Report of the Domestic Homicide Review Panel into the death of Mrs K.

1.1 Executive summary

The chair and the panel of this Domestic Homicide Review wish to extend their sincere condolences to the family of Mrs K in this tragic case.

1.1.1 **Judges Summing up**

1.1.2 The court case surrounding the death of Mrs K was conducted at Chelmsford Crown Court. The Judge, in trial, Charles Gratwicke, said the manslaughter of Mrs K was "not a mercy killing", but accepted that Mr K was suffering from dementia himself and that this had impaired his ability to form rational judgments. He said: "This was from every angle a tragedy, as you know, there's no evidence that she was in pain or suffering any more than anyone else who has succumbed to dementia. He continued to state "Your ability to form a rational judgment was substantially impaired when you came to the settled intention to kill your wife."

1.1.3 The judge accepted that Mr K had been a devoted husband to his wife, strived to take care of her and that there was no malice in her killing.

1.1.4 Mr K was sentenced to six years for manslaughter, five years for possession of a firearm, 12 months for possession of ammunition, with the custodial terms to run concurrently and to be served in a secure psychiatric hospital.

1.1.5 This overview report has been commissioned by the Tendring Community Safety Partnership concerning the death of Mrs K that occurred in December 2015

1.1.6 The death of any person in circumstances such as examined herein is a tragedy. Family members were contacted by the chair of the review panel, advising them of the purpose of the Domestic Homicide Review and asking whether they wished to take part in the review process. The family stated that they did not feel that they could take part in the review although agreed to a telephone conversation.

1.2 Reasons for conducting the review

1.2.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2001, Section 9. Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The Act states that a DHR should be a review:

Of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
A person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or
A member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

1.2.2 The purpose of a Domestic Homicide Review (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 upon, and what is expected to change as a result;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.2.3 This overview report has been commissioned by the Tendring Community Safety Partnership concerning the death of Mrs K that occurred in 2015. The independent chair and report writer for this review is Elizabeth Hanlon, who is independent of Tendring Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective who has several years' experience of partnership working and involvement with several previous domestic homicide reviews, partnership reviews and serious case reviews. She has just completed writing a Domestic Homicide Review for Watford District Council, Hertfordshire. She is also chairing and writing three domestic homicide reviews for Essex. She is also the current independent chair for the Hertfordshire Safeguarding Adults Board.

1.2.4 It is important to understand what happened in this case at the time, to examine the professionals' perspective within the context at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key events forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.2.5 The dynamics of the relationship between Mr and Mrs K were examined throughout the review process in relation to a Domestic Homicide Review, however the main focus of the panel was identified early on as the couple's vulnerability and caring responsibilities.

1.2.6 The panel analysed the relationship between Mr and Mrs K and took into consideration whether agencies believed that Mr K was coercive and controlling to Mrs K throughout their relationship. This was not felt to be the case by the panel.

1.2.7 The Home Office were notified by Tendring Community Safety Partnership (CSP) on 12th January 2016 of their intention to carry out a Domestic Homicide review. The Essex Coroner was also notified that a Domestic Homicide Review was taking place. The inquest into the death of Mrs K was opened on the 22nd February 2016. In view of the subsequent criminal conviction of Mr K, a decision was then made that a formal inquest was no longer required. The Domestic Homicide Review was started on the 1st April 2016 when the first meeting took place. A press statement was produced by the chair of the Tendring CSP

following consultation with other partner agencies. This will be amended prior to any publication of the report.

1.2.8 The chair of the review held discussions with the Senior Investigating Officer in the case from the Kent and Essex SCD Major Investigations Team. The Domestic Homicide Review processed was explained and following consultation with the Crown Prosecution Service a decision was made that the review could continue and would run parallel to the criminal investigation. Disclosure issues were discussed at the meeting with the Police representative and a process was put in place.

1.2.9 The findings of each individual IMR are confidential. At the beginning of the meetings of the review panel, attendees were asked to sign a confidential agreement.

1.2.10 Scoping letters were sent to all district, borough and unitary councils in Essex. They were also sent to Essex Police, Essex CRC (Essex Probation), ECC Safeguarding Adults Board, Colchester and Tendring Refuge, NHS England (GP's), NHS England Eastern Area, North Essex Partnership University Foundation Trust, East England Ambulance Service, ECC Public Health, Openroad, Oxford Road, Westminster Drug Project, CPS, Victim Support. Also Metropolitan Police Service, London Borough of Redbridge Council. At a later date scoping letters were also sent to Bluebird Care, Safer Places, Seven Kings Health Centre, King George Hospital.

1.2.11 Chronologies and Internal Management Reviews were subsequently requested and received from: Careline, Essex County Council Adult Services, CHUFT (Colchester Hospital University Foundation NHS Trust), Residential Care Home, ACE (Anglian Community Enterprise), East of England Ambulance, North Essex Partnership University Foundation Trust Services.

1.2.12 This overall report is based on the relevant information obtained from those IMR's. These reports were written by professionals who are independent from any involvement with the victim, family, friends or the perpetrators. Should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan will be the overall responsibility of the Tendring Community Safety Partnership. It is essential that any resulting ownership and recommended activity is addressed accordingly.

1.2.13 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report are shared by the membership of the review panel, commissioning officers and members of the Tendring Community Safety Partnership. The associated reports from agencies will not be individually published.

1.2.14 Relevant family members of the victim will be briefed about the report in accordance with policy and practice of the CSP and such consultation will take place prior to the publication of the report.

1.2.15 The review panel made the decision that family members of both Mr and Mrs K would be contacted and given the opportunity to contribute to the review. As such relevant family members were identified by the Police Family Liaison Officer. Initial letters were sent to one of Mr K's sisters who lived close to them and three nieces and nephews. The report writer has spoken to one of Mr and Mrs K's nieces regarding the process. She however identified that she did not feel that the family wished to have any further contact with the review process. At this time no contact has been received from any of the other relatives identified.

1.2.16 The panel also wished to consider psychiatric reports presented to the court at the time of sentencing. These have been received through the Police and any relevant comments have been imbedded within the report.

1.3 The Review Panel

Name	**Position/Organisation**
Elizabeth Hanlon	Independent chair and report writer
Leanne Thornton	Community Safety Manager, Tendring District Council
Karen Neath	Management and Members Support Manager, Tendring District Council
Paul Secker	Essex County Council, Director for Safeguarding
Caroline Venables	Detective Inspector, Essex Police Public Protection Command
Janette Rawlingson	Detective Inspector, Essex Police Public Protection Command (from September 2016)
Lisa Poynter	Safeguarding Adult Lead ACE Anglian Community Enterprise
Ruth Manning	Adult Social Care - ECC
Jane Whitington	Safeguarding Adults Lead, North East Essex CCG
Chrissy Edwards	Registered manager, Bluebird Care
Julie Curtis	Manager Residential Care Home
Cllr Lynda McWilliams	Tendring District Council
Melanie Arthey	Clinical Specialist Safeguarding, North Essex Partnership University NHS Foundation Trust. (NFPUFS)
Helen Edwardson	Safeguarding Adults Lead, Colchester Hospital University Foundation NHS Trust (CHUFT)
Simon Chase	Safeguarding lead, East of England Ambulance NHS Trust
Claire Ellington	Service Development Manager, Tendring District Council Careline
David Williams	Senior Operations Policy advisor, Adult Social Care

1.3 Terms of reference

1.3.1 **Scope**

1.3.2 The agreed dates between which the DHR considered agency involvement with Mrs K and her husband, the perpetrator Mr K, was from 1ST January 2013 to the 28th December 2015. These dates were chosen due to the start of agency involvement with Mr and Mrs K.

1.3.3 At the first panel meeting the scope of the DHR was extended, following consultation with Essex Adult Social Care and Essex Safeguarding Adults Board to include any vulnerabilities identified by agencies surrounding Mr and Mrs K.

1.3.4 It was considered important that the review understands and analyses, from a multi-agency perspective, for the time Mr and Mrs K lived in Essex, the couples' overall vulnerabilities, their capacity to care for themselves, their levels of independence and their ability to manage their deteriorating health, both physically and emotionally and Mr K's caring responsibilities. Mrs K had not been identified as an adult at risk, however was in need of care and support. The panel also considered whether the agencies were sensitive to the Equality Act 2010 including age, disability, gender, reassignment, marriage/civil partnership, pregnancy and maternity, race, sex, sexual orientation, religious beliefs and specialist needs on behalf of Mr and Mrs k were properly considered and appropriate actions taken and recorded.

1.3.5 **Purpose** of the review was to:

- To gain an understanding of what domestic abuse, both physical and emotional, Mrs K suffered, if any, within the family environment.
- Establish the appropriateness of agency responses to both Mr and Mrs K - both historically and immediately prior to Mrs K's death.
- If and how agencies assessed risks within the family household and care settings.
- If and how agencies assessed needs for care and support within the household and care settings.
- Establish whether single agency and inter-agency responses to any concerns about Mrs K were appropriate.
- Identify, on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures within the various agencies areas of responsibility.
- Were agencies responses good practice and proportionate?
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic abuse is a feature.
- To identify the effectiveness of inter-agency communications and information sharing.

1.3.6 The Review excludes consideration of who was culpable for the death of Mrs K as this is a matter for the criminal investigation.

1.3.7 Did the agencies comply with domestic abuse protocols agreed with other agencies, including information sharing.

1.3.8 Did the agencies have policies and procedures for risk assessments and risk management for domestic abuse victims or perpetrators and were these assessments correctly used?

1.3.9 **Contact and support from agencies:**

- Were practitioner's sensitive to the needs of the victim and their family?
- Did actions and risk management plans fit with the assessments and decisions made?
- Were appropriate services offered or provided?
- Did this case say anything about how agencies support families where an adult has serious deteriorating physical and/or emotional health which reaches the stage of creating extreme difficulties both for the carer and the adult being cared for?

1.3.10 **Any additional information considered relevant:**

1.3.11 If any additional information became available that informed the review this should be discussed and agreed by the independent chair and the review panel and confirmed by the chair.

1.3.12 Unless specifically indicated all agencies have current Safeguarding and Domestic Abuse policies and procedures in place within their organisations. They also carry out relevant training for all relevant staff within their organisations.

1.4 Details of parallel reviews/processes

1.4.1 At the beginning of the review process there was very limited information obtained from agencies regarding their involvement with the family. All agencies checked their records in relation to their involvement with Mr and Mrs K regarding any incidents of domestic abuse, nothing was held by any agency. As a result, a decision was made, following liaison with Essex Social Care and the Essex Safeguarding Adults Board that the review would be widened to look at agency's involvement with Mr and Mrs K to include any vulnerabilities identified. This review would also be fed back to the Essex Adult Safeguarding Board. It was however felt that this did not meet the criteria for a Safeguarding Adults Review. This decision was taken by the Chair of the Essex Safeguarding Adults Board.

1.5 Subjects of the review

Name	**Relationship**	**Ethnic Origin**
Mrs K	Victim	White British
Mr K	Husband/perpetrator	White British

1.5.1 The victim in this case was an 82 year old lady. She was married to the perpetrator at the time of her death who was 86 years of age. They had been married since June 1966. They both moved to Essex at the beginning of 2013 to live closer to Mr K's sister. Mr K was the primary care giver for his wife. He had a history of heart disease and had a congenital absence of his left arm. Mrs K was diagnosed with mixed dementia following an initial assessment by a memory assessment nurse on the 8th July 2013.

1.5.2 Mrs K was admitted to a Residential Care Home on 28 March 2015 as an emergency placement following a referral by the Community Matron, as Mr K was not able to provide care for her at home. This was initially considered to be a short term respite care placement.

1.5.3 The Manager of the residential care home and Community Matron went to undertake a pre-admission assessment on 27 March 2015 at the home of Mrs K. The Manager had been previously approached by Mr and Mrs K's relatives regarding admission due to Mr K being unable to cope. This was identified at least a month before admission. The Manager and the Community Matron found prescribed and dispensed medication for Mrs K spread over the dining room table, most being unopened and unused, covering at least the preceding six months. Mrs K was noted to be in an unkempt state and had a previously diagnosed fractured arm. The pre-admission assessment determined that the home was able to meet the care needs of both Mr and Mrs K and that they would be self-funding. The home had been requested due to Mr K's sister already being a resident in the Residential Care Home. Although their admission was deemed urgent by the Community Matron, Mr K postponed it to the following day. Mrs K was a Resident at the Residential Care Home from 28 March 2015 to the morning of her death. Mr K also stayed at the Residential Care Home on a trial basis with his wife on the 28th March 2015, however he discharged himself on 1st April 2015 after staying only 4 days. Mr K returned to live at the couple's home address where he lived independently until the date of Mrs K's death.

1.5.4 Between April and 23 December 2015, Mr K regularly visited his wife on average twice a week. In early December 2015, he requested a week stay to spend Christmas with his wife. On 26 December 2015, Mr K asked a member of staff to call him a taxi as he wanted to go home for a short time. When he came back, the taxi driver said to the staff he was very shaky and unsteady on his feet. On the morning of 28 December 2015, the day of the shooting incident, staff on duty do not recall any unusual behaviour or interaction by Mr K apart from thinking that he hadn't appeared to have been in a very good mood. He had breakfast with his wife and sister as he had done the previous 4 days. After breakfast, a carer wheeled Mrs K through to the main lounge. It was at this point that Mr K entered the lounge and shot his wife causing her death. It is believed that the gun belonged to Mrs K's father and was a World War 1 1934 Enfield Revolver. It was brought to the Residential Care Home by Mr K in a carrier bag.

1.5.5 At the trial the expert forensic psychologist, told the court that Mr K had been diagnosed as suffering from Vascular Alzheimer's Disease which had caused progressive

frontal lobe dementia. This was identified following an MRI scan which was conducted on Mr K. He confirmed it was this condition which he believed had led Mr K to his beliefs about the care provided at the home and led to his view that the "only possible response was for him to shoot his wife, and he also planned to shoot himself and his sister".

1.5.6 The purpose of a Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Mr and Mrs K, to evaluate it fairly, and if necessary to identify any improvements for future practice.

1.6 Agencies involved in the review, all agencies involved provided Internal Management Reviews (IMR's)

1.6.1 North Essex Partnership University Foundation Trust (NEPUFT)

1.6.2 North Essex Partnership University Foundation Trust provides Mental Health Services - NHS assessment and treatment of Mental Disorder. This includes Adult Mental Health and Criminal Justice Mental Health Services. The Trust provides services across a large part of Essex, stretching from Harwich in the north, to Harlow and Epping in the west, and south to Maldon and South Woodham Ferrers, just over 1,000 square miles. The Trust serves a community of more than one million people, employing more than 2,000 staff across over 60 sites with 300 plus in-patient beds and around 15,000 patients we care for in the community. From 1st April 2017 NEPUFT changed to the Essex Partnership University Foundation NHS Trust.

