Joint Domestic Homicide Review and Safeguarding Adults Review Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Tendring Community Safety Partnership

A Review into the death of 'May' in February 2023

Report produced by Joanne Majauskis

Date: June 2026

Preface

This is a Joint Domestic Homicide Review (DHR) and Safeguarding Adult Review (SAR) Report referring to the life and death of "May". This is a pseudonym, as is the name "Tim" which will be used to refer to her husband. The children's names are also pseudonyms. The pseudonyms were chosen by their family and will be used throughout the report.

I would like to begin by expressing my sincere sympathies, and that of the panel, to the family and friends of "May". We appreciate the input from them during this difficult process.

May's daughter has provided some words of tribute about her parents:

> May and Tim met at school, as Tim was best friends with May's brother. They began 'courting' and married in 1961.
>
> They had two children, Jane and John, and they were great parents.
>
> Life was good for May and Tim, the children were settled, and they had close friends who they socialised and enjoyed holidays with. They were devoted to each other.
>
> May enjoyed line dancing, being part of the WI club and going out for meals. She had lots of friends and when Jane's son was born, May and Tim looked after him for two days a week while Jane worked. May loved looking after her grandson and would play games and sing nursery rhymes to him.
>
> May is greatly missed by Jane, and her family (sadly John passed away from cancer in 2021).
>
> Jane continues to support her father.

The review was commissioned by the Tendring Community Safety Partnership and Essex Safeguarding Adults Board on receiving notification of the death of May in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004. It follows the guidance set out by the Home Office.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address the issues that it has raised. I would like to thank all those who contributed.

Contents

1. Review Process

1.1 This summary outlines the process undertaken by the Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) Review Panel in reviewing the death of 'May', an 80-year-old female and resident of the Tendring Community Safety Partnership area.

1.2 The summary will use the pseudonym's "May" and "Tim" throughout.

1.3 The review process began when Essex Police notified SETDAB and Tendring Community Safety Partnership of the homicide on 22nd February 2023.

1.4 The Core Group met to discuss the case on 28th March 2023 and considered the circumstances of the case, with the assistance of thorough scoping from organisations. A decision was reached that the homicide met the criteria for a Joint Domestic Homicide Review and Safeguarding Adults Review and an Independent Chair, Joanne Majauskis, was appointed to carry out the review.

1.5 Where it was established that there had been contact, agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members.

1.6 Agencies that were deemed to have relevant contact were asked to provide an Individual Management Review (IMR) and a chronology detailing the specific nature of that contact. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.

1.7 Partnership workshops were held on 16th May 2023 and on 16th October 2023 to consider the case and capture key issues for this report.

1.8 At the time the reviews commenced there was also a criminal investigation, which was resolved with the conviction of Tim in January 2024.

1.9 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998, enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the review is to prevent a similar crime.

2. Contributors to the review

2.1 The following agencies contributed to this Review through submitting a chronology, an IMR or a Summary Report:

- Essex Adult Social Care
- East Suffolk and North Essex NHS Foundation Trust (ESNEFT) -Colchester Hospital
- Northeast Essex Community Services (NEECS)
- Clacton Community Practices
- Care Call (Provide)
- Careline Tendring Council

- East of England Ambulance Service NHS Trust (EEAST)
- Essex Partnership University Trust (EPUT)
- Tendring Crossroads
- Essex Police

3. Involvement of family, friends and wider community

3.1 An introduction to May and Tim's daughter, Jane, was made by Police Family Liaison Officers, who passed her a letter introducing and setting out the purpose of the review, the letter included the Home Office prepared leaflet for family and friends, as well as details about AAFDA.

3.2 Tim originally pled not guilty to murder so no further contact was made with anyone involved in the case to ensure no interference with the criminal justice process. However, in November Tim changed his plea to guilty and following this the chair met with Jane.

3.3 The Chair would like to thank Jane for her engagement and the contribution she made to this review.

3.4 The chair also attempted to make contact with Tim. This took a considerable amount of time as Tim was initially moved between prisons due to poor health. Following his transfer, the chair attempted to make contact but it took several weeks before an interview could be arranged.

