Domestic Homicide Review

Overview Report

Elaine

Died: July 2021

Chair and Overview Report Author: Cherryl Henry-Leach

Date: 09.06.2023

Tributes to Elaine

“Elaine was a lovely kind-hearted, generous, loving and witty lady who can only be described as a bottle of champagne waiting to pop…

She will be sadly missed.”

Elaine’s son, Peter

Contents

1. Introduction

The panel formally expresses its sincerest condolences to the family and friends of Elaine[1].

The panel formally thanks Peter, who is also the son of Elaine and brother of the perpetrator and his partner for their contributions to this report.

2. Establishing the Domestic Homicide Review Process

2.1 Case Summary

In the early hours during the summer of 2021, neighbours were alerted to smoke coming from an address in the seaside town of Southend, Essex. The female occupant of the property, a ground-floor apartment, now known to be Elaine, could be heard shouting for her son, the perpetrator. The neighbour who resided above Elaine's home, evacuated the property and called the fire service. Whilst waiting for the fire service to attend, the neighbour attempted to gain entry into the apartment but was unable to gain access and rescue due to the volume of smoke. The fire service arrived soon after, and rescued Elaine who required hospital admission. She died shortly after in hospital.

The perpetrator was Elaine's son, who resided with her and was her main carer. CCTV in the area captured him leaving the property 80 seconds before the smoke was observed to be bellowing from the property. Essex Police located the perpetrator at the address of his friend and arrested him on suspicion of Elaine's murder and arson with intent to endanger life.

The panel also received confirmation from the Police that, during his trial, when the perpetrator returned to the family home, he told police officers at the scene of the fire that he had left the house to purchase a drink from a nearby fast-food establishment and, prior to leaving the home, had left a battery on charge in the hallway.

Forensic assessments undertaken indicated that the perpetrator would have passed the seat of the fire and been aware of the fire being alight when he left the property. The Police investigation also established that the perpetrator undertook extensive internet searches to research the method of Elaine's death. During his trial, there was an apparent indication that the perpetrator had a financial motivation when he murdered his mother. He also claimed that he was addicted to Codeine. The sentencing judge did not accept this alleged addiction as mitigation and passed a life sentence for the murder of Elaine, with a minimum tariff of 27 years before he can be considered for parole. This reflected, in the judge's view, the perpetrator's level of

[1] The contributing family members have requested that the deceased is named as Elaine and other names have been changed in accordance with their wishes. They have requested the person responsible for Elaine's death is referred to "the perpetrator". As the perpetrator did not contribute to this review and so has not consented, this request has also been requested.

premeditation. He was also charged and sentenced to 8 years imprisonment for an offence of arson with intent to endanger life, which will run concurrently to the life sentence.

2.2 Decision Making

The statutory requirement to complete a Domestic Homicide Review (DHR) rests with the Community Safety Partnership (CSP) for the area in which a domestic homicide takes place.

Essex Police, having due consideration to the definition of domestic homicide set out in Section 1 of the 2004 Act[2] (see Section 2), in line with locally agreed protocols, notified the Southend, Essex, and Thurrock Domestic Abuse Board (SETDAB) very soon after Elaine's death and the perpetrator's arrest.

The SETDAB team then liaised with the Southend Community Safety Partnership. Agencies across Essex were asked to share any information they held in relation to Elaine and the perpetrator.

An initial Core Group in early August 2021 was convened, where the known information was considered by agencies. At this meeting, it was agreed that in the absence of any safeguarding concerns being raised prior to Elaine's death, in relation to either Elaine or the perpetrator, the case did not meet the criteria for a Safeguarding Adults Review (SAR). It was also agreed that the case met the criteria for a Domestic Homicide Review and this review would explore, as part of its Terms of Reference, if there should have been involvement with Elaine and the perpetrator from Adult Social Care and/or Safeguarding.

2.3 The Domestic Homicide Review Chair and Panel, including Independence Statements

The chair and author of this report, Cherryl Henry-Leach, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR chair and holds the requisite skills as set out in the statutory guidance for the undertaking of Domestic Homicide Reviews[3]. This includes her experience in relation to domestic violence and abuse, having been active in this area of work for nearly three decades. These have included managerial roles at local, regional and senior management/executive national levels in both the voluntary and statutory sector.

Information received from the Senior Investigating Officer indicated that the Fire Service had no prior involvement with Elaine and her family. Their only involvement was in relation to the fatal incident which resulted in Elaine's murder. On this basis, they were not asked to be members of the panel. The panel agreed this this was a proportionate approach, not dis-similar to other agencies (e.g. the ambulance service)

[2] The Domestic Violence, Crime and Victims Act 2004. - GOV.UK (www.gov.uk)

[3] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)

who are involved in a fatality and have no prior involvement with the subjects of statutory reviews.

All panel members and Individual Management Review (IMR) authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact. The panel membership was:

Name	**Role**	**Agency**
Lynn Scott Sarah Range	Head of Adult Social Care – Assessment and Wellbeing Head of Quality Practice & Principal Social Worker	Southend Council, Adult Social Care
Tendayi Musundire	Associate Director for Safeguarding	Essex Partnership University Trust (EPUT)
Sharon Connell	Head of Safeguarding	Southend Clinical Commissioning Group (CCG)
Michelle Williams	DA Co-ordinator	Southend, Essex & Thurrock Domestic Abuse Board
Simon Ford Gemma Robinson	Head of Community Safety Community Safety Data & Insights Analyst	Southend Community Safety Partnership
Paul Hill	Business Manager	Southend Safeguarding Partnership (SSP)
Paul Hodson* Alice Faweya	Associate Director for Safeguarding MSE Named Nurse for Safeguarding Adults	Mid and South Essex NHS Foundation Trust (Southend Hospital)
Jules Bottazzi DI Ben Pedro Anido	Head of Strategic Vulnerability Centre Head of Operational Development Crime and Public Protection Command	Essex Police

Sarah Conlon	CEO	Safe Steps (DA Service)
Paula Blundell	Manager SEAS	South Essex Advocacy Service
Aliyah Monroe	Advanced Customer Support Senior Leader - Essex	Department for Work and Pensions (DWP)

*** Since left organisation**

2.4 Parallel Reviews and DHR progression

Very soon after Elaine's death, a postmortem was undertaken, and this confirmed that her cause of death was a cardiac arrest which had been compounded by smoke inhalation. An inquest was opened by His Majesty's Coroner in July 2021. This process was adjourned pending the outcome of the criminal trial. Communication channels were established with the Coroner who, at the time of authoring this report, is deciding whether to re-open the inquest. To aid in this process, it was agreed that a confidential copy of this report would be provided to her prior to Home Office approval.