1.6.3 Anglian Community Enterprise.

1.6.4 Anglian Community Enterprise (ACE) is a Community Interest Company, limited by shares and employee owned, it is commissioned and funded predominantly by the NHS. It launched as a new Social Enterprise on 1st January 2011, prior to this the organisation operated as an NHS body as North East Essex Provider Services.

1.6.5 Intermediate Care Service (ICS) & Falls Prevention Service

1.6.6 The Falls Prevention Service is part of the Community Intermediate Care Service and works closely with GPs and other health and social care professionals. The team is made up of registered and unregistered staff and is complemented by a team of specially trained volunteers. They provide help and advice to reduce the risk of falls, trips and slips in the community by putting in place steps to remove or reduce future risk where possible.

1.6.7 The service has a specific acceptance criterion in that if someone has had a referrals and been discharged within the past 3 months they will not meet the criteria for a new referral.

1.6.8 Community Matron Service (CMS)

1.6.9 The Community Matron Service proactively manages people with multiple long term conditions, supporting self-care, self-management and enables independence through the sophisticated application of holistic person-centred approaches to care.

1.6.10 Community Nurses

1.6.11 Community Nurses are central to the ability of individuals to remain in their own home or a residential setting. They play a key role in assessing and treating patients in their own home environment or Community Health building, co-ordinating care and being clinical team leaders.

1.6.12 GP Surgeries

1.6.13 GP surgeries offer General Practice services, appointments with a Doctor or a Practice nurse for general health treatment and advice.

1.6.14 Tendring Careline.

1.6.15 Tendring Careline is an Emergency Community Alarm Service offered by Tendring District Council. It has a Control Centre based in Clacton-on-Sea which operates 24/7/365. It has approximately 3000 Tendring Service Users and provides the ability for them to call for help in an emergency.

1.6.16 The service installs an alarm in the property of the Service User which can be activated at the push of a button, usually worn on a pendant around the neck or on a wristband. This places a call to the Control Centre via the Service Users telephone line. The alarm includes both a speaker and microphone which allows the Service User to talk directly to the Control Centre even if they are not near the alarm. Tendring Careline is audited annually and is accredited to Platinum standard by the Telecare Services Association.

1.6.17 Colchester Hospital University Foundation NHs Trust (CHUFT)

1.6.18 CHUFT is an acute healthcare Trust which covers North East Essex and its population of 325,000. The Trust has 759 acute adult beds. The Trust provides emergency healthcare to in patients admitted through the emergency pathway and healthcare through an out patient's pathway.

1.6.19 East of England Ambulance NHS Trust (EEAST)

1.6.20 EEAST covers the six counties which make up the East of England - Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk and provides a range of services, but is best known for the 999 emergency services. Its diverse area is spread over about 7,500 square miles and contains a mix of rural, coastal and urban areas – from Watford to Wisbech and Cromer to Canvey Island. The services are tailored to meet the needs of each community's differing environmental and medical needs.

1.6.21 Residential Care Home

1.6.22 The Residential Care Home is registered with the Care Quality Commission to provide residential care (without nursing) for up to 57 adults. They provide accommodation and personal care to older people in a residential setting for those whose needs can be met after assessment. Residents come mainly from Walton on the Naze, Frinton on Sea and the surrounding areas. Referrals for assessment prior to admission are made by General Practitioners, District Nurses, Community Matron, Social Services, families or friends. Residents have access to their personal General Practitioners, local GP practice, District Nurse teams, Community Psychiatric Nurse service, dentist, optician, chiropodist and other health care professionals under the National Health Service. Medication and treatments as prescribed by the relevant health professionals are given to residents. The home is regularly inspected by the Care Quality Commission. The Quality Monitoring Team of Essex County Council Social Services also carries out review of Policies and procedures.

1.6.23 Bluebird Care

1.6.24 Bluebird Care is a franchise network of domiciliary care providers. They offer care and support to people living in their own homes. They offer packages of support dependant on the needs of the individual.

1.6.25 Essex Adult Social Care (Adult Operations)

1.6.26 Adult Operations is responsible for delivering Essex County Council's statutory duties for looking after the county's vulnerable adults. This means offering appropriate assessments, reviews, safeguarding and care to meet identified needs of residents

1.7 Overview

1.7.1 Mr and Mrs K did not have any children. It is believed that Mr K was one of 13 siblings. No family have been identified for Mrs K. It is believed that the reason that Mrs K was placed into the specific Residential Home was due to the fact the one of Mr K's sisters, was already living there. Mr K's other sister was also living across the road from Mr and Mrs K and helped in support given to Mrs K. Letters were sent to Mr K's sister and three nephews and nieces identified through the investigation.

1.7.2 The author of the report phoned one of Mr and Mrs K's nieces to discuss the review process and to ask whether they wished to take part in the review.

1.7.3 She stated that the family felt that they did not wish to participate in the review but that she was happy to discuss Mr and Mrs K over the phone. She described them as a very loving couple who had been married for 50 years. She stated that Mr K had spent all of his time looking after his wife but that he had found it harder as time went on due to her dementia. The family had always advised Mr K to seek additional help and support but they stated that he was a very proud man who did not wish to ask for help either personal or financially.

1.7.4 She stated that she and other family members were not aware of any domestic incidents within the household and that they both presented as a loving couple. Mr and

Mrs K were described as doing everything together and that Mr K had found it very difficult when his wife was diagnosed with dementia and even harder as she deteriorated

1.7.5 No agencies have reported any incidents of domestic abuse, either physical or emotional within Mr and Mrs K's relationship. Their relationship has been described by family members as very loving and that Mr K spent all of his time caring and supporting his wife. Whilst at the Residential Care Home staff described their relationship as very loving and caring. Although Mr K was not staying at the Residential Care Home he regularly visited his wife on average twice a week. During his visits, he would sit with his wife and often brought grapes and chocolates. Carers from Bluebird Care also identified throughout the review that their carers had no safeguarding concerns regarding Mr and Mrs K's relationship and that they never witnessed any forms or suggestions of domestic abuse within the relationship.

1.7.6 Mrs K went into respite care at a residential home with a view to it becoming a permanent placement. There are no records of this placement being arranged by social care on their system as this appears to have been a privately funded placement

1.7.7 It is notable that following Mrs K's placement in residential care and the two subsequent memory medication monitoring appointments that there had been a decline in Mrs K's level of functioning. There is documented evidence from the care staff that there had been a decline in her mobility, cognition, level of functioning and behaviour in that she had become aggressive during personal care interventions, and that risk assessments were carried out and recorded, both electronically and also in the letters to the GP following appointments.

1.7.8 It must be acknowledged that this couple were experiencing such a range of dilemmas around the same time: deteriorating health and mobility, with increased episodes of falling for Mrs K, worsening dementia; leaving their home and moving into care; economic strain and frustration with the funding system for care for Mrs K. This was likely to be extremely challenging and stressful to confront and manage alone.

1.7.9 There is clear evidence throughout this overview that interagency communication could be improved. Agencies appear to have worked in a silo manner rather than in an integrated partnership that placed the individuals at the centre of their care. This had an overall impact on the quality of care the couple received and opportunities to support them in a coordinated manner were overlooked.

1.7.10 The care, readily offered and given, was focused on a needs led assessment and planned intervention based on each service's referral criteria, fulfilling contractual requirements. Whilst this approach often encompassed more than individual needs and circumstances, a more holistic care assessment incorporating an awareness of what others were doing would assist in understanding Mr and Mrs K's environment and the significant life changing events they were experiencing.

1.7.11 The wellbeing principle and the concept of meeting needs sit at the core of the Care Act. It is quite clear that whether or not an adult can fund their own support, Social Care

must take steps to offer to establish what their needs are and to assist them to meet them, whether eligible or otherwise. This does not appear to have happened in this case.

1.7.12 At the beginning of the review it was identified that Mr K had a history of heart disease and had a congenital absence of his left arm but this did not appear to affect his day to day living. Family suggested that he had been made to do everything himself as a child and learnt to deal with his disability at a very early age.

1.7.13 It has been identified throughout the IMR's that Mrs K deteriorated quickly throughout the last month of living at home. She had seven falls within a short space of time which were reported to the 999 system either directly by Mr K or through Careline. It was as a result of one of these falls that Mr K was advised by the ambulance crew to contact his GP for more support. As a result of this contact, and a visit from the Matron a decision was made for both Mr and Mrs K to go into a Residential Care Home, initially as respite care. Help and support were being provided by Bluebird Care, however Mr K was finding it very difficult to cope with his wife's illness.

1.7.14 Although Mr K was receiving support for his wife via Bluebird care, this support was self-obtained by Mr K. Mrs K had been identified as a person in need of care and support, however this did not appear to have been provided in this case. Adult Social Care had been notified that additional support was required, however they failed to act on these notifications in a timely manner. It was identified by other agencies that Mr K had reported to them that he was unable to cope with the care of his wife.

1.7.15 It has also been identified by agencies and family members that Mr K had refused additional help when offered. Mr K cited financial concerns, however this did not actually appear to be the case. There seems little doubt that Mr K was both very proud and very independent and wished to care for his wife. In some ways, as a couple, they were more vulnerable because they did not have any children or immediate relatives highlighting their vulnerabilities. The panel considered whether Mr k was controlling his wife by refusing additional help and support. Bluebird Care felt that Mr K was very loving and supportive of his wife and that everything he did was for her benefit. Although money was discussed by Mr K as a reason for not providing additional help there was nothing to suggest that this was being used as a reason for control as Mr K appeared to be happy to spend money when required to help his wife be comfortable. Mrs K was attended at the home address by a hair dresser every fortnight and always appeared to be happy and contented.

1.7.16 No assessments took place regarding Mr and Mrs K's circumstances once it was identified that they were financially able to pay for their own care. It appears that both Mr and Mrs K were let down in this aspect as an assessment of need should have taken place and additional care and support identified. It may well have been the case that Mr and Mrs K would still have had to have paid for their support, however the correct help and support could have been identified at an earlier stage. This may have resulted in additional support being put into the home address which may have resulted in Mrs K being able to stay at home longer. Throughout the review it appears that Mr and Mrs K were looked at as

individuals and not as a couple. Further consideration should have been given into how Mr K was coping, or not, with his wife's worsening health.

1.7.17 This is a very tragic loss of life. It does appear that more support could have been offered to Mr K prior to his wife going into care, however, Mrs K was being fully cared for in a Residential Care Home nine months before her death. It has been shown that Mrs K was being cared for to a high standard within the Residential Care Home and that she appeared to be happy. She was being visited on a regular basis by her husband and showed signs of being pleased when he visited. It has been identified that Mr K was suffering from early stages of dementia at the time of killing his wife and was therefore impeded in forming rational judgements.

1.7.18 There are no indications as to how Mr K was coping both emotionally and physically during the time his wife was in the care home. This vital question does not appear to have been asked of him which again is something that should have been highlighted due to the fact that Mr and Mrs K had been together for a great amount of time and that he had been her sole carer.

1.7.19 Within ACE's IMR it has been identified that Mr and Mrs K were dealt with on a case by case basis and that a more holistic approach was required. It has been identified that care was given to both Mr and Mrs K but that this care was on a needs basis and upon presentation. If a holistic approach had been used agencies might have identified that Mr K was the sole carer for his wife whose health was deteriorating due to her dementia and that additional support was required. Realistically it appears that Mrs K may well have had to go into a Residential Care home as her needs were such that she required full time care, however if additional support had been offered and taken up by Mr K it might have meant that Mrs K could have stayed in her own home longer or at least it might have meant that the transition into care might have been easier for Mr K.

1.7.20 Upon attendance at the home address by the community matron and the manager of the care home, it was noted that several months of medicine were seen throughout the address. The GP noted in their IMR's that medication reviews were undertaken, however these were completed mainly with Mr K, due to his wife's illness and also mainly over the telephone. It does not appear that direct consideration was given as to whether Mrs K was receiving her medication in an appropriate manner. Staff at Bluebird Care were aware that Mr K provided his wife with her medication on a daily basis and no concerns were raised by them regarding misuse of medication throughout the review process.

1.7.21 During the Police investigation it became apparent that family members were aware that Mr K had a gun within the family home as it had been a topic of conversation over time, although the gun had not been seen by anyone. Family members were told that the gun was a World War replica which had been kept as a momentum and did not believe that it was capable of being fired. There was no suggestion throughout the whole review that Mrs K was frightened of the gun or that she was significantly aware of it.

1.8 Recommendations

1.8.1 North Essex Partnership University Foundation Trust

1.8.2 No recommendations have been identified for North Essex Partnership University Foundation Trust.

1.8.3 Anglian Community Enterprise.

1.8.4 During the period covered by this IMR there were six referrals to the Falls Prevention Service from external agencies following falls, and four comprehensive assessments were carried out in the home and advice given. Intervention was provided in relation to the service specification however It does not appear that consideration was made as to whether this was an ongoing issue that needed further enquiry to reduce long term risk and intervention. There is little evidence of case management surrounding both Mr and Mrs K and their long term care and needs support.

Recommendation 1
The Falls prevention service should put in place a clear procedure surrounding the case management of individuals regarding their care and support needs. Trigger points to be identified within the care plan appropriate to the individual needs to include liaison to take place with identified carers and family members.

1.8.5 It has been highlighted during the IMR that medication was reported as an issue (loss/lack of) on multiple occasions and opportunity to review this risk was overlooked by the GP practice possibly due to high rates of locum Doctors and ineffective record keeping. A clear process should be put in place to identify risk and initiate appropriate and proportionate risk assessment and reviews of these risks to ensure appropriate risk management

Recommendation 2
The GP surgery should have a clearly documented process in place that identifies medication risk and initiate appropriate and proportionate medication reviews, in accordance to the identified risk and its complexity.

1.8.6 At interview the Lead GP indicated that most of the contacts and care plans for Mrs K were completed by the Memory Clinic and shared with them. Although he had no direct contact with Mrs K, he could see she had minimal contact with the surgery since registration and they felt she was being managed by the North Essex Partnership University Foundation Trust Team. Mrs K had cognitive impairment documented in her notes but there was never an occasion to check Mental Capacity in relation to Mrs K's ability to make decisions.

1.8.7 When reflecting on the case he felt the surgery should be more proactive flagging up patients who are elderly with co-morbidities and have not been seen for 6 months. There were three episodes where further prescriptions needed to be issued due to loss or lack of

medications, which should have flagged a face to face review from the GP surgery, rather than it being undertaken over the telephone.

