Safeguarding Adults Review

Domestic Homicide Review

Overview Report

Case of Kimmi

Died October 2020

Independent Author: Mr Jon Chapman **August 2022**

Contents

1. Introduction

1.1 This is a combined review which brings together the requirements of a Domestic Homicide Review (DHR) and a Safeguarding Adults Review (SAR) into the circumstances of the deaths of Kimmi and Alfred. They had been married for 42 years and lived together on a farm in Essex where they had lived for most of their married life. Alfred had suffered a long history of serious illness. Kimmi was diagnosed with vascular dementia five years ago and Alfred took on a caring role for his wife.

1.2 During the period of the first lockdown due to Covid 19, Kimmi and Alfred had reduced care support and were unable to undertake their usual routine. In July 2020, Kimmi suffered a fall in the home and injured her hip necessitating a hospital admission and operation. It was also apparent that Kimmi's dementia condition was also deteriorating.

1.3 Kimmi was discharged with a reablement plan in August 2020, a number of services were involved with Kimmi and Alfred. The family view on the subsequent care was that it was uncoordinated and difficult for the family to navigate and understand.

1.4 In August 2020, just prior to Kimmi's discharge from hospital there was a concern raised regarding the circumstances of her fall and then in late September, there were some concerns raised regarding the care that Alfred was affording his wife. This resulted at the end of September in a safeguarding concern being raised about the way Alfred had treated Kimmi. After discussion between Adult Social Care (ASC) and the family it was decided that the family would make contact with their father in the first instance. The day after this discussion with Alfred took place he used a legally possessed firearm to shoot Kimmi, killing her, and then using the same weapon to take his own life.

1.5 This review has included liaison with the family. The panel would like to thank the family for this at what is a very difficult time for them. The report has been anonymised in line with guidance and good practice and the family have assisted with this.

2. The Review Process

2.1 The purpose of a Safeguarding Adults Review (SAR)

2.1.1 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.

2.1.2 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 in future.

2.1.3 On 17th December 2020, The Essex Safeguarding Adults Board review sub-group considered the circumstances of this case and agreed that it met the criteria for a SAR.

2.1.4 The Essex SAR sub-group was aware that the Southend, Essex and Thurrock Domestic Abuse Board was discussing with the Chelmsford Community Safety Partnership and Home Office whether a Domestic Homicide Review (DHR) would be undertaken and maintained contact with the board whilst these discussions were ongoing.

2.2 The purpose of a Domestic Homicide Review (DHR)

2.2.1 The case was referred to the Southend, Essex and Thurrock (SET) Domestic Abuse Board by Essex Police on 6th October 2020. The SET Core Group convened on 20th November 2020 and considered the circumstances of the case, with the assistance of thorough scoping from relevant organisations. The core group agreed that as the case was being reviewed as a SAR, there was no requirement to undertake to review in accordance with the statutory guidance under section 9(1) of the Domestic Violence, Crime and Victims Act 2004.[1]

2.2.2 This decision was conveyed to the family who agreed with the position, and also conveyed to the Home Office who have oversight and a quality assurance role over the DHR process. In October 2021, the Home Secretary wrote to the Chelmsford Community Safety Partnership directing that a DHR would take place in addition to the already agreed SAR. It was agreed at this stage that the SAR and DHR would be jointly undertaken and one overview report cover both reviews.

2.2.3 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

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

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.[2]

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

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.[3]

2.2.5 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.

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

[2] 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].

[3] This was amended by the Domestic Abuse Act 2021 - https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted (accessed 01/12/21)

2.3 Parallel Reviews

2.3.1 A police investigation has taken place and reports were prepared for HM Coroner. An inquest took place in October 2021 and established that the cause of death for Kimmi was unlawful killing and for Alfred was suicide.

2.3.2 HM Coroner took the step of providing a subjective statement on the verdicts. The Coroner reported that it was unusual for him to add such a statement, however given the circumstances this was warranted. His summing up recognised the couple as loving and devoted to others and Alfred needed more support in his caring role than he wanted to admit or accommodate. His devotion to his wife included the need to keep her at home and whilst HM Coroner recognised that it was not his role to determine why someone died, he referred to the level of distress that Alfred had shown, following the conversation with his daughters about the safeguard having been raised. The daughters in their statement, reported that they had been in contact with him throughout the evening to try to console him and reassure him that they would support him and get him through this. Part of his distress is that she would be removed from her home. His outcome was suicide.

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	
Paul Bedwell*	Board Manager	Essex Safeguarding Adults Board
Michelle Williams	DA Coordinator	Southend, Essex and Thurrock Domestic Abuse Board
Alison Clark	Interim Director Safeguarding & Quality Assurance, Adult Care Services	Essex County Council
Brid Boraks	Service Manager, Adult Care Services	Essex County Council
Lisa Elliott/ Scott Kingsnorth	Strategic Centre, Crime and Public Protection Command	Essex Police

Jane Reeve	Lead professional for Safeguarding	Provide
Leila Francis	Designated Nurse Safeguarding	Mid Essex CCG
Caroline Dollery	Lead Safeguarding GP	GP Practice
Sarah Wark	Adult Safeguarding Nurse	Mid & South Essex NHS Foundation Trust
Alice Faweya	MSE Named Nurse for Safeguarding Adults	Mid & South Essex NHS Foundation Trust
Sara Rashid	Director	Care Provider
Tendayi Musundire	Head of Safeguarding	Essex Partnership University Trust
Claire Stockwell-Lance	Area Manager	Alzheimer's Society
Nikki Taylor	Community Domestic Abuse Practitioner Service Manager	Next Chapter
Spencer Clarke	Public Protection Manager	Community Safety Partnership
Caroline Sexby	Safeguarding Specialist Practitioner for Adults	East of England Ambulance Service

* Michala Jury from 12/01/22

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 There were three panel meetings. There was a practitioner event (facilitated reflective workshop) in November 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.

2.6 Confidentiality

2.6.1 The issue of confidentiality was addressed before each panel meeting, both verbally and in writing. 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.

2.7 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 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 the beginning of January 2017 – the beginning of October 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 Trust (EPUT)	IMR and Chronology
Mid Essex Clinical Commissioning Group (CCG)	IMR and Chronology
Provide (Community Health Provider)	IMR and Chronology
Domiciliary Care Provider	IMR and Chronology
Mid & South Essex NHS Foundation Trust	IMR and Chronology
Essex Police	IMR and Chronology
Alzheimer's Society	Chronology

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 Hertfordshire senior 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 a Quality and Effectiveness Board for a CCG and is currently the independent chair for an area's Adult and Children Safeguarding Review Group.

2.8.4 The chair and author has undertaken Safeguarding Adults 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 (Race, religion or belief, age, sex, sexual orientation, pregnancy and maternity, gender reassignment, marriage or civil partnership, disability).

2.9.2 Kimmi and Alfred were both of white British heritage. It is recognised that whilst domestic abuse is perpetrated against men and within same sex relationships that women are significantly more likely to be the victim of abuse[4]. Reporting of domestic abuse by older persons is known to be low and this is examined in more detail at section 7.7.

2.9.3 Kimmi suffered from dementia which significantly impacted on her cognitive ability and therefore is included as a disability under the Equality Act. This was recognised by The All-Party Parliamentary Group on Dementia report in 2019[5]. The report focused on the importance of promoting disability rights for people with dementia in six areas: employment, social protection, social care, transport, housing and community life.

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, Chelmsford Community Safety Partnership Board and Essex Safeguarding Adults Board.

[4] British Crime Survey England and Wales, March 2020
[5] All Party Parliamentary Group on Dementia,2019, Hidden No More: Dementia and disability

2.10.2 The report will also be disseminated to all agencies involved in the review, which includes health commissioners, The Domestic Abuse Commissioners Office and the Police, Fire and Crime Commissioner for Essex.

3 Involvement of family, friends, and wider community

3.1 A very important area of any review is to capture the views of the family and the others who were close to Kimmi and Alfred, to understand what their challenges were and to try to understand how the situation was for them. In taking any views into account it is important to balance those against what is established by other parts of the review.

3.2 In this case there are three children, who although they did not reside with their mother and father, were very close to them and remained very involved in their care and support.

3.3 The family were spoken to at the commencement of the review process and gave their initial views. They then submitted to the review two very full written submissions with their views and feelings and responded to the specific terms of reference, which had been shared with them. The family were not invited to and did not attend any panel meetings. When the author for the review was appointed, he made contact with the family again and they were very critical of the time that the review process was taking. In October 2021, the family were understandably very involved with the inquest and submitted their views for the information of HM Coroner.

3.4 The author has had the opportunity to meet with some of the family members again. Another area that they found very difficult was the decision by the Home Office that the case should also be reviewed as a Domestic Homicide Review and the time that was taken for this decision to be made. This was a view which they requested was reflected in the report.

3.5 The author was able to access the statements made by friends and neighbours for the purposes of the inquest and where relevant these have been reflected in the review.

4. Background information

4.1 The victim in this case Kimmi had been married to Alfred for 42 years. They lived together in a large, detached house in a rural village in Essex. The house formed part of a family farm where the couple had lived since being married.

4.2 The house was split into three floors. The ground floor comprised of a hallway, lounge/dining room and kitchen/breakfast room. From the hallway a set of stairs took you to the lower ground floor which comprised of an office, storage rooms, utility room

and the large garage. From the hallway you also take a set of stairs to the first floor which comprised of a number of bedrooms and a bathroom. The main bedroom was where Kimmi and Alfred were found. The room consisted of two single beds that were pushed together to resemble a double bed. There was an en-suite bathroom connected to the room.[6]

4.3 The couple had raised their three children at the farm, all of whom had left the family home to pursue their own lives. The children, although not living in the local area, with one resident abroad, were very close to their parents and kept in regular contact.

4.4 Both Kimmi and Alfred were well known in the local area, having lived there for such an extended period and had been involved in the local community activities over the years. They had some neighbours who knew the family well and were considered family friends.

4.5 The day before Kimmi's death, a neighbour of the couple describes going to the house to help Alfred with a computer issue. During this visit the neighbour noted that Alfred appeared stressed, and he disclosed that Kimmi's carers had noted some bruising on her and that he had been accused of causing it. He stated that Kimmi had fallen in the bathroom. Alfred had also made a statement some weeks previously to the effect that he had already lost Kimmi and that he was ready to end it all.

4.6 On the morning of the Kimmi's death, another neighbour was due to visit, Alfred called the neighbour and stated that they should not bother coming over as he was going to shoot himself. The neighbour was unable to re-contact Alfred.

4.7 At 8.40am the same day the police received a call from Alfred, he stated that he had just shot his wife as she had dementia and had recently had an operation. He gave police his details and stated that when they arrived, he would be lying next to her.

4.8 Police and emergency services attended the home address and found Kimmi and Alfred in their bed upstairs. Both appeared to have gunshot wounds to their heads. Both were taken to hospital, where sadly Alfred died on the same day and Kimmi died two days later.

4.9 The scene examination and the post-mortem examinations were consistent with the view that Alfred had shot Kimmi, using a rifle licenced to himself before using the same weapon to shoot himself. This view was confirmed by the later inquest.

[6] Taken from police report for inquest

Access to licensed firearms

4.10 Alfred was a licensed shotgun certificate holder and had been since 1989 and was a licensed firearms certificate holder since 1987. Both licences were due to be renewed or expire on 31st January 2022. This allowed Alfred to lawfully possess 6 shotguns, 2 rifles (.22) and 2 sound moderators. The home address was fitted with two lockable gun cabinets. On attendance of police on the days of the deaths, one of the rifles was with Alfred and the remaining firearms were found in the cabinets. Over the years the process for application and renewal of licences has changed and this will be discussed within the section on analysis.

5. Chronology

Background

5.1 In 2007, Alfred suffered a stroke and in 2009 was diagnosed with a rare form of Leukaemia (Plasmacytoid Dendritic Cell Neoplasm). After a very poor initial prognosis Alfred responded to intensive treatment over several years to become clear of the cancer. In 2013, Kimmi spent some time in hospital following a serious asthma attack.

5.2 It became apparent at a late stage of his review that Alfred had been prescribed and taken anti- depressant medication (Citalopram) since the time of his stroke. This prescription was annually reviewed by the GP. There is record that Alfred attempted to reduce this in 2016 but was not able to do so due to Kimmi's diagnosis. This is a relevant factor in considering firearms licensing and will be developed further in this report.

5.3 In February 2017, Kimmi's GP made a referral for her to undertake a memory assessment, this followed concerns from the family noting a decline in her cognitive ability. This initial assessment took place in April 2017. Kimmi felt that she had no current concerns and continued with her daily activity and maintained her own personal care. She described them as having a good social network and undertaking activities such as gardening. Alfred said that his wife had become increasingly confused and muddled. Kimmi was advised at this appointment that she should cease from driving, and this was conveyed to the DVLA.

5.4 A disclosure letter was sent by the mental health trust to Kimmi and at an appointment in August 2017, both Alfred and Kimmi wished to discuss the content of the letter, which they were not happy with. Kimmi was provided with information on Alzheimer's Society and support that was available. The concerns expressed by Alfred were followed up with a call by a doctor. Records indicate that the doctor found Alfred impolite and curt and

stated that a therapeutic relationship could not be maintained with Alfred.

