Joint Domestic Homicide Review and Safeguarding Adults Review Overview Report

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.

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Section One - Introduction

1. Introduction

1.1 This is a combined review which brings together the requirements of a Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) into the circumstances surrounding the death of May, an 80-year-old female and resident of the Tendring Community Safety Partnership area.

1.2 May was killed by her husband, Tim (aged 84), in the home they shared, in February 2023. Tim pled guilty to murder and was sentenced to ten years in prison in January 2024

1.3 According to her family, May had been suffering from dementia for approximately five years, although she wasn't formally diagnosed until three years before her death. Her condition had deteriorated over this time and Tim had become a full-time carer for her.

1.4 May's voice is mostly absent from this review. Agencies reported that the majority of their contact took place with Tim as May's condition left her unable to communicate with them in a meaningful way.

2. Confidentiality

2.1 The findings of this review are confidential. Information is available only to participating professionals and their line managers until the review has been approved by the Home Office. Following approval, the report should be shared appropriately within and between organisations in order to disseminate the learning.

2.2 Before the report is published the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB), Domestic Abuse Team, Essex Safeguarding Adults Board (ESAB) Team and Tendring Community Safety Partnership will circulate the final version to all members of the review panel, The Police, Fire and Crime Commissioner for Essex, The DA Commissioners Office and the family members. The family will be notified of the publication date.

2.3 To protect the identity of those involved the following pseudonym's have been used throughout this report:

May and Tim

3. The Review Process

3.1 Purpose of a Domestic Homicide Review (DHR)

Statutory Guidance (Section 2.7) states the purpose of the DHR Review is to:

3.1.1 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;

3.1.2 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;

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

3.1.4 Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

3.1.5 Contribute to a better understanding of the nature of domestic violence and abuse; and

3.1.6 Highlight good practice.

3.2 Purpose of a Safeguarding Adults Review (SAR)

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

3.2.2 The purpose of the Review is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learnt and applied to future cases to prevent similar harm occurring.

3.2.3 The Essex Safeguarding Adults Board (ESAB) SAR Subcommittee considered the circumstances of this case and agreed that it met the mandatory duty for a SAR to be conducted.

3.2.4 Both the SET Core Group and ESAB SAR Committee agreed that both the reviews should be coordinated and undertaken together to ensure that the most efficient opportunity for learning is realised and that the contact with May's family is coordinated.

4. Terms of Reference

4.1 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.

4.2 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?

4.3 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.

5. Contributors to the review

5.1 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

6. Review Panel

6.1 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)

7. Review Chair and Overview Report Author

7.1 The Southend, Essex and Thurrock Domestic Abuse Board appointed Joanne Majauskis as DHR Chair and Overview Report Author.

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

7.3 Joanne completed Independent Domestic Abuse Chair Training with Advocacy After Fatal Domestic Abuse (AAFDA). AAFDA are a Centre of Excellence for Reviews after Fatal Domestic Abuse and for Expert and Specialist Advocacy and Peer Support.

7.4 Joanne has been working Independently for three years and is not employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

8. Equality and Diversity

8.1 The nine protected characteristics in the Equality Act 2010 were assessed for relevance to the review: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender), sexual orientation.

8.2 Factors that were felt to be relevant in the case included disability; May had a diagnosis of dementia and had been living with this diagnosis for several years whilst Tim acted as her carer. This is of specific relevance to this case and will be explored throughout the report. A member of the Alzheimer's Society was also invited to join the panel.

8.3 Age as a protected factor was considered in this case as was marriage. May was 80 years old at the time of her death and Tim was 84 years old. They had been married for 61 years. It was noted that Tim and May had agreed not to put each other in a home as they got older and given the longitude of their marriage, consideration must be given to Tim's caring role, his perception of responsibility to look after May and the barriers that may have imposed on him accepting help.

8.4 Consideration has been given to the intersection of age, disability and long-term caring within the context of a longstanding marriage, and how these factors can create hidden vulnerabilities. May's diagnosis of dementia, alongside her advanced age, meant that she was increasingly reliant on Tim, who had assumed a significant and enduring caring role. Within this dynamic, May's voice was not directly heard by professionals, and Tim acted as the primary gatekeeper to services, influencing both access to support and the extent to which agencies were able to engage with her independently. This intersection of factors may have obscured risk, limited professional curiosity, and reduced opportunities for services to fully understand May's lived experience and level of vulnerability.

8.5 It is also noted that there are additional barriers facing older people in accessing services. In the paper, 'Breaking down the barriers: Older people and complaints about health care' the Parliamentary and Health Service Ombudsman concluded that "It is clear that older people can find it hard to know how to raise a concern or a complaint and feel less confident to push for what they need." This was given consideration in this report, however, it does appear that help was offered by various services but was refused by Tim.

8.6 Gender should be given consideration in all Domestic Homicide Reviews. Gender is considered a risk factor as the overwhelming majority of victims of domestic abuse are female with the perpetrators being overwhelmingly male. Statistics show that the majority of intimate partner homicides are disproportionately perpetrated by men on women (ONS, 2020). In this case, reflections were made as to whether agencies may have intervened differently had the genders of the two people involved been reversed and a female had reported violent and aggressive behaviour from a male partner.

9. Methodology

9.1 Essex Police notified SETDAB and Tendring Community Safety Partnership of the homicide on 22nd February 2023.

9.2 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.

9.3 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.

9.4 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.

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

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

9.7 The panel acknowledges that the completion of this review exceeded the recommended timeframe. This was primarily due to the need to avoid any interference with the criminal justice process, which concluded in January 2024. In addition, there were delays in arranging an interview with Tim due to his health and transfers within the custodial estate, which extended the time required to secure his engagement. The panel considered it important to obtain his account prior to finalising the report to ensure a comprehensive understanding of the circumstances. While these factors contributed to the extended timescale, agencies remained engaged throughout the review process.

10. Involvement of family, friends and wider community

10.1 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.

10.2 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.

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

10.4 The chair also attempted to make contact with Tim. This took a considerable amount of time. Firstly, as Tim was initially moved between prisons due to poor health. Following his transfer, the chair attempted to make contact with various people at the prison on numerous occasions but was repeatedly met with no response to emails or passed on to other contacts. It took several weeks before contact was made, and an interview arranged. This was facilitated by the Probation service due to the lack of contact from other prison staff.

10.5 The chair visited Tim in prison at the end of June 2024. Information from this interview has been included in this report and reflected upon in the analysis section of this document.

10.6 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.

11.Dissemination

11.1 After the report has been agreed by the panel, it will be presented to the SAR Subcommittee and the Community Safety Partnership. It will then be sent to the Home Office Quality Assurance Panel for final approval before publication.

11.2 The report will be disseminated to all the agencies who were involved in the case and the Essex Police and Crime Commissioner, May's family and the Domestic Abuse Commissioner's Office.

Section Two - The Facts

12. Introduction to the Facts of the Case

12.1 May was 80 years of age at the time of her death; she had been living with a formal diagnosis of dementia for approximately three years. May lived together with her 84-year-old husband Tim at their home, and Tim was also her primary carer.