3.5 The chair visited Tim in prison at the end of June 2024.

3.6 May's daughter was provided with a copy of the report before it was concluded to allow her to consider this in private and without time pressures. Tim was offered a copy of the report but declined.

4. Review Panel

4.1 The panel for this review was made up of the following representatives:

Joanne Majauskis	Independent Chair
Michelle Williams	SETDAB Senior Domestic Abuse Partnership Officer
Leanne Thornton	Tendring Community Safety Partnership (CSP)
Michala Jury	Essex Safeguarding Adults Board (ESAB)
James Butler	ESAB
Patsy Rutland	ESAB
Ben Pedro Anido	Essex Police
Tendayi Musundire	Essex University Partnership NHS Foundation Trust (EPUT)
Nicola Taylor	The Next Chapter
Alex Keramidas	The Alzheimer's Society
Antony Alcock	Essex Police

Gemma Tomsett	The Alzheimer's Society
Nicola Peterson	East Suffolk and North Essex NHS Foundation Trust (ESNEFT) -Colchester Hospital
David Evans	Northeast Essex Community Services (NEECS)
Alison Clark	Essex Adult Social Care (ASC)
Elaine Oxley	Essex ASC
Adam Seomore	Provide
Claire Ellington	Tendring District Council Careline
Jane Whitington	Suffolk and Northeast Essex ICB
Jackie Brandon	Provide
Adam McGoldrick	Tendring District Council
Caroline Sexby	East of England Ambulance Service (EEAST)
Paul Bedwell	East of England Ambulance Service (EEAST)

5. Domestic Homicide Review Chair and Overview Report Author

5.1 Essex Safeguarding Adults Board (ESAB) and the Southend, Essex and Thurrock Domestic Abuse Board appointed Joanne Majauskis as Chair and Overview Report Author.

5.2 Joanne is an independent consultant and trainer with over fifteen years' experience working in the Domestic Abuse Sector. Joanne has experience of working both in frontline and strategic management roles. Joanne is also an Associate Lecturer for the Department of Violence Prevention, Trauma and Criminology (School of Psychology) at the University of Worcester having completed her own Master's in Dynamics of Domestic Violence with a Distinction in 2015.

5.3 Joanne completed Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA) in 2021 and the AAFDA Bespoke Qualification: Certificate in Chairing a Domestic Homicide Review (Level 3) in 2024. AAFDA are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

5.4 Joanne has been working independently for four years is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

6. Terms of Reference

6.1 This report will consider relevant past agency contact and involvement with May and Tim and in particular will focus on the time from February 2020 until the time of the incident. This is the timeframe in which May is said to have been suffering from dementia and very little information before this time was identified during scoping for either party.

6.2 The independent chair agreed the Terms of Reference for the Review with the panel. The family were also consulted. The key issues identified were:

Case specific

- What evidence is there that care and support was person centred and that May's voice was present in the discussions and decisions made?
- How did May's diagnosis of dementia impact her ability to make informed decisions?
- What could agencies have done to ensure that Tim was fully supported as a carer?
- What were the barriers to Tim accepting support?
- What was the impact on May of Tim not accepting help?
- Who assesses the ability of the carer to care?
- What consideration was given regarding Tim's health and wellbeing impacting on his ability to care for his wife, was this assessed and understood?
- What protocols are in place when a carer denies agencies access to the patient?
- Were there any signs, signals of concerns regarding domestic abuse or coercive controlling behaviour. If so, how was this addressed?
- Were risk assessments undertaken following disclosures of violent behaviour from May towards Tim? Or when Tim disclosed becoming angry and agitated with May?
- How effectively did agencies share information appropriately, if this did not happen what were the barriers or challenges for agencies?
- Did the Covid Pandemic have any impact on Tim and May in terms of isolation and access to services?

Generic

- Whether local service provision is adequate and sufficiently prioritised in local planning arrangements?
- Whether local agencies have robust domestic abuse and safeguarding policies and procedures in place both individually and on a multi-agency basis?
- Whether training is available to, and accessed by, staff in relation to responding to the above issues?

6.3 Agencies completing Independent Management Reports (IMRs) were required to analyse these issues in relation to their contact with May and Tim, 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.

