
- establish whether single agency and inter-agency responses to any concerns about Walter were appropriate;
- identify good practice that was in place;
- establish how well agencies worked together and identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic violence is a feature;
- consider whether appropriate and timely safeguarding adult procedures were put in place for both Walter and Sarah and;
- determine whether a person-centered approach was taken to understand the outcomes that Walter wanted and to facilitate this e.g. family conference, mediation and making safeguarding personal.

(6) The Panel was asked to consider the role of any practitioners or agencies that had not come into contact with Walter and Sarah that might reasonably have been expected to do so.

(7) The scope of the DHR was been extended, following consultation with Essex Adult Services to include any vulnerabilities identified by agencies surrounding Walter. It was considered important that the review understands and analyses, from a multi-agency perspective, Walter's overall vulnerabilities, his capacity to care for himself, his level of independence and his ability to manage his identified health issues, both physically and emotionally.

2.17 A Partnership Learning Review (PLR) event was facilitated with staff who had direct involvement with Walter and/or Sarah. The purpose of this event was to understand the environment that staff members were working in at that time and the reasons for their actions. This was to help to identify some of the underlying systems that could have contributed to practice. The PLR event is a requirement of the ESAB Safeguarding Adult Review Procedure. Nineteen staff members attended the PLR event representing 6 organisations. The output from the PLR event informed the findings of the review.

3.0 Case Summary

3.1 Walter was born in Plymouth on a ferryboat. He was in the Navy for many years. A friend said that Walter was a 'ladies' man'. He enjoyed the company of women and

could be very charming. We understand that he was married five times and had six children. The panel were unfortunately unable to find any relatives of Walter.

3.2 Walter was described by his friend L as ‘fun loving’ and a man who ‘would do anything for anybody.’ Walter described himself on more than one occasion as ‘a big softie.’ Practitioners at the Learning Event said that Walter seemed to genuinely care about Sarah and wanted to keep her safe.

3.3 Sarah was brought up in a loving and supportive family. She is described by her family as ‘kind’, ‘caring’ and ‘determined’. Sarah’s daughter says that her mother is very resourceful and if she sets her mind on something she will find a way to achieve her goal.

3.4 Sarah married her first husband when she was twenty-five. Sarah did not take drugs until she met her husband who was a drug user. Sarah’s marriage broke up and she started a new relationship with Tom. Sarah was known to the police for petty crimes- theft from shops, obtaining money under false pretences and on one occasion breaking and entering a house and stealing a handbag. Sarah was also the victim of crime as drug dealers sought recompense for unpaid drug debts.

3.5 Sarah was a victim of domestic violence from her partner Tom. Sarah reported this abuse to the police and was referred to a Woman’s refuge. The Refuge referred Sarah’s case to the MARAC (Multi Agency Risk Assessment Conference).[2] Noted in the MARAC minutes, information received from the STARs nurse and the support worker from the women’s refuge that Tom had been given notice to move out of the home address by June 25th 2015. It has been shown in the IMR’s that support was given to Sarah by agencies at the time of the domestic incident and that agencies believed that as Tom was moving out of the home address that Sarah would be safe.

3.6 When Sarah experienced a physical assault by her partner Tom, she moved out of their house to stay with Walter. This was not known to agencies at the time who believed that Tom had moved out of the home address. It was Sarah’s father’s intention to evict Tom so that Sarah could move back home. However, Tom claimed that the Council advised him to wait until he received an eviction notice or he would be making himself homeless. Information was received by the STAR’s nurse that Sarah and her daughter thought that making Tom homeless would make the situation more volatile.

3.6 Sarah has a very supportive family who were doing everything that they possibly could to support her and help her get her life back on track. They accept that services could not help Sarah unless she was willing to help herself. However, the tremendous support network that Sarah had and her own resourcefulness were not used to help achieve the outcome that Walter wanted – for Sarah’s needs to be met as well as his own.

[2] A regular local meeting of professionals to discuss high risk domestic violence cases and co-ordinate the response.

3.7 At the time of his death Walter was living in social housing -a one bedroomed ground floor flat. Social housing is housing provided by the council through a housing provider.

3.8 Walter was the tenant of the property. Sarah had been staying with Walter since December 2012. Sarah slept in the bedroom and Walter slept in the living room on a sofa-bed.

3.9 Walter and Sarah described themselves as grandfather and granddaughter. Walter explained to all of the professionals he came into contact with, that his wife had asked him, before she died, to take care of Sarah. Walter also described Sarah as his carer. Despite Walter describing Sarah as his carer no carers assessment was completed regarding Sarah or any support offered. It is believed that Walter got companionship from living with Sarah. Although Sarah abused Walter, he remained loyal to her until his death.