5.5 At an appointment in September 2017, Kimmi was diagnosed with mixed dementia[7]. At the appointment she was said to be softly spoken and looked to her husband for reassurance and answers to some questions. Alfred stated that Kimmi was overwhelmed by the appointment. A management plan was discussed which included consideration of the use of cognitive enhancers, but this was not deemed advisable due to Kimmi's asthma. An appointment was to be arranged with the Alzheimer's Society to discuss support, and healthy living and mental stimulation was discussed.

5.6 In early February 2018, Alfred contacted NHS 111 as Kimmi had a cough and high temperature. An ambulance was requested and visited Kimmi at home. She is recorded as being unable to move her right side and query whether this was due to a stroke. A report was forwarded from NHS 111 to the GP but there is no record that the GP followed this up.

5.7 In October 2018, the GP received a report from the Gastroenterology Department at the hospital following a referral for Kimmi's heartburn. She was diagnosed with Barrett's Oesophagus[8]. She was prescribed medication, and a further procedure was recommended in three years' time. There is no information on consent for this procedure or consideration of Kimmi's mental capacity.

5.8 In September 2018, Kimmi attended a dementia review at her GP surgery. There was a review of the advanced dementia care plan, although there is no evidence on what this looked like as it is not evident in the records. She was prescribed medication for high blood pressure but information on Kimmi's mental capacity and whether Alfred was able to make decisions in her best interest is lacking. The couple said they were 'coping well' but there is no evidence that a carer assessment was considered.

5.9 In November 2018, the family started to look for support, the daughters recognised that Alfred was undertaking a caring role for his wife, but he required more help. They contacted the GP, lead doctor for dementia but established that Kimmi was not flagged as having dementia with the GP. This was despite the GP surgery having the status of a Dementia Friendly Service. The family contacted ASC and informed them that Alfred was caring for Kimmi but needed support with personal care for their mother. The family were provided with information, including information on carer assessments. The family stated they would inform Alfred and would consider getting private care.

[7] Mixed dementia - Mixed dementia' is a condition in which a person has more than one type of dementia. Alzheimer's disease and vascular dementia is the most common type.

[8] Barretts oesophagus – abnormal cells forming in the lining of the food pipe, see as a pre-cancerous condition.

5.10 At the beginning of December 2018, Alfred contacted the Alzheimer's Society for support. Kimmi was allocated a support worker and an assessment was undertaken, during which she was supported by a friend. The Alzheimer's Society requested a carers assessment from ASC on Alfred's behalf. The referral stated that *'dementia has recently become more of a challenge for the couple and now Kimmi cannot be left alone, Alfred is finding life increasingly more challenging.'*

5.11 Information gathering for the carers assessment started in February 2019 (there is evidence that an emergency assessment was signed by Alfred in January 2019). He stated that it was becoming more difficult to leave Kimmi on her own and he included her in his daily tasks, including taking her out on the tractor. He stated that if he continued without support, he would make himself ill. Alfred was providing Kimmi with personal care, meals, medication, housework, managing finances and correspondence, laundry and shopping.

5.12 The outcome of the assessment was that Alfred had eligible needs as a carer and support would allow him some respite. He was given funding to allow him a sitting service for four hours per week. The carers emergency plan was completed in mid-March 2019, this was 14 weeks after the original referral from the Alzheimer's Society.

5.13 In May 2019, Kimmi had a medication review at the pharmacist. It was noted that she would not comply with use of an inhaler for her asthma. Alfred stated that all the family had encouraged its use but Kimmi would not take notice.

5.14 At the beginning of October 2019, the GP surgery contacted Kimmi by phone but spoke to Alfred who said Kimmi was not able speak. The reasons for this are not recorded and did not appear to be explored further. The surgery then spoke to one of the children and as a result there was a successful appointment involving Kimmi, Alfred and the daughter. Alfred and the daughter expressed concerns regarding Kimmi's increasing dementia.

5.15 At this appointment patient information sharing forms were completed for each of the three children and for Alfred. Whilst the form for Alfred was signed by Kimmi, the other three were not. There was no consideration of mental capacity, and this had not been assessed for Kimmi since her diagnosis two years earlier. Nor was there any evidence of discussion or advice on regarding Lasting Power of Attorney (LPA).

5.16 In March 2020, the UK went into national covid lockdown and this impacted on all services that agencies were able to provide. The sitting service which was Alfred's only respite had to terminate their support. The family did try to replace the service but without success.

5.17 In April 2020, ASC undertook a review of the carer assessment. This was undertaken by a conversation on the phone with Alfred who claimed that he and Kimmi were doing well but Kimmi was deteriorating. He said that they spoke to their children daily. He said that he had increased the sitting service from four hours daily to six and was happy to pay for this service himself. Also, in April the GP surgery contacted one of Kimmi's children (not recorded who) regarding a Diabetes Prevention Programme. Alfred was also contacted regarding a dementia review. He stated that they were coping well and had good supportive neighbours and did not require any additional support.

5.18 In late July 2020, an ambulance was called to the farm on a report that Kimmi had fallen. She was conveyed to hospital. A history was taken from her, which included that she was able to mobilise up to one mile with a zimmer frame. It was recorded that at this time she was in receipt of a care package consisting of two visits per day. She was taken for surgery (right hemi-arthroplasty surgery[9]). Before surgery was undertaken Kimmi's mental capacity was assessed and she was assessed as not having capacity regarding her health care decisions. A decision on surgery was made, in consultation with her husband on a best interest basis.

5.19 Kimmi's fall had a significant impact on Alfred, who had discovered her in the hallway. He had tried to assist by moving her, not realising the seriousness of her injury. He had to summon the assistance of neighbours before emergency services arrived. The fall and the guilt that he felt for moving his wife continued to have an impact on him.

5.20 Following the surgery Kimmi continued to be treated in hospital on a best interest basis. It was noted that she was unable to recognise members of her family from photographs. She was assessed by Occupational Therapy (OT) and it was recorded she was confused and disorientated and she was unable to recall the mechanism of her fall. In the following days when she was seen by the OT and Physiotherapy, Alfred was present, and it was noted that Kimmi engaged better when he was present.

5.21 At the beginning of August 2020, whilst Kimmi was still in hospital Alfred made contact with the ASC Discharge to Assess Team (DtA), he was seeking support in the form of reablement when Kimmi was discharged from hospital. He was made aware that ASC would complete an assessment post discharge. It was recorded that he was happy with this arrangement.

5.22 Hospital records show that one of Kimmi's children was involved in a discussion on discharge planning as Alfred was overwhelmed by the planning process. Options were discussed and it was agreed that the best option for Kimmi was for her to be discharged

[9] Right hemi-arthroplasty surgery - A hemiarthroplasty is a surgical procedure that involves replacing half of the hip joint

home with a care reablement package and a private funded sit in service. The equipment required was discussed and identified as a Rotunda, slide about commode and bed stick.

5.23 The referral for reablement went through to a provider who did not have capacity to fulfil the requested 14 hours per week, which included 4 visits with two carers. Another provider was sought and located to commence the care.

5.24 Around the same time an anonymous call was made to the hospital and passed to the adult safeguarding nurse. This call raised a concern about the way in which Kimmi had fallen and suggested that Alfred had been responsible. There was liaison with the hospital ward staff and no concerns over safeguarding were noted. No further action was taken, and no other referrals were made.

5.25 The hospital records indicate that the family wished for Kimmi to return to her home address quickly and it should be borne in mind that this was a time when some covid restrictions were in place and it was thought by the family that Kimmi's dementia would be best managed in surroundings familiar to her.

5.26 On 12th August 2020, Kimmi was discharged home. The family describe this as being a distressing and frustrating period for them trying to access and understand what support was available. The family after making many calls arranged care with the same provider who was commissioned to provide the enablement package and privately resourced care between 10.00 am and 8.00 pm, in addition to the reablement package. Kimmi was sent home without incontinence pads and no provision had been made for this, leaving the family to source these for Kimmi who was doubly incontinent.

5.27 Provide (community health provider) is a commissioned service to deliver health and social care services in the community. At the time of her discharge Kimmi was open to the Provide services of Chelmsford City Integrated Care Team (district nurses), Early Supported Discharge, Admission Avoidance and Resettlement Team (ESDAAR), Adult Continence Service and Community Unscheduled Therapy.

5.28 The day following Kimmi's discharge she was seen and assessed by the district nurse. A referral was made to the continence team. On examination of all pressure areas her sacrum[10] was slightly red but the skin not broken. An order was placed for pressure relieving equipment. It was noted that a mental capacity assessment was required but none was undertaken on this visit, in the belief it would be completed on a visit the following day, which it was not.

[10] Bottom of the spine

5.29 At this time the family were chasing whether an OT assessment was to be undertaken. The request for a home visit as to suitability for home discharge was not received until the day following the discharge and this was passed to EDSAAR. There appeared to be some confusion on what equipment Kimmi had been discharged with to support her. The family requested a profiling bed as Kimmi was trying to leave the bed and the family were struggling to manage this. The family were advised to get the care agency to contact ASC to undertake an OT assessment for a profiling bed. EDSAAR were only able to order a bed if the need was considered a health one, if it was considered a social care issue the request had to be made through ASC.

5.30 Four days following Kimmi's return home she was discharged from the case load of the district nurses. Alfred had been shown how to administer anticoagulant injection and as Kimmi was noted to still be red in pressure areas, the advice was to apply cream and turn her regularly. There were no safeguarding concerns identified and it had previously been noted that there was a good support network of family and carers. At the same time Kimmi was discharged from the EDSAAR service. At the time of discharge from these services there still had been no mental capacity assessment. There is also still no evidence of an enquiry to see whether there was any LPA in place.

5.31 The family were concerned that there was a lack of support for Kimmi in the morning before the carers arrived and at the end of the day. The care arrangement was 30 minutes 4 times per day. The domiciliary care provider requested ASC that the provision be increased by 1 hour in the morning and 1 hour in the evening. Discussion between ASC and the care provider more latterly decided that an increase in care was not required as everything was going well.

5.32 Kimmi's case was discussed at a multi-disciplinary team meeting (MDT) at the GP surgery, it was recorded by the Provide MDT coordinator that the discharge from hospital had been poor. The same day the family contacted Provide and raised concerns that they had not been updated on referrals that had been made and the situation at home was getting worse. Although Provide were not commissioned to give a service when there was a reablement package in place they agreed to undertake an assessment. This was undertaken by phone by a community therapist due to covid restrictions. The family confirmed that they were receiving support from carers 4 times a day and that they were also privately funding support to give their mother full time supervision.

5.33 On 26th August 2020, there was discussion between the hospital physiotherapist and ASC, the referral dated 14th August 2020 was sent to ASC which requested EDSAAR involvement. The referral was picked up by an ASC occupational therapist. After conversation with Kimmi and the care provider it was deemed that the ASC OT support was not required, and that she was 'steadily improving.' At the same time the family

were contacting Provide and asking when their mother would be seen by a community physiotherapist. They were informed that Kimmi was now second on the list and this sat within the permitted 18-week guideline[11].

5.34 At the beginning of September 2020, the Provide Physiotherapist and a Therapy Assistant (TA) undertook a mobility assessment. It was noted that Kimmi lacked mental capacity, but no capacity assessment was undertaken. Alfred informed the Physiotherapist that he had Lasting Power of Attorney (LPA) for matters of health and finance, and it was therefore agreed that the assessment would proceed in Kimmi's best interests. This was viewed as a thorough assessment and as a result a handling belt, commode for use downstairs and a medical chair were ordered for delivery the next day. The family were updated on the assessment and plan and advised on risks of Kimmi using the stairs. There followed discussion between Provide and ASC on Kimmi's use of the stairs and whether there should be an assessment for a stair lift.

5.35 On 8th September 2020, the Provide Physiotherapist and TA returned to the home address and checked on the progress of the equipment that had been ordered. On this occasion a mental capacity assessment was undertaken, which confirmed that Kimmi lacked capacity to consent to the assessment. A stair assessment was undertaken, and it showed that she was unable to place her feet without assistance and found verbal instructions difficult due to her cognitive impairment. The Physiotherapist advised Alfred that Kimmi should not use the stairs due to safety concerns and the risk of her falling. It was apparent that Alfred found this advice difficult and was described as being passively angry, tearful and upset. Alfred was of a view that he would take his wife downstairs in any case. It was left the Physiotherapist would liaise with the ASC OT regarding a stairlift.

5.36 Later the same day the Physiotherapist informed the family of the assessment and agreed that there would be liaison with ASC regarding a stairlift and advice was given on the reablement service and use of the handling belt.

5.37 Two days later the Physiotherapist received a call from Alfred who expressed his displeasure with the decision regarding the use of the stairs and asked that it be reversed. The Physiotherapist explained that this was not possible but did agree that they could attend later the same day and assist in repositioning Kimmi's bed and commode downstairs as an interim measure. Alfred was described as being tearful throughout.

5.38 At this time the family were also concerned regarding how their mother's care would be delivered at the end of the reablement package on 23rd September 2020. The family

[11] NHS Constitution (NHS 2012) – maximum waiting time from referral to treatment no longer that 18 weeks.

articulated concerns that when asked their father would state that he was able to cope but they were concerned that this was not the case. They were informed that two weeks before the end of the package the care provider would undertake an assessment to determine what was required. ASC also allocated the case to a Community Support Worker (CSW) to complete and eligibility assessment for services. Alfred continued to be very upset regarding his wife having to remain upstairs and was critical of the Provide Physiotherapist's assessment and threatened them with court action.

