The London Borough of Havering

Community Safety Partnership

DOMESTIC HOMICIDE REVIEW:

INDEPENDENT OVERVIEW REPORT

INTO THE DEATHS OF

AVA and OLIVER

(Pseudonyms)

On

10/07/2017

PREPARED BY Margaret Doe Independent Consultant

With contributions from

NICHE Independent Consultancy

Concluded July 2020

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1. Purpose of the DHR

1.1 This report of a Domestic Homicide Review examines agency responses and support given to AVA (mother) the Victim and OLIVER (son) the perpetrator and suicide victim, as residents of a London Borough prior to the point of their deaths on the 10th July 2017. AVA was killed by her son OLIVER who then took his own life.

1.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

Who this report is about

1.3 AVA and OLIVER were mother and son. They lived in the same home (of which AVA was the owner) for all of OLIVER' 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' father) by suicide 12 years previously both struggled emotionally. OLIVER is said to have become depressed. In 2016, AVA and OLIVER suffered at the hands of rogue builders who defrauded them 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 this, AVA is reported to have suffered from anxiety and depressive episodes.

Victims Background

1.3 AVA was born in the east end of London, she grew up in East Ham and when the war started moved to Brentwood, she then moved to Hornchurch. She was one of four children.

1.4 AVA attended Romford County High School whereby she gained qualifications. Upon leaving school, she worked as a secretary for an architect. She enjoyed acting, dancing and gymnastics.

1.5 AVA met her husband in a restaurant she visited regularly and it is understood they married in 1953. They lived with her husband's family upon marrying and moved to AVA's current home in 1954. Her son, OLIVER was born in the September of 1962.

1.6 AVA used to enjoy gardening but became unable to continue doing this. She also liked reading but struggled to follow the plot and struggled to complete crosswords. This ability had declined over the previous two years.

Perpetrator's Background

1.7 OLIVER had always lived at home with his parents and said that he had a close relationship with his mother. He reported that his father suffered from anxiety, was on a lot of medication for this and also suffered from Waldenstrom's Macroglobulinemia (a type of non-Hodgkin lymphoma) living with this for seven years before taking his own life by hanging himself in the family garage in September 2005. His body was discovered by OLIVER.

1.8 OLIVER had a degree in psychology and worked as a specialist care worker. OLIVER had at one time a 'Brown belt' in Jiu Jitsu (a Japanese martial art).

1.9 Records indicate that OLIVER said he first realised the "futility of life" when he was a teenager and first had suicidal thoughts at the age of 14 years old. He reported that he continued to have these thoughts throughout his life and that following relationship difficulties, he researched various suicide methods but did not act on this or harm himself in any way. He said that he previously had counselling in the context of relationship difficulties but did not find this helpful.

1.10 The records also indicate that OLIVER had been heavily involved with socialist and liberal activism (particularly with regards to the environment), however became disillusioned with this when he realised that people were "not interested" and spoke at length about society becoming "cold". Records state that he also mentioned people finding him "arrogant" and "challenging" in an alternately self-deprecating and superficially pleased manner.

1.11 It is known that OLIVER used alcohol as a coping mechanism prior to February 2017 when he made a serious attempt to take his own life by stabbing himself in the neck with a kitchen knife, five months prior to the murder/suicide. OLIVER had been drinking at this time. He stated that this

was due to his fears about losing his home and the stress of caring for his mother whose needs had grown considerably. OLIVER's close friend confirmed that OLIVER used alcohol to self-medicate and cope with the difficulties in his life. OLIVER was sectioned under the MH Act Sec 2 following this attempt on his life. At the time of the murder/suicide, OLIVER was awaiting support and treatment from the psychology services in the Borough in which he resided.

Relationship between AVA & OLIVER

1.12 The records reviewed and accounts given to the investigator of the individual management review of Health and Adult Social Services indicated that AVA and OLIVER cared about each other and had a close bond. However, it is stated by family that OLIVER was a spoilt child and was selfish. As an adult, he was also very controlling of his home environment and his mother in that as she became less able they as a family unit became more isolated; did not see family members and rarely went out. OLIVER had two friends one of whom he was closer to. The close friend is said to have had a good relationship with both OLIVER and his mother AVA and considered that the relationship was a good one, with both having a good sense of humour. The close friend has contributed to this review.

The Homicide and Suicide Incident

1.13 On 10 July 2017, OLIVER and AVA were found dead at home. A carer employed by a home care service who was providing care that day to AVA found a note protruding from the letterbox (This service was provided by a Local Authority commissioned organisation that help people to remain at home with home care services).

1.14 The note gave instructions to call the police, explained that it was a suicide and to enter the house through the side gate and the unlocked back door. On entering the house other notes were found with the contact details of OLIVER's close friend and a request to 'phone him', a personal note to his close friend, and another note saying that his life was ruined, that it had gone from bad to worse and he had no future.

1.15 The carer found both AVA and OLIVER deceased in the bathroom on the floor. We have not been able to view the post mortem reports however; we understand the cause of death to be stab wounds to the neck for both AVA and OLIVER.

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

Decision to carry out a DHR

1.17 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The statutory Home Office Guidance for DHRs states:
"Domestic Homicide Review means a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by—
(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken."

On 10th July 2017, police were called to an address in a London Borough where two bodies were discovered. Investigations revealed an apparent murder and suicide situation involving mother and son. The DHR is to include OLIVER due to his mental health problems, previous serious suicide attempt and subsequent suicide. The decision was taken following consideration of how best to integrate work to undertake the NHS Serious Incident Investigation and the Safeguarding Adults Review on behalf of the Local Authorities Safeguarding Adults Board and the local authorities Community Safety Partnership.

Timescales

1.18 This review began on 7th February 2018. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. The reason for the delay of the DHR is due to the overlapping processes of Safeguarding Adults Review and NHS Level 3 Serious Incident Review.

Confidentiality

1.19 Pending Home Office approval following the completion of the final DHR, the findings of each review are confidential to the local authority's

Community Safety Partnership and Safeguarding Adults Board. Information is available only to participating officers/professionals and their line managers.

Terms of Reference

1.21

The Terms of Reference were drawn up by the Domestic Homicide Review Panel on 7th February 2018 to:
Review the circumstances of the deaths of AVA and OLIVER.
Examine the actions of the Local Authority teams and individual members of staff that knew AVA and OLIVER prior to their deaths.
Review the decision making and communications and to examine in detail any assessments of AVA and OLIVER that were undertaken.
Review how risks were assessed and managed via safeguarding and sec 42 enquiries and safeguarding strategy meetings and so on.
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.
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.

Methodology

1.22 The Local Authority Community Safety Partnership concluded 16th January 2018 that the circumstances of this case clearly fell within the above criteria. The matter was referred to the Community Safety Partnership & discussed with Chair of Safeguarding board, and the DHR panel was formed 7th February 2018. The panel appointed NICHE, 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 the clinical commissioning group area where AVA and OLIVER resided sometime in May 2018, and a joint Individual Management Review (IMR) for the Local Authority Health and Adult Social Care on 16th August 2018. The Joint report provides a single narrative and a merged chronology for both the Local Authority 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.

