The London Borough of Havering
Community Safety Partnership

Domestic Homicide Review
Executive Summary

Regarding

AVA & OLIVER

(Pseudonyms)

Date of Deaths – July 2017

Author: Margaret Doe

(Contributions NICHE Independent Consultancy)

DHR Report

Concluded July 2020

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1. THE REVIEW PROCESS

This summary outlines the process undertaken by The London Borough of Havering Community Safety Partnership Domestic Homicide Review panel, in reviewing the homicide and suicide of AVA and OLIVER who were residents in their area.

The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities, and those of their family members: AVA and OLIVER.

OLIVER was White British, aged 54yrs and the son of AVA, who was White British and aged 89yrs. OLIVER and AVA were estranged from their family and so there were no close relatives who had any involvement with them. OLIVER had a close friend (Friend 1) whom he turned to for support.

It was the conclusion of the Metropolitan Police investigation that OLIVER killed AVA and then took his own life in the bathroom of their home. Both AVA and OLIVER had knife wounds to the neck. There were no criminal proceedings. The coroner's inquest has now concluded in July 2020. Ava was unlawfully killed by her son OLIVER, who then took his own life.

Havering Community Safety Partnership concluded on 16th January 2018 that the circumstances of this case clearly fell within the criteria for a domestic homicide review (DHR). The DHR panel was formed on 7th February 2018. All agencies that potentially had contact with AVA & OLIVER prior to the point of death were contacted and asked to confirm whether they were involved with them. Those who confirmed contact were: family General Practitioner (GP); Adult Mental Health Services; Adult Social Services (LBH); University Queens Hospital (QH); BARTS Royal London Hospital (RLH); Goodmayes NHS Hospital (GH) and the Metropolitan Police (Police).

2. CONTRIBUTORS TO THE REVIEW

The panel appointed NICHE Health & Social Care Consultancy, which is an independent management consultancy specialising in supporting health care providers with issues of safety, governance and quality including the undertaking of independent investigations following very serious incidents. NICHE completed a level three Serious Incident Report for Health services in LBH (Barking, Havering & Redbridge Clinical Commissioning Group CCG), including the GP's contributions in

May 2018 and a joint Individual Management Review (IMR) for Health and Adult Social Care in LBH on 16th August 2018. The Joint report provides a single narrative and a merged chronology for both the LBH IMR and the Serious Incident investigation. The Metropolitan Police completed an Individual Management Review of their involvement with AVA and OLIVER in the previous months to their deaths. OLIVER's close friend (friend 1) provided background information for the review alongside a niece of AVA's. Both family and friend 1 have expressed their distress and frustration separately that the LA made little or no contact with them in this serious and complex family situation in relation to the needs of both AVA and OLIVER.

3. THE REVIEW PANEL MEMBERS

Paul McCarthy	Interim Learning and Business Partnerships Manager-Safeguarding Boards, **DHR Board Chair**
Barbara Nicholls	Director - Adult Social Care
Carol White	Integrated Care Director -LFT NHS Foundation Trust
Diane Egan	Community Safety Partnership – Community Safety and Development Manager Havering
John Ross	Detective Superintendent - Police
Eve McGrath	Adult Designated Nurse for Safeguarding CCG
Shakira Gordon	Training and Development Officer - Safeguarding Adults Board
Lynn Glancy	Programme Officer – Safeguarding Adults Board
Sue Denby	Consultant - NICHE
Vicki Nicholson	Women's Aid

The members of the panel consist of professionals who have had no direct involvement in the management or oversight of this matter. The Panel have met on 5 occasions.

4. CHAIR OF THE PANEL AND AUTHOR OF THE OVERVIEW REPORT

Paul McCarthy was appointed as chair of the DHR Panel. Paul McCarthy is an independent Social Work Consultant. He qualified as a social worker in 1983 and is

currently registered as a Social Worker with the HCPC. He has held a number of senior management roles in children's services and disability services in local authorities. He has extensive experience of overseeing complex multi-agency safeguarding investigations. Paul McCarthy worked in an interim capacity in Havering from February 2017, overseeing the work of their adults and children's safeguarding boards; he has never been directly employed by any of the agencies party to this review. The Community Safety Partnership were satisfied this was sufficiently independent of the agencies and bodies involved. Whilst this remains the case, the CSP has now moved to the practice of independently commissioning authors and chairs for DHRs.

The Safeguarding Adults Review Panel Chair Paul McCarthy appointed Margaret Doe as Overview Report Author on 1st July 2018 to complete the DHR overview report. Margaret Doe is a self-employed Social Care Consultant who has extensive experience in Safeguarding relating to children's social services, including writing individual management reviews (IMRs) and serious case review (SCR) overview reports regarding matters (including criminal) where children have suffered abuse or have died. Ms Doe has been employed on an interim basis within the LA as Service Manager for Safeguarding Children from 2015 – 2016; and a consultant for Children Services from June 2018 – July 2018. Margaret Doe has no connection with the Community Safety Partnership or Safeguarding Adults Board for the Local Authority. Margaret Doe has never been an employee of any of the organisations involved in this DHR.

5. TERMS OF REFERENCE FOR THE REVIEW

1. To review the circumstances of the deaths of AVA and OLIVER.
2. To examine the actions of the Havering Local Authority teams and individual members of staff that knew AVA and OLIVER prior to their deaths.
3. To review the decision-making and communications and to examine in detail any assessments of AVA and OLIVER that were undertaken.
4. To review how risks were assessed and managed via safeguarding, sec 42 enquiries, safeguarding strategy meetings and so on.
5. To identify any practice or policy issues for individual Local Authority teams, or the Local Authority as a whole, arising from the review, with specific reference to safeguarding of vulnerable adults.

6. To identify any multi-agency issues for the local partnership arising from the review, particularly in relation to joint working and safeguarding concerns shared in relation to OLIVER and AVA.
7. To prepare a report for the Community Safety Partnership and the Safeguarding Adults Board that identifies any lessons to be learned and makes recommendations for future policy and practice.

The DHR Chair and the report author would like to extend thanks to the DHR Panel for their contributions and expertise in supporting the completion of the report. Thanks are also extended to NICHE, the Independent Consultancy who prepared the level Three Serious Incident Report and the joint Individual Management Review for LFT Health Services and Adult Social Care; and for their liaison with extended family and close friends.

The Chair, author and panel members would also like to express their sincere sympathy to the family and friends of AVA and OLIVER and extend thanks to those who contributed to the review.

6. SUMMARY BACKGROUND

AVA and OLIVER were mother and son. They lived in the same home (of which AVA was the owner) for all of OLIVER's life. AVA was an elderly woman who in recent years had memory problems and some mobility difficulties, with a dementia diagnosis in early 2017. In previous years, she had cared for her son in terms of everyday living arrangements. OLIVER had not worked for the previous ten years. As time went on there was a gradual role reversal as OLIVER became AVA's carer, as she grew frailer with age. Following the death of AVA's husband (OLIVER's father) by suicide 12 years previously, both struggled emotionally. OLIVER is said to have become depressed. In 2016, OLIVER and AVA suffered at the hands of rogue builders who came to the door stating his roof needed repair. Ultimately, they were defrauded of over £50,000. This had a deeply profound effect on OLIVER and his mental health in terms of his worries for his and his mother's future and whether they would lose their home due to her growing care needs. This also impacted on AVA, who initially was very angry with her son about the fraud and was very upset. Following the fraud AVA is reported to have suffered from anxiety and depressive episodes.

