Safeguarding Adult Review
Domestic Homicide Review
Case of Carol

(Died January 2023)

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Version 0.11

Contents

1. Introduction

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.

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.

1.3 In May 2021, family members raised a concern with Adult Care Services (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.

1.4 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 they had concerns regarding the cancellation of the care package based on Carol's ability to cope without support.

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.

1.6 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.

1.7 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

2. The Review Process

It was agreed that this review would be undertaken as a Safeguarding Adult Review and Domestic Homicide Review.

2.1 The purpose of a Safeguarding Adult Review (SAR)

2.1.1 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.

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 This case was discussed at the Essex Safeguarding Board review subcommittee, where it was agreed that the circumstances surrounding Carol's death meet the criteria for a SAR.

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 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]

2.2.2 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.

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

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]

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

2.2.4 The definition of Domestic Abuse 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

2.3 Parallel Reviews

[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].

2.3.1 The case was referred to HM Coroner and the case opened for inquest and adjourned on the basis of the ongoing criminal investigation.

2.3.2 There was a police investigation and this DHR and SAR has maintained appropriate contact with the prosecuting authorities to ensure that the investigation proceeded without hinderance, whilst furthering the learning opportunities presented by the DHR and SAR.

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. This included a representative from a Domestic Abuse Services provider and a representative from the Alzheimer Society.

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

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 3 panel meetings, during which the panel was able to discuss and consider the themes and learning opportunities presented by the circumstances.

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.

2.6.2 The issue of confidentiality was also addressed in the terms of reference, balancing confidentiality and transparency against the legal requirements surrounding disclosure.

2.6.3 In accordance with guidance and practice pseudonyms have been used throughout this report to protect the identity of those involved.

2.7 Methodology and contributors to the review

2.7.1 The panel drafted and agreed terms of reference for the reviews (appendix A), which identified the scope of the review and the organisations who had supported Carol and her family. Each of these agencies were asked to provide a chronology of their contact. They were also asked to provide an Individual Management Report (IMR), a summary report or undertake initial scoping depending on their level of involvement. The timeframe for this review was set as from 1st September 2020 – 31st January 2023. Whilst this was the given timeframe, agencies were asked to consider and provide information which was outside of these parameters if they considered it relevant.

2.7.2 The following organisations provided information to the reviews as indicated below. In some cases, this was a formatted Individual Management Report (IMR), or where the involvement was to a lesser extent, a summary report was requested. Each agency also provided a chronology to detail their involvement with Carol.

2.7.3 The agreed timescales for the review were 1st September 2020 - 22nd January 2023, these dates were agreed to cover the most significant timeframe. Agency authors were also asked to consider any information outside of these dates and include it in their reports.

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

2.8 Report author

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

2.8.2 The panel chair and author is a retired senior Hertfordshire police officer who has both operational and strategic experience of safeguarding and domestic abuse. He managed operational safeguarding teams and had strategic responsibility at a Force level for domestic abuse. He led a 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.

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 Adult and Children Safeguarding Partnership in another area.

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

2.9 Equality and Diversity

2.9.1 The nine protected characteristics were considered by the review (race, religion or relief, age, sex, sexual orientation, pregnancy and maternity, gender reassignment, marriage or civil partnership, disability).

2.9.2 Carol was a lady of white British heritage. The protected characteristics of age, sex and disability were particularly considered in these reviews.

2.9.3 Whilst domestic abuse is perpetrated against men and within same sex relationships, it is known that women are significantly more likely to be the victim of abuse[4].

2.9.4 It is recognised that identification and reporting of domestic abuse in older women is low[5]. This can be due to a number of factors, such as generational attitudes[6], an element of acceptance and the lack of services or knowledge of them for older victims.

2.9.5 Carol suffered from dementia which impacted on her cognitive ability and therefore is included as a disability under the Equality Act. This was recognised by the All-

[4] British Crime Survey England and Wales, March 2020

[5] 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

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

Party Parliamentary Group on Dementia report in 2019[7]. 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, Rochford Community Safety Partnership Board and Essex Safeguarding Adults Board.

2.10.2 The report will also be shared with all agencies involved in the case, the Police Fire and Crime Commissioner for Essex and the Domestic Abuse Commissioners Office.

3. Involvement of family, friends, and wider community

3.1 Carol's relatives, who had some involvement with Carol and Paul during the relevant timeframe, were contacted by the author of this review. This included how the reviews would be conducted and the objectives of the DHR and SAR. They were provided with the terms of reference for reviews and an opportunity to comment on and discuss them. At the time, the family stated that they did not wish to be involved in the review. This contact involved Carol's wider family. These wishes needed to be respected, particularly in the context of the criminal investigation into their family member.

