Uttlesford Community Safety Partnership

Domestic Homicide Review and Safeguarding Adults Review

Case of Valerie

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Contents

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.

2. The Review Process

2.1 The purpose of a Domestic Homicide Review (DHR)

2.1.1 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.

2.1.2 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]

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

2.1.4 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.

2.1.5 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.

[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 the Domestic Abuse Act 2021

The new offence, which does not have retrospective effect, came into force on 29th December 2015.

2.1.6 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 reason for the delay in hearing the case was due to a hiatus put on reviews due to the covid pandemic. 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) and there were other potential mental health reviews. Liaison commenced with the appropriate partners at this early stage.

2.2 Purpose of a Safeguarding Adults Review (SAR)

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

2.2.2 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.

2.2.3 On 20th August 2020, The Essex Safeguarding Adults Board (ESAB) SAR Committee considered the circumstances of this case and agreed that it met the mandatory duty for a SAR to be conducted.

2.2.4 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 Valerie's family is coordinated.

2.3 Parallel Reviews

2.3.1 At an early stage it was recognised that the circumstances of this case would necessitate other reviews taking place. The Essex Partnership University NHS Foundation Trust (EPUT) were undertaking a Serious Incident Investigation (SI).

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

2.3.2 NHS England identified that the case met the criteria for an independent investigation into a mental health homicide, sometimes referred to as mental health homicide review. The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient (Mark) so that the NHS can:

- Be clear about what – if anything – went wrong with the care of the patient.
- Minimise the possibility of a reoccurrence of similar events.
- Make recommendations for the delivery of health services in the future.

2.3.3 At the time the reviews commenced there was also a criminal investigation, which was resolved with the conviction of Mark in September 2020. A subsequent inquest found that Valerie was unlawfully killed.

2.4 Panel membership

2.4.1 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
Caroline Venables	Safeguarding Adults Review Officer	Essex Safeguarding Adult Board
Paul Bedwell	Board 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 of Safeguarding and Quality Assurance (Adults)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 NHS Foundation Trust
Zivai Muyengwa	Safeguarding Lead	West Essex CCG

2.4.2 Both the panel members and the authors of Individual Management reports were from organisations involved in the case but had no direct involvement in the case and were independent in that sense.

2.5 Timescales

2.5.1 The DHR overview report should be completed within six months of the date of the decision to proceed unless the review panel formally agrees an alternative timescale with the Community Safety Partnership (CSP).

2.5.2 The review commenced in October 2020 and concluded in September 2021, when the review was agreed at the Essex Safeguarding Adults Board. There were three panel meetings between October 2020 and February 2021. There was a practitioner event (facilitated reflective workshop) on 21st January 2021. This event was facilitated virtually due to Covid restrictions. The engagement of professionals before, during and post the event was good, demonstrating reflective and professional comment and challenge. The views gathered during this event are incorporated into the narrative of the report and help to focus the learning and recommendations.

2.5.3 The report was presented to the Essex Safeguarding Adults Board and Uttlesford Community Safety Partnership.

2.6 Confidentiality

2.6.1 The issue of confidentiality was addressed before each panel meeting. Panel members were reminded that information shared for the purposes of the reviews should not be shared with third parties without the consent of the panel or the originating agency.

2.6.2 The family were consulted on whether they wished for pseudonyms to be used to

aid anonymity of the report, but it was their wish that their mother and brother's names were used.

2.7 Methodology and contributors to the review

2.7.1 The panel drafted and agreed terms of reference for the reviews (at appendix A), which identified the scope of the review and the organisations who had been involved in the case. Each of these agencies was asked to secure their case records and provide a chronology of their contact. In addition, they were asked to provide an Individual Management Report (IMR), a summary report or undertake initial scoping depending on their level of involvement. The timeframe subject to this review is from 1st November 2017 to 1st March 2020.

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

Agency	**Submission to be made**
IMR / Chronology	
Essex Adult Social Care	IMR and Chronology
Essex Partnership University NHS Foundation 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

2.8 Report author

2.8.1 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.

2.8.2 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.

2.8.3 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.

2.8.4 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.

2.9 Equality and Diversity

2.9.1 The nine protected characteristics were considered by the review in the context of Valerie's and Mark's access to services and whether there were any barriers to them being able to access these services. It was identified that the characteristics of age, race and sex were areas which had potential to feature in this review and would therefore be a focus for panel consideration.

2.9.2 Valerie was a lady of white European heritage. The panel was mindful of the age of the victim Valerie and the relationship with Mark, her son. Particularly with regard to providing caring support to one another. Both Valerie's age and her lack of mobility contributed to Valerie being isolated and unable to leave her home address. Another factor which is explored in some detail is Mark's mental health and how this impacted on his ability to access services and in turn how this also impacted on Valerie's access to support.

2.9.3 It is recognised that identification and reporting of domestic abuse in older women

is low[4]. This can be due to a number of factors such as generational attitudes[5], an element of acceptance and the lack of services or knowledge of them for older victims.

2.9.4 Valerie also became more isolated due to increasing lack of mobility. Public Health research found that disabled people more likely to experience domestic abuse, they also experience domestic abuse that is more severe, more frequent and lasts for longer periods[6]. Disabled people experience domestic abuse in wider contexts and by greater numbers of significant others, including intimate partners, family members, personal care assistants and health care professionals[7].

2.10 Dissemination

2.10.1 After the report has been agreed by the Home Office Quality Assurance Panel, this report will be presented to the Southend, Essex and Thurrock Domestic Abuse Board and Essex Safeguarding Adults Board.

2.10.2 The report will be disseminated to all the agencies who were involved in the case and the Essex Police and Crime Commissioner.

3 Involvement of family, friends and wider community

3.1 Valerie's husband at the time of the review was deceased. She had two other children apart from her son Mark, who is the perpetrator in this case. A daughter, who is older than Mark and a son, who was younger than Mark.

3.2 Both the brother and sister were contacted, both by letter and in person, by the chair of the reviews and informed that they were taking place and how they would be undertaken. The terms of reference for the reviews were shared with the family and any comment invited on the areas to be addressed. They were also made aware of support and advice available to families involved in reviews processes but choose not to

[4] McGarry J, Simpson C, Hinchliff-Smith K (2011) The impact of domestic abuse for older woman: a review of the literature. Health and Social Care in the Community, 19, 1

[5] Safe Lives 2016, Safe Later Lives: Older People and Domestic Abuse

[6] *Disability and Domestic Abuse, Risk, impact and response*, Public Health England, 2015.