1.8.8 The practice feels more optimistic of achieving these quality improvements now that they have secured permanent staff.

Recommendation 3
The GP surgery should recognise their role and responsibility in relation to the case management of patients with dementia and those with complex needs.

1.8.9 The matron reported at interview that Mr K was very frustrated about money and the cost of care. The matron was not aware of the referral to social services. The matron reported during interview that at the time, in her role as a GP practice matron she was unable to complete a full holistic assessment of patient's due to time constraints. Priority was given to finding Mr and Mrs K a place of safety.

Recommendation 4
The GP surgery should have a clear role descriptor in place for the role of the practice matron. Ensuring the role is supported to work collaboratively with both internal and external agencies, is patient focused and supports holistic assessment.

Staff need to work collaboratively internally and externally to support individuals in decision making and best interest decisions

1.8.10 Essex County Council Adult Social Care.

1.8.11 In the case of Mrs K, it appears from the chronology that they failed to adhere to the Care and Support Guidance. The fact that Mrs K was self- funding and the couple had savings in excess of the capital limit appears to have influenced the way in which the matter was handled, resulting in her not receiving a full assessment of her needs. This is not consistent with the Care and Support Guidance. Mr K contacted Social Care about his needs as a carer but it was not identified that Mrs K herself would have benefited from an assessment.

Recommendation 5
Social Care staff are to be reminded that assessments of needs should be offered to those adults appearing that they may have the need for care and support, irrespective of whether they are self-funders or not.

1.8.12 Tendring District Careline

1.8.13 No recommendations have been identified for Tendring District Careline.

1.8.14 Colchester Hospital University Foundation NHS Trust (CHUFT)

1.8.15 No recommendations have been identified for Colchester Hospital University Foundation NHs Trust.

1.8.16 East of England Ambulance NHS Trust

1.8.17 The reporting systems in place around falls assessment and safeguarding are robust and working, however, the reconciliation of falls referrals evidenced on the PCR by the ambulance crews differs from the SPOC log and the author of the IMR will seek assurance from the SPOC Managers that the systems are robust and ambulance crews will be reminded through the clinical manual and notices of the importance of a falls referral through SPOC.

Recommendation 6
All staff are to be reminded to make the appropriate falls referrals through the SPOC referral pathway only with the patients agreed consent.

1.8.18 Residential Care Home.

1.8.19 There is currently no Policy on domestic abuse and no training of staff on this subject. It is recommended that the care home train their staff in relation to domestic abuse to consider people who are either resident within the home or visitors of those residents who fit the criteria for domestic abuse.

Recommendation 7
SOVA training to be reviewed to include a module on Domestic Abuse.

1.8.20 Bluebird Care

1.8.21 Bluebird care do not currently have a Domestic Abuse policy however their staff must complete DA training within their Care Certificate.

Recommendation 8
Bluebird Care to consider the development of a Domestic Abuse policy within its Policies and Procedures.

1.8.22 All agencies

1.8.23 It was identified throughout the review process that several agencies held relevant information regarding both Mr and Mrs K. There was no identified co-ordinated triage system in place where agencies could have shared information. This appeared to be the case as neither Mr nor Mrs K were subjected to safeguarding concerns and were not identified as adults at risk under the Care act.

Recommendation 9 – Professional meetings
Agencies are to be trained regarding multi-agency Professional meetings and the importance of their attendance at these meetings. The sharing of all relevant information especially where the adult does not fall under Safeguarding but where agencies have concerns regarding their health and care needs.

Recommendation 10 – Risk management
All agencies to raise awareness regarding the importance of carrying out risk assessments prior to carrying out visits within people's homes. Agencies to look at the wider picture surrounding the escalation of concerns within agencies and the right referral process where risk has been identified.

Main Overview Report.

The chair and the panel of this Domestic Homicide Review wish to extend their sincere condolences to the family of Mrs K in this tragic case.

Section 1: Introduction

1.1 Background

1.1.1 Tendring forms part of the North Local Policing Area (LPA) which also includes Maldon, Braintree, Uttlesford, Colchester and Chelmsford. The Tendring District has many geographic, demographic and economic characteristics that make it distinctive from other areas. A large majority of people living in Tendring consider it a good place to live, which is reflected in the number of individuals who have decided to retire to the area. A very high proportion of residents are over the age of 65. The District has the highest proportion of people over 65 per capita in Europe. The population is dispersed into five main areas of settlement and a number of villages with differing community needs and aspirations.

1.1.2 The largest town in the Tendring district is Clacton-on-Sea, with a population of over 53,000.

- The population of Tendring (2011 Census) is 138,048.
- 48% of residents are male and 52% female.
- Tendring has a higher than average population aged 65 and over (16,500 Males 20,700 Females).

1.1.3 **Judges Summing up**

1.1.4 The court case surrounding the death of Mrs K was conducted at Chelmsford Crown Court. The Judge, in trial, Charles Gratwicke, said the manslaughter of Mrs K was "not a mercy killing", but accepted that Mr K was suffering from dementia himself and that this had impaired his ability to form rational judgments. He said: "This was from every angle a tragedy, as you know, there's no evidence that she was in pain or suffering any more than anyone else who has succumbed to dementia. He continued to state "Your ability to form a rational judgment was substantially impaired when you came to the settled intention to kill your wife."

1.1.5 The judge accepted that Mr K had been a devoted husband to his wife, strived to take care of her and that there was no malice in her killing.

1.1.6 Mr K was sentenced to six years for manslaughter, five years for possession of a firearm, 12 months for possession of ammunition, with the custodial terms to run concurrently and to be served in a secure psychiatric hospital.

1.2 The Commissioning of the review

1.2.1 This overview report has been commissioned by the Tendring Community Safety Partnership concerning the death of Mrs K that occurred in 2015. The independent chair and report writer for this review is Elizabeth Hanlon, who is independent of Tendring Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective who has several years' experience of partnership working and involvement with several previous domestic homicide reviews, partnership reviews and serious case reviews. She has just completed writing a Domestic Homicide Review for Watford District Council, Hertfordshire. She is also chairing and writing three domestic homicide reviews for Essex. She is also the current independent chair for the Hertfordshire Safeguarding Adults Board.

1.2.2 It is important to understand what happened in this case at the time, to examine the professionals' perspective within the context at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key events forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.2.3 The dynamics of the relationship between Mr and Mrs K were examined throughout the review process in relation to a Domestic Homicide Review, however the main focus of the panel was identified early on as the couple's vulnerability and caring responsibilities. The panel also analysed the relationship between Mr and Mrs K and took into consideration whether agencies believed that Mr K was coercive and controlling to Mrs K. This was not felt to be the case by the panel.

1.2.4 The death of any person in circumstances such as examined herein is a tragedy. Family members were contacted by the chair of the review panel, advising them of the purpose of the Domestic Homicide Review and asking whether they wished to take part in the review process. The family stated that they did not feel that they could take part in the review although agreed to a telephone conversation.

1.2.5 The Home Office were notified by Tendring Community Safety Partnership (CSP) on 12th January 2016 of their intention to carry out a Domestic Homicide review. The Essex Coroner was also notified that a Domestic Homicide Review was taking place. The inquest into the death of Mrs K was opened on the 22nd February 2016. In view of the subsequent criminal conviction of Mr K, a decision was then made that a formal inquest was no longer required. The Domestic Homicide Review was started on the 1st April 2016 when the first meeting took place. A press statement was produced by the chair of the Tendring CSP following consultation with other partner agencies. This will be amended prior to any publication of the report.

1.2.6 The chair of the review held discussions with the Senior Investigating Officer in the case from the Kent and Essex SCD Major Investigations Team. The Domestic Homicide Review processed was explained and following consultation with the Crown Prosecution Service a decision was made that the review could continue and would run parallel to the criminal investigation. Disclosure issues were discussed at the meeting with the Police representative and a process was put in place.

1.2.7 The findings of each individual IMR are confidential. At the beginning of the meetings of the review panel, attendees were asked to sign a confidential agreement.

1.3 The Review Panel

Name	Position/Organisation
Elizabeth Hanlon	Independent chair and report writer
Leanne Thornton	Community Safety Manager, Tendring District Council
Karen Neath	Management and Members Support Manager, Tendring District Council
Paul Secker	Essex County Council, Director for Safeguarding
Caroline Venables	Detective Inspector, Essex Police Public Protection Command
Janette Rawlingson	Detective Inspector, Essex Police Public Protection Command (from September 2016)
Lisa Poynter	Safeguarding Adult Lead ACE Anglian Community Enterprise
Ruth Manning	Adult Social Care - ECC
Jane Whitington	Safeguarding Adults Lead, North East Essex CCG
Chrissy Edwards	Registered manager, Bluebird Care
Julie Curtis	Manager Residential Care Home
Cllr Lynda McWilliams	Tendring District Council
Melanie Arthey	Clinical Specialist Safeguarding, North Essex Partnership University NHS Foundation Trust. (NFPUFS)
Helen Edwardson	Safeguarding Adults Lead, Colchester Hospital University Foundation NHS Trust (CHUFT)
Simon Chase	Safeguarding lead, East of England Ambulance NHS Trust
Claire Ellington	Service Development Manager, Tendring District Council Careline
David Williams	Senior Operations Policy advisor, Adult Social Care

1.4 Reasons for conducting the review

1.4.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2001, Section 9. Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The Act states that a DHR should be a review:

Of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
A person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or
A member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

1.4.2 The purpose of a Domestic Homicide Review (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 upon, and what is expected to change as a result;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.5 Terms of reference

1.5.1 **Scope**

1.5.2 The agreed dates between which the DHR considered agency involvement with the Mrs K and her husband, the perpetrator Mr K, was from 1ST January 2013 to Mrs K's date of death. These dates were chosen due to the start of agency involvement with Mr and Mrs K.

1.5.3 At the first panel meeting the scope of the DHR was extended, following consultation with Essex Adult Social Care and Essex Safeguarding Adults Board to include any vulnerabilities identified by agencies surrounding Mr and Mrs K.

1.5.4 It was considered important that the review understands and analyses, from a multi-agency perspective, for the time Mr and Mrs K lived in Essex, the couples' overall vulnerabilities, their capacity to care for themselves, their levels of independence and their ability to manage their deteriorating health, both physically and emotionally and Mr K's caring responsibilities. Mrs K had not been identified as an adult at risk, however was in need of care and support. The panel also considered whether the agencies were sensitive to the Equality Act 2010 including age, disability, gender, reassignment, marriage/civil partnership, pregnancy and maternity, race, sex, sexual orientation, religious beliefs and specialist needs on behalf of Mr and Mrs k were

1.5.5 **Purpose** of the review was to:

- To gain an understanding of what domestic abuse, both physical and emotional, Mrs K suffered, if any, within the family environment.

- Establish the appropriateness of agency responses to both Mr and Mrs K - both historically and immediately prior to Mrs K's death.
- If and how agencies assessed risks within the family household and care settings.
- If and how agencies assessed needs for care and support within the household and care settings.
- Establish whether single agency and inter-agency responses to any concerns about Mrs K were appropriate.
- Identify, on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures within the various agencies areas of responsibility.
- Were agencies responses good practice and proportionate?
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic abuse is a feature.
- To identify the effectiveness of inter-agency communications and information sharing.

1.5.6 The Review excluded consideration of who was culpable for the death of Mrs K as this is a matter for the criminal investigation.

1.5.7 Did the agencies comply with domestic abuse protocols agreed with other agencies, including information sharing.

1.5.8 Did the agencies have policies and procedures for risk assessments and risk management for domestic abuse victims or perpetrators and were these assessments correctly used?

1.5.9 **Contact and support from agencies:**

- Were practitioner's sensitive to the needs of the victim and their family?
- Did actions and risk management plans fit with the assessments and decisions made?
- Were appropriate services offered or provided?
- Did this case say anything about how agencies support families where an adult has serious deteriorating physical and/or emotional health which reaches the stage of creating extreme difficulties both for the carer and the adult being cared for?

1.5.10 **Any additional information considered relevant:**

1.5.11 If any additional information became available that informed the review this would be discussed and agreed by the independent chair and the review panel and confirmed by the chair.

1.5.12 Unless specifically indicated all agencies have current Safeguarding and Domestic Abuse policies and procedures in place within their organisations. They also carry out

relevant training for all relevant staff within their organisations. All agencies policies and procedures were examined throughout the review process by the IMR writers and were identified as being up to date, relevant and effective.

1.6 Details of parallel reviews/processes

1.6.1 At the beginning of the review process there was very limited information obtained from agencies regarding their involvement with the family. All agencies checked their records in relation to their involvement with Mr and Mrs K regarding any incidents of domestic abuse, nothing was held by any agency. As a result, a decision was made, following liaison with Essex Social Care and the Essex Safeguarding Adults Board that the review would be widened to look at agency's involvement with Mr and Mrs K to include any vulnerabilities identified. This review would also be fed back to the Essex Adult Safeguarding Board. It was however felt that this did not meet the criteria for a Safeguarding Adults Review. This decision was taken by the Chair of the Essex Safeguarding Adults Board.

1.7 Subjects of the review

1.7.1 The victim in this case was an 82 year old lady. She was married to the perpetrator at the time of her death who was 86 years of age. They had been married since June 1966. They both moved to Essex at the beginning of 2013 to live closer to Mr K's sister. Mr K was the primary care giver for his wife. He had a history of heart disease and had a congenital absence of his left arm. Mrs K was diagnosed with mixed dementia following an initial assessment by a memory assessment nurse on the 8th July 2013.

1.7.2 Mrs K was admitted to a Residential Care Home on 28 March 2015 as an emergency placement following a referral by the Community Matron, as Mr K was not able to provide care for her at home. This was initially considered to be a short term respite care placement.

1.7.3 The Manager of the residential care home and Community Matron went to undertake a pre-admission assessment on 27 March 2015 at the home of Mrs K. The Manager had been previously approached by Mr and Mrs K's relatives regarding admission due to Mr K being unable to cope. This was identified at least a month before admission. The Manager and the Community Matron found prescribed and dispensed medication for Mrs K spread over the dining room table, most being unopened and unused, covering at least the preceding six months. Mrs K was noted to be in an unkempt state and had a previously diagnosed fractured arm. The pre-admission assessment determined that the home was able to meet the care needs of both Mr and Mrs K and that they would be self-funding. The home had been requested due to Mr K's sister already being a resident in the Residential Care Home. Although their admission was deemed urgent by the Community Matron, Mr K postponed it to the following day. Mrs K was a Resident at the Residential Care Home from 28 March 2015 to the morning of her death. Mr K also stayed at the Residential Care Home on a trial basis with his wife on the 28th March 2015, however he discharged himself on 1st April 2015 after staying only 4 days. Mr K returned to live at the couple's home address

where he lived independently until the date of Mrs K's death. The review panel were unsure as to the reasons for Mr K to leave the residential home.