7. Summary of the Chronology

7.1 This chronology covers the period from 1st February 2020 up to the date of the homicide. This is the timeframe in which May is said to have been suffering from dementia and very little information before this time was identified during scoping for either party.

7.2 Agencies with records prior to the start date above were asked to summarise any information that may have had an impact or had potential to have an impact on the key lines of enquiry from the Terms of Reference.

7.3 There was a large volume of medical records for May that have been omitted from this summary as they were not relevant to the learning in this review (they are included in the

full report). However, they did highlight the amount of care that May needed, the potential for caregiver stress but also the multiple opportunities to offer, request and accept help.

Combined chronologies

7.4 29th October 2020 – The GP had a triage call with Tim regarding May. Tim reported that May was disorientated about the day, time, season, month etc. He said that she doesn't recognise her daughter's name and can't remember where the toilet is in the house. Tim says he has to do everything for her such as getting food on the table and washing her, although she is able to dress herself. The GP made a referral for the Memory Assessment Service at EPUT.

7.5 18th November 2020 – The GP had a phone consultation with Tim regarding May. Tim reported that May has been 'feeling down' for about a year and that she was stressed from all the investigations including the brain scan from the memory clinic. Tim says she states she sometimes wishes she was not here but has no thoughts of deliberate self-harm. Tim feels that counselling would not be suitable. The GP suggests sertraline and a medication review in four weeks.

7.6 20th November 2020 – Tim attended the GP for a blood pressure check. The GP reported that the clinic was running behind by approximately 15mins. The GP notes that this had left Tim agitated and visibly anxious as May had refused to attend the appointment with him and was home alone. Tim says he is concerned and worried about May and her memory problems and talks 'nervously' about her throughout the consultation. He tells the GP that he is fine and that he wouldn't take any additional tablets even if his blood pressure was high. The GP reports that he explained to Tim the importance, not only to him, but also to May that he takes care of himself.

7.7 13th January 2021 – The GP had a phone consultation with Tim regarding May. Tim reported that May was becoming aggressive and could not relax. The GP advised that she remain on the same dose of sertraline (50 mg) and that she also take Lorazepam as per her prescription, to be reviewed in two weeks.

7.8 1st March 2021 –The EPUT memory assessment team held a Multi-disciplinary meeting regarding the results of May's assessment and scan. They concluded that's she had a diagnosis of mixed dementia (Alzheimer's Disease and Vascular dementia) and could be prescribed with up to 10mg of Memantine.

7.9 18th March 2021 – The Alzheimer's Society completed a telephone triage with Tim regarding May. Tim stated he feels equipped to cope as he helped care for his mother-in-law for six years who also had dementia. Tim said he felt that everything was fine at the moment, and they were coping well. Tim stated that they have a daughter who lives in Kent who supports them when she can. Tim was told to contact the society if he needs anything and agreed to a follow up call in six months' time.

7.10 7th September 2021 – The GP made a 'keeping in touch call' to Tim. Tim stated that he was doing fine and didn't need any further support at the moment, he said he would like a call in six months' time. The helpline number was given to him again.

7.11 21st December 2021 –The pharmacist undertook a medication review for May. Tim mentioned that her dementia was progressively getting worse and said that he would contact the dementia team to discuss this.

7.12 5th January 2022 - The EPUT dementia team held a multi-disciplinary team meeting with the Consultant Psychiatrist, Community Mental Health Nurse and an Administrator after receiving a letter from the clinical pharmacist regarding the concerns that had been raised regarding May's deterioration. The conclusion of the meeting was for May to remain on 10mg Memantine but to consider an increase if her kidney function increased further.

7.13 28th March 2022 – A memory monitoring appointment was completed for May between the dementia team and Tim via telephone. Tim informed them that May's mood was good but occasionally she could become irritable in the late afternoons. They discussed the use of Diazepam (10mg) which Tim said had a good effect. Tim informed them that May was sleeping, eating and drinking well. Tim was offered the telephone numbers for the Alzheimer's Society and Crossroads befriending service which he declined as he reported that he already has these available. There are no other concerns raised so a review was scheduled to take place in six months' time.