The perpetrator maintained his innocence and the case was adjourned for criminal trial in November 2022.

The inaugural panel meeting was held in November 2021. Prior to this meeting, a full scoping exercise was undertaken and an independent DHR Chair was commissioned by the SETDAB team on behalf of the Southend Community Safety Partnership. In March 2022, the panel agreed that, as some of the individuals who would be invited to contribute to this review were likely to be called as witnesses in the criminal trial, this review would be paused and recommenced once the trial concluded and the outcome shared with the panel.

In early December 2022, the perpetrator was found guilty by a jury, at the conclusion of his trial. The review resumed December 2022, and attempts were made to support Elaine's son, Peter, to contribute to this review. Peter advised he was finding it difficult to contribute at this point in time, following the perpetrator's conviction for the murder of his mother, and it was agreed that contact would be deferred until he felt able to contribute. In the meantime, the review progressed. When the final report was shared with Peter, he advised the Chair that he had begun to process events and made further contributions. These are incorporated into the published report where appropriate following them being agreed by the panel and shared with the Home Office Quality Assurance Panel for information.

This review concluded in May 2024, after the report was agreed by the Home Office.

2.5 Equality and Diversity

Throughout this review the panel were mindful of the nine protected characteristics[4]. The review considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). The protected characteristics of gender reassignment, religion/belief, and sexual orientation do not pertain to this case in that this review established, as far as it possibly could, that neither party was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs.

The panel determined that special consideration was warranted to age, gender, sex, maternity, and disability throughout this review to determine if the responses of agencies were motivated or aggravated by these characteristics. Multiple disadvantages grounded in traditional gender roles, economic disparities, and barriers to health and mental health services shape the ageing process of women and make older women more vulnerable to violence and abuse than their male counterparts[5]. Although prevalence figures are variable, the likely lifetime prevalence for women over the age of 65 is between 20% and 30%. It is estimated that approximately 120,000 individuals aged 65+ have experienced at least one form of abuse in England and Wales[6].

Elaine was a 66-year-old heterosexual white British female. Elaine was the mother of two adult sons, Peter, and the perpetrator. Neither of Elaine's sons have children. The panel considered biological factors relevant to this case, namely, the perpetrator was the biological son of Elaine. The panel confirmed that Elaine was not registered as being a person living with a disability, but the panel noted that, in her later life, she experienced substantial mobility issues that fell within the legal definition of a disability[7].

Peter recalled that the perpetrator returned to live with his mother some years ago, when his relationship (of that time) came to an end. As Elaine's mobility decreased as a result of her increasing age, the perpetrator became her main carer.

Peter advised the panel that Elaine was extremely supportive of both her children and their partners. The panel found no evidence within the review that the perpetrator's sexual orientation was a contributing factor to the murder of Elaine.

The perpetrator is a white British male who was aged 40 at the time of Elaine's murder. It is understood that he had been in a heterosexual relationship that broke down when he was aged 28 and, it was at this point in his life, he returned to the

[4] Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)

[5] Choi 2016: International movement to promote human rights of older women with a focus on violence and abuse against older women; https://journals.sagepub.com/doi/10.1177/0020872814559562

[6] https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

[7] The Equality Act 2010 defines a person as being disabled if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities. https://www.gov.uk/definition-of-disability-under-equality-act-2010

family home to reside with his mother. The panel understands that the perpetrator was in an intimate relationship with another male at the time of the murder.

Whilst the perpetrator was not registered as having a disability throughout the scope of the review the panel considered the perpetrator's diagnosis of back pain in relation to the Disability Discrimination Act (DDA). The perpetrator's inconsistent compliance with treatment made it challenging for the panel to fully understand his condition and to determine the impact it may have had on his situation and his decision to murder his mother.

2.6 Confidentiality

The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel for DHRs. Information is publicly available only to participating officers/professionals and their line managers.

The review author discussed the use of pseudonym names with the victim's family in order to protect the identity of the victim, the perpetrator, and family members. Although the family requested the use of pseudonym names, they were clear that this would not successfully protect confidentiality due the details of the murder, which took place in a close community.

Otherwise, this review has been suitably anonymised in accordance with the 2016 guidance. The specific date of death and other lead identifiers have been removed, but the independent chair and review panel members are named.

2.7 Dissemination

The following recipients have received/will receive copies of this report:

- Panel members listed below.
- Family members
- Police and Fire Crime Commissioner
- DA Commissioners Office.

2.8 Media Coverage

Media enquiries and publication were managed by the Southend Community Safety Partnership and coordinated through the panel. No information was shared about the DHR until it was published.

3. Terms of Reference

The overall purpose of a Domestic Homicide Review[8] 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;

[8] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph

- 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 inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

Timescales for the Review

- Minimal agency involvement with either Elaine or the perpetrator was a feature of this case. To ensure a meaningful review that was proportionate to the known agency information, the timeframe for this review commenced on 1st January 2018 to the date of Elaine's death.
- Agencies with records prior to the start date above summarised their involvement. Any relevant information from agencies that fell outside the timeframe which has an impact or has the potential to have an impact on the key lines of enquiry is included.

Case Specific Terms

The panel also agreed the following case-specific terms to ensure a focused review:

1. To review if practitioners involved with the family were knowledgeable about potential indicators of domestic violence and/or abuse within familial relationships (i.e., non-intimate relationships), including coercive control, and aware of how to act on concerns about domestic violence and/or abuse.
2. To determine if appropriate consideration as to how accessible the support was that was given by agencies involved with the family when making decisions in terms of the level and support provided to members of the family. This includes the family's capacity to understand those decisions and how they can respond to them.
3. To establish if there were any opportunities for professionals to "routinely enquire" if domestic abuse, including coercive control, was being experienced by the victim that were missed, and if those enquiries would have recognised the victim's need for appropriate support, including being undertaken safely in line with best practice.

4. To establish how the impact of Covid affected this family specifically around isolation and access to services.

5. To establish the relationship between agencies regarding Elaine's physical health and if she was receiving care that met her needs.

6. To establish if there was misuse of prescription medication in this case and if so, how can agencies manage the potential for misuse in the future.

7. To establish if there was appropriate information sharing between agencies in relation to any family members. If this did not happen, what were the barriers or challenges for agencies.

