SETDAB Southend, Essex & Thurrock Domestic Abuse Board

Essex Safeguarding Adults Board

Safer Chelmsford

**Safeguarding Adults Review**

**Domestic Homicide Review**

**Executive summary**

**Concerning the Death of Kimmi**

(Died October 2020)

**August 2022**

**Author – Jon Chapman**

## Contents

# 1. The Review Process

## 1.1 Introduction

1.1.1 This is a combined review which brings together the requirements of a Domestic Homicide Review (DHR) and a Safeguarding Adults Review (SAR) into the circumstances of the deaths of Kimmi and Alfred. They had been married for 42 years and lived together on a farm in Essex where they had lived for most of their married life. Alfred had suffered a long history of serious illness. Kimmi was diagnosed with vascular dementia five years ago and Alfred took on a caring role for his wife.

1.1.2 During the period of the first lockdown due to Covid 19, Kimmi and Alfred had reduced care support and were unable to undertake their usual routine. In July 2020, Kimmi suffered a fall in the home and injured her hip necessitating a hospital admission and operation. It was also apparent that Kimmi's dementia condition was deteriorating.

1.1.3 Kimmi was discharged with a reablement plan in August 2020, and a number of services were involved with Kimmi and Alfred. The family view on the subsequent care was that it was uncoordinated and difficult for the family to navigate and understand.

1.1.4 In August 2020, just prior to Kimmi's discharge from hospital, there was a concern raised regarding the circumstances of Kimmi's fall and then in late September there were some concerns raised regarding the care that Alfred was affording his wife. This resulted at the end of September in a safeguarding concern being raised about the way Alfred had treated Kimmi. After discussion between Adult Social Care and the family it was decided that the family would make contact with their father in the first instance. The day after this discussion with Alfred took place he used a legally possessed firearm to shoot Kimmi, killing her, and then used the same weapon to take his own life.

## 1.2 The purpose of a Safeguarding Adults Review (SAR)

1.2.1 Section 44 of the Care Act 2014 sets out that Safeguarding Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

1.2.2 The purpose of the Review 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 learnt and applied to future cases to prevent similar harm occurring in future.

1.2.3 On 17th December 2020, The Essex Safeguarding Adults Board review sub-group considered the circumstances of this case and agreed that it met the criteria for a SAR.

1.2.4 The Essex SAR sub-group was aware that the Southend, Essex and Thurrock Domestic Abuse Board was discussing with the Chelmsford Community Safety Partnership and Home Office whether a Domestic Homicide Review (DHR) would be undertaken and maintained contact with the board whilst these discussions were ongoing.

## 1.3 The purpose of a Domestic Homicide Review (DHR)

1.3.1 The case was referred to the Southend, Essex and Thurrock (SET) Domestic Abuse Board by Essex Police on 6th October 2020. The SET Core Group convened on 20th November 2020 and considered the circumstances of the case, with the assistance of thorough scoping from relevant organisations. The core group agreed that as the case was being reviewed as a SAR, there was no requirement to undertake to review in accordance with the statutory guidance under section 9(1) of the Domestic Violence, Crime and Victims Act 2004.[1]

1.3.2 This decision was conveyed to the family who agreed with the position, and also conveyed to the Home Office who have oversight and a quality assurance role over the DHR process. In October 2021, the Home Secretary wrote to the Chelmsford Community Safety Partnership directing that a DHR would take place in addition to the already agreed SAR. It was agreed at this stage that the SAR and DHR would be jointly undertaken, and one overview report cover both reviews.

1.3.3 The purpose of a DHR is to :-

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
e) contribute to a better understanding of the nature of domestic violence

[1] Section 9(1) of the Domestic Violence, Crime and Victims Act 2004 https://www.legislation.gov.uk/ukpga/2004/28/section/9

and abuse.
f) highlight good practice.[2]

1.3.4 It is important that the process of this domestic homicide review has due regard to the legislation concerning what constitutes domestic abuse which at the time of this case was defined as:

*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional.*[3]

1.3.5 The Government definition also outlines the following:

*Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*.

*Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

1.3.6 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship. The new offence, which does not have retrospective effect, came into force on 29th December 2015.

## 2. Contributors to the review

2.1 A panel was appointed to oversee, and quality assure the review process. The panel was selected to represent the agencies involved but also organisations that would bring the requisite specialist knowledge to the reviews. The review membership is as shown below.

| Name | Role | Organisation |
|---|---|---|
| Jon Chapman | Independent Chair | |
| Paul Bedwell* | Board Manager | Essex Safeguarding Adults Board |

[2] Assets.publishing.service.gov.uk. 2016. *Multi Agency Statutory Guidance for The Conduct Of Domestic Homicide Reviews*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf [Accessed 4 January 2021].

