Safeguarding Adult Review

Domestic Homicide Review

Executive summary

Case of Carol

(Died January 2023)

July 2024

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Contents

Foreword

Any death is a tragedy for the family. This review is particularly sad due to the circumstances and how those impact on any family. The panel formed to conduct this review and the independent author would like to extend to Carol's family their sincere condolences and respect their decision not to engage in the review process.

1. The Review Process

1.1 Introduction

1.1.1 This is a combined review which brings together the requirements of a Domestic Homicide Review (DHR) and a Safeguarding Adult Review (SAR) into the circumstances of the death of Carol. This Executive summary will focus on the Domestic Homicide Review.

1.1.2 At the time of her death Carol was 88 years of age. Carol was diagnosed with dementia in November 2019. Carol had two adult sons, Paul and David. More latterly Paul had lived with his mother.

1.1.3 In May 2021, family members raised a concern with Adult Social Care (ASC) citing concerns over Carol's safety and requested an urgent assessment. Assessments were undertaken by ASC in May 2021 and again in July 2022. As a result, Carol was provided with a formal care package.

1.1.4 Over a period of time, Paul tried to cancel the care package on Carol's behalf. The domiciliary care provider (DCP) highlighted on a number of occasions that they had concerns regarding the cancellation of the care package based on Carol's ability to cope without the support.

1.1.5 In September 2022, the care package was concluded at Carol's request. At the end of January 2023, paramedics were called to Carol's address on the report of an 88-year-old female who was unresponsive and not eaten for several days.

1.1.6 On attendance the paramedics found Carol naked on the floor, covered with a duvet. Paul stated his mother had been there for three days and that he could not move her. It transpired that Paul had attended work and left her on the floor. Carol was found to be hypotensive and hypothermic. Carol was taken to hospital and died later that evening.

1.1.7 Paul was interviewed by police and a file of evidence has been submitted to the Crown Prosecution Service (CPS) to support a case of causing or allowing the death of a vulnerable adult.[1] Paul was not convicted of any offences.

[1] Section 5, Domestic Violence, Crime and Victims Act 2004

1.2 The purpose of a Domestic Homicide Review (DHR)

1.2.1 The case was referred to the Southend, Essex and Thurrock (SET) Domestic Abuse Board and Rochford Community Safety Partnership (CSP) by Essex Police in February 2023. The SET Core Group convened in March 2023, and considered the circumstances of the case, with the assistance of thorough scoping from relevant organisations. The core group agreed that the case met the criteria for a DHR in accordance with the statutory guidance under section 9(1) of the Domestic Violence, Crime and Victims Act 2004.[2]

1.2.2 The purpose of a DHR is to: -

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
c) apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
e) contribute to a better understanding of the nature of domestic violence and abuse.
f) highlight good practice.[3]

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

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— A and B are each aged 16 or over and are "personally connected" to each other, and the behaviour is abusive. Behaviour is "abusive" if it consists of any of the following— physical or sexual abuse; violent or threatening behaviour;

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

[3] 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 17/10/23].

controlling or coercive behaviour; economic abuse psychological, emotional or other abuse.

1.2.4 The Domestic Abuse definition specifically states:

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependant 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.

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

1.3 The purpose of a Safeguarding Adult review (SAR)

1.3.1 Section 44 of the Care Act 2014 sets out that Safeguarding Adult Boards must arrange a Safeguarding Adult Review (SAR) 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.

1.3.2 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.

1.3.3 This case was discussed at the Essex Safeguarding Board review sub-group, and it was agreed that the circumstances surrounding Carol's death meet the criteria for a SAR.

2. Contributors to the review

2.1 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	
Michala Jury	Board Manager	Essex Safeguarding Adults Board (ESAB)

James Butler	ESAB Safeguarding Adults Review Officer	Essex Safeguarding Adults Board
Val Billings	Senior DA Partnership Officer	Southend, Essex and Thurrock Domestic Abuse Board
Kylie Rowsthorne	Project Officer	Southend, Essex and Thurrock Domestic Abuse Board
Jane Norris	Service Manager	Adult Care Services, Essex County Council
Ben Pedro-Anido	Detective Inspector	Essex Police
Louise Barrow	Operations Manager	Novus Care
Emma Dymock	Head of Operations	Novus Care
Tendayi Musundire	Head of Safeguarding	Essex Partnership University Trust
Gemma Tomsett	Dementia Support Manager	Alzheimer's Society
Tania Woodgate	CEO	Changing Pathways (Domestic Abuse Service)
Andy Parkman	Community Safety Manager	Community Safety Partnership
Paul Bedwell	Safeguarding Business Manager	East of England Ambulance Service