8. To establish how professionals carried out assessments, including whether assessments and management plans in relation to any family member took account of any relevant history:

    - If any assessments could have afforded opportunities to assess risk.

    - Were there any warning signs of serious risk leading up to the incident in which the victim died, that could reasonably have been identified, shared, and acted upon by professionals, including the use of markers/warning indicators within agency systems.

9. To establish if any agency or professionals consider that any concerns they may have raised were not taken seriously or acted upon by others.

10. To identify learning in relation to community awareness, including how community and/or faith groups and other potential access points for support, are supported to identify Safeguarding issues and/or victims of domestic abuse and share concerns with professionals, including if pathways for community and/or faith groups require development.

11. To review the appropriate use of legislation and relevant statutory guidance pertinent to the family's situation.

12. To consider how issues of diversity and equality were considered in assessing and providing services to the family's protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, sexual orientation, gender reassignment, pregnancy and maternity, marriage or civil partnership. This will include consideration of how agency awareness and understanding of relevant cultural, race, religious, or nationality issues, and consideration of equality duties, impacted on responses and interventions.

13. To establish whether local safeguarding procedures were being properly followed, and how effectively local agencies and professionals worked together in relation to domestic abuse.

14. To establish if there are any issues locally affecting public confidence in the protection of people in vulnerable situations.

15. To identify any shared learning from ongoing Domestic Homicide Reviews with similar emerging themes.

16. To identify any good practice and changes that may have already taken place.

17. Establish for consideration what may need to change locally, and/or nationally, to prevent serious harm to victims of domestic abuse in similar circumstances.

18. If neighbours, employers, work colleagues, community/family members, appear to have been aware of domestic abuse in the family – consideration to be given as to whether appropriate information is readily available to members of the public regarding the unacceptability of domestic abuse and how to seek help for someone.

19. Agencies completing IMRs will be required to analyse these issues in relation to their contact with Elaine and the perpetrator, with specific reference to:

    - What policies, procedures, and guidelines provide the framework for the agency's response to the above issues.
    - What training is available to, and accessed by, staff in relation to responding to the above issues.
    - What communication should have taken place between agencies in relation to the above issues; whether this took place; the quality and outcomes of that communication.

4. Methodology

Throughout this report the term domestic abuse is used interchangeably with domestic violence and the report uses the cross-government definition of domestic violence and abuse in line with the Domestic Abuse Act 2021[9].

This review has followed the 2016 statutory guidance for Domestic Homicide Reviews[10] issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.

On notification of the homicide, a total of 32 agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek IMRs for all organisations and agencies that had contact with Elaine and the perpetrator. This enquiry established that no issues of domestic abuse were reported to Essex Police in relation to this family.

9 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

29 agencies returned a nil-contact, and after panel consideration, 1 IMR was commissioned from EPUT, and 6 summary reports were also provided. All reports included a chronology of agency involvement.

The chronologies were combined, and a narrative chronology was written by the Overview Report Writer.

4.1 Independence and Quality of IMRs

The commissioned IMR was written by an author independent of case management or delivery of the service concerned. This was also the case for the summary reports. All reports received were comprehensive and enabled the panel to analyse the contact with Elaine and/or the perpetrator, and to produce the learning for this review.

Where necessary, further questions were sent to agencies, and responses were received.

The reports have informed the panel's discussion and any recommendations made in this report. They have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the Terms of Reference for this review.

4.2 Documents Reviewed

In addition to the document above, further documents reviewed during the review process have included previous DHR and SCR reports in the area, Victim Impact Statements of the family for the criminal trial, and DHR Case Analysis from the Home Office.

4.3 Involvement with Family and Friends

The Police advised the panel that the family were extremely close-knit and neither Elaine nor the perpetrator had many close friends outside of the family home. The Police investigation did not identify any individuals outside of the family who could give further insight as to the prevalence of domestic abuse within Elaine's relationship with the perpetrator.

The independent chair made contact with Elaine's surviving son, Peter. Contact was made initially through Essex Police, and he was offered the opportunity to participate in the Review in a way and at a time of his choosing. The chair also was clear that they did not have to participate if they did not wish to. Peter later advised through the Police Family Liaison Officer that he was struggling to do so once the trial date was confirmed. It was agreed that, if he wished, he could be involved once the review process resumed after the conclusion of the criminal justice process. The chair of the review has undertaken two interviews with Peter. During each contact with Peter, the chair explored his support needs and although advocacy was offered, this was declined. When Peter's National Homicide Service Support Worker became ill, Peter decided not to receive further support but was fully aware of how he could self-refer back into service if he chose to.

At the initial interview with Peter, he was supported by the Police Family Liaison Officer as there was, at this time, a live ongoing criminal investigation. Peter had the opportunity to comment on the Terms of Reference for the Review and agreed to these. Peter confirmed that he was being supported and satisfied with the support he was receiving from his allocated National Homicide Service Support Worker. Peter shared his shocked distress over the actions of his brother and advised that there was "no indication to me or my partner that even suggested he was going to kill Mum." At the conclusion of the trial, attempts were made by the chair to reinitiate contact with Peter, following the Police advising this was in line with his wishes. Peter did respond and was given the opportunity to read and comment on the content of the draft report prior to publication. His contributions, feedback, and suggestions have been included where appropriate to do so within this report. When asked what outcome he would wish to see from this review, Peter advised that he believed "family members in receipt of Carer's Benefit should be monitored, checked on, to be sure that they are doing what they are paid to do."

Given the devastating impact the murder of his mother by his brother had on him, which he described as being "overwhelming" at times, the chair is extremely grateful for the time and assistance extended by Peter in support of this review.

Throughout the course of this review, the chair and panel experienced difficulties in locating the perpetrator so that he could, in line with the statutory guidance, be invited to contribute to the review. Toward the end of the review, the panel were assisted by colleagues form the National Probation Service, who advised on the perpetrator's location. The perpetrator was written to by the chair. This letter invited him to contribute to the review. At the time of this report being authored, there was no response to this correspondence from the perpetrator. The panel agreed that his lack of response amounted to him declining to contribute to this review.

4.4 Contributors to the Review

- EPUT
- Southend Clinical Commissioning Group/ GP practice
- Mid and South Essex NHS Foundation Trust (Southend Hospital)
- Southend Adult Social Care
- Department for Works and Pensions (DWP)

Having received confirmation their agencies had no involvement with either Elaine or the perpetrator prior to Elaine's murder, the Police and the Ambulance Service were also asked to provide very short reports that outlined their involvement in relation to the fatal incident only.