12.2 May and Tim had been married for 61 years.

12.3 Tim was reportedly struggling to manage May's frequent falls, her incontinence issues, and her physical and verbal actions due to her dementia.

12.4 In February 2023, Tim called Police and Ambulance services stating that he had killed his wife at their home address. May died of her injuries in hospital. Tim told police that he had tried to get her into the bathroom following an incontinence episode but had "just lost it".

12.5 Tim was charged with May's murder and originally held on remand, but his defence team put in an appeal to the courts, who granted bail to his daughters address in Kent.

12.6 Tim originally pled not guilty to murder and guilty to manslaughter but later changed his plea to guilty.

12.7 Tim was sentenced to ten years in prison. The judge remarked that Tim, had "stubbornly" declined extra support. He said the defendant saw the murder as a "misguided act of mercy" and added the case was an "utter tragedy".

12.8 May's voice is sadly absent from this review. Agency documentation identifies that May was not able to communicate due to her Dementia and that May did not give, 'appropriate

answers to questions'. Although May was present and involved in assessments, it has been identified that May was difficult to understand when she communicated.

13. Chronology

13.1 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.

13.2 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.

13.3 There is a large volume of medical records for May included in the chronology. Whilst this is not directly relevant to the learning in this review, it highlights the amount of care that May needed. This in itself, shows the potential for caregiver stress but also the multiple opportunities to offer, request and accept help. Medical records for Tim were limited and have mostly been omitted as not relevant to the review.

Combined chronologies

13.4 5th May 2020 – A medication review for May was conducted by the pharmacist with Tim speaking on May's behalf (with consent). This was completed over the phone due to the Covid-19 outbreak. No issues were reported and May was well. May was not directly spoken to during this review

13.5 10th September 2020 – May's GP carried out a review for her over the telephone with Tim speaking on her behalf. May was not directly engaged in the consultation. The GP advised Tim of May's worsening kidney functions (she had a diagnosis of chronic kidney disease stage 4). The GP advised Tim to take May to get her blood pressure checked as this hasn't been done recently and also to bring an early morning urine sample to reception to test for proteinuria. The GP referred May to the Nephrology Unit at Colchester Hospital. Tim reported that May is well.

13.6 16th September 2020 – The GP had a telephone consultation with Tim regarding May. Tim reported that he had talked to May following the GPs last phone call and she said she did not want any intervention in her life other than taking medications so if her kidney fails, she will refuse to have dialysis. This information was relayed via Tim, and May's views were not independently verified by the GP. Tim told the GP that he was concerned that it could be one of her medications causing her kidney problems, it was noted that May's renal functions worsened after starting on Candesartan. This was followed by a face-to-face consultation later that day. The GP agreed to stop Candesartan and review again after two weeks. Tim was given a form to bring May back for a blood test.

13.7 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. All information was provided by Tim, with no direct assessment of May's presentation at this stage.

13.8 3rd November 2020 – May attended an outpatient clinic appointment with Tim at Colchester hospital.

13.9 5th November 2020 – The GP had a phone consultation with Tim regarding May. May's nephrology consultant advised her to stop Bendroflumethiazide and restart Candesartan again as her blood pressure was very high.

13.10 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. This disclosure was made by Tim, and May was not directly spoken to regarding her mood or wishes. Tim feels that counselling would not be suitable. The GP suggests sertraline and a medication review in four weeks.

13.11 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. He explained the risks of having raised blood pressure and suggested that Tim invest in a blood pressure monitor at home to prevent him coming back to the surgery. Tim states that this has already been suggested and he is not interested. Tim's anxiety about leaving May alone is noted, alongside the absence of professional engagement with May directly.

13.12 23rd November 2020 – Tim called EPUT to raise concerns about May having developed shaking in her hands. A member of the team called Tim back to complete an MRI head scan questionnaire with him as part of the memory assessment pathway. Tim was advised to contact the GP regarding the tremor in May's hands.

13.13 24th November 2020 – The GP phoned and talked to Tim regarding May's hand shaking. Tim said it happened most of the previous night. On questioning, Tim said that it happens as she is trying to hold a cup or anything in her hands. He stated that he didn't mention it to the nephrologist the previous week as it was "not too bad". The GP felt that is may be due to anxiety, and Tim agreed. Tim felt that May had been very anxious since the referral to memory clinic and has started to feel that her memory is worsening. The GP advised to continue sertraline to help May's anxiety. The GP also warned Tim about the side effects of benzodiazepines, and it was agreed to review the need for medications after May's MRI.

13.14 2nd December 2020 – EPUT completed a memory assessment with May at their home address, Tim was also present.

13.15 7th December 2020 – May underwent a urinary tract ultrasound at Colchester Hospital.

13.16 18th December 2020 – May had a skull MRI at Colchester Hospital.

13.17 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.

13.18 29th January 2021 – Tim called EPUT to enquire about May's MRI head scan. He was advised that the results had not yet been received from the scanning department.

13.19 1st February 2021 – Tim phoned the GP to advise that the Lorazepam that was prescribed two weeks ago was not helping much. Tim said that May's dementia and the related behaviour issues are continuing. Tim said that May wants to go out in the afternoons and obviously can't, so she gets upset and agitated. The GP advised Tim to increase her sertraline to 100mg and increase diazepam by 1/2 tablet.

13.20 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.

13.21 4th March 2021 – The Consultant Psychiatrist from EPUT called Tim to discuss the diagnosis of mixed dementia and subsequent medication along with information regarding possible side effects and follow up information. Tim was also made aware of dementia helpline and crisis contact details.

13.22 4th March 2021 – EPUT referred May to the Alzheimer's Society for an information meeting.

13.23 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. The assessment relied on Tim's account, with no direct input from May.

13.24 6th April 2021 – Colchester hospital cancelled May's outpatient appointment.

13.25 9th April 2021 – Tim phoned the Dementia Service helpline (EPUT) querying as to whether Memantine should be given in two half doses now that it had been increased. Staff advised accordingly with no further action.

13.26 26th April 2021 – An ambulance was called for Tim after he was found by neighbours having passed out/fainted. He had fallen, banged his head and been knocked unconscious. The fall was unwitnessed, and Tim was found lying on the hallway floor confused and with facial abrasions. When the ambulance arrived, Tim was alert and sitting on a chair. He was confused, had a headache and was unable to recollect events. Tim had a seizure lasting approximately one minute which was witnessed by the ambulance crew. Observations showed hypertension and sluggish pupils but no stroke symptoms.

13.27 27th April 2021 – May was due for a telephone review with the Nephrology clinic at Colchester Hospital but they were unable to reach her by phone. Tests showed that she was stable, and she was discharged back to care of the GP.

13.28 5th May 2021 – The GP had a telephone consultation with Tim regarding his seizure. Tim was on medication for epilepsy but had not had a seizure since he started taking the medication 20 years ago. Tim said he was concerned about driving and the GP confirmed that he cannot

drive for one year after an unprovoked seizure, which is what had occurred, Tim said he will return his driving license to the DVLA. Tim agreed to make contact if he has any further concerns or issues.