5.39 Three days after the case had been allocated to the CSW they started an assessment of Kimmi's needs. The CSW called Alfred on the phone, he was out working at the time, and it is reported that he became agitated when the CSW asked to speak to Kimmi and discuss finances. Alfred stated that he had LPA for Kimmi, but this was not explored further by the CSW. The CSW obtained consent from Kimmi to speak to the family regarding the assessment. The CSW then contacted the family and discussed what support was required. The family stated that the same level of care was required, and they would fund this.

5.40 On 18th September 2020, Kimmi was discharged from the care of the Provide Physiotherapist, before doing so the PT liaised and gave a full handover to the GP and to the ASC OT. At the same time the family were trying to establish what the care package would be when the reablement ended. Alfred also emailed Provide to establish what was happening regarding the stairlift assessment and stated Kimmi was spending all her time upstairs, which he was unhappy about.

5.41 On 25th September 2020, the CSW contacted one of the family to see if the family had accessed private care. The family stated that there had been a family meeting and that Alfred was stubborn and wanted to continue to support Kimmi himself. Advice was given regarding requesting a medicine review from the GP and the CSW agreed to refer to a health navigator to support Kimmi. The CSW contacted the care provider to establish if the reablement package was still being delivered as the contract with Essex County Council ASC had finished on 23rd September 2020. It was confirmed that the care was still being delivered and that the domiciliary care provider intended to raise a safeguarding concern. The CSW did not appear to make any enquiry into what the nature of the concern was.

5.42 On 28th September 2020, the ASC OT contacted the CSW to confirm that after discussion with the Provide Physiotherapist there was agreement that a stairlift was feasible, but the case would be handed over to the Independent Workforce Team as this was a longer piece of work. The CSW also liaised with the team manager regarding the safeguarding concern and suggested that the case could now be allocated to a social worker. The same day the Alzheimer's Society were contacted by the GP requesting that

they contact the family as they were struggling to support Kimmi and desperately needed help.

5.43 The following day the care provider contacted ASC and informed them that Alfred would not be privately funding the 4-double handed calls each day and would be providing the care himself. The care provider confirmed that they had been asked by the family to continue to provide the 7 hours daily sitting service. ASC advised to continue to provide the 4 calls daily while discussions took place.

5.44 The care provider made a safeguarding referral at the end of the working day on 29th September 2020. The referral stated that '*during recent visits to Kimmi carers have reported that Alfred (husband) had been telling the sitting carers that if Kimmi does not eat, the carers are to slap her on the back. He also makes the carers walk Kimmi around the house in just her underwear. No night clothes at all. Just a thin sheet. Carers have reported that after a fall he picked her up, threw her on the bed and had a go at her for falling over.'*

5.45 Discussions between ASC and the care provider continued, and the care provider expressed concerns over whether Alfred would be able to provide the care that Kimmi required and what risks the termination of care may present. The care provider stated that they were going to submit a safeguarding concern the previous week and now undertook to submit this the same day. The CSW was advised by their Team Manager to consult with a senior social worker, which they did and were advised to close their involvement in the case.

5.46 The safeguarding referral was triaged in early October 2020, by a different team within the Local Authority. There was contact between ASC and the domiciliary care provider, who confirmed that the family were not aware of the concern being raised. The family were contacted regarding the concern and stated that they were not aware of such incidents. They accepted that their father could be stubborn and obstinate. The family were concerned that any approach to Alfred could lead to all care for Kimmi being withdrawn. It was agreed that a family member would contact Alfred in the first instance. A decision was made by ASC that the concern should progress to a s42 enquiry.[12]

5.47 At 8.30 am the following day Essex Police received a call from Alfred stating that he had shot his wife and he intended to shoot himself. The emergency services responded

[12] S42, Care Act 2014 - The Care Act introduced a legal duty to make enquiries about safeguarding concerns, under section 42. Th safeguarding duties apply to an adult who: Has needs for care and support (Whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

to the call and both Alfred and Kimmi were conveyed to hospital where Alfred died the same day and Kimmi two days later.

6. Overview

6.1 Both Alfred and Kimmi were known mainly to health services and to a more limited degree to Adult Social Care. Most of the detail of services involvement with the couple is contained in other sections of this report.

6.2 What did agencies know about Kimmi

6.2.1 Kimmi was known mainly to health services having been a sufferer of asthma, and more latterly dementia. She was supported for a period by the Alzheimer's Society. She spent a period in hospital in July/August 2020 following a fall at home and was then supported on discharge by domiciliary care provider ASC and community healthcare providers.

6.3 What did agencies know about Alfred

6.3.1 Alfred was known to police as a licenced firearms certificate holder and had been known in this capacity since 1987. He was known to health services as having suffered a stroke and then fought a rare form of leukaemia, which he was in remission from. He was supported by the Alzheimer's Society and by ASC who undertook a carer assessment in 2019 and provided some support to care for Kimmi.

7. Analysis

7.1 Kimmi's Dementia and diagnosis

7.1.1 In January 2017 Kimmi attended her GP surgery with Alfred for a memory assessment. There is no evidence that Kimmi's mental capacity was assessed. Other tests were later completed (ECG) and records are not clear as to who the results of the tests would be shared with. The GP made a referral to the Memory Assessment Service.

7.1.2 Kimmi was diagnosed with dementia in September 2017, the notes from the hospital trust indicate that an appointment was to be made with the Alzheimer's Society in a months' time. Although the Alzheimer's Society could not initially access any records of their involvement at the diagnosis stage, the Memory Assessment Service records would indicate that a representative of the Alzheimer's Society was present at the time of the diagnosis, as was practice at this time. There are no records to indicate what advice or support that Alfred and Kimmi were given at this time, this is due to the Alzheimer's Society changing the system on how records were kept.

7.1.3 During the diagnosis process Kimmi and Alfred made a complaint regarding the disclosures that were made within the diagnosis letter. In dealing with the complaint a doctor recorded that he found Alfred rude and curt, and the doctor did not believe that they could continue a therapeutic relationship with him. This comment and recording does not indicate how the relationship would be maintained with Kimmi and Alfred and did not appear to put Kimmi at the centre of the decision making care discussions.

7.1.4 Discussion with the Alzheimer's Society and EPUT give an insight into how difficult, and what an impact, the diagnosis of dementia can mean for a family. Alfred was a man who had endured his own medical challenges, having fought Leukaemia. The diagnosis was going to have a significant impact on the couple's lifestyle and consideration should have been given to what support Alfred required as a carer at this stage.

7.1.5 Understanding a person's wishes for the future and how these can be achieved is very important and these need to be considered at an early stage of diagnosis. For this to happen the right advice, guidance and signposting is required. The resulting support is reliant on the person with dementia or those close to them accessing it but in this case there is no clear evidence that the support and guidance was available to Kimmi and Alfred.

7.1.6 The diagnosis meeting held by the Memory Assessment and Support Service (MASS) is a relatively short meeting lasting about half an hour. During the meeting it was recorded that Kimmi looked to her husband for reassurance and she was softly spoken. It was recorded that the diagnosis was 'taken on board by the husband' but there is no indication that Kimmi understood the diagnosis. There was no mental capacity assessment and when discussed with professionals for this review it was the view that there would have been discussion with the GP at the time of the referral and the reassurance on the patient understanding achieved at this time. It is not clear that this is the case and consideration should be given to a patient's mental capacity at the time that the diagnosis is explained. In fact, in January 2017, when early-stage memory tests were undertaken by the GP, prior to the referral to the dementia service, the GP recorded that Kimmi did not appear to have the ability to comprehend the test result information.

7.1.7 Kimmi's GP surgery has the Alzheimer's Society recognition as a Dementia Friendly Surgery[13]. This accreditation by the Alzheimer's Society involves an awareness for all staff at the GP surgery, suggestions as to how to support persons with dementia at the surgery more effectively and accessing support from the Alzheimer's Society. In the case of the GP surgery where Kimmi was registered this included an action plan which covered training, administration, and clinical aspects of delivering a dementia focused

[13] Alzheimer's Society - https://www.alzheimers.org.uk/dementia-professionals/resources-gps/gp-practices (accessed 03/12/21)

service. This included good practice for care plans, completing the patient's life story and key events for the future and confirming end of life plans with patients. It is not apparent that any of this was in place for Kimmi. There was reference in the GP records of a dementia care plan but there is no evidence that this existed. It is fair to point out that Kimmi's diagnosis and support was at the beginning of the practices journey towards accreditation.

7.1.8 There does not appear to have been any consideration, at this stage, as to the support that Alfred may require going forward and there is no record of a carer assessment being considered or offered. This would be a routine part of the MASS assessment and if it was felt there was a need a referral sent to the Local Authority, in accordance with the local pathway. NICE guidance on dementia assessment, management and support, details the necessity for the service to be person centered but also recognises the importance of recognising, enhancing and supporting the carers input.[14]

7.1.9 Information given at the time of diagnosis is really important as due to the deteriorating nature of the illness there are decisions to be made which may have a relatively narrow time frame for consideration. There is no evidence to suggest that Kimmi's wishes regarding ongoing care were discussed and recorded. There is no evidence that advice on decision making was recorded as being given to Kimmi or Alfred. It is apparent that as this case progresses agencies relied on the fact that Alfred had Lasting Power of Attorney (LPA)[15] for Kimmi for decisions relating to health and welfare, this having been stated by Alfred. Enquiries made for the purposes of this review with the Office of the Public Guardian reveal that there is no LPA in place for Kimmi for matters of health and welfare.

7.1.10 This review is also focused on understanding if there were any signs of domestic abuse or coercive controlling behaviour prevalent at the various stages of the case. Whilst there is absolutely no indication of domestic abuse within the relationship at the time that Kimmi was diagnosed with dementia, this could have been recognised as a potential risk event. It has long been recognised that when a woman becomes pregnant there is an increased risk of domestic abuse and over time the development and accepted practice has been that women are routinely asked about domestic abuse at ante-natal appointments. There is emerging evidence that there can be a link between carer stress and coercive control and there is a recognised rise in the area of abuse in the older

[14] National Institute for Health and Care Excellence (NICE) (2018) *Dementia: assessment, management, support for people living with dementia and their carers* NG97. Available at: https://www.nice.org.uk/guidance/ng97 (Accessed: 02/12/21).

[15] Lasting Power of Attorney - A lasting power of attorney (LPA) is a legal document that lets (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. https://www.gov.uk/power-of-attorney (accessed 02/12/21)

generation. There should be a discussion as to whether there should be a similar discussion with older people to that of pregnant women when they enter what might be a risk time of life such as diagnosis of a debilitating condition which will involve partner or family member caring for them. This would at least give a greater understanding of the dynamics of the relationship at that time to understand if there are any changes as time goes on.

Learning – This case underlines the impact on people, and their families, when they are diagnosed with dementia. At the point of diagnosis there are a myriad of considerations to be made and important information to be given and received. It is important at a point of referral that GPs are confident that the person has the mental capacity to understand the situation and referral, and where necessary an assessment should be undertaken. Likewise, on diagnosis the mental capacity of the person should be considered. Information and signposting for the person and family is important. It should be recognised that at the point of diagnosis this is unlikely to be understood and retained and there should be structured follow up on this information, which should include the importance of future planning and LPA consideration. The role of the carer should be considered and if agreed a carer assessment undertaken. Where GP's or other agencies seek the status of being dementia friendly, whilst this is commendable, they should ensure that they are able to meet this expectation. What the review panel found was that good quality early discussion with persons diagnosed with dementia and their carers and clear recording of these would build a sound foundation on which to base later decisions and discussions.

Recommendation 1

The Mid Essex Clinical Commissioning Group, Memory Assessment and Support Service (EPUT) and Alzheimer's Society review the dementia diagnosis pathway to ensure that there is a fully joined up approach to ensure that patient receives full information regarding support and that information is clearly understood. This should include: -

- Appropriate use of Mental Capacity Assessment at relevant times.
- What support is available and how it can be accessed.
- That there is clear enquiry into and recording of the patient's wishes and plans for the future.
- That there is consideration of a carer assessment and carer stress.
- That there are clear and routine enquiry and recording into social and financial circumstances to include the consideration of domestic abuse.

7.2 Review and assessment

7.2.1 Between November 2017 and October 2019 Kimmi had a number of contacts

with the GP. During this period there can also be recognised a pattern where Alfred would claim to professionals that he was coping well and did not require help but there may have been indications that this was not in fact the case.

7.2.2 In February 2018, Alfred contacted the NHS 111 number as Kimmi had a cough and high temperature, as a result an ambulance attended and treated Kimmi. She was diagnosed with a respiratory infection and advised that this should be followed up with the GP. The report from NHS 111 was forwarded to the GP but there is no record of any follow up from the GP or antibiotics being prescribed which was advised by the ambulance service.