At the inaugural panel meeting, concern was shared that the perpetrator may have been taking Elaine's prescribed analgesia. The chair met with the Police and the Southend Clinical Commissioning Group. The chair is grateful for the report provided by the Southend Clinical Commissioning Group which calculated Elaine's prescriptions received alongside dates these were requested. This enabled the

Police and the panel to be assured this concern was without finding, and the information was also shared with the criminal investigation team.

In line with the statutory guidance for the undertaking of such reviews, the chair attempted to invite the perpetrator to contribute to this review. There appears to be no defined pathway to enable this with the statutory guidance, and the panel invites the Home Office to give this consideration in future updates to this guidance. The perpetrator has not given his consent to be referred to by name in this report and is referred to as "the perpetrator" throughout this report.

4.5 Independence and Expertise

Review panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

The panel met a total of four times, with the first meeting of the panel on the 19th October 2021. The final panel meeting was held on 22nd March 2023.

The chair wishes to thank everyone who contributed their time, patience, and cooperation to this review.

5. Chronology

Peter also confirmed that his family were insular but lived in close proximity to his mother and his brother, and so would frequently visit them.

Although the period for this review began in 2018, the panel were made aware by the senior investigating officer that there was a historical record of domestic abuse by the perpetrator against a previous partner. The Police advised the panel that this appeared to occur at the time of a relationship breakdown. The whereabouts of the perpetrator's ex-partner could not be established by the panel so the panel could fully determine if this historic incident was relevant to this review.

Peter advised that Elaine gave birth to Peter at a young age and was a single parent. After she married the perpetrator's father (who became Peter's stepfather), she became pregnant and gave birth to the perpetrator. Peter recalled that from a very young age, the perpetrator shared a close relationship with Elaine and his father but described them as "cosseting the perpetrator as a child". As he became older, Peter recalled, they indulged the perpetrator, who, developed a sense of entitlement in relation to their finances, and was reluctant to become financially independent, preferring to undertake casual labour in return for cash, rather than entering paid employment.

Peter also informed the review that, after Elaine experienced a stroke, and it was apparent this would adversely impact on her mobility over the long term, there was a family discussion about the care she needed, and the perpetrator volunteered to care for Elaine once he learned that he would receive Carer's benefit for so doing so. Peter advised that he agreed to this, advising that "at the time, mum was clear she wanted to stay at home, and I was living close to them, so felt this was the best possible outcome. But over a few months it became clear that while [the perpetrator] was

happy to receive the carer's benefit, he didn't want to do the work that was required, like cleaning the house. When I tackled him about this, mum would step in and ask me to leave her alone. I thought this was due to her spoiling him, and to prevent any ill feeling, would keep my views to myself".

Peter described Elaine as a "very private person, but she was a lady – those who knew her remember her fondly" and that he enjoyed "quality time with her, watching soaps on the TV when the perpetrator was out of the house". He described the perpetrator as being "very much a socially isolated individual" who did not associate with individuals of his own age group, preferring to associate "with younger adults who would smoke weed". Peter believes this contributed to the perpetrator developing a dependency on cannabis. Although Peter is not aware that the perpetrator had significant financial issues in adulthood, he believes the perpetrator would use his income (namely Carer's Allowance) to fund this dependency.

Peter also described how, prior to the Covid 19 pandemic restrictions, the perpetrator:

- Rekindled his relationship with a previous partner.
- Was anxious that Elaine would not be supportive of this relationship. However, Peter found that Elaine, believing the perpetrator had resumed his friendship, was happy although she may not have been aware the relationship was intimate.
- Would spend weekends with his partner. Initially, he would request Peter look after Elaine whilst he was away. Peter described enjoying this time with Elaine, without the perpetrator being present.
- Accepted the gift of a car from his partner, which meant that Elaine did not need "a mobility car and so there was more money going into the house."

It was with a high degree of surprise that Peter became aware, during the Covid 19 pandemic restrictions, that the perpetrator had asked a friend to care for Elaine when he visited his partner. Peter advised "During Covid, he [the perpetrator] would tell us we weren't allowed to visit and would be quite awkward when we did. And we didn't very often, but when we did, he would go in his shed, but his body language and attitude made it clear he didn't want us there. Sometimes I'd pop in on my own to see mum, and he'd be the same. He was always present - even if he was in his shed there was always the chance he'd come in and create tension. When he did that, I would simply leave out of respect for mum. But by then I was unhappy with the state of the house and mum would ask me not to say anything to him for a quiet life…one day, it was a weekend, I didn't see his car, so I called into see mum. That was when she told me [name withheld] was fetching her meals in. I was so embarrassed as the house [wasn't clean and tidy] and, because I didn't want people thinking I didn't care about mum, went to see [name withheld], and that's how I become aware that [name withheld] had been looking after her when he was away for some time, and I had no idea…I was angry because, by this time, the house wasn't looked after and I was becoming frustrated that he was claiming benefit as my mother's carer but not caring for her. Plus, it looked bad on me - like I didn't care, which wasn't the truth…If he'd

spoke to me, we could have come to an agreement that meant he had more time to himself to do what he wanted. Instead, he never gave me the chance, and I believe that was because he knew I wasn't happy with the level of care he was giving mum."

Peter also recalled that in the weeks prior to her murder, Elaine told him that the perpetrator had pressed her into getting a life insurance policy. Elaine, Peter advised, did take out the policy but named Peter as beneficiary upon her death, stating "in that way, mum was the beneficiary because it meant she could have the funeral and send off she deserved…looking back now, having processed what [the perpetrator did], I wonder if he was trying to keep me from finding out he'd pressed mum into doing that. I didn't ask him about it, mum told me in confidence and asked me not to speak to him about it. I reckon she didn't want him to know that she'd put me down [as beneficiary] and not him…I didn't see this as abuse, I thought he [the perpetrator] was making sure that he had money when mum passed away…"

The panel were advised that, in 2010, Elaine was assessed in relation to difficulties with daily living and mobility; appropriate support and aids were given. Telephone contact on an annual basis with Elaine was undertaken in line with policy at the time. In 2016, when the routine telephone contact was undertaken, Elaine complained that some of her equipment was not working. Elaine was also recorded as experiencing medical issues that impacted on her lower limbs and her mobility, and clinical standards were adhered to her in her treatment.