7.14 4th October 2022 – An ambulance was called by a friend of May and Tim as Tim had fallen and hit his head. He stated that he was helping May get out of bed earlier today, and he slipped and hit his head. The bleeding was controlled so there was a no send response and advice was given over the phone. There was a G.P. follow up later that day, Tim reported a large laceration to right side of head requiring sutures or glue so he was advised to attend the Urgent Treatment Centre where they closed the wound.

7.15 1st November 2022 – The Alzheimer's Society spoke to Tim who advised that he was managing currently. Tim explained that he cooks the meals and helps May with personal care and medication. Tim advised that he also does the chores as May is not great on her feet and suffers from mobility issues. Tim advised that unfortunately May had become incontinent and he is buying her pads. Tim was advised that it is important that he looks after himself and gets plenty of respite. Tim advised that daughter supports him and he has the Dementia Team number but feels he is able to manage currently. It was agreed to call again in six months' time.

7.16 8th November 2022 - ESNEFT NEECS completed an initial patient assessment with May. It was noted that May had minimal communication due to her Dementia, so Tim speaks for her. Tim reported that May recently had a fall, and the neighbour helped him get her up from the floor. Tim said that a friend had given them a frame to use, but due to her Dementia, May is not sure how to use it. Tim said he was going to look into Careline, but he didn't feel May would push the button if he wasn't there. Tim said he goes shopping with dial a ride on a Friday morning and May is left in the chair where she stays until he is back. Tim was offered a sit in service for May when he goes shopping which he refused.

7.17 10th November 2022 – The GP had a telephone call with Tim who reported increased violent behaviour from May; throwing items around and "getting herself worked up." She was taking Diazepam but Tim stated that it wasn't that effective. The GP requested an urgent dementia referral and suggested they trial May taking mirtazapine at night.

7.18 15th November 2022 – ESNEFT NEECS have an initial patient assessment with May. Tim said he was looking to get some respite as he was finding it difficult 24/7, he was given the Adult Social Care number to contact. It was noted that Tim was still refusing to have anyone to come in and assist him.

7.19 1st December 2022 –EPUT called Tim to discuss May's current presentation. Tim reported that May was refusing to accept help, became violent towards him and was throwing items around the house. He says that it takes him around an hour to assist May with her personal care in the morning due to her aggression. EPUT referred them onto the Dementia Intensive Support Team (DIST); an assessment was arranged to take place at their home the following day.

7.20 2nd December2022 – A face to face assessment was completed with May and Tim by a community mental health nurse. Tim raised concerns around May's agitation and her aggressive behaviours. Tim reported that he had no care package in place, he said that he was reluctant to have carers to support with personal care needs. Despite explaining the challenges that can come with dementia Tim still declined to seek support. He stated that he was reluctant to approach Social Care as he believes his wife would be self-funding due to their savings. He reported having the contact number for social care.

The recommendation from the assessment outcome was for May to be discussed in the Dementia Support Team (DST) multi-disciplinary team (MDT) meeting for a medication review regarding her behaviours. Tim was encouraged to contact Social services and was signposted to the Alzheimer's Society, Crossroads and Colchester Catalyst for support. He was further advised to contact the crisis helpline or the police if there were any safety concerns for him or his wife.

7.21 6th January 2023 – Social Care Connect made a referral for Millbrook Healthcare regarding fitting Careline following a request from Tim. Referrals were also made to NHS physiotherapy, and to Crossroads for a taster session for possible respite. A carers assessment was also initiated on the system.

7.22 9th January 2023 - EPUT completed a memory monitoring appointment at Tim and May's home. Tim reported that Social Services were involved and supporting May with a fall detector and pendant. Tim said that May was expecting to go to Millicent's day centre and Crossroads support in the near future. Tim said that May didn't always want to get up in the morning and required some encouragement which could lead to some agitation. An Addenbrooke's Cognitive assessment tool was completed due to May's cognitive decline.

7.23 10th January 2023 – ASC contacted Tim to instigate a new Social Care Connect Intervention. The outcome of the intervention was for an Occupational Therapy assessment assigned to an independent workforce team. It was noted that Crossroads had advised that Tim declined their taster service.