[3] This was amended by the Domestic Abuse Act 2021 - https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted (accessed 01/12/21)

| | | |
|---|---|---|
| Michelle Williams | DA Coordinator | Southend, Essex and Thurrock Domestic Abuse Board |
| Alison Clark | Interim Director Safeguarding & Quality Assurance, Adult Care Services | Essex County Council |
| Brid Boraks | Service Manager, Adult Care Services | Essex County Council |
| Lisa Elliott/ Scott Kingsnorth | Strategic Centre, Crime and Public Protection Command | Essex Police |
| Jane Reeve | Lead professional for Safeguarding | Provide |
| Leila Francis | Designated Nurse Safeguarding | Mid Essex CCG |
| Caroline Dollery | Lead Safeguarding GP | GP Practice |
| Sarah Wark | Adult Safeguarding Nurse | Mid & South Essex NHS Foundation Trust |
| Alice Faweya | MSE Named Nurse for Safeguarding Adults | Mid & South Essex NHS Foundation Trust |
| Sara Rashid | Director | Care Provider |
| Tendayi Musundire | Head of Safeguarding | Essex Partnership University Trust |
| Claire Stockwell-Lance | Area Manager | Alzheimer's Society |
| Nikki Taylor | Community Domestic Abuse Practitioner Service Manager | Next Chapter |
| Spencer Clarke | Public Protection Manager | Community Safety Partnership |
| Caroline Sexby | Safeguarding Specialist Practitioner for Adults | East of England Ambulance Service |

* Michala Jury from 12/01/22

## 3. Agencies involved

3.1 The following organisations provided information to the reviews as indicated below: -

| **Agency** | **Submission to be made** |
|---|---|
| **Essex Adult Social Care** | IMR and Chronology |
| **Essex Partnership University Trust (EPUT)** | IMR and Chronology |

| | |
|---|---|
| **Mid Essex Clinical Commissioning Group (CCG)** | IMR and Chronology |
| **Provide** | IMR and Chronology |
| **Care Provider** | IMR and Chronology |
| **Mid & South Essex NHS Foundation Trust** | IMR and Chronology |
| **Essex Police** | IMR and Chronology |
| **Alzheimer's Society** | Chronology |

## 4. Author of the overview report

4.1 The panel chair and author was selected by the DHR Core Group from a pre-determined list of authors. He can demonstrate independence of all the agencies involved in the review at this time and in the past.

4.2 The panel chair and author is a retired senior Hertfordshire police officer who has both operational and strategic experience of safeguarding and domestic abuse. He managed operational safeguarding teams and had strategic responsibility at a Force level for domestic abuse. He led a project which introduced Multi Agency Risk Assessment Conferences (MARAC), Independent Domestic Violence Advisors (IDVA), Specialist Domestic Violence Courts (SDVC) and SARCs into a policing area.

4.3 Since retirement from the police he has been the chair of a charity delivering domestic abuse outreach and refuge. He has chaired Quality and Effectiveness Board for a CCG and is currently the independent chair for an areas Adult and Children Safeguarding Review Group.

4.4 The chair and author has undertaken Safeguarding Adult Reviews, Domestic Homicide Reviews, Safeguarding Children Practice Reviews and Multi Agency Public Protection Procedures Serious Case Reviews and has undertaken the AAFDA accredited training on undertaking a DHR.

## 5. Terms of reference for the review

5.1 The panel drafted and agreed terms of reference for the reviews. This included identified key learning areas.

- To develop an understanding of Kimmi's vulnerabilities, her health and care needs, capacity to care for herself and her level of independence, and consider how

effective was inter-agency collaboration, communication and information sharing in providing treatment to Kimmi.