13.29 24th May 2021 – The Alzheimer's Society completed their six-month check-up call with Tim. Tim reported that things were going well, and no support was needed at this time, but said he was thankful for the call.

13.30 14th June 2021 – May had a check-up with the GP, Tim was with her. The GP reported that May was fully aware why she was attending on this day.

13.31 26th July 2021 – May had a consultation with the GP. She had stopped Bendroflumethiazide as her kidney function rate had dropped but now cannot put on her shoes. Her kidney function level had now risen so the GP advised her to restart the medication.

13.32 3rd August 2021 - An Associate Practitioner from the EPUT dementia team had a telephone consultation with Tim to discuss the medication that had been prescribed by the team (Memantine). Tim reported that May was compliant with her medication regime and there were no reported side effects. Tim explained that he was managing well and supported all of May's activities of daily living with no concerns raised. Tim was given the dementia helpline number and it was agreed for a review to take place in six months' time.

13.33 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. No direct contact with May is recorded.

13.34 25th October 2021 – The GP reviewed May's dementia plan and noted that May was seen regularly and there were no concerns.

13.35 21st December 2021 – The pharmacist undertook a medication review for May. He noted that May needed an up-to-date liver function test but that it was difficult for Tim to bring her to the surgery. Tim mentioned that her dementia was progressively getting worse and said that he would contact the dementia team to discuss this.

13.36 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. It was noted that her kidney function had increased. The Clinical Pharmacist queried as to whether her Memantine dosage should be increased to 15mg and if appropriate to raise it further to 20mg. The conclusion of the meeting was for May to remain on 10mg Memantine but to consider an increase if her kidney function increased further.

13.37 24th January 2022 – May had a check-up and blood test with the GP but they were unable to get blood, so she was referred to the practice phlebotomist.

13.38 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. Tim reported that playing country/western music helped May to become calm. 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.

13.39 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. A friend helped clean the wound but was concerned due to the depth of the cut. The wound was bleeding on the drill site where Tim had a previous procedure for a cranial bleed. 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 no blurred or double vision, no headache or nausea. However, there was a large laceration to right side of head requiring sutures or glue so Tim was advised to attend the Urgent Treatment Centre where they closed the wound.

13.40 7th October 2022- May was referred Into North East Essex Integrated Care Teams (ESNEFT NEECS) for Community Rehabilitation.

13.41 20th October 2022 –Tim attended the GP to have his stitches removed. They were due to be removed a week previously, but it was noted that Tim had been unable to leave May due to her dementia. Tim attended alone and it was noted that he was alert and interactive.

13.42 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 may be a good idea to speak to the GP about a referral to the incontinence nurse as that way the NHS can provide the pads. Tim informed them that he finds that May is sleeping a lot more during the daytime and has restless or disturbed nights. Tim was advised of the importance of keeping May mentally and physically active during the daytime and was given suggestions of various strategies that will allow that. 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. All information was provided by Tim, with no direct input from May.

13.43 4th November 2022 – Tim phoned the GP asking for an incontinence referral as May has become doubly incontinent. He stated it has been going on for some time, but he has just been coping and buying pads but they are now not containing it. A Referral is made to ESNEFT NEECS the same day.

13.44 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 she was unhurt, and that a friend had given them a frame to use, but due to her Dementia, May is not sure how to use it. It is noted that they don't have Careline or a keysafe. 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 assists with all of May's washing,

dressing, toileting, meal and drink preparation and the housework. Tim requested a walking frame as he says May cannot walk without holding onto something in their bungalow. The frame she had didn't have wheels and she was trying to push it rather than lift it. Tim also felt he couldn't get her to an outpatient's appointment. It was noted that May was very unsteady on her feet and has a shuffling gait and keeps freezing. Tim has to assist with all transfers, holding both of her hands, May also needed lots of verbal prompts to mobilise and for transferring. A follow up was arranged to assess and order equipment to assist May. Tim was offered a sit in service for May when he goes shopping which he refused.

13.45 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." May was not directly spoken to regarding these incidents or her experience. 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. Tim was told to call the practice in the meantime for any concerns with new medication.

13.46 15th November 2022 – ESNEFT NEECS have an initial patient assessment with May. She was observed using the new walking frame which she was able to mobilise and push. Tim reported she would not use the toilet seat that had been supplied but said she may in the future. Tim said that the bed stick and perching stool (for washing) were helpful. 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.

13.47 17th November 2022 – ESNEFT NEECS completed an incontinence assessment with May. May was present and tried to join in the assessment, was not able to actually participate due to her dementia making her difficult to understand. It was noted that May was mobile with some difficulty and Tim reported that she wasn't getting on with her frame as she didn't understand how to use it and just kept lifting it off the floor. Tim said that May was aware of her needs to use the toilet and would ask during the day but was not able to recognise where the toilet was independently. May was wearing a pad for protection but was not generally wet, although nighttime was variable, and she sometimes had accidents. Tim also reported that May would take the pad off at night and he would find it on the bedroom floor. He said that he had a waterproof sheet on the bed and then lays towels over it in case she has an accident. It was suggested that he purchase incontinence pads for the bed to use instead of towels and also to perhaps not put a pad on May overnight if she is going to take it off anyway.

May was currently wearing pull pads which Tim was purchasing. It was explained to Tim that they don't provide pull up pads and also that May did not meet the criteria for pads to be provided at that time as she was using the toilet, only having infrequent accidents and due to taking a pad off herself overnight. Tim said he totally understood this and was grateful for the information given. It was advised that this could be reassessed in the future if and when things deteriorated, and May became regularly incontinent or non-mobile.

13.48 24TH November 2022 – ESNEFT NEECS had a telephone call with Tim. Tim was trying to use the walking frame with May but said that sometimes she will use it and sometimes she won't. He said that May had trouble due to her dementia and was unable to understand how to use the frame and needed lots of prompting.

13.49 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 explained that May was recently assessed by the continence team but he was told that she is not entitled to incontinence pads, which they have to purchase themselves. Tim said that he no longer drives and utilises dial a ride to complete his weekly shopping. He also reported 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.

13.50 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 such as throwing items around the home. Tim said this had been on-going for a period of time. Tim reported that there had been some issues regarding May experiencing incontinence at night and he was purchasing the pads. He had recently been assessed by the continence team for him to be informed that his wife would not be entitled to pads as she utilises the toilet. Tim reported that he had no care package in place and utilises dial a ride each week to complete the shopping. He also explained that May can take a long time to tend to her personal hygiene and dressing needs.

Tim said that he was reluctant to have carers to support with personal care needs, he reported to have been managing well himself. This decision effectively limited external professionals' access to May and reduced opportunities for independent assessment of her needs. Tim repeatedly referred back to how he took care of his mother-in-law stating that he was used to this. 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.

Tim stated that he was responsible for administering May's medication, he said that after giving it to her twice he had stopped it due to making her very drowsy and as she had a fall in the night due to her mobility having been affected. He said as a consequence of this he decided to stop the medication and had informed the GP. This reflects that Tim was overseeing medication decisions on May's behalf, with limited direct clinical input at that time.