3.10 Police records show an association between Walter and Sarah as early as April 2009 when police stopped a VW Golf owned by Walter. Sarah and others were in the car. At this time police recorded that the officer believed that Sarah was taking advantage of Walter.

3.11 In September 2016 Walter told his support worker that he was thinking of getting a court order against Sarah. It is likely that Walter told Sarah he would be giving up his flat to move into sheltered accommodation hours before Sarah set light to a piece of furniture that she had moved into the centre of the room.

3.12 The Fire and Rescue Service were called to a fire at Walter's address. Police and Fire and Rescue responded immediately. Walter was rescued from the premises by the fire crew and CPR and treatment commenced at the scene. However, despite the best efforts of the fire crew and attending paramedics Walter was declared dead at the scene.

3.13 A Post Morten examination concluded that Walter's death was a result of inhalation of fire fumes.

3.14 Sarah was charged with the offences of arson with intent to endanger life. Sarah was sentenced to 12 years imprisonment in relation to manslaughter and 8 years in relation to the arson to run concurrently with the manslaughter conviction.

4.0 Analysis

4.1 This review found that there were some aspects of adult safeguarding where awareness could be improved:

- Raising awareness of adult safeguarding
- Interface between Domestic Abuse and Safeguarding Adults
- Making Safeguarding personal
- Information Sharing and Joint decision-Making
- Cuckooing – the use of vulnerable adults' homes as drug dens
- The misuse of prescribed medications such as Pregabalin

- Police awareness of when to raise a safeguarding concern to the police safeguarding triage

4.2 This DHR/SAR found many examples of good practice. The staff caring for Walter were resourceful and innovative in finding ways to support him in difficult circumstances. The cash donation sought from a local church, food bank vouchers and assistance in installing a landline telephone and Careline.

4.3 Concerns were first raised that Walter might be experiencing financial abuse in August 2014, when an Iceland worker contacted the police. Although a safeguarding referral was made and financial abuse substantiated, Walter did not want any intervention. Walter was assessed as having the mental capacity to make this decision.

4.4 Between August 2014 and September 2016 a number of professionals became concerned about the situation. Six safeguarding referrals were raised surrounding his contact with Sarah and her partner Tom and subsequently closed for the same reason that Walter understood the risks associated with his unwise decision not to take any action against Sarah or ask her to move out. As he had the mental capacity to make this decision, the safeguarding referrals were closed on each occasion. However, adult social care referred Walter to One Support for his general housing and support needs.

4.5 A number of professionals were involved in providing care and support to Walter as he had multiple health conditions including diabetes, macular degeneration and a heart condition. Community nurses visited Walter daily from January 2016 to check Walter's blood glucose levels. A support worker from One Support visited Walter several days a week from June 2016 and formed a close working relationship with Walter. A community nurse became concerned in July 2016 that lack of food, as a result of financial abuse, was lowering Walter's blood glucose levels. This led to one of the safeguarding referrals. A further safeguarding referral was made in August 2016 by community nursing as Walter had lost a significant amount of weight. In total six safeguarding referrals were made regarding Walter. Walter had a social care assessment and a review of his plan of care during the period covered by this review. The Care Assessment and Care plan were comprehensive. As well as addressing health needs the Care plan included referral to the fire service for fire prevention checks, obtaining a gas detector, getting a telephone landline installed and access to Careline.

4.6 Although the safeguarding referrals were closed for different reasons, care and support staff worked together to ensure Walter had food. Food banks and on one occasion a small donation from a local charity were accessed on Walter's behalf.

4.7 The GP also made a safeguarding referral when it was discovered that Sarah was believed to be obtaining medication prescribed for Walter to use or sell as it had a market value for drug dealers.

4.8 When Walter contacted the police to report the theft of his bankcard by Sarah in December 2013 and then withdrew his allegation claiming it was a

misunderstanding, a PCSO became involved. This review found that there was only one occasion when this process was followed and that was the first incident reported to the police by the Iceland worker. The panel identified that there was a missed opportunity for a safeguarding referral to be made to adult services after the incident of a reported theft by Walter against Sarah. Concerns raised by the PCSO to adult social care led to a community care assessment and assessment by community nursing. PCSO's also became involved following an assault on Sarah by Tom where concerns were identified regarding Walters living conditions. When Sarah's domestic violence case was discussed at a MARAC meeting, Walter was identified as a vulnerable adult living within the same household and a safeguarding referral was made to adult social care

4.9 Adult social care's safeguarding function, community nursing, the GP practice, the police and One Support, all worked closely with Walter over a period of two years. Although Walter would not agree to any action that would have a negative impact on Sarah, he allowed his support worker, community nurse and social workers to support him the best they could and to minimise his risk of harm. Walter had a social care assessment and a review of his plan of care during the period covered by this review. The Care Assessment and Care plan were comprehensive.