[7] Hague, G., Thiara, R. and McGowan, P. Making the Links: Disabled Women and Domestic Violence. London. Women's Aid, 2007.

be supported by advocacy. Both the brother and sister expressed a wish to be involved in the review. The family were not invited to the panel meeting but kept appraised of the progress of the review. The brother, in particular, wanted conversations with the review chair to be undertaken in person, but unfortunately due to the Covid restrictions, this was not possible. It was at the request of the family that this report has not been anonymised.

3.3 The brother and sister would describe their mother as a lady with a keen mind and they had no concerns regarding her ability to understand and retain information and make informed decisions. She was a very kind lady, who wanted to see her children happy and cared for. Over recent years they would say that Valerie had almost given up and her hoarding activity was a product of this.

3.4 An attempt was made to visit Mark is prison for the purposes of this and the other reviews into this case. Mark agreed but as arrangements were made for this to happen Mark sadly died.

3.5 As Covid restrictions eased the author of the report was able to see the brother and sister in a face-to-face meeting with the completed report and discuss the findings and learning.

4. Background information

4.1 Valerie lived with Mark in a small Essex village, the house they lived in was a Local Authority property and where the family had lived since the children were born. Valerie had two sons the eldest being Mark and one daughter.

4.2 Mark had lived with his mother for around the past 20 years, having suffered from significant mental ill health, which will be explored in more detail later in this report. Valerie's husband died from cancer in 2014 and this left just Valerie and Mark at the address. More latterly Valerie had reduced mobility and Mark assumed more of a caring role for his mother.

4.3 On an evening at the beginning of March 2020, Mark approached his next-door neighbour. Mark was obviously blood stained and made comments which led the neighbour to call the police. Police and ambulance attended the address and found

Valerie, apparently lifeless, slumped in a chair located in a downstairs room, which was used by Valerie as a bedroom. Valerie was heavily bloodstained and had suffered multiple stab wounds and a deep laceration to her neck.

4.4 Mark was arrested and made a number of comments accepting responsibility for his mother's death, citing a deterioration in her dementia as a reason for killing her. A subsequent post-mortem examination of Valerie showed that she had suffered over 40 knife wounds, mainly to the neck, although there was evidence of defence wounds.

4.5 In September 2020, after a trial on the discreet area of diminished responsibility[8] on the basis of mental health Mark was found guilty of the offence of murder and was sentenced to life imprisonment, with a minimum of 20 years.

5. Chronology

Background and early life

5.1 Valerie's husband died in 2014. Valerie's daughter did not live in the family address and grew up with her grandparents. Mark's brother would describe a difficult younger life at home.

5.2 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.

5.3 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

[8] There is a four-stage test, of which all four elements must be proved: (i) Whether the defendant was suffering from an abnormality of mental functioning (ii) If so, whether it had arisen from a recognised medical condition (iii) If so, whether it had substantially impaired his ability either to understand the nature of his conduct or to form a rational judgment or to exercise self-control (or any combination) (iv) If so, whether it provided an explanation for his conduct

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.

5.4 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.

5.5 In November 2005, he was again admitted to hospital for a period of two weeks, this followed Mark abusing alcohol and cannabis. Mark had formed persecutory ideas and as a result had stopped taking his medication. On admission he was described as being depressed.

5.6 In August 2007, Mark was again admitted to hospital as an informal patient, he was suffering depression and persecutory ideas. During his admission Mark was diagnosed with Paranoid Schizophrenia. He was a patient for two months before being discharged, with a plan to be supported by the Home Treatment Team and he was referred to the Drug and Alcohol services.

Transfer of mental health services

5.7 Mental health services to this point had been delivered by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), in November 2015 the service was transferred to what became Essex Partnership University NHS Foundation Trust (EPUT). The transition process was not straightforward. Existing patients were offered an appointment to assess their ongoing needs. Mark was offered an appointment, which he did not attend, and he was therefore discharged from the service without being assessed.

Timeframe in focus

5.8 Valerie had both her hips replaced in 1999 and revision surgery in 2008 and as a result she was unable to negotiate the stairs and for this reason she lived mainly in a downstairs room of the house. She was able to mobilise for short distances with the assistance of a stick or walking frame. In recent years she rarely ventured outside.

5.9 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 regarding concerns he had about caring for his mother. The GP agreed to make a referral to the Psychiatrist on Mark's behalf. On making this referral the GP was asked to re-direct the request to the Access and Assessment Service (A&AS), as Mark had not been seen by the Psychosis Team for over 6 months.

5.10 In May 2018, Valerie was admitted to hospital with pain to her knee, having been referred by the GP. 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.

5.11 The A&AS attempted to contact Mark on three occasions by phone in early December 2018, without success. They wrote to Mark offering an appointment for March and contacted the GP. Around this time Mark expressed to his GP that he had not had a break from caring for his mother for over 3 years.

5.12 In January 2019, there was the first indication that Mark was using his mother's medication. During a telephone consultation Mark stated that he used his mother's Codeine if he ran out. In February 2019, again during a phone consultation Mark stated that he was having trouble reducing his Codeine use and requested Lorazepam[9].

5.13 In February 2019, Mark contacted the A&AS and expressed concerns regarding the transfer of his notes from the previous service and not wanting 'to start from scratch again' with a service. Mark informed the new service that it was pointless offering him

[9] Lorazepam – belongs to a group of medicines from the benzodiazepines used to treat anxiety and sleeping problems related to anxiety.

an appointment that was not a home visit as he would not be able to attend. He stated that he was severely anxious and that he required Diazepam.

5.14 Mark did not attend his March appointment for assessment and as a result a further appointment was made for May. He then cancelled this appointment the day it was due to occur and stated that he was feeling much better. As a result, the A&AS contacted the GP to see what recent contact there had been and whether there had been any changes in medication. The GP confirmed that Mark had not actually been seen in surgery since November 2018. It was agreed that a further appointment would be offered and if not taken up then the GP would undertake a home visit to assess Mark's mental health.

5.15 In late May 2019, Mark stated that he felt strongly that he did not need the services of the A&AS. The assessment team liaised with the GP who expressed a concern about Mark being discharged without the assessment taking place. An appointment was offered and accepted by Mark for early July. This was to be a home visit from the Consultant Psychiatrist. Mark later cancelled this appointment. This was the second appointment he had cancelled.