1.7.4 Between April and 23 December 2015, Mr K regularly visited his wife on average twice a week. In early December 2015, he requested a week stay to spend Christmas with his wife. On 26 December 2015, Mr K asked a member of staff to call him a taxi as he wanted to go home for a short time. When he came back, the taxi driver said to the staff he was very shaky and unsteady on his feet. On the morning of 28 December 2015, the day of the shooting incident, staff on duty do not recall any unusual behaviour or interaction by Mr K apart from thinking that he hadn't appeared to have been in a very good mood. He had breakfast with his wife and sister as he had done the previous 4 days. After breakfast, a carer wheeled Mrs K through to the main lounge. It was at this point that Mr K entered the lounge and shot his wife causing her death. It is believed that the gun belonged to Mrs K's father and was a World War 1 1934 Enfield Revolver. It was brought to the Residential Care Home by Mr K in a carrier bag.

1.7.5 At the trial the expert forensic psychologist, told the court that Mr K had been diagnosed as suffering from Vascular Alzheimer's Disease which had caused progressive frontal lobe dementia. This was identified following an MRI scan which was conducted on Mr K. He confirmed it was this condition which he believed had led Mr K to his beliefs about the care provided at the home and led to his view that the "only possible response was for him to shoot his wife, and he also planned to shoot himself and his sister".

1.8 Objectives of the review

1.8.1 The purpose of a Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Mr and Mrs K, to evaluate it fairly, and if necessary to identify any improvements for future practice.

1.8.2 Scoping letters were sent to all district, borough and unitary councils in Essex. They were also sent to Essex Police, Essex CRC (Essex Probation), ECC Safeguarding Adults Board, Colchester and Tendring Refuge, NHS England (GP's), NHS England Eastern Area, North Essex Partnership University Foundation Trust, East England Ambulance Service, ECC Public Health, Openroad, Oxford Road, Westminster Drug Project, CPS, Victim Support. Also Metropolitan Police Service, London Borough of Redbridge Council. At a later date scoping letters were also sent to Bluebird Care, Safer Places, Seven Kings Health Centre, King George Hospital.

1.8.3 Chronologies and Internal Management Reviews were subsequently requested and received from: Careline, Essex County Council Adult Services, CHUFT (Colchester Hospital University Foundation NHS Trust), Residential Care Home, ACE (Anglian Community Enterprise), East of England Ambulance, North Essex Partnership University Foundation Trust Services.

1.8.4 This overall report is based on the relevant information obtained from those IMR's. These reports were written by professionals who are independent from any involvement

with the victim, family, friends or the perpetrators. Should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan will be the overall responsibility of the Tendring Community Safety Partnership. It is essential that any resulting ownership and recommended activity is addressed accordingly.

1.8.5 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report are shared by the membership of the review panel, commissioning officers and members of the Tendring Community Safety Partnership. The associated reports from agencies will not be individually published.

1.8.6 Relevant family members of the victim will be briefed about the report in accordance with policy and practice of the CSP and such consultation will take place prior to the publication of the report.

1.8.7 The review panel made the decision that family members of both Mr and Mrs K would be contacted and given the opportunity to contribute to the review. As such relevant family members were identified by the Police Family Liaison Officer. Initial letters were sent to one of Mr K's sisters who lived close to them and three nieces and nephews. The report writer has spoken to one of Mr and Mrs K's nieces regarding the process. She however identified that she did not feel that the family wished to have any further contact with the review process. At this time no contact has been received from any of the other relatives identified.

1.8.8 The panel also wished to consider psychiatric reports presented to the court at the time of sentencing. These have been received through the Police and any relevant comments have been imbedded within the report.

1.8.09 Agencies involved in review

1.8.10 North Essex Partnership University Foundation Trust (NEPUFT)

1.8.11 North Essex Partnership University Foundation Trust provides Mental Health Services - NHS assessment and treatment of Mental Disorder. This includes Adult Mental Health and Criminal Justice Mental Health Services. The Trust provides services across a large part of Essex, stretching from Harwich in the north, to Harlow and Epping in the west, and south to Maldon and South Woodham Ferrers, just over 1,000 square miles. The Trust serves a community of more than one million people, employing more than 2,000 staff across over 60 sites with 300 plus in-patient beds and around 15,000 patients we care for in the community.

1.8.12 Anglian Community Enterprise.

1.8.13 Anglian Community Enterprise (ACE) is a Community Interest Company, limited by shares and employee owned, it is commissioned and funded predominantly by the NHS. It

launched as a new Social Enterprise on 1st January 2011, prior to this the organisation operated as an NHS body as North East Essex Provider Services. ACE incorporates several services within their portfolio, including Intermediate Care Service, Falls Prevention Service, Community Matrons, Community Nurses and the GP Services.

1.8.14 Intermediate Care Service (ICS) & Falls Prevention Service

1.8.15 The Falls Prevention Service is part of the Community Intermediate Care Service and works closely with GPs and other health and social care professionals. The team is made up of registered and unregistered staff and is complemented by a team of specially trained volunteers. They provide help and advice to reduce the risk of falls, trips and slips in the community by putting in place steps to remove or reduce future risk where possible.

1.8.16 The service has specific acceptance criteria in that if someone has had a referral and been discharged within the past 3 months they will not meet the criteria for a new referral.

1.8.17 Community Matron Service (CMS)

1.8.18 The Community Matron Service proactively manages people with multiple long term conditions, supporting self-care, self-management and enables independence through the sophisticated application of holistic person-centered approaches to care.

1.8.19 Community Nurses

1.8.20 Community Nurses are central to the ability of individuals to remain in their own home or a residential setting. They play a key role in assessing and treating patients in their own home environment or Community Health building, co-ordinating care and being clinical team leaders.

1.8.21 GP Surgeries

1.8.22 GP surgeries offer General Practice services, appointments with a Doctor or a Practice nurse for general health treatment and advice.

1.8.23 Tendring Careline.

1.8.24 Tendring Careline is an Emergency Community Alarm Service offered by Tendring District Council. It has a Control Centre based in Clacton-on-Sea which operates 24/7/365. It has approximately 3000 Tendring Service Users and provides the ability for them to call for help in an emergency.

1.8.25 The service installs an alarm in the property of the Service User which can be activated at the push of a button, usually worn on a pendant around the neck or on a wristband. This places a call to the Control Centre via the Service Users telephone line. The alarm includes both a speaker and microphone which allows the Service User to talk directly to the Control Centre even if they are not near the alarm.

1.8.26 Tendring Careline is audited annually and is accredited to Platinum standard by the Telecare Services Association.

1.8.27 Colchester Hospital University Foundation NHs Trust (CHUFT)

1.8.28 CHUFT is an acute healthcare Trust which covers North East Essex and its population of 325,000. The Trust has 759 acute adult beds. The Trust provides emergency healthcare to in patients admitted through the emergency pathway and healthcare through an out patient's pathway.

1.8.29 East of England Ambulance NHS Trust (EEAST)

1.8.30 EEAST covers the six counties which make up the East of England - Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk and provides a range of services, but is best known for the 999 emergency services. Its diverse area is spread over about 7,500 square miles and contains a mix of rural, coastal and urban areas – from Watford to Wisbech and Cromer to Canvey Island. The services are tailored to meet the needs of each community's differing environmental and medical needs.

1.8.31 Residential Care Home

1.8.32 The Residential Care Home is registered with the Care Quality Commission to provide residential care (without nursing) for up to 57 adults. They provide accommodation and personal care to older people in a residential setting for those whose needs can be met after assessment. Residents come mainly from Walton on the Naze, Frinton on Sea and the surrounding areas. Referrals for assessment prior to admission are made by General Practitioners, District Nurses, Community Matron, Social Services, families or friends. Residents have access to their personal General Practitioners, local GP practice, District Nurse teams, Community Psychiatric Nurse service, dentist, optician, chiropodist and other health care professionals under the National Health Service. Medication and treatments as prescribed by the relevant health professionals are given to residents.

1.8.33 The home is regularly inspected by the Care Quality Commission. The Quality Monitoring Team of Essex County Council Social Services also carries out review of Policies and procedures.

1.8.34 Bluebird Care

1.8.35 Bluebird Care is a franchise network of domiciliary care providers. They offer care and support to people living in their own homes. They offer packages of support dependant on the needs of the individual.

1.8.36 Essex Adult Social Care (Adult Operations)

1.8.37 Adult Operations is responsible for delivering Essex County Council's statutory duties for looking after the county's vulnerable adults. This means offering appropriate assessments, reviews, safeguarding and care to meet identified needs of residents.

Section 2: The Facts

2.1 Case specific background

2.1.1 This matter relates to the murder of Mrs K who was a resident at a Residential Care Home in Essex by her husband. Her husband had also been staying at the home for the previous week, to spend some time with his wife over the Christmas period. They had been married for nearly 50 years.

2.1.2 Police were called to the Residential Care Home following a call from the staff manager stating that a resident had shot his wife in the head at the home in a communal area. Mr K said he did it to help his wife who had said she couldn't stand to live any longer. She suffered from severe dementia.

2.1.3 A witness stated that she saw Mr K leave the home in the morning sometime in a taxi and said he had to pick something up. When he returned she took his coat off him and thought it felt heavy and said so to him but he made no comment about it at all. She said she thought he had the same coat and bag when he returned as he did when he left. The taxi driver did say that Mr K told him he was feeling faint and woozy that morning. The taxi driver stated that he took Mr K home where he remained for a few minutes before getting back into the taxi and returning to the Residential Care Home.

2.1.4 Later that day Mr K had entered the lounge where his wife was at about 8.00am carrying a straw type bag over his shoulder and didn't appear to be in a very good mood. Mr K was then seen to kill his wife with a gun he had taken out of his bag. Following the shooting of Mrs K her husband attended the reception carrying a gun and remarked that he could not pull the trigger. He was shaking visibly. The gun was taken from him and locked away in the medicine cupboard and he was taken into a room and remained with staff prior to police attendance.

2.1.5 Police attended the Residential Care Home and Mr K was arrested on suspicion of murder and conveyed to Colchester police station. During conveyance to the police station Mr K made various comments admitting to his actions. He stated to the officer after arrest that he could not pull the trigger on himself and that he had shot his wife as he did not want to see her suffer anymore.

2.1.6 A Constable confirmed the gun they made safe was an Enfield revolver capable of holding 6 bullets and had no clear safety mechanism. He saw two empty compartments once the cylinder was exposed and three bullets that had not been discharged.

2.1.7 Mr K has a number of health issues ranging from a previous heart attack in 2004 and current ischaemic heart disease, osteo arthritis, gout, and cataracts. He was also born with only one arm.

2.2 Family Composition

Name	Relationship	Ethnic Origin
Mrs K	Victim	White British
Mr K	Husband/perpetrator	White British

2.3 Individual Management Reviews

2.3.1 The aims of the Individual Management Reviews (IMRs) were to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and Identify examples of good practice within agencies.

2.3.2 The independent chair and overview report writer guided the IMR authors through the process for the development of the IMR, as follows:

- Securing agency records;
- Commissioning IMRs;
- Gaining consent to view records;
- Drawing up a chronology;
- Conducting a desk-based review which investigated the agency's involvement relative to the agency's policies and procedures; relevant partnership / multi-agency policies and protocols; professional standards and good practice; and national and local research and evidence-based practice;
- Conducting interviews with relevant staff;
- Writing the IMR including analysing the information and making recommendations;
- Ensuring the report is quality-assured through the process of counter-signing by a senior accountable manager; the same guidance includes advice on:
- Conducting parallel investigations of disciplinary matters and complaints which will not be reported which are internal agency matters;
- Providing feedback and debriefing to relevant staff;

2.3.3 IMR authors were informed of the primary objectives of the process, which was to give as accurate as possible an account of what originally transpired in the agency's response to Mr and Mrs K and to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors were encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or experiencing domestic abuse.

2.3.4 Agencies each prepared a chronology of their agency involvement and significant events during the specified time period. These chronologies were analysed by the Review

Panel.

2.3.5 IMR authors produced a first draft of their reports which were quality assured within their own organisations through the signing-off process. These IMRs were then analysed by the Review Panel and discussed with the authors at meetings on the 18th July and the 5th September 2016. Copies of IMRs had been circulated to all the panel members prior to these meetings and panel members were able to cross-reference significant events and highlight missing information. Authors then reviewed their IMR's which were again supplied to the review panel for a further review meeting which was held on the 17th October 2016. Authors then produced final reports.

2.3.6 Although Bluebird Care attended the initial meeting and submitted a chronology they did not submit an IMR. The CSP manager met with Bluebird care management at their premises and talked them through the IMR writing process. Unfortunately, an IMR was still not submitted and a decision was made by the panel that the chair would visit Bluebird care and ask them an identified list of questions that were considered relevant to the review. These questions were submitted in writing by panel members. The chair visited Bluebird care on the 5th October. All questions were answered fully and all relevant documentation including care plans and risk assessments were supplied to the chair. It was not felt that the lack of Bluebird writing an IMR was due to being obstructive but more a result of unfamiliarity with the process. The manager of Bluebird Care was interviewed on the 5th October together with staff who regularly visited Mr and Mrs K. The care package for Mrs K came as a result of a referral from Mr K.

2.4.1 Key event analysis of involvement from the Internal Management Reviews.

2.4.2 No agencies have reported any incidents of domestic abuse, either physical or emotional, including coercive or controlling behaviour, within Mr and Mrs K's relationship. Their relationship has been described by family members as very loving and that Mr K spent all of his time caring and supporting his wife. Whilst at the Residential Care Home staff described their relationship as very loving and caring. Although Mr K was not staying at the Residential Care Home he regularly visited his wife on average twice a week. During his visits, he would sit with his wife and often brought grapes and chocolates.

2.4.3 Carers from Bluebird Care also identified throughout the review that their carers had no safeguarding concerns regarding Mr and Mrs K's relationship and that they never witnessed any forms or suggestions of domestic abuse within the relationship.

2.4.4 Mr K was identified as having heart failure in 2012 and was assessed by the Cardiac Rehabilitation Service during a home visit where they documented that he was tearful when discussing his hospital admission, felt that he 'nearly gave up' post operatively due to feeling so low but hospital staff kept him going. It was identified at this time that Mr K was caring for his wife who had the first stages of dementia. It was discussed how they would manage but Mr K declined a referral to social services at that time for additional support in caring for his wife.