Tim reported that May was eating and drinking well and had a good sleep pattern. There had been a history of falls and Tim told the nurse that May had poor mobility. She had a walking frame available to utilise, but he explained that she did not always use this correctly and she would hold onto furniture to mobilise or he would hold her wrists to support.

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 advised to contact the GP surgery to arrange for a urine sample to be tested. Tim was also 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.

13.51 7th December 2022 – May's case was discussed DST MDT meeting. The Consultant Psychiatrist was updated that the initial assessment that had been completed. Questions were raised from the meeting by the consultant regarding May's medication and the number of falls she had since the Mirtazapine was stopped. They unsuccessfully attempted to make contact with Tim so planned to contact him the next day to discuss the information required.

13.52 8th December 2022 – EPUT telephoned Tim regarding yesterday's meeting. Tim explained that he was giving May Diazepam twice per day but administering a whole tablet (2mg) at 10am and 6pm, rather than separating the doses as prescribed. Tim said that the Mirtazapine was making May drowsy, and she had four falls when he was mobilising her to the toilet. He explained that she continued to be unsteady but felt that her mobility was better than when taking the Mirtazapine. A discussion took place around anti-psychotic medication options to which Tim said he felt that May needed some medication to assist in calming her down and would be happy for anti-psychotic or other medication options to be explored further in the next MDT.

13.53 9th December 2022 –An initial patient assessment was completed with ESNEFT NEECS. A half step had been fitted so that May was safe to enter and exit their home with Tim. Tim reported that May is not remembering to use the frame when mobilising so he is having to help her by holding her hands. Tim reported that his daughter was going to look into getting someone to sit with May whilst he goes shopping as May is a risk of falling if she gets up whilst alone. Tim was given the Adult Social Care (ASC) number to enquire about respite and a possible sit in service. The plan was to discharge May as no more therapy input was deemed appropriate.

13.54 14th December 2022 – EPUT phoned Tim to arrange a memory monitoring appointment. May's case was discussed at MDT with a plan to advise the GP that Mirtazapine has been stopped by Tim and May was to start on Risperidone twice daily.

13.55 16th December – Tim was telephoned regarding the outcome from MDT. Tim said he would call the GP and chase for the medication change on Monday and was happy with the change.

13.56 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.

13.57 9th January – Adult Social Care close the case.

13.58 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. It was mentioned that May was also in the process of being assessed for a wheelchair. Tim said that May didn't always want to get up in the morning and required some encouragement which could lead to some agitation. Tim reported a recent fall where May did not utilise the walking frame correctly and informed the assessor that he didn't feel that Care Line would work. An Addenbrooke's Cognitive assessment tool was completed due to May's cognitive decline. Tim reported no side effects from the Memantine 10mg, so a further medication monitoring was planned for six months' time.

13.59 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 and to chase the email sent to Millbrook to ask that Care Line be fitted sooner. It was noted that Crossroads had advised that Tim declined their taster service.

13.60 10th January 2023 – EPUT telephoned Tim who informed them that he had followed up with the GP regarding the recent medication changes but was told that they had not received the prescription letter from the MDT. An email was sent to the GP surgery requesting for medication to be prescribed was discussed in the Dementia Support Team MDT.

13.61 12th January 2023 – The GP issues Risperidone and discussed potential side effects and dose with Tim.

13.62 16th January 2023 – The GP made a home visit to review May's dementia advance care plan and medication. A needs assessment was offered to Tim. Tim told the GP that May likes music and sings along to her favourite songs on YouTube. It was noted from the Adult Social Worker review that a wheelchair would be supplied soon. It was also recorded that May had a carer and that no safeguarding issues are identified

13.63 16th January 2023 – May was referred back to ESNEFT NEECS by ASC due to her increased falls. It was noted that she was given a walking frame two months ago but does not use it properly, so Tim has put it away. Tim was advised to encourage her to use the frame and guide her throughout until she was able to use it independently May was mobile around the bungalow with handheld assistance from Tim but did not understand her capabilities and often tried to mobilise unaided but was unsteady. ASC requested a walking aids assessment due to May's 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 May gets agitated without diazepam. Tim said he assists May with washing and dressing, housework and meals. 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.

13.64 18th January 2023 –ASC close May's case following a phone call during which Tim declined a carers assessment.

13.65 18th January 2023 – Carecall was connected in Tim and May's home for the monitoring and response service.

13.66 20th January 2023 – Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported to be fine.

13.67 21st January 2023 - Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported to be fine.

13.68 23rd January 2023 – ASC phoned Tim to book an Occupational Therapy Assessment but he declined the assessment and the case was closed.

13.69 23rd January 2023 - Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported to be fine.

13.70 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 said that

he has tried encouraging her to use the walking frame, but she is still not getting on well with it. 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. Tim was advised that if there was any decline in mobility, he could request the GP to send a new referral

13.71 3rd February 2023 - Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported as fine.

13.72 10th February 2023 - Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported as fine.

13.73 15th February 2023 - Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported as fine.

13.74 16th February 2023 –Tim called an ambulance to say that May had fallen, was unhurt but couldn't get up. This was redirected to Careline, who were commissioned by Tendring Council, as part of Operation Pendant (see 14.52), to attend in place of an ambulance in these cases. Careline attended and assisted May in getting off the floor.

13.75 16th February 2023 – Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported as fine.

13.76 17th February 2023 - Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported as fine.

13.77 18th February 2023 – Provide Carecall attended Tim and May's home in response to a call to say that May had fallen. She was uninjured, lifted and all was reported as fine.

13.78 19th February 2023 – Tim called an ambulance as May had a fall, but she was not injured. Tim said that he had made May comfortable and warm on the floor. Tim also 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 who attended and assisted May up.

13.79 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. He stated that he had called an Ambulance over the weekend and was advised to call the surgery. The ANP discussed care input, but Tim declined this saying he felt he can manage and wants to. This reduced opportunities for professionals to engage with May independently and to fully assess her needs during a period of increasing concern. Tim reported that he cannot go out now, so he has the shopping delivered. Tim said that he had contacted Social services and asked for a re assessment - but did not want care input. The ANP discussed crossroads and the help available, but Tim declined. The ANP made a referral for an assessment with the dementia clinic.

13.80 20th February 2023 – Provide Carecall responded to a call between 7.05pm and 7.25pm. May had fallen in the bathroom; she was helped to a wheelchair and then onto a chair. She had no injuries and was OK when they left.

13.81 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".

13.82 February 2023 – EPUT received a referral from the Advanced Nurse Practitioner based at the GP surgery requesting an assessment due to May's increased confusion. It stated that May was having frequent daily falls due to wanting to follow Tim around their home, and that they are both housebound. The referral further reported that Tim will not accept any care input at present. This continued to restrict agencies' ability to engage directly with May despite escalating concerns.

Section Three - Overview and Analysis

14. Summary of Information known to Agencies, Family and Friends

14.1. The overview will summarise information provided by the agencies, family and friends during the period under review.

