Domestic Homicide Review:

Executive summary

Concerning the Death of Valerie

April 2021

Contents

1. The Review Process

1.1 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 of the death of Valerie. Valerie was killed by her son Mark, in March 2020. Mark was arrested and charged with the offence of murder. In September 2020, Mark was convicted of the offence of murder and sentenced to a term of life imprisonment. In March 2021, whilst serving his sentence Mark died, believed to have taken his own life.

1.2 At the time of her death Valerie was 78 years of age, her son Mark was 49 years old at the time of his arrest. Valerie and Mark lived together in a small village in Essex in local authority housing.

1.3 Mark has a brother who is four years younger than him and an older sister who spent her childhood living with grandparents.

1.2 The purpose of a Domestic Homicide Review (DHR)

1.2.1 It was agreed at the start of this review that the case met the criteria for a Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) and that those reviews would be conducted jointly. The terms of reference for the reviews were jointly drafted by the panel and included the requirements for an NHS Independent Investigation, although this investigation report is being separately presented.

1.2.2 The purpose of a DHR is to: -

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

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

c) apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

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

e) contribute to a better understanding of the nature of domestic violence and abuse.

f) highlight good practice.[1]

1.2.3 It is important that the process of this domestic homicide review has due regard to the legislation concerning what constitutes domestic abuse which at the time of this review was defined as[2]:

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

1.2.4 The Government definition also outlines the following:

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

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

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

1.2.6 The case was referred to the Southend, Essex and Thurrock (SET) Domestic Abuse Board by Essex Police on 4th March 2020. The SET Core Group convened on 13th August 2020, and considered the circumstances of the case, with the assistance of thorough scoping from relevant organisations. The core group unanimously agreed that the case met the criteria in accordance with statutory guidance under section 9(1) of the Domestic Violence, Crime and Victims Act 2004.[3] The Core Group from an early stage also recognised that the case was likely to meet the criteria for a Safeguarding Adults Review (SAR). The case also fitted the criteria for an NHS Mental Health review and early links were made and continued with this review team.

[1] Assets.publishing.service.gov.uk. 2016. *Multi Agency Statutory Guidance for The Conduct Of Domestic Homicide Reviews*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf [Accessed 4 January 2021].
[2] Definition amended by Domestic Abuse Act 2021
[3] Section 9(1) of the Domestic Violence, Crime and Victims Act 2004 https://www.legislation.gov.uk/ukpga/2004/28/section/9

2. Contributors to the review

2.1 A wide scoping request was made to all relevant agencies and those that held relevant information were requested to provide information according to their level of involvement and taking proportionality into account.

2.2 The below listed agencies provided information as indicated.

2.3 Those agencies that provided IMR's of information in the form of summary reports identified staff within their agency who had not been involved in case but was of an appropriately senior level within the agency to effectively represent them, either by role or experience.[4]

Agency	Submission to be made
	IMR / Chronology
Essex Adult Social Care	IMR and Chronology
Essex Partnership University Trust (EPUT)	IMR and Chronology
West Clinical Commissioning Group (CCG)	IMR and Chronology
	Summary report
Uttlesford District Council	Summary report
	Initial Scoping
Cambridge & Peterborough Foundation Trust (CPFT)	Initial Scoping report
Addenbrookes Hospital	Initial Scoping report
Department for Work & Pensions (DWP)	Initial Scoping report

3. Agencies involved

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

Name	Role	Organisation
Jon Chapman	Independent Chair	
Val Billings	DA Coordinator	Southend, Essex and Thurrock Domestic Abuse Board
Jacob Nurdan	DA Officer	Southend, Essex and Thurrock Domestic Abuse Board
Fiona Gardiner	Community Safety Manager	Uttlesford Community Safety Partnership

[4] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2016, para 66.

Caroline Venables	Safeguarding Adults Review Officer	Essex Safeguarding Adult Board
Paul Bedwell	Safeguarding Adults Manager	Essex Safeguarding Adult Board
Lisa Dakin	Independent Investigator	NHS England
Mette Vognsen	Head of Investigations	NHS England
Bev Jones	Chief Executive Officer	Next Chapter, Domestic Abuse Support
Fiona Davies	Director Adult Social Care	Essex Adult Social Care
Helen Brown	Detective Inspector	Essex Police
Paul Dibell	Detective Inspector	Essex Police
Joni Thompson	Clinical Director	Open Road, Drug and Alcohol Recovery Service
Tendayi Musundire	Head of Safeguarding	Essex Partnership University Trust
Zivai Muyengwa	Safeguarding Lead	West Essex CCG

4. Author of the overview report

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

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

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

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

5. Terms of reference for the review

5.1 The panel drafted and agreed terms of reference for the reviews. The timeframe subject to this review is from 1st November 2017 to 1st March 2020. This also included identified key learning areas.