3.2 There was also some evidence of involvement of the community, either supporting Carol or reporting concerns. This contact was provided confidentially, and those providing it wished that this was maintained and did not wish to be involved in these reviews.

3.3 A view from a professional who dealt with Carol was that '*Carol presented to be humorous and confident to communicate her wishes and feelings. She was aware of her diagnosis and shared that she was aware that this had some impact on her – whilst she wanted to retain her autonomy.'*

[7] All Party Parliamentary Group on Dementia, 2019, Hidden No More: Dementia and disability

4. Background information

4.1 In August 2019, Carol was referred by her GP to the Memory Assessment Service (MAS). In September 2019, Carol was seen by the service at her home and was accompanied by her grandchild. In November 2019, Carol was diagnosed with dementia when she attended an appointment with a psychiatrist from the service. Records show that she was accompanied by her son, but his details were not recorded.

4.2 In December 2019, Carol was discharged from MAS to the care of her GP, although there is a record that Carol saw a MAS consultant in March 2020, at which time Carol was signposted to support services.

4.3 There is some confusion over medication that Carol was prescribed at this time. The MAS records would indicate that Carol was prescribed medication whilst the records from the GP indicate that she was not. Further enquiry with the GP has shown that they provided a prescription for Donepezil[8]. This was reviewed by the GP at the appointment in March 2020, and it is recorded that Carol was doing well on the medication. There was no repeat prescription made for the medication as it was not requested by Carol, and the letter from MAS did not request it.

4.4 Carol also suffered from diabetes for which she was medicated. Within the timeframe in focus, Carol is described as being mobile and being able to visit the local shops independently.

4.5 Carol resided in her own home, Adult Social Care (ASC) records would indicate that in August 2021, her son Paul moved into her property to assist caring for her.

4.6 There were concerns raised by other members of Carol's family and by neighbours regarding Carol's ability to care for herself.

4.7 Following an ASC assessment, Carol was given a package of support, which included daily calls. It is clear that at various stages Paul requested that this care package was reduced or ceased. He would contact the care provider regularly and be abusive and make complaints.

[8] Donepezil is a medicine that helps with some types of dementia.

4.8 Ultimately, the care was cancelled as a result of a request from Carol, supported by Paul. In January 2023, an ambulance was called by a care support company on a report of Carol being unresponsive. She was conveyed to hospital where she died later the same day.

4.9 It was apparent that Paul had allowed Carol to remain on the floor for a period of days, having discovered her there. This included leaving the house to go to work. He did not summon assistance. Paul was interviewed for the offence of allowing or causing the death of a vulnerable person. At the time of this report a decision from the Crown Prosecution Service was awaited.

4.10 The postmortem examination revealed the cause of death to be multi-organ failure, hypothermia, dehydration and dementia. The pathologist stated on the report that there appeared to be a clear link between the extended period of time Carol was on the floor and her death.

5. Chronology

5.1 In September 2020, a safeguarding referral was made to ASC by Carol's grandchild after a neighbour had raised concerns about possible self-neglect. 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. She is described by the social worker as presenting as humorous and confident to communicate her wishes and feelings.

5.2 These discussions covered the support that was available and how it would work for Carol. The process of Lasting Power of Attorney process was explained, as well as safety and support in the home. The discussion gave a clear insight into Carol's routine and some information on her family and past.

5.3 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.

5.4 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.

5.5 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. On this visit Carol was observed as being alert and orientated to talk to. Carol agreed to using blister packs and a message was left with Carol's son, but it does not record which son this was. The GP wrote to ASC requesting an assessment for Carol.

5.6 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. The GP highlighted the issue of Carol not taking her medication and her diabetes becoming poorly controlled. The GP felt that Carol required more structured daily care and assistance with daily tasks and medication.

5.7 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.

5.8 The safeguarding concern was closed with the conclusion that an adult social care assessment and care planning was more appropriate. The assessment was started, which concluded in mid-June 2021, and although ASC have records of a financial assessment being considered, there is no record that a financial assessment actually took place.

5.9 The assessment recorded that Carol had dementia but maintained a good level of independence. Carol was unsteady on her feet and had experienced falls. The assessment concluded that there should be a referral to occupational therapy for walking aids and a bathroom assessment, and to a technology assistance provider. Also, that twice daily care package (30 minutes each) should be put in place.

5.10 Before the care package started there continued to be concerns raised about

Carol's ability to support herself. At the beginning of June 2021, the GP contacted ASC and re-iterated their concern about Carol's inability to manage her medication.

5.11 In June 2021, the community nurse visited Carol at home to conduct a diabetic foot check. The nurse noted that Carol had not been taking her medication correctly, and most had not been taken at all.