2.4.5 The first emergency call regarding Mrs K was received by the East of England Ambulance NHS Trust on 6th January 2013 at 11.05, whereby Mrs K had fallen in her home. Mrs K was assessed and treated for a non-injury fall. The patient was referred to the falls referral service and Primary Care, as a possible cause for the fall was a urinary tract infection (UTI) that the crew wished to be assessed further. The victim was left at the scene in care of her family.

2.4.6 Mrs K was registered with the GP at the surgery on 17th January 2013 and had a further 12 contacts with surgery staff. Mr K registered at the surgery on 25th January 2013 and had his new patient health check on this day with a healthcare assistant. Mr K was seen by the GP on six occasions

2.4.7 The next two calls were received on 3rd March 2013, by the East of England Ambulance NHS Trust for Mrs K who had fallen with a possible arm injury. The assessment confirmed a potential fractured arm and hospital transportation was arranged and Mrs K was transported to hospital.

2.4.8 Mr K attended CHUFT on a number of occasions between March and December 2013. Each admission was related to a known cardiac condition. The cause was fully investigated and treated.

2.4.9 On the 20th March 2013 Intermediate Care Service (ICS) received a referral from the hospital rehabilitation service for falls prevention input for Mrs K. An assessment was completed and she was discharged on the 4th April 2013.

2.4.10 The next call received by the East of England Ambulance NHS Trust in relation to Mrs K was on the 16th May 2013 and was from a GP at Caradoc Surgery, who arranged for an ambulance to transport her to Colchester Hospital to assess for a potential hip/knee injury that had occurred earlier that day, when Mrs K had fallen whilst walking with the carers.

2.4.11 Mrs K was referred to NEPUFT by her GP in 2013 due to memory problems. She was seen by a memory assessment nurse for initial assessment on 8th July 2013. At this time, she was living at home with her husband. Mrs K's husband was referred to the carers' assessment team in Essex County Council at the point of the patient's initial assessment. Mrs K was subsequently diagnosed with mixed dementia. Mr K declined to take up any additional support.

2.4.12 Bluebird Care started a care package for Mrs K as a result of a referral from Mr K. The care commenced on the 4th May 2013 and ended on the 30th April 2015. Visits were initially arranged for every Friday until 1st September 2014 when they were increased to twice a week. All visits were scheduled for 1 hour and involved showering Mrs K, changing her clothing and applying cream to her legs which were dry. The care package was stopped on 6th March 2015 following the admittance to hospital of Mrs K as a result of a fall, her care then restarted on the 20th March 2015. From the 20th March Mrs K had a visit every morning

until 28th March when she was taken into residential care. All medication was administered to Mrs K by Mr K. Bluebird staff stated that they would take Mrs K for a shower or bath and that when bringing her back into the living room her medication would be placed on a table by her chair. They stated that they were aware of Mrs K taking her medication and had no cause for concern regarding this.

2.4.13 Staff were aware of lots of bags containing medication being left in the lounge area. They stated that the medication was still in pharmaceutical bags and was either left on the table or in the lounge cabinet. It appears that there were a lot of bags seen in the house however staff stated that Mr K appeared to know what each bag contained and where Mrs K's medication was. Bluebird care have a policy regarding the returning of excess medication and staff are trained in the safe disposal of medication.

2.4.14 Bluebird staff stated that the house itself was untidy and especially so closer to Mrs K moving into residential care. They identified that there was sufficient food in the house and that Mr K would cook meals for both of them and would often go out and bring them back fish and chips. The carers stated that they would wash Mrs K' s hair but that Mrs K had a hairdresser come to the house every fortnight who would wash and dry her hair.

2.4.15 They described Mr K as being a very proud man. They had talked to him on a few occasions regarding increasing the care for Mrs K and also offering to support in household chores. This appears to have been initially agreed by Mr K but then he would change his mind and stated that he didn't want any additional support. Staff took this as concerns over money however this was never spoken about by Mr K.

2.4.16 On 15th July 2013 an email was received into Adult Social care from the Memory Clinic requesting a carers assessment, advised that it wasn't urgent as Mrs K has a private care package once a week to shower and dress her. Social Care were advised that both Mr and Mrs K had substantial savings. Adult Social Care sent a letter to Mr and Mrs K with information regarding the Carers emergency plan. It does not appear that any contact was made at that time with Mr or Mrs K.

2.4.17 On 13th August 2013, Mr K's sister attended the surgery concerned that Mrs K has dementia and had no medication, she reported Mr K was in hospital. Mr K had been admitted to hospital.

2.4.18 The next call received by the East of England Ambulance NHS Trust relating to Mrs K occurred on 16th November 2013 at 04.54. It was assessed that Mrs K had fallen and was uninjured whilst transferring from the toilet to her bed. A falls referral was completed and the patient was left at home in the care of her husband.

2.4.19 On the 4th February 2014 a telephone call was made to Mr K from Social Care to ascertain if he required a carer's assessment. Mr K advised them that he was managing at the moment and that he was attending a bowls club and his wife was ok on her own for about 3 hours. Mr K stated that his wife "can just about wash and dress and he cooks their meals". He stated that she has a Careline pendant.

2.4.20 On the 11th March 2014 Careline received a call regarding Mrs K having fallen. A falls referral was made.

2.4.21 On the 5th April 2014 Adult Social Care made a contact call with Mr K to discuss any additional support required. Mr K advised that his wife had fallen last year getting out of bed. He stated that he had equipment in place for her bed and chair although was experiencing difficulties regarding transferring Mrs K to the toilet. Mr K was advised regarding additional available equipment but this was declined. Information was sent to Mr K regarding additional available services.

2.4.22 On 8th June 2014 The GP undertook a medication review with Mr K over the telephone who reported that he was giving all Mrs K her medications and she was doing well.

2.4.23 The next call received by the East of England Ambulance NHS Trust relating to Mrs K occurred on the 11th June 2014 regarding a fall. A falls referral was made and received by the falls team. An assessment took place.

2.4.24 The next call was received on 2nd February 2015 at 08.59, whereby Mrs K had fallen in the shower. The call originated from CareLine. The crew assessed and treated for a non-injury fall, completed a falls service assessment and again left the patient on scene in care of her husband.

2.4.25 The next emergency call was received on 1st March 2015 at 14.34 in relation to Mrs K having fallen outside her property. The call originated from CareLine and it was reported that her husband was on scene but unable to get to her as she had fallen against the front door. Advice was to convey to the nearest hospital for further assessment, however Mrs K wished to remain at home. Therefore, the Paramedic left Mrs K at home in the care of her husband. It was also highlighted that carers attended twice per week to support with day to day living tasks.

2.4.26 The next attendance occurred on 3rd March 2015 at 05.07, whereby Mrs K had fallen out of bed. The call again originated from CareLine. It was assessed and determined that no injury had occurred. A falls referral was considered but not completed as the victim had advised that the falls team were already aware of her and due to be assessed soon. Therefore, the patient again remained at home in the care of her husband. The author would have expected a falls referral to have been made.

2.4.27 A subsequent emergency call was received at 13.44 again via CareLine. Again the information received was for a fall involving Mrs K who was believed to be uninjured. The responders were aware of the previous emergency call and decided that the patient would be conveyed to Colchester Hospital for further assessment as this was the second fall in a day and provided a clinical impression of acpoia (unable to cope) and a possible UTI.

2.4.28 Further history was provided by Mr K that he could only afford carers bi-weekly and he himself was unable to cope and was considering a Residential Care Home for his wife. The victim was conveyed to Colchester Hospital without further incident.

2.4.29 Mrs K was referred to Rapid Assessment Service (RAS) on 4th March 2015 the Emergency Assessment Unit in Colchester Hospitals University FT (CHUFT) following a fall and possible Urinary Tract Infection (UTI) as she was becoming increasingly confused.

2.4.30 During this admission swelling was noted on Mrs K's left arm, an X-ray confirmed that there was a historical dislocation and fracture of the left shoulder which had not healed.

2.4.31 It was identified that her husband was struggling to cope as the primary carer and noted that they have a private carer twice a week. Community Hospital Staff liaised with the social worker regarding care options for Mr and Mrs K.

2.4.32 The social worker advised that as they were self- funding they would have to increase the care package they already had in place with Bluebird Care. Mr K expressed that they had had daily care prior to admission, but as they were self-funding it got too expensive so reduced this to twice weekly. This was a missed opportunity for intervention by Social Care to identify support needs.

2.4.33 A referral was received into Adult Social Care advising that Mrs K had been admitted into hospital.

2.4.34 A referral was received by the Community Rehabilitation centre on 19th March 2015 by a technical assistant and Mrs K was visited on 20th March 2015 where a full assessment and care plan was completed. The assessment was completed by agency staff and a follow up visit took place on 24th March 2015. They were unable to gain access on 28th March 2015 and 29th March 2015 but then received a message that Mrs K was in residential home.

2.4.35 It was documented by Associate practitioners; who visited the couple's home to complete an exercise programme initiated on discharge, that Mr K was very supportive but that he struggled to support Mrs K with transfers due to the congenital absence of left forearm. They also recorded that Mrs K had difficulty in hearing which they felt sometimes affected her understanding.

2.4.36 The next emergency call received was on the 21st March 2015 at 10.17, whereby Mrs K had fallen from her bed and it was believed to be uninjured. Crew attended and assessed to confirm that it was indeed a non-injury fall. A referral was completed regarding a falls service assessment and again left the patient on scene in care of her husband. Reference was now made that carers were present daily and not bi-weekly.

2.4.37 Mr K was seen on two further occasions by the GP, during a visit in March 2015. Mr K stressed that he could not cope at home and with caring for his wife or himself with his reduced mobility related to his knee pain and reduced knee movement. He reported, and the matron documented, that Mrs K kept falling over and there were trip hazards around the house. Respite care was discussed and funding options. Arrangements were then made for assessment by a residential Care Home manager with Mr K's consent.

2.4.38 The matron reported at interview that Mr K was very frustrated about money and the cost of care. The matron was not aware of the referral to Social Services, she also reported

during interview that at the time, in her role as a GP practice matron, she was unable to complete a full holistic assessment of the patient due to time constraints. Priority was given to finding Mr and Mrs K a place of safety.

2.4.39 On 25th March 2015 at 06.35, an emergency call was received for Mrs K who had fallen in her home. It was apparent that the fall had occurred approximately two hours previously. Mrs K refused hospital admission. Therefore, the Paramedics referred the victim to the Intermediate care team in order to provide ongoing assessment and support. Also no falls referral was made on this occasion as it was determined that the falls team were due the same day to complete a falls assessment. The patient was therefore left at the scene in care of her husband with onward referrals completed and documented. Again, the author would have expected a falls referral to have been completed.

2.4.40 A referral to community nursing was received from Ambulance crew who had attended in response to a fall on the morning of 25th March 2015. An Emergency nurse visited and completed a holistic nursing needs assessment. She commented that the husband was struggling and was concerned as he was finding care so expensive. Mrs K did not have sufficient nursing needs to qualify for Continuing Healthcare funding so she referred to social care following a discussion with her team leader and Mrs K's GP.

2.4.41 A call was made into Adult Social Care by the District Nurse requesting an assessment for Mrs K. The District Nurse advised that Mr K was Mrs K's main carer and that he was struggling and that Mrs K needed more care than she was currently receiving. The District Nurse advised that Mr and Mrs K couldn't afford to self-fund care visits every day. Social Care advised that due to the financial situation they would not support financially and advised that extra visits would need to be organised with Bluebird care privately. Mr K would be referred for a carers assessment.

2.4.42 A call was made by Social Care to Mr and Mrs K. They spoke to Mrs K who passed the phone to her husband as she didn't understand who was on the phone. A decision was made that it was appropriate to speak to Mr K regarding his wife. Mr K advised Social Care that they were self-funders and that his wife had a care visit every morning for his wife.

2.4.43 The next call was received on 26th March 2015 at 06.20, for Mrs K who had fallen and was believed to be uninjured. The crew completed their assessment and determined that it was indeed a non-injury fall. The victim refused any further falls referral and hospital transportation if it was needed. Therefore, she was left in care of her husband.

2.4.44 On 27th March 2015, an emergency call was received at 06.30 relating to Mrs K who had fallen and was unable to get up. Ambulance crew attended and confirmed that it was a non-injury fall. The patient disclosed that both the falls team and physiotherapist were involved. Mrs K was awaiting confirmation of a UTI, the family were on scene and advised that they were trying to arrange Mrs K going into a nursing home of which the crew suggested speaking with the GP. Mrs K again refused any further falls referral or hospital admission.

2.4.45 On the 27th March 2015 the Matron met the Residential Care Home manager at the couple's home, it was noted during the visit that medication was scattered everywhere and it was at this point that Mr K made the decision that both he and Mrs K would go into respite care.

2.4.46 Mrs K was admitted to the Residential Care Home on 28 March 2015 as an emergency placement following a referral by the Community Matron, as Mr K was not able to provide care for her at home.

2.4.47 Five further referrals were received and acted upon whilst Mrs K was a resident in the Residential Care Home. These were for general health appointments.

2.4.48 The GP service was informed by Mr and Mrs K's family that they had gone into a residential home and as such a Senior Physiotherapist attended to review the care plan following change of residence. At interview the practitioner relayed: 'Mrs K spoke with me, she said she was on holiday, she recalled she had had a Total Knee Replacement and it was stiff and that she was doing the same exercises that they were doing in the home'. This recollection indicated insight and understanding from Mrs K into her condition and that she felt her stay in the residential home was temporary.

2.4.49 An initial offer to Mr K of a carers assessment was declined, however on the 9 April 2015 Social Care offered a further carer's assessment and that offer was accepted. The assessment itself did not take place until 13 May 2015 by which time Mrs K had gone into residential care and Mr K stated he had ceased to be a carer. At no point did Social Care consider the sustainability of Mr K's role as a carer. The assessment was not personalised and did not consider the real nature of both Mrs and Mr K's needs.

2.4.50 Between April and 23 December 2015, Mr K regularly visited his wife on average twice a week. During his regular visits, he would sit with his wife and often brought grapes and chocolates which he carried in the same Tesco 'bag for life'. The staff interviewed recalled him visiting the Residential Care Home each time carrying the same bag. His visits were brief and interaction with senior staff was cordial. He always requested the staff to call him a taxi at the end of his visits and waved good-bye to the staff.

2.4.51 On 13th August 2015 a DOL's referral was received into Social Care, the case was allocated to an assessor but was not completed prior to Mrs K's death. It is not felt that the lack of a DOL's assessment would have had an impact on Mrs K's care in the residential home.

2.4.52 In early December 2015, Mr K requested a week stay to spend Christmas with his wife. The home caters for short stays and had no reason not to accommodate Mr K over Christmas period. As is the normal practice, an updated medical record from Mr K's GP was received on 23 December 2015, the day of his admission. Mr K had requested to self-medicate and an assessment was carried out for that purpose. He met the criteria to self-medicate.