Tim

14.2 Tim said that he and May retired to the coast some time ago and shortly after, his Mother-in-Law moved in with them as she was diabetic and needed to be cared for.

14.3 Approximately a year after moving in May's mother was diagnosed with Alzheimer's. Tim said that May and himself looked after her for six years whilst she had this diagnosis until she passed away. Tim said that his mother-in-law would occasionally go to a care home to provide them with some respite; however, they had concerns over the care she received there.

14.4 Tim said that whilst she was at the home if she refused her insulin injection, which she sometimes did due to her dementia, the care staff in the home wouldn't administer it, leading to obvious concerns about her welfare. Tim said that May and himself would also have to visit at lunchtime to ensure that she ate her lunch as she often wouldn't eat without encouragement. The care home had also told Tim and May that May's mother was incontinent and would use incontinence pads whilst she was there. Tim said that she wasn't incontinent at home but did need regularly reminding to go to the toilet which didn't happen in the care home.

14.5 Tim said that about 20 years before her death, May had also had job as a cleaner in a care home. May observed similar things in the care home she worked to those she had witnessed

with her mum, with residents not receiving the standard of care that she felt they should have. Tim recalled that at this time that May had said to him 'Promise me you'll kill me rather than let me go into a care home". Tim said that she had repeated this often to both him and to friends of the couple.

14.6 Tim became a carer for May when she started to experience symptoms of dementia about five years before her death. Over time her condition deteriorated, and he had to care for all of her needs. Tim said that this included washing and dressing her. He said that May didn't like this as "she had her dignity". She didn't want to go to the bathroom with him and would try to go to bed fully dressed rather than have him dress/undress her.

14.7 Tim said that in 2019 he had a bleed on his brain. Friends called an ambulance for him. Tim was in hospital for a month and Tim and May's daughter cared for May. Tim said she deteriorated over this time. Tim said that the bleed caused him some residual issues which affected his balance and caused his legs to swell meaning that for a while he had to use a walker. Prior to this Tim said he had driven to the supermarket with May but afterwards he couldn't drive so they used dial-a-ride which they found really good. However, May had a fall in the supermarket which made him reluctant to take her and then with the onset of the pandemic and social distancing they switched to having their shopping delivered.

14.8 Tim noted that the pandemic was a challenging time for May as she would want to go out and didn't understand why they couldn't.

14.9 Tim also spoke about May's violent behaviour towards him and said that this increased over time. He said that May would hit him and occasionally would throw the footstool across the room.

14.10 He recalled an incident in October 2022 (13.39 in the chronology) when she had caused him injuries. Tim said that it was early in the morning, and he was aiding May to the bathroom. May struggled to walk unaided and had trouble using a frame. Tim said he found that the best way to help her was to hold her hands and walk backwards, guiding her. On this morning, May pushed Tim backwards and he fell against a wall causing a gash to his head. He said that he tried to clean this up himself by holding a flannel on it. However, their gardener saw him and it was still bleeding so he suggested he go to the hospital where he received eight stitches. The notes from this incident say that Tim said he had slipped whilst helping his wife.

14.11 Tim said he did mention the violent incidents to the G.P. and asked for medication for May to help with this. May was prescribed diazepam four times a day but Tim said he struggled to get her to take it so would give it to her twice daily. Tim also noted that they would sometimes run out of the medication. He said that as Diazepam is a controlled drug it is only prescribed in small numbers and Tim said that if he couldn't get the prescription or get to the pharmacy then they might go without the medication for a week. Tim said that as a controlled drug he would have to ring to order it and couldn't order it online, he would then have to find time to go to the pharmacy which was difficult as he had to leave May.

14.12 Tim said that there had been no direct enquiries from any agency about May's violent behaviour and if he was ok or needed further support with this. However, he said that if anyone had asked he would have told them that he was ok.

14.13 One of the main themes that emerged from this review was around Tim's help-seeking barrier and refusal of offers for help. Tim said that he turned down offers of carers as May could be violent and would sometimes hit him when he tried to help her. He was worried that she would do this to the carers and felt that it wasn't fair to subject anyone to this.

14.14 Tim said that at one point they had allowed a carer into the home on a trial basis. Tim said that someone had come to aid May with a bath and her bedtime routine. Tim noted that the carer had smelled very strongly of cigarette smoke which, he said, both May and him found disagreeable. Tim also recalled that when she had helped May with washing, she didn't use any soap but only used water which they found odd, and he said he felt like they needed to rewash her after. Tim said that following this visit himself and May jointly decided they would be better off doing it themselves so cancelled any further visits.

14.15 Tim also noted that he was reluctant to engage with services, in particular Social services due to his perceptions of what might happen if they were involved. Tim said that when he had watched programmes on television where children were hurt or killed he had noted that there was often a reflection that the children should have been removed from the home earlier. Tim said he was fearful that if there was intervention from social services, they may deem him unfit to care for May. He said he was concerned that she might be taken and put into a home which he knew was against her wishes.

14.16 Tim recounted the last few days before he murdered May. He said that May was increasingly having falls in the home and he was regularly using Carecall to help her get up. However, on 19th February 2023 he called an ambulance instead. When Tim was asked about why he called the ambulance instead of Careline, he said he did this as he wanted medical advice on why she kept falling. On this occasion, the ambulance call taker, told Tim to ring the G.P. and it was suggested that she was tested for a Urinary Tract Infection. However, Tim said that it was not possible to get May to give a urine sample, so she was given antibiotics as a precautionary measure.

14.17 Tim said that May's condition had deteriorated considerably. Tim said that she used to enjoy listening to music on YouTube and would sing along but had stopped doing this. If Tim left the room, she would try to follow him and would fall over. Tim said that the Saturday before the murder, she was doubly incontinent for the first time, Tim said this wasn't a problem for him, but he knows she wouldn't have liked it. Tim said that when you have been married for that long you accept things, he said he didn't really notice the deterioration in May's condition as he was with her on a daily basis. However, Tim said that on the morning of the murder, he looked at her and realised that "May didn't know me, she didn't know my daughter, she didn't know herself so I killed her".

14.18 Tim said that he was diagnosed with adjustment disorder during his trial. He said that he was ok caring for May but he realised that she had no life. In hindsight he says he realises his attitude towards accepting assistance was not helpful.

Jane

14.19 May and Tim's daughter, Jane, said that her parents had a lovely relationship.

14.20 Jane recalls that her mum started to show signs of dementia in 2018, Jane said her Mum and Dad came for Christmas dinner and her Mum kept repeating herself.

14.21 In 2019, when Tim had the bleed on his brain and was in hospital for a month, Jane's mum came to stay with her. Jane recalls that during this time her Mum was unable to make a cup of tea and would often leave the door open. Jane said that her mum's condition had gotten worse during this time due to not being in her home environment.

14.22 Jane said that she would visit her parents approximately every five weeks from her home in Kent and during the Covid lockdown, she would call them every Sunday.

14.23 Jane said that as her Mum's condition deteriorated, she was unable to hold a conversation and didn't know that she was her daughter.