Specific

- Were the needs of Valerie and Mark assessed, in particular the carer role provided?
- Was there evidence of carer stress in the relationship between Valerie and Mark, and if so how was this addressed?
- Were the mental health needs of Mark assessed, and if so were any assessments timely and what action was taken?
- How able was Mark to adhere to his medicine regime and what was the impact of not doing so?
- Was there any indication that Mark posed a risk to himself or others?
- Was consideration given to the mental capacity of both Valerie and Mark?
- Was there evidence of Valerie having a voice in decisions?
- Was Valerie empowered to make her own decisions and involved in all decision making about her? If not, what were the barriers?
- Were there any indications that the relationship between Valerie and Mark featured controlling or coercive behaviour?
- Were there any concerns amongst family / friends / colleagues or within the community, and if so how could such concerns have been harnessed to enable intervention and support?
- To what extent was information shared with GP's within the same practice about the health and welfare of Valerie and Mark?

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?

Good practice

- The review would like to identify and learn from any instances of good practice with the case.

6. Summary chronology

Background and early life

6.1 Valerie's husband died in 2014. Valerie's daughter did not live in the family address and grew up with her grandparents.

6.2 Mark left home when he was around 18 years of age, to live in London, at the time he was a Graphic Designer. Mark's medical records would indicate that it was around this time that he started to abuse alcohol and illicit drugs. He admitted the use of cannabis, ketamine and amphetamines. As a young man Mark suffered bouts of depression and compulsive behaviour.

6.3 In September 2001, Mark returned to live at home with his mother and father. He was using drugs and the family were very concerned about him. Mark caused himself harm by cutting his wrists. Mark then spent five months in hospital where he was diagnosed with Paranoid Schizophrenia. During his stay in hospital Mark made a serious attempt to take his own life by hanging. Mark was again admitted to hospital in July 2004, as a voluntary patient due to a deterioration in his mental health. He was diagnosed with Psychotic Depression, after an improvement he was discharged into the community. In November 2005 and August 2007, Mark was again admitted to hospital as an informal patient, he was suffering depression and persecutory ideas.

Timeframe in focus

6.4 Valerie had both her hips replaced in 1999 and revision surgery in 2008 and as a result her mobility became more limited. Valerie could walk short distances with support but increasingly became more housebound.

6.5 Throughout 2017 and into 2018, the GP had regular contact with both Valerie and Mark, concerning general health issues or ongoing medication. It can be noted that often Mark made contact with the GP or spoke to them on his mother's behalf. In November 2018, Mark spoke to his GP and expressed concerns he had about caring for his mother.

6.6 In May 2018, Valerie was admitted to hospital with pain to her knee. Valerie was in hospital for three days and during that period she engaged well with several assessments. With her consent, both Mark and her daughter were contacted. Mark disclosed that her cared for his mother, but she was isolated, not leaving the address and she would benefit by having a befriending service for company once a week, as this would allow him to get out also. During the assessments it was recorded that Valerie appeared fully cognitively intact with there being no concerns regarding her mental capacity. Valerie was discharged to the care of Mark with pain relief for her knee. It would appear that there was no further action to put in place the discussed befriending support.

6.7 In November 2015, the mental health service supporting people in Mark's area changed. The transition is recognised as not being streamlined and effective as it could have been. Th

access and assessment service for the new provider wrote to Mark offering on appointment and phoned on three occasions, but no contact was made.

6.8 In January 2019, it became apparent that Mark was taking his mother's medication. There was a series of cancelled and missed appointments for Mark to be seen for an assessment by the mental health service. The GP expressed concerns regarding Mark's deteriorating mental health and the possibility he was abusing his medication.

6.9 In July and August 2019, Valerie's family expressed concerns regarding Mark's deteriorating mental health. The brother contacted the GP and expressed concerns over his mother and brother's wellbeing. The brother stated that Mark was drinking more alcohol, was neglecting his medication, and could not be trusted to be truthful. He also expressed a concern that his mother was effectively a prisoner in her own home. There was an internal discussion with the GP surgery regarding this concern but no evidence that it was shared any further. Mark's sister also contacted the GP and expressed her concern that Mark had cancelled her mother's diabetic review. She felt that her brother was undergoing a mental health crisis. The GP suggested that the sister should contact social care.