3. Agencies involved

3.1 The following organisations provided information to the reviews to the level indicated below: -

Agency	**IMR[4]/ Chronology**	**Summary Report**
Rochford District Council – Community Safety Partnership (CSP)		X
Essex Adult Social Care (ASC)	X	
Essex Police		X
East of England Ambulance Service Trust (EEAST)		X
Audley Mills Surgery		X
Novus Care	X	

[4] IMR – Individual Management Report – a more detailed report with analysis

Essex Partnership University NHS Trust (EPUT)		X
Southend Adult Care Services		X

4. Author of the overview report

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

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

4.3 Since retirement from the police, he has been the chair of a charity delivering domestic abuse outreach and refuge. He has chaired a Quality and Effectiveness Board for a CCG and is currently the Independent Chair for an Adult and Children Safeguarding Partnership in another area.

4.4 The chair and author has undertaken Safeguarding Adult Reviews, Domestic Homicide Reviews, Safeguarding Children Practice Reviews and Multi-Agency Public Protection Procedures Serious Case Reviews and has undertaken the AAFDA accredited training on undertaking a DHR. The author maintains continuous professional development as a member of the AAFDA Domestic Homicide Review Network.

5. Terms of reference for the review

5.1 The panel drafted and agreed terms of reference for the reviews. This included identified key learning areas.

- To understand the relationship between Carol and Paul and in particular the context of him supporting her.

- To understand whether there was consideration of a carers assessment for Paul and how his views and wishes were understood.

- To understand what Carol's care and support needs were, how these were assessed and were the plans put in place appropriate.

- To understand whether Carol had autonomy and capacity to make decisions regarding her care, and what safeguarding and oversight was in place to ensure the care she received was adequate and in her best interests.

- To understand to what level dementia was impacting on Carol and how this was being supported.

- To understand if there was any form of control or coercion exerted on Carol.

- To understand what the concerns were regarding the care being reduced for Carol and how those concerns were raised and addressed.

- What evidence is there that care and support was person centred and that Carol's voice, including her lived experience and wishes, was present in the discussions and decisions made?

- Was Carol ever considered or assessed for support from Continuing Health Care?

Standard considerations

- Whether local service provision for domestic abuse is adequate and sufficiently prioritised in local planning arrangements. In particular, services that can be identified by and accessed by older people.

- Whether local agencies have robust domestic abuse and safeguarding policies and procedures in place both individually and on a multi-agency basis?

- Whether training is available to, and accessed by, staff in relation to responding to the above issues?

- Were the principles of Making Safeguarding Personal demonstrated in practice?

Good practice

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

5.2 The time parameters that the review will focus on are from 1st September 2020 - 22nd January 2023. It was also made clear to agencies that any matter which was outside this timeframe but was considered relevant should be included in their report.

6. Summary chronology

6.1 In September 2020, a safeguarding referral was made to ASC by Carol's grandchild, a concern was raised and both Carol and her grandchild were spoken to by a social worker at some length. The recording of this dialogue is extensive and clearly shows that Carol was able to express her views and wishes. The records would indicate that whilst Carol was suffering some memory loss, she acknowledged this, but she was able to make her wishes known.

6.2 The safeguarding concern was closed later the same month on the basis that Carol had received information and advice to assist her, and the family were arranging some housework support for her. Carol and her family were asked whether they were happy with the action taken and they agreed they were.

6.3 In September 2020, Carol had a virtual diabetes clinic with her GP. The review showed that Carol had not been taking her medication for about one year. This was discussed with Carol's grandchild in November 2020, and she said she would get blister packs arranged.

6.4 In May 2021, Carol was again assessed in virtual diabetes clinic. It was evident that Carol was still not taking her medication. Prescriptions had not been requested or issued for some time. A plan was made for a GP home visit, which took place within one week. The GP also wrote to ASC requesting an assessment for Carol.

6.5 The visit by the GP was undertaken with a neighbour present. The neighbour also made an 'anonymous' referral to ASC raising a concern regarding Carol being able to care for herself, with evidence of rotting food and maggots in the kitchen. This coincided with the concern raised by the GP.

6.6 Carol's grandchild also contacted ASC and spoke with a social worker and explained her concerns regarding Carol's ability to care for herself and in

particular her inability to manage her medication. The social worker arranged to visit the following day.

6.7 The safeguarding concern was closed with the conclusion that an adult social care assessment and care planning was more appropriate. The assessment recorded that Carol had dementia but maintained a good level of independence. Also, that twice daily care package (30 minutes each) should be put in place.

6.8 Before the care package started there continued to be concerns raised about Carol's ability to support herself.

6.9 An initiation form was sent by ASC to the Domiciliary Care Provider (DCP) with care to commence in mid July 2021. The form included that Carol had a dementia diagnosis, which manifested in her over-buying food, which then deteriorated. It requested assistance with daily tasks including medication management. It acknowledged that there was a son living at the address, but he did not appear to be in a position to provide the care that Carol required.