The Department for Works and Pensions confirmed that, at the beginning of and throughout 2018, Elaine and the perpetrator were in receipt of appropriate benefits. This included a successful claim for Carer's Allowance in relation to Elaine's support needs/daily living. They were recorded as living together.

In March 2018, the perpetrator was seen by his GP as he was experiencing palpitations and attended a follow-up appointment. An ECG was undertaken and found to be normal. The perpetrator self-reported as suffering from anxiety and suggested that caffeine consumption could be a factor. He was prescribed beta blockers to be taken as and when he felt "panicky or experienced his heart racing".

In May 2018, the GP surgery undertook a medication review with Elaine. She was described as being generally well, although it was noted that she had a chronic health issue that impacted on her lower limbs and mobility.

In November 2018, Elaine received a routine vaccine, and her prescribed medication was processed on a repeat prescription basis. The panel were assured that Elaine had been in receipt of these medications for a long period of time to enable symptom management and the repeat prescriptions were processed routinely and within expected timescales.

In March 2019, Elaine required an assessment and clinical treatment, with a planned discharge following a further review the following week with a discharge from treatment planned. Elaine's GP notes referenced that Elaine had not attended a screening appointment.

In April 2019, the perpetrator attended the GP surgery as he was experiencing issues with his balance. This was clinically assessed as being linked to a vestibular disorder[11]. Blood screening was requested, and the perpetrator was asked to come back for a clinical review. The perpetrator did not attend for the blood tests or return to see his GP.

In July 2019, a review of Elaine's medication was undertaken by her GP and her medication was re-authorised and routine tests were requested. The following week, Elaine had been seen by a GP Nurse Practitioner at home who prescribed the appropriate medication. A further home visit was undertaken the following week to reassess Elaine's condition and her response to treatment. Elaine advised the attending clinician that she had ceased taking her medication, she experienced side effects that exacerbated a longer-standing issue that impacted on her mobility. Alternative medication was prescribed. The following week a further home visit to Elaine was undertaken. Elaine was described in her notes as sitting in a chair, reported to have reduced appetite but advised she was drinking well. The clinician noted that her symptoms had improved, any observed discomfort at that time correlated with her illness. Elaine was advised to continue the prescribed course of medication and to contact the surgery if her symptoms did not improve.

Two days later, at the beginning of August, her GP undertook a telephone consultation with Elaine who was still experiencing some discomfort linked to her infection. The GP referred Elaine back to District Nursing. This referral was processed on the same day and Elaine was visited by the District Nurse the following day. On arrival, Elaine was noted by the Nurse to have struggled to the door as her son who is the main carer had popped out. Scheduled visits by the District Nurse were then undertaken every other day throughout August and September.

A month later, in September 2019, the District Nurse recorded that Elaine's son was present at a home visit and did not record any concerns in relation to their interactions. By mid-September, Elaine's had progressed, and the District Nurse visits were reduced to monthly visits, which took place routinely and in line with clinical guidelines.

In mid-December 2019, Elaine requested a further home visit. A telephone consultation was undertaken by the District Nurse. A home visit was arranged and undertaken three days later. On this second visit, just before the Christmas holidays, it is recorded that Elaine requested her left leg be "dressed for protection" and this was undertaken by the District Nurse. The panel were advised that this was in line with her clinical presentation.

Throughout January to March 2020, Elaine was visited weekly by the District Nurse and no concerns are recorded, with Elaine being described in the stages of recovery that would be expected given the nature of her illness. In the middle of February, her GP recorded that Elaine had not responded to messages offering routine vaccines, and she received a telephone call from GP Surgery staff at the beginning of national

[11] Inner ear disorder that may cause dizziness and balance problem.

COVID-19 restrictions, to advise her that a routine check needed to be cancelled in line with those restrictions.

Throughout March to June 2020, Elaine received a combination of telephone consultations and home visits in relation to her ongoing illness. At the end of May Elaine advised the District Nurse in a telephone conversation that her son would be able to undertake her care, and this was in line with previous discussions between the District Nurse, Elaine, and the perpetrator.

In early June, the perpetrator contacted the GP and shared his concern about Elaine's health. A nurse practitioner undertook a home visit with Elaine the following day and Elaine was prescribed appropriate medication. Throughout August to the beginning of January 2021, checks were routinely undertaken by GP staff.

At the beginning of September 2020, Elaine became entitled to her State Pension and her claim for Employment Support Allowance came to an end.

In November 2020 Elaine contacted her GP surgery complaining of a new illness that was appropriately treated.

In March 2021, Elaine was sent a text message reminding her to book for Covid vaccination. In March there were two further contacts with Elaine in relation to medical ailments that were appropriately treated. All other recorded entries throughout this timeframe relate to routine medication reviews and are not relevant to this review**.**

6. Overview of Agency Involvement

6.1 Adult Social Care

Elaine first became known to Adult Social Care on 27th September 2010, following a request for Occupational Therapy to undertake a review of the adaptation and equipment provided to support bathing and handrails to support climbing steps into the property. She was assessed as meeting the Care Act 2014 eligibility criteria as outlined below: -

- Condition one - The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.
- Condition two - As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations.
- Condition three - As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's well-being.

Adult Social Care records have recorded annual telephone reviews up until 2017, when a local decision was made to discontinue annual reviews for simple pieces of equipment. During this period, no concerns arose that warranted the professionals undertaking this telephone contact to consider or progress referral for re-assessment of her needs or additional support, including in relation to safeguarding. In the last telephone review, Elaine did not express or identify any other support she required

for care or support and was noted as being aware of how to make a referral for support if needed in the future.

6.2 Essex Partnership NHS Foundation Trust (EPUT)

District Nurses were involved in Elaine's clinical care, and this included visits to her home, both before and throughout the pandemic. There was no evidence or concerns about their relationship, or the support Elaine received from the perpetrator. It was recorded that when the perpetrator was in the home, he ensured Elaine's privacy so that the District Nurses were able to see Elaine alone during visits and during her consultations and that he was always polite when interacting with them.

6.3 GP Surgery

It was confirmed that Elaine was under the care of her GP for a history of oedema[12], as well as routine appointments and tests. Her care was confirmed to be in line with clinical guidelines. The perpetrator had been seen by the GP for palpitations and appropriate physical health advice was provided.