On 10 July 2017, OLIVER and AVA were found dead at home. A carer employed by Local Authority commissioned organisation who was providing care that day to AVA found a note protruding from the letterbox.

The carer found both AVA and OLIVER deceased in the bathroom on the floor. The police concluded that the cause of death to be stab wounds to the neck for both AVA and OLIVER. On the 12th July 2017, a Special Post Mortem (SPM) examination took place. The provisional cause of death for both was recorded as stab wounds to the neck.

AVA died at the age of 89 at the hands of her son OLIVER. OLIVER died aged 54 by his own hand.

Both OLIVER and AVA came to the attention of the Police and to Adult Social Care following the fraud of over fifty thousand pounds in November 2016. AVA's deteriorating cognitive ability and memory difficulties were identified in 2016 via OLIVER reporting these to her GP. Adult Mental Health Memory Service began the process of assessment for dementia in early 2017 and the service remained involved up until AVA's death in July 2017. OLIVER became known to Adult Mental Health Services due to a serious suicide attempt in February 2017 where he stabbed himself in the neck. He was sectioned under the Mental Health Act.

7. SUMMARY CHRONOLOGY

On 23 November 2016, a police report expressed concerns and alerted the Local Authority (Adult Social Services) to the fact that AVA and her son had been victims of fraud involving a sum of about £50,000. This related to the police investigation regarding the fraud, which Trading Standards had reported to the police on the 16th November 2016. The police noted that AVA was frail and vulnerable but also felt her son was somewhat vulnerable and seemed to be responsible for all her care needs.

A call from the Local Authority to her son resulted in AVA being allocated Social Worker 1 (SW1) and an assessment was undertaken on 16 December 2016. However, at this point both AVA and her son declined a package of care. Records indicate that this was due to their concerns about financial contributions, which did not abate despite reassurance.

A further police report was received by the Local Authority on 30 December 2016, expressing concerns about the deterioration in the relationship between mother and son, with some concerns raised for OLIVER's mental well-being. The police had been called after neighbours reported hearing arguing and a female screaming for help. The caller stated this was a regular occurrence.

On attendance the officers called an ambulance for OLIVER, who appeared to be having convulsions. Eventually this was cancelled as OLIVER stated he would see his GP. The arguing was said to be about the substantial loss of money from the fraud. The officers commented on their concerns about OLIVER's depression and the burden of caring for his mother AVA. The incident was referred to Adult Social Care. AVA was allocated to locum Social Worker 2 (SW2). AVA was first referred from her GP to the Older Adult Assessment Team (OAAT) on 16 January 2017. The referral request was for a memory assessment and this was brought to the attention of the Foundation Trust Memory Assessment service.

On 30 January 2017, a Memory Assessment service initial assessment was undertaken. Her son reported that she was calling out in her sleep and had screamed. The neighbours had heard this and called the police. At the time of the assessment, her son reported that his mother's memory had deteriorated gradually since 2011 and had declined further in the last two years. He said that she repeated questions and conversations frequently.

OLIVER reported he had been completing a lot of the activities of daily living in the household for the past two years. He said he needed to assist his mother due to her arthritis and her deteriorating physical health.

During her assessment completed by the Memory Service AVA stated she felt down, tearful and depressed and felt this was in response to the incident where her and her son were defrauded out of £50,000 by a bogus roofing company. The GP had prescribed antidepressants on 26th November 2016.

An Addenbrookes Cognitive Examination was undertaken on AVA in relation to possible dementia and was given a score of 63 out of 100. It was understood that this score is below the cut off for 'likely dementia'.

Social Worker 2 (SW2) visited the home on the 3rd of February. SW2 discussed with AVA and OLIVER the concerns reported by the police regarding the neighbours hearing screaming late at night. AVA stated she had provoked her son, as she was upset and angry about the fraud. They had a shouting match and then the police arrived. AVA stated that the 'wailing' had come from her son as he was very upset. They both reported they were fine and did not need anything from LBH.

Two days later on February 5th, the police and ambulance service were called by OLIVER's close friend as he was concerned for his welfare. The police found blood around the stairs and OLIVER lying in the bath (receiving first aid from an off duty police officer) having a deep knife wound to his neck. AVA had been found in the street by the off duty officer screaming hysterically. She was said to be in a state of shock. Her hands were covered in blood where it seems she had tried to take the knife from her son.

OLIVER was transported to Hospital for his injuries and was later transferred to Goodmayes Hospital where he was assessed under the Mental Health Act section 2. AVA was taken to a local Hospital for safeguarding purposes.

LBH were contacted directly and they offered assurances AVA would remain in hospital overnight, that the house would be cleaned and daily care arranged for AVA before her discharge. Police reports were completed for both OLIVER and AVA and forwarded to the multi-agency safeguarding hub (MASH). This was a good response to the events that took place, with good multiagency coordination.

A Foundation Trust social worker entry stated that an assessment was completed and that AVA should not be discharged due to a police investigation. The safeguarding alert stated that AVA had given consent to the alert being completed and that she had 'mental capacity' to do so. (The Mental Capacity Act states *('that a person lacks capacity if they are unable to make a specific decision at a specific time because of an impairment of, or disturbance, in the functioning of mind or brain'*).

The close friend of OLIVER visited AVA at the hospital on the 6th February. He was told that AVA was to be discharged. He spoke with the Foundation Trust social worker from the community treatment team. He expressed his concerns about AVA being discharged due to her dementia, her need for a full package of care and a medication

review due her sleeplessness and that the house was covered in blood. He was concerned as she was not able to care for herself. The friend was reassured arrangements would be made for the house to be cleaned. Unfortunately, this did not happen. Friend 1 was recorded as 'acting next of kin' to AVA due to OLIVER's hospitalisation. Both AVA and OLIVER were estranged from extended family. Friend 1's position is that he was nominated as her replacement Attorney in the event that OLIVER was unable to act for her regarding finances and property via a legal agreement. This has been confirmed via the Solicitor who drew up the agreement. It is clear at this point Friend 1 was a significant person to them both.

AVA was discharged home later the same evening. Later that evening a neighbour called the police as AVA was wandering outside in just her nightgown looking very confused. The Police found AVA who was seen to be visibly upset and shaking and cold to the touch. She was upset about the blood in the bathroom. Police contacted the Local Authority 'out of hours' adult social care, expressing concerns AVA had been discharged home and that the place was still covered in blood and was unlikely to be able to look after her-self. An ambulance returned AVA to hospital in the early hours of the morning.

AVA's mental capacity had been assumed on her discharge from Hospital on 6th February 2017. This decision was reviewed as part of the CTT (Community Treatment Team) Sec 42 enquiry on the 7th February, which found that AVA had not had an assessment of her mental capacity. An assessment was completed and showed she was traumatised due to the attempted suicide of her son, which impacted on her capacity to make decisions. AVA was transferred to a Care Home.

Whilst the Hospital made the decision to discharge AVA, it was clear there was a lack of coordinated discharge planning between Acute Trust, Foundation Trust Treatment Team (CTT) and Local Authority SW2. An assessment completed by an Occupational Therapist on the 8th February concluded AVA would require a high level of care and assistance on discharge. Alongside this, the Mental Health Liaison Team received a referral from the Hospital who carried out an assessment on AVA regarding her hospital admission. The assessment took place on or around the 8th February and concluded '*there may be a future risk to AVA if he (OLIVER) has strong suicidal intent and potentially killing her jointly'.*

The Section 42 Enquiry completed by the CTT (Community Treatment Team) set out clearly the failings in the initial discharge arrangements; the presenting risks and the absence of an assessment of AVA's mental capacity. However, this enquiry also lacked the formulation of a care plan for AVA – which had it been in place could have led to a multi-agency safeguarding conference to consider all aspects of AVA's needs and the circumstances of her son's attempted suicide.