5.16 During June 2019, there were three contacts with the GP, the first was a home visit during which the GP noted that Mark displayed a stable mood. Within days Mark was seen in the surgery and expressed concern regarding his deteriorating mental health. He then contacted the surgery by phone requesting an increase of Lorazepam. The GP was concerned that Mark was abusing this medication.

5.17 There was limited contact in July 2019, but in August Mark's 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 was unlikely 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.

5.18 At the end of August 2019, Valerie failed to attend a retinopathy appointment, but this was not followed up. 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.

5.19 At the beginning of September 2019, the GP followed up the concerns by making a home visit to see Valerie and Mark. The GP did not note any concerns except the state of the property. 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.

5.20 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.

5.21 In October 2019, the GP had contact with Mark over his medication, He was requesting an increase of Lorazepam, which was declined. Mark stated that he was suffering crippling anxiety and poor sleep. Mark had further contact with the GP in early November on behalf of his mother, requesting an increase in Codeine for her.

5.22 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.

5.23 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.

5.24 At the same time Mark was referred to the Psychosis Team, an Associate Practitioner (AP)[10] was asked to make contact with Mark, which they did in December 2019. Mark

[10] 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.

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 A&AS requested that the GP considered a referral to social care for Valerie.

5.25 During December 2019, Mark contacted the GP on a number of occasions requesting an increase in medication, which was declined.

5.26 In early January 2020, Mark informed the GP that he was unable to take his mother to a chest x-ray appointment. 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.

5.27 The social worker also contacted Mark's brother who went into some detail regarding his concerns. He stated that despite best efforts his 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. He stated that his brother was not sleeping or managing his medication. Mark had become fixated on his neighbours and heard voices. The brother 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 brother and sister would be present.

5.28 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 Promethazine. The GP passed on these concerns to ASC and was informed that a social worker was visiting the family the following week.

5.29 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 Valerie and Mark.

5.30 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.

5.31 A referral for OT was made the next day, but the case not allocated until 12th February 2020. Due to workload pressures it could not be completed and was re-allocated on 21st February 2020.

5.32 Through the latter part of January 2020, the GP surgery had almost daily contact with Mark, mostly regarding Valerie suffering acute laryngitis and the need for him to reduce his Lorazepam medication. At the end of the month the GP wrote to EPUT, requesting a review of Mark's medication and made a further referral to ASC.

5.33 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 and they were re-assured that this would not be the case.

5.34 On 6th February 2020, the GP had telephone contact with Mark. The GP noted that Mark was still abusing Lorazepam. Mark also stated that he was stressed as his mother was unwell.

5.35 The following day, Mark failed to attend an appointment with the Consultant Psychiatrist from the Psychosis Team. A further appointment was made for April. He did have contact with the GP and stated that his mother was much better. Mark requested more Codeine but was challenged by the GP on use and admitted that he had been using his mother's prescription as he had a bad knee. The GP recorded that on the next occasion Valerie would have to be seen in person, to establish if she still required the Codeine.

5.36 On 10th February 2020, The GP had a lengthy telephone contact with Mark regarding him overusing medication. The GP wrote to EPUT 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.

5.37 On 21st February 2020, the OT liaised with the ASC social worker and then made telephone contact with Valerie, who requested they speak to Mark. Mark explained his mental health conditions and then gave a medical history of his mother. He stated that she had not left the house since April 2018 and he assisted with her personal care, washing her whilst she was on the commode. A home visit was arranged for 4th March 2020.

5.38 On 24th February 2020, the GP sent another letter to the EPUT A&AS 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.

5.39 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.

5.40 The following day the sister contacted the EPUT A&AS psychiatrist 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.

5.41 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.

5.42 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.

5.43 to In early March 2020, Mark had contact with his neighbour who was relatively unknown 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. He made various comments indicating that he had harmed his mother.

5.44 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.

6. Overview

6.1 What did know agencies about Valerie

6.1.1 It was known by agencies that Valerie had suffered limited mobility for some years, dating back to 2013. She had not been away from the address since April 2018. She been involved in Mark's care for around 20 years and this caring relationship had changed over more recent years, with Mark assuming a caring role for his mother.

6.1.2 Valerie did not have any known communication barriers and professionals recorded that she was able to understand and retain information given to her and make decisions, although there is evidence that she would defer to Mark when dealing with some professionals.

6.2 What did know agencies about Mark

6.2.1 It was known that Mark had suffered mental ill health for a considerable period of time. There was little evidence of Mark displaying harmful or violent behaviour to others, except when he assaulted his father, this was thought to be in defence of his mother.
Mark was the subject of emotional and physical abuse in his younger years by his father. The full extent of this does not appear to have been known to agencies and therefore

did not feature in assessments. Mark did attempt to cause harm to himself, most significantly by attempting to hang himself in 2001.

6.2.2 Mark was providing care to his mother over an extended period of time, this included personal care. In more recent years it is evident that Mark and his mother were living together in a downstairs room of the house. Valerie due to her mobility and Mark due to his mental health.

6.2.3 It was recognised that Mark was struggling both with his own mental health and as a result of caring for his mother. It was recognised by both professionals and members of the family that Mark's mental health was becoming more of a concern, and this was exacerbated by his overuse of prescribed medication and his use of alcohol.

7. Analysis

7.1 Were the needs of Valerie and Mark assessed, in particular in the carer role provided?

Was there evidence of carer stress in the relationship between Valerie and Mark and if so, how was this addressed?

7.1.1 When Mark returned to the family address around 20 years ago, between his spells in hospital Valerie undertook a caring role. Since the death of Valerie's husband (2014) and when Valerie became more immobile, Mark assumed a caring role for his mother. Mark very much viewed himself as a carer and the family would support that he did a lot for his mother, but this had been more difficult for him in the year preceding Valerie's death.

7.1.2 EPUT undertook a carer assessment for Valerie in March 2016. The assessment gave some details of her social history. At that time, the information Valerie gave was that she had a social circle and attended events away from the home with friends. This assessment did not identify any safeguarding concerns. Valerie did state that she felt she was keeping her son alive and he regularly said that if she died, he would kill himself. No care assessment was undertaken for Mark as a carer for his mother, although it was acknowledged that he was performing this role.