7. Analysis Against the Terms of Reference

The panel established that practitioners involved with Elaine and the perpetrator were knowledgeable about potential indicators of domestic violence and/or abuse within familial relationships (i.e., non-intimate relationships), including coercive control, and aware of how to act on concerns about domestic violence and/or abuse. The panel received assurance that Safeguarding training is mandatory for all staff working in the NHS, for adult safeguarding it is in line with the requisite intercollegiate document/framework[13]. The panel was also advised that paramedics and General Practitioners are expected to be working to develop Level 3 competencies which were introduced in this revised framework. It was also confirmed to the panel that further training has been delivered by e-learning during the Covid-19 pandemic and forms part of mandatory training requirements.

Research[14] suggests that domestic abuse impacting older people will often be in a family context and that training and understanding is needed around this including the importance of support for carers. The panel received confirmation that domestic abuse is included in both adult and child safeguarding training packages and domestic abuse training has been delivered by the Named GP Safeguarding to the primary care Safeguarding Forum via Microsoft Teams. The IMRs provided on behalf of the health professionals involved in Elaine's care determined that these clinicians had sufficient knowledge and experience to have identified potential indicators of domestic violence and/or abuse within familial relationships. They identified no concerns when they

[12] Swelling caused due to excess fluid accumulation in the body tissues. Oedema can occur in any parts of the body. In Elaine's case, this impacted on her lower limbs and her mobility.

[13] Adult Safeguarding: Roles and Competencies for Health Care Staff August 2018 file:///C:/Users/cherr/Downloads/007-069.pdf

[14] Bows, H (2017) Practitioner views on the impacts, challenges, and barriers in supporting older victims of sexual violence. Violence Against Women, 24(9), pp.1070-1090 (open access)

observed interactions between Elaine and the perpetrator, and the panel were satisfied that had they had concerns, they would have sought advice, and the appropriate action would have been undertaken. The panel noted that a Domestic Abuse and Older People E'Learning had been developed by SETDAB, which addresses these issues and is available free of charge across agencies, but current take-up is low. It agreed that, on the basis of the evidence available to it during the review, the panel could not conclude that domestic abuse was a feature of Elaine's life, or that indicators of domestic abuse were missed by professionals who had contact with her. Despite this finding, the panel agreed that the research base supports the need to ensure that agencies involved in this review and who support older people should share and embed DA & Older People E'Learning within their organisations.

The panel considered if any opportunities were missed for professionals to "routinely enquire" if domestic abuse, including coercive control and/or financial abuse, was being experienced by Elaine. The panel's extensive enquiries found nothing in Elaine's or the perpetrator's contacts with primary care that would indicate the relationship between her, and her son was in any way problematic. There were no presentations in relation to any physical or mental health issues for Elaine that may have indicated hidden harm. Elaine interacted well with the clinicians treating her and these interactions were undertaken with a degree of privacy as the perpetrator was either not home when they occurred or absent himself for the duration of any home visits. The panel agreed that Elaine had opportunities to speak with professionals alone, and Elaine did not share any concerns or anxieties about her relationship with the perpetrator.

Peter firmly expressed his view that formal checks should be undertaken to ensure that a carer claiming Carer's Allowance was providing care under a family or informal arrangement. A person is eligible if the person they care for meets certain criteria[15]. The DWP panel member advised that Carer's Allowance policy and processes are kept under review to see if the allowance is continuing to meet its objectives. Additionally, that DWP already has processes in place to inform relevant authorities (e.g. police and social services) as appropriate when they become aware of safeguarding issues.

The review noted Peters concerns about how the level of care being provided by a family member could benefit from checks being undertaken, but also reflected on Census Data[16] that suggests the number of informal carers peaked at 5.6 million in 2012/13 and 5.4 million in 2016/17. The 2020/21 estimate of 4.2 million was the lowest recorded since 2007/08, but the number then increased to 4.9 million in 2021/22. In November 2022, there were 1.4 million Carer's Allowance claimants. Being mindful that checking on high number of carer's would require the introduction of a systemic national approach, it agreed that the Home Office should be invited to consider how the learning from this review could be shared with the Department for Work and

[15] https://www.gov.uk/carers-allowance

[16] https://researchbriefings.files.parliament.uk/documents/CBP-7756/CBP-7756.pdf

Pensions and structured into any reviews or reforms of entitlement to Carer's Allowance. It agreed that, locally, family members and community members can raise concerns about the level of care provided to people in similar circumstances to Elaine, and this is covered further in this analysis below.

The panel considered research[17] pertinent to Elaine's situation and noted that, as an older woman, Elaine may have been reluctant to talk about problems at home given her vulnerability and dependency on the support the perpetrator gave her, particularly because the perpetrator was her son[18]. The panel hypothesised that whilst this *may* have been the case, Elaine may have been reluctant or embarrassed to ask for help if she was experiencing any difficulties with the perpetrator, there was no evidence from this review to support this hypothesis. It also considered if the perpetrator manipulated his presentation as a caring carer to professionals whilst deliberately emphasising and reinforcing Elaine's dependency on him, as a way of asserting and maintaining his control over her, given academic research[19] suggests this is not unusual for older women experiencing domestic abuse.

The panel also considered further research[20] that highlights the experiences of older women who experience domestic abuse is likely to be significantly underreported, and a contributing factor could be due to an individual's presentation being viewed as the result of a victim's health and social care needs, without enquiries being made around domestic abuse. The panel was also aware that practitioners treating Elaine did not identify any concerns in the way Elaine and the perpetrator interacted, but it was assured, that had they identified concerns, these would have been responded to appropriately and safely in line with best practice. It also noted that although opportunities were presented when clinicians were with Elaine in her home, and the perpetrator was not present, it was not recorded that Elaine had been *asked* if her home life or if her relationship with her son was problematic or a cause of concern for her. The panel was also mindful that NICE guidance[21] advises people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion. Elaine did not present with indicators of possible domestic violence or abuse, and the panel agreed that the evidence from this review fell short of enabling the panel to state this review had established that

[17] Carthy, NL and Holt, A (2016) Domestic abuse and older adults, British Psychological Society Northeast of England Branch Bulletin, Issue 5, Winter

[18] https://www.solacewomensaid.org/sites/default/files/2018-05/Solace-Silver-Project-Evaluation-Report-2013-16-Feb-16.pdf "In almost a quarter of cases the service user was experiencing abuse from an adult son or daughter or from grandchildren…The dynamics of offspring abuse were found to be somewhat different from partner abuse as the bond and love between child/parent is different from 27 that of a partner and the complexities of shame and guilt came to the fore as the mother felt that her parenting skills were under scrutiny." Wong, S., Jonge, A.D., Wester, F., Mol, S.S.L., Romkens, R.R., Lagro-Janssen, T. (2006) Discussing partner abuse: Does doctor's gender really matter? Family Practice, 23(5), 578-586

[19] https://olderpeople.wales/library/Support_Services_for_Older_People_Experiencing_Abuse_in_Wales.pdf

[20] Older People's Commissioner for Wales. 2021. Support Services for Older People Experiencing Abuse in Wales https://olderpeople.wales/library/Support_Services_for_Older_People_Experiencing_Abuse_in_Wales.pdf

[21] https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse#quality-statement

routine enquiry for domestic abuse is not established in the community in respect of older people with health/care needs as learning from this review.