2.4.53 On 21st December 2015 a referral was made by the Residential Care Home for Community Matron to assess Mrs K's chest symptoms with a view to avoiding GP visit and hospital admission.

2.4.54 The next attendance in relation to Mrs K was on the 28th December 2015 when a 999 call was placed by an unknown 3rd party, to attend a female who is believed to be deceased or severely injured-shot in head. The victim was recognised as life extinct.

2.4.55 Mr K was not admitted again to CHUFT until the day following his wife's death on the 29th December 2015.

2.4.56 Agency involvement in the care and support of Mr and Mrs K.

2.4.57 North Essex Partnership University Foundation Trust

2.4.58 Regular routine appointments were carried out on time and were recorded appropriately, these included risk assessments. Mr K was referred for carers support at the very start of the memory assessment process. It is noted in home visits completed by the Dr prior to Mrs K's transfer to residential care that the need for further support was discussed with Mr K but they were advised that this was not required.

2.4.59 Mrs K had been in permanent 24 hour care in a residential home since March 2015. There is evidence in the last case review that there had been deterioration in her mental and physical state in that she had become aggressive to staff during personal care interventions and her mobility has deteriorated to the point that she required the use of a wheelchair. She was provided her medication by care staff at the residential home.

2.4.60 No risk to Mrs K from her husband was identified throughout, and on the medication review on 10th December 2015 it was noted that the Residential Care Home staff reported she cheered up when her husband visited.

2.4.61 Anglian Community Enterprise.

2.4.62 It is clear from the interactions in this review that ACE has effective and robust referral processes in place to ensure the right service is mobilised for the right need at the right time.

2.4.63 ACE strongly supports collaborative working with other agencies and endeavours to support this whenever possible. Consideration of social worker involvement over the timeline given in the scope of this review can be evidenced on several occasions. In 2013 the Cardiac Rehabilitation nurse offered a referral to social services for support with care issues raised and this was declined by Mr K. During Mrs K's community hospital admission, the nurse liaised with the ward linked social worker regarding Mr K's 'struggling with care' and was advised that as they were self- funding, he would have to increase the package.

2.4.64 A referral was made on to social care direct on the 25th March 2015 by the Community Nurse after she had completed the Nursing Needs Assessment (NNA) for support of Mr K as he 'could not cope', liaison also occurred with the GP at this time.

2.4.65 ACE has a clinical supervision policy in place however the review identified that this is not being uniformly put into practice and some staff are lacking the support required to help them develop as skilled and informed practitioners. This is an ideal opportunity for staff to reflect on safeguarding matters and develop strong and informed direction to support individuals. This should therefore be a priority action for the organisation.

2.4.66 Communication could be improved both with external agencies and other services under ACE's umbrella, to support vulnerable adults with North Essex Partnership University Foundation Trust needs. Practitioners need to be appropriately informed in relation to these needs to enable them to critically analyse situations and support individuals as effectively as possible through effective risk assessment. They need an identified case manager or keyworker so that the patient/couple can remain central and information is fed back to one person. The care closer to home model now in existence should cover these identified areas.

2.4.67 Had a case manager or key worker been identified for Mrs K it is likely that communication could have been improved across services, which may have facilitated a patient centred joint plan of care. It was evidenced in interview that services such as the brokerage scheme for self- funding couples was considered appropriate and may have addressed some of Mr K's frustrations with the funding system through information and education, however, due to lack of the overview achieved by a case manager this consideration occurred too late in the timeline of care interventions. This additional support may possibly have resulted in the provision of assistance to both Mr. and Mrs. K in a structured and planned way that addressed their needs in a holistic needs orientated way.

2.4.68 From April 2016 ACE have been commissioned to provide the adult services under the umbrella contract term of 'Care Closer to Home'. This new way of working for nursing and therapy teams creates better integration across the system where teams working closely aligned to GP practices offering the people of North East Essex an integrated and seamless network of patient-centred services based closer to where they live. This model of care is designed to improve clinical outcomes and the individual's experience of the care, so that:

- People with long-term conditions and their family/carers are supported to be independent in their own homes, avoiding hospital admissions.
- People are enabled and empowered to take control of their health and social care need.
- People make a good recovery from episodes of ill health or following injury.

2.3.69 The Care Closer to home model includes the allocation of a case manager to co-ordinate care and the creation of this role will lead to a position where the person is more supported to identify a care pathway, rather than be the mere recipient of a range of services. The evidence for the expansion of roles within the organisation is reflected in contextual information above. The training that is being sourced and delivered alongside the

implementation of the Care Closer to Home contract is envisaged to develop holistic case managers and would be wise to consider developing risk assessments in practice that address current culture and practice.

2.4.70 The IMR author has identified through this review that both Mrs K and Mr K had numerous interactions with services in the period within the scope of the review. The services provided were timely and appropriate in response to the referral received. Nothing in this review has indicated that this was not the case. It is evidenced in the records of Mr and Mrs K and throughout the interviews that the approach to the couple was as separate individuals rather than consideration of them as a couple with strong interdependencies.

2.4.71 Essex County Council Adult Social Care

2.4.72 In the case of Mrs K, it appears from the chronology that social care failed to adhere to either the Fair Access to Care Guidance relating to the period up to the 31 March 2015 when the Community Care Act was in force or the Care and Support Guidance. The fact that Mrs K was self- funding and the couple had savings in excess of the capital limit appears to have been uppermost in considerations. A referral to social care was offered to Mr K by other agencies on several occasions however these were declined by Mr K. Social care did initially discuss care with Mr K over the phone who stated the he was coping with supporting Mrs K.

2.4.73 On the 25 March it was documented that due to the financial situation advice was given that social care would not support financially at this time. Advice was given that extra visits would need to be organised with Bluebird Care privately. Mr K was to be referred for carers assessment, however no assessment however took place due to Mrs K going into residential care.

2.4.74 There appears to have been no attempt to assess Mrs K's needs. As a result, it was not known whether the above advice to increase care visits was appropriate to meet Mrs K's needs, or to ensure that Mr K was properly supported. This is not consistent with either the Care and Support Guidance or Essex County Councils' practice guidance.

2.4.75 A further point to note is that the admission to the Residential Care Home occurred without an assessment of need and followed a telephone conversation in which Mr K requested a carer's assessment. There is therefore the possibility that an opportunity to prevent Mrs K's admission to the Residential Care Home was missed.

2.4.76 Since Mrs K's death Adult Social Care have adopted the "Good Lives" model of care and support model as the preferred approach to meeting needs. This places emphasis on prevention and it is clear that this applies to all who approach social care for support.

2.4.77 Annex C sets out the Good Lives model as a graphic for clarity. The model;

- is for all those who approach social care for help irrespective of their financial status, or the support they may have in place;
- is intended to ensure that issues are resolved before a crisis arises;

- is designed to ensure swift resolution where a crisis exists;

2.4.78 Safeguarding is at the core of the model ensuring that the approach to implementation is firmly based on the primary consideration of keeping people safe. It is based on three conversations, which can be repeated as required. This approach gives effect to the asset model of assessment and meeting need set out in the Care and Support Guidance.

2.4.79 Good Lives has been rolled out across Adult Operations, including Social Care Direct, where staff have been implementing the new approach in a phased way. This has now been fully implemented.

2.4.80 There was a Deprivation of Liberty (DOL's) referral by the Residential Care Home into Social Care on the 13 August. This was received by the DOL's team within Social Care and had been allocated to a team although had not been authorised. It is felt, however, that this would not have had any impact on the care Mrs K received.

2.4.81 Tendring District Careline

2.4.82 Tendring Careline Operators acted within the parameters of the service, and with the Service Users best interests, on each occasion they were called. There were no deviations in service levels no matter which Operators handled the calls.

2.4.83 All calls were handled with necessary expedience and sensitivity. Any requests for follow up action or referrals were completed in a timely manner by the Operators and the Service Users were kept as safe as possible. Event logs and Serious Incident Reports were found to be factual and complete.

2.4.84 Colchester Hospital University Foundation NHs Trust (CHUFT)

2.4.85 When Mr K informed staff that he felt that he was unable to cope with his wife when she was admitted in 2015, Staff appropriately acknowledged this and referred Mr K for further social care assessment and review of the current care provision and support to Mr and Mrs K. CHUFT did not discharge Mrs K but transferred her to Clacton hospital to await full social care assessment. This was the most appropriate action

2.4.86 Mrs and Mr K were treated appropriately by CHUFT staff. All treatment was provided in a timely manner and in line with trust guidance. There were no safeguarding concerns or concerns regarding domestic abuse identified by staff.

2.4.87 The clinical records have been reviewed for the admission into A&E by ambulance with chest pain. It is clearly documented under the social history section that Mr K lived in a bungalow with his wife who has dementia and that he was the main carer. The documentation further provided evidence that Mr K informed staff that his sister lived close by and was assisting in caring for Mrs K. The staff did not raise any further concerns as Mr K had reassured them that his wife was receiving support. Mr K also informed staff that his sister was a next of kin contact.

2.4.88 East of England Ambulance NHS Trust

2.4.89 It is felt that the Trust staff attending acted within expected clinical guidance, correctly clinically assessed and treated appropriate to their knowledge and skill level. At no point is it evident that there was a lack of medical care or intervention from the crews attending.

2.4.90 The author would have expected a falls assessment referral to be completed on every contact which is in line with the Trust Medical Record Policy. However, on a number of occasions the crew were unable to as the victim did not consent for the referral, which is a valid exception. In addition, over all attendances, there were no more than two attendances receiving the same clinician, making it difficult to spot trends that may have determined alternative care pathways for the victim.

2.4.91 In addition, the number of calls to the victim over the timescale was recorded at 15 calls (14 attendances, this was over a time span of nearly three years and therefore not excessive.)

2.4.92 Whilst the timescale involved a period three years, a number of different clinicians attending the victim, the author would not expect a trend to be spotted by the attending crews and therefore no safeguarding referrals were made around the vulnerability of the victim.

2.4.93 It is noteworthy that seven calls were received in March 2015, but again to no attending crew being the same, it would have been difficult to spot trends and on all occasions, either a falls referral was completed or the patient declined as she had indicated that the falls team were aware of her.

2.4.94 The Trust has introduced a policy to support patients with complex and individual needs who may call upon the emergency services regularly and set criteria for inclusion. Annex D. When applying the criteria to the Mrs K, she would have met the threshold. However, the threshold would have been considered from the earliest April 2015, but which time the victim had been placed into Residential Care and would not have been pursued as no further calls were identified until the victim's death on 28th December 2015.

2.4.95 Residential Care Home.

2.4.96 The Residential Care Home does not have a bespoke domestic abuse policy, however it has a Safeguarding of Vulnerable Adults Policy in line with and in conformity with Essex County Council Safeguarding Guidelines. The Safeguarding of Vulnerable Adults Policy outlines the steps to be taken by staff and others to report any form of abuse, aggression and bullying. The Home also has a 'No Secrets' Policy.

2.4.97 The practice of pre-admission assessments, person-centred care planning, regular reviews, mental capacity assessments, risk assessments, referrals to other agencies are carried out to the required standards. Policies and Procedures are suitable and appropriate for a Residential Care Home for Older People. The Safeguarding of Vulnerable Adults Policy is given due importance. Staff are trained according to Essex County Council and Care

Quality Commission guidelines. The Residential Care Home performs these functions well as evidenced by good successive reports by the Care Quality Commission.

2.4.98 As there was no evidence of risk of harm, no referrals were made, except for Deprivation of Liberty Safeguard (DOL's) application to Essex County Council made in August 2015 due to Mrs K's dementia

2.4.99 Bluebird Care

2.4.100 Bluebird carry out mandatory Safeguarding training and are refreshed every year. They have a training manager in house who receives training from the Local Authority. All Safeguarding guidelines are published on their internal web pages. The Tendring manager is the Safeguarding lead and will refer all Safeguarding concerns through to the relevant authority. Bluebird do not have separate Domestic Abuse guidance or training but state that Domestic Abuse training is incorporated in their care certificate which every care worker has to achieve. Bluebird Care is subjected to CQC inspections and have received a recent good graded inspection.

2.4.101 Bluebird Care review their care plans and risk assessments on a regular basis and will discuss additional needs as required. They were aware that Mr and Mrs K were self-funders. A referral to Social Care regarding additional support and a financial assessment was discussed with Mr K, however this was refused as Mr K stated that he did not want Social Care assessing his personal circumstances.

2.4.102 All care assessments and risk plans were carried out timely. Additional support was recommended to Mr K and on some occasions accepted. The amount of care provided was increased following a care review as additional support needs had been identified. Referrals were made to the falls assessment team through the appropriate mechanisms and an Occupational Therapy Assessment was also requested by making a referral to the GP.

2.4.103 The carers had no safeguarding concerns and felt that although they considered the house to be dirty they felt that Mrs K was well cared for. She appeared to be well fed, clean and tidy. The house was always warm and Mrs K had plenty of clothing and blankets. Staff identified a deterioration with Mrs K s general health a month before she moved into the Residential Care Home

Section 3: Analysis

3.1 Family involvement and perspective

3.1.1 Mr and Mrs K did not have any children. It is believed that Mr K was one of 13 siblings. No family have been identified for Mrs K. It is believed that the reason that Mrs K was placed into the specific Residential Home was due to the fact the one of Mr K's sisters, was already living there. Mr K's other sister was also living across the road from Mr and Mrs K and helped in support given to Mrs K. Letters were sent to Mr K's sister and three nephews and nieces identified through the investigation.

3.1.2 The author of the report phoned Mr and Mrs K's niece to discuss the review process and to ask whether they wished to take part in the review.

3.1.3 She stated that the family felt that they did not wish to participate in the review but that she was happy to discuss Mr and Mrs K over the phone. She described them as a very loving couple who had been married for 50 years. She stated that Mr K had spent all of his time looking after his wife but that he had found it harder as time went on due to her dementia. The family had always advised Mr K to seek additional help and support but they stated that he was a very proud man who did not wish to ask for help either personal or financially.

3.1.4 She stated that she and other family members were not aware of any domestic incidents within the household and that they both presented as a loving couple. Mr and Mrs K were described as doing everything together and that Mr K had found it very difficult when his wife was diagnosed with dementia and even harder as she deteriorated.

3.1.5 A letter was sent to Mr K through his clinical psychiatrist at the hospital he is detained at advising him of the review and asking whether he wished to take part. An additional request was made through Mr K's social worker. The panel were advised by the social worker that she did not feel that it would be in Mr K's best interest to be spoken to regarding the review.