6.10 Within three weeks the care package was reduced to one call per day with the evening call being dropped on the basis that Carol's son, Paul, was there to support her in the evening. It is not recorded who actually made this request. The decrease in care was made at the end of July 2021.

6.11 During August and September 2021, Carol's other son, David, made contact with ASC on three occasions, stating that he was not receiving any response. He wished to cancel the care package, stating that it was not working for the family and his brother, Paul, was moving into the Carol's home to support her. There is no evidence that these requests received a response.

6.12 Around the same time the DCP contacted ASC requesting contact with the social worker to express their concerns about Paul also cancelling the care package as they felt that Carol was not in a position to support herself. This included the DCP raising a safeguarding concern that when a carer went to Carol's address, the gas burners had been left on and the house was described as being in disarray. Paul was at home at the time and stated that he could not care for Carol all the time and directed the carers to leave the house. The DCP raised the concern that on each morning visit they were either not being allowed access or being told to leave by Paul. There was a discussion between the social worker and the DCP and all the concerns were passed to the social worker who said they would visit Carol jointly with the DCP.

6.13 There is no evidence that this joint visit took place at this time. ASC did have a conversation with 'the family' regarding the concerns but it is not clear who this was with. It is recorded that 'the family' were not willing to pay for the service if the carers did not stay for the allocated time. There is little evidence that Carol was part of this discussion or that her views were sought and effectively recorded.

6.14 The safeguarding concern was closed on the basis that it would be addressed by a review of the support plan. The DCP was not informed of this decision until they made enquiries in March 2022, despite chasing the result of the safeguarding referral on a number of occasions.

6.15 At the beginning of April 2022, the DCP spoke to ASC regarding their ongoing concerns about Paul attempting to cancel the service and regularly refusing carers entry to the address. The carers also had ongoing concerns that Carol's medication was not being managed and they were unable to assist with this as the evening call had been cancelled. It was agreed that a joint visit would be undertaken. Unfortunately, when this was arranged Paul was not present, so the meeting did not go ahead. There is no indication that the opportunity was taken to have a discussion with Carol.

6.16 During April and into June 2022, there continued to be complaints from Paul regarding the care service and this included a complaint to the Social Care Ombudsman. In mid-July 2022, the DCP records show that they received a call from Carol, who wished to cancel her care. The DCP could hear the son Paul in the background dictating to Carole what to say and in their view was being aggressive. This information was passed to ASC. The DCP stated in their view the care should not be cancelled, that Paul could be aggressive towards staff and that he was being forceful towards Carol. ASC have no record of this contact.

6.17 At the beginning of August 2022, a carer raised a concern with the DCP that Carol was unable to manage her medication. ASC decided that Carol's case should be allocated to a social worker to undertake a care and support review. There followed a telephone discussion between the social worker and the DCP. The DCP raised concerns that Carol was unable to take her medication without support. The DCP also raised environmental concerns regarding decaying food. It was the view of the carers that if the support was removed Carol would be at risk.

6.18 At the beginning of September the support plan review was completed. It concluded that Carol was able to mobilise, wash and dress independently.

Although repetitive the social worker recorded that there was no reason to doubt Carol's mental capacity acknowledging her dementia diagnosis. Carol was recorded as being adamant that she did not require care support and wished to cancel the service.

6.19 On 13th September 2022, the care package was cancelled by the Local Authority. There is no further agency contact with Carol until late January 2023. An ambulance was called to Carol's address by Paul. Carol was found on the floor, where she had lain for several days. She was taken to hospital and later the same day she died.

7. Key issues arising and lessons to be learned

7.1 Carol had a diagnosis of dementia and was prescribed medication for this. The pathway for her continued care and review of her condition was not clear and there was some confusion over the ongoing prescription of her medication. This point has been raised in a previous review and should be addressed.

7.2 When the care assessment was undertaken there is no record of a financial assessment taking place, there are records of it being considered but not that it was completed. The Care Act Statutory Guidance states that where a local authority has decided to charge, it **must** carry out a financial assessment of what the person can afford to pay and, and once complete, it must give a written record of that assessment to the person. This did not happen and there is evidence that the family were confused about being charged (contact January 2022 and July 2022). There is also no record of attendance allowance being discussed with Carol at any of the assessments or any information being given to her or family on this.

7.3 There needs to be more consideration of the potential of carers exercising coercive control on the person they are caring for. The voice of the person needs to be clear in all interactions with the person. Although there are some good examples of this in this review, it is not always the case. There continues to be a lack of consideration of a carers assessment. This would assist practitioners to fully understand the carers capability to care for the person but also the sustainability of that care.