- To what extent were Alfred's carers needs assessed and were carers assessments offered? Was there stress in the caring relationship and if so, how did it present for Kimmi and Alfred?
- To identify any difficulties agencies encountered when supporting Kimmi that impacted on the case?
- To consider whether protected characteristics as codified by the Equality Act 2010 impacted on Kimmi's care and case management (Race, Religion or belief, Age, Sex, Sexual orientation, Pregnancy and maternity, Gender reassignment, Marriage or civil partnership, Disability)
- To what extent was Kimmi's voice heard and her wishes and feelings considered, understood and respected by practitioners when planning her care and assessing risk, including risk to others?
- To identify whether agencies complied with any safeguarding protocols that have been agreed within and between agencies including protocols covering:
    - Raising safeguarding concerns
    - Information sharing
    - Risk assessment, management and review
- To explore firearms licensing and renewal processes, including when and how they are renewed and what information is considered when assessing suitability? How can concerns regarding health, domestic abuse and caring stressors be shared with Essex Police firearms licensing to enable appropriate assessment of risk?
- To review the previous DHR commissioned in Essex which touched on firearms licensing of vulnerable persons to explore the extent of information sharing with General Practitioners and other agencies when assessing suitability? To establish the extent and sustainability of any changes of procedure.
- Whether preventative actions could have been taken by agencies?
- To understand how older victims of domestic abuse are identified in Essex and explore domestic abuse service provision across Essex for older adults or those with dementia experiencing abuse.
- To understand the impact of the Covid pandemic on both Kimmi and Alfred and the agencies providing services to them.
- To identify any best practice that was in place.

5.2 The timeframe subject to this review will be from 1st January 2017 – 4th October 2020.

## 6. Summary chronology

6.1 The victim in this case Kimmi had been married to Alfred for 42 years. They lived together in a large, detached house in a rural village in Essex. The house formed part of a family farm where the couple had lived since being married and had run a

family business. The couple had raised their three children at the farm, all of whom had left the family home to pursue their own lives. The children, although not living in the local area, with one resident abroad, were very close to their parents and kept in regular contact. Both Kimmi and Alfred were well known in the local area, having lived there for such an extended period and had been involved in the local community activities over the years. They had some neighbours who knew the family well and were considered family friends.

6.2 Alfred was a licensed shotgun certificate holder and had been since 1989 and was a licensed firearms certificate holder since 1987. Both licences were due to be renewed or expire on 31st January 2022. This allowed Alfred to lawfully possess 6 shotguns, 2 rifles (.22) and 2 sound moderators.

6.3 In 2007 Alfred suffered a stroke and in 2009 was diagnosed with a rare form of Leukaemia (Plasmacytoid Dendritic Cell Neoplasm). After a very poor initial prognosis Alfred responded to intensive treatment over several years to become clear of the cancer. In 2013, Kimmi spent some time in hospital following a serious asthma attack.

It became apparent at a late stage of this review that Alfred had been prescribed and taken anti- depressant medication (Citalopram) since the time of his stroke. This prescription was annually reviewed by the GP. There is record that Alfred attempted to reduce this in 2016 but was not able to do so due to Kimmi's diagnosis. This is a relevant issue in considering firearms licensing.

6.4 In February 2017, Kimmi's GP made a referral for her to undertake a memory assessment, this followed concerns from the family noting a decline in her cognitive ability, in September 2017, Kimmi was diagnosed with mixed dementia[4]. Kimmi was reviewed at her GP surgery and there are references to an advanced dementia plan, but this plan is not evident as being in place.

6.5 In November 2018 the family started to reach out for support as they recognised that Alfred was finding it more difficult to care for Kimmi. A feature of this review is that Alfred found it difficult to accept support and was adamant that he wished to care for his wife, in the same way she had cared for him during his illness. The Alzheimer's Society supported Alfred to request a carers assessment. The outcome of the assessment was that he had eligible needs as a carer and support would allow him some respite. He was given funding to allow him a sitting service for four hours per week.

6.6 In March 2020, the UK went into national covid lockdown and this impacted on all services that agencies were able to provide. The sitting service that was Alfred's only respite had to terminate their support. The family did try to replace the service

[4] Mixed dementia - Mixed dementia' is a condition in which a person has more than one type of dementia. Alzheimer's disease and vascular dementia is the most common type.

but without success.

6.7 In late July 2020, an ambulance was called to the farm on a report that Kimmi had fallen. She was conveyed to hospital. She was taken for surgery (right hemi-arthroplasty surgery[5]). Before surgery was undertaken Kimmi's mental capacity was assessed and she was assessed as not having capacity regarding her health care decisions. A decision on surgery was made, in consultation with her husband on a best interest basis. Kimmi's fall had a significant impact on Alfred, who had discovered her in the hallway. He had tried to assist by moving her, not realising the seriousness of her injury. Alfred had to summon the assistance of neighbours before emergency services arrived. The fall and the guilt that Alfred felt for moving his wife continued to have an impact on him.