3.2 Analysis of agency involvement

3.2.1 The admission to the Residential Care Home occurred without an assessment of need and followed a telephone conversation in which Mr K requested a carer's assessment. Contact with Mr and Mrs K was limited to conversations with Social Care triggered predominantly by referrals from the Memory Clinic requesting assessments. Whilst Adult Social Care did react to those requests they did not appear to have progressed to consideration of a face to face assessment to establish needs, which given the nature of the need and age of the adults might have been expected.

3.2.2 This seems, at least in part, to have stemmed from their status as self-funders and their perception that their needs were being met by the care they were paying for. There doesn't appear to be any joined up thinking in relation to Mr and Mrs K's needs as a couple and each were looked at in silo.

3.2.3 This approach is inconsistent with the Care and Support Guidance and their own practice guidance. Its consequence in this case appears to have been the loss of opportunities to fully establish the needs of both Mr and Mrs K and to consider how best to support them as couple (Care and Support Guidance, Department of Health, 2016).

3.2.4 Overall responses to Mr and Mrs K appear to have been predicated on three things;

- they had care going in so were not urgent,
- they were funding that care themselves and that any increase in needs could be met by them

- because the contact was made by Mr K, the needs of Mrs K were not appropriately considered.

3.2.5 The wellbeing principle and the concept of meeting needs sits at the core of the Care Act. It is quite clear that whether or not an adult can fund their own support, responsible agencies must take steps to establish what their needs are and to assist them to meet them, whether eligible or otherwise.

3.2.6. Bluebird were contacted by Mr K, in relation to arranging care for his wife, and an assessment visit took place at the home address. Both parties were present. A full care assessment took place on the initial visit where it established the level of care required. It was identified that Mr and Mrs K were self-funders at this time. A full generic care plan and risk assessments were completed. These identified what type of care was required linked to the required outcomes. It was established with Mr K that he would continue to provide medication for his wife.

3.2.7 The care plan was agreed with both Mr and Mrs K. Staff were aware of Mrs K having dementia, however they were happy that she could consent to their involvement and the care provided. All care plans and risk assessments were reviewed on a regular basis and agreed and signed by Mr and Mrs K. Reviews took place after 48 hours, 1 month, 3 months and 6 months and every 6 months thereafter.

3.2.8 At the reviews additional support was offered to Mr K, including help around the house. This was taken up by Mr K on a couple of occasions but was then cancelled straight away, afterwards citing monetary issues. At no time were any safeguarding concerns raised by staff visiting the address. Bluebird Care were aware of the advocacy service but did not feel that it was necessary in this case as Mrs K appeared to be consenting and happy with the care provided. Staff from Bluebird Care made referrals to the Falls prevention team after Mrs K fell on a couple of occasions that they were present at. They did not receive any feedback in relation to these referrals. A request for an occupational therapist assessment was also completed. This referral was made directly to the GP

3.2.9 Mrs K went into respite care at a residential home with a view to it becoming a permanent placement. There are no records of this placement being arranged by social care on their system as this appears to have been a privately funded placement

3.2.10 Mrs K's care at the Residential Care Home was carried out following an Individual Personalised Care Plan. As is the practice, the Residential Care Home received a summary of Mrs K's current medical condition and current medication at the time of admission from the General Practice.

3.2.11 The care plan included the mental capacity assessments which identify the types of decisions and preferences Mrs K was capable to make. It was assessed that she was able to make simple decisions of daily living such as food preference, clothes to wear, participation in daily activities etc., but not complex decisions such as management of her financial affairs. In line with these assessments, the DOL's referral was made. At no stage during her stay did she communicate that she had been subject to domestic abuse prior to admission.

She did not communicate or give any other indication that she did not wish her husband to visit her.

3.2.12 It is notable that following Mrs K's placement in residential care and the two subsequent memory medication monitoring appointments that there had been a decline in Mrs K's level of functioning. There is documented evidence from the care staff that there had been a decline in her mobility, cognition, level of functioning and behaviour in that she had become aggressive during personal care interventions, and that risk assessments were carried out and recorded, both electronically and also in the letters to the GP following appointments.

3.2.13 During her stay at the home from March to December 2015, Mrs K's care needs were being met. During this period, there were no concerns regarding her husband's regular visits, indeed visits by family are a beneficial aspect of Residential Care Home life. There was no evidence of risk of harm by Mr K towards his wife during his frequent visits during the nine month period. Hence, his request to spend a week over Christmas with his wife was seen as beneficial to both of them and certainly not as a risk to her.

3.2.14 It must be acknowledged that this couple were experiencing such a range of dilemmas around the same time: deteriorating health and mobility, with increased episodes of falling for Mrs K, worsening dementia; leaving their home and moving into care; economic strain and frustration with the funding system for care for Mrs K. This was likely to be extremely challenging and stressful to confront and manage alone.

3.2.15 There is clear evidence throughout this overview that interagency communication could be improved. Agencies appear to have worked in a silo manner rather than in an integrated partnership that placed the individuals at the centre of their care. This had an overall impact on the quality of care the couple received and opportunities to support them in a coordinated manner were overlooked.

3.2.16 The care, readily offered and given, was focused on a needs led assessment and planned intervention based on each service's referral criteria, fulfilling contractual requirements. Whilst this approach often encompassed more than individual needs and circumstances, a more holistic care assessment incorporating an awareness of what others were doing would assist in understanding Mr and Mrs K's environment and the significant life changing events they were experiencing.

3.2.17 The wellbeing principle and the concept of meeting needs sit at the core of the Care Act. It is quite clear that whether or not an adult can fund their own support, Social Care must take steps to offer to establish what their needs are and to assist them to meet them, whether eligible or otherwise. This does not appear to have happened in this case.

Section 4: Conclusion and Recommendations

4.1 Conclusion

4.1.1 All information was analysed at the initial scoping meeting and at subsequent panel meetings in relation to any reported incidents of domestic abuse within the household. Relatives and staff from Bluebird care and the Residential Care Home were also spoken to regarding any concerns they might have had regarding domestic abuse within the relationship. There were no concerns identified by any relatives or within any agency. Everyone who had contact with both Mr and Mrs K stated they were a very close knit couple who appeared to be very loving and caring towards each other.

4.1.2 At the beginning of the review it was identified that Mr K had a history of heart disease and had a congenital absence of his left arm but this did not appear to affect his day to day living. Family suggested that he had been made to do everything himself as a child and learnt to deal with his disability at a very early age.

4.1.3 It has been identified throughout the IMR's that Mrs K deteriorated quickly throughout the last month of living at home. Prior to going into the residential care home she had seven falls within a short space of time which were reported to the 999 system either directly by Mr K or through Careline. It was as a result of one of these falls that Mr K was advised by the ambulance crew to contact his GP for more support. As a result of this contact, and a visit from the Matron a decision was made for both Mr and Mrs K to go into a Residential Care Home, initially as respite care.

4.1.4 Although Mr K was receiving support for his wife via Bluebird care, this support was self-obtained by Mr K. Mrs K has been identified as a person in need of care and support, however this did not appear to have been provided in this case. Adult Social Care had been notified that additional support was required, however they failed to act on these notifications in a timely manner. It is not felt that Mrs K would have met the criteria for a safeguarding adult referral. It was identified by other agencies that Mr K had reported to them that he was unable to cope with the care of his wife.

4.1.5 It has also been identified by agencies and family members that Mr K had refused additional help when offered. Mr K cited financial concerns, however this did not actually appear to be the case. There seems little doubt that Mr K was both very proud and very independent and wished to care for his wife. In some ways, as a couple, they were more vulnerable because they did not have any children or immediate relatives highlighting their vulnerabilities. The panel considered whether Mr k was controlling his wife by refusing additional help and support. Bluebird Care felt that Mr K was very loving and supportive of his wife and that everything he did was for her benefit. Although money was discussed by Mr K as a reason for not providing additional help there was nothing to suggest that this was being used as a reason for control as Mr K appeared to be happy to spend money when required to help his wife be comfortable. Mrs K was attended at the home address by a hair dresser every fortnight and always appeared to be happy and content.

4.1.6 No assessments took place regarding Mr and Mrs K's circumstances once it was identified that they were financially able to pay for their own care. It appears that both Mr and Mrs K were let down in this aspect as an assessment of need should have taken place and additional care and support identified. It may well have been the case that Mr and Mrs

K would still have had to have paid for their support, however the correct help and support could have been identified at an earlier stage. This may have resulted in additional support being put into the home address which may have resulted in Mrs K being able to stay at home longer. Throughout the review it appears that Mr and Mrs K were looked at as individuals and not as a couple. Further consideration should have been given into how Mr K was coping, or not, with his wife's worsening health. A carers assessment should have been completed on Mr K.

4.1.7 It had been identified in the Residential Care Home IMR that upon attending the home address a large amount of medication was seen lying around the house. Bluebird Care stated that they also saw an amount of medication, however they had no concerns regarding its usage and were happy that Mr K was properly administering his wife with her medication. The GP noted in their IMR's that medication reviews were undertaken, however these were completed mainly with Mr K, due to his wife's illness and also mainly over the telephone. It does not appear that direct consideration was given as to whether Mrs K was receiving her medication in an appropriate manner.

4.1.8 Mrs K's Mental Capacity was also discussed at panel meeting and it has been identified in agencies IMR's that appropriate assessments took place throughout their dealing with both Mr and Mrs K.

4.1.9 This is a very tragic loss of life. It does appear that more support could have been offered to Mr K prior to his wife going into care, however, Mrs K was being fully cared for in a Residential Care Home nine months before her death. It has been shown that Mrs K was being cared for to a high standard within the Residential Care Home and that she appeared to be happy. She was being visited on a regular basis by her husband and showed signs of being pleased when he visited. It has been identified that Mr K was suffering from early stages of dementia at the time of killing his wife and was therefore impeded in forming rational judgements.

4.1.10 There are no indications as to how Mr K was coping both emotionally and physically during the time his wife was in the care home. This vital question does not appear to have been asked of him which again is something that should have been highlighted due to the fact that Mr and Mrs K had been together for a great amount of time and that he had been her sole carer. A carers assessment was accepted by Mr K; however, this did not take place due to the fact that Mrs K had already gone into the residential care home.

4.1.11 Within ACE's IMR it has been identified that Mr and Mrs K were dealt with on a case by case basis and that a more holistic approach was required. It has been identified that care was given to both Mr and Mrs K but that this care was on a needs basis and upon presentation. If a holistic approach had been used agencies might have identified that Mr K was the sole carer for his wife whose health was deteriorating due to her dementia and that additional support was required. Realistically it appears that Mrs K may well have had to go into a Residential Care home as her needs were such that she required full time care, however if additional support had been offered and taken up by Mr K it might have meant

that Mrs K could have stayed in her own home longer or at least it might have meant that the transition into care might have been easier for Mr K.

4.1.12 During the investigation it became apparent that family members were aware that Mr K had a gun within the family home as it had been a topic of conversation over time, although the gun had not been seen by anyone. Family members were told that the gun was a World War replica which had been kept as a momentum and did not believe that it was capable of being fired. There was no suggestion throughout the whole review that Mrs K was frightened of the gun or that she was significantly aware of it.

4.1.13 Essex Police had recently launched a two-week firearms amnesty so residents can surrender any unwanted or unlicensed firearms and ammunition. It ran from Monday, October 31 until Friday, November 11 2016. During that time members of the public were encouraged to hand in unwanted firearms, ammunition, imitation firearms, and air or gas-powered weapons to one of eight police stations.

4.1.14 During this period anyone surrendering firearms were advised that they would not face prosecution for illegal possession. They could also choose to remain anonymous when handing the items in. Forty-seven firearms and nineteen rounds of ammunition were handed in during the first seven days of the Essex Police's firearms amnesty.

4.1.15 The aim of the amnesty was to ensure firearms do not end up in the wrong hands and used in crime, and provides protection from prosecution for the possession of the firearm as it is being handed in.

4.1.16 Essex Police were also encouraging members of the public to hand in imitation firearms, BB guns and air weapons. These can be almost impossible to tell apart from the real thing but can provoke the same feelings of fear when seen or used in crime.

4.2 Recommendations

4.2.1 North Essex Partnership University Foundation Trust

4.2.2 No recommendations have been identified for North Essex Partnership University Foundation Trust.

4.2.3 Anglian Community Enterprise.

4.2.4 During the period covered by this IMR there were six referrals to the Falls Prevention Service from external agencies following falls, and four comprehensive assessments were carried out in the home and advice given. Intervention was provided in relation to the service specification however It does not appear that consideration was made as to whether this was an ongoing issue that needed further enquiry to reduce long term risk and intervention. There is little evidence of case management surrounding both Mr and Mrs K and their long term care and needs support.

Recommendation 1
The Falls prevention service should put in place a clear procedure surrounding the case management of individuals regarding their care and support needs. Trigger points to be identified within the care plan, appropriate to the individuals needs to include liaison to take place with identified carers and family members.

4.2.5 It has been highlighted during the IMR that medication was reported as an issue (loss/lack of) on multiple occasions and opportunity to review this risk was overlooked by the GP practice possibly due to high rates of locum Doctors and ineffective record keeping. A clear process should be put in place to identify risk and initiate appropriate and proportionate risk assessment and reviews of these risks to ensure appropriate risk management

Recommendation 2
The GP surgery should have a clearly documented process in place that identifies medication risk and initiate appropriate and proportionate medication reviews, in accordance to the identified risk and its complexity.

4.2.6 At interview the Lead GP indicated that most of the contacts and care plans for Mrs K were completed by the Memory Clinic and shared with them. Although he had no direct contact with Mrs K, he could see she had minimal contact with the surgery since registration and they felt she was being managed by the North Essex Partnership University Foundation Trust Team. Mrs K had cognitive impairment documented in her notes but there was never an occasion to check Mental capacity in relation to Mrs K's ability to make decisions.

4.2.7 When reflecting on the case he felt the surgery should be more proactive flagging up patients who are elderly with co-morbidities and have not been seen for 6 months. There were three episodes where further prescriptions needed to be issued due to loss or lack of medications, which should have flagged a face to face review from the GP surgery, rather than it being undertaken over the telephone.

4.2.8 The practice feels more optimistic of achieving these quality improvements now that they have secured permanent staff.

Recommendation 3
The GP surgery should recognise their role and responsibility in relation to the case management of patients with dementia and those with complex needs.

4.2.9 The matron reported at interview that Mr K was very frustrated about money and the cost of care. The matron was not aware of the referral to social services. The matron reported during interview that at the time, in her role as a GP practice matron she was

unable to complete a full holistic assessment of patient's due to time constraints. Priority was given to finding Mr and Mrs K a place of safety.