On the 14th February, a Foundation Trust Mental Health Liaison meeting concluded that AVA had possible cognitive decline in the preceding six months. Her mental health had not been fully assessed due to her high anxiety. The memory assessment service made efforts to keep in touch with the situation regarding OLIVER and attempted to raise their concerns about OLIVER resuming a caring role for his mother with the psychiatric services at a local mental health hospital.

On the 14th February, the care home manager requested a seven day standard Deprivation of Liberty (DoL). This process was completed by the Section 12 Approved Doctor regarding mental capacity, mental health and eligibility assessments. The final part was completed by LBH Safeguarding Senior Practitioner 1 who found that the best interest requirement was met and that is was appropriate to request a deprivation of liberty for a period of three months. This was due to the many issues requiring clarification before AVA could return home to the care of her son, including the potential risk he could pose to his mother.

On the 22nd February, it is stated in the Local Authority case notes that the Memory Assessment Service confirmed a diagnosis of Dementia for AVA. A decision was made not to inform OLIVER at this point due to his mental state and until further information was available.

OLIVER remained in hospital and under Section 2 of the Mental Health Act until 28th February 2017, when he returned home. His attempted suicide was reported to be related to the fraud of £50,000; however, a key factor was noted to be OLIVER's alcohol consumption. He admitted to drinking heavily. He did not present as depressed and was not prescribed antidepressants. OLIVER was reported to have a history of alcohol problems, having been prescribed medication for alcohol withdrawal in the past. The hospital records indicate that OLIVER did not present with any risk of suicide or risk of harm to others.

OLIVER was seen by a clinical psychologist on the 22nd February. OLIVER reported the ward environment was stressful for him and he wanted to return home to prepare the house for his mother's discharge. He stated that one of the main contributing factors to his suicide attempt was alcohol use, which he wanted to stop. He felt that having input from the psychology service would be helpful for him. He was to be provided information on the alcohol service.

On the 23rd and 27th February, attempts were made by the locum Consultant Psychiatrist Memory Assessment Service to contact the Consultant Psychiatrist of OLIVER. There was no facility to leave a message; therefore, the memory assessment consultant sent an email to the psychiatric consultant for OLIVER inviting them to the discharge (Care Programme Approach) CPA meeting, which in essence can conclude if a person needs a Care Coordinator. The Ward Consultant stated he did not receive this information. The Consultant had understood OLIVER was referred for a carer's assessment and so did not think direct contact was necessary. The Consultant also stated that he was not aware of or contacted by older peoples services. It is concerning that the opportunity to liaise and discuss and plan future actions did not take place and that the communication between these two key services at this critical point failed.

On the 6th March, according to LBH records SW4 carried out an assessment to AVA's mental capacity. The records indicate a discussion about the here and now, and AVA was clear she wanted to return home to the care of her son. The Home Manager was spoken to, who reported that OLIVER appeared dishevelled when he has visited. OLIVER reported he had made big changes in his life and one of these was he had given up alcohol; he realised he had been drinking very heavily. On the 9th March, AVA was discharged home to the care of her son with a three times per day care support package in place.

On the 13th March, LBH SW2 returned from annual leave and expressed her concerns about AVA returning home so soon after the very serious attempt of suicide by her son. SW2 arranged to carry out a joint home visit with the Foundation Trust HTT (Home Treatment Team) to assess the home situation, which was agreed.

The joint visit took place on March 17th. The HTT record indicated that overall the home was well organised and tidy. OLIVER was reported to be unkempt with greasy hair and dishevelled clothes. AVA was reported to look well. OLIVER repeated he was no

longer drinking alcohol and had good insight into why he 'went into crisis'. He reported having no suicidal/self-harming thoughts. The visit concluded that OLIVER would be discharged from HTT that day and LBH would continue working with OLIVER and AVA. At this point, the situation appeared settled and neither the HTT professional nor SW2 reported ongoing significant concerns. The LBH record indicate OLIVER expressed good insight into why he attempted suicide and had felt overwhelmed with his mother's dementia; the fraud and his use of alcohol. He was ready to accept the help he needed. OLIVER was also keen to start attending sessions with the psychology service.

On the 25th March some eight days, later the Re-ablement Home Care Service attending to AVA made contact with the Preventative Assessment Team (PAT) requesting an urgent review. OLIVER was said to be very controlling of AVA, cutting her food and measuring it; not allowing her underwear to be changed and shouting at AVA and making her cry. AVA was reported to be concerned her son had gone downhill and may try to take his own life. HTT carried out a joint visit to the home on the same day. OLIVER was noted to be self-neglecting wearing dirty clothes and not washing. He reported he had a cough and this was making him irritable. He told the professionals there was nothing to worry about. The HTT worker spoke with AVA who stated she was just worried about her son's cough. The HTT worker confirmed with AVA she could call for help if needed.

On the 29th March, AVA and OLIVER's immediate neighbour wrote an email to the Local Authority Multi Agency Safeguarding Hub (MASH) setting out their concerns regarding OLIVER and AVA. They reported shouting swearing screaming and banging in the middle of the night alongside hearing bizarre noises on a regular basis. They reported at times they were seriously concerned OLIVER would hurt his mother and reported they had heard him threaten to kill her. The neighbour also stated that something really had to be done. They were concerned for his mental state.

The MASH service made enquires with HTT; they were informed there had been a visit 3 days previously, arguments were a normal pattern of behaviour and that the case was closed to HTT. An assumption was made by one professional that required challenge from the other professional in terms of the exploration of possible domestic

abuse. The neighbour was advised by the MASH to call the police if they had further concerns.

The Adult Social Care LBH Duty Social Worker (SW6) became aware of the response from the HTT via the MASH and SW6 spoke to the Service Manager expressing her concerns about AVA's vulnerability. The Service Manager contacted the Senior Social Worker within HTT to discuss the matter and try to find a way forward due to the vulnerability of both and the potential risks to AVA; specifically the assumption she had the mental capacity to ring for assistance or help if needed, and a potential risk of domestic abuse. No specific actions emerged from the exchange. It was stated that OLIVER had been referred to psychological services, although he had not yet received an appointment. It was also known there was a lengthy waiting time for the service. This exchange took place via email.

A home visit took place on 30th March by LBH Social Worker 7 (SW7) and her manager to assess the concerns raised by the neighbour. HTT were unable to join them and it was noted there had not been a visit by the allocated social worker *'for a while'*. OLIVER provided an explanation that his mother had wax in her ears and that was why he was heard shouting. Both appeared well with good interaction. However, the previous concerns raised by SW6 and the Service Manager were not discussed.

On the 31st March, SW6 completed an LBH Sec 42 Adult at Risk Evaluation record which noted the neighbours' concerns, the history relating to OLIVER's attempted suicide and that the threshold for section 42 was met as AVA had care, support needs, and was at risk of abuse, and an inquiry was to be undertaken. The enquiry was transferred to SW2, however she was about to leave the employment of LBH. The case was then transferred to SW5. This was a timely opportunity to bring together the agencies involved, including the GP, Psychological Services, the social workers and managers to discuss the background and concerns and to formulate clear planning for both including a safeguarding plan. Unfortunately, this did not happen.