5.12 The family contacted ASC on at least two occasions to try to establish what the situation was in achieving support but had difficulty in getting a response. A neighbour also contacted ASC and expressed their concerns, in particular regarding Carol not taking her medication.

5.13 An initiation form was sent by ASC to the domiciliary care provider (DCP) with care to commence on 14th 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.

5.14 A referral was sent by ASC to the technology assistance provider which included information that one of Carol's sons resided with her but that he did not appear to recognise the level of Carol's vulnerability, or to identify the risk in the home. The referral also recognised that Carol had difficulty managing her medication.

5.15 Shortly after starting the care package, the DCP raised a concern with ASC, the GP and Paul that Carol was not taking her medication properly, and that the medication was spread around the house. They requested a medication safe.

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

5.17 During August and September 2021, 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.

5.18 In mid-January 2022, Paul contacted ASC and requested that the care package was cancelled as the family were not aware that there would be a charge for the service and that the carers were only staying for 10 minutes.

5.19 Around the same time, the DCP contacted ASC requesting contact with the social worker to express their concerns about Paul 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 were being told to leave by Paul. The DCP was attempting to plan visits at times Paul would not be present in order that access could be gained to the home and support given to Carol.

5.20 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.

5.21 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. It was recorded that 'the family' agreed for this to be reviewed as part of the support plan process. At the beginning of February 2022, a home visit was completed by ASC. It was agreed that the carers would try and support Carol to have a bath, but this does not appear to have been communicated to the DCP. ASC stated that they would follow up this visit with a call within a week, however, there is no evidence that this happened.

522 There is little evidence that Carol was part of this discussion or that her views were sought and effectively recorded.

5.23 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. This update was being followed up by the DCP as they were receiving regular contact from Paul requesting that the service was

cancelled. On occasions Paul was abusive to staff when he spoke with them.

5.24 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 and so the meeting did not go ahead. There is no indication that the opportunity was taken to have a discussion with Carol.

5.25 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. There is evidence of the DCP attempting to get a response from ASC about the continued requests for cancellation of the care, but none was forthcoming. ASC recognise that during this time there was no allocated social worker.

5.26 In mid July 2022, the DCP records show that they received a call from Carol, who wished to cancel her care. She stated that she was being charged £260 and that her son did everything for her. The DCP could hear Paul in the background dictating to Carol what to say, and in their view, was being aggressive. This information was passed to ASC. The DCP stated that 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.

5.27 At the beginning of August 2022, a carer raised a concern with the DCP that Carol was unable to manage her medication. Carol was unable to 'pop' the blister pack and deal with the medication unless the care staff were present. A communication was sent to ASC to this effect.

5.28 ASC attempted to contacted Carol on the number they held for her, but there was no response, so a message was left. The following day the grandchild responded stating that her number should be removed from the records, and Carol herself or David could be contacted. Attempts were made to contact David with no response.

5.29 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.

5.30 At the beginning of September 2022, the support plan review was completed. It concluded that Carol was able to mobilise, wash and dress independently. The ASC records would indicate that a carer (DCP) was present for part of the conversation with Carol. The review included speaking with Paul, who said that he could put Carol's medication out and she would administer it 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.

5.31 When interviewed for this review the social worker felt that the DCP was concerned about the living conditions rather than the care being provided by Paul; that the care package was to support with medications, which is a health need, and therefore it was not felt appropriate to continue to provide the care whilst all other needs were being met by Paul.

5.32 On 10th September 2022, two days after the completion of the review, the DCP contacted ASC by email enquiring whether a review had been conducted as they had been informed it would be joint. The email also stated an intention to make a safeguarding referral about Carol's inability to manage her medication. ASC records show that no referral was received, but there was email correspondence between ASC and the DCP. On the 12th of September 2022, the DCP sent an email stating that the visit the previous day had seen evidence of the medication not being taken.

5.33 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 via the technology care assistance provider. 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.

6. Overview

6.1 Carol was known to agencies due to her diagnosis for dementia and ongoing treatment for diabetes. Carol became known to ASC and then the DCP when concerns were raised by her GP, neighbours, and family about her ability to cope.

6.2 The engagement of these agencies will be discussed in the next section under the key lines of enquiry identified for this review.

7. Analysis

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

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

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.

7.1.1 Carol's son, Paul, moved in with his mother to support her. It is not clear exactly when this happened and there is some evidence to suggest that this happened gradually, with him initially spending some nights with his mother and this gradually increased to a point where he lived with Carol.