1.23 This report relies on both NICHE reports, the expertise of the investigators and the independence of the author in undertaking all interviews and the reading of all documentation provided by the agencies; Health Services (including the GP) and Hospitals. Further to this NICHE sought expert guidance with regards to OLIVER, expert clinical advice for the Serious Incident independent investigation, consulting a Doctor who is the Deputy Medical Director for an acute NHS Trust with a focus on operations. With regards to AVA, expert clinical advice for the Serious Incident independent investigation was provided by a doctor who is an old age psychiatrist and a family & systemic psychotherapist. This report also relies on the chronology and IMR prepared by the Specialist Crime Review Group, Metropolitan Police.

Review Panel Members

1.24

The DHR Panel membership consists of the following professionals:	
Paul McCarthy DHR Chair	Interim Partnerships and Learning Manager – LB
Barbara Nicholls	Director Adult Social Care - LB
Carol White	Integrated Care Director - LFT
Diane Egan	Community Safety and Development Manager - LB
John Ross	Detective Superintendent - Police
Eve McGrath	Adult Designated Nurse for Safeguarding - CCG
Vicki Nicholson	Women's Aid
Sue Denby	Consultant NICHE
Shakira Gordon	Training and Development Officer LB Safeguarding Boards
Lynn Glancy	Programme Officer – LB Safeguarding Adults Board

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

Chair of the panel and author of the overview report

1.25 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. Margaret Doe has a Diploma in Social Work & Higher Education. Margaret Doe has no connection with the Community Safety Partnership or Safeguarding Adults Board for the Local Authority. Ms Doe has been employed on an interim basis in the Local Authority as Service Manager for Safeguarding Children from 2015 – 2016; and a consultant for Children Services from June 2018 – July 2018. Margaret Doe has never been an employee of any of the organisations involved in this DHR.

1.26 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. He worked in an interim capacity in the Local Authority from February 2017 overseeing the work of their adults and children's safeguarding boards. Mr McCarthy has never been an employee of any of the organisations involved in this DHR. 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.

Contributors to the review

1.27 Below is a list of agencies and others who have contributed to this review;

- NICHE Independent Consultants – via CCG including GP contributions (Clinical Commissioning Group) Serious Incident Report
- NICHE Independent Consultants – via Joint Local foundation Trust (LFT); University Hospital (UH); Health & Adult Social Care Management Review
- Metropolitan Police – via Individual Management Review report

- Family members have contributed to Joint LFT Health & Adult Social Care management Review
- Close friends of OLIVER, friend 1 and friend 2 have contributed to Joint NELFT Health & Adult Social Care management Review

Parallel Reviews

1.28 On Wednesday 12/07/2017, a special post mortem (SPM) took place at a local hospital, regarding AVA. The Home Office consultant forensic pathologist conducted the SPM. The provisional cause of death was stated as stab wounds to the neck. The pathologist also noted defensive wounds present to both hands.

1.29 On Wednesday 12/07/2017, a SPM took place at a local hospital, by the pathologist regarding OLIVER. The provisional cause of death was stated as stab wounds to the neck.

The full Inquest date took place in June 2020 and concluded that AVA was “unlawfully killed” and Oliver died by “suicide”.

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 along with the joint Individual Management Review for LFT Health Services and LBH 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.

Equality and Diversity

1.30 The main subjects of this report are white British. AVA was an older female (89yrs). She appeared to have been the victim of domestic abuse; specifically controlling & coercive behaviour and potentially physical abuse and neglect. Her age and diminished ability to care for herself were likely to have been contributory factors. Alongside this, OLIVER was suffering with mental health issues which impacted on his ability to effectively care for his mother and appears not to have been fully recognised as a risk factor. Overall, AVA’s diminished physical and mental capacity alongside OLIVER’s mental health challenges led to a complex set of circumstances, requiring a high degree of focus with robust multiagency partnership cooperation. There is no information or inference in agency records to indicate that any incident mentioned in this report

was motivated or aggravated by ethnicity, faith, sexual orientation, linguistic or other diversity factors. The Local Authority has clear policies regarding equality and diversity, and completes quality impact assessments annually.

Dissemination

1.31 List of recipients who will receive copies of the review report. All members of the Domestic Homicide Review Panel and any agencies (including the Home Office), the Safeguarding Adults Board and any individuals that the panel deem appropriate.

Background Information (the facts)

1.32 For the purposes of this report, the Local Authority Adult Social Care Services will be referred to as LA. The Foundation Trust that oversees the area where AVA and OLIVER resided (Health Services) will be referred to as LFT.

LFT Mental Health Liaison Services work with all adults presenting to the acute general hospital with mental health difficulties. The team signposts or refers patients to primary or community care.

Home Treatment Team – HTT provides acute home treatment crisis intervention for adults whose mental health is so severe they would otherwise be admitted to a psychiatric hospital. It is an integrated service for people with severe and complex mental and behavioural disorders such as schizophrenia, bipolar affective disorder and severe depressive disorder. Care is usually provided in the patient's home. LFT describe HTT as a service not suitable for people with mild anxiety disorder, a primary diagnosis of alcohol or substance misuse associated with brain damage, learning disabilities with no dual diagnosis with mental health, a recent history of self- harm but not suffering from a psychotic illness or severe depressive illness or a crisis related solely to relationship issues.

The Local Authority Access Assessment & Brief Intervention Team – AABIT is a service for adults needing community mental health services. The team provide initial mental health assessment and referral to other mental health services or organisations. The team can offer brief interventions for up to 6 months.

Acute Care Assessment Team – ACAT Referrals to HTT are assessed by the ACAT.

Community Treatment Team CTT (work with adults with acute physical needs who could potentially be treated at home rather than in A&E).

Memory Assessment Service consists of a team of doctors, nurses, psychologist, occupational therapists and other health care practitioners; who provide assessment, diagnosis and treatment for people who have memory difficulties.

The Metropolitan Police will be referred to as Police.

Commissioned Home Care Provider – provided home care for AVA and is a national provider of home care to support people to live independently.

The Local Authority Safeguarding Adults Board is overseen and led by a multi-agency partnership of organisations which have responsibility to provide strategic and operational advice across the partnership."
Referrals are managed and processed via the Multi-Agency Safeguarding Hub (MASH) for adults. The LA SAM (Safeguarding Adults Manager) role is to provide strategic and operational advice across the partnership. This includes expertise and high quality service in those exceptional cases where they are required to chair or investigate.

The LA Adult Community Team (ACT) South is a team of social workers, occupational therapists and community care assessors. They complete assessments and reviews with people who have long term conditions, manage safeguarding adult referrals, and provide case management both short or long term for cases including complex cases

1.33 AVA and her son OLIVER lived in a privately owned property in a London borough. AVA had lived there since 1954, following her marriage. AVA's husband took his own life in 2005 by hanging himself in the garage of the property. OLIVER discovered his father's body. It is stated this followed a terminal cancer diagnosis and lengthy cancer treatment. OLIVER had lived at the property all his life.