4.10 Walter received comprehensive care and support. Staff worked closely with Walter earning his trust and working within the boundaries that Walter set. They used discretion, checking that he was alone before discussing sensitive issues. This was a complex case where a man who had the mental capacity to make decisions about his care chose to stay living with Sarah despite experiencing daily abuse.

4.11 Professionals and the public demonstrated that they knew when and how to refer to safeguarding adult services. The Police did on occasions, however fail to identify the need to alert safeguarding concerns to the Police Safeguarding of Vulnerable Adults (SOVA) team and safeguarding adults. The Police have taken action since the commencement of this review to address this by establishing an Adult Triage Team (formally SOVA) to provide advice and assistance in the co-ordination of the Police and partner agencies response to vulnerable adults.

4.12 When Walter refused safeguarding adult intervention his wishes were respected, as he was deemed to have the mental capacity to make that decision. Adult Social Care instead put in place a comprehensive care plan to minimise risk and to support Walter. This included daily contact with a support worker who developed a close working relationship with Walter.

4.13 Walter's Support worker was working closely with him and had taken time to build a trusting relationship. However, the Support worker was working without strategic direction, as she was not supported by an integrated and effective care management approach to planning, risk assessment and a person-centred approach to positive risk taking.

4.14 The Essex County Council Adult Safeguarding Enquiry form records what the adult's views are on the safeguarding process in their own words. This is good, as it clearly represents the person's wishes. The form then has some options to record the 'Adult's desired outcome.' This is a tick box with an option 'other'. This partly

meets the Making Safeguarding Personal guidance to record in the person's own words the outcomes that they want to achieve. However, it misses an important point. Walter's desired outcome was to keep Sarah safe as well as himself. This has been reported in the chronology and IMRs but the outcome Walter wanted was not explored with him and recorded. The three completed Safeguarding Enquiries state what Walter *does not want*, 'the safeguarding process to continue.'

4.15 The Community nursing service also provided daily input to monitor Walter's blood glucose levels. The Primary care team addressed Walter's health care needs including an investigation into the cause of Walter's frequent falls.

4.16 The health care and support staff working with Walter worked closely together, sharing information through joint visits and referrals across agencies. However, this was a particularly challenging case involving an elderly man who had mental capacity and made what were considered to be unwise decisions and a woman who misused substances. Both Walter and Sarah were victims of abuse.

4.17 The information gained throughout the review shows that agencies working with Walter worked closely together to share information and concerns, however despite agencies working together there was not a formal process for discussing the case and agreeing a coordinated response to minimise and review the risk.

4.18 Walter was not subject to an adult safeguarding strategy meeting as he refused to participate in the safeguarding process. In the absence of the safeguarding process there was not a formal system for partners to share intelligence and information and to jointly assess and respond to risk. Any professional could have initiated a multi-agency team meeting but without a clear protocol nobody took the lead for arranging a meeting.

4.19 The Police IMR found that whilst there were a number of safeguarding notifications made that resulted in a response from both the police and social care, there were a number of occasions where this wasn't the case. This had the cumulative effect of an incomplete picture of the relationship between Walter, Sarah and Tom. This information could have helped inform a joint risk assessment of Walter.

4.20 A multi-agency team meeting that included agencies working with Walter and Sarah could have resulted in a better understanding of the situation and the options available. It would have drawn on the expertise of domestic abuse agencies as well as safeguarding adults. A wider range of legal and social work options may have been explored.

4.21 The definition of domestic violence is, 'Any incident or pattern of incidents of controlling, coercive, threatening behavior, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of age or sexuality.' Domestic violence includes financial abuse and emotional abuse.

4.23 The Police were correct in not following the procedure for reporting Walter as a victim of domestic violence and quite rightly referred him to the Safeguarding Adult Team and the Police SOVA team. However, there was an opportunity for the

safeguarding adults team to benefit from the expertise of domestic abuse agencies in the risk assessment and management of abuse.