7.1.2 There is evidence that Paul supported Carol to at least one medical appointment. Often in agencies records it is not clear who is actually accompanying or supporting Carol as the records show 'son' or 'family'. It is important that agencies are specific when recording information, particularly when the supporting individual is being relied on to advocate for the person.

7.1.3 The most helpful insight into Carol's life and needs is from the ASC assessment in September 2020. The allocated social worker spoke to Carol at some length. During this discussion, Paul's support by living with Carol is described as a temporary measure. The grandchild does raise a concern that Paul does not share information on appointments with the wider family and he had not noticed or dealt with the 'mess' in the house or the issue of rotting food in the fridge.

7.1.4 Paul did display aggression towards the care staff, he was abusive to them both in person and on the phone when contacting the office. The DCP would attempt to make calls to Carol when they knew that Paul would not be present as they knew he

would restrict their entry to the house and the support they were able to give to Carol.

7.1.5 There was a feeling from the DCP that Paul was acting in a controlling way by refusing the care package and preventing carers entering the address. Whilst the overall concerns of the carers not being able to enter the address were raised with ASC, there was not a direct reference to the possibility that Carol was being subjected to coercion and control.

7.1.6 There is clear evidence that Paul wished to cancel the care package, and this was based on the cost of the service. Carol made a call to the DCP in July 2022, requesting that the care package was cancelled. The person taking the call at the DCP recorded that they could hear Paul in the background prompting Carol and in the view of the DCP staff member, Paul was being aggressive.

7.1.7 This information was passed to ASC by telephone, although there would appear to be no record of it. This was a clear indication that Paul was acting in a controlling manner towards Carol and warranted further consideration. The DCP should have submitted a safeguarding referral. This would have allowed an opportunity for Carol to be seen on her own to fully understand her wishes.

7.1.8 Throughout the discussion and review undertaken by ASC of the care package there is no consideration of a hypothesis that Carol was not making independent and uninfluenced decisions. Where care is provided on an informal basis the possibility of coercion should always be a consideration, in particular where there are circumstances which may increase a risk, such as the cancellation of a care plan. In this case it was clear that Paul was the main driver for the plan to be cancelled and his motivation was one of finance, and this should have raised a red flag for, at the very least, the possibility of coercion to be explored.

7.1.9 A particular concern where there is the co-existence of domestic abuse and dementia is that domestic abuse may not be recognised and responded to effectively, increasing the risk of harm to the older victim-survivor.[9]

7.1.10 In April 2022, ASC and the DCP planned a joint visit after the DCP had raised concerns about Paul attempting to cancel the service. Unfortunately, this visit did

[9] Williams, J., Wydall, S., Clarke, A. H. 2013. Protecting older victims of abuse who lack capacity: the role of the Independent Mental Capacity Advocate, Elder Law Journal, 3(2), pp. 167-174

not go ahead as Paul was not present. This would have been an ideal opportunity to create a safe space for a discussion with Carol to try to understand what she really wanted and to explore whether she was able to make autonomous decisions without influence from Paul or anyone else. For an individual who is experiencing abuse from a partner or family member who is also their carer, time spent alone with a practitioner may be the only opportunity they have to disclose what is happening to them. Therefore, it is extremely important for practitioners to create a safe space away from partners and family members, and to let the older person know they are a safe person to talk to about anything that is troubling them. [10]

7.1.11 The area of economic abuse was discussed and considered by the panel, although Paul wished to cancel the care package there was no evidence of this. Carol still had access to her finances, as evidenced by her tendency to over-buy groceries on a regular basis.

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.

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

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

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

[10] Wydall,S., Freeman, E. and Zerk, R. 2020. Transforming the Response to Domestic Abuse in Later Life, Centre for Age, Gender and Social Justice

7.2.1 There was an assessment of Carol's care needs in September 2020, which has been covered in the previous section and gives good insight into her needs. There was evidence of Carol's wishes and needs being explored and good evidence that Carol, and her grandchild who had raised the concerns, were signposted, and advised on support services. This included care agencies, information on Power of Attorney, information on gas monitoring and safety, information on supportive technology, a key safe to provide access to those supporting her and the Herbert Protocol.[11] The safeguarding concern was closed on the basis that the family would make private arrangements having received information and support. The family confirmed that they were content with the support at this stage.

7.2.2 A further assessment was undertaken by ASC in June 2021, was guided by section 18[12], Care Act 2018. This assessment followed concerns raised by Carol's GP, grandchild, and neighbour. It was identified that Carol did have care and support needs as defined by the eligibility criteria and a care and support plan was devised to meet these needs. This included care call twice daily to support Carol with her care needs.