7.2.3 In June 2018, a letter was sent to Kimmi as part of dementia monitoring but there was no response. It is unlikely on what was known at that time, although mental capacity assessment was limited, that Kimmi would have been able to understand and respond to the letter. The lack of enquiry regarding LPA prevented the correspondence being sent to Alfred. In October 2019, the GP surgery did seek to address the sharing of patient information by the family completing patient information sharing forms. One was completed for each of the children and one for Alfred. The only form signed was that of Alfred with an indecipherable signature purporting to be that of Kimmi but none of the others were signed. There was still a lack of consideration as to Kimmi's mental capacity and best interest decision making.

7.2.4 The GP was notified of other procedures for Kimmi, in October 2018, she was diagnosed with Barrett's oesophagus and in April 2018 the GP was notified of an asthma review by the hospital respiratory department. This review acknowledged that Kimmi was non-compliant with her prescribed inhaler regime. Alfred stated that they were doing well but this was not further explored. It is apparent that Kimmi's mental capacity was not considered in these appointments and there is no evidence of Kimmi's views being sought and therefore her voice is lacking.

7.2.5 In September 2018, Kimmi had a dementia review with the GP. The GP recorded that Kimmi and Alfred were doing really well and were active as they were farmers. There is no reference to a dementia care plan, or the areas of guidance specified in the NICE Guidance on managing dementia, which would include providing a copy of the plan to the patient and family and consideration of mental capacity.

7.2.6 In November 2018, it was clear that the family started to reach out for support. One of the daughters made contact with ASC requesting advice. Signposting advice was given, which the ASC IMR[16] author for this review states is not unusual, as contacts are appropriately triaged. The daughter was given information to pass to Alfred and return to ASC if required.

[16] Adult Social Care Individual Management Report

7.2.7 The next day, Alfred sought the support of Alzheimer's Society. Whilst the Alzheimer's Society records suggested that Kimmi had not been supported previously by the society, the records of EPUT would suggest that a member of their staff had been present at the diagnosis meeting in 2017. On referral the Alzheimer's Society made enquiries about allowances and whether there was an LPA in place, Alfred responded that there was not. Kimmi was seen at beginning of December 2018, within the assessment there is an indication of Kimmi's feelings, the assessment discussion was undertaken in the presence of a neighbour to support Kimmi, who stated that Kimmi struggled with domestic chores, her personal care and that she was not eating properly. They also raised a concern over Alfred and the caring role and that he had difficulty accepting help. This assessment made a referral to ASC for an assessment under the Care Act.

7.2.8 The assessment was not completed until March 2019, although it is recorded that Alfred signed the assessment in January 2019. The outcome of the assessment was that Alfred had eligible needs as a carer and was allocated funding to provide a sitting service 4 hours per week. Although the referral was for a carer assessment for Alfred, there was an opportunity for consideration of Kimmi's needs. During the Alzheimer's Society assessment, it had been noted that Kimmi was struggling with all daily tasks and could not be left alone. Adopting a Whole Family approach to care assessment may have prompted this consideration.
'*The intention of the whole family approach is for local authorities to take a holistic view of the person's needs, in the context of their wider support network.* [17] [18]

7.2.9 It was as result of the Alzheimer's Society involvement that the family were able to engage the services of a care agency, which they privately funded. The family are very complimentary regarding the service assistance given by the agency. This agency started their care in December 2019 and concluded due to the lockdown in March 2020. From discussion with this agency there is a noticeable difference in presentation of both Kimmi and Alfred from their engagement to the presentation post the hospital discharge. From their engagement, they describe a calm domestic situation and had no concerns over Alfred's care of Kimmi. They describe Alfred as a '*larger than life character'* but he did not present them with any concerns. Their care pre-dated Kimmi's fall and hospitalisation and after Kimmi's discharge from hospital a staff member was invited to visit Kimmi at home. They noticed a significant decline in Kimmi's physical health and cognitive ability.

7.2.10 In April 2020, there was a review of the carer assessment, although Alfred stated that Kimmi had deteriorated, he said that he was able to cope. This review was undertaken

[17] Care and Support, Statutory Guidance, DoH 2014

[18] Essex Safeguarding Adults Board – Think Family - https://www.essexsab.org.uk/learning-development/set-learning-from-reviews/ (accessed 14/02/22)

on the phone due to covid, this was also another opportunity to consider an assessment regarding Kimmi's own needs.

Learning It is important that the voice of the person is sought and that it is recorded. Particularly the long term wishes of the person. There is no doubt that a coordinated approach and the use of a dementia care plan would have assisted this. There was not enough enquiry and follow up on the issue of LPA or requests to see and understand the document. In February 2020, the Court of Protection registered an Enduring Power of Attorney[19] for Kimmi with appointees named jointly as Alfred and the three daughters, but this was in relation to property and financial affairs and not health and welfare (which is not possible under an Enduring Power of Attorney). When agencies are dealing with persons with dementia they should understand and seek to see the documentation of Enduring or Lasting Power of Attorney. This will assist in understanding the persons wishes and the status of the attorney as a decision maker. In this case professionals regularly deferred to Alfred. Alfred was seen by some as a dominant and forceful character and it can be seen why professionals would refer to him, especially when Kimmi appeared to defer conversation and decisions to him. Professionals should always seek to ensure that there is clear evidence of the person being involved the decision-making processes and where this is not possible that there is clear recorded path through the Mental Capacity Act and principles of best interest decision making, guided by available legal measures in place such as EPA and LPA. This need for focusing on Making Safeguarding Personal was identified in an earlier Essex SAR and DHR, the case of *Valerie*. When considering and undertaking Care Act assessments a whole family approach should be considered.

Recommendation 2

All agencies should ensure that enquiry is made at an early stage as to whether a person has in place an Enduring or Lasting Power of Attorney and that the provisions of the authority are well understood by all parties. Where possible the authority should be seen and recorded and where there is any doubt an enquiry should be made to the Office of the Public Guardian.

Recommendation 3

The Essex Safeguarding Adult 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 as identified in the *Valerie* review.

[19] An EPA allows an attorney to make decisions about property and financial affairs even if the donor lacks capacity to manage their own affairs under the Enduring Powers of Attorney Act 1985, which was replaced by the Mental Capacity Act 2005.

Recommendation 4

All agencies involved in this review should consider how they deliver services to those suffering with dementia and how a whole family approach would assist the person and those supporting them. There should be clear consideration of the stress that can be present for those family members with caring responsibilities. This should be supported by appropriate training.

7.3 Hospital admission

7.3.1 Kimmi fell and sustained an injury to her hip in July 2020. She was conveyed to hospital and had surgery. At the time of the fall, before ambulance attended, Alfred summoned the assistance of neighbours. The neighbours were concerned that Alfred had moved Kimmi, Alfred had done this to assist Kimmi[20]. The family state that the fall and Alfred's actions in moving his wife after the fall, which was well intentioned, had a profound impact on Alfred, upsetting him greatly.

7.3.2 Kimmi's mental capacity was assessed, and she was deemed not to have capacity and the consent for surgery was taken on a best interest basis with Alfred involved in the discussions. The family were very concerned regarding the care that Kimmi would need when leaving hospital and immediately started to liaise with agencies to understand what support would be available.

7.3.3 It should be noted that the hospital admission was undertaken just four months after the first national lockdown and all services were experiencing the significant impact of the virus. The family were also impacted in that Alfred was allowed access to visit Kimmi, but for isolation reasons the wider family were not. Alfred was very keen to get his wife home, this in itself is not surprising. Kimmi had supported Alfred through a difficult illness previously and he no doubt wished to do the same for his wife.

7.3.4 NICE guidance recognises at any one time 1 in 4 beds are occupied by persons with dementia (pre covid data) and that a person suffering from dementia being in hospital can trigger distress, confusion and delirium, this can contribute to a decline in functioning and reduced ability to return home to independent living.

7.3.5 It was recognised that Kimmi was confused and disorientated, she was unable to recognise photographs of members of her family and on admission to the ward was unable to recollect the mechanism of her fall. Kimmi was assessed by the physiotherapist and it was noted she responded better when Alfred was present.

7.3.6 In early August 2020, there were discussions between the family and services regarding the hospital discharge and the care and support that Kimmi would need once discharged. The family would describe this period as a very frustrating, worrying and

[20] Witness statements from Coroner bundle

confusing time, which was very difficult for a family to navigate and understand. The author of this review on receiving the individual agency reports would agree with this, finding it difficult to see clarity and coordination in the planning of care and support.

7.3.7 The NICE guidance on the transition of patients with social care needs from inpatient to community care[21] details that from admission a multi-disciplinary team (MDT) should be identified and at each shift handover or ward round the person should be assessed towards discharge. The guidance states that persons should be updated with the plans and that there should be a single health or social care practitioner to coordinate the discharge. The family state that this was not their experience and all the information that they received they had to search for.

7.4 Hospital discharge

7.4.1 ASC received contact from Alfred and referral from the hospital, the Covid 19 Hospital Discharge Requirement March 2020 were followed. They were informed that a referral had been made to Essex Cares Limited (ECL). It is not the practice of ASC to offer a Care Act assessment at this stage.

7.4.2 The family were concerned that Kimmi's dementia was becoming more acute whilst she was in hospital and that she needed to return to familiar surroundings and have contact with family members. The family felt that the discharge process was becoming overwhelming for Alfred and notified the hospital to this effect.

7.4.3 The hospital provided three options to the family for support.

1.Discharge to home with care reablement and Alfred to support, with appropriate equipment in place.
2.Discharge to home with care reablement and a private arrangement for funded sit in service and appropriate equipment in place.
3. Discharge to an inpatient care bed (care home placement) with 24-hour care in place.

The family agreed that option two would suit Kimmi as she had previously expressed views that she would not wish to be in a residential care setting having experienced this within the wider family previously. There was not at this stage consideration of Alfred as a carer. He had previously stated that he got frustrated dealing with Kimmi's dementia and her needs were now going to be more significant. The options discussed with the family would indicate that Alfred was part of the discharge planning, and his input was necessary as part of the support was the privately funded sitting service. If this was the

[21] National Institute for Health and Care Excellence (NICE) (2015) *Transition between inpatient hospital settings and care and home settings for adults with social care needs* NG27. Available at: https://www.nice.org.uk/guidance/ng27 (Accessed: 02/12/21).

case the sitting service should have been funded from the outset. Had this been the case this would have impacted on decisions the family made going forward. As it was this was not offered to the family.

It was around the time of discharge planning that a safeguarding concern was raised with the hospital, which will be discussed in more detail at section 7.6, but this should have been factored into the discharge discussions and considerations.

7.4.4 Had a carers assessment been offered to Alfred at this stage, or indeed at any stage he may well have declined but it should have been considered. There is also something to be considered about how the offer of an assessment is framed. More consideration needs to be given to the person being offered the assessment and what would allow them to make a more informed decision. Had the offer been very much framed around Kimmi's overall wellbeing then it may be the case that Alfred would have viewed the assessment more positively.

7.4.5 The post discharge support was made more complex as ECL were not able to provide a service due to capacity, and therefore a service provider was commissioned from the *Live at Home Framework*. Due to this, the coordinated service which ECL would provide by bringing therapy as part of the service was not present and arrangements were made for occupational therapy to be provided by ASC and physiotherapy by the community provider (Provide). Had the service been provided by ECL there would have been weekly MDT meetings, but this was not the case as this was a framework arrangement. Had this been in place it would have assisted the overall coordination of care.

7.4.6 Another factor that would have assisted the overall coordination was a care coordinator. This would have helped the family to understand what was available and the rationale for decisions. This point is well developed in the ASC IMR for this review, which references the Discharge to Assess Hospital Discharge Guidance. The author also makes the point that process in Mid Essex at the time of the review had not developed to the point of having a single point of contact on this function.

7.4.7 Kimmi was discharged from hospital to her home address on in August 2020, with an agreed care package which was part funded by the family. The family had used the same care provider as that commissioned by the Council for the reablement service. This was able to provide some continuity of care.

7.4.8 Alfred contacted the GP soon after discharge for advice on medicines and as a result the GP made a referral to EPUT for a dementia review. As a result of this the Dementia Intensive Support Service (DISS) contacted Alfred and discussed night sedation with him. Advice was given and it is recorded no further support was requested. It is apparent that the review the GP anticipated was not communicated to DISS in the referral and as a result DISS was not aware of the wider picture of support requirements

for Kimmi and Alfred. EPUT and other services involved with Kimmi for her dementia were not involved in the discharge planning. This appears to be a gap, and due to the time since Kimmi's last review, her change in circumstances and the recognised deterioration of her condition, the involvement of these services and a review of her condition would have been timely and good practice.

7.4.9 There is evidence that Kimmi lacked capacity and whilst in hospital decisions on care were made on a best interest basis, in consultation with her family. There is little evidence of seeking to achieve Kimmi's voice and keeping her central to the discharge planning. It may be the case that conversations were had with family about this, but it is not evident. There is little recorded consideration of who had any authority to make decisions on Kimmi's behalf or of any Mental Capacity assessments regarding Kimmi's discharge. As previously highlighted a clear dementia care plan would have assisted in understanding Kimmi's wishes, this was not apparent but also neither was any consideration of its existence in the discharge planning process.