7.24 16th January 2023 - May was referred back to ESNEFT NEECS by ASC due to her increased falls. Tim stated that they had a wheelchair assessment booked for the following day and that Careline was due to be installed on 18th January. Tim reported that he was managing quite well and did not feel he needed any additional help. Tim said he was planning on making arrangements to drop May off at Millicent's, the day care centre, for respite once she gets a wheelchair.

7.25 18th January 2023 –ASC close May's case following a phone call during which Tim declined a carers assessment.

7.26 18th January 2023 –Carecall was connected in Tim and May's home for the monitoring and response service.

7.27 20th- 23rd January 2023 – Provide Carecall attend Tim and May's home on three separate occasions in response to calls that May has fallen.

7.28 23rd January 2023 – ASC phoned Tim to book an Occupational Therapy Assessment but he declined the assessment and the case was closed.

7.29 24th January 2023 – The GP phoned Tim to arrange a physiotherapy review with May. Tim said that May was not in a good mood today, so it was not appropriate to visit. Tim felt he was managing at the moment and did not need any physio input. It was agreed to review this again the following week and to discharge May from community rehabilitation.

7.30 3rd /10th /15th /16th /17th /18th February 2023 - Provide Carecall attend Tim and May's home on six separate occasions in response to calls that May has fallen.

7.31 19th February 2023 – Tim called an ambulance as May had a fall, but she was not injured. Tim stated on the call that her dementia was worsening, she has poor mobility, gets angry and agitated with him when assisting with her hygiene and has bouts of aggression towards him. It was agreed that Tim would contact the dementia team and speak with the GP regarding her worsening dementia and a possible Medication review. There were two hour delays for an ambulance so it was assigned to the Careline Team. The responders expressed concerns that the ambulance service had sent them as this was May's sixth fall in the last 2-3 days. It was also noted that she had not eaten in over 24 hours. Tim said this was due to the prolonged period of time she had been asleep, and he had been struggling to wake her. A follow up call was made later that evening.

7.32 20th February 2023 – The Advanced Nurse Practitioner (ANP) from the GP surgery made a home visit to May. Tim reported deterioration in May's confusion over the last two weeks. He said that if he leaves a room, May wants to follow him, resulting in daily falls, although he reports no injuries. Tim said that May can be aggressive at times, throwing chairs. Tim said he currently has no care in place but has access to the helpline. The ANP discussed care input, but Tim declined this saying he felt he can manage and wants to. Tim reported that he cannot go out now, so he has the shopping delivered. The ANP discussed crossroads and the help available, but Tim declined. The ANP made a referral for an assessment with the dementia clinic.

7.33 20th February 2023 – Provide Carecall responded to a call that May had fallen in the bathroom. She had no injuries and was OK when they left.

7.34 21st February 2023 – Tim made a call via Service Provider PLUSNET PLC to the Police informing them that he has just killed his wife. He told them that she had dementia, and he had problems getting her up in the mornings. He said that she messed herself last night and he tried to get her in the bathroom to wash her down. He tried to get the wheelchair to get her in but he just "lost it".

8. Key issues arising from the review

8.1 May's voice is sadly absent from this review. Whilst there is some evidence from agencies that suggest they tried to convene with May most relied on Tim to obtain information about the needs of May and any previous wishes, if any.

8.2 May appeared to be mostly present at assessments and it has been identified that May had communication difficulties and was difficult to understand but there is no evidence to

suggest anyone attempted to use any communication tools to support May with her communication.

8.3 There is no reference to any Mental Capacity Act Assessment or to whether Tim had lasting Powers of Attorney to make decisions in relation to May's care and support needs. There is also no evidence to suggest that a Care Act Assessment was offered despite Tim frequently mentioning that May had some violent outbursts.

8.4 Tim carried out all daily activities for May, however, his ability to sustain this caring role does not appear to have been explored at any depth. There appeared to be a lack of consideration given to the informal caring arrangements or the impact on Tim as the carer, especially given his age and own health concerns.

8.5 Tim's help-seeking and refusal of offers for help was one of the main themes that emerged from this review. There are numerous barriers to why Tim may have declined help and again there appears to be a lack of professional curiosity and enquiry around this. There is evidence of unmet need among older people, but the simple explanation of service 'refusal' hides a more complex picture. Tim had told NEECS that 'May was his wife, and it was his job, and that May wouldn't accept anybody else caring for her. This could have been discussed and the importance of his self-care as well as May's reiterated.