1.34 On Monday 10/07/2017, AVA's regular carer attended the home address shortly before 09:30am and found a note protruding from the front door letterbox stating 'Call Police'. She removed the note which had further details written upon it stating '9th July 2017, suicide, side gate unlocked, back door unlocked, call police.' She entered the property and found the lifeless bodies of both AVA and her son OLIVER, in the bathroom. The carer called for the emergency services.

1.35 AVA had suffered fatal stab injuries to her neck. She also had defensive injuries to her hands. OLIVER had suffered a fatal injury from a stab wound to his neck. A black handled kitchen knife was recovered from under OLIVER's right leg.

Police and the London Ambulance Service (LAS) attended in response to the emergency call and entered the venue. LAS completed recognition of life extinct for both victim and suspect at 09:52am.

1.36 The police investigation has concluded that OLIVER fatally stabbed AVA in the neck before taking his own life by the same method. There is no evidence of other third party involvement.

Involvement of Family and Friends

1.37 The DHR leaflet providing information for families and friends has been sent to all parties involved.
It is understood via the NICHE author that the family did not require an advocate although contributed to the NICHE reports. However OLIVER's close friend has an advocate via AAFDA (Advocacy after Fatal Domestic abuse) who was appointed 24th April 2018 following referral from Victim Support on behalf of Friend 1.

1.38 The terms of reference were shared with the family and friends of AVA and OLIVER by the author of the NICHE report.

1.39 The family and friends have not met with the Review Panel. However, friend 1 and his advocate liaised with the Chair of the Review Panel regarding the DHR Report and met to discuss the report and agree amendments and additional recommendations to which both appeared satisfied.

1.40 The family and friend were updated regularly by the NICHE author. The NICHE draft reports have been reviewed by the close friend in private with plenty of time to do so, and had the opportunity to comment and make amendments as required. The family members have requested not to see any draft reports preferring to see the final documents when completed. However the panel chair is remained in touch with family members.

Family involvement

1.41 NICHE made contact with the extended family of AVA and OLIVER. A niece and her husband met with the author and spoke of AVA and OLIVER. The niece and her husband informed that there are five surviving close relatives of AVA, including AVA's older sister (suffering from severe dementia) and her two daughters, and two children of AVA's brother although they had not been in touch with either AVA or OLIVER for a few years. They stated that from a very early age the family had noticed that

OLIVER was “odd”, an “unusual character”. He was seen as a troubled individual affected by the death of his father and the circumstances in which he found his body in the garage of the home in 2005. The niece told NICHE that OLIVER and AVA were close but “not a happy close”. OLIVER didn’t want his mother to have friends and wanted control of her and the home. OLIVER obsessed about small things and was not capable of seeing the “big picture”. He felt disadvantaged in life, much as his father did.

1.42 He was also viewed as having been a “spoilt young child” who had only ever lived at home with his mother and who grew into a “demanding adult”. OLIVER was seen by the family as bullying his mother and that she put her son before herself, as she did with her husband.

1.43 The family were concerned that they were not contacted either by the police, LFT, LA or by the close friend about the deteriorating situation with OLIVER and AVA, and were not aware of any attempt to contact the family in order to safeguard OLIVER and AVA.

1.44 They feel that the situation between AVA and OLIVER should have been ‘self-evident” and that the Local Authority Adult Social Services did not protect AVA. Their view is that OLIVER should not have been discharged home from Hospital to become AVA's carer in her vulnerable state and it was reasonably foreseeable that harm would come to AVA.

Involvement of Friends

1.45 NICHE spoke to two close friends (friend 1 and friend 2 of OLIVER, both of whom who had had known OLIVER since about 1994, and first came into contact with him through work and martial arts training. Friend 1 was the main friend who contributed to this report. OLIVER had informed Friend 1 that he would use his name as next of kin when required. It is noted in the merged chronology of professional involvement that at the time Oliver was in hospital that he informed nursing staff that friend 1 was ‘acting next of kin’ for his mother Ava. This information was shared with the LA social worker. This is the only reference throughout all professional records which refers to friend 1 in any capacity as next of kin. In the UK there isn’t a clear rule around who can be your next of kin, except in the case of children under 18. However Friend 1 was recorded in that capacity during the period of time OLIVER was hospitalised

Friend 1 has stated to the NICHE author that AVA had asked him to act as her ‘deputy power of attorney’ in 2012. There is no record of this in any of the professional records. AVA appointed Friend 1 her ‘replacement Attorney’ in the event that OLIVER was unable to act for her. The Lasting

Power of Attorney was registered with the Office of the Public Guardian in October 2014. This has been confirmed by the senior lawyer who drew up the agreement. Checks have been made with the Office for the Public Guardian. Records show OLIVER registered as holding 'LPA' (Lasting Power of Attorney) for his mother Ava dated 10/10/14.

1.46 OLIVER had a degree in psychology and worked as a specialist care worker and at the time was a 'Brown belt' in Jiu Jitsu (a Japanese martial art). He trained with his friends. OLIVER was described by one of his friends (Friend 2) as someone that could be relied upon, was a kind and decent man and was a "best mate". Friend 1 described OLIVER and his mother as having a mutually supportive, affectionate and very caring relationship, with both having "an amazing sense of humour". He described AVA as being "clever and sharp as a button", even though she was losing her memory. Friend stated that after his father's death, OLIVER had a period of severe stress and that he threatened a service user whilst at work and was subsequently suspended and eventually dismissed two years later. Friend 1 wrote him a reference and he commenced work as a specialist worker in a school between 2009 and 2010. Friend 1 told us that he knew that he had difficult relationships with some colleagues at the school and his impression was that "something happened at the school". As a result, OLIVER's contract ended. OLIVER did not work from that point onward.

1.47 In August 2016 OLIVER complained to his friend (Friend 1) that he couldn't sleep, that his mother was confused and was wakening him up in the night. His friend encouraged him to take her to the doctors.

1.48 In October 2016, OLIVER and his mother experienced a fraud associated with the roof of the house. According to his friend, the builders knocked on the door and said they had a missing roof slate and explained that work was required. The builders initially quoted £2,500. OLIVER accepted the price of the work; however the price of the job escalated as the builders allegedly found further faults with the roof and eventually they lost over £50,000. Ultimately, Local Authority Trading Standards department and the police became involved. The police in turn contacted the Local Authority Adult Social Services to relay their concerns about OLIVER. OLIVER was worried his mother would be placed into care. He was described by Friend 1 as having OCD (obsessional compulsive disorder). There is no evidence of a formal diagnosis. OLIVER had refused home care provision. The close friend stated that this experience apparently left OLIVER a broken man.

1.49 OLIVER contacted Friend 1 on the 5th February 2017 the day he attempted suicide. He said he was going to kill himself but did not say how. OLIVER was “stammering” and asking for help. OLIVER had panic and fear in his voice and said he couldn’t take it anymore. His friend contacted both the police and the ambulance service, that arrived to find that OLIVER had slashed his neck with a knife. OLIVER had told his friend previously that he would “exit” if he became a burden. He did not tell his friend what had pushed him to this point, but his friend knew he was ‘self-medicating’ with alcohol.

1.50 Friend 1 stated he visited both OLIVER and AVA in hospital and asked them both if they wanted any family contacted which they did not.