6.8 Following the surgery Kimmi continued to be treated in hospital on a best interest basis. It was noted that she was unable to recognise members of her family from photographs. She was assessed by Occupational Therapy (OT) and it was recorded she was confused and disorientated and she was unable to recall the mechanism of her fall. In the following days when Kimmi was seen by the OT and Physiotherapy, Alfred was present, and it was noted that Kimmi engaged better when he was present.

6.9 Hospital records show that one of Kimmi's children was involved in a discussion on discharge planning as Alfred was overwhelmed by the planning process. Options were discussed and it was agreed that the best option for Kimmi was for her to be discharged home with a care reablement package and a private funded sit in service. The equipment required was discussed and identified as a Rotunda, slide about commode and bed stick.

6.10 The referral for reablement went through to a provider who did not have capacity to fulfil the requested 14 hours per week, which included 4 visits with two carers. Another provider was sought and located to commence the care on 12th August 2020. Around the same time an anonymous call was made to the hospital and passed to the adult safeguarding nurse. This call raised a concern about the way in which Kimmi had fallen and suggested that Alfred had been responsible. There was liaison with the hospital ward staff and no concerns over safeguarding were noted. No further action was taken, and no other referrals were made.

6.11 On 12th August 2020, Kimmi was discharged home. The family describe this as being a distressing and frustrating period for them trying to access and understand what support was available. The family, after making many calls, arranged care with the same provider who was commissioned to provide the enablement package and privately resourced care between 10.00 am and 8.00 pm in addition to the reablement package. Kimmi was sent home without incontinence pads and no

[5] Right hemi-arthroplasty surgery - A hemiarthroplasty is a surgical procedure that involves replacing half of the hip joint

provision had been made for this, leaving the family to source these for Kimmi who was doubly incontinent.

6.12 Kimmi was initially seen by the district nursing service but was quite quickly discharged from this service. Mental Capacity assessments were not evident, the discharge and agencies depended on the fact that Alfred stated that he had a Lasting Power of Attorney for Health and Welfare. This review established that this was not in fact the case. There was an Enduring Power of Attorney in place for finances and premises only.

6.13 On 8th September 2020, the Physiotherapist and Therapy Assistant visited the home address and checked on the progress of the equipment that had been ordered. On this occasion a mental capacity assessment was undertaken, which confirmed that Kimmi lacked capacity to consent to the assessment. A stair assessment was undertaken, and it showed that she was unable to place her feet without assistance and found verbal instructions difficult due to her cognitive functioning. The Physiotherapist advised Alfred that Kimmi should not use the stairs due to safety concerns and the risk of her falling. It was apparent that Alfred found this advice difficult and was described as being passively angry, tearful and upset. Two days later the Physiotherapist received a call from Alfred who expressed his displeasure with the decision regarding the use of the stairs and asked that it be reversed. The Physiotherapist explained that this was not possible but did agree that they could attend later the same day and assist in repositioning Kimmi's bed and commode downstairs as an interim measure.

6.14 The family became increasingly concerned as to how Kimmi's care would be managed at the end of the reablement package. ASC undertook an eligibility assessment, the assessor spoke to Alfred on the phone and was informed that he had LPA for his wife, but this was not explored further. Believing that they would not be eligible for care to be funded, the family agreed to privately fund the care going forward.

6.15 The domiciliary care provider continued to deliver the care package post the date it should have finished as they felt that Alfred would not be able to care for his wife on his own and required support. At this time there was discussion between the care provider and ASC during which concerns about the way Alfred cared for his wife were raised. There is a disparity in the record for these agencies at which point it was made clear that there was a safeguarding concern. At the beginning of October, the care provider raised a safeguarding concern with the Local Authority. After careful consideration it was decided that the concern would be discussed with the family before speaking with Alfred. The allegations were discussed with the family who spoke to Alfred. The following day Alfred killed Kimmi using licensed firearm and then shot himself.

## 7. Key issues arising and lessons to be learned

7.1 The diagnosis of dementia is a very significant one with a real impact for the person and those who support them. It is imperative early discussions take place with the person, putting them at the centre and with their family to fully understand their wishes for the future and these are appropriately recorded. This should include information on areas that may become important such as Lasting Power of Attorney.

7.2 This review, like others has highlighted the significance of assessing the needs of carers. It has shown how difficult it is for some people who require support to accept that support when it is offered. This allows agencies to reflect on how the offer being made can be more accessible. We also recognise in this review the need for carers to be involved in discharge planning. Discharge planning, where the person has dementia needs to include the agencies that are supporting the person, giving at the very least an awareness of the discharge and ensuing plan.