A further police referral was made on the 4th April by the police officer investigating the fraud. They raised their concerns about OLIVER's mental health and felt it was deteriorating. It was also stated that if he continues to remain untreated he could attempt suicide again. On the same day, a HTT professional attended the home to assess OLIVER and could see that whilst OLIVER had no specific mental health needs

such as hallucinations or paranoia, he had fluctuating moods with good and bad days. He was again noted as dishevelled and malodorous (smelling strongly). OLIVER was offered HTT provision for a short period to monitor his mental state and assess risk, but this was refused. OLIVER wanted to wait for the psychological service. OLIVER was provided with information and advised there may be a call the following day from the team doctor. He refused to consider antidepressants.

On the 11th April, AVA and OLIVER requested a reduction in her care and only wanted a morning call. This request was made via email. This was agreed, it appears without question. On the 13th April, the same neighbour contacted the LBH Adult Safeguarding Team via email raising further concerns that OLIVER was abusing AVA. The neighbour stated that for the previous three nights she had been woken in the middle of the night by banging noises and OLIVER screaming and shouting. The neighbour stated that something needed to be done urgently and that OLIVER was a great danger to his mother and himself. This information was shared with the mental health service who stated that the information would be noted and that OLIVER was waiting for counselling. There is no evidence the Local Authority responded or took any action at this point.

SW5 visited AVA and OLIVER at home on the 27th April, 27 days after section 42 criteria was met for a safeguarding enquiry to take place. The Local Authority case records indicate that OLIVER and his mother presented as well. There is no mention of his appearance and the ongoing issue of his self-neglect. OLIVER did not report any feelings of wanting to self-harm or harm his mother. He wanted to care for her at home. AVA supported this. The concerns raised by the neighbour were not discussed. Neither were spoken to alone.

On the 25th May, a joint visit took place by SW5 and the Acting Team Manager. OLIVER stated he had his ups and downs but had two good friends who support him. AVA said she gets on well with her son but is hard of hearing in one ear. AVA described herself and OLIVER and ‘we’. OLIVER also reported that he gets frustrated with his mother and her dementia as she repeats herself often. SW5 noted that OLIVER smelled strongly of body odour and thought he was self-neglecting. The record concludes that OLIVER knows how to seek help if needed and to contact the Local Authority if needed.

On the evening of the 30th May, the police were called by a neighbour due to hearing a disturbance (shouting). OLIVER explained he had bought a takeaway and he had been given the wrong order which is what the shouting was about. The officer spent time with OLIVER and AVA and did not identify and concerns regarding domestic abuse but did record that OLIVER required further support from HTT.

On the 31st May, a builder working at the premises next door to AVA and OLIVER called police due to hearing a female screaming. The police attended and OLIVER explained that AVA had tried to evacuate her bowel using her fingers and he had to grab her arm as she was attempting to touch or grab her hair. AVA initially reported OLIVER had slapped her face but then agreed with OLIVER's explanation. She was noted as very distressed. The ambulance service attended along with the Local Authority Interim Team Manager and Foundation Trust AABIT (Assessment and Brief Intervention Team) social worker. OLIVER said he was finding it very difficult to cope, feeling overwhelmed with despair and he had become increasingly angry and agitated and was struggling to control this. He also said he had previously cut down his alcohol intake but that it had begun to increase again. The Local Authority Manager arranged for AVA to be admitted to a care home with her agreement. OLIVER agreed to a mental health assessment. The outcome of this assessment was to recommend completion of DATIX (incident report) for disclosure of possible aggression, a safeguarding alert was to be completed and referral to the Home Treatment Team made.

It is clear from the records and interviews that the attending police officers had recognised the stress OLIVER was suffering. However, AVA was potentially a victim of domestic assault or abuse; not necessarily that OLIVER had deliberately slapped her; but that potentially he had handled her very roughly to the extent that AVA was screaming loudly enough to be heard next door. The officers that attended the home of AVA and OLIVER responded in an appropriate manner and supported both OLIVER and AVA by contacting both mental health services with regard to OLIVER, and adult support services with regard to AVA. There was clear recognition of their vulnerabilities and a desire to improve the circumstances of both.

However given the history and previous concerns my view is that this was a missed opportunity in terms of recognising and considering the potential of domestic abuse as AVA clearly stated that her son had slapped her across the face although is stated to

have quickly retracted this and was noted to be agreeing with her son's account of events.

On the same day (31st May), OLIVER returned home following the assessment undertaken by AABIT. OLIVER was referred to ACAT (Acute Crisis Assessment Team arm of HTT). A safeguarding alert was also completed regarding AVA, although the social worker did not submit this until a week later as she wanted to seek AVA's consent.

The records indicate that ACAT requested a joint visit with AABIT but this was declined due to lack of resources. AABIT staff stated that recruitment was a concern and caseloads were high due to this with caseloads of around 70 patients at the time. The Level Three Serious Incident Report concluded AABIT caseloads were excessive particularly in an access and assessment team offering a brief intervention service. The outcome was that OLIVER did not have a joint assessment, which could have resulted in HTT agreeing to provide a service.

This incident offered a further opportunity for a multiagency safeguarding conference to take place to consider the issues of safeguarding and domestic abuse including coercive control, to bring together the key agencies and to formulate a multiagency plan for both AVA and OLIVER.

A home visit took place on 2nd June with the Foundation Trust ACAT Clinical Team Lead and ACAT Community Psychiatric Nurse to OLIVER. OLIVER felt he needed mental health support, as he was concerned that social services would assess his ability to care for his mother at home and would not consider him able to do so. He was open to taking medication. He said he wanted to care for his mother. He was lost without her. He also reported drinking again but not to an extent where he needed to be admitted to hospital. He did not report he found caring for his mother difficult as he had stated 2 days previously. The outcome of this assessment was that there was no role for HTT. AABIT would continue to work with him and commence medication if needed despite the fact that AABIT had excessive caseloads and there was no care plan in place.

It was clear that OLIVER had an alcohol problem, but this was not considered in terms of the potential further risk of suicide or indeed his ability to care for his mother. The

National Confidential Inquiry into Suicide and Homicide by Patients with a Mental Illness; Annual Report (2017) regarding alcohol states that '*much of the risk to others is related to co-existing drug or alcohol misuse rather than mental illness itself*'. It states that '*a greater focus on alcohol and drug misuse is required as a key component of risk management in mental health care, with specialist substance misuse and mental health services working closely together'*.

The assessment undertaken by ACAT did not reference OLIVER's previous history of self-harm, or provide any indication that the fact that he was drinking alcohol again may increase his risk to himself or others. The Local Authority should have been aware of the increased alcohol consumption and any risk assessment should have included his ability to care safely and appropriately for his mother.

Following this OLIVER visited his mother in the residential home over a three day period. He spoke with the AABIT social worker on the 5th June reporting he was feeling much better. He was worried that his mother was in respite and thought she may be placed in permanent residential care, which he did not want to happen. He was concerned her house would be sold and he would have nowhere to live. He felt able to care for her himself.

On the 6th June SW5 visited OLIVER at home. He was told he had been allocated to SW5 which was an unusual arrangement. They discussed the incident leading up to AVA being admitted into respite care. OLIVER stated that he was increasingly becoming agitated and wound up as he was struggling with being a carer for his mother, in contrast to what he told the AABIT social worker the day before. He was still waiting for therapy at local Psychological Services. SW5 supported the idea of OLIVER beginning to take anti-depressants. However, there appears to be no consideration of OLIVER's alcohol consumption and the potential impact of this on his ability to care for AVA. A package of care was discussed regarding his mother's return home which OLIVER declined. SW5 was due to visit AVA to discuss this. The issue of OLIVER's personal hygiene was also raised to which OLIVER responded he had no sense of smell. SW5 left OLIVER a carer's assessment form for him to complete. At this point SW5 should have commenced an assessment of OLIVER in his own right.