Learning – The discharge from hospital is a really important process not only to ensure the wellbeing of the patient but also to prevent any further harm and re-admission to hospital. In this case the discharge like all other services was significantly impacted by the covid pandemic and the consequences of it. In any scenario it is important that where families are eligible for financial support for care that this is made clear as this will impact on their decisions. There needs to be good coordination, which would be enhanced by a structured multi-disciplinary approach and the role of a coordinator both pre and post discharge. In the case where the patient has a condition such as dementia it is important that the services involved in the dementia care are involved in, and aware of, the discharge plan and how they can support it. The voice of the person and their wishes should be reflected in the process, and that there has been clear consideration of mental capacity and best interest principles.

Recommendation 5

Mid and South Essex NHS Foundation Trust, Essex Adult Social Care and EPUT need to ensure that where a person is eligible for funding to support care that this is made clear to the person, and where appropriate the family, in order that informed decisions on ongoing care can be made.

Recommendation 6

Where Adult Social Care commission care providers outside of the usual arrangements they need to ensure that the care provider is supported by a care coordinator and that the provider is part of weekly multi-disciplinary meetings.

Recommendation 7

All agencies involved in the hospital discharge process need to ensure that carers are involved in the process and their needs are considered and where necessary a carers assessment takes place post discharge.

Recommendation 8

Essex Safeguarding Adults Board should give consideration as to how to support agencies in understanding the importance of carer assessments and advise on how the offer can made more accessible and effective for carers.

Recommendation 9

Mid and South Essex NHS Hospital Trust should ensure that when formulating discharge plans for persons with dementia that relevant dementia services are included in the plan and appropriately notified of the discharge.

Recommendation 10

That the Discharge to Assess approach continues to be developed across all areas of Essex which will include embedding the care coordinator approach on discharge and developing a multi-agency discharge hub. To ensure that this development maintains multi-agency focus there should be effective oversight of the development plan from the Integrated Care Board.

7.5 Post discharge care and needs assessment

7.5.1 The family feel that adequate planning was not in place at the time of Kimmi's discharge, and this necessitated a lot of chasing and follow up by them which all added to their anxiety and frustrations. It is recorded by the hospital that the family were keen to receive their mother home, this was no doubt exacerbated by Kimmi's dementia and the anxiety caused by the covid pandemic. The hospital record that just prior to the discharge the family recognised there was a 'positive risk' to the discharge and that they would be staying with their mother for a few days, and if this did not work they would re-assess other options. The family would describe the whole discharge as a 'mess' and that they were continually requesting further information and equipment.

7.5.2 The lack of coordination is further highlighted by other examples. Kimmi was doubly incontinent and was discharged without any incontinence pads, leaving the family to source these. The community healthcare provider (Provide) were unable to provide continence products in the first instance as there had been no referral from the GP and Kimmi was not previously known to the service. The domiciliary care provider started

their service the day after Kimmi was discharged. Five days after the discharge the care provider contacted ASC and requested an additional 30 minutes care twice a day (mornings and evenings) for personal care. After some dialogue between ASC and the care provider it was stated that the extra care was not required and that all was going well.

7.5.3 It was recognised by the community healthcare provider that Kimmi lacked mental capacity to consent to care and that a mental capacity assessment was required but this was not undertaken for some time. On one occasion the district nurse (DN) attended to give an anti-coagulant injection and recorded that Kimmi was not verbal, but Kimmi was willing to have the injection and did not pull away. It is recorded that there was a friend present, this was likely to have been the domiciliary care provider. This would indicate a lack of curiosity as to who was present. Again, there was a lack of curiosity by professionals as to the status of Alfred and the daughters in decision making.

7.5.4 More latterly there was discussion with Alfred, regarding the administration of the anti-coagulant to his wife. Family members were encouraged to be involved in care particularly in extraordinary circumstances such as the pandemic. After instruction and demonstrating competence in the administration of the injection, this function was left to Alfred to undertake. Whilst it is evident that clear instructions were given, there does not appear to have been any consideration as to the wider impact of the care that Alfred was required to be giving his wife, and the impact that this increased responsibility may have.

7.5.5 There was some confusion regarding the equipment that Kimmi had been discharged with. Two days after the discharge the ESDAAR nurse completed an admission avoidance assessment and recorded that *Kimmi had been discharged without a package of care or therapy referral, no pressure relieving equipment or pads for use when incontinent.*[22] The district nurse ordered a high-risk mattress and the family had requested a profiling bed as the carers were struggling to cope. The divisions in commissioning between health and social care meant that health can only order the bed if there was a health need, as this was considered a social care need a request would have to be made to ASC. This was left with the family to arrange which added to their stress and two weeks later the request had not been progressed. It is not clear if the profiling bed was ever sourced. Commissioners from health and ASC need to review the fragmentation of services that prevented the family accessing equipment for Kimmi in a timely way.

7.5.6 One area that Alfred found particularly difficult and resulted in disagreement between him and community therapy was the assessment over Kimmi's use of stairs. This did not

[22] Community Healthcare Provider IMR

take place until early September, but this was within the 18-week waiting time allowed by the NHS Constitution. Whilst this is the case the community healthcare provider undertake to see patients within two days if the condition would lead to a hospital admission. Whilst Kimmi's condition was not likely to lead to an immediate hospital admission it could have been given more priority within the ESDAAR service. This is highlighted as following a request from the family the request was expedited on the basis it should be a hospital avoidance visit.

7.5.7 The assessment took place the next day and Alfred had informed the therapist that he had LPA for both health and finance. There was no request to see the LPA. It was recognised that a Mental Capacity Assessment was required but it did not take place at this time but was completed on a second visit one week later. On the first visit further, equipment was ordered including a handling belt[23]. The equipment was delivered in a very timely way and there was good follow up for a second visit. Advice on the first visit was that Kimmi should not attempt the stairs without the assistance of two carers and when she was not too tired.

7.5.8 On the second visit the physiotherapist, following a thorough assessment, advised Alfred that Kimmi should not use the stairs as it was not safe for her to do. Alfred disagreed with the assessment and became tearful and upset. The decision by the physiotherapist is seen as being robust and there is evidence of good practice with the physiotherapist following up the decision with liaison with the reablement team regarding an assessment for a stair lift. There was also contact with one of the daughter's because Alfred had become so upset.

7.5.9 This good practice continued when two days later Alfred contacted the physiotherapist and again challenged the decision. A compromise was helpfully discussed by facilitating a move for Kimmi to the downstairs area as a temporary measure. Alfred initially agreed to this but later cancelled the visit to arrange this following discussion with his family. The desire that Alfred had for Kimmi to use the stairs is contrary to the experience of the domiciliary care provider who evidenced that Alfred was strongly against Kimmi being downstairs and accessing the communal areas.

7.5.10 Throughout September the family were concerned what the position would be for Kimmi's care once the reablement package concluded. Around the same time that Alfred was in dispute with the therapy team he was contacted by a Community Social Worker (CSW) from ASC to initiate the care assessment. The children had conveyed that they were concerned that Alfred took on too much and would not readily accept help.

[23] Handling belt – a thick band worn around the waist with tow handles to help carers assist with transfers.

7.5.11 Whilst it was usual for an assessment to be completed post hospital discharge the covid measures on assessment meant that between 19th March 2020 and 31st August 2020 the eligibility, including the financial aspect of the assessment, need not be completed and this would be established at a later date. Kimmi' s case fell within this period, but a full assessment was completed including the financial eligibility. Had the covid measures been used it would have meant that the care would have been funded for a further period. This would have been likely to have allowed Alfred to be much more positive about retaining the care. The initial discussion with Alfred was on the phone and when the CSW asked to speak to Alfred and started to discuss financial matters he became angry and effectively withdrew from the conversation.

7.5.12 Although there was follow up with the family, the fact that the care would have to be personally funded was pursued. This resulted in Alfred ultimately stating that he would undertake the care himself, something he was as it later became apparent, not in a position to do. Again, during these conversations, it was taken that Alfred had LPA and therefore he was the decision maker. This was in fact not the case and had this been known more consideration could have been given to making decisions in Kimmi's best interests, which may not have accorded with Alfred's views and wishes.

7.5.13 Following the assessment the support plan was that Alfred would be meeting Kimmi's personal care needs and would be keeping the sitting service for 7 hours per day. At the same time, a safeguarding concern had been raised by the domiciliary care provider and this was moving towards a section 42 enquiry. It is the view of the ASC review author that whilst there was a suggestion of a safeguarding concern the reablement package should not have concluded. It is also clear that Alfred and the family were making decisions on the basis that they would have to fund care and that they would have continued with the care if they knew it could be funded.

7.5.14 The domiciliary care provider continued to provide care post the conclusion of the reablement package, as they felt there was a risk to Kimmi by not doing so. This has to be viewed as good practice on behalf of the care provider.

7.5.15 There was management oversight on the care assessment but there is not clear sign off for the assessment at managerial level due to an omission. The ASC IMR deals in some detail with the supervision and overview of practice, and the learning regarding this is included within the agency single recommendations.

7.5.16 Many of the issues experienced by Kimmi and the family emanate from the already highlighted issue of a lack of coordination and regular liaison between agencies delivering services. Agencies tended to operate in silos and whilst there was some liaison between them, decisions were taken in isolation. Had there been a MDT structure in place decisions would have been taken in a much more informed fashion.

There was continued reliance on the fact that Alfred had LPA for health and welfare decisions and a lack of consideration of the Mental Capacity Act. While Alfred was making decisions that were thought to be in Kimmi's best interests this was less of an issue, but as the care progressed there was more concern about his decisions, and these would have been more easily challenged had the correct position of the LPA been established.

Learning – It is important that there is an early and clear understanding with families as to the function of a Lasting Power of Attorney and that when agencies engage with families, they establish exactly what authorities are in place, and where there is any doubt clarity is sought from the Office of the Public Guardian. The coordination of care has already been highlighted but there needs to be a discussion between health and social care commissioners to establish how professionals and families can access appropriate support equipment in a timely and non-bureaucratic fashion.

Recommendation 11

Essex Adult Social Care and Provide should ensure that the responsibilities for the procurement of equipment to support patients on their discharge from hospital is well understood by all parties concerned and is seamless to avoid confusion and delay to the patient.

7.6 Safeguarding

7.6.1 There are two areas where safeguarding concerns were raised in this case. The first was whilst Kimmi was an inpatient at the hospital following her fall. On 10th August 2020, four days before her discharge, an anonymous call was received by the adult safeguarding designated nurse which raised a concern over the mechanism of Kimmi's fall and intermated that Alfred had been responsible. The safeguarding lead attended the ward and after discussion with ward staff decided that no further intervention was required.

7.6.2 It is difficult to see how this concern could have been alleviated to the degree of taking no further action by discussion with nursing staff alone. The hospital IMR acknowledges that this concern should have been dealt with by a referral to ASC and any action taken as a result of a multi-agency decision in accordance with hospital and local safeguarding procedures.

7.6.3 Information gained post the deaths of Kimmi and Alfred has revealed that the source of this concern also attempted to raise the same concern with ASC but gave up after being unsuccessful on three separate occasions, having called on three different numbers. The source of the information was informed that Kimmi was a patient at hospital and therefore called there. The source had previously discussed the concern with a County Council employee who they knew on a personal basis. This indicates that the source was

tenacious in wishing to report this concern. Post the deaths the source also indicated that they had concerns regarding other abuse perpetrated by Alfred on Kimmi.[24]As part of this review ASC have attempted to trace the calls made to them but there are no records of these.

7.6.4 The failure to appropriately deal with this safeguarding concern raises a number of issues and leads to missed opportunities. Following safeguarding procedure would have:-

- Allowed the concern to be properly investigated and substantiated or negated. Without that investigation opportunity it has left the matter unresolved, with the implications of that. In particular, the difficulty that leaves for the family who only became aware of this post their parents death.
- The information may have impacted on the discharge and the plans which were being put in place.
- Importantly, there are in this case and many others, very limited opportunities to gain knowledge of and review the ownership and licence holding of firearms (further discussed at section 7.9). A referral and resulting investigation may have highlighted the issue of firearms in the household and a discussion around continued possession at that stage.

7.6.5 The second safeguarding concern presented as a result of discussions between ASC and the domiciliary care provider. On 16th September the care provider care staff became concerned regarding Alfred's treatment of Kimmi. As a result, the care provider made records of this at the home, which it claims were removed by persons unknown. The following day there was what is described by the care provider as a crisis meeting between staff and management regarding the concerns. This included concerns that Alfred was shouting and being aggressive to care staff, refusing to leave his wife with carers during showering, shoving Kimmi, dragging her inappropriately with the handling belt and restricting Kimmi's access to areas of the house despite Kimmi's wishes. The care provider states that there was continued dialogue with ASC regarding these concerns, although on reflection accepts that a formal safeguarding concern should have been raised. There is some dispute as to when and in what detail these concerns were discussed between the care provider and ASC.

7.6.6 The first record ASC has of this concern is 25th September 2020, with a safeguarding concern not being received until 29th September 2020. There is an indication that ASC were aware of these concerns at an earlier point, but they were not recorded, or any action taken. The referral was progressed to a s42 enquiry on 1st October 2020.

7.6.7 The social worker took the decision to call the children and explain the safeguarding concern before speaking to Alfred. In the circumstances this was an understandable

[24] Information from Coroners bundle and IMR ASC

approach. The concern was that direct contact would alienate Alfred further and there was a risk that all support would be withdrawn. Involving the family in the contact was considered a proportionate and measured approach. Had there been knowledge of the earlier safeguarding concern, the approach and decision making at this time may have been different.