8.6 Tim disclosed in interview that he was scared that if he engaged with Social Care, he would be deemed unfit to care for May and she would be put in a home. He also voiced concerns around the quality of care that May could have received in a home. In December 2022, Tim disclosed to the community mental health nurse that he did not want Social Service intervention as he believed his wife would be self-funding due to their savings. This highlights the importance of agencies being clear about their role, the services they offer and what interventions are likely to happen. Had this conversation taken place, Tim may have felt more inclined to accept help.

8.7 There was a lack of a carer assessment and whilst Tim turned this down, the reasons for him doing so should have been considered more fully. Had a carer's assessment been carried out, there would have been a greater understanding of the pressures that Tim faced on a daily basis.

8.8 There were several occasions where Tim had disclosed that he was struggling to manage the care needs of May full time. On most of these occasions Tim was given contact numbers or referrals were made on his behalf that he later turned down. The impact this may have had on May does also not appear to have been considered. Best practice would have been to follow up on referrals and investigate the reasons for his refusal.

8.9 Furthermore, whilst various offers of help were made, at no time does Tim appear to have been asked what he thought may have been helpful in supporting him in his role. One way to address the very complex issue of service refusal with older people is to include them in the service planning.

8.10 Consideration should also have been given to the possibility of coercive control as a factor. In addition to not accepting offers of help, there were occasions when Tim cancelled appointments or refused to give professionals access to May. Whilst there is no evidence to suggest coercive control played a factor, this should always be considered especially where the involved party does not appear to have a voice.

8.11 Conversely, from the information provided, risks of harm appeared to be directed from May towards Tim. Tim made numerous disclosures of violent and aggressive behaviour from May however, this again does not appear to have been explored. On one occasion, Tim sustained an injury which he states happened after May pushed him. He told health professionals he had fallen but there could have been more enquiry into this.

8.12 There is no evidence to suggest that measures were taken to safeguard Tim from harm. The panel reflected on whether a different approach would have been taken, and the risk of harm been given more regard had the gender roles been reversed.

8.13 Generally, there appears to be a lack of consideration of the various risks present in this case. Tim had a history of seizures and had previously suffered from a brain bleed. Had this happened again whilst in the home, he would have had no assistance and May effectively would have been left alone. On occasion, Tim also disclosed leaving May to run errands, there appears to be no consideration given to the safety of May when this happened.

9. Conclusion

9.1 There is evidence of good practice throughout the review. May and Tim had regular contact from services, were frequently offered support, advised of relevant services and referrals were made promptly.

9.2 Interventions should be personalised and have due regard to the principles of the Mental Capacity Act 2005. Regard for this is not fully evidenced within recording. It cannot be known what the outcome of a mental capacity assessment would have been, had one been carried out, but by not completing this May was not given the opportunity to make any informed decisions.

9.3 There was a clear deterioration in May's condition, with Tim making disclosures of violence towards him, and her escalating falls and issues with incontinence. He also made reference to not being able to leave her with one person to manage her care needs. Their neighbours, who often helped with May, moving away was another escalating factor that could have been explored. May not having eaten in 24 hours when Careline attended and admissions from Tim of not administering medication as prescribed were also concerns that should have been addressed. These were all high risk factors that should have prompted professionals to instigate more professional curiosity and prompted safeguarding protocols.

9.4 Thorough risk assessments should have been undertaken with consideration given to the risks posed to both May and Tim and these should have been acted on accordingly with robust safety plans put in place. Only the documentation from EPUT mentioned undertaking risk assessments but these appear to be in relation to May only and there are no actions associated with them. There is no evidence of risk assessments or consultation on levels of risk with senior staff from Adult Social Care.

10. Recommendations

Recommendations referring to "all agencies involved in the review" include the following agencies: Essex Adult Social Care, East Suffolk and North Essex NHS Foundation Trust (ESNEFT), Colchester Hospital and North East Essex Community Services (NEECS), Suffolk and North-East Essex ICB, Clacton Community Practices, Care Call (Provide), Careline Tendring Council, East of England Ambulance Service NHS Trust (EEAST), Essex Partnership University Trust (EPUT).