Noting the murder of Elaine was caused following a fire set in her home by the perpetrator, the Panel considered the need to undertake fire safety checks in the homes of persons with limited mobility. It established that fire safety checks are available as a free service to all in the area, and so makes no recommendation in relation to this.

During the trial, the Crown's case indicated that financial motivation may have been a factor in the perpetrator's decision to murder Elaine. The panel were concerned that the perpetrator may have subjected Elaine to financial[22] or economic abuse[23]; and wanted to explore this further, being aware it can be an indicator of coercive control[24]. In exploring this further, the panel was mindful of research[25] that indicates that financial abuse and economic abuse of older people can be difficult to detect, has a degree of invisibility, and can be a feature of abuse that can span protracted amounts of time[26]. The panel confirmed that Elaine and the perpetrator were both in receipt of the appropriate benefits that they were entitled to, and that Elaine's age would not have adversely impacted on her entitlements to those benefits. Based on the evidence available to the panel, it found no evidence that suggested that Elaine was economically dependent on the perpetrator, or that the perpetrator created economic instability, thereby limiting her ability to access safety. Peter also advised that he did not consider Elaine being "pressured into taking out life insurance as abuse" and so did not, at the time, think there was a need to discuss this with professionals.

When considering how issues of diversity and equality were considered in assessing and providing services to Elaine's protected characteristics under the Equality Act 2010, the panel agreed that there was evidence of excellent practice in relation to how Elaine's care and support was adapted to ensure her accessibility to medical

[22] https://www.ageuk.org.uk/information-advice/health-wellbeing/relationships-family/protection-from-abuse/financial-abuse/ Financial abuse is the mistreatment of someone in terms of their money or assets, such as their property. Financial abuse often occurs alongside other forms of abuse.

[23] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted; https://www.anncrafttrust.org/what-is-financial-abuse/; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf paragraphs 63 – 67; Economic abuse refers to behaviour that has a substantial adverse effect35 on an individual's ability to acquire, use or maintain money or other property, or to obtain goods or services. 36 This can include an individual's ability to acquire food or clothes, or access transportation or utilities. These behaviours can include an attempt to control through restriction, exploitation and/or sabotage.

[24] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf "Economic abuse can also amount to the offence of controlling or coercive behaviour, under section 76 of the Serious Crime Act 2015, where it takes place repeatedly or continuously, the victim and the perpetrator are "personally connected" and the behaviour has a serious effect on the victim".

[25] Older People's Commissioner for Wales. 2021. Support Services for Older People Experiencing Abuse in Wales https://www.gov.wales/sites/default/files/publications/2019-06/safeguarding-older-people-in-wales.pdf; https://survivingeconomicabuse.org/what-is-economic-abuse/

[26] https://survivingeconomicabuse.org/what-is-economic-abuse/

care, particularly during the Covid-19 pandemic. The panel found evidence of good information sharing between agencies in relation to Elaine and found no evidence to suggest that there were barriers or challenges in relation to information sharing that impacted on her care, which was delivered in a timely and consistent manner. This included Elaine 's capacity to understand those decisions and how they could respond to them.

The panel noted that Elaine was murdered during the period of the Covid-19 Pandemic[27]. It explored the impact of the pandemic in relation to Elaine, specifically around isolation and access to services.

The risk of Covid-19 (SARS-CoV-2) infection is understood[28] to be greater in adults over 60 years who are at a heightened risk of severe illness, hospitalisation, intensive care unit admission, and death. At the start of the pandemic, and during the period of national Covid-19 restrictions, many older adults were understandably very concerned about the risk to themselves, and this continues[29]. Elaine's condition did not fall within the 'shielding' criteria[30], but the panel agreed it was reasonable to assume that she would have felt vulnerable and concerned about the potential impact on her health should she have been infected by Covid.

Elaine's health and mobility were already impaired prior to the pandemic; she was described as 'housebound' by one professional and would have needed help to get around outside of the home. Due to the limited agency information shared with it during this review, the panel were not fully clear how much of an impact National Covid-19 restrictions would have had on her daily living. The panel was able to confirm that Elaine did not indicate to primary care staff that Covid-19 was having an adverse impact on her mental health and well-being. The panel understood that Elaine was invited to receive Covid-19 vaccinations when these were made available to her. Elaine did not attend for the vaccine and reminders were sent to her. The panel clarified how Elaine could have received the vaccine if she was unable to travel to the vaccination site, and were informed that, at Elaine's request, her GP surgery would arrange for her to receive the vaccination at home.

The panel also commended the practitioners who continued to provide Elaine's in-person care during the period of national restrictions.

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[27] https://www.instituteforgovernment.org.uk/sites/default/files/2022-12/timeline-coronavirus-lockdown-december-2021.pdf

[28] Troutman-Jordan & Kazemi 2020 COVID-19's impact on the mental health of older adults: Increase in isolation, depression, and suicide risk. An urgent call for action https://pubmed.ncbi.nlm.nih.gov/32720720/ . See also: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1010501/HEMT_Wider_Impacts_Falls.pdf

[29] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf

[30] https://www.gov.uk/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk At the time under review, the guidance required those at higher risk (e.g., compromised immunity) to stay home and not interact with members outside of their household.

Limited agency contact was a feature in this case and nearly all contacts considered by the panel with Elaine and the perpetrator related to their physical health and well-being. There was frequent liaison between primary care and the District Nursing Service in the management of her care. There were no indicators to suggest that there were any difficulties and the use of the same patient record system facilitated information sharing to good effect. It also noted that the assessments carried out and care management and treatment plans agreed with Elaine were cognisant of her relevant medical history. The panel agreed that although these assessments and discussions with Elaine could have afforded the opportunity to assess risks posed to her by the perpetrator, there was no indication that this was necessary.