7.6.8 The family made contact with Alfred on the 1st October and the following day Alfred took Kimmi's life and then his own. There is some indication of Alfred's state of mind as a result of the investigation for HM Coroner. Alfred had disclosed to a family friend about two weeks previously that he was struggling to cope and that he felt he had lost Kimmi already and felt like ending it all. On the day that Alfred was contacted by his daughter he spoke to a family friend and stated that he was being accused of hurting Kimmi and was visibly upset. He denied harming her and said that she had fallen whilst trying to use the commode.

7.6.9 There is no suggestion that any agencies had any indication, or could have had any indication, that Alfred would take the extreme action that he did. The safeguarding concerns that were starting to be recognised on or around the 17th September 2020, should have been made subject to a safeguarding concern at an earlier point. This said, it is difficult to see how the approach would have been different. The learning from this case, and other similar tragic cases should prompt agencies to consider what the early indications might be for homicide and suicide. The ASC IMR author makes this point and indicates that there have been similar cases both within Essex and wider.

7.6.10 The care provider feels that had there been more regular and structured contact with ASC then they would have been able to articulate a scenario that their staff were witnessing of Alfred being under increasing pressure. The care provider recognises that more has been done in recent times within the *Live at Home Framework* to enhance and for there to be a more inclusive approach toward domiciliary care provider but there is still scope for this relationship to improve. In particular as the requirement for care increases, Essex County Council commissioned, on average, 113,000 hours of domiciliary care per week, supporting around 6,300 Adults, as of June 2020 and this is projected to increase[25].

Learning – It is critical that agencies recognise and raise safeguarding concerns in a timely manner in line with current procedures. This case highlights the potential impact for this not happening and opportunities being missed. Whilst the eventual outcome of this case could not be predicted we should use this review and others that involve carers (particularly male carers) taking extreme action, to reflect on and establish whether

[25] Essex County Council, Live at Home Proposed Framework 2021.

there are commonalties in the cases that would assist professionals and families to identify and early signs of potential suicide or homicide.

Recommendation 12

Mid and South Essex NHS Hospital Trust should ensure that every safeguarding concern raised is appropriately investigated and recorded in accordance with current policy and procedures, this assurance should include audit activity.

Recommendation 13

Essex Safeguarding Adults Board should ensure that all domiciliary care providers are aware of their responsibilities to raise safeguarding concerns and are aware of the mechanism to do this in a timely way and should seek to ensure that providers, where involved, are engaged in multi-agency discussions.

Recommendation 14

The Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should review and reflect within their thematic reviews on recent cases of suicide and homicide, which involve a caring relationship to establish if there are any early signs or indicators to assist in prevention and support. Any findings should be shared with Essex Suicide Prevention Steering Board and Essex Health and Wellbeing Board.

7.7 Domestic Abuse

7.7.1 After consideration the Community Safety Partnership felt this case was more appropriate to be reviewed on a safeguarding basis rather than as a domestic homicide review. After referral to the Home Office and a request from the Home Secretary the case was considered both a Safeguarding Review and Domestic Homicide Review. Whilst the direct circumstances of Kimmi's death are a domestic homicide, the question and consideration of domestic abuse in cases such as this more complex.

7.7.2 Kimmi and Alfred had been married for 42 years, in that time there are no recorded instances of domestic abuse being reported or suspected. The family would strongly refute that there was any domestic abuse in the relationship, they would describe their father as a stubborn and proud man. Alfred described himself as getting frustrated and angry with Kimmi's dementia. Alfred and Kimmi had a group of neighbours and friends who knew them well. Following the deaths, and as part of the enquiry for HM Coroner, some of these made statements. One person described Alfred as being heavy handed and forceful on occasions in his care for Kimmi. He was also described as being domineering towards Kimmi and a person who could be volatile.

7.7.3 Alfred is also described as being loving and caring by both family, neighbours and professionals involved in the care of Kimmi. The carer for Crossroads, who knew the couple well before covid lockdown described the relationship as loving and did not witness any behaviour that they would describe as controlling or abusive. It is absolutely clear that Alfred wanted to care for Kimmi through her dementia in the same way that she had cared for him through his leukaemia. There is no doubt that Alfred found accepting help difficult, this was flagged to agencies by both family and friends. Alfred was also struggling not only to cope with the diagnosis of Kimmi's dementia and the sense of loss but the functional caring aspects of Kimmi's care. In 2018, Alfred contacted the ASC for support having attended a dementia talk, it is clear that Alfred wanted to be actively involved in Kimmi's care. The stress of the caring role was not effectively understood, as previously highlighted.

7.7.4 These difficult circumstances were exacerbated by the challenges presented by the covid pandemic (discussed more fully in the next section) but all these factors conspired together to create for Alfred and Kimmi and their situation 'the perfect storm.'

7.7.5 It is recognised that identification and reporting of domestic abuse in older women is low[26]. This can be due to a number of factors such as generational attitudes[27], an element of acceptance and the lack of services or knowledge of them for older victims. In this case although some who knew Alfred felt he was a forceful character no one reported concerns apart from the anonymous referral in August of 2020, which did allude to abusive behaviour, but as already highlighted was not pursued. Where opportunities are given to older persons, supported by specialist advice the identification of domestic abuse in the group increases. A recent report into hospital based domestic abuse advocacy identified that Independent Domestic Abuse Advisers (IDVAS) based in hospital settings increased the identification of previously hidden victims of domestic abuse, including older victims[28].

7.7.6 The recognition of stress emanating from a carer responsibility is not new. A 2011 report from Association of Directors of Adult Social Care (ADASS) draws a distinction between intentional harm and unintentional harm caused by carers[29]. It makes the case that some of the actions by carers are unintentional and caused by the lack of coping skills. The same report also cites a report from 2009 which details that half of the persons interviewed as part of the study, who were caring for persons with dementia, admitted

[26] 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

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

[28] Dheensa, S., Halliwell, G., Daw, J. *et al.* "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Serv Res* 20, 129 (2020).

[29] ADASS (2011) Safeguarding Adults Advice Note. London: ADASS

being abusive within the recent past.[30]These reports recognise that the effective method of identifying this type of stress and abusive behaviour taking place as a consequence is by careful and effective assessment.

7.7.7 There is clear evidence that Alfred cared deeply for his wife and wanted to support her, at times to the exclusion of other support. This was extremely stressful for Alfred and this was exacerbated by a number of other factors at the time. This at times may have resulted in Alfred presenting in what would be considered as controlling or emotionally abusive behaviour. The extent of this cannot be determined but there were some limited opportunities to intervene and understand this better. What is clear is that there was not generic consideration of the possibilities of abusive behaviour as a risk factor for persons involved in relationships such as Kimmi's and Alfred's and how this could be mitigated. There needs to be better general consideration of the possibility of domestic abuse based on certain known risk factors such as dementia, caring responsibility, mental capacity, inability to verbalise, age, generational factors, and isolation (due to any number of factors but including Covid).

7.7.8 It is interesting that none of the 24 questions on the generic Domestic Abuse Stalking and Harassment (DASH) risk assessment[31] reference any questions in relation older victims or perpetrators, caring responsibility or mental capacity. This area has been raised with Safer Lives. DEWIS Choice, is referenced on the SETDAB website and provides information on safety planning with older people. DEWIS Choice is an initiative in Wales and seeks to provide support to persons of 60 years and above in crisis situations and transform the response for persons in later life[32]. They are currently developing resources for professionals on supporting persons with dementia where there is domestic abuse. SETDAB has already launched an online learning resource on domestic abuse and older persons based on the research from DEWIS Choice.

Learning – There continues to be barriers for older persons reporting domestic abuse and for professionals to consider the possibility of domestic abuse within caring relationships and how this might be addressed. The opportunities for the identification of domestic abuse are limited and there needs to be consideration of how these limited opportunities can be fully maximised to ensure that in relevant cases appropriate support is in place. The J9[33] initiative raises awareness and increases knowledge and understanding of domestic abuse for staff in public and voluntary sector organisations. In the course of their work, staff may come into contact with someone they suspect is a victim of domestic abuse, or a client may reveal that they are suffering abuse. The training

[30] Cooper, Claudia et al, Abuse of people with dementia by family carers: representative cross-sectional survey" quoted in BMJ 2009 338.b155 22 January 2009

[31] Safelives DASH risk assessment checklist - https://safelives.org.uk/node/516 (accessed 02/12/21)

[32] DEWIS Choice - https://dewischoice.org.uk/ (accessed 03/01/22)

[33] J9 - https://setdab.org/j9-initiative/ (accessed 14/02/22)

aims to ensure that staff are equipped to respond appropriately and effectively. This training and initiative should focus on organisations providing services and supporting older persons and in particular those supporting persons with dementia.

Recommendation 15

Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should review how and where messages and information on domestic abuse is made available to forums that older people might access. They should then work with Essex Safeguarding Adults Board to promote these messages.

Recommendation 16

Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should consider how awareness of, and services for, domestic abuse in older persons can be supported and should include.

- Health commissioners consider how sustainable funding can be achieved for health based independent domestic violence advocacy (IDVA).
- That the J9 initiative is implemented in services delivering support for older persons and in particular those suffering with dementia.

Recommendation 17

All agencies involved in this review should cascade and embed the SETDAB domestic abuse and older people E Learning package within their organisations adopting a 'Think Family' approach.

7.8 Impact of covid

7.8.1 There is no doubt that the covid pandemic and the associated effects of it had a significant impact on two areas in this review. The first is the impact to Kimmi and Alfred, their lifestyle and the way in which they were able to interact with their support network. The second is the way in which it impacted on agencies delivering support and care and the ways in which they had to adapt the delivery of their services.

7.8.2 Kimmi and Alfred were receiving support at the time of the first national lockdown in the form of sitting service and had a cleaner who came in to help them. When the first lockdown happened in March 2020, both these support mechanisms stopped. Prior to the lockdown, Kimmi and Alfred went out to dinner once and week and this contact also had to stop. The normal and regular face to face contact they had with family and

friends also stopped. This in effect inhibited the aspects of activity that dementia sufferers are recommended to focus on, being physically, mentally and socially active.

7.8.3 In April 2020, ASC conducted a carer review, although this was post lockdown Alfred did not raise any of the limitations imposed by lockdown as being an issue and there is no evidence that the review considered the impact of covid 19 and the lockdown. The GP had contact in April 2020, with one of Kimmi's daughters regarding a diabetes prevention referral and later in the same month for an annual dementia review when Alfred was spoken to. During the contact with Alfred he was positive, stating that Kimmi was stable, managing her own personal care and did not require any further support. During these contacts there is a lack of evidence that the additional pressures from the covid pandemic were considered. The GP made a 'safe and well call' in June 2020 in response to the covid pandemic, which is good practice but again Alfred stated they had all the support they needed.

7.8.4 In the early stages of the first lockdown and as time progressed, agencies were working within new covid guidance and increased pressure. This is articulated in the IMR's for this review. Agencies implemented working from home policies and face to face contact with clients and colleagues was limited. Agencies also highlighted high levels of staff shortages due to sickness and staff having to isolate. The pressure and increased workloads during this period should not be overlooked.

Learning – Most of the learning of the pressures of the covid pandemic have been highlighted in other sections of this report. The general effect of the pandemic was to magnify and expand the pressures that already existed for individuals and professionals exponentially.

7.9 Firearms Licencing

7.9.1 Alfred was a licenced shotgun and firearms certificate holder and had been so for firearms since 1987 and for shotguns since 1989. He had lawful possession of six shotguns and two firearms. For a person to be permitted to possess firearms the Chief Officer of police for the area must be satisfied the person has good reason to possess a shotgun, firearm or ammunition, has the ability to store them securely and has the intention to use them reasonably and lawfully without endangering public safety.[34]

7.9.2 It is apparent that Alfred had been taking prescribed anti-depressant medication since 2008, this had been reviewed on an annual basis by his GP. At the time of the first

[34] Firearms Act 1968 (as amended) allows the Chief Officer to delegate powers specified within the act.

prescription of this medication and on each firearms renewal thereafter Alfred would have been expected to notify the police firearms licensing department. This information would have initiated a review on Alfred's suitability to possess firearms and may have initiated an enquiry with his GP for further information. It is not possible to say whether there would have been any changes in the licensing arrangements for Alfred, this would depend on the assessments undertaken on the circumstances that existed at the time.

7.9.2 Both Firearms and Shotgun certificates have an application process and a process for renewal. The process of application and granting a certificate is more stringent than that of a renewal. A renewal is progressed very much on a basis of changes since the last renewal and on a risk basis. Alfred last had his licences renewed in February 2017 and they were next scheduled to be renewed in January 2022. On the last renewal in 2017, Alfred was deemed low risk, being under the age of 70 at the time of the renewal and no issues had been highlighted. This being the case the renewal was progressed by telephone interview, in line with the guidance.[35]

7.9.3 There is a record that Alfred's leukaemia was discussed and considered. The licences were renewed under the category of minimal concern or change and that a visit should be undertaken every two years. A letter was sent to the GP and no concerns were raised. The Police IMR concludes that the shotgun/firearm certificates were issued in accordance with policies and procedures at the time and therefore appropriately.