Recommendation One:

10.1 All agencies involved in the review should ensure that robust policies and procedures are in place to support consistent risk assessments, safety planning, and appropriate referrals when violence is disclosed. Particular attention should be given to recognising and responding to older people, who are often overlooked as potential victims of domestic abuse.

Recommendation Two:

10.2 All agencies involved in the review to ensure that staff receive training on Safeguarding, the Mental Capacity Act, Domestic Abuse and the importance of professional curiosity as appropriate to their role. This should include content on how to make enquiries about how carers are managing and how to onward signpost to safety net if required

Recommendation Three:

10.3 All agencies involved in the review to ensure that Safeguarding contact details are available for all staff.

Recommendation Four:

10.4 All agencies involved in the review to ensure that when referrals are deemed necessary or appropriate for vulnerable or elderly individuals that they make a direct referral and do not rely on the vulnerable adult to do it themselves. Referrals should be bridged to ensure that contact is made and the referral accepted.

Recommendation Five:

10.5 North East Essex Community Services to review their Mental Capacity Act assessment documentation to ensure community-based staff are confident in competing a mental capacity act assessment.

Recommendation Six:

10.6 Adult Social Care to review practice to ensure that individuals they are working with are consulted and that practice is person centred. Staff should ensure that individuals are aware of the services offered and possible interventions that might take place. Adult Social Care to review policies and procedures to ensure that quality assurance is carried out by an appropriate staff member at case closure.

Recommendation Seven:

10.7 Adult Social Care to review practice to ensure that staff are operating a whole family approach to their interventions. Review current allocation processes to ensure that safeguarding and Care Act assessments are recognised, and joint visits are undertaken where appropriate.

Recommendation Eight:

10.8 Adult Social Care to produce practice guidance for working with families where there is an elderly person with caring responsibilities. This should include specific guidance where the cared for person has a diagnosis of dementia, to consider mental capacity and ensure their voice is understood. Guidance should also be provided on when to intervene where the carer is refusing help from agencies or where their own health and wellbeing is being impacted by their caring responsibilities.

Recommendation Nine:

10.9 Clacton Community Practices (G.P.) to ensure that patients at risk from unplanned admissions to hospital or high intensity users at the practice to have allocated pre-booked slots for reviews. The frequency of which should be agreed between the patient, family/carer and the practice multi-disciplinary team.

Recommendation Ten:

10.10 Clacton Community Practices (G.P.) to ensure that care plans are agreed and reviewed at a frequency appropriate to the individual patient and their needs and that carers are supported with input from the social prescriber and care co-ordinator.

Recommendation Eleven:

10.11 Clacton Community Practices (G.P.) to review practice to ensure that a structured multi-disciplinary approach with a named clinician is used to case manage vulnerable patients (including those with a diagnosis of dementia) and support family and carers.

Recommendation Twelve:

10.12 Provide Carecall to review policies and standard operating procedures in relation to the escalation of frequency of falls management and ensure this is included in and embedded in practice.

Recommendation Thirteen:

10.13 Provide Carecall to discuss with service users who they would like on their contact list and be aware of family members and their role within the family, using the 'Think Family' model.

Recommendation Fourteen:

10.14 Tendring Careline to review their safeguarding policies and procedures and ensure that there are clear guidelines and criteria relating to the escalation and referral of cases. In particular where there has been an escalation in falls or where an individual has not eaten in the last 12-24 hours.

Recommendation Fifteen:

10.15 EPUT to put procedures in place that Multi-disciplinary Team meeting actions are completed to ensure follow-up calls and information sharing with G.P.s is completed as scheduled.

Recommendation Sixteen:

10.16 EPUT to ensure that enquiry is made into how carers are managing and that carers assessments are offered when completing Memory Monitoring appointments. Where this is declined, there should be enquiry into the reasons for the refusal and this should be documented.

Recommendation Seventeen:

10.17 Ministry of Justice to send correspondence to prisons regarding the Domestic Homicide review process and the importance of engaging with Domestic Homicide Panels and allowing access to prisoners.