7.3 The discharge process in this case was complicated and difficult for the family to understand and navigate. The Discharge to Assess approach is being developed in Essex and this important work needs to continue with a view to providing patients and families good coordination of the care and support. This coordination was complicated in this case due to the covid pandemic and due to this the usual commissioning framework for care was not used. One of the effects of this was that the usual multi-disciplinary meetings that would normally occur did not take place. The commissioning of some aspects of care were complicated by being under the auspices of social care or health and consideration should be given to how this can be streamlined.

7.4 There were instances in this case where safeguarding concerns should have been more effectively initiated and investigated. When Kimmi was in hospital and a concern was received regarding the nature of her fall, this should have initiated a multi-agency enquiry, which, in turn, may have led to a question over Alfred's possession of firearms. At a later stage the domiciliary care provider had concerns regarding the care afforded by Alfred to Kimmi, these concerns should have been made subject to a safeguarding concern at an earlier stage.

7.5 The review has allowed a reflection on how information on domestic abuse and the support available is made accessible to older persons. There are several current initiatives which can be built on to better support this section of the community, particularly those with dementia. (J9, Dewis Choice and the E Learning package)

7.6 The area of licensed firearms and how this feeds into the prevention of suicide and homicide presents a considerable challenge. Whilst it is accepted that someone intent on causing harm can resort to any number of methods, recent cases and experience has shown that where legally held firearms are held, they are likely to be used. All agencies should raise the awareness of the potential of firearms being

present, particularly in some communities such as that of farming. There is some innovative work being undertaken by the police and the GP practice involved in this case and this should be considered in other areas. The Home Office should also consider how the National Firearms Management system can be made more appropriately available to other agencies involved in the assessment of risk.

## 8. Conclusions

8.1 This is a tragic case where a person who wished to care for his wife felt that there was no option for them except to take her life and then take his own. Whilst this review does not seek to excuse Alfred's actions, it does seek to understand them. This case, as others in the Essex area and wider have demonstrated, is that there is still the need for better consideration and implementation of the Care Act in relation to the assessment of carers and being able to support them. This has to been seen as a critical area, particularly as we rely on around 1 in 8 adults to provide care. For carers coming to terms with a close relative with dementia there should be support which helps them to understand what they are likely to encounter and how they can navigate this.

8.2 When Kimmi was discharged from hospital the family found the provision of services confusing and uncoordinated. This was at a time when agencies were encountering a very challenging time due to the covid pandemic, but agencies need to plan how the services are delivered and how they can be more coordinated as the issues of the pandemic continue to be present.

8.3 There needs to be better understanding of the generational attitudes and barriers to persons being able to accept support. How these attitudes effect and impact those who are close to them and who may rely upon them. Agencies need to better understand how the stress from caring for someone can manifest, be able to identify this and be able to support people to prevent the situation becoming worse and potentially manifesting in other forms of abuse. This review found that a key area was understanding the person and their circumstances by having quality conversations which are recorded to provide a foundation for care and support as time goes on.

8.4 The use of lawfully possessed firearms needs to be considered, it is apparent that when they are available and accessible, they will be used by those with tendencies towards homicide and suicide in a domestic scenario. Whilst it is fully accepted that other means of harm could easily be adopted, we need to be able to identify better means of making relevant persons aware of the existence of firearms.

## 9. Recommendations from the review

As part of the review process agencies were asked to reflect and identify areas of development and recommendations for their organisations. Some have demonstrated significant reflection. These actions will be progressed by the agencies and the progress overseen by the SETDAB and Safeguarding Adults Board.

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### Recommendation 1

The Mid Essex Clinical Commissioning Group, Memory Assessment and Support Service (EPUT) and Alzheimer's Society review the dementia diagnosis pathway to ensure that there is a fully joined up approach to ensure that patient receives full information regarding support and that information is clearly understood. This should include: -

- Appropriate use of Mental Capacity Assessment at relevant times.
- What support is available and how it can be accessed.
- That there is clear enquiry into and recording of the patient's wishes and plans for the future.
- That there is consideration of a carer assessment and carer stress.
- That there are clear and routine enquiry and recording into social and financial circumstances to include the consideration of domestic abuse.

### Recommendation 2

All agencies should ensure that enquiry is made at an early stage as to whether a person has in place an Enduring or Lasting Power of Attorney and that the provisions of the authority are well understood by all parties. Where possible the authority should be seen and recorded and where there is any doubt an enquiry should be made to the Office of Public Guardian.