7.9.4 There was a change in procedure in April 2020, all applications must now be accompanied by a Medical Screening Report (MSR) from the GP. This requires the applicant to make a full medical disclosure which informs the GP of the application and requires the GP to place a Firearm Alert code on the patients GP record. There is no requirement for a GP to monitor or assess a patient who holds a certificate but there is a duty for a GP to disclose information where they believe the patient may present a risk of death of serious harm to themselves or another.[36]At the time of the 2017 renewal the MSR process was not in place but after the renewal was agreed a post issue letter was sent to the GP, allowing the GP to notify of any relevant medical condition. On the renewal for Alfred in 2017 there was no information received by the police licensing department from the GP.

7.9.5 It has been recognised nationally that the response from GP's to MSR's has been variable and as a result licences have been issued on the basis that there is no medical information, where in fact there has been no response from the GP. British Medical Association Guidance states that GP's can refuse to engage the firearms certification

[35] Essex Police Procedures – Licensing of Firearms, 2016
[36] Home Office Guidance on Firearms Licensing Law, April 2016

process on the grounds of conscientious objection because of religious or ethical beliefs. If this is the case they should inform the police.[37]

7.9.6 In these circumstances it would have been very difficult for professionals to be aware that Alfred was a firearms licence holder and that there were firearms held on the premises. His renewal in 2017, pre-dated Kimmi's diagnosis of dementia and Alfred becoming a carer. The alert for firearms would be on Alfred's GP record and not on Kimmi's. Although health staff from the community healthcare provider have access to the health IT system it would only be by checking Alfred's record that the alert would be apparent.

7.9.7 The lead for the domiciliary care provider was very robust during discussions for this review that as a care provider with a responsibility for the safety of staff, they would not have provided staff to the address had there been a knowledge of firearms on the premises. The health staff for community healthcare provider are encouraged to ask the client a question regarding firearms being on the premises but during interview for this review disclosed that they had never been confident to do so.

7.9.8 The home address was a working farm in a rural area and Alfred was a working farmer, it could be reasonably considered that Alfred would have lawful access to firearms and as such all agencies should be encouraged to ask persons to self-disclose the existence of firearms on premises as part of a risk assessment when committing staff to the environment. This review fully accepts that this will not capture the existence of non-legally held firearms or that harm can be caused in any number of ways. That said, this review and others have recently shown that where there is ready access to firearms they are used in a homicide/suicide context.

7.9.9 Creating a more general awareness of the existence of firearms held on a legal basis, information that is readily available to police, has created a challenge to this and other reviews. A previous review involving firearms (mentioned in the terms of reference for this review) led to the changes implemented in 2020, for the alerts for be present on a person's records. It also made a recommendation regarding a licence holder accessing a memory clinic. This is now in place with the duty placed on the GP for notification of concerns. This aspect would not have impacted on this case as it was Kimmi and not Alfred the licence holder, accessing the memory service.

7.9.10 It would seem that the best way for agencies be able to access information on firearms being held would be when a notification is sent from police (MSR) that an alert is placed on the address of the licence holder as opposed to the individual, in effect a 'firearm

[37] British Medical Association – The Firearms Licensing Process (2021) - https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/the-firearms-licensing-process (accessed 04/01/22)

held at address' marker. This may require an alert being placed on more than one person's record as SystemOne (Health IT system) works on individual records. It is recognised that all health agencies and indeed other agencies do not have access to SystemOne. Consideration could be given to how these other agencies can be notified of the existence of firearms. This may be by ensuring that other agencies, as well as the GP, are sent the MSR.

7.9.11 The GP practice involved in this case has partnered with Essex Police and The British Association for Shooting and Conservation to introduce an initiative focused on suicide prevention to ensure that there is good information exchange to allow better assessment of risk on the possession of licensed firearms. This involves the GP practice audit clerk reviewing all records and ensuring alerts are on all relevant records. They have also developed a package of awareness training and the initiative involves a training for staff in GP practices. The partners should be congratulated on this excellent initiative and should seek to ensure that this good practice is widely shared.

7.9.12 There are currently over 25,000 shotgun or firearms certificates on issue in Essex (20729 shotgun and 5130 firearms)[38]. It would not be feasible to undertake an audit on these to establish if each has a corresponding record on SystemOne but a starting point may be to interrogate the health system as to how many firearm alerts there currently are on the system to understand how this equates with the number of firearms on issue.

Learning – There still remains a significant challenge in transferring information on persons who legally hold firearm certificates and therefore possess firearms. This presents a potential risk to those persons, their families, the general public and professionals who interact with those persons on a regular basis in a mixture of risk-based scenarios. Whilst this information is known within the wider safeguarding system it creates a liability where it is not disclosed to those who would need the information to inform risk assessment.

Recommendation 18

Essex Police to form a working group with the relevant partners of Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board SETDAB to :-

- Better understand if there are methods of providing firearms licensing information to agencies involved with persons in potential risk situations.

[38] Home Office National Statistics, July 2020, Firearm and Shotgun certificates

- Outline the Firearms Suicide Prevention Workshops which are already being delivered and seek to widen the range of participants of these.
- Raise awareness of how practitioners working within health and safeguarding across all agencies can quickly and easily learn if a person of concern is a licensed firearms holder, or if there are legally held firearms at the address.

Recommendation 19

The Home Office should initiate discussions to establish if the National Firearms Licensing System managed by the Home Office could be made available on a restricted basis to appropriate partners for the purpose of managing and mitigating risk.

Recommendation 20

Essex Integrated Care Board works with Essex Police to roll out the suicide prevention programme to all Essex GP practices and involves Essex Suicide Prevention Steering Board.

8. Conclusions

8.1 This is a tragic case where a person who wished to care for his wife felt that there was no option for them except to take her life and then take his own. Whilst this review does not seek to excuse Alfred's actions, it does seek to understand them. This case, as others in the Essex area and wider have demonstrated, is that there is still the need for better consideration and implementation of the Care Act in relation to the assessment of carers and being able to support them. This has to been seen as a critical area, particularly as we rely on around 1 in 8 adults to provide care. For carers coming to terms with a close relative with dementia there should be support which helps them to understand what they are likely to encounter and how they can navigate this.

8.2 When Kimmi was discharged from hospital the family found the provision of services confusing and uncoordinated. This was at a time when agencies were encountering a very challenging time due to the covid pandemic, but agencies need to plan how the services are delivered and how they can be more coordinated as the issues of the pandemic continue to be present.

8.3 There needs to be better understanding of the generational attitudes and barriers to persons being able to accept support. How these attitudes effect and impact those who are close to them and who may rely upon them. Agencies need to better understand how the stress from caring for someone can manifest, be able to identify this and be able to support people to prevent the situation becoming worse and potentially manifesting in other forms of abuse. This review found that a key area was understanding the person and their circumstances by having good quality conversations

which are recorded to provide a foundation for care and support as time goes on.

8.4 The use of lawfully possessed firearms needs to be considered, it is apparent that when they are available and accessible, they will be used by those with tendencies towards homicide and suicide in a domestic scenario. Whilst it is fully accepted that other means of harm could easily be adopted, we need to be able to identify better means of making relevant persons aware of the existence of firearms.

9. Recommendations

As part of the review process agencies were asked to reflect and identify areas of development and recommendations for their organisations. Some have demonstrated significant reflection. These areas and recommendations are shown at appendix B.

Recommendation 1

The Mid Essex Clinical Commissioning Group, Memory Assessment and Support Service (EPUT) and Alzheimer's Society review the dementia diagnosis pathway to ensure that there is a fully joined up approach to ensure that patient receives full information regarding support and that information is clearly understood. This should include: -

- Appropriate use of Mental Capacity Assessment at relevant times.
- What support is available and how it can be accessed.
- That there is clear enquiry into and recording of the patient's wishes and plans for the future.
- That there is consideration of a carer assessment and carer stress.
- That there are clear and routine enquiry and recording into social and financial circumstances to include the consideration of domestic abuse.

Recommendation 2

All agencies should ensure that enquiry is made at an early stage as to whether a person has in place an Enduring or Lasting Power of Attorney and that the provisions of the authority are well understood by all parties. Where possible the authority should be seen and recorded and where there is any doubt an enquiry should be made to the Office of Public Guardian.

Recommendation 3

The Essex Safeguarding Adults 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 as identified in the *Valerie* review.

Recommendation 4

All agencies involved in this review should consider how they deliver services to those suffering with dementia and how a whole family approach would assist the person and those supporting them. There should be clear consideration of the stress that can be present for those family members with caring responsibilities. This should be support by appropriate training.

Recommendation 5

Mid and South Essex NHS Foundation Trust, Essex Adult Social Care and EPUT need to ensure that where a person is eligible for funding to support care that this is made clear to the person, and where appropriate the family, in order that informed decisions on ongoing care can be made.

Recommendation 6

Where Adult Social Care commission care providers outside of the usual arrangements they need to ensure that the care provider is supported by a care coordinator and that the provider is part of weekly multi-disciplinary meetings.

Recommendation 7

All agencies involved in the hospital discharge process need to ensure that carers are involved in the process and their needs are considered and where necessary a carers assessment takes place post discharge.

Recommendation 8

Essex Safeguarding Adults Board should give consideration as to how to support agencies in understanding the importance of carer assessments and advise on how the offer can made more accessible and effective to carers.

Recommendation 9

Mid and South Essex NHS Hospital Trust should ensure that when formulating discharge plans for persons with dementia that relevant dementia services are included in the plan and appropriately notified of the discharge.

Recommendation 10

That the Discharge to Assess approach continues to be developed across all areas of Essex which will include embedding the care coordinator approach on discharge and developing a

multi-agency discharge hub. To ensure that this development maintains multi-agency focus there should be effective oversight of the development plan from the Integrated Care Board.

Recommendation 11

Essex Adult Social Care and Provide should ensure that the responsibilities for the procurement of equipment to support patients on their discharge from hospital is well understood by all parties concerned and is seamless to avoid confusion and delay to the patient.

Recommendation 12

Mid and South Essex NHS Hospital Trust should ensure that every safeguarding concern raised is appropriately investigated and recorded in accordance with current policy and procedures, this assurance should include audit activity.

Recommendation 13

Essex Safeguarding Adults Board should ensure that all domiciliary care providers are aware of their responsibilities to raise safeguarding concerns and are aware of the mechanism to do this in a timely way and should seek to ensure that providers, where involved, are engaged in multi-agency discussions.

Recommendation 14

The Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should review and reflect within their thematic reviews on recent cases of suicide and homicide, which involve a caring relationship to establish if there are any early signs or indicators to assist in prevention and support. Any findings should be shared with Essex Suicide Prevention Steering Board and Essex Health and Wellbeing Board.

Recommendation 15

Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should review how and where messages and information on domestic abuse is made available to forums that older people might access. They should then work with Essex Safeguarding Adults Board to promote these messages.

Recommendation 16

Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board should consider how awareness of, and services for, domestic abuse in older persons can be supported and should include.

- Health commissioners consider how sustainable funding can be achieved for health based independent domestic violence advocacy (IDVA).

- That the J9 initiative is implemented in services delivering support for older persons and in particular those suffering with dementia.

Recommendation 17

All agencies involved in this review should cascade and embed the SETDAB domestic abuse and older people E Learning package within their organisations adopting a 'Think Family' approach.

Recommendation 18

Essex Police to form a working group with the relevant partners of Essex Safeguarding Adults Board and Southend, Essex and Thurrock Domestic Abuse Board SETDAB to :-

- Better understand if there are methods of providing firearms licensing information to agencies involved with persons in potential risk situations.
- Outline the Firearms Suicide Prevention Workshops which are already being delivered and seek to widen the range of participants of these.
- Raise awareness of how practitioners working within health and safeguarding across all agencies can quickly and easily learn if a person of concern is a licensed firearms holder, or if there are legally held firearms at the address.

Recommendation 19

The Home Office should initiate discussions to establish if the National Firearms Licensing System managed by the Home Office could be made available on a restricted basis to appropriate partners for the purpose of managing and mitigating risk.

Recommendation 20

Essex Integrated Care Board works with Essex Police to roll out the suicide prevention programme to all Essex GP practices and involves Essex Suicide Prevention Steering Board.

Recommendation 21

Southend, Essex and Thurrock Domestic Abuse Board and Essex Safeguarding Adults Board should seek assurance that where agencies have identified recommendations or areas of development for their own organisation there is plan for these to be implemented. (At appendix B).

Appendix A

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

Victim:

Name of Victim:	Kimmi

Suspected perpetrator:

Name of suspected Perpetrator:	Alfred

1 Introduction

1.1 Kimmi and Alfred were a husband and wife and lived on a working farm in Essex. They had been married for a number of years and have three daughters who no longer lived with them. In October 2020, emergency services attended the farm on the report of a female with gunshot wounds and a male stating that he was going to shoot himself. Ambulance and police discovered Kimmi and Alfred with injuries consistent with being shot. They were conveyed to hospital where they subsequently died. A police investigation followed which determined that Alfred had shot his wife and then shot himself, with a legally held firearm.

1.2 Prior to their deaths both Kimmi and Alfred had been supported by services over a period of years. Alfred had been a long sufferer of Leukaemia (Plasma Cytoid Dendritic Cell Neoplasm). Five years ago, Kimmi had been diagnosed with Vascular Dementia, and Alfred effectively became her carer. From February 2019, Alfred was supported in his care of Kimmi by a sitting service.