OLIVER was advised his GP would commence him on anti-depressants and be invited to attend a group 'Your Mood Matters'. OLIVER remained open to AABIT. OLIVER did

not have a care plan in place despite operational guidance. The Level Three Incident Report found that OLIVER did not have a medical review by either HTT or AABIT. There was no Consultant Psychiatrist review and only one medical HTT contact in spite of OLIVER's two treatment episodes. This was a further missed opportunity.

On the 12th June, SW5 visited AVA at the Residential home. It is noted AVA was confused and did not remember SW5 from the last visit. She was unable to retain the information about carer arrangements and kept repeating the same questions regarding OLIVER and what was going to happen to him. SW5 noted that AVA has expressed a wish to go home. Given AVA's anxiety and her lack of ability to recall or remember the conversation this should have led to consideration and assessment of her mental capacity. No assessment was completed. The legislation and guidance states that capacity should be assumed; however, given the circumstances and the level of risk it would have been appropriate to consider assessing AVA.

On the 20th June a member of staff of the Residential Home recorded that AVA was agitated and seen arguing with OLIVER outside. The care worker went outside and calmed them both down. This went on for a period of 30 minutes. The home manager reported this to SW5 on the 21st June. SW5 stated she would speak to her manager but considered this an isolated incident and she was going ahead with the care package as planned and did not attempt to discuss what the argument was about. OLIVER also stated that the anti-depressants had not 'kicked in yet'. OLIVER's needs as a carer were not adequately assessed, and that leaving a carer's assessment for OLIVER to complete (on 6th June) was not an adequate response to his situation. OLIVER required an assessment in his own right.

An AABIT social worker entry dated 21st June referred to a telephone discussion with OLIVER where he expressed concern about the care package being put in place for his mother which OLIVER stated neither of them wanted. The social worker went through the last time they had met where AVA had been admitted to the Residential home. OLIVER was reminded about what he had experienced and how he had presented at that point and the social worker suggested that this might happen again if appropriate support was not put in place. OLIVER agreed it was probably the right thing to do. OLIVER spoke about the antidepressants not yet having any positive impact.

The AABIT social worker also recorded a call to AVA's social worker who confirmed the package of care but reported that OLIVER and AVA were very resistant to this at first. OLIVER was also resistant to taking part in any groups stating he could not leave his mother alone. OLIVER was still waiting for therapy from the psychological service. It seemed there was a waiting period of around eight months. It was agreed both social workers would keep in touch.

The manager of the residential unit noted that AVA has been 'displaying extremely repetitive behaviours today' (23rd June), was fixated on her situation and that she was anxious about what was happening next. An MRI was carried out on AVA the same day in relation to the dementia diagnosis.

Local authority social care records state on the 27th June AVA was discharged home with a care package of three visits per day with a home care service providing home care from this date. OLIVER reported to SW5 the antidepressants had not yet kicked in fully.

On 4 July 2017, the Home Care provider Manager emailed the Local Authority Home Care Brokerage Department and SW5 to inform them about concerns raised by one of the carers (Carer 1) who visited AVA on 30 June, 1 and 2 July 2017. She found AVA in the living room shaking and crying saying her legs were very cold. The carer took advice from her office and called an ambulance. Immediately following this OLIVER started to shout, was slamming doors and throwing things and was being very rude to his mother. When AVA tried to get off her chair he shouted and told her to sit back down. AVA attempted to speak with OLIVER on a number of occasions where OLIVER would respond 'we are not discussing this'. There was a long wait for the ambulance so the carer remained at their home. After a couple of hours OLIVER told the carer he wasn't well himself and was on antidepressants. As the situation had calmed down, AVA seemed better and both said they were now fine the carer took further advice from the office and cancelled the ambulance. The carer visited the following two days. She noticed that AVA had the same eating pattern i.e. two biscuits and tea each morning, shop bought sandwich for lunch and two biscuits and tea in the evening. The carer also noted that AVA was sat in the same chair and didn't appear to move from it all day. OLIVER stated that he ordered take-outs for later on. On one morning OLIVER is said to have 'fought' with the carer not to change AVA's underwear

and that she had remained in her night wear each day. The carer's opinion was that AVA didn't have a say in any of this. She constantly referred to OLIVER asking 'what do you think is best".

On Sunday 2nd July in the morning the carer noticed AVA had a bed sore. OLIVER claimed it had been there since February. This was reported to the Office. In the evening, AVA had been changed back into the same nightwear she had been in previously. The Home Care provider Manager asked for advice via email about steps to follow in addition to monitoring the situation in the home. There is no evidence that a LBH 'Concern Reporting Form' was completed following receipt of this information.

At this point, there are significant reported concerns. AABIT had not been able to make contact with OLIVER and had not attempted to make further contact. SW5 had been notified via email. There is no evidence SW5 read or responded to the concerns at that point.

On the 6th July at 10:39am, the Home Care Provider manager contacted the Local Authority Home Care Brokerage department again to inform them that the evening carer (carer 2) had also made a report via telephone that morning concerning AVA and her son. The carer reported that AVA seemed extremely confused and frightened. There was bruising on her arms and when the carer questioned where they came from, OLIVER spoke for her and said they didn't know how they got there. Later when the carer was attempting to wash AVA, OLIVER rushed into the bathroom and stopped her from this. The carer was able to see bruising on AVA legs to which OLIVER stated happened when he was dressing her. OLIVER also told the carers not to feed his mother, as he would do so. AVA seemed to have become more withdrawn and when the carer tried to engage in conversation with AVA, OLIVER stood there and answered all of the questions. The HOME Care Provider Manager asked for this information to be sent to the appropriate person as she was becoming very concerned about the wellbeing of AVA.

Later that afternoon SW5 visited AVA and OLIVER with a care assessor. The notes from the visit recorded by SW5 state that AVA was asked about the concerns that took place on the 30th June where it was reported AVA had cold and itchy legs and that OLIVER had shouted at her and she was crying. SW5 also said there were concerns about AVA's diet. OLIVER denied shouting at his mother and said the carers are liars

and he did not want them coming back although shortly after agreed that they could return. A suggested way forward was offered to OLIVER which was to provide day centre provision and assistance with food preparation to which OLIVER agreed. The recording does not indicate whether AVA was asked about these arrangements or whether she agreed. The case notes states to '*raise a safeguarding of bruising to nose*' and to discuss the case with the Acting Team Manager regarding long-term placement. There is no reference to the concerns raised by carer 2 about bruising to AVA's arms and legs, or that AVA seemed to have become more withdrawn and that any questions put to AVA were answered by OLIVER.

In interview, OLIVER's close friend said that on Thursday 6 July 2017 OLIVER rang him and was very angry because the Local Authority Social Worker 5 had alleged that he had been abusive to carers, slamming doors in carers' faces, was curt, rude and rough with his mother. He was very upset and told his friend he was worried she was going to be taken into permanent residential care. OLIVER told his friend that his mother's psychiatrist and the Local Authority Social Worker were due to visit on Tuesday 11 July 2017 to provide a diagnosis for her.