1.51 When OLIVER was in Hospital following his suicide attempt, his friend commented that he thought OLIVER had ‘OCD’. When he went to OLIVER’s home to collect belongings for him he found three drawers organised with three ironed items in each and items organised in order in the fridge. His friend remarked that although he thought he had known him for 23 years he felt at this point that he didn’t know him at all.

1.52 When OLIVER was discharged from hospital he told Friend 1 he had stopped drinking and he seemed to have ‘perked up a bit’. The friend stated later AVA had been discharged home with a care package in place.

1.53 Friend 1 stated that OLIVER hated the carers coming in and had developed a nocturnal routine staying up until the early hours. Neighbours later contacted police about screaming and shouting in the night. Concerns arose again about OLIVER and his mental health. AVA was then placed into respite care.

1.54 Friend 1 also said that one of OLIVER’s biggest fears was that he didn’t own the house, and that if his mother went into permanent residential care the house would be sold and he didn’t know what he would do. Friend 1 also reported that OLIVER was very scared at this point.

1.55 His friend advised him to take his health seriously or he wouldn’t be able to look after his mother, however OLIVER didn’t want to take medication because he worried that medication would make him worse and he wouldn’t be able to look after her. Instead, he self-medicated with alcohol.

1.56 The close friend stated that on AVA’s return home after a number of weeks (9th March), they started receiving home care support service again which AVA had agreed to; OLIVER was by this time taking antidepressant medication prescribed by his GP. All seemed to be going ok.

1.57 On Thursday 6 July 2017, OLIVER rang his friend and was very angry because the LA 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 his mother was going to be taken into permanent residential care.

1.58 OLIVER told his friend that his mother's psychiatrist and the LA Social Worker were due to visit on Tuesday 11 July 2017 to provide a diagnosis for her. OLIVER and the close friend spoke on the phone on the 9th July 2017 and OLIVER said "you know what that means". His friend offered to be there for the planned visit however OLIVER snapped back a "no point" response. OLIVER' friend tried to offer reassurances.

1.59 His friend received a handwritten note from OLIVER dated 9 July 2017 which read "*I'm so sorry! It's just hopeless. You did all you could to help. I tried to sound upbeat but I was going to bits inside. You've been a friend and a brother to me. Look after yourself and the children*".

2 Chronology of events prior to murder/suicide incident

2.1 On 23 November 2016, a police Merlin (Metropolitan Police database that stores information on Adults & Children who have become known to the police where there are reasons regarding vulnerability) expressed concerns and alerted LA 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.

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

2.3 A further police Merlin was received by LA 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 about the substantial loss of money from the fraud. They noted AVA spoke

across OLIVER. The officers commented on their concerns about OLIVER's depression and the burden of caring for his mother AVA. The police Merlin was processed through the Multi Agency Safeguarding Hub (MASH) and referred to LA Adult Social Care. AVA was allocated to an LA locum Social Worker 2, who called the home and arranged a visit for 30 January 2017. A separate merlin was not created for OLIVER although it was clear the officers had concerns for his health and wellbeing.

2.4 Prior to this visit taking place, AVA was first referred from her GP to the LFT 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 LFT Memory Assessment service. The referral was discussed in the memory service referral meeting where a history of her family, her medical issues, her medication history and her anxiety due to fraud were noted.

2.5 On 30 January 2017, a LFT 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, was not able to get to the point, talked in rhymes and had odd modes of expression.

2.6 OLIVER said that 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. AVA had a history of falls and fell when she had a urinary tract infection on 3 December 2016.

2.7 AVA was aware that her memory was becoming worse and that she may become confused at night. 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.

2.8 It was noted that her GP had prescribed an antidepressant (mirtazapine 15 mgs) on 26 November 2017.

2.9 An Addenbrooke's Cognitive Examination' (ACE) was undertaken and AVA was given a score of 63 out of 100. It was understood that this score is below the cut off for 'likely dementia'. The plan was to discuss in the LFT Memory Assessment Service case review meeting.

2.10 The chronology shows that Social Worker 2 visited the home on the 3rd of February. SW2 discussed with AVA and OLIVER the concerns raised 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 LA.

2.11 Two days later on February 5th, the police and ambulance service were called by OLIVER's close friend (friend 1) 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. She had superficial cuts to her hands. OLIVER was transported to a local Hospital for his injuries. AVA was taken to a different hospital for safeguarding purposes. The police contacted LA directly by telephone to alert them to the incident. The Duty Police Inspector designated this event as a critical incident; thus ensuring agencies were contacted directly. LA 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 Merlin reports were completed for both OLIVER and AVA. This was a good response to the events that took place with good multi-agency coordination.

2.12 AVA was transferred to the observation ward within the A&E department and then onto the Elder Receiving Unit. The Hospital raised a safeguarding alert regarding AVA's admission (noted on BHRUT briefers template). A LFT 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'*).

2.13 The close friend of OLIVER visited AVA at the hospital on the 6th February. The LA records note friend 1 as acting next of kin, which had been recorded at the hospital. He was told that AVA was to be discharged. He spoke with the LFT CTT 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.

2.14 However the nursing assessment completed indicated AVA was medically fit for discharge. It stated the family friend would visit AVA at home and that LA had arranged for a four times a day home care package. On the 6th February it is reported that the Hospital Site Manager stated that there were no safeguarding issues as OLIVER was in hospital. It was later found that a formal 'mental capacity' assessment was not completed for AVA by the LFT social worker at that time. AVA was considered fit for discharge and was returned home.

2.15 AVA was discharged home that evening. Later on that same evening a neighbour called the police as AVA was wandering outside in just her nightgown looking very confused. On arrival AVA was seen to be visibly upset and shaking and felt cold to the touch. She was upset about the blood in the bathroom. Police contacted (the Local Authority) LA 'out of hours' adult social care, expressing concerns AVA had been discharged home and that the place was still covered in blood. They also expressed the view she was unlikely to be able to look after herself. Police called an ambulance and AVA was returned to hospital in the early hours of the morning.

2.16 LFT CTT commenced a safeguarding enquiry on the 7th February into the discharge arrangements completed on the 5th February and stated that AVA's '*mental capacity should have been fully demonstrated in the assessment'.* The mental capacity assessment was arranged for the 9th February. Through that assessment it was concluded that '*AVA' physical and emotional wellbeing was compromised due to anxiety and she could not retain information'.* It was concluded that the trauma may have brought about psychological changes and affected her 'capacity'.

2.17 The decision to discharge AVA on the 6th February by the Hospital on the basis that AVA agreed to go home and was assessed as having capacity was premature. It did not allow for a comprehensive assessment of her needs, the potential risks, and her capacity to make informed choices about her safety. The notes indicate there was an email exchange between the LFT CTT social worker and LA allocated social worker where it was stated that "SW2 had advised via email that on the 3.2.2017 she had visited AVA and her son and stated "they declined all help proposed by me". The LFT SW added that both were involved in the discharge planning. Whilst the Hospital made the decision to discharge AVA, the NICHE findings state there was a lack of coordinated discharge planning

between the Hospital, LFT Community Treatment Team (CTT) and LA SW2. Whilst AVA was known and had been assessed by the LFT Memory Service, and it was considered she had memory problems linked to dementia, this information appeared not to have been considered as part of the assessment to return her home. The event itself would have been extremely distressing, and this was noted as having a significant impact with AVA being fixated on the traumatic event she had witnessed with her son, making it in my view difficult for AVA to focus on any conversation therefore '*causing an impairment or disturbance of her mind'*. An assessment completed by an occupational therapist on the 8th February concluded AVA would require a high level of care and assistance on discharge. The plan following these assessments was for the LA Joint Assessment & Discharge Team to assess AVA and that LFT CTT no longer needed to be involved.