6.10 At the beginning of September 2019, the GP followed up the concerns by making a home visit to see Valerie and Mark. Mark admitted to drinking 6-10 units of alcohol daily. The GP noted that he was double bolting the front door and had taped up the letterbox. The GP agreed to make a referral for a carer assessment. Mark stated that caring for his mother was very important for him.

6.11 The GP made a referral to the Early Intervention Team who made contact with Mark and Valerie who stated that they required gardening and housework support. The social worker made a referral to the community agent for support.

6.12 In mid-November 2019, the Consultant Psychiatrist (CP) attempted to make contact with Mark, when this was unsuccessful, they followed this up with an unannounced visit to the home address. Mark agreed to an assessment. The CP reviewed Mark's medication. Mark stated that he would like support to be able to leave the house and help to support his mother.

6.13 At the end of November 2019, Mark' s brother made contact with the GP again to express his concerns about Mark's mental health and his ability to care for his mother. The GP followed this up with a home visit the following day. The GP established that Mark was providing Valerie with her personal care, helping her with the commode and washing her.

6.14 At the same time Mark was referred to the Psychosis Team, an Associate Practitioner (AP)[5] was asked to make contact with Mark, which they did in December 2019. Mark was disappointed that he was not contacted by a member of staff who he knew. He stated that he was not ready to see the AP but would contact them when he was. The access and assessment team requested that the GP considered a referral to social care for Valerie.

6.15 During December 2019, Mark contacted the GP on a number of occasions requesting an increase in medication, which was declined. In mid-January 2020, the GP made a referral to social care. This referral followed a call by Mark's brother to the GP expressing concerns regarding Marks's ability to care for his mother. The brother further stated that his mother was neglecting herself. The referral to ASC stated that in the opinion of the GP, that Valerie had mental capacity, but was very much persuaded by Mark. Valerie was bedbound and had not ventured outside for a considerable time. The social worker made contact with Mark, who stated that he was not sleeping, which impacted on his caring role.

6.16 The social worker also contacted Valerie's family who went into some detail regarding their concerns. They stated that despite best efforts their brother had not been able to provide adequate care to his mother for some time, due to his own mental health, which was not being addressed. They stated that his brother was not sleeping or managing his medication. Mark had become fixated on his neighbours and heard voices. The family felt that his mother's health was deteriorating, and support had been discussed for gardening and housework, but his mother needed personal care. It was agreed that when the social worker was to see Valerie and Mark, that the family would be present.

6.17 A district nurse attempted to visit the home to take blood from Valerie but was not allowed access by Mark. During the visit Mark admitted to the nurse taking his mother's medication. The GP passed on these concerns to ASC and was informed that a social worker was visiting the family the following week.

6.18 On 20th January 2020, the ASC social worker started the Care Act Assessment, this was during a home visit with Valerie and Mark, with the brother and sister also present. During the visit Valerie recognised that Mark was struggling to support her and explained that the District Nurse had been refused entry the previous week as it was an unexpected visit. Respite was offered to allow the house to be de-cluttered but this was declined by

[5] Associate Practitioner - Although they are not registered practitioners they have skills and experience in a particular area of clinical practice through their experience and training.

Valerie and Mark.

6.19 Valerie agreed to accept help from carers, but as Valerie had limited mobility it was decided by the social worker that there needed to be an Occupational Therapy (OT) functional assessment first before the care package could start. Valerie stated that she did not want the Adult Safeguarding concern to progress further. There is no record of the Care Act Assessment being completed.

6.20 A referral for OT was made the next day, but the case not allocated immediately and was delayed some weeks. Through the latter part of January 2020, the GP surgery had almost daily contact with Mark, mostly regarding Valerie. At the end of the month the GP wrote to the mental health provider, requesting a review of Mark's medication and made a further referral to ASC.

6.21 At the beginning of February 2020, staff from the local authority housing department visited Valerie and Mark at the address as a result of a report from a contractor that the house was overly cluttered. The staff noted that Mark and Valerie were living in one downstairs room and that they were co-dependent on one another for care. Housing options were discussed with them, Valerie's concern was that they would be separated. They were re-assured that this would not be the case.

6.22 At the beginning of February, the GP had telephone contact with Mark. The GP noted that Mark was still abusing medication. Mark also stated that he was stressed as his mother was unwell. The following day, Mark failed to attend an appointment with the Consultant Psychiatrist from the Psychosis Team. A further appointment was made for April.