14.24 Jane reiterated what Tim had said about having concerns about the quality of care in a home for her Mum and said that her Dad had said he didn't think it was far for carers to have to deal with her aggressive behaviour.

14.25 Jane said that her parents had very helpful neighbours who would aid Tim if May had a fall but they had moved two weeks before the murder.

14.26 Jane described her dad as stoic and old fashioned and said she felt this was why he found it hard to accept help.

North East Essex Community Services (NEECS)

14.27 May was referred into the service in October 2022 by her G.P. for assessment for a walking aid. May was assessed by an Associate Practitioner working with Occupational Health (OH) and Physiotherapy (PT). Equipment was requested for May and she was discharged in December 2022 as therapy input was no longer deemed appropriate as it was felt that May had reached her optimum level of mobility.

14.28 In November 2022, a further request was made by the G.P. for an incontinence assessment. However, May did not meet the criteria for continence pads to be provided at that time as she was using the toilet and only having infrequent episodes of incontinence, therefore May was discharged from the service.

14.29 A new referral came from Adult Social Care in January 2023 for May to see a physiotherapist due to her increased incidence of falls. During this assessment, it was identified that May wasn't using the walking frame as Tim reported she had not been using it correctly. It was found that May could only use the frame with guidance which Tim was encouraged to do. Following the face-to-face assessment, there were two follow up phone calls to arrange visits. On the first call, Tim had stated that May was not in a good mood, so it was not appropriate for the visit to go ahead. On the second call, Tim advised that he felt he was managing, and that further PT input was no longer required. At that point, May was discharged from the service.

Adult Social Care (ASC)

14.30 In January 2023, Tim phoned Adult Social Care Connects to request Careline as he was concerned about May's frequent falling.

14.31 The Specialist Customer Advisor was able to briefly speak with May, and she confirmed that she would agree to Careline but could not recall experiencing any falls until Tim prompted her.

14.32 Tim confirmed that he was the main carer for his wife who had dementia and that she was frequently experiencing falls. Tim said the neighbours often helped her up, but they were moving soon and he would therefore like Careline.

14.33 Tim explained that he supported May with all of her personal care needs and said he was coping with his caring role but would like the opportunity to meet his friends. He said he was able to undertake shopping on a Friday morning with Dial a Ride, but this was the only opportunity to leave May alone. Tim also disclosed that May was getting physically aggressive and would hit out at him and that she experienced sundowning.

14.34 Following the call, ASC made a referral for Careline, a referral to NHS Physiotherapy and a referral for a Crossroads taster session to enable possible respite for Tim in his caring role. A carer's assessment was also initiated on the system.

14.35 Four days after the initial call, Crossroads contacted ASC to advise them Tim had cancelled the taster session. ASC contacted Tim who confirmed that May was continuing to have falls and said that the Physiotherapist had not been in contact. Tim advised that he was unable to access day services as May needed a wheelchair and they had been waiting for a wheelchair assessment since before Christmas. Tim said he cancelled the Crossroads taster session as May followed him everywhere he goes and was agitated, and he did not think one person would be able to care for her.

14.36 On 19th January, a Community Support Worker from the Independent Workflow Team contacted Tim to offer a carers assessment, however he declined stating that he did not want a home visit or a carers assessment, the worker encouraged a visit, but Tim was reported to strongly decline so the case was closed.

14.37 Tim was also contacted regarding an Occupational Therapist Assessment for May but declined this stating that all he needed was the Careline in place and he now had that. The OT offered other technology that might help, however, Tim declined again advising that he was always with May. The case was closed to Adult Social Care

Clacton Community Practices (G.P.)

14.38 Tim and May joined the practice in August 1999.

14.39 Tim saw the G.P. periodically for health reasons, not of note to this review.

14.40 It was noted that in November 2020 whilst attending for a health check, Tim became anxious because they were running late, and he had left May at home after she refused to attend with him.

14.41 Tim also received a home visit following the incident where he had stitches in his head. The notes record this as an accidental injury.

14.42 May was seen regularly by the G.P. due to her dementia, these contacts are detailed in the chronology.

14.43 It is noted in her records that in September 2020, Tim had spoken to the G.P. regarding May's declining kidney function and had said that May did not want any intervention other than

taking medication and did not want to see a Nephrologist. Tim said he felt her kidney problems may be due to the medication so the G.P. did a medication review and stopped her blood pressure tablet as her blood pressure was ok, with a review booked for two weeks' time.

14.44 Tim first mentioned May's dementia during a consultation in October 2020. Tim said that May was disoriented, couldn't remember things, could be very forgetful and wasn't remembering her daily living activities. Tim said he felt it could be the start of dementia, so a referral was made to the memory clinic.

14.45 In November 2020, during a consultation at the memory clinic, Tim reported that May had been "feeling down" for almost a year but said she had no thoughts of self-harm. Her mood was discussed at length, and she was prescribed anti-depressants. At a subsequent review, Tim reported this was helping her anxiety and "calming her down".

14.46 May was given a diagnosis of mixed dementia (both vascular and Alzheimer's) at the memory clinic in March 2021.

14.47 Tim was offered a Social Care referral in November 2021 due to May's decreasing mobility and dementia, but he declined this. He also declined the sitting service.

14.47 In November 2022 it was noted that Tim reported increasing violent behaviour from May, saying that she had been throwing things around and getting herself worked up. Tim said that May had Diazepam which had previously been controlling this but not recently. Tim was advised to increase this, and May was also prescribed Mirtazapine.

14.48 The last contact recorded by the G.P. was the day prior to May's murder when a home visit was made to her by the senior nurse practitioner. On this visit, Tim said that May had been getting more confused and having daily falls over the past two weeks. He stated that she would follow him whenever he left the room and could be aggressive at times and start throwing chairs. The care was discussed and support offered including a referral to ASC which Tim declined saying he was managing. Tim also said that he was unable to go out as he didn't feel like leaving May on her own.

Provide CIC (Carecall)

14.49 ASC made a referral to Millbrook Healthcare regarding a personal alarm for May on 6th January 2023 to aid when she fell. An onward referral was made to Provide Carecall to supply the monitoring service which began on 18th January.

14.50 Between 18th January and 21st February 2023, Carecall logged 11 visits, which are detailed in the chronology. On each of these occasions, the control room operator spoke to Tim and a community responder was dispatched. The last visit was in the evening of 20th February.

14.51 Each visit would last approximately 20 minutes, with responders checking everything was ok after lifting May. No concerns were noted on any of the visits.

Tendring District Council (Careline)

14.52 Tendring Careline was commissioned by the North East Essex CCG (now Suffolk and North East Essex ICB) to deliver a pilot project called Operation Pendant, which can respond to 999

calls for non-injured fallers in the community. When Tim rang an ambulance on 19th February 2023, after May had fallen, the call was redirected to Operation Pendant.

14.53 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. May was left with a cup of tea and a slice of toast, and a follow up call was made later that evening.

Alzheimer's Society

14.54 The Alzheimer's Society Dementia Advisers made four 'in touch' calls to Tim. Each time, Tim said he was coping well. He was provided with the Dementia Support Line number to call should he need any future support.