### Recommendation 3

The Essex Safeguarding Adults Board should use this review to build on the Making Safeguarding Personal Project to include seeking innovative means of facilitating the ability of adult's voices to be effectively heard as identified in the *Valerie* review.

### Recommendation 4

All agencies involved in this review should consider how they deliver services to those suffering with dementia and how a whole family approach would assist the person and those supporting them. There should be clear consideration of the stress that can be present for those family members with caring responsibilities. This should be supported by appropriate training.

### Recommendation 5

Mid and South Essex NHS Foundation Trust, Essex Adult Social Care and EPUT need to ensure that where a person is eligible for funding to support care that this is made clear to the person, and where appropriate the family, in order that informed decisions on ongoing care can be made.

### Recommendation 6

Where Adult Social Care commission care providers outside of the usual arrangements they need to ensure that the care provider is supported by a care coordinator and that the provider is part of weekly multi-disciplinary meetings.

### Recommendation 7

All agencies involved in the hospital discharge process need to ensure that carers are involved in the process and their needs are considered and where necessary a carers assessment takes place post discharge.

### Recommendation 8

Essex Safeguarding Adults Board should give consideration as to how to support agencies in understanding the importance of carer assessments and advise on how the offer can made more accessible and effective to carers.

### Recommendation 9

Mid and South Essex NHS Hospital Trust should ensure that when formulating discharge plans for persons with dementia that relevant dementia services are included in the plan and appropriately notified of the discharge.

### Recommendation 10

That the Discharge to Assess approach continues to be developed across all areas of Essex which will include embedding the care coordinator approach on discharge and developing a multi-agency discharge hub. To ensure that this development maintains multi-agency focus there should be effective oversight of the development plan from the Integrated Care Board.

### Recommendation 11

Essex Adult Social Care and Provide should ensure that the responsibilities for the procurement of equipment to support patients on their discharge from hospital is well understood by all parties concerned and is seamless to avoid confusion and delay to the patient.

### Recommendation 12

Mid and South Essex NHS Hospital Trust should ensure that every safeguarding concern raised is appropriately investigated and recorded in accordance with current policy and

procedures, this assurance should include audit activity.

### Recommendation 13

Essex Safeguarding Adults Board should ensure that all domiciliary care providers are aware of their responsibilities to raise safeguarding concerns and are aware of the mechanism to do this in a timely way and should seek to ensure that providers, where involved, are engaged in multi-agency discussions.

### Recommendation 14

The Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should review and reflect within their thematic reviews on recent cases of suicide and homicide, which involve a caring relationship to establish if there are any early signs or indicators to assist in prevention and support. Any findings should be shared with Essex Suicide Prevention Steering Board and Essex Health and Wellbeing Board.

### Recommendation 15

Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should review how and where messages and information on domestic abuse is made available to forums that older people might access. They should then work with Essex Safeguarding Adults Board to promote these messages.

### Recommendation 16

Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should consider how awareness of, and services for, domestic abuse in older persons can be supported and should include.

- Health commissioners consider how sustainable funding can be achieved for health based independent domestic violence advocacy (IDVA).
- That the J9 initiative is implemented in services delivering support for older persons and in particular those suffering with dementia.

### Recommendation 17

All agencies involved in this review should cascade and embed the SETDAB domestic abuse and older people E Learning package within their organisations adopting a 'Think Family' approach.

### Recommendation 18

Essex Police to form a working group with the relevant partners of Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board SETDAB to :-

- Better understand if there are methods of providing firearms licensing information to agencies involved with persons in potential risk situations.
- Outline the Firearms Suicide Prevention Workshops which are already being delivered and seek to widen the range of participants of these.
- Raise awareness of how practitioners working within health and safeguarding across all agencies can quickly and easily learn if a person of concern is a licensed firearms holder, or if there are legally held firearms at the address.

### Recommendation 19

The Home Office should initiate discussions to establish if the National Firearms Licensing System managed by the Home Office could be made available on a restricted basis to appropriate partners for the purpose of managing and mitigating risk.

### Recommendation 20

Essex Integrated Care Board works with Essex Police to roll out the suicide prevention programme to all Essex GP practices and involves Essex Suicide Prevention Steering Board.

### Recommendation 21

Southend, Essex and Thurrock Domestic Abuse Board and Essex Safeguarding Adults Board should seek assurance that where agencies have identified recommendations or areas of development for their own organisation there is plan for these to be implemented.