7.2.3 Within the ASC records there is a reference to the completion of a Mental Capacity Assessment (MCA). The MCA was regarding finances and according to the details Carol lacked mental capacity, but no details of a best interest decision are recorded.[13]

7.2.4 When the request for service was made to the DCP, it included the need for Carol to be supported with managing her medication. There had for some time been concerns raised that Carol was not taking her medication (GP, grandchild and neighbour). The two calls allowed carers to support the medication at morning and evening times. Carol's inability to manage her medication was recognised in the ASC assessment and in the referrals that were made for other support.

7.2.5 Within weeks the evening call was cancelled at the request of 'the family'. It is not clear who made this request or what consideration was given to Carol's wishes when a decision was made to withdraw the evening care. The basis for the cancellation of the evening call was that Paul was living with Carol and was able to

[11] The Herbert Protocol is a national scheme that encourages carers, family and friends to provide and put together useful information, which can then be used in the event of a vulnerable person going missing.

[12] Sections 18 and 20 of the Care Act set out when a local authority must meet a person's eligible needs.

[13] IMR Adult Social Care

support her in the evenings. There had been significant concerns on the management of Carol's medication management, but it does not appear that this was considered when it was agreed that the care package would be reduced.

7.2.6 The concerns regarding Carol's medication management continued to be a concern that was raised by the DCP, making the point that they were unable to support the evening medication as the support had been reduced and there was evidence that Carol was not coping with her medication. More consideration could have been given to the care package being reduced and Carol's own wishes and needs could have been more evident.

7.2.7 The assessment conducted in June 2021 did not reflect the views of Carol's family, including those of Paul. This would have allowed a deeper understanding of the views, feelings and ability of the family to help to meet Carol's needs.

*'An assessment **must** be person centred, involving the individual and any carer that the adult has, or any other person they might want involved.'*[14]

This was also identified as an area of improvement in a past Essex Safeguarding Adults Review involving the death of a woman in 2017, which was published in May 2022.[15]

7.2.8 When the care assessment was undertaken, although 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.

7.2.9 Whilst there are no records that the request for care to be removed (made by the family) was based on financial considerations, this aspect was not explored in the re-assessment in September 2022, and had this have been the case, Carol and the

[14] DoH, Care and Support Statutory Guidance, June 2014

[15] SAR, Althea Cribb, Case of Sonia, ESAB 2022, https://www.essexsab.org.uk/published-sars (accessed 15/11/23)

family may have been more receptive to keeping the care in place.

7.2.10 Carol was diagnosed with dementia in October 2019. She commenced medication in December 2019 and was discharged from the Memory Assessment Service to her GP for ongoing care. There is little evidence that Carol's dementia was re-assessed following this.

7.2.11 In January 2022, the Dementia Navigator Team, which is jointly funded by Essex County Council and Southend City Council received contact from Essex Partnership University Trust (EPUT), requesting that the Dementia Navigator Service make contact with David as he had reported that she was isolated and not able to get out much.

7.2.12 The Dementia Navigator followed this up in March 2022, with a phone call but when there was no response the request was closed. There is little evidence that Carol's dementia was reviewed or that there was any care plan in place for the dementia. A previous Essex SAR into the death of a lady in 2020 who suffered dementia, which was published in September 2023[16] made recommendations to review the pathways for the care of dementia, which included the consideration of domestic abuse. It would appear that the pathways for those suffering from dementia still are not clear. The GP surgery have acknowledged that the process of reviews could be more structured and have now introduced a process where all conditions are reviewed on an annual basis on the birthday of the patient to ensure that they are not missed.

7.2.13 The eligibility for NHS Continuing Health Care (CHC) in Carol's case was discussed by the panel and information provided on this by professionals (ICB). It was the view of the panel that it would have been unlikely, considering Carol's condition and circumstances that she would not have been eligible for CHC. That said, it was the financial aspect of the care that appeared to be causing the family concern and financial support may have allowed the care to be kept in place. Health and social care joint processes should be in place to identify individuals for whom it may be appropriate to complete an NHS Continuing Healthcare Checklist to establish whether a full assessment of eligibility for NHS Continuing Healthcare is needed.

Recommendation 3

[16] SAR, Jon Chapman, Case of Kimmi, ESAB 2023, https://www.essexsab.org.uk/published-sars (accessed 15/11/23)

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 that: i) a financial assessment has taken place ii) the person is provided with a copy of the financial assessment and its outcome, which should be clearly explained and iii) if so, the person is made aware of any benefits/ allowances that may provide assistance with such care costs.

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 from dementia and that there is clear support and a process for 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 that where a person is being supported an accurate record is made of the supporters' details and their relationship to the person.