East of England Ambulance Service NHS Trust (EEAST)

14.55 The EEAST had five contacts with Tim and May.

14.56 There were two calls for Tim. One in April 2021 after he fell and knocked himself out. The second call was in October 2022 following the incident when Tim said he was pushed by May and hit and head, an ambulance did not attend on that occasion.

14.57 They received three calls regarding May, all in February 2023. Two of the calls were on 19th February, both regarding falls. Tim told the call operator that he was concerned about the number of calls he was making to Carecall and was worried they would stop attending. He was assured this was the correct route to take when it was a non-injury fall. Tim mentioned May's deteriorating condition and that she would throw footstools across the room. The call taker also managed to ascertain that Tim had not been giving May her medication as prescribed. The call was completed with an agreement that Tim would rearrange a dementia assessment.

14.58 The third contact regarding May was when Tim phoned to say that he had killed her.

Essex Partnership University Trust (EPUT)

14.59 May was initially referred to the North East Essex Dementia Service in November 2011. Where she had a Memory Assessment and received a diagnosis of mixed dementia. She had a follow up monitoring appointment five months later.

14.60 A second referral was made by the G.P. in November 2022 due to May's increased violent behaviour and an assessment was undertaken in their home. Following this May was prescribed Risperidone by a Consultant Psychiatrist and a multi-disciplinary team meeting took place.

14.61 A further referral was received from the Advanced Nurse Practitioner, requesting another assessment for May due to her increased confusion. They reported frequent daily falls due to May wanting to follow Tim around their home. The referral also stated that Tim would not accept any care input at present time.

15. Analysis

North East Essex Community Services (NEECS)

15.1 Following referrals to NEECS May was seen in a shorter timeframe than expected and it was established that Tim was the main carer for May and carried out all activities of daily living. Documentation clearly identifies that May was not able to communicate effectively to fully participate in any of the assessments that were carried out. Staff did not record any concerns in relation to the ability of Tim to care for May, staff identified during interview how the house was always tidy and how well presented both Tim and May were. One member of staff commented that there were no '*inappropriate behaviours towards May*' and that Tim seemed to be '*coping well*'.

15.2 It is also documented within the patient records that throughout their contact with Tim, he was regularly informed of services available to assist in caring for May and contact details for these were offered to him. Referrals were reviewed by the same staff member which was identified as good practice.

15.3 However, there were some missed opportunities for appropriate safeguarding actions or referrals to have taken place, particularly when considered alongside wider patterns of declining support and increasing care needs.

15.4 In November 2022, it was recorded that Tim had disclosed that he was struggling to manage the care needs of May full time, and that she became agitated when she did not have her 'Diazepam'. In response to this he was informed of the telephone number for Adult Social Care. However, it was also recorded that Tim was still refusing anyone to help him at home. This could have prompted an adult safeguarding concern, identifying that Tim was struggling with the care needs of May or staff could have considered contacting the Safeguarding Lead to ask for advice in relation to Tim declining support.

15.5 Tim also disclosed that he would often leave May at home when he went shopping. Staff members did not appear to consider the safety of May or whether Tim thought that leaving May was safe or whether there were any safe actions he took to keep her safe. Again, this could have prompted staff to consider raising an adult safeguarding concern with Essex ASC.

Adult Social Care (ASC)

15.6 The initial contact to ASC was in relation to Careline. It was confirmed with May that she consented to the Careline referral but there is no evidence in the records to suggest that May was consulted further about her care and support needs or if her ability to participate in decisions about her care and support needs were considered.

15.7 There is also 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.

15.8 A Carers Assessment and an Occupational Therapy Assessment were offered, and a Community Support Worker was assigned to work with Tim and an Occupational Therapist was assigned to work with May, however all communication occurred via Tim and again May's capacity to consent to an Occupational Therapy Assessment does not appear to have been considered.

15.9 Referrals were made to Millbrook and Crossroads in a timely a fashion and this was a good response by the advisor to attempt to support Tim's requests.

15.10 However, there does appear to be a lack of professional curiosity and information sharing with EPUT and the G.P. that might have better helped to understand potential risk factors and May and Tim's care/carer needs. This limited the development of a shared multi-agency understanding of risk.

15.11 For instance, Tim did disclose that he couldn't leave May with one person to manage her care needs, that she was high risk of falls, he could not leave her alone in the home and that she presented with agitation and sun downing. Tim also mentioned that his neighbours provided support to May when she had fallen and that they were moving. These factors could all have been considered as high-risk factors to instigate more professional curiosity and support Tim to accept the required assessments.

15.12 More generally, Tim's ability to sustain his caring role should have been explored further and it could have been considered that their marriage of 60 plus years made him believe that it was his duty to continue in the role. There is a limited understanding of Tim's access to services in his own right to manage his mental and physical health needs.

15.13 Furthermore, whilst there is no suggestion of coercive behaviour on his part, this could have been considered and explored as a reason to why Tim was reluctant to have intervention from outside agencies.

15.14 The Community Support Worker and Occupational Therapist do not appear to have discussed the outcome of their interventions with one another despite them happening days apart. It would be expected that linked family members would be considered as part of any intervention as Adult Social Care take a whole family approach to their work.

15.15 There was also no contact with any other professionals that were involved with May and Tim that could have helped support Tim to accept support or to support professionals to understand risk factors.

15.16 It was also noted in the Independent Management Report that the decision to close cases was not signed off by a senior member of staff.

Clacton Community Practices (G.P.)

15.17 It is noted in the Independent Management Report that Tim never mentioned at any of his appointments that he was struggling and was offered support by various agencies. He presented as having full capacity and May appeared to be well looked after.

15.18 However, there are recorded in the notes, details which could have prompted more professional curiosity, particularly in the context of increasing dependency and reliance on Tim as the sole informant.

15.19 For instance, there are incidents of Tim becoming stressed at the surgery due to having to leave May at home, there is also evidence of him seeking help around May's incontinence and her agitated behaviour. He was often referred for assistance and then later turned it down but the reasons for this do not appear to have been explored.

15.20 There is also an incident recorded in September 2020 regarding May's declining kidney functioning, where May appears to have declined a referral to a kidney specialist. Tim said that she did not want any intervention other than medication. However, May does not appear to have been consulted nor any attempt made to discuss this with her.

15.21 In November 2020, May was prescribed anti-depressants after Tim disclosed that she had been feeling low for the past year. In the Independent Management Report, it states that her mood was discussed at length but not whether the reasons for this were explored in any way. During the consultation, it was noted that Tim told the G.P. that May had said she "sometimes wishes she was not here". It is not clear whether consideration was given to the possibility of coercive control or abuse in the home as a reason for May's low mood.

Provide CIC (Carecall)

15.22 May and Tim were only known to Provide Carecall for a short period (18 January - 20 February 2023) and staff attended the home on eleven separate occasions within the recommended response time.

15.23 The Independent Management Report notes that there was no evidence to demonstrate Tim was struggling or required further support at any visit. There was also no evidence of aggressive behaviour from either Tim or May.