2.18 At this point LA senior practitioner 1 stated in her interview as part of the NICHE investigation that a Section 42 Adult at Risk Evaluation (Care Act 2014) was undertaken regarding AVA, the threshold was met and this information was passed to the Joint Assessment & Discharge Team. This safeguarding enquiry was completed by LFT CTT. However NICHE were told by the Joint Assessment & Discharge Team they were not involved in AVA's discharge, as she was subsequently admitted to a local care home. (A section 42 enquiry is completed at a point where there are allegations or concerns that an adult is potentially at risk from abuse or neglect). The process of the enquiry will determine if there are risks within the balance of probabilities, and if so, what actions need to be taken, including any actions required to keep the adult safe whilst the enquiry is ongoing and ultimately whether a protection plan should be in place. The assessment set out clearly the failings in the initial discharge arrangements; the presenting risks and an assessment of AVA's mental capacity. However, there is no clear planning process. Had the enquiry been concluded in line with procedural guidance, there was potential for a multi-agency safeguarding case conference to be held, and the opportunity for information to be formally shared and a safeguarding plan put into place. This could have given opportunity to consider potential contact with extended family and friends.

2.19 Alongside this, LFT 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 considered her past psychiatric and personal history, alongside her medical history and current health and social circumstances, insight and capacity among other things. The assessment

completed did not provide a risk related care plan. The finding regarding this assessment by the NICHE investigation states that the assessment of 'mental capacity' was unclear. Further to this, the assessment stated that '*there may be a future risk to AVA if he (OLIVER) has strong suicidal intent and potentially killing her jointly'.* When spoken to by the NICHE investigator, the LFT Mental Health Liaison Nurse based this on his assessment of AVA and the circumstances. His view about the high risk to AVA was based on his experience of what potentially could happen; although he did not consider this to be imminent as OLIVER was being detained under sec 2 of the Mental Health Act. Whilst the nurse did not considered the risk to be imminent, this was a significant concern that needed to be shared more widely via a further safeguarding alert and directly discussing those concerns with a senior manager and AVA's social worker. No risk management plan was developed. The NICHE report states that further action was recorded on 10th February 2017, that discussion took place with the LFT CTT service, with a plan to hold a multi-agency meeting before AVA's next discharge to ensure her safety. However this did not take place. There was a need at this point to complete a comprehensive risk assessment.

2.20 AVA was reviewed on 11th February by another nurse in the LFT Mental Health Liaison Team. Although no formal capacity assessment was completed, she was found to have limited insight as to why she was in hospital and difficulties with her memory. Risks were deemed to be a potential deterioration of her mental health, unsteadiness on her feet and concerns for her son's welfare.

2.21 On the 14th February, a LFT 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 plan was to wait for a placement for AVA, with LFT memory assessment service to follow up in the community. It is noted in the NICHE investigation report that 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. AVA was admitted to a local care home on the 13th February. Funding was agreed to the 9th March. On the 14th February the care home manager requested a seven day standard Deprivation of Liberty (DoLs). This process was completed by the Section 12 Approved Doctor regarding mental capacity; mental health and eligibility assessments. The final part was completed by LA 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 needing to be clarified before AVA could return home to the care of her son including the potential risk he could pose to his mother. The issue identified by the MH Liaison Nurse (risk of suicide and homicide) was not considered at this point. There is a 21 day period for DoLs applications to be processed and approved. In this instance, due to a backlog in the system the application was not approved and AVA was discharged home. LA have had an exponential increase in DoLs applications and this is likely to have contributed to the delay in approval. However at the time of discharge, it appears that there were no concerns about AVA's 'mental capacity' and the plans in place to provide home care and support OLIVER in his role as carer were satisfactory. A carer's assessment had not been completed at this time.

2.22 On the 15th February, OLIVER was admitted to LFT Mental Health in-patient unit under Section 2 of the Mental Health Act from Hospital. The initial risk assessments on the 16th and 19th February stated that OLIVER stabbed his neck with a knife in an attempt to end his life. He was reported to be remorseful and regretful. No evidence was found of OLIVER being a risk to others. This 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. He was prescribed Thiamine (vitamin B1) due to his known alcohol problem. Thiamine is prescribed for a person who drinks alcohol heavily which causes thiamine deficiency. OLIVER was reported to have a history of alcohol problems, having been prescribed 'chlordiazepoxide' for alcohol withdrawal in the past. The hospital records indicate that OLIVER did not present with any risk of suicide of risk of harm to others.

2.23 On the 21st February, the LA team manager recorded that the funding for AVA's respite care had run out. This was being dealt with through a request to the Head of Service. The allocated social worker was on leave and SW 4 was asked to complete these tasks. It is noted that AVA has not been seen by a social worker to discuss her care needs since her admission to the care home. SW4 had also been on leave. Given the complexity of the situation it is regrettable AVA was not seen and that the social worker did not have an overview of AVA's needs and progress. Alongside this, the DoLs application became lost with this lack of attention and focus.

2.24 On the 22nd February, it is stated in LA 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.

2.25 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. At this point, the Safeguarding Advisor LFT advised on the case file that OLIVER required a carer's assessment with support from LA. The Care Act 2014: Assessment and Eligibility sets out the local authorities' duties in relation to assessing people's needs and their eligibility to publicly funded care and support.

2.26 Havering Memory Service discussed AVA, with a plan that the doctor was to contact the Ward Consultant Psychiatrist to discuss concerns about OLIVER resuming care of his mother. On the 23rd and 27th February, attempts were made by the Memory Assessment Service locum Consultant Psychiatrist to contact the Ward Consultant Psychiatrist. There was no facility to leave a message therefore the consultant sent an email to the Ward consultant inviting them to the discharge (Care Programme Approach) CPA meeting, which in essence can conclude if a person needs a Care Coordinator. During the NICHE investigation interview with the Ward Consultant, he 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. This is concerning in that the opportunity to leave a message did not seem to be possible, and that the communication between these two key services at this critical point failed. Had the consultant attended this meeting, there was an opportunity to discuss and consider the complexity of the situation, and for a single professional to be appointed to coordinate and manage a plan to meet both OLIVER and AVA's needs and identify potential risks.