6.23 In mid-February 2020, The GP had a lengthy telephone contact with Mark regarding him overusing medication. The GP wrote to the mental health provider requesting an urgent home visit for Mark, as he had indicated that he would not attend any scheduled visit and therefore was unlikely to receive appropriate support. The GP expressed concern that Mark was increasingly '*overusing hypnotic medication* '(Lorazepam). The letter indicated that Valerie had informed the GP that if Mark did not get the medication, he would cry and state that he wanted to end it all. Two weeks later the GP sent another letter to the mental health provider requesting an urgent medical assessment for Mark due to his escalating paranoia and increase use of medication to help him stay calm. The letter further stated that Mark had stated he would end his life if admitted to hospital.

6.24 The same day Mark's sister spoke to both the GP and the OT and voiced concerns

regarding her mother and Mark's ability to care for her. She told the OT that Mark was over medicating and using alcohol, he was paranoid, particularly regarding neighbours but she did not feel that Mark would harm his mother or anyone else. The sister expressed a view that Mark required a period in hospital to stabilise his medication and use of alcohol. The OT was to liaise with the ASC social worker regarding the concerns raised by the sister. The following day the sister contacted the mental health provider psychiatrist and again conveyed her concerns regarding her brother becoming increasingly unwell, over medicating and using excessive alcohol. The psychiatrist informed the sister that the case was now open to the Psychosis Team and contact would be made with that team.

6.25 On 27th February 2020, an Associate Practitioner (AP) from the Psychosis Team attempted to contact Mark, without success. The AP requested that a Community Psychiatric Nurse (CPN) followed this up with a visit the following day.

6.26 On 28th February 2020, the CPN attempted a home visit to see Mark to assess whether a Mental Health Act Assessment was required. The CPN attended the wrong address and contact with Mark was not made. The plan was to follow this up the following week.

6.27 On 1st March 2020, Mark had contact with his neighbour who was relatively unknown to him or his mother. Later the same day, Mark called on the neighbour's house and made comments to them which caused them to call the police. Police attended Valerie's home address and were greeted by Mark. Mark made various comments indicating that he had harmed his mother.

6.28 Valerie was discovered in a chair in the front room, she was deceased, and it was later established that she had suffered in the region of 40 stab and cut wounds to her body, the main ones to her neck and abdomen.

7. Keys issues arising from the review

7.1 The family were significantly concerned regarding their mother's ability to care for Mark and Mark's ability to care for his mother due to his escalating mental health issues. They raised these concerns through their GP and referrals were made to the mental health assessment service and adult social care. The assessments that then took place were not coordinated, timely or effective.

7.1 Agencies failed to fully understand the challenges facing Valerie and Mark and therefore they remained unaddressed. There was a lack of exploration of the dynamics of the relationship between VJ and MJ and the potential for control or coercion within that relationship was not considered

8. Conclusions

8.1 Mark was left without an effective mental health assessment for around three years. When asked the family state that they could not recall a time when they considered Mark's mental health care to be effective. During this time Mark's mental health continued to decline. Mark was self-medicating and abusing his mother's medication. As there was no mental health assessment in conjunction with a medication review this was not addressed. At the same time Mark was abusing alcohol.

8.2 Valerie and Mark relied on each other for care but due to Mark's mental health issues and Valerie's medical conditions and lack of mobility, they struggled. This caring relationship was never really understood because it was not assessed. This left both Valerie and Mark without the support they obviously needed.

8.3 Professionals did not consider the potential for coercive control being exerted by Mark on Valerie. Whilst it would not have been in any parties' interests to seek a criminal prosecution and indeed the criminal threshold would not have been met, consideration of the coercive and controlling nature of the relationship would have allowed professionals a much better understanding of the dynamics of it and how communication with both Valerie and Mark could have been improved.

8.4 There was a lack of consideration of how Mark's mental health impacted on Valerie and the care and support that she required. This is underlined by the apparent lack of contact between EPUT and ASC when they were trying to undertake assessments. There also seemed to be a lack of understanding by the mental health services about the impact of Marks's condition allowing him attend appointments and prioritise his treatment. He was offered outpatients appointments when there was little likelihood of him attending.

8.5 The family feel strongly that there was a lack of feedback to them when they raised concerns. They would exclude the GP from this. They were at times under the impression that support had been put in place for their mother, when this in fact was not the case. The family feedback was one of the major missing aspects of the agency response as it left them without the ability to challenge the inactivity.

8.6 The service provided by EPUT and ASC could not be evidenced as being person centred and lacked multi agency coordination.