On the 7th July at 12:19pm, SW5 telephoned Senior Practitioner 2 (SP2). SW5 stated that she noticed a small mark to the side of AVA's face during a visit. OLIVER stated that it happened accidentally, caused by her glasses when he was assisting her. SW5 also stated that AVA was unable to comment on how it happened due to her dementia. SW5 also said she had been considering residential placement for AVA; that she had limited capacity around decision making but wants to 'remain in her own home'. SW5 wanted to uphold that wish if at all possible and enquired of Senior Practitioner 2 if 'the new injury' constitutes a safeguard. Due to the history, SP2 notes this would need to be 'raised as a safeguard and an action plan put in place via case management'. SW5 reported she was requesting a day centre place and SP2 encouraged her to inform the 'panel' this would form the dual function of providing respite for the carer and to monitor for new bruising. It was agreed to put in extra support rather than separate mother and son, but should be monitored carefully.

On the same day at 17:47pm senior practitioner 1 responded to the safeguarding referral raised by SW5 and recorded that she believed the section 42 threshold was met and that an enquiry needed to take place that linked with the mental health team

who have had experience of family relationships ending in Safeguarding Adult Reviews. SP1 recommended that the referral be passed to ACT for an enquiry. It isn't clear why SP2 didn't recommend the same actions and there is no evidence of any communication between the two senior practitioners.

At this point there is a great deal of information to be concerned about. However, the information had not been brought together as one significant concern, or shared with key professionals. There is an absence of an evaluation and assessment, which could have provided an opportunity for cross agency analysis, clear thinking and decision making. Just prior to the last visit carried out by SW5 there was also a clear opportunity to hold a strategy meeting given the serious worries expressed by the home carers about AVA's welfare and safety. There was then a second opportunity to convene such a meeting immediately after the home visit.

Immediate action should have taken place to contact mental health professionals regarding a possible deterioration of OLIVER's mental health alongside convening a multiagency strategy meeting as AVA was potentially suffering domestic violence and was described by SW5 as unable to provide any explanation due to her dementia and to consider whether protective action was required.

OLIVER contacted his GP on the 7th July requesting a home visit as he was worried AVA might have a urine infection. The GP and a colleague carried out the visit, noting that AVA had stomach pains, constipation and had lumps and bruises on her shins from falling. This in contrast to what OLIVER told carer 2 that they had occurred when dressing AVA. The GP has stated that from their perspective they had no concerns and were satisfied with the explanation given. However had there been multi-professional meetings and planning from the outset it is likely the GP would at the very least been alerted to concerns for AVA's welfare and OLIVER's deterioration in his mental health and been aware of any potential outcome of this.

The final contact with OLIVER is noted as a telephone call on the 7th July (from the NELFT records) advising him of a Joint visit set for the 11th July. The close friend spoke with OLIVER on the 9th July where he offered to attend the meeting on the 11th but OLIVER refused this.

On 10 July 2017, AVA and OLIVER were found dead at home.

8. KEY ISSUES ARISING FROM THE REVIEW

Health Services

1. There was a lack of coordinated discharge planning between Acute Hospital Trust, the Foundation Trust CCT and the Local Authority. AVA's mental capacity was assumed.
2. AVA's capacity had not been formally assessed by the Foundation Trust CTT. The CTT Social Worker undertaking the safeguarding enquiry report on the 7th February concluded that "*her mental capacity should have been fully demonstrated in the assessment*"
3. There was a lack of professional ownership of OLIVER's alcohol problem from the initial identification of this on the Hospital Ward. The whole responsibility of the referral to alcohol services was placed on OLIVER, and there was no evidence of joint working with the alcohol services.
4. Had HTT and HAABIT carried out a joint assessment on 2nd June there would have been opportunity for a joint view and assessment with potential reallocation to the Home Treatment Team.
5. The assessment did not reference OLIVER's previous history of self-harm or provide any indication that the fact that he was drinking alcohol again may increase risk to him-self or others.
6. OLIVER had no Consultant Psychiatrist review and only one medical HTT contact in spite of two treatment episodes and three referrals.
7. Memory Assessment Service team had concerns about OLIVER resuming a caring role for his mother at this time and attempts were made, unsuccessfully, to contact the Ward Consultant Psychiatrist.

Adult Social Care

Mental Capacity

1. AVA's mental capacity was assumed at points where there were clear indicators to assess this. This included LBH at the point of AVA's discharge from Hospital. At the point of AVA's discharge from the first Care Home, a Deprivation of Liberty assessment concluded that she should be deprived of her liberty due to ongoing concerns about her mental state in relation to the

attempted suicide of her son and the traumatic impact of this; however there was no formal assessment of her mental capacity prior to discharge.

2. During a visit by SW5 on 12th June AVA was noted as confused, anxious, worried, and unable to retain information about a return home care package and did not remember SW5. Given this, consideration should have been given to assessing her capacity to make decisions and understand any potential risks including risk of domestic abuse.
3. On 7th July, following concerns raised by Carers 1 and 2, SW5 carried out a home visit and following this alerted SP2 to a bruise to AVA's nose. SW5 stated AVA was unable to say how the injury occurred due to her dementia and that she exhibited limited capacity. An immediate assessment should have been carried out as part of a section 42 enquiry.

Safeguarding and Adult Risk Evaluation

1. There were three clear points where the Local Authority undertook Adult at Risk Threshold Evaluations. The first was on 31st March when a neighbour sent an email to the MASH (Multi Agency Safeguarding Hub) regarding their concerns about the welfare of both AVA & OLIVER. These concerns were taken very seriously by SW6 and the Service Manager with the outcome that threshold was met for a Sec 42 enquiry to commence. However, there is no evidence that this was ever completed.
2. On 31st May, police were called to the home due to screaming being heard by a builder. OLIVER was agitated and struggling with caring for his mother. At this point OLIVER's mental health was assessed and AVA was admitted to a Care Home. Whilst AVA had been placed in a care home, a Section 42 safeguarding enquiry should have commenced to evaluate the risks and assess OLIVER' regarding possible domestic abuse and AVA's mental capacity.
3. On 7th July following two separate concerns raised by Carers 1 and 2, Senior Practitioner 1 reviewed the concerns raised and stated Local Authority records that there was a large body of concern for AVA as a result of the difficulties OLIVER was experiencing. SP1 clearly saw the situation as high risk and formed the view that AVA did not have the mental capacity to be able to protect herself. However, there is no reference to the bruising on AVA's arms and legs

seen by carer 2 and it is not clear how these concerns was responded to or questions raised as to the type of bruising seen. Whilst SP1 recommended a Section 42 enquiry should take place, there was no sense of urgency. The Safeguarding Adult Protocol states that 'Where there have been multiple safeguarding concerns raised for an "adult" decide if these ongoing concerns as a collective meet the threshold for Section 42 enquiry' and in these circumstances they could have. These included attempted suicide, alcohol dependence, self-neglect, low mood, OCD tendencies, concerns about abusive behaviour and reported threats made to his mother AVA. Immediate action was required in terms of referral for a further mental health assessment of OLIVER and protecting AVA.

Metropolitan Police

1. Metropolitan Police had contact with AVA and OLIVER on eight occasions. There were four occasions where Merlin reports were completed to document vulnerabilities for both. On those occasions the evidence suggests that officers were professional, effective, caring and focused on ensuring the right services were contacted and in place for both.
2. On 31st May, a builder working at the premises next door to AVA and OLIVER called police due to hearing a female scream. OLIVER reported he grabbed AVA's arm as she had faecal matter on her fingers. AVA was reported as very distressed and initially stated she had been slapped. The officers recorded that AVA said she had been slapped. In hindsight, the officer said this was an inaccurate recording. They stated that AVA was agreeing with OLIVER's description of what had happened. However this was a potential opportunity to consider domestic abuse to be a risk and elevate the concerns to an appropriate level, with the opportunity for a MARAC referral. Whilst it is accepted, it is unlikely a MARAC meeting would have taken place; there was an opportunity for a multi-agency safeguarding meeting to take place and bring those agencies involved together to consider the issues and risks.