2.27 NICHE interviewed the LFT Safeguarding Team Advisor Adult Acute and Rehabilitation Directorate. This is a staff facing service providing support and advice to LFT staff on safeguarding matters. The Advisor had recorded on the electronic care record that OLIVER was likely to be discharged home. In interview, the Advisor explained that this was not standard practice. However, she had attended a LFT performance and quality safety group meeting and was informed of AVA's discharge home from Hospital, and was aware of OLIVER being a patient. On the basis of this, she spoke with the Ward Manager to ensure they were aware of AVA's discharge and the potential seriousness of the situation. The Ward

Manager requested she make a note on the file so that this would not be forgotten. The note, dated 22nd February, stated that the suggested plan for OLIVER to care for AVA would require a carer's assessment and social care input, liaison between Ward and the LFT memory Service about OLIVER's discharge home, with LFT Home Treatment Team (HTT) being aware of AVA and services she was accessing. She suggested that all the services should liaise with each other. This was a good intervention providing good professional advice.

2.28 Also on the 23rd February, SW4 visited AVA. His records report that AVA wanted to return home to be cared for her by her son. When interviewed by the NICHE investigator, SW4's view was that AVA had 'capacity' although she was forgetful. He did not record or clarify his rationale for assuming this. At this point due to the high risk and complex situation, SW4 should have assessed and formulated a safeguarding plan for AVA.

2.29 OLIVER was discharged from hospital on the 28th February. He was referred by the consultant psychiatrist to LFT Home Treatment Team (HTT), which was accepted. OLIVER had made it clear he wanted his mother to return to his care. He was worried about having to pay for her care and was concerned about their financial situation. A referral had been made to the Local Authorities Psychological Services and OLIVER was provided with information on alcohol services. He was prescribed thiamine due to his alcohol issue. His diagnosis was '*mental and behavioural disorder, alcohol use and adjustment disorder with a negative reaction to stress'.* OLIVER was considered low risk despite chronic thoughts of suicide, as he had never presented to the service before and that his self-harm occurred whilst intoxicated. It is clear at this point OLIVER had an alcohol addiction issue. There was a lack of multi-agency discharge planning given the seriousness and complexity of the situation, and a missed opportunity to liaise with family and friends in terms of forming a wider protective network for AVA and OLIVER.

2.30 On the 6th March, according to LA records SW4 carried out an assessment of 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, and was asking AVA to sign papers when there. (OLIVER later reported these were bills etc. that needed to be paid) OLIVER was also spoken to on the phone by SW4, and it was stated that the three time per day package of care was part of a protection plan for AVA. OLIVER reported he had made big changes in his life, and one of these was that he had given up alcohol; he realised he

had been drinking very heavily. OLIVER was provided with support to claim benefits. No evidence of a protection plan was found in the case records. The NICHE investigator expressed some concern that the assessment didn't fully demonstrate the rationale for assuming AVA had capacity to understand the potential risks associated with this. The previous assessment carried out by Senior Practitioner 1 under DoLs, which recommended a period of 3 months deprivation of liberty, appeared not to have been taken into account. According to the NICHE investigation report, LA Adult Safeguarding Team, when interviewed by NICHE, expressed surprise AVA was thought to have capacity at this point; given that a week earlier she did not and also expressed concern that all seemed to be well with OLIVER so quickly after such a serious attempt to take his own life. Around this time the investigating police officer for the fraud also contacted LA asking if it would be appropriate to contact OLIVER and AVA regarding statements.

2.31 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.

2.32 On the 13th March, LA 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 made arrangements to carry out a joint home visit with LFT HTT to assess the home situation which was agreed.

2.33 The joint visit took place on March 17th. The LFT HTT record indicated that the home was well organised and tidy. (OLIVER was said to suffer from OCD). He 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 LA would continue working with OLIVER and AVA and ensure respite would be put in place as required. The closing record from HTT indicated that OLIVER's mental state was settled and stable, with no further thoughts of suicide. He stated he was also abstaining from alcohol. AVA was receiving a package of care and ongoing support through LA. OLIVER was discharged to the care of his GP.

2.34 At this point the situation appeared settled and neither the HTT professional nor SW2 reported ongoing significant concerns. The LA record indicates 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. SW2 made the right decision to request to jointly assess the home situation with LFT HTT, and this should be seen as good practice. Despite the failings regarding AVA's capacity and the question as to the speed of OLIVER' recovery, it appeared to SW2 and the HTT professional believed that some tentative progress had been made.

2.35 However by the 25th March, some eight days later the Re-ablement home care service (A third sector organisation was the initial provider, transferring to LFT Integrated Rehabilitation & Re-ablement on 19th April 2017) 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 AVA's 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. Duty SW4 notified LFT HTT on 27th March who agreed to visit. SW4 also passed on the concerns to SW2 and the PAT. On the same day, OLIVER cancelled AVA's MRI (Magnetic Resonance Imaging) scan arranged by the Memory Service and was 'quite irate' on the phone when doing so. The appointment was rearranged. LFT HTT carried out a joint visit to the home on the 27th. OLIVER was noted to be dishevelled, with outgrown hair and beard. He was reported as 'malodorous' (smelling very unpleasant). OLIVER reported he was irritable but was getting by and that he wasn't drinking. AVA stated she was only concerned about his cough. The HTT assessment indicated there were no signs of OLIVER deteriorating. His mood was noted as 'euthymic' (his mood appearing neutral). He was given clear instructions on how to seek help should he need it i.e. the HTT record indicates OLIVER was adamant that there was nothing to worry about. He had a cough and that was making him irritable. There was no evidence he was an immediate risk to himself or others. OLIVER did not want the case reopened with HTT. HTT records indicate the case was closed. The records do not refer to OLIVER's self-neglect, his irritability and his angry behaviour towards AVA. It is unclear if this was this taken into account by the HHT professional carrying out the visit despite his neutral mood at the point of the visit; or if this information was shared with SW2. These were concerning behaviours displayed by OLIVER towards AVA and were not explored or considered in the context of risk to AVA.

2.36 On the 29th March AVA and OLIVER's immediate neighbour wrote an email to LA 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. This was further indication of potential risk of harm to AVA in the context of domestic abuse.

2.37 On the 30th March, LFT HTT note an administrative record was made that there was a call from the MASH Team to enquire whether OLIVER was open to mental health services. The administrator stated the records showed LFT HTT attended the home 3 days previously and was closed to HTT; and that OLIVER arguing with his mother was 'their usual pattern of behaviour'. OLIVER was noted to be open to Psychological Services. However, OLIVER was not receiving any service from them as there was a waiting list due to a high volume of referrals; nor was he accessing services to support his alcohol problems. The neighbour was advised to call the police if there were further concerns. The neighbour was not spoken to directly.