7.1.3 The GP's surgery was in regular contact with both Valerie and Mark. From as early as May 2017, Mark disclosed that he was caring for his mother and struggling due to his own health. Similar disclosures were made in July, November and December 2018. It was clear that Mark was identifying that he was struggling to cope.

7.1.4 There were also concerns raised by the family to the GP, EPUT and ASC regarding Mark's ability to cope in July and August 2019. This was followed up by the GP and a referral made to Early Intervention. Contact was made and low-level support for gardening and housework was discussed. The contact was made by phone and not face to face. This was a missed opportunity to meet with Mark and Valerie and offer a carers assessment to Mark. There was a focus on the practical support instead gaining a real understanding of what was required for both Mark and Valerie. There was no follow up on the community care arranged, and in reality, no support transpired.

7.1.5 In May 2018, Valerie was admitted to hospital with a painful knee. She was assessed there, and Mark was spoken to with her consent. Unusually for him, Mark requested support in the form of a befriending service for his mother, which would allow him to leave the house. Unfortunately, this was not followed up and did not happen. This again was a missed opportunity to give support to both Valerie and Mark.

7.1.6 In November 2019, the Consultant Psychiatrist (CP) undertook an unannounced visit to the house and saw Mark and Valerie. It is recorded they stated that they did not want personal support but would like practical support to allow Mark to get out. The CP wrote to the GP and requested a referral was made to ASC. The CP could have made the referral directly to ASC and informed the GP. This would have been better practice and would have ensured that the referral was made.

7.1.7 Apart from the concerns noted by professionals and family there were physical signs that Valerie and Mark were not coping. They were living and sleeping in one room and Mark was undertaking his mother's personal care. In February 2020, staff from the local authority housing department visited Valerie and Mark, responding to concerns of hoarding raised by a contractor attempting to carry out work. The staff felt that Mark and Valerie were co-dependent on one another.

7.1.8 In January 2020, a social worker visited Valerie and Mark, the brother and sister were also present. At this meeting a carers assessment was offered to Mark, which he declined. This request warranted further exploration with Mark on his own to really understand his ability to care for his mother, and indeed himself. At this time there were a number of people raising concerns and this contact lacked the required professional curiosity to fully understand what support was required. It was obvious that Mark was suffering with mental health problems but there was no liaison with either the GP or the mental health service.

7.1.9 It was agreed that there was a need for a care package to be put in place, but this was delayed awaiting an OT assessment, which did not start for four weeks. The ASC

IMR recognises that the care package should not have been delayed and Valerie should have been offered the reablement service pending the OT assessment at this stage.

7.1.10 At this meeting the safeguarding concern was closed at Valerie's request and a Care Act Assessment was to be undertaken, this assessment did not occur and therefore the care and support needs for either Valerie or Mark were not understood and therefore not addressed.

7.1.11 The caring relationship between Valerie and Mark was not assessed despite a number of agencies being involved. There was a lack of coordinated multi-agency working to understand what was being undertaken by each agency. When ASC became involved there lacked contact with the GP and EPUT, which would have assisted in understanding what support was available. Overall, there was a lack of consideration of Mark's mental health in his ability to care for his mother, this is underlined by the lack of contact by ASC with the GP and EPUT.

7.1.12 There was clear evidence of carer stress both disclosed by Valerie and Mark and noted by professionals, but this was not effectively addressed. There needs to be greater awareness and consideration of carer stress and this would be partly achieved by more consideration and focus on providing carer assessments. The lack of carer assessment was identified in a previous local DHR and SAR in the case of 'Walter.'[11]

7.1.13 A guide published by the Local Government Association and The Association of Directors of Adult Social Care[12] identifies that '*In general, families and carers make an invaluable contribution to society and the support of carers is integral to the Care Act (2014). However, practitioners should be aware of and vigilant against the potential of 'the rule of optimism', when professionals may place undue confidence in the capacity of families to care effectively and safely, affecting professional perceptions and recognition of risk of harm, abuse or neglect.'* It may be that it was this rule of optimism which prevented professionals undertaking a carer assessment.

7.1.14 A number of professionals visited the address at various stages, the GP, social worker and housing staff. There is reference to the house being cluttered but there is no real exploration of this. Professionals did not venture past the downstairs room and the wider family more latterly had been prevented from entering other areas of the house

[11] Klee,D, February 2018, Report of the Domestic Homicide Review and Safeguarding Adult Review Joint Panel into the death of Walter available at https://setdab.org/wp-content/uploads/2019/04/Colchester-Domestic-Homicide-Review-2016.pdf (accessed: 8th February 2021)
[12] Local Government Association and Association of Directors of Social Services,2015, Adult Safeguarding and Domestic Abuse, A guide to support practitioners and managers

by Mark. It is surprising that more consideration was not given to the very poor living conditions in the house.

7.1.15 The family did not feel that Mark would cause harm to their mother but did feel that the state of the house was an increasing risk of fire and that this was increased by Mark's locking doors and increasingly restricting access. This aspect of environmental neglect should have been addressed and considered in the context of the potential risk and harm to Valerie and Mark.

7.2 Were the mental health needs of Mark assessed and if so, were any assessments timely and what action was taken?

7.2.1 One of the identified factors in the assessment and ongoing support of Mark's mental health issues was the transition of the service between providers. In 2015 Mark was being supported by Cambridgeshire and Peterborough Foundation Trust (CPFT), having been referred by his GP as he was feeling 'anxious and paranoid'. A short history of engagement with CPFT shows that Mark undertook what is described as a 'valuable piece of work' with a named professional. This is relevant as Mark refers to this professional at a later date when he is not fully engaging with EPUT. The CPFT records also show that there was a history of failing to attend appointments.

7.2.2 The service transferred to what was to become EPUT in November 2017, the history and transfer of records would have greatly assisted those taking on Mark's care. It is recognised that the transfer of records and details of patient care was not good. Also due to discrepancies in patient lists, each patient was written to and offered an appointment for an initial assessment. As Mark did not respond, he was discharged from the Psychosis service. It is recognised that this was not an appropriate response. This was a missed opportunity to assess Mark's mental health and left him without ongoing support. It can be seen from later engagement with Mark that he did not respond well to written information and did not respond to outpatient appointments, due to his condition.