15.24 Provide Carecall have an escalation process, if a service user falls more than three times in one day or has a fall and then has a second fall within one to two hours, they call an ambulance. If triggered Adult Social Care are informed. Escalation procedures were adhered to as May never met the threshold for escalation. May fell twice on the 18 February 2023 but not within one to two hours of each other. The staff documented that on both occasions there were no concerns.

15.25 However, in the days leading up to her murder, May's alarm was activated daily from 15 February to 18 February 2023, which was suggestive of an escalation in her needs and a deterioration of her condition. This was potentially a missed opportunity to consider a safeguarding referral.

15.26 It was also noted in the Independent Management Report that Carecall were not aware that May and Tim had a daughter, and this was not included on the referral. This highlights the importance of ensuring all family are included in the referral and captured on the contact list to best support the service user.

Tendring District Council (Careline)

15.27 Careline only had one contact with May when they attended the home in place of an ambulance following a non-injurious fall. The responder did note concerns at the time as detailed in 14.53, however this was not pursued as they were advised by the operator that a team of support was going in the following day.

15.28 However, the responder should have raised a safeguarding concern immediately or referred the case back to the ambulance service (due to the number of falls in a short period and lack of food). This could have resulted in an urgent safeguarding concern being raised and action on this taken accordingly in the days following.

East of England Ambulance Service NHS Trust (EEAST)

15.29 The EEAST Independent Management Report states that all attendances and contacts were dealt with in accordance with Trust policy, procedures, and processes.

15.30 It should be noted that the clinician callback on the 19th of February was thorough, supportive and took a broad holistic approach. The clinician took time to reassure Tim that he would be correct to call Careline for a non- injury fall and that it was set up to deal with repeat falls if necessary. Through exploration and questioning the call handler was also able to identify non-compliance with the medication prescribed. This enabled a discussion where Tim was encouraged to consider and consent to following the stated doses until a discussion could be had with the G.P. This was updated in the patient notes which are seen by the G.P. However, given the nature of the disclosure there was an opportunity for a safeguarding referral to be considered.

Essex Partnership University Trust (EPUT)

15.31 May was diagnosed with mixed dementia in March 2021, and relied upon Tim to complete all aspects of activities of daily living. Staff offered Tim information and contact numbers of support services if required in the future.

15.32 Tim and May engaged with the North East Essex Dementia Service and attended all arranged appointments/visits. Tim informed the staff that he was receiving some support from various agencies and further input was due to take place. In December 2022, Tim agreed for a referral to be made to ASC. However, Tim did not take up the support and it is unclear from EPUT records whether this was followed up or they were aware he had turned this down.

15.33 It was noted at the initial memory assessment appointment which took place in December 2020 that May was experiencing significant cognitive problems and relied upon Tim to support answering questions during this assessment. At the memory monitoring appointment that took place no cognitive testing tools were completed due to cognitive decline. This indicates that possibly due to her short-term memory problems she was unable to make informed decisions.

15.34 Tim reported that he had power of attorney for finance only and during the assessment he advocated for his wife and was able to share relevant information regarding his wife's preferences and interests and past history.

15.35 It is noted in the Independent Management Report that Risk Assessments are updated upon each memory monitoring appointment and visit. EPUT state that they were not aware of any violent or aggressive behaviour until November 2022 when they received a referral from May's G.P. A home visit assessment conducted by the Dementia Intensive Support Team in

December highlighted an increased risk of violence and aggression from May towards Tim, and it is noted that this information was updated within the risk assessment. However, it does not state whether any actions were carried out to address this risk other than advising Tim to call the crisis team or police if his or May's safety was at risk.

15.36 It was also highlighted in the Independent Management Report that changes regarding May's medication, that occurred following a multi-disciplinary meeting, were not shared with her G.P.

15.37 In addition there was a lack of communication and information sharing following a medication review for May. In December 2022, Tim was advised about new medication for May and told there would be a follow up call in a weeks' time but this was not completed until a month later. A letter was also created to inform the G.P. but this was not sent. Therefore the medication had not been commenced.

15.37 Across all agencies, consistent themes emerge in relation to the Terms of Reference. The intersection of age, disability and long-term caring within a marital relationship contributed to a form of hidden vulnerability. May's reliance on Tim meant her voice was rarely heard directly, with Tim acting as the primary point of contact and influencing access to services.

This limited opportunities for independent assessment of May's needs and risks, alongside a pattern of support being declined without consistent exploration or escalation as needs increased. While services were offered appropriately, professional curiosity, consideration of safeguarding, mental capacity, and direct engagement with May were not consistently maximised.

In addition, limited multi-agency information sharing reduced the development of a shared understanding of risk. As a result, although single-agency responses were often appropriate, there was a lack of coordinated oversight of the increasing pressures within the caring relationship.

Section Four – Lessons Learnt

16. Conclusion

16.1 There is evidence of good practice throughout the review. May and Tim had regular contact with services, were frequently offered support, and referrals were made in a timely way. However, despite this level of service involvement, there was no coordinated safeguarding oversight of the increasing risks within the household.

16.2 May's voice is sadly absent from this review. Although she was present at some assessments, professionals predominantly relied on Tim to communicate on her behalf. There is no evidence that alternative communication approaches were explored to support her participation.

16.3 Consideration of the Mental Capacity Act 2005 is not consistently evidenced. May was not afforded the opportunity to have her capacity formally assessed or to make informed decisions about her care.

16.4 Tim undertook all aspects of May's care; however, his ability to sustain this role was not sufficiently explored. While he was offered support, repeated refusals were accepted without consistent professional curiosity or exploration of underlying reasons.

16.5 There were multiple indicators of escalating risk, including May's deterioration, increased falls, incontinence, aggression, and Tim's disclosures of struggling to cope. Additional risk factors included isolation, reliance on informal support, and concerns regarding medication management. These cumulative factors did not prompt consistent safeguarding responses or escalation.

16.6 The pattern of help-seeking alongside refusal of support was a key theme. However, refusal of services appears to have limited further professional intervention, rather than prompting deeper enquiry, flexible engagement, or alternative approaches to support.

16.7 There was limited consideration of the broader dynamics within the caring relationship, including the impact of long-term caring, potential barriers to accepting support, and the need to balance both May and Tim's needs. Opportunities to undertake a carers assessment, explore Tim's fears about intervention, and involve him in support planning were not fully maximised.

16.8 Risks to both May and Tim were not consistently assessed or addressed. While there were indications of aggression from May towards Tim, there is no evidence that safeguarding measures were considered for either party.

16.9 Overall, while individual agency responses were often appropriate, the absence of coordinated multi-agency working, combined with limited professional curiosity in the context of repeated service refusal, reduced the likelihood of identifying and responding to the escalating risks within the home.

17.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:

17.1 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:

17.2 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:

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

Recommendation Four:

17.4 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:

17.5 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:

17.6 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:

17.7 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:

17.8 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 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:

17.9 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:

17.10 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:

17.11 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:

17.12 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:

17.13 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:

17.14 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:

17.15 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:

17.16 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:

17.17 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.