2.38 On the same day, locum SW6 contacted LFT HTT. SW6 was advised that HTT provided short term intervention and that LA were to put appropriate support in place for AVA to reduce the risk of him becoming overwhelmed. HTT further stated they were aware of OLIVER and recent concerns which were not new and that his pattern of behaviour was to argue with his mother. (An assumption made by one professional that required challenge from the other professional in terms of the exploration of possible domestic abuse). They had spoken to AVA, who reported no concerns and AVA was advised by the HTT professional to call the police if needed. There is no evidence of a 'capacity' assessment being completed. OLIVER was not under their care and they had done their bit. HTT did not provide any further advice or input. SW6 was unhappy with this response and discussed her concerns with the LA Safeguarding Service Manager. The Safeguarding Service Manager emailed the mental health Senior Social Worker (Team Lead Domestic Violence Champion and MARAC representative) with concerns about the situation and OLIVER's ability to meet his mother's needs, given that when he is overwhelmed he drinks alcohol to cope. The Service Manager raised a number of points including questioning the assumption that AVA could summon help if required; ensuring the social worker for AVA would discuss a referral to MARAC (Multi Agency Risk Assessment Conference) and refer to local police for monitoring. The Service Manager urged that they work together to ensure the risks were managed. The response to this from the LFT HAABIT Senior was to repeat that an assessment had

been completed on the 27th March; that AVA had been advised to contact the police and that OLIVER had been referred to psychology services. The Senior Social Worker wanted to know what the Service Manager expected them to do. It was also asked whether OLIVER had given consent to the referral to AABIT. The LFT HTT Senior Social Worker agreed to review OLIVER's current recorded mental state, and also set out the challenges for them in that unless OLIVER was suicidal he would not meet the criteria for the Crisis Response Team. HTT did not arrange to review OLIVER at home. This seemed a reasonable point to make in terms of what the service could not provide, and in my view highlighted a gap in service resource for anyone with mental health needs that did not fit a certain criteria. However, the Senior Social Worker who is noted as a MARAC representative did not respond regarding a way forward to address potential risks of domestic abuse to AVA. It is also worthy of comment that this exchange took place via email. It is not clear if either attempted to telephone the other to try to discuss and agree any positive way forward.

2.39 On the 30th March, a visit to OLIVER and AVA was arranged and duty SW7 attended along with a team manager to assess the concerns raised by the neighbour about shouting and screaming being heard. The records also indicate that the '*visit was undertaken as mental health services could not attend and the south team had not visited for a while'*. The records state OLIVER presented as well with no clear signs of mental health issues. Good interaction was noted between OLIVER and AVA. OLIVER reported that his mother had wax in her ears and that was he was shouting to be heard. OLIVER acknowledged his underlying metal health issue and thought that his care may be interpreted as aggressive. A request was made by LA for a change in the package of care for AVA to include home respite and a day of social inclusion out of the home for AVA. It is concerning that, given the questions previously raised regarding AVA having 'capacity', and the HTT advice for AVA to call the police if needed, that the opportunity to assess the risk issues was not addressed during the visit. This was a critical point, where the services involved seemed unable to work together to identify how to address the concerns raised by the neighbour and understand the risks posed to AVA, alongside understanding OLIVER and his mental health needs and issues.

2.40 On the 31st March, SW6 completed an LA Sec 42 Adult at Risk Evaluation record. This notes the neighbours' concerns, the history relating to OLIVER's attempted suicide, that the threshold for section 42 was noted as met as AVA had care and 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 LA. The case was then transferred to SW5. Friend 1 has recently stated that communication with SW2 had been good however once the case transferred he was not contacted at any point by SW5. This was a critical moment.

2.41 At this point, had a strategy/professionals meeting been convened, with: an opportunity to share information and concerns; to reflect and evaluate AVA and her ability to protect herself with regard to DV/abuse; to evaluate OLIVER's behaviours/mental health needs (and lack of appropriate service access); and the risk he was posing to his mother, there was potential to reconsider both their care needs and plan accordingly. The opportunity to refer the case for a Multi-Agency Risk Assessment Conference panel (MARAC) could have been an outcome of any strategy meeting. However, a strategy meeting did not take place, nor is there evidence that the enquiry was completed. Alongside this, there is no evidence that at this point a LA manager had oversight of the case and therefore no appropriate supervision to ensure good practice with regard to case transfer and planning. This was a significant event and a missed opportunity.

2.42 The chronology does not indicate further activity with AVA or OLIVER from LA or HTT at this point. There was no known liaison with the family GP or with the Psychology Service to either request input or support.

2.43 On the 4th April, a Police Merlin was raised by the officers investigating the fraud case via the MASH. They reported concern for OLIVER's mental health. They reported OLIVER was stressed and seemed angry when speaking about the case. OLIVER stated he was depressed and he no longer had support from HTT. He also found visits from social workers stressful. The officer expressed concerns that if OLIVER remained untreated he could make another attempt on his life. The officer sent an email to the social worker in LA and also contacted the LFT HTT to set out their concerns. LA recorded that section 42 threshold was not met for OLIVER and the matter was referred on. On the same day, a HTT professional attended the home to assess OLIVER. The HTT worker carried out an assessment 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. 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. (A visit took place on 6th April)

2.44 On the 11th April, three weeks after concerns were raised by the initial re-ablement provider, 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. The records indicate that the same neighbour contacted the LA 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 LA responded or took any action at this point. This a further critical event which should have led to professionals having raised concerns for AVA and for safeguarding actions to take place (multi-agency meeting).

2.45 AVA had been referred to the LFT re-ablement service on the 13th April, which commenced on the 20th April and attended the home of AVA to assess and assist in her day to day self-care.

2.46 On the 21st April, SW5 telephoned and spoke to OLIVER arranging a visit for the 27th April to complete the section 42 enquiry.

2.47 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. It is not clear why there had been such a delay. The LA 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. He stated AVA was hard of hearing and he had to shout to be heard. The option of an audio appointment was discussed. AVA expressed her feelings of love for her son, and that they work together and support each other and want that to continue. The recording does not mention any of the previous concerns raised by the neighbour. The recording does not consider AVA's capacity in terms of making informed decisions or understanding any potential risks. There is no indication whether AVA was spoken to alone. There is no reference to the requested reduction in care visits made via

email and the impact of this on AVA and OLIVER. Alongside this there is no evidence of a discussion with OLIVER and the further assessments completed by HTT. There is no clear plan outlined at the conclusion. This was another missed opportunity to fully assess the needs of AVA, and to assess the potential risks of OLIVER acting almost as sole carer to AVA at this point.

2.48 On the 8th May, the Acting Team Manager LA noted in a supervision record that a joint visit was to take place. The records indicate there is no further contact by LA with AVA and OLIVER until 25th May, just over two weeks later.

2.49 On the 9th May, the LFT re-ablement service is noted to have ceased on the 28th April as AVA declined any further input. It is not clear if LA was notified.

2.50 On the 25th May, a joint visit took place by SW5 and the Acting Team Manager. The case record describes the visit in the following way:

OLIVER and AVA were having tea and biscuits. 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 as 'we'. OLIVER described how he washes his mother's hair back and lower legs and she cleans her teeth. He 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 LA if needed. The record does not provide an assessment, professional opinion and evaluation of the home situation for AVA or OLIVER. There are no questions regarding the reduction of care for AVA, despite OLIVER stating he found caring stressful. The question of potential risk to AVA from OLIVER was not considered, alongside the issue of AVA's capacity to understand any potential risks to herself or to understand her current circumstances. All of this should have been considered as part of a section 42 enquiry.

2.51 On 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. The Met Police IMR identified that a Police Merlin report was completed for OLIVER, but there should have been a separate report completed for AVA due to her vulnerabilities.