7.2.3 In November 2018, the GP referred Mark to the Psychosis team, as his case had not been open for the previous six months the case was passed back to the A&AS, which caused a delay. In December 2018, a telephone screening assessment was undertaken with Mark. It was recognised that Mark required to see a psychiatrist to have his medication reviewed. Mark was sent a letter offering him an appointment in March 2019, three months after the initial GP referral. In February 2019, Mark contacted the service and requested a home visit as he was experiencing severe anxiety. There was no action and Mark failed to attend the March appointment.

7.2.4 Mark was not then seen until November 2019, one appointment was cancelled by Mark, but actual contact was not made until one year after the GPs referral. This face-to-face contact was as result of an unannounced visit. As a result of this visit the CP made a referral to the Psychosis pathway.

7.2.5 During this period the family and GP had raised concerns regarding Mark's deteriorating mental health. Mark was not allocated a care coordinator but an associate practitioner. Mark was contacted by phone but did not wish to engage with someone he did not know. Despite Mark's request for a home visit, he was offered an appointment in February 2020, which he failed to attend. Another appointment was then sent to Mark for April 2020, this was 5 months since the CP referral with no assessment taking place.

7.2.6 The AP was aware that Mark was not engaging but was unable to make a referral for an assessment as they were not a registered nurse. The AP requested that a CPN undertake a visit to assess Mark. This happened at the end of February, the day before Valerie was killed but the CPN went to the wrong address and did not follow up to establish the correct address.

7.2.7 Mark's mental health was not adequately assessed and the response to concerns regarding his mental health were not dealt with in an appropriate or timely fashion. This left Mark without the support he required.

7.2.8 The initial issues with the service were due to the way in which it transitioned from one area to another. Once referrals were made the response to them was poor with long delays and a confused response between professionals in different teams within EPUT. There was an over reliance on outpatient appointments, which Mark was unlikely to attend. Where he did not attend it was not robustly followed up.

7.2.9 The lack of response in a timely fashion caused the family considerable frustration, which they attempted to address through the GP. The family were clear that Mark would not attend any appointments and for him to be assessed a visit was necessary, as was the case by the CP in November 2019. Unfortunately, the service reverted to writing to Mark and offering out-patient appointments.

7.2.10 Just before Valerie's death a home visit was attempted by a CPN but the wrong address was visited. This appears to have been an error as the records show the right address was available. On realising the mistake, the CPN did not then visit the right address but left the visit to be followed up the following week. The fact that the no assessment was being undertaken could have been communicated for consideration of an assessment over the weekend.

7.3 How able was Mark to adhere to his medicine regime and what was the impact of not doing so?

7.3.1 Between January 2019 and February 2020, the GP's at various stages raised concerns regarding either Mark over medicating or using medication that was not prescribed to him.

7.3.2 During a telephone review with EPUT in December 2018, Mark himself requested a medication review by a psychiatrist, recognising the issues he faced but this did not occur.

7.3.3 Despite these concerns the medication continued to be prescribed although requests for an increase in Codeine and Lorazepam were resisted. The GP had requested EPUT to undertake a review of medication but due to the lack of timeliness of assessments this did not take place. In February 2020, the GP asked an urgent review for Mark as he was overusing 'hypnotic medication'.

7.3.4 In conjunction with this medication abuse, Mark was excessively relying on alcohol and his mental condition was deteriorating and his paranoia increasing. Mark was not able to adhere to his medication and was self-medicating. Whilst this was reviewed by the GP, it required a review in conjunction with a mental health assessment to ensure that Mark's condition was being managed. This did not happen.

7.3.5 In addition to Mark being non-compliant with his medication it was recognised during the EPUT Serious Incident investigation that Mark was on the correct medication, but he was on an inadequate dose for his condition. A medication review would have addressed this.

7.3.6 The family continually raised concerns regarding Mark's abuse of medication and his use of it in conjunction with his abuse of alcohol, but these concerns were not heard by the mental health service and were not addressed.

7.3.7 Mark was abusing his mother's medication, and this would have meant that Valerie was not able to take medication prescribed to her presenting a risk to Valerie's own health and welfare. This does not seem to have been a consideration when the medication abuse was being considered.

7.4 Was there any indication that Mark posed a risk to himself or others?

7.4.1 There is no recorded violent behaviour involving Mark apart from an incident several years ago where he is said to have assaulted his father, in defence of his mother. When

his sister expressed concerns regarding Mark's mental health, she did also state that she did not feel that he would harm his mother. There were no known direct indicators that Mark posed a threat to others.

7.4.2 The fact remains that it was recognised by professionals and by family that Mark was displaying increasing anxiety and paranoia, his medication was being poorly managed, and it has since been established that his medication dose was insufficient to effectively manage his condition. Although the ultimate act of violence by Mark could not be foreseen, there were circumstances which presented a risk and without proper assessment and management the risk was not mitigated. Without this mitigation it would be difficult to say that Mark did not pose a potential risk.

7.4.3 On the same basis Mark posed a risk to himself, particularly when considering his history of self-harm. Although any determined attempts to take his own life were quite historical, he had in more recent times spoken about ending his life.

7.4.4 Mark's unassessed and therefore inadequately treated mental health caused ongoing inadvertent risk in areas such as fire at the home and this was very much the concern of the family as opposed to Mark causing intentional harm.

7.5 Was consideration given to the mental capacity of both Valerie and Mark?

7.5.1 There is evidence that Valerie had mental capacity, and this was considered at various stages of her interaction with professionals. In May 2018, when she was an inpatient for a short time in hospital, she was described as '*cognitively intact, no cognitive concerns. Fully alert and orientated, extensive history given in line with previous medical notes.'*

7.5.2 In January 2020, when the GP made a referral to ASC, it was assessed that Valerie had capacity and when she was seen by the social worker regarding the safeguarding concern and assessment, she was deemed to have capacity. This view is also supported by the family.

7.5.3 There is no recorded assessment of Mark's mental capacity but it was recognised that he had diagnosed mental health conditions and any compulsory care required, if consent had not been given, was more likely to have been undertaken under the Mental Health Act, as opposed to the Mental Capacity Act.

7.5.4 In February 2020, when the housing staff visited Valerie and Mark, there is evidence that both Mark and Valerie were making decisions regarding their future housing options. There is also evidence that this discussion was focused on them at the centre of the decisions being made.

7.6 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?

7.6.1 Valerie had become increasingly isolated, much of this was due to her mobility and access to support services but she was confined to one room in the house. She was not venturing out and Mark's brother expressed a concern that she was a prisoner in her own home. Although the GP followed this concern up the comment was never really explored, either with Valerie or the brother. It was the brother's concern that Mark was limiting his mother's contact with others. The brother had attempted to address this and at the time of Valerie's death she was due to leave the house to visit him.