9. DOMESTIC ABUSE

Domestic violence (DV) in previous years was associated mainly with physical violence; however is now defined broadly to include all aspects of physical, sexual, psychological and economic abuse committed by a family member. Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship. The National Charity 'Safelives' reports on data, research and feedback from services and survivors on older people and domestic abuse. The Spotlights Report 'Hidden Victims: Older people and domestic abuse October 2016' highlights older people as a hidden group and focuses on tailoring appropriate and effective services for victims and perpetrators. They raise concern that domestic abuse in older people is not recognised by professionals.

There were six episodes which indicated potential domestic abuse over a period of six months. The first was on the 30th December 2016 in the early hours of the morning, when a neighbour called police after hearing arguing and a female screaming for help.

Whilst there were no allegations of domestic violence, the neighbour's comments of this being a regular occurrence were not followed up. This was processed through the MASH and SW2 carried out a follow up visit on the 3rd February 2017. AVA stated she had provoked her son and was shouting because she was upset and angry about the fraud. AVA stated the 'wailing' had come from OLIVER as he was very upset. There is no evidence that the possibility of domestic abuse was considered. Two days later OLIVER attempted to take his own life.

The second noted incident and concern was reported on 25th March by Family Mosaic, the carer service attending to AVA in the home. OLIVER was described as very controlling said to be cutting her food and measuring, not allowing AVA's underwear to be changed along with shouting at AVA and making her cry. OLIVER also cancelled an MRI appointment for AVA despite this being part of her assessment regarding dementia. HTT agreed to carry out an assessment of OLIVER (27th March 2017), which did not show signs of deterioration in his mental health. Whilst it was appropriate to assess OLIVER's mental health, the professional did not appear to give any consideration to the possibility of domestic abuse in the context of 'coercive control'. Neither did the Local Authority carry out a visit to assess AVA's wellbeing or whether she was at any risk of or suffering domestic abuse from OLIVER, despite the reported concerns. The neighbour wrote a letter to the MASH Service setting out their concerns

regarding OLIVER and AVA on the 29th March. The concerns related to shouting swearing, screaming and banging in the middle of the night, and expressed worry that OLIVER would hurt his mother. On the 30th March, Duty SW6 discussed her concerns regarding the situation with her Service Manager. The email communication between the Service Manager and the HTT Manager did not prompt action regarding possible domestic abuse from either agency, although it was raised by the Local Authority Service Manager.

On the 11th April, an email was received from OLIVER and AVA requesting a reduction in care in the mornings. The evening call had already ceased. This seemed to be accepted and agreed without question. It wasn't in anyway clear that it was AVA who had made the request. This should have raised concern with the SW5 due to the overall presenting risks and was potentially an indicator of 'coercive control'.

The third incident took place on the 31st May. The police were called again by a builder in the next-door neighbour's house, who was concerned due to hearing a female screaming loudly for help. AVA initially reported OLIVER had '*slapped her face';* however, OLIVER stated he was stopping AVA from putting her hand in her hair which had faeces on it. AVA was noted to be upset and then went onto agree with OLIVER's explanation. At the very least, OLIVER had handled AVA very roughly as she was heard to be screaming loudly next door. This was a further point when domestic abuse should have been considered and acted upon.

On the 20th June, OLIVER was seen to be arguing with AVA in the Care Home for a period of 30 minutes. Neither was questioned about the argument, although SW5 was alerted to this.

The fourth incident occurred when AVA was discharged home on the 27th June 2017. On 4th July, the Home Care Provider reported to the Local Authority and SW5 via email that on a visit by Carer 1 on 30th June AVA was found to be shaking, crying and feeling cold. Having taken advice she called an ambulance. OLIVER at this point began shouting, slamming doors and being very rude. He was shouting at AVA and would not speak to her when she tried to speak to him. AVA was noted as having a limited diet controlled by OLIVER. OLIVER was also reluctant for AVA about changing her underwear, who also remained in the same nightwear. AVA did not seem to have any say in this and referred constantly to OLIVER for his view.

The fifth incident took place on the 6th July, when the Home Care Provider Manager again contacted the Local Authority Brokerage Department stating that Carer 2 had visited on the previous evening and found AVA to be extremely confused and frightened. There was bruising on AVA's arms and legs. OLIVER spoke for AVA and gave no clear explanation of how they had occurred.

The sixth incident related to bruising seen on AVA's nose by SW5 on her visit to the home, regarding the concerns reported on the 4th July. SW5 reported this to Senior Practitioner 2. While both were concerned, no immediate action was taken.

The Home Office Statutory Guidance on 'Controlling or Coercive Behaviour in an Intimate or Family Relationship' (December 2015) sets out comprehensively the offence of 'controlling or coercive behaviour', not as a single incident but a 'purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another'. The definition of domestic violence and abuse is out lined in the following way:

Controlling behaviour: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

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

The definitions include other forms of abuse; however in this context relates to OLIVER's behaviour towards his mother AVA. These behaviours included: isolation from family and professionals (no contact with extended family, cancelled appointments & carer support), deprivation of basic needs (warmth and comfort), what Ava ate (minimal diet) or wore (remaining in soiled night clothes), enforced rules which were humiliating and degrading (remaining in the same chair for long periods, shouting and ignoring questions), threats to kill (heard by the neighbour). Alongside this is the question of whether there was any financial abuse relating to day-to-day needs (purchasing of food and essentials) and ownership of the home they lived in (insistence that the home must not be sold). The issue of who managed the family

finances is not clear, including the significant sum of money defrauded from OLIVER and AVA. In this context all professionals that had involvement with OLIVER and AVA had responsibility to understand and recognise the signs of this form of domestic abuse.

At this point, the issue of potential domestic violence and coercive controlling behaviour was now highly visible. Given the significant history of concerns, immediate actions should have been taken to protect AVA. There was a clear need for mental health services to be involved and carry out a further mental health assessment of OLIVER, with AVA being placed into a care home to safeguard her, allowing the opportunity for a multiagency conference to take place to formulate a protection plan.

10. CONCLUSIONS

AVA and OLIVER were two vulnerable people who, due to particular circumstances, had complex individual needs. The intention of each professional was clearly intended positively. However each profession had its own demands; pressures; targets and processes to meet. There were significant moments where certain professionals' seemed to attempt to grasp those complexities and expressed their concerns about how best to go forward. There were also events when those directly in the frontline reported – very clearly – matters that were of concern. Were those events responded to appropriately, and within agency procedures and guidelines, it is likely there would have been evidence of professional recognition, accountability and response to the needs of AVA and OLIVER, with understanding of the risks and issues each were facing. Had this been the case, there was potential for clear risk assessments and safeguarding actions to have been taken.

Professionals should have awareness and understanding of the complexities of domestic abuse of the elderly, including abuse by close family members who are carers (Safelives Spotlights Report: Hidden Victims 2016). Professionals should have been mindful of this in their practice. There was the potential for recognition and therefore intervention on this basis. In addition, had the frequent neighbour referrals been fully considered and examined, this may have led to greater concern regarding possible domestic abuse.