7.4 Other local reviews have highlighted the need for a whole family approach when considering support and services. This approach is set out in the Southend, Essex and Thurrock Safeguarding Adults Guidelines.

'*Think Family aims to promote the importance of a whole-family approach,*

ensuring practitioners work in partnership and collaboration with families recognising and promoting resilience and helping them to build their capabilities."[5]

Ensuring this approach is adopted would assist professionals to consider all aspects of the family needs which support and impact on the person.

7.4 This review highlights the need for there to be careful consideration where a care package is removed. The views of all involved are important and there should be careful consideration where there is a possibility of the person is being influenced by others.

7.5 It is important that where a person is supported, the details of the person supporting them are accurately recorded, together with their relationship to the person that they are supporting.

7.6 Where there is evidence of consideration of Carol's mental capacity, it was referred to in general terms and not focused on specific decisions. Mental Capacity neds to be considered by agencies and decisions and rationale should be b clearly recorded.

8. Conclusions

8.1 Although independent, Carol required support with day-to-day tasks, this was reflected in the care plan for support that was agreed. In particular, Carol required support with her medication. This was recognised by a number of agencies and her wider support network.

8.2 Carol's son Paul requested that the care plan was removed, the DCP raised repeated concerns regarding the removal of this plan and the ability for Paul to support his mother. They also had concerns that Paul was limiting care access to his mother and acting in a controlling way toward her.

8.3 Paul's ability to care for his mother was not effectively considered and a carers assessment would have helped to inform this. There was sufficient information to question Paul's ability to provide the care that his mother required. The consideration of offering relevant person carers assessment is a repeating theme in local Safeguarding Adult Reviews in Essex.

8.4 The care plan was reviewed and on the basis that Carol was requesting that it

[5] Southend, Essex and Thurrock Safeguarding Adults Guidelines, version 9, September 2023

stopped, and it was terminated. This was not subject of any follow up. Within 3 months emergency services were called to Carol's home where she was found collapsed on the floor and it is apparent that she had been in this state for some time, with Paul's knowledge and without medical care being summonsed or given. These circumstances would tend to support the view that Paul was not able or not willing to provide the support his mother required.

8.5 There is no evidence of physical domestic abuse but there are indications that Paul was controlling to towards his mother and his behaviour sought to isolate her from her support networks. More consideration should have been given to this behaviour and the motivation for it.

9. Recommendations from the review

Recommendation 1

Essex Adult Social Care should remind all domiciliary care providers that where there is a concern that a person with care and support needs is being the subject of coercion or controlling behaviour by another, a safeguarding referral should be made.

Recommendation 2

Essex Adult Social Care should consider how practitioners can be encouraged to consider the possibility that a person is being subject of coercive or controlling behaviour and how this is impacting on their ability to make independent and uninfluenced decisions.

Recommendation 3

Essex Adult Social Care should ensure that: -

- Assessments include the views of other relevant persons, carers and family members and this is recorded.
- Where the Local Authority is to charge for care and support, there has been a financial assessment, of which the person has a copy, and the person is clear on what the charge will be, and what assistance may be available.

Recommendation 4

Essex Safeguarding Adult Board should be assured that the recommendation from the previous review in the case of Kimmi has clarified the pathways for persons suffering dementia and that there is clear support and review post diagnosis. This should include ensuring clarity in ongoing prescription of medication.

Recommendation 5

Essex Safeguarding Adult Board and Southend, Essex and Thurrock Domestic Abuse Board should reiterate to agencies of the partnerships that practitioners accurately record a person's details who are referred to and involved in a person's care.

Recommendation 6

Essex Safeguarding Adult Board should seek reassurance that delays in response from ASC from contact by professionals and the public has been addressed.

Recommendation 7

Essex Adult Social Care should ensure: -

- That when reviews are being undertaken which may lead to the removal of a care package that previous concerns and risks are considered.
- That the person's finances are considered as a possible reason for the request for the care and support to be terminated.
- That there is clear guidance to professionals in what circumstances legal advice is sought in cases where person is considered to have mental capacity but is considered to be vulnerable.

Recommendation 8

All agencies should ensure that their practitioners understand their responsibilities under the Mental Capacity Act in accordance with their roles.

Recommendation 9

Essex Adult Social Care should consider the learning from recent Safeguarding Adult Reviews regarding the lack of understanding in considering and undertaking carer assessments and develop processes to ensure that the gap is closed. This should be overseen and monitored by the Safeguarding Adults Board.

Recommendation 10

All agencies when delivering services and support to a person should consider the Think Family approach. The Safeguarding Adults Board should consider how this can be promoted.