7.6.2 Whenever professionals saw Valerie, it was in the presence of Mark, this was very much due to the circumstances at the house. Both Valerie and Mark were living in one room and the rest of the house was not accessible due to clutter. Even the brother and sister, more latterly, were prevented from other areas of the house when they visited.

7.6.3 Due to these factors there is limited evidence of Valerie expressing her views and being empowered to make decisions. Where decisions were made it is not clear that these were undertaken without the undue influence of Mark, either directly or indirectly.

7.6.3 Mark's brother's view is that Mark has a direct influence over all of Valerie's dealings with professionals. He states that he did try to impart this information when he disclosed that in his view his mother was a prisoner in her own home. He feels that Mark listened to all her calls and in most instances spoke to professionals on her behalf.

7.6.4 The more indirect influence came from Valerie's fear that if Mark was sectioned and taken to hospital, he would end his life. This fear, Mark's brother and sister feel, was reinforced by Mark when he spoke to his mother. This can also be seen in Valerie's interaction with the GP where she discloses that if Mark did not get his medication, he just sat on the floor and cried.

7.6.5 The brother recounts the assessment in January 2020, where he challenged his mother for not disclosing to the social worker how bad Mark was. Valerie responded that she could not do anything else as she could not be responsible for him going into hospital.

7.6.6 It was difficult for professionals to be able to get Valerie in a position where she could be spoken to without the presence of Mark. What is required firstly is recognition of the importance of Valerie's voice being heard and the fact that Mark had potential to

influence her. In this case this was apparent to the GP, where they recognised that Valerie had capacity but could be persuaded by Mark.

7.6.7 Following that recognition, it is important that records indicate the fact that any discussions or decisions are not made without a person capable of influencing them unduly being present.

7.6.8 A means of independent discussion needs to be sought according to the circumstances, in this case this may have involved the GP surgery or agencies working more closely together to achieve this. In this case ASC and EPUT were both seeking assessments at the same time, closer working would not only have enhanced the assessments but allowed for planning to ensure that independent discussion is at the very least possible.

7.7 Were there any indications that the relationship between Valerie and Mark featured controlling or coercive behaviour?

7.7.1 Mark was a carer for Valerie and this was recognised by agencies although not assessed and therefore not properly understood. The identification of when a carer relationship becomes controlling or coercive is difficult for professionals to identify and deal with. Part of this difficulty is due to the subtlety of any abuse and how this can be determined over the everyday care being afforded. The form of abuse may not be recognised by the abuser, person being abused or those close to the situation. This is because the behaviour, although controlling may be viewed within the norms of the relationship.

7.7.2 There are, in this case, indications that Mark was controlling towards Valerie. He dominated her contact with agencies, cancelled her appointments and monitored her calls. This behaviour has to be balanced against Mark's own mental health condition and the responsibility he felt to care for his mother. At the same time Mark was providing Valerie with her daily personal care and she relied on this.

7.7.3 Mark's brother states that it was clear that Mark was controlling Valerie and that she was unable to push back as she feared that Mark would be sectioned and if that happened, he would harm himself. The brother witnessed Valerie being verbally dominated and not able to express herself. More latterly Mark's brother and sister became aware that Mark was also financially abusing his mother by using her money to sustain his alcohol use. Mark's sister would not describe Mark as controlling but does recognise that Mark monitored Valerie's phone calls but she saw this as part of Mark's paranoia.

7.7.4 When explored whether consideration was given to reporting or getting support for this abuse, it was considered by the family that the most important issue was to get Mark support for his mental health problems and this in turn would alleviate the pressures on their mother. They felt that the correct route for this was through the GP. Whilst the control was recognised it was not identified as potential domestic abuse.

7.7.5 There was a lack of consideration by professionals of the potential of controlling or coercive behaviour. The GP spoke regularly with the household and it became the norm for this conversation to be with Mark, even if the subject was Valerie. This was in the knowledge that Valerie had capacity. There could have been more challenge on this arrangement and discussion with Valerie to understand better her wishes.

7.7.6 There is no evidence of any consideration of domestic abuse in the form of coercive control by any of the mental health professionals involved in the case or indeed subsequently in the Serious Incident Investigation and this raises a question as to what the routine consideration of domestic abuse is within the organisation.

7.7.7 When ASC became involved the social worker described the relationship between Valerie and Mark as very close and there was no indication or sense of controlling or coercive control being present but this was never tested as all conversations were conducted with Mark present. The brother states that he was not contacted by professionals to gather his views or concerns, had this happened he would have given his view on control, and this may have led to more consideration.

7.7.8 The difficulty for professionals in distinguishing coercive control in caring relationships is identified in 2016 Guidance developed by Department of Health, women's aid and Research in Practice for Adults [13]. The guidance concludes that '*It shows that people with social care needs are likely to be at higher risk of coercive control and domestic abuse than the general population, reiterating the importance of social workers and social care practitioners being able to appropriately recognise and respond to it.*' It recognises that there is a need to equip professionals to be able to identify the potential for this type of abuse and what is referred to as carer stress presenting in forms of abuse.

7.7.9 Whilst equipping the workforce with the knowledge to help them to consider the possibility of this type of abuse it has also been shown that by having domestic abuse professionals in the right settings, such as hospitals, it will create more opportunities for the recognition and disclosure of abuse from groups where it has traditionally been more hidden, such as the older population. In this case an opportunity may have been presented when Valerie was in hospital in 2018. Interestingly, it was on this admission that Mark was contacted by the hospital, and he suggested some befriending service support for his mother on discharge, unfortunately this was not followed up.

7.7.10 A report published in December 2019 concluded that '*Hospital IDVAs can identify survivors not visible to other services and promote safety through intensive support and*

[13] Department of Health, women's aid, RiPfA (2016), Supporting people with social care needs who are experiencing coercive control: Guidance sheet four: The experience of people with care and support needs. Department of Health, London available at https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Guidance-sheet-four-the-experience-of-people-with-care-and-support-needs....pdf (accessed 09/02/21)

access to resources. The co-location of IDVAs within the hospital encouraged referrals to other health services and wider community agencies. Further research is required to establish the cost-effectiveness of hospital IDVA services, however our findings suggest these services could be an efficient use of health service resources' [14]

7.8 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?