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

7.3.1 The DCP continued to raise concerns about Carol's ability to manage her medication, and their concerns that Paul was not able or willing to support this. The previous information from family and professionals would also support this. The reduction in the care package by removing the evening call had also highlighted this, with difficulties in Carol managing medication.

7.3.2 In January 2022, the DCP raised a safeguarding concern after Paul had made several requests for the care package to be cancelled. Paul had also told carers to leave the address and, on occasions, refused them entry. The safeguarding referral was closed on the basis that the care plan would be reviewed.

7.3.3 ASC visited Carol and Paul and it was agreed that the care would continue and would be reviewed by a phone call within a week. There is no record that this follow

up call was ever made.

7.3.4 Over the following months, Paul continued to pressurise the DCP to cancel the care. There were calls made and letters sent to the DCP, this included a complaint to the Ombudsman.

7.3.5 In July 2022, the DCP again contacted ASC informing them that Paul wanted the care package cancelled. During the discussion regarding this it became evident to ASC that the grandchild was no longer supporting Carol and she requested that her details were removed from Carol's records.

7.3.6 Paul's brother was informed by ASC that before the care was cancelled a review would have to take place. This was to be a joint review by ASC with the DCP but was undertaken by the social worker alone after a joint visit could not be arranged.

7.3.7 In early September 2022, the support plan was reviewed by the social worker. Carol was spoken with, and it was noted that she was able to mobilise. Whilst this was not a joint visit with the DCP, a carer did visit during the discussion and assisted Carol with medication. Although Carol was repetitive in her responses, the social worker recorded they had no reason to doubt Carol's mental capacity. Paul was present during the discussion, and he gave assurance regarding the care he was able to provide. Carol was recorded as being adamant that she wished for the care package to be cancelled. There was no recorded consideration of the impact that Paul may have had on Carol's ability to make uninfluenced decisions.

7.3.8 In September 2022, the care package was removed. At the same time, the DCP informed ASC of an intention to raise a safeguarding concern on the basis of what their staff had witnessed regarding Paul's inability to manage his mother's medication. ASC emailed the DCP and informed them that raising a safeguarding concern was not required and that the medication was being managed.

7.3.9 The DCP again raised concerns with ASC, providing a recent account which supported the medication was not being managed. They also raised a concern about a call that a carer had witnessed from Carol's bank regarding money withdrawal.

7.3.10 There was significant evidence that a number of family members and professionals had raised concerns that Carol was unable to manage her medication, and that

Paul was not in a position to support her. When the review of the care package was undertaken in September 2022, there was not sufficient consideration of the previous risks and concerns. These could have been achieved from records and from more discussion with Carol's wider support network.

7.3.11 There was a risk of this care being withdrawn and to mitigate this a review should have put in place to ensure that the informal care arrangements were meeting Carol's need. There was also a need for clearer consideration of Carol's mental capacity regarding the decision to remove her care and consideration of the possibility that Carol was being coerced, which should be extended to consider when or if, legal advice should be sought. Mental Capacity should also have been considered by other agencies, such as the GP and DCP, when considering the decisions that Carol was making.

7.3.12 Where there is evidence of consideration of Carol's mental capacity, it was referred to in general terms and not focused on specific decisions. On one occasion where it was deemed Carol lacked capacity in relation to finance (June 2021), there is no record of what the following action would be, in terms of the need for a best interest process.

7.3.13 Had there been a clear position of Carol's mental capacity at various stages, there could have been consideration of Deputyship, particularly when the grandchild was still involved with Carol's care but the position regarding Carol's mental capacity is not clear. The IMR from ASC states that although there is reference to an MCA in the support plan, there is no MCA documentation within the records. The ASC IMR makes a recommendation regarding MCA (appendix B), but it would be appropriate that this recommendation is broader and relative to all agencies.

7.3.14 The Southend, Essex and Thurrock (SET) MCA Guidance states that all agencies should consider MCA, and this includes day to day decisions. Whilst these day-to-day decisions may not require recording on an MCA Assessment form, they should be carefully recorded in case or care records.[17]

7.3.15 The guidance also gives professionals advice on situational incapacity, where a person may not be able to make their own decisions due to duress or undue influence and in this case, there is evidence of Carol being influenced by Paul. The

[17] SET Mental Capacity Act and Deprivation of Liberty policy and Guidance, version 3, December 2023

guidance directs that in complex situations practitioners should speak to their managers and consider seeking legal advice.

7.3.16 There is evidence that both professionals (DCP, Fire Service and GP) and members of the family had difficulty in making contact with ASC and that on multiple occasions responses to calls were not responded to[18]. The ASC IMR for this review identified an action for delays in response to be raised with the team, and re-designing the contact recording process, to ensure that any gaps in call backs are identified, and an escalation process is in place. The Safeguarding Adults Board should ask for reassurance that this gap has been addressed.