Recommendation 4
The GP surgery should have a clear role descriptor in place for the role of the practice matron. Ensuring the role is supported to work collaboratively with both internal and external agencies, is patient focused and supports holistic assessment.

Staff need to work collaboratively internally and externally to support individuals in decision making and best interest decisions

4.2.10 Essex County Council Adult Social Care.

4.2.11 In the case of Mrs K, it appears from the chronology that they failed to adhere to the Care and Support Guidance. The fact that Mrs K was self- funding and the couple had savings in excess of the capital limit appears to have influenced the way in which the matter was handled, resulting in her not receiving a full assessment of her needs. This is not consistent with the Care and Support Guidance. Mr K contacted Social Care about his needs as a carer but it was not identified that Mrs K herself would have benefited from an assessment.

Recommendation 5
Social Care staff are to be reminded that assessments of needs should be offered to those adults appearing that they may have the need for care and support, irrespective of whether they are self-funders or not.

4.2.12 Tendring District Careline

4.2.13 No recommendations have been identified for Tendring District Careline.

4.2.14 Colchester Hospital University Foundation NHS Trust (CHUFT)

4.2.15 No recommendations have been identified for Colchester Hospital University Foundation NHs Trust.

4.2.16 East of England Ambulance NHS Trust

4.2.17 The reporting systems in place around falls assessment and safeguarding are robust and working, however, the reconciliation of falls referrals evidenced by the ambulance crews differs from the logs and the author of the IMR will seek assurance from Managers that the systems are robust and ambulance crews will be reminded through the clinical manual and notices of the importance of a falls referral through single point of contact.

Recommendation 6

All staff are to be reminded to make the appropriate falls referrals through the Single Point of Contact referral pathway only with the patients agreed consent.

4.2.18 Residential Care Home.

4.2.19 There is currently no Policy on domestic abuse and no training of staff on this subject. It is recommended that the care home train their staff in relation to domestic abuse to consider people who are either resident within the home or visitors of those residents who fit the criteria for domestic abuse.

Recommendation 7
SOVA training to be reviewed to include a module on Domestic Abuse.

4.2.20 Bluebird Care

4.2.21 Bluebird care do not currently have a Domestic Abuse policy however their staff must complete DA training within their Care Certificate.

Recommendation 8
Bluebird Care to develop a Domestic Abuse policy within its Policies and Procedures.

4.2.22 All agencies

4.2.23 It was identified throughout the review process that several agencies held relevant information regarding both Mr and Mrs K, however no one agency appeared to own the risk. There was no identified co-ordinated triage system in place where agencies could have shared information. This appeared to be the case as neither Mr nor Mrs K were subjected to safeguarding concerns and were not identified as adults at risk under the Care Act.

Recommendation 9 – Professional meetings
Agencies are to be trained regarding multi-agency Professional meetings and the importance of their attendance at these meetings. The importance of sharing of all relevant information especially where the adult does not fall under Safeguarding but where agencies have concerns regarding their health and care needs.

Recommendation 10 – Risk management
All agencies to raise awareness regarding the importance of carrying out risk assessments prior to carrying out visits within people's homes. Agencies to look at the wider picture surrounding the escalation of concerns within agencies and the right referral process

where risk has been identified.

Annex A – IMR writers

The IMR Author for North Essex Partnership University Foundation Trust was Melanie Arthey, Clinical Specialist in Safeguarding. She is experienced in giving specialist consultation and supervision in safeguarding throughout age ranges including CAMHS and older adults. She carries out training in safeguarding to level 3 the Care Programme Approach and risk management. She is also an experienced ward manager (sister) in adult acute North Essex Partnership University Foundation Trust as well as specialist North Essex Partnership University Foundation Trust rehabilitation wards. She is experienced in both Domestic Homicide panels and writing Internal Management Reviews.

The IMR author for Tendring District Council Careline was Mark Westall. He is the Head of Service for Tendring Careline and the line manager of the Control Centre Service Development Manager, Claire Ellington. It is her duty to manage the day to day operation of the service and staff.

The IMR author for the East of England Ambulance NHS Trust was Simon Chase. He is the Safeguarding Lead with the regional safeguarding responsibility for EEAST, covering the six counties within East of England (Norfolk, Suffolk, Cambridgeshire, Bedfordshire, Hertfordshire and Essex) for children, young people and vulnerable adults. This is his fourth IMR as an author.

The IMR author for the Residential Care Home was Dr Kristan Malhotra. The author is a Company Director who visits the home on a regular basis and is in contact with the Responsible Individual and Registered Manager regularly. The author does not line manage staff. The author has had no involvement with the victim or the perpetrator or any family member.

The IMR author for Colchester Hospital University Foundation NHS Trust was Helen Edwardson who is the Safeguarding Adults lead.

The IMR author for Adult Operations was David Williams. He is the Senior Operational Policy Advisor within Adult Social Care.

The IMR author for Anglian Community Enterprise was Catherine Sands who is the lead for Clinical Quality and Safety. The author has worked in the NHS for over 30 years. Previous experience includes: Lead for Specialist Support nurses for End of life Care, Locality lead for Community nurses and Out of Hours Community Nursing manager. The author had no previous involvement with Mr or Mrs. K or their extended family, neither has she line managed any of the staff involved in the case.

Annex B – Key timeline of events.

06/01/13 - Call received into the East of England Ambulance NHS Trust regarding Mrs K having fallen.

03/03/13 - The next two calls were received on 3rd March 2013, by the East of England Ambulance NHS Trust for Mrs K who had fallen with a possible arm injury.

20/03/2013 – Intermediate Care Service received a referral from the hospital rehabilitation service for falls input for Mrs K. An assessment was completed and discharged 04/04/2013.

04/05/13 – Care package put in place by Bluebird Care at the request of Mr K.

04/06/13 – A falls referral was received.

08/07/13 – Mrs K was assessed and diagnosed with mixed dementia.

15/07/13 – Adult Social Care sent a letter to Mr and Mrs K with information regarding the Carers emergency plan.

31/07/13 – Mr K was admitted to CHUFT, staff considered Mrs K's needs as they were aware that he was Mrs K's carer. Mr K advised them that his wife was being looked after by his sister.

13/08/13 – Mr K's sister attended the surgery concerned that Mrs K had dementia and had no medication and that her husband was in hospital.

16/11/13- Careline report Mrs K fallen out of bed.

04/02/14 – E mail into Social Care from Memory clinic requesting carers for Mrs K as she has memory problems. Advised not urgent as Mr K manages and has a private care package.

05/04/14 – Call to Mr K from Social care to discuss support requirements. Mr K stated that he is managing. Mr K advised that he has a care package once a week for his wife. Mr K advised that they both had savings.

11/03/14 – Careline receive a call re Mrs K fallen.

12/03/14 –Fall referral received.

08/06/14 – The GP undertook a medication review with Mr K over the telephone who reported that he is giving Mrs K all her medication and that she is doing well.

11/06/14 – Careline report a fall from Mrs K.

11/06/14 – Fall referral received.

02/02/15 – Careline report Mrs K has fallen in the shower, ambulance attended.

05/02/15 – Fall referral received.

01/03/15 – Careline receive a call re Mrs K fallen, ambulance attended.

03/03/15 – Careline receive a call re Mrs K fallen, ambulance attended.

04/03/15 – Referral to Rapid Assessment Service for Mrs K following a fall and possible UTI (Urinary Tract Infection). It was identified that her husband was struggling to cope as the primary carer and noted that they had private care twice a week. Community Hospital staff liaised with the social worker regarding options for Mr and Mrs K and were advised that as they were self-funders they would have to increase the care package they already had in place. This was then increased to daily care for Mrs K.

20/03/15 – Community Rehabilitation completed a full assessment and care plan of Mrs K at her home address. It was noted that Mr K was very supportive but that he struggled to support Mrs K with transfers due to the congenital absence of his left forearm.

21/03/15 – Fall referral received.

21/03/15 – Ambulance attended Mrs K re fall.

25/03/15 – Careline receive a call re Mrs K fallen, ambulance attended.

25/03/15 – A referral to Community Nursing was received from Ambulance crew who attended a fall. An emergency nurse visited and completed a holistic needs assessment. She commented that the husband was struggling and is concerned that he is finding care so expensive. Mrs K does not have sufficient nursing needs to qualify for Continuing Healthcare so a referral was made to Social Care.

25/03/15 – Call to Social Care from District nurse requesting an assessment for Mr and Mrs K. She advised that Mr K is the main carer for Mrs K and that Mr K was struggling and that Mrs K needs more care than she is currently receiving. She advised that Mr and Mrs K could not afford to self-fund more care visits a day.

26/03/15 – Careline receive a call re Mrs K fallen, ambulance attended.

27/03/15 – Careline receive a call re Mrs K fallen, ambulance attended.

27/03/15 – Pre assessment carried out at Mr and Mrs K's home address following a call to the GP from Mr K. Attendance by Community Matron and manager of Residential Care Home.

28/03/15 – Emergency placement for Mrs K at Residential Care home. Mr K also went in with his wife for a trial period to look at full time residency.

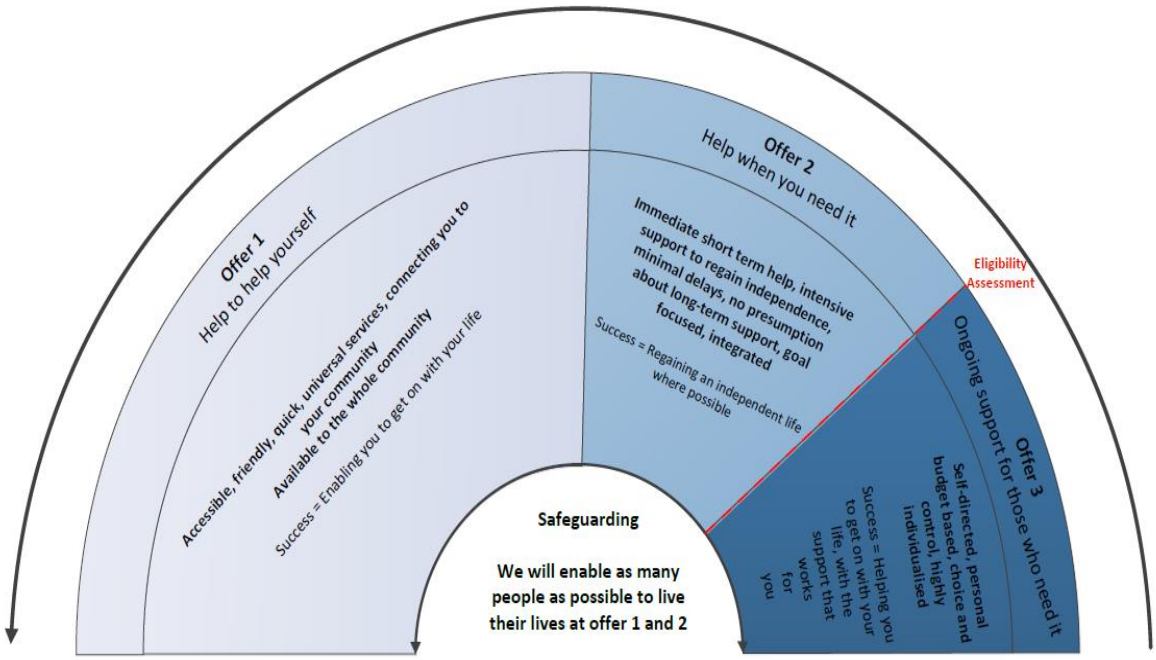
01/04/15 – Mr K discharged himself from Residential Care Home.

09/04/15 – Phone call to Mr K from Social care. Mr K described his wife as prone to falling and that she couldn't get herself up. Discussed a carers assessment and Mr k stated "well I'd be happy for any help at all".

13/05/15 – Phone call to Mr K from Social Care who were advised that Mrs K had been placed into a Residential Care Home. Mr K was spoken to regarding a visit from the community Social Worker which was accepted.

28/12/15 – Death of Mrs K reported.

Annex C – The Good Lives Model (Adult Social Care)



The Three Conversations

The power of listening

Conversation 1:
'How can I connect you to things that will help you get on with your life – based on your assets, strengths and those of your family and neighborhood. What do you want to do? What can I connect you to?'

Conversation 2:
When people are at risk – 'What needs to change to make you safe?
How do I help make that happen?
What offers do I have at my disposal, including small amounts of money and using my knowledge of the community to support you?
How can I pull them together in an 'emergency plan' and stay with you to make sure it works'?

Conversation 3:
What is a fair personal budget and where do the sources of funding come from?
what does a good life look like?
how can I help you use your resources to support your chosen life.?
Who do you want to be involved in good support planning?

6 Essex County Council

Annex D – East of England NHS Ambulance Service policy re supporting patients with complex and individual needs.

The aim of the policy is to consider patients who may:

• Have a long term condition with an acute exacerbation or require support to manage their condition appropriately at home.

• Be experiencing a specific episode of ill-health or difficulty.

• Also have unmet social or healthcare needs and alcohol, substance or North Essex Partnership University Foundation Trust related healthcare issues.

• Be unaware of more appropriate entry points into the NHS.

Not all of these callers require an emergency response from a qualified clinician. They may call a substantial number of times per 24-hour period, involving call handlers, the clinical support desk and emergency responders.

2.4.174 For the purposes of this Policy, a person may be defined as using the service regularly or frequently if they call:

• Children < 18 years: 3 or more times within a 6 month rolling period.

• Adults > 18 Years: 5 or more times in a month period. 12 or more calls in a 3-month period 15 or more calls in a 1-month period from a communal address.

2.4.175 For the purposes of this Policy, a person may be defined as having complex care needs if; • Their condition is such that the provision of specific information may materially alter the care pathway for that patient. • The provision of specific care information will ensure that the patient receives treatment in line with the most recent guidance and best practice (that may not have been covered off in training updates).

2.4.176 This Policy outlines the ways in which EEAST can determine, agree and mobilise appropriate alternative care pathways for people calling 999 regularly, frequently or with very specific and defined needs that may not be covered in core training.

Annex E – Glossary

CSP	County Safety Partnership
IMR	Internal Management Reviews
RAS	Rapid Assessment Service
ICS	Intermediate Care Service
NFPUFS	North Essex Partnership University NHS Foundation Trust
ACE	Anglian Community Enterprise
CHUFT	Colchester Hospital University NHS Foundation Trust
EEAST	East of England Ambulance Trust
DOLS	Deprivation of Liberty Safeguards
Memantine	Memory loss medication
RAS	Rapid Assessment Service
CQC	Care Quality Commissioners
SPOC	Single Point of Contact
SCD	Social Care Direct
MDT	Multi-Disciplinary Teams