7.8.1 The family did raise their concerns mainly with the GP, but also with EPUT and ASC. The GP was responsive and when the concern was raised, carried out a home visit the next day. The family are very complimentary about the response of the GP, recognising that at times the GP put in extended time trying to reassure the family and access the right support.

7.8.2 Where the concerns were raised regarding Mark's mental health the family state that the service was not responsive. Mark was left without being seen for an extended period and there was no feedback to the family, which they state left them with a sense of helplessness and frustration.

7.8.3 When ASC became involved, whilst the family were involved, at the meeting in June they feel that their voice was not heard. The professionals involved were not curious enough to try to understand the core issues and Valerie was left without support while an OT assessment was delayed.

7.9 To what extent was information shared with GP's within the same practice about the health and welfare of Valerie and Mark?

7.9.1 There were numerous contacts by the GPs and Valerie and Mark. Within the review timeframe (November 2017 – March 2020) Valerie received 32 telephone contacts and 4 home visits. During the same period Mark received 29 telephone contacts, 8 surgery appointments and 5 home visits. These were recorded as GP contacts and does not take into account other surgery contact. The attention by the GP surgery was extensive and responsive and as a result there are 9 separate GPs involved in making the contact to either Valerie or Mark.

7.9.2 At times the contact was almost daily. The GP records are maintained with details of the contacts and these notes would be available to all GP's providing care.

[14] Halliwell, G., Dheensa, S., Fenu, E. *et al.* Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Serv Res* **19,** 718 (2019). https://doi.org/10.1186/s12913-019-4621-0 (accessed 09/02/21)

7.9.3 Although there were concerns regarding Mark misusing his and his mother's medication there is strong evidence that the GP's took measures to manage this. Mark was seen in the surgery face to face in April 2019, September 2019, January 2020 and February 2020. There were also lengthy telephone contacts in October 2019 and February 2020.
There were also requests from the GP to the mental health service to review the medication, which for the reasons explained, did not occur.

7.9.4 The feedback from the family was that the GP practice was extremely helpful and responsive to their concerns and they feel that they did all they could to resolve the issues they raised.

7.10 Local service provision, policies and training

7.10.1 Within the term of reference, organisations were asked to consider the local provision of services. Whether organisations had in place appropriate policies and that appropriate training was available and delivered.

7.10.2 The Uttlesford Community Safety Partnership has protecting vulnerable people, including those suffering domestic abuse as one of their three 2020-21 strategic priorities.[15] There is scope for the Community Safety Partnership to be more responsive in signposting local services.

7.10.3 The CCG monitors and audits GP training, who receive Level 3 Safeguarding Training, which aligns to the Intercollegiate Document, Adult Safeguarding Roles and Competencies for Health care Staff 2018. The GP practice in this case have also accessed J9 Domestic Abuse training.[16]

7.11 Highlighted good practice

7.11.1 The response and ongoing support offered by the GP practice to Valerie, Mark and the family throughout this case is recognised as good practice. The family recognise that the time that GPs spent with them attempting to access support was above and beyond what they could expect.

7.12 Implementation of change during this review

7.12.1 As of March 2020 the Mental Health Access and Assessment service (A&AS) was disestablished as was the Specialist mental health pathway teams (formally the Psychosis

[15] Uttlesford District Council Community Safety Partnership - https://www.uttlesford.gov.uk/csp (accessed 24/03/21)
[16] J9 Initiative - https://setdab.org/j9-initiative/ (accessed 24/03/21)

pathway and the Specialist mental health pathway). These teams have since been transformed to become three separate locality Specialist Community Mental health teams within specific areas.

7.12.2 The aim of the transformation is that all the community mental health services are fully aligned to each of the locality areas within West Essex. Assessments, treatment support and care are now all delivered within the locality team rather than within several different teams.

7.12.3 The return to a locality base is aimed to strengthen the collaborative working with primary care colleagues resulting in improved communication channels and a shared approach to the care and support of the local population. GP's now have direct access to locality consultants if they have any immediate concerns or require advice.
It is hoped that this will alleviate the confusion regarding case ownership and responsibility that was evident in this case.

8. Conclusions

8.1 Mark was left without an effective mental health assessment for around three years and this had a considerable impact on Valerie and other members of the family. 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 may not have been in any parties' interests to seek a criminal prosecution and indeed the criminal threshold may 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 Mark's condition allowing him to 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 learnt

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.

9.11 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

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.

Appendix A – Terms of Reference

Terms of Reference for a joint Domestic Homicide Review and Safeguarding Adults Review into the death of Valerie

Victim:

Name of Victim:	Valerie

Perpetrator:

Name of Perpetrator:	Mark

1 Introduction

1.1 Valerie and her son, Mark, lived together in their address in Uttlesford. On 1st March 2020 emergency services were called to the address where they found Valerie deceased.

1.2 Mark was arrested on suspicion of murder and on 8th September 2020 was convicted of murdering his mother.

1.3 On 4th March 2020, a notification was made to Southend, Essex and Thurrock (SET) Domestic Abuse Team in accordance with The SET Domestic Homicide Protocol 2017. [17]

1.4 The first core group meeting was scheduled to take place in March 2020 but due to the covid pandemic, the process was paused, and the group met in August 2020. At this meeting it was agreed that the case meet the criteria for a DHR.

1.5 On 20th August 2020 the case was reviewed by the Essex Safeguarding Board SAR Committee and it was agreed that the case met the mandatory duty to conduct a Safeguarding Adult Review (SAR) as set out by section 44 Care Act 2014 .[18]

1.6 A Mental Health Homicide Review has also been commissioned by NHS England under the NHS serious incident framework[19]. Although a separate process, the DHR/SAR panel will have cross representation from this review to ensure effective communication. The terms of reference for this review are at appendix A for information.

1.7 There has been agreement between The Uttlesford Community Safety Partnership, The Southend, Essex and Thurrock Domestic Abuse Board and Essex Safeguarding Adults Board that the DHR and SAR will be conducted jointly to coordinate and enhance the learning and development opportunities.

[17] SET Domestic Homicide Protocol -
[18] Section 44, Care Act 2014 - https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[19] NHS serious incident framework - https://www.england.nhs.uk/patient-safety/serious-incident-framework/

2 Principles of the review

2.1 Objective, independent & evidence-based.

2.2 Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.

2.3 Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations.