Recommendation 6
Essex Safeguarding Adult Board should seek reassurance that delays in response from ASC, from contacts 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 a 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.

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

7.4.1 There is no record that Paul was ever offered a carer assessment, or that consideration was ever given to him as a carer. To the contrary, when ASC staff were interviewed for this review, it was stated that it was considered that Paul did not provide a caring role for Carol. This was despite clear evidence that Paul, his

[18] ASC IMR

brother, the grandchild, Carol and professionals had stated that Paul was caring for Carol and expressed concerns over the level of care Paul was able to give.

7.4.2 Statutory guidance on the Care Act[19] states '*Where an individual provides or intends to provide care for another adult, local authorities must consider whether to carry out a carer's assessment if it appears that the carer may have any level of needs for support.'* The guidance goes on to say that the assessment must address the issue of sustainability of the care to be provided. Factored into this must be a consideration of whether the carer is able, and whether the carer will continue to be able, to care for the adult needing care.

7.4.3 The importance of recognising the challenge on carers supporting a person with dementia is also particularly recognised. NICE guidance on dementia assessment, management and support, details the necessity for the service to be person centred but also recognises the importance of recognising, enhancing and supporting the carers input.[20] In the advice that Carol was given at the time of her dementia diagnosis, or subsequently there is no record of the consideration of support for carers.

7.4.4 There would still appear to be a gap in understanding the needs of carers and offering them the opportunity for an assessment. Two recent Essex joint SARs and DHRs have included recommendations on carer assessments.

In the case of Valerie published February 2022 (died March 2020) the following recommendation was made: -

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

In the case of Kimmi published September 2023 (died October 2020): -

Essex Safeguarding Adults Board should give consideration as to how to support agencies in understanding the importance of carers assessments and advise on

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

[20] 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).

how the offer can be made more accessible and effective to carers.

Despite these recommendations and this theme being identified in other Essex SARs (John 2022), this continues to be an area requiring development.

7.4.5 The case of Kimmi also 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.*'[21]

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

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.

7.5 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?

7.5.1 One of the six safeguarding adults principles is Empowerment, where adults are encouraged to make their own decisions and are provided with support and information. Making Safeguarding Personal is a person-centred approach which means that adults are encouraged to make their own decisions about how they live their lives and how they manage their safety and are provided with support and information to empower them to do so.[22] Essex Safeguarding Adults Board Safeguarding Strategy sets three priorities, the first of which is Prevention and

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

[22] Essex Safeguarding Adults Board,2023, Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines, version 9

Awareness. One of the objectives which underpins that priority is '*We will ensure that the voices of adults at risk are sought, heard, listened to and acted upon, and that we engage with local communities ensuring we are transparent about what we are saying we are going to do and how we will measure it.'*[23]

7.5.2 There is good evidence that Carol was at the centre of the of the assessment in September 2020. Her views and wishes were clearly sought and recorded. At this time Carol was supported by her grandchild. Over time, the grandchild was involved less in supporting Carol and this support was provided more by Paul.

7.5.3 The DCP had concerns that Paul wished to remove the support they provided to Carol and were concerned regarding his motivation. They felt that Paul was a controlling influence and he demonstrated this by limiting their access to provide care, and on one occasion during a phone call, prompting Carol in her responses.

7.5.4 The Act places a duty (section 67) on local authorities to arrange independent advocacy if the authority considers an individual would experience 'substantial difficulty' in participating in (amongst other things) their assessment and / or the preparation of their care and support plan. The duty does not arise if the local authority is satisfied that there is some other person who is an appropriate representative.

7.5.5 There was no doubt that Carol's grandchild was an appropriate representative. If the concerns and circumstances were fully considered there may have existed a concern as to whether Paul was an appropriate representative. The recording of the social worker would suggest that Carol did not have substantial difficulty in participating in the assessment or review, but in cases where a concern exists regarding a person being able to make uninfluenced or uncontrolled decisions the role of an advocate could be considered.

8. Lessons Learned

8.1 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

[23] Essex Safeguarding Adults Board Safeguarding Strategy 2021-2024 - https://www.essexsab.org.uk/about (accessed 29/11/23)

been raised in a previous review and should be addressed.

8.2 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.

8.3 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.

8.4 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.'*[24]

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

8.5 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.

8.6 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.

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

8.7 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.

9. Conclusions

9.1 Although independent, Carol required support with day to day tasks which 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.

9.2 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.

9.3 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 the relevant person a carers assessment is a repeating theme in local Safeguarding Adult Reviews.

9.4 The care plan was reviewed and on the basis that Carol was requesting that it stopped, it was terminated. This was not subject to 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 summoned 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.