Elaine was described as having restricted mobility but was able to move around the home. Subsequently, most of the consultations with her took place by phone or home visit. It is noted that she did not always take up the offers for vaccinations/screening, the panel were unable to determine if this was an individual choice or if she found it difficult to travel to the GP surgery. The panel also noted the interactions with Elaine did not identify any concern that would have suggested to those practitioners in routine contact with her that this was the result of the perpetrator controlling her or restricting her access to support.

The panel explored whether appropriate consideration was given to the accessibility of the support received by the perpetrator, including when professionals made decisions on the level and support provided to him as a member of Elaine's family. The perpetrator was in receipt of Carer's Allowance and Income Support on the basis that he was Elaine's main and full-time carer. On the face of it, there were no indicators that the perpetrator needed support that would have entitled him to a carer's assessment under the Care Act 2014.

The panel also considered how carers can access support if they are struggling with their caring responsibilities. The panel noted that a carer's assessment would have been offered to the perpetrator if there was any indication this would be appropriate. The panel found no evidence that this was given consideration by professionals who were in contact with him or Elaine. Based on the evidence available to it, the panel agreed that as there was not any indicator or evidence to suggest to the practitioners that this was required, no offer of a carer's assessment was made to him. The panel then considered if a carer's assessment should be routinely offered when professionals identify a family member as a carer. Government guidance[31] states that a carer is someone over the age of 18 who regularly looks after someone who is ill, elderly, or disabled, and that every carer is entitled to a free assessment, undertaken by the local authority. The panel noted that in Southend, there is an extremely low threshold for carers to access support and this does not require referral by the local authority as an individual can self-refer. It also includes peer support which could have enabled the perpetrator to express any frustrations he may have been experiencing

[31] https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carer-assessments/

in the care of his mother. It was not so clear to the panel if the perpetrator, Elaine, or their wider family would have known this was the case.

The GP consultation in March 2018 showed that the perpetrator was experiencing palpitations that were linked to anxiety. The perpetrator suggested that this may be because of coffee consumption and did not indicate that this was related to his caring responsibilities. The panel questioned if further exploration could have been undertaken around the cause of the perpetrator's palpitations and anxiety with the potential consideration of referrals for counseling and follow-up support.

At the initial DHR panel meeting Essex Police highlighted that there had been a suggestion to the officers investigating Elaine's murder that the perpetrator may have been taking Elaine's codeine tablets for his own use. The perpetrator also stated during his trial that he was addicted to codeine. It was advised that the perpetrator was not prescribed codeine but noted that he could purchase it in lower doses over the counter[32]. A review of Elaine's prescription record (from 2010 to 2021) was undertaken on behalf of the panel. This showed that there was nothing remarkable in the prescription requests for codeine and reflected what would be expected for a patient with Elaine's health issues. In view of this finding, the panel was assured that Elaine's annual medication reviews, which were confirmed to be routinely undertaken, did not present any cause for concern that required discussion with her and were satisfied that had there been any concern there would have been appropriate discussion. The panel was unable to establish that the perpetrator was addicted to codeine and if this could have presented a further opportunity for professionals to explore with him the impact this could have on his caring responsibilities, or if the perpetrator required support from agencies to manage this.

The evidence available to the panel did not identify any members of Elaine's community who may have been aware of domestic abuse in her family. As such, there was limited opportunity for the panel to assess if members of the public were clear on the unacceptability of domestic abuse and how to seek help for someone. Due to the limited information available to it, the panel did not identify learning in relation to community awareness, including how community and/or faith groups and other potential access points for support, are supported. Whilst exploring this as part of the review, the panel were mindful of research[33] that suggests older victims of abuse are often excluded from awareness-raising activity. However, there was no evidence to suggest to the panel this was a feature in relation to Elaine or her situation and so the panel could not identify this as learning from this review or make a recommendation in relation to it. The panel, therefore, invites the Southend Community Safety Partnership to consider how it can ensure future communications activity supports increased awareness of age variations in domestic abuse through education,

[32] Codeine is a painkiller that is part of a group of medicines called opiates. It's used to treat pain, for example, after an operation or an injury. About

[33] Ishkanian, A (2014) Neoliberalism and violence: the big society and the changing politics of domestic violence in England, *Critical Social Policy*, 34(3), pp.333–353; Mears, J (2015) Violence against older women: activism, social justice, and social change, *Journal of Elder Abuse and Neglect*, 27(4–5), pp.500–513; Women's Aid (2017) Survival and beyond: domestic abuse report 2017

advertisements, and media campaigns. This would enable the Southend Community Safety Partnership to build on its current ongoing activity with community and/or faith groups that supports the public to identify safeguarding issues and/or victims of domestic abuse and share concerns with professionals.

Based on the evidence shared with it during this review, the panel did not identify or establish any issues that affected local public confidence in the protection of people in vulnerable situations. There was no evidence available to the panel that suggested any shortcomings in the use of legislation and relevant statutory guidance pertaining to the family's situation. This includes the panel's consideration of how local safeguarding procedures were followed, and how effectively local agencies and professionals worked together in relation to domestic abuse.

The panel was aware that Elaine was murdered shortly after another DHR was commissioned locally in relation to a case with similar demographic features. The respective DHR chairs consulted but did not identify any shared learning or similar emerging themes from their ongoing local Domestic Homicide Reviews.

8. Conclusions

The limited evidence available to the panel did not enable it to identify what may need to change locally, and/or nationally, to prevent serious harm to victims of domestic abuse in similar circumstances. Based on the information shared with it, the panel did not identify any warning signs of serious risk leading up to the fatal incident resulting in Elaine's murder, which could reasonably have been identified, shared, and acted upon by professionals, including the use of markers/warning indicators within agency systems. The panel also did not identify any concerns raised by any agency or professionals that were not taken seriously or acted upon by others.

The chair and panel extend its sincere condolences to Peter and others who knew Elaine and thank all who contributed to this review.

9. Lessons Identified and Recommendations

Learning point 1 – we need to ensure that practitioners are aware of the training available to them to enable their heightened awareness of domestic abuse perpetrated against older people and appropriate responses.

As this learning was immediately acted upon and progressed, with appropriate reassurance being received by the panel, the panel makes no recommendation.

The Home Office is invited to consider how the learning from this review could be shared with the Department for Work and Pensions and structured into any reviews or reforms of entitlement to Carer's Allowance.