2.4 Respecting equality and diversity.

2.5 Openness and transparency whilst safeguarding confidential information where possible.

2.6 Recognising and encompassing the principles of adult safeguarding (Empowerment, Prevention, Protection, Proportionality, Partnerships and Accountability) and making safeguarding personal.

3 Key lines of enquiry

3.1 The Review Panel will consider the following:-

Case 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.

4 Scope of the Review

Agency	Panel Member	IMR/ Chronology	Summary report
Essex County Council, Adult Social Care	Yes	Yes	N/a
Essex Partnership University NHS Foundation Trust (EPUT)	Yes	Yes	N/a
West Clinical Commissioning Group (CCG)	Yes	Yes	N/a
Uttlesford District Council	Yes	N/a	Yes
Southend, Essex & Thurrock Domestic Abuse Board	Yes	N	N
Essex Safeguarding Adults Board	Yes	N	N
NHS England – Independent Investigator	Yes	N	N
Next Chapter	Yes	N	N
Essex Police	Yes	N	N
Open Road	Yes	N	N
Cambridge & Peterborough Foundation Trust (CPFT)	N	N	Yes
Addenbrookes Hospital	N	N	Yes
Department for Work & Pensions (DWP)	N	N	Yes

4.1 Agencies will be asked to provide an Individual Management Report (IMR) and chronology. Templates will be provided for both.

4.2 The timeframe subject to this review will be from **1st November 2017 – 1st March 2020**

4.3 Agencies with records prior to the start date above are to summarise their involvement. Any information from agencies which falls outside the timeframe which has an impact or has potential to have an impact on the key lines of enquiry should be included.

5 Family involvement

5.1 The review will seek to involve the family of the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure

6 Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an Individual Management Review, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this review, therefore all material received by the Panel must be disclosed to the Senior Investigation Officer and the police disclosure officer if required.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

7 Timescales

7.1 All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. If necessary, a revised timeline will be communicated to the Home Office. The Review commenced in August 2020 and subject to the conclusion of the criminal trial and family involvement, will aim to conclude by March 2021.

8 Media strategy

8.1 Any media activity or responses on this review should be led and coordinated through the review panel.

9 Chairing & Governance

9.1 An independent chair has been appointed to lead on all aspects of the review and will report to Uttlesford Community Safety Partnership and the Essex Safeguarding Adults Board. A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies. Uttlesford Community Safety Partnership and the Essex Safeguarding Adults Board will sign off the final report and submit it to the Home Office Quality Assurance process.

Mental Health Homicide Investigation – Terms of Reference

The investigation will examine the NHS contribution into the care and treatment of the service user from his first contact with specialist mental health services up until the date of the incident.

- Critically examine and quality assure the NHS contributions to the Domestic Homicide Review
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user
- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family
- Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway
- To work alongside the Domestic Homicide Review panel and Chair to complete the review and liaise with affected families
- To provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone

Appendix B

Single Agency Actions

West Essex Clinical Commissioning Group

1. Involving the patient who has mental capacity to decide on specific decisions about their care and putting them at the centre of it.
2. Where there are significant delays in referrals that impact on individuals an escalation pathway should be in place.
In deterioration in serious mental illness the GP Practice needs to escalate to Health commissioners within the CCG and to follow an agreed pathway in ICS or ICP when CCGs are abolished.
3. All Primary Care General Practitioners and Practice practitioners are trained in Domestic Abuse and in particular familial domestic abuse around controlling and coercive control, Neglect and acts of omission.

Adult Social Care

1.There is a strategy discussion between the Manager/Supervisor and the allocated worker to discuss the outcome of the safeguard and home visit and agree next steps.
2. To ensure that all workers are aware of their responsibilities to follow up actions, to safeguard adults and carers appropriately in line with making safeguarding personal.
3. To ensure that all workers are responsible for regularly updating the adults on the progress of the actions agreed including colleagues who form part of the MDT.
4. To work with providers like EPUT Mental Health and consider joint training which would also staff to build their networks of professionals to contact when support is required.
5. Quality Assurance processes are revisited to ensure that there is focus on decision making with safeguarding processes, assessments and reviews.
6. That reablement is maximised in similar circumstances.

Essex Partnership University NHS Foundation Trust

Transfers of care from one service to another
1. All transfers of care for patients subject to CPA should be in accordance with the CPA Policy and should ensure that a robust hand over from Care Coordinator to Care Coordinator takes place, where possible in the presence of the patient. This should also include transfer of vital clinical information including the most up to date psychiatric and risk assessments.
Allocation of Care Coordinator
2. New patients referred to mental health teams who are have serious mental illness (such as Schizophrenia) with complex presentation (dual diagnosis) should be assessed by a registered health or social care professional.

3. The registered health or social care professional should coordinate the care and provide regular feedback to the multi-disciplinary team, particularly when the patient is relapsing.
4.The mental health team in West Essex to have objective measures to risk rate a patient at the multidisciplinary team meeting and any downgrading of risk should be based on these objective measures.

Leadership

5. A reflective discussion should be held within the CMHT to clarify roles and responsibility of the MDT including accountability for decision making.

Communication

6. All failed urgent domiciliary visits should be communicated to the team leader and where appropriate out of hours/ weekend worker to enable a risk assessment to be undertaken and agree an on-going plan of care. This plan must be clearly documented in the patient's clinical records**.**
7. Any significant concerns from the GP regarding a patient's health must be brought to the attention of the patient's Consultant Psychiatrist and appropriate action undertaken.
8. Allocation of a staff member by the team, where appropriate, should be communicated to the next of kin/family. The identified staff, where appropriate, should then engage and work with the family in providing care and treatment to the patient.

Culture and Multi-Disciplinary Team (MDTs)

9.Consideration should be given to more active involvement of the team Consultant in chairing the MDT meeting jointly with Team Manager/ Leader to ensure senior clinical oversight and scrutiny.
10. Consultant Psychiatrist for the team to take active role in key decisions regarding patient care particularly discharges of patient with severe mental illness. In discharging a patient, appropriate safety netting must be undertaken by the team.

Safeguarding

11.The West Essex Community Mental Health teams to have a scenario-based learning session on safeguarding issues. This should include the importance of considering the needs of patients who are carers and additional support required including respite care.

Clinical System

12.The template for Psychiatric assessment on Paris to be reviewed to ensure the assessments are documented and communicated in a structured manner.