9. Lessons to be learned

9.1 There is still a lack of awareness across agencies of the necessity and benefits of a carers assessment, this would have assisted for professionals to understand the needs of Valerie and Mark.

9.2 There is a need to reinforce the requirement for professionals to demonstrate professional curiosity in all contacts and elements of their work.

9.3 The mental health services (EPUT) were not responsive to the referrals for assessment. There was a lack of understanding of what Mark required and how it was to be delivered. Appointments where Mark did not attend were not followed up effectively.

9.4 Where safeguarding concerns are identified they should be referred appropriately by the organisation identifying them and not passed to another organisation to be referred as this may lead to misinterpretation or the referral not being made.

9.5 Where there is a concern regarding a patient with mental health issues misusing or over medicating, a medication review should take place as a matter of urgency in conjunction with a mental health assessment.

9.6 Where there are cases with clients with both care and support and mental health needs, agencies need to work closely together to ensure that assessments are complimentary and effective.

9.7 Where a care and support package is required immediately but there are moving and handling concerns and a specialist assessment is indicated, consideration needs to be given as to how to provide support in the meantime rather than waiting for the outcome of that additional assessment.

9.8 Valerie was not seen at any stage on her own and therefore it is difficult to say that she was expressing an uninfluenced view. Where contact is not on a one to one basis it should be recorded, and a view given on the how much emphasis can be attributed to the decision in light of any influencing factors.

9.9 Organisations should be more aware of domestic abuse in the form of coercive control and how this may present in a carer/ care receiver relationship. This should be considered in assessments and contacts.

9.10 That there is good case oversight, review and quality assurance, to ensure that services are person centred and the required outcomes are met.

8.11 That there is timely feedback to family members who make referrals, that where appropriate their views are sought and form part of the assessment and decision-making process.

10. Recommendations from the review

Recommendation 1:

The Essex Safeguarding Adults Board (ESAB) should seek assurance from all partners that there is an understanding of the requirement of carer assessments under the Care Act and from Adult Social Care, and that these are effectively undertaken.

Recommendation 2:

EPUT and Essex Adult Social Care to: -

(a) Develop closer working relationships, in particular undertaking coordinated assessments working towards joint care planning and provide a progress update to ESAB.

(b) EPUT and Adult Social Care should provide evidence that activity is coordinated withing the terms of the Section 75 agreement (NHS 2006)

Recommendation 3:

EPUT should provide evidence and demonstrate to ESAB that: -

(a)The recommendations within their internal investigation report are being implemented and the progress of that implementation.

(b)That the transformation of the assessment service and delivery pathways have delivered the anticipated service improvement.

(c)That where referrals are made from the community that the response is timely and feedback on the course of action is offered

(d) That where there is evidence of medication misuse by a client a timely medication review is undertaken.

(e) That EPUT reviews their Access Policy to take into account the fact that persons not attending appointments are vulnerable due to mental health issues and may require additional support.

(f) That all of the above are managed in order to ensure learning is embedded within practice

Recommendation 4:

The Essex Safeguarding Board should highlight to partner agencies the importance of making appropriate safeguarding referrals with reference to the LGA/ADASS guidance `Understanding what constitutes a safeguarding concern and how to support effective outcomes and the 'Safeguarding Concerns Framework'.

Recommendation 5:

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

Recommendation 6:

All agencies involved in this review should consider how it can continue to promote a positive culture of professional curiosity which supports effective multi-agency working and how this can be assured and monitored through reflective supervision and performance management

Recommendation 7:

All agencies in this review should ensure that professionals who are responsible for services are aware that coercion and controlling behaviours can form part of complex relationships and of the ways that this may manifest.

Recommendation 8:

EPUT and their commissioners should review their current policies and procedures in relation to Domestic Abuse and coercive control and provide evidence that this is embedded in their training and practice.

Recommendation 9:

The Essex Safeguarding Adults Board continues to promote the Hoarding Guidance and be assured it is understood and that agencies consider and use the available tools to assess and seek support for hoarding behaviour.

Recommendation 10

Contributing agencies to this review should provide the SETDAB and ESAB with assurance that the single agency actions identified in the Individual Management Reports are completed and reported on.

Recommendation 11:

Essex Adult Social Care should provide assurance to Essex Safeguarding Adults Board that where a care and support package is required immediately but there are moving and handling concerns and a specialist assessment is indicated, consideration is given as to how to provide support in the meantime rather than waiting for the outcome of that additional assessment.

Recommendation 12:

Uttlesford Community Safety Partnership to ensure that local domestic abuse services and SET DAB resources are promoted to local agencies and communities.