9.5 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.

10. Recommendations

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 the 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.

Appendix A

Terms of Reference for a joint
Domestic Homicide Review and Safeguarding Adult Review
into the death of Carol

Victim:

Name of Victim:	Carol

Suspected perpetrator:

Name of suspected Perpetrator:	Paul

1 Introduction

1.1 The victim, Carol was an 88 year old lady at the time of her death. Carol lived with her son, Paul. Carol was being supported by domiciliary care providers.

1.2 In January 2022, Paul contacted Adult Social Care (ASC) and requested that the care for his mother was stopped. A concern was raised by the domiciliary care provider (DCP) on the care being ceased and Carol's ability to cope.

1.3 In late January 2023, an ambulance was called to Carol's address where she was found on the floor following a fall. Carol was conveyed to hospital where she died later that day.

1.4 At the time of the ambulance attendance Paul had been present and stated that his mother fell two days previously. It is believed that no assistance had been called until the ambulance attended.

1.5 On 23rd February 2023, a notification was made by police to Southend, Essex and Thurrock (SET) Domestic Abuse Team in accordance with The SET Domestic Homicide Protocol 2017. [25]

1.6 On 28th March 2023, the case was reviewed by the SET Domestic Homicide Review (DHR) Core Group and a decision was made that the criteria had been met and a DHR and a Safeguarding Adult Review (SAR). Further, it was decided these reviews would be undertaken jointly.

1.7 There is a current police investigation into whether Paul's behaviour or lack of response to his mother's fall reaches a criminal threshold.

2 Principles of the review

2.1 Objective, independent & evidence based.

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

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

2.4 Respecting equality and diversity.

[25] SET Domestic Homicide Protocol -

2.5 Openness and transparency whilst safeguarding confidential information where possible.

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

2.7 The review will give due consideration to the Safeguarding Adult Review SCIE Quality Markers to assist in maintaining best practice.

3 Key lines of enquiry

3.1 The Review Panel will consider the following: -

Case specific

- 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 whether the plans put in place were 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 there is 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.

- Whether the principles of Making Safeguarding Personal were demonstrated in practice.

Good practice

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

4 Scope of the Review

Agency	Panel Member	IMR/ Chronology	Summary report
Rochford District Council – Community Safety Partnership (CSP)	X		X
Essex Adult Social Care (ASC)	X	X	
Essex Police	X		X
East of England Ambulance Service Trust (EEAST)	X		X
Audley Mills Surgery	X		X
Novus Care	X	X	
Essex Partnership University NHS Trust (EPUT)	X		X
Changing Pathways – Specialist Domestic Abuse Service	X	N/A	N/A
Southend Adult Care Services			X

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 September 2020 - 22nd January 2023**

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 in the review process, taking account of the family wishes and seeking views as to who else should be involved.

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 The review will be cognisant of the ongoing criminal investigation and liaise with police and if appropriate CPS.

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. The family will be consulted on this.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

7 Timescales

7.1 All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. If necessary, a revised timeline will be communicated to the Home Office. The Review commenced in June and subject to the conclusion of the criminal investigation will seek to conclude at the end of December 2023.

8 Media strategy

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

9 Chairing & Governance

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

Appendix B

Single Agency Actions

Essex Adult Social Care*	
1	To review the ECC ASC process for when new referrals contain social care and safeguarding needs identified as requiring assessment at the same time. To ensure there are no delays in referring for either if both required, and not preferring one route over the other if both required.
2	To review the ECC ASC process from point of assessment identifying a care need and agreeing a formal care plan is required, to the point that is delivered, to consider how to reduce delays in meeting identified needs.
3	Carers Assessments to be a key part of training and supervision discussions, to ensure the ability and support needs of informal carers is fully considered when deciding with adults/their representatives, how their care needs will be met.
4	The social worker's reflection that a follow up visit will now be part of their practice to ensure informal care arrangements are meeting the identified needs, especially when risks to the adults for cessation of a care package are identified, to be considered for practice expectations across the County.
5	Mental Capacity Assessments recording and practice requirements are reinforced through practice standards discussions, supervision and training.
6	To share delays in response with the team redesigning the contact recording process to ensure any gaps in call backs are identified and an escalation process is in place, to avoid delays in responses to contacts.

7	To ensure all workers are aware of the need to record all contacts in case notes and update the new contact process in MOSAIC to reflect all follow up to contacts received.
8	To ensure assessment and review training includes all the elements identified here including when to undertake reviews, talking with adults and carers separately, recording of views and wishes of all relevant parties and recording all contacts clearly.

*As identified in the Essex Adult Social Care IMR