1.3 The Covid lockdown which started in March 2020, impacted not only on Kimmi's and Alfred's lifestyle but also on the service that agencies were able to support them with.

1.4 In July 2020, Kimmi suffered a fall at home and fractured her right hip. After treatment Kimmi was discharged from hospital. A package of support was put in place, which was part funded by the family. Alfred and the family were very involved with the provision of care and at various time expressed concerns of the care being provided.

1.5 At the beginning of October 2020, the care provider raised a safeguarding concern over Alfred's treatment of Kimmi. This was reported to the Local Authority and an enquiry

commenced. Adult Care Services contacted the family with the concerns on the understanding that they would approach Alfred in the first instance. The following day, what transpired to be fatal injuries, were caused to Kimmi and Alfred.

2 Principles of the review

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

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 Objective, independent & evidence based.

3 Key lines of enquiry

3.1 The Review Panel and involved agencies will consider the following: -

Case specific

1. To develop an understanding of Kimmi's vulnerabilities, her health and care needs, capacity to care for herself and her level of independence, and consider how effective was inter-agency collaboration, communication and information sharing in providing treatment to Kimmi.
2. To what extent were Alfred's carers needs assessed and were carers assessments offered? Was there stress in the caring relationship and if so, how did it present for Kimmi and Alfred?
3. To identify any difficulties agencies encountered when supporting Kimmi that impacted on the case?
4. To consider whether protected characteristics as codified by the Equality Act 2010 impacted on Kimmi's care and case management (Race, Religion or belief, Age, Sex,

Sexual orientation, Pregnancy and maternity, Gender reassignment, Marriage or civil partnership, Disability)

5. To what extent was Kimmi's voice heard and her wishes and feelings considered, understood and respected by practitioners when planning her care and assessing risk, including risk to others?
6. To identify whether agencies complied with any safeguarding protocols that have been agreed within and between agencies including protocols covering:

- Raising safeguarding concerns.
- Information sharing.
- Risk assessment, management and review

7. To explore firearms licensing and renewal processes, including when and how they are renewed and what information is considered when assessing suitability? How can concerns regarding health, domestic abuse and caring stressors be shared with Essex Police firearms licensing to enable appropriate assessment of risk?
8. To review the previous DHR commissioned in Essex which touched on firearms licensing of vulnerable persons to explore the extent of information sharing with General Practitioners and other agencies when assessing suitability? To establish the extent and sustainability of any changes of procedure.
9. Whether preventative actions could have been taken by agencies?
10. To understand how older victims of domestic abuse are identified in Essex and explore domestic abuse service provision across Essex for older adults or those with dementia experiencing abuse.
11. To understand the impact of the Covid pandemic on both Kimmi and Alfred and the agencies providing services to them.
12. To identify any best practice that was in place.

4 Scope of the Review

Agency	Panel Member	IMR/ Chronology	Summary report
Essex County Council, Adult Social Care	Yes	Yes	
Essex Partnership University Foundation Trust (EPUT)	Yes	Yes	
Mid Essex CCG (MECCG)	Yes	Yes	
Provide	Yes	Yes	
Essex Safeguarding Adults Board	Yes	No	
Essex Police	Yes	Yes	

Mid and South Essex NHS Foundation Trust (Basildon Hospital)	Yes	Yes	
Domiciliary Care Provider	Yes	Yes	
Domestic Abuse Provider	Yes	No	
Southend, Essex and Thurrock Domestic Abuse Board	Yes	No	

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 January 2017 – 4th October 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 Media strategy

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

8 Chairing & Governance

8.1 An independent chair has been appointed to lead on all aspects of the review and will report to 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. The Essex Safeguarding Adults Board will sign off the final report and associated action plan.

Appendix B

Agency self-identified recommendations and areas of development

Provide

All staff to be reminded of the importance of completing MCA assessments in a timely manner and to check completion if delegating this to another member of the team.

Provide to raise awareness with staff around the use of the Firearms icon and the need to ask questions about firearms within Holistic and risk assessments.

Mid and South Essex NHS Trust

Additional learning from the ongoing SAR process will be incorporated into training and the safeguarding procedures. Safeguarding procedures to include advice regarding anonymous allegations.
Mental Capacity and Best Interest Policy has been reviewed and updated since this incident. Further communication and learning on the use of best interest decision making to be undertaken.
Actions from this SAR will be included within the Safeguarding Strategic plan and monitored by the MSE Safeguarding Committee. This will comply with SMART principles (Specific, Measurable, Achievable, Realistic and Time specific).
Safeguarding Team to be informed that anonymous safeguarding concerns must be discussed with the Safeguarding Team within Social Care. Decision not to further investigate anonymous allegations must not the sole decision of one agency so that information can be shared to safeguard the individual.

Mid Essex CCG

Consideration of a working group to be established to discuss and clarify Essex Police process and how health professionals can support the Firearms Certification process to protect the most vulnerable *(see References - Wessex)*
Include consideration of 'flags' within S1 records to identify those patients who are holders of firearms certificates.

Learning and development in terms of:

- how a person with dementia has their previous wishes captured
- mental capacity assessments – enable more person-centred approach
- independent advocates and their role – the ability to support/represent people who have a diagnosis of dementia – authorisation of a person's 'lost voice' to represented

• power of attorney – insight into who is allowed to make decisions on behalf of another person

A meeting will be offered with DMC to establish learning from this review
Consideration of points below:

- Lead professional should be identified to oversee all agencies involved with vulnerable patients – improve partnership working and a person-centred approach.
- Documentation within S1 records should indicate whether there are any concerns regarding patients and their mental capacity and ability to consent – is further learning regarding mental capacity assessment/s required.
- Additional learning from the ongoing SAR process will be incorporated.
- An action plan will be formulated to reflect the above. This will comply with SMART principles (Specific, Measurable, Achievable, Realistic and Time specific.

Essex Adult Social Care

- Following on from this incident, there were recommendations and actions that were taken within the Discharge to Assess team. These included inter-team communication, allocation process and case management support. These actions and recommendations to be reviewed with the Discharge to Assess Team by 1 October 2021.

- The Discharge to Assess approach in Mid Essex, is still in the process of developing and the Hospital Discharge and Community Support: Policy and Operating Model (updated July 2021) is a continuum from the Covid 19 Hospital Discharge Requirements set out in March 2020. From the Councils perspective, there need to be a clear understanding of how Discharge to Assess will be supported and developed within each quadrant, enabling multi-agency discussions to progress at pace. Internal ECC workshop on the 26 September 2020 to consider elements of this case, in recognising the developments required in considering needs of carers as part of the discharge, embedding a care co-ordination approach on discharge, and the support in developing a multi-agency discharge hup/care co-ordination centre. Action Plan to be agreed as part of this workshop, of which supports a multi-agency approach.

- Adult Social Care Connect complete the Carers Assessments and reviews for those carers where the 'cared for person' is not known to Essex County Council, for example, they may be arranging their own care. Carer's Assessments and Reviews for this cohort, needs to demonstrate consideration for a Care Act Assessment being discussed for the Cared for Person and support that the cared for person is receiving from MDT, which will have a bearing on the impact of caring on the carer. The Contact Centre Lead, to work

with her team, in reviewing practice and implementing plan to ensure this is happening and provide an update to Practice Governance Board by 1 December 2021.

- Carers Assessments need to be considered as part of the Discharge to Assess process from Acute and Community Hospitals and will be addressed as part of the Discharge to Assess implementation plans within Essex, with system partners. However, in the meantime, a piece of work, will be led by Adult Social Care on how the ward led referrals are considering carers needs, ensuring that the discharge plan considers immediate needs and enabling Adult Social Care to determine the urgency of completing Carers Assessments. Initial discussions and implementation plan to be agreed with Broomfield hospital by 1 October 2021.

- Alongside the above, for those discharged on a reablement program, arrangements for Carers Assessments to be considered at point of initial assessment by the reablement provider, and an early referral to be progressed to ASC, if indication that it cannot wait until the cared for persons assessment is completed. For those adults transferred to an Interim Placement on discharge from Hospital, before the adult goes home, Carers Assessment will be offered in all cases. Communication to be sent to reablement providers by 1 October 2021 and the Discharge to Assess team to ensure that carers needs are considered and recorded as part of the welfare calls that they are currently making, post discharge.

- Internal communication with all ASC staff reminding of the need to complete Carer's assessments and review, when there is any indication of a change in the level of care that the carer is having to provide or indication that the caring role has been having an increase impact on wellbeing. This will also include consideration of the sustainability of the carers support and understanding the impact on carers when there is an increase reliance of more formal support.

- As part of the ASC Connect program the plan is to reduce the use of spot purchased domiciliary providers as in lieu or reablement services by increasing the capacity of the dedicated reablement provider EC. As part of this there are weekly improvement cycles in Mid Essex. However there remains currently, a reliance on domiciliary providers to provide this service. All adults using this service will now have a care manager/care co-ordinator allocated by the Discharge to Assess team, at point of discharge, where planning for assessments, including MDT involvement will start. Review of this approach by the 1 December 2021 led by Team Managers of the Discharge to Assess service.

- All staff reminded to ensure that reablement services are not ended until:

  a. for those adults who have agreed for a Care Act Assessments to be completed, that the ongoing support plan is agreed.

b. for those who do not want a Care Act Assessment and who have agreed to arrange their own care that there is clear communication with them from Adult Social Care around the end date of the service and opportunity for the adult to discuss any risks associated with potential gaps between the end of reablement and in them arranging on going services.

- Review of the current training offer to ASC staff in managing conflict and having difficult conversations and ensuring that this will be incorporated into the requirements of the Systemic Practice training that is currently in the early planning stages. This recommendation to be taken forward forward with Service Manager for Safeguarding and Quality Assurance have recommendations that inform the systemic practice training by 1 October 2021.

- Practice session on recording of case note with Practice Leads and Senior OT to be arranged for the Discharge to Assess teams, focusing on good practice, with a structured approach using the SOAP approach (Subjective, Objective, Analysis and Plan). Practice sessions to be completed by 1 December 2021 and a review of the content and outcome to be provided to Mid Service Managers by D2A Team manager by 1 January 2022

- Practice of appending case notes to be reviewed by Practice Leads and recommendations to be considered at the ASC Practice Governance Board by 1 October 2021

- Adult Social Care have updated their guidance in relation to Home Visits in response to the easing of restrictions and the approach within the Discharge to Assess Team is that not visiting the adult to complete and assessment, is the exception. The Managers of the Discharge to Assess Teams have been asked to complete a proportional audit on activity over a 2-week period in September in relation to face to face visits and report back to Mid Service Managers on the outcome by end of September 2021.

- As part of the Connect Supporting Independence (SID) program, allocation meeting and SID meetings, which provides a forum to discuss cases that are stuck, have been introduced into the Neighbourhood teams within Mid Essex, with a weekly improvement cycle review. Consideration now needs to be given to rolling this out within the Discharge to Assess teams and need to have an implementation plan agreed by 1 October 2021. In the meantime, evidence that case workers are demonstrating their planning in relation to completing assessments and reviews, and this to be clearly recorded on Mosaic with Team Managers reviewing this, as part of their Quality Assurance process.

- There is a new Quality Assurance process being implemented in Adult Social Care and this is being piloted within Discharge to Assess Teams in October and November 2021. The learning and recommendations from this case will be shared with the officers completing the audit process, requesting that there is particular attention given to these.

- The role of Community Support Workers within the Discharge to Assess Team in Mid Essex had been reviewed following the incident and this included the complexity of allocations. Further review of the resources required within a discharge to assess needs to be carried out as part of the systemwide development of discharge to assess teams and timescale for this to be kept under review.

- When working with adults who have arrangements for LPA in place, such arrangements need to be clearly documented and copies of LPA documents to be available within Mosaic Case Management system. Communication to go to all staff in Mid Essex by 20 of September 2021 reminding them of this requirement.

- There needs to be further practice development with the Adult Social Care teams in Mid Essex in relation to the interdependency between safeguard referral, assessments, and reviews in making safeguarding personal. This will promote a culture of considering the impact on the adult of the safeguard from point of initial verbal reports rather than waiting for the formal referral to be made. Development plan with Practice Leads and Senior Social Workers to be agreed by 1 October 2021

- Adult Social Care to implement the systemic concept of Safe Uncertainty in managing safeguard referral, from point of triage to investigations. Plans are in early stage of inception and linked to Systemic Practice Training (which is one of the 6 key priorities agreed by the Practice Governance Board) expect to have pilot sites by end of January 2022.

- There needs to be consideration on training to Adult Social Care Staff on early signs or indication of risks associated with Homicide and Suicide. This should include scenarios where this is potentially a planned approach by both parties, or situations where there is potential or actual domestic abuse. A paper to be taken to the Practice Governance Board a paper for discussion in order to determine training and practice requirements.

- There is a need to remind the workforce in how they manage information around risk to vulnerable adults, that come to their attention outside of work and as part of their private life. In Mid Essex, this will review this, in the context of registration requirements for social workers and occupational therapists, by a group of practitioners and recommendations to be reported back to Service Managers by 1 December 2020.

Essex Police

No self-identified recommendations

Essex Partnership University Foundation NHS Trust

No self-identified recommendations