Alongside this, the added complexities of mental health and alcohol abuse noted in the National Confidential Inquiry into Suicide and Homicide by Patients with a Mental Illness; Annual Report (2017) regarding alcohol is that '*much of the risk to others is related to co-existing drug or alcohol misuse rather than mental illness itself*'. It states that '*a greater focus on alcohol and drug misuse is required as a key component of risk management in mental health care.'* OLIVER's alcohol use contributing to his mental health was not considered in relation to risk to AVA by the agencies involved. Tragically, AVA lost her life at the hands of her son who also then took his own life. There are significant lessons to learn here, from the perspective of understanding a very complex, multi-layered situation where both adults' needs became intertwined through the many agencies involved. Although there were moments where some individual professionals attempted to seek clarity and bring together those involved, those efforts were ill-fated.

11. LESSONS TO BE LEARNED

Issues of domestic abuse, specifically coercive control and mental health, were not recognised or considered. OLIVER's observed behaviours were assumed to be related to his mental health difficulties. Alongside this, the lack of knowledge and awareness of domestic abuse of older people led to a narrow perspective of thinking, and it is clear that professionals will need to review and consider this going forward, through appropriate multi agency training and individual developmental programmes.

There was an apparent lack of a joined-up approach by Mental Health services to patients, both on the ward and when discharged to the community care services – including a lack of joined-up working between each of the community MH services. The Psychological Service seems to have been working in isolation to other MH services, with no opportunity for liaison with them to potentially bring forward treatment. There should be consideration of a review of MH services communication pathways, particularly in relation to identifying and monitoring levels of complexity and need. Alongside this, HAABIT caseload management is a challenge that requires focus.

Adult Social Care were unable to address the presenting risks, despite instigating section 42 enquires on a number of occasions. There were no identified systems to track and closely oversee Sec 42 enquiries, ensuring completion of clear holistic

written assessments and protection planning requiring sign off/review. Arrangements need to be in place to address this gap. This should be supported by monthly audit and screening activity by the management team, including senior managers.

In terms of whether the deaths could have been predicted or prevented, there are a number of factors that could have contributed to the deaths of AVA and OLIVER. That is not to say their deaths were predictable, as no one could have specifically known that OLIVER would kill his mother and then take his own life. However, there were significant indicators and events that should have alerted professionals to take certain decisions and actions. These included controlling and coercive behaviour; isolation from family and support services; deprivation of basic needs in terms of warmth and comfort; control of food; enforced rules threats and aggressive and potentially violent behaviours. There were also indicators of control of finances.

AVA's niece's description of her background presents a picture of a kind and capable women who enjoyed life up until her very recent years. It is likely she was carer and supporter to both her husband and her son. The impression given by her extended family is that she had been close to them, up until the tragic death of her husband. Despite her own grief, she remained a loving and caring mother to her son OLIVER. However as she reached the point in her life where her memory was failing and her ability to care for herself deteriorated, there was a reversal of responsibilities.

Friend 1 was a significant person in the lives of OLIVER and AVA. This was clearly indicated by the request of AVA to friend 1 to replace OLIVER as power of Attorney in terms of property and finance should OLIVER become incapacitated. It is also significant that friend 1 was seen as next of kin to OLIVER and was recorded as 'acting next of kin' for AVA during the period OLIVER was hospitalised. Friend 1 felt close to OLIVER and AVA and has fond memories of both. Friend 1 has been deeply affected by their deaths. Significant friendship involvement is an important factor and needs to be considered in the context of adults with complex needs who are estranged from family – in this case a vulnerable mother and son. They, like family, can bring a different perspective and potentially enable better understanding and relationships between those receiving services and the professionals involved.

OLIVER had his own life challenges, particularly following the death of his father. He struggled in his work settings, described a sense of failure in his personal life.

Following the fraud of a considerable amount of money, OLIVER was deeply affected and suffered from depression. The health records indicate OLIVER had a significant alcohol problem for which he had previous treatment. Alongside this, the greater the deterioration there was in AVA's health meant there was greater pressure on OLIVER to care for her. The evidence indicates that OLIVER was abusive to his mother, compounded by his alcohol use and mental health problems. It is likely following the fraud OLIVER's sense of security for the future had been significantly undermined and he appeared to be fixated on the risk of losing the family home. His behaviour became more controlling and abusive. Despite all of this, AVA remained a loyal and loving mother to her son up until her death. Issues of domestic abuse, specifically controlling or coercive behaviours, alongside risk regarding physical abuse and neglect and the links between alcohol abuse and mental health, were not recognised or considered.

Ensuring human rights are met, alongside individuals' right to make decisions on the assumption individuals have mental capacity to do so, is a fundamental element of working in social care and health settings. However, closer attention should have been paid to Ava's capacity and ability to understand the potential risks posed by her son. OLIVER's observed behaviours were assumed to be related to his mental health difficulties. Alongside this, the lack of knowledge and awareness of domestic abuse of older people led to a narrow perspective of thinking, and it is clear that professionals will need to review and consider this going forward through appropriate multi agency training and individual developmental programmes. On this basis, additional guidance is required regarding carer's assessments where it has been identified that carers have mental health issues, alcohol or substance misuse addiction and where there is risk of self-harm or suicide.

The circumstances surrounding AVA and her care needs due to her dementia and her son OLIVER's mental health needs was complex. Had there been a multiagency response and plan in place, it is possible that the deaths of AVA and OLIVER could have been prevented. This also was the conclusion of the DHR Panel.

12. RECOMMENDATIONS FROM THE REVIEW

1. Domestic Abuse Governance Boards (Adult Safeguarding Board and Community Safety Partnership) to monitor referrals and engagement of older people with domestic abuse services and action plan accordingly.

2. Adults Safeguarding Board to ensure specific training for all professionals on the incidences of abuse within a caring relationship and/or where dementia or other mental/physical disabilities are present.

3. LA should ensure that, where there are services in place for a carer e.g. mental health; risk of self-harm; substance abuse issues, they should consider risk both to the 'carer' and the person being cared for; ensuring carers concerns and worries are heard and understood and contribute to the planning of service provision. LA ASB should also consider in complex situations how extended family or friends could be part of a supportive/protective network.

4. Adults Safeguarding Board to oversee and ensure professional development and training programmes regarding safeguarding and domestic abuse are in place, are purposeful and can be applied systemically across the partnership. They should set out how to apply the learning, and understand what the barriers are for implementing change.

5. Foundation Trust and Local Authority to ensure that domestic abuse is fully considered at adult safeguarding enquiries through the implementation of training to ensure recognition of the dynamics of abuse between intimate partners or family members.

6. All agencies should support and encourage the development of professional curiosity within their staff groups, particularly in relation to engaging with the wider network of family and friends to inform decision making in complex cases.

7. Local authority and all agencies should ensure that there is effective managerial involvement in case transfers between staff, particularly agency staff, to ensure that there is continuity of understanding and that key issues do not become lost at the point of case transfer.

8. Implement a multi-agency domestic abuse training programme for Foundation Trust Health Services, specifically Mental Health Services and Local Authority Adult Social Care, that addresses aspects of domestic abuse including adults who require care in the home by a family member.

9. All agency governance bodies to review Quality Assurance Frameworks and audit arrangements to include management and supervision arrangements; completion and outcomes of Section 42 Enquiries and planning including domestic abuse; frequency and quality of mental capacity assessments; care planning and overall to ensure each agencies employee's understand the importance of joint partnership working.

10. All agency Governance bodies to ensure staff are aware of and understand 'Quality Assurance' and its relevance and importance in their day to day working.

11. Clinical Commissioning Group to enhance General Practitioner Training with regard to domestic abuse of older people.

12. NHS England along with the London Safeguarding Board are to ensure the learning from this case are widely distributed due to the complex and unusual circumstances.

Margaret Doe

DHR Report Author

Final July 2020