4.24 There are also a number of legal actions and sanctions (criminal and civil) that can be used in adult safeguarding and domestic abuse. Sarah was a victim of domestic abuse. By bringing together the expertise of adult safeguarding and domestic abuse services, a wider range of social work and legal options could have been explored in achieving an outcome that was acceptable to Walter.

4.25 Further considerations could have been used by agencies regarding the removal of Sarah from Walter's property. An injunction keeping her away from his home address could have been obtained through the courts; however, this again would have had to come from Walter in relation to his decision-making. It is felt that had Walter ultimately made that decision then agencies involved with him would have helped and supported him through this process. The safeguarding adult team would have benefited from the expertise of domestic abuse agencies in the risk assessment and management of Walter's case.

4.26 During panel discussions it was identified that housing were aware of incidents involving Sarah, Tom and Walter taking place at Walters home address. Housing stated that as Walter was the named tenant the only action that they could take would be in relation to Walter. This would have resulted in the eviction of Walter and not Sarah or Tom. This was raised as a missed opportunity by the panel who believed that the Housing agency should have held a multi-agency meeting to discuss what was taking place at Walters address and to look at other ways of dealing with the situation.

4.27 Walter had the mental capacity to make a decision but he should have had the information on all of the options to help him to achieve the outcome that he wanted. Throughout this case Walter was consistent in his wish to care for Sarah and to maintain her friendship. Making Safeguarding Personal guidance and best practice suggests approaches to enable a person to achieve outcomes such as maintaining a relationship with a perpetrator whilst managing the situation to reduce risk; for example, family conferences, mediation and negotiation on a wide range of options.

4.28 Sarah was not considered for safeguarding adult services when she experienced abuse by Tom. Sarah was also a victim. Both Walter and Sarah were complex cases that needed the expertise of domestic abuse and safeguarding adult teams. These two teams, working with both cases, would have had access to a wider range of tools, resources, expertise and information to enable Walter and Sarah to consider the options available to them.

4.29 In September 2016 Walter told his support worker that he was thinking of getting a court order against Sarah. It is likely that Walter told Sarah he would be giving up his flat to move into sheltered accommodation hours before Sarah set light to a piece of furniture that she had moved into the centre of the room.

5.0 Recommendations

5.1 The key learning from this review is for a multi-agency approach to sharing information and jointly assessing and responding to risk when a person has mental capacity but makes unwise decisions. This learning will benefit people who self-neglect as well as vulnerable adults who experience domestic abuse.

Recommendation 1. Southend, Essex and Thurrock Safeguarding Adult Boards to revise the SET safeguarding adult procedures to make it explicit that there is a formal process for agencies concerned about safeguarding risks for an adult with needs for care and support to convene a multi-agency meeting. This meeting should have representation from all partners involved who can share information and develop an action plan.

Recommendation 2. Southend Essex and Thurrock Safeguarding Adult Boards to review the Safeguarding Enquiry form (SETSAF1) and guidance so that the person's desired outcome is recorded in their own words and the significance of this is understood by practitioners.

Recommendation 3. The Essex Safeguarding Adult Board to ensure appropriate training and development is provided by its partners to increase practitioners' understanding of Making Safeguarding Personal, while working with people who have mental capacity but make what others may consider unwise decisions and people with fluctuating capacity, for example, people who misuse substances. This recommendation is to include external partners such as housing associations.

Recommendation 4. NHS England and North East Essex Clinical Commissioning Group to further to raise awareness on the potential misuse of prescription drugs particularly Pregabalin and Gabapentin with GP practices and prescribers across Essex including circulation of the Public Health England guidance.

Recommendation 5. Police – To provide assurance to the Essex Safeguarding Adult Board that the arrangements put in place since WALTER's death are sufficiently robust to collate police information to get a complete picture of adults at risk and appropriate triage in considering referrals for adult safeguarding.

Recommendation 6. Southend, Essex and Thurrock Domestic Abuse Board to revise the MARAC referral form to require all members of the household to be named, to ensure MARAC can include them in their considerations.

Recommendation 7. The Safeguarding Adult Board, and Children's Safeguarding Board to raise awareness of Cuckooing and County Lines, exploitation of children, young people and vulnerable adults with the general public and professional staff.

Recommendation 8. The Safeguarding Adult Board to run an awareness campaign surrounding adult safeguarding specifically targeting supermarket workers and other retailers.

Recommendation 9. The Safeguarding Adult Board and Essex Domestic Abuse Board to develop effective and clear links and arrangements in working with adults with care and support needs who experience domestic abuse,

Recommendation 9. The Home Office to consider aligning the Domestic Abuse definition and the definition of a Domestic Homicide Review.