2.52 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. The London Ambulance Service attended along with the LA Interim Team Manager and LFT 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 police record states that AVA was very emotional and repeatedly told officer she loved her son, she was sorry and that he needed help. The Police Merlin reported '*upon talking to AVA she stated that her son had slapped her across the face'.* The officers contacted the London Ambulance Service and OLIVER left voluntarily with them for a mental health assessment. The LA Acting Team manager discussed with AVA whether she could cope at home on her own and she said she could not. AVA was admitted to a Residential home for two weeks respite. She was reported to settle well. In the assessment report the LFT AABIT worker noted that it was unclear whether OLIVER was being aggressive towards AVA. OLIVER said he had started drinking again and the level had begun to increase. He reported drinking six cans of beer and three whiskeys the night before. The outcome of this assessment was to recommend completion of DATIX (incident report) for disclosure of possible aggression, safeguarding alert to be completed and referral to the Home Treatment Team.

2.53 The police officers who attended the incident were interviewed as part of the IMR process. The question was raised as to why the incident was not reported as a domestic violence assault. The officers explained that this was 'inaccurate/inappropriate wording' and that AVA was agreeing with her son's explanation that he pulled her arm to stop her putting her hand into her hair which had faeces on it. It is noted that there was no injury. The officers had attended the home previously and had knowledge of OLIVER and AVA. They concluded that the incident regarded two vulnerable adults who both had safeguarding and care needs. The officers recorded that AVA said she had been slapped but they did not report it as a crime. In hindsight the officers stated in interview this was an inaccurate recording. They stated that AVA was agreeing with

OLIVER's description of what had happened. The Police Individual Management Review reported that the attending officers spent over two hours at the home building rapport with both AVA and OLIVER. They sought support from the appropriate agencies and also sought guidance from their line manager who supported their decision. A Merlin was completed in respect of OLIVER only.

2.54 It is clear the officers had recognised the stress OLIVER was suffering. However, AVA was still 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.

2.55 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. A Police CRIS (Crime Reference) report was not completed. Officers again completed one Merlin report in regard to OLIVER and not AVA, which might suggest they had not fully recognised any potential risks to AVA from OLIVER.

2.56 On the same day (31st May), OLIVER returned home following the assessment undertaken by LFT AABIT. OLIVER was referred to LFT 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 NICHE investigation report noted that consideration could have been given to override this. The records indicate OLIVER as having suicidal thoughts every day, deterioration in his mental state with low mood and becoming increasingly angry and agitated with a past history of attempted suicide.

2.57 The records indicate that LFT ACAT requested a joint visit with LFT AABIT but this was declined due to lack of resources. The NICHE investigator was informed by LFT AABIT staff that recruitment was a concern and caseloads were high due to this, with caseloads of around 70 patients at the time. The conclusion of the NICHE report was that

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. Ultimately, a home visit to OLIVER took place on 2nd June with LFT ACAT Clinical Team Lead and LFT ACAT Community Psychiatric Nurse. The LFT records were noted as 'presenting situation' and 'referral outcome decision'. 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.

2.58 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 NICHE investigation report noted that the clinical message from 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, with specialist substance misuse and mental health services working closely together'*. The NICHE investigation report found the assessment undertaken by LFT ACAT did not reference his 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. I would go further and say that in addition to this any risk assessment should have included the potential risk to his ability to care safely and appropriately for his mother.

2.59 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 felt able to care for her himself. OLIVER also stated that HTT did not feel he was acute enough to require their input. OLIVER asked if he could commence on anti-depressants. It was agreed this would be discussed at the next clinical meeting.

2.60 On the 6th June SW5 visited OLIVER at home. At this point OLIVER had been allocated to SW5. This 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 Psychological Services. SW5 supported the idea of OLIVER beginning to take anti-depressants and it was agreed SW5 would speak to the GP about prescribing these. 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. SW5 asked about putting a care package in place for AVA, to which OLIVER said they have both declined this. SW5 was to discuss this with AVA on his next visit to the respite placement. SW5 also informed OLIVER that his mother had expressed a wish to return home. There is no mention in the recording of consideration of AVA's 'capacity' at this point. SW5 also brought up the issue of OLIVER's personal hygiene. The residential unit staff reported that he smelt. OLIVER said he had no sense of smell. SW5 requested that he change his clothes before he visits again. SW5 left a 'carer's assessment form' for OLIVER to complete. Given OLIVER's state of mind and the history, this seems ill-considered and instead what was required was a thorough and detailed assessment of OLIVER in his own right in relation to his needs.

2.61 The records also show at this time that the safeguarding alert regarding AVA had still not been submitted, as the AABIT social worker had not yet had consent from AVA. Alongside this, OLIVER spoke with the AABIT social worker and stated that AVA's social worker had said she was free to come and go from the residential home as she pleases, which he was surprised about as he thought she couldn't leave the home. The safeguarding alert was finally sent on the 8th June with AVA's consent; who said she and her son get on very well and he never makes her feel scared or worried. She was looking forward to going home.

2.62 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 NICHE investigation found that OLIVER did not have a medical review by either HTT or AABIT. There was no Consultant Psychiatrist review and only one medical LFT HTT contact in spite of OLIVER's two treatment episodes. Given this, and the risk history of OLIVER, the NICHE investigation found that OLIVER should have had a review by the LFT HTT Consultant Psychiatrist and following

the fact that LFT ACAT had not accepted the referral would have expected escalation to the LFT AABIT Consultant Psychiatrist, according to the operational policy requirements. This was a further missed opportunity.

2.63 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. AVA thought the incident had happened the previous night. She presented as anxious and worried about her son. They discussed a care package and SW5 asked if AVA was agreeable to stay in respite for a little longer. She agreed to this, but kept asking what was going to happen to OLIVER, as she was worried about him. AVA also asked if SW5 could speak to both her and OLIVER together as she didn't want to upset him. 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. Whilst the legislation and guidance states that capacity should be assumed given the circumstances and the level of risk it would have been appropriate to consider assessing AVA.

2.64 The records indicate that in a telephone conversation the same day with OLIVER, SW5 spoke about the care package, to which OLIVER stated the previous care package of 30 minutes was not long enough. SW5 informed OLIVER that his mother had asked for her to speak with both of them about the care package, and it would be in place to minimise the stressors for both of them. SW5 also noted that if the police were called again his mother would be placed permanently in a home. Through the NICHE investigation, SW5 was interviewed and in relation to this comment, she stated that she asked OLIVER how he would feel if his mother was placed in permanent care. She also asked AVA the same question in a meeting with both of them the following day. Both were clear they did not want this to happen. AVA wanted to go home and that they were a team. This seemed an inappropriate and unprofessional question to ask two vulnerable adults within a complex and risky situation.

2.65 On the 20th June, a member of staff of the Home recorded that AVA was agitated and seen arguing with OLIVER outside. The care worker went outside and calmed them both down. They carried on arguing for a period of about 30 minutes until the care worker asked them to come inside. 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 care package as planned. On the

same day, OLIVER telephoned SW5 to say he had completed as much as he could of the carers assessment. OLIVER also stated that the anti-depressants had not 'kicked in yet'. SW5 stated that if he were unable to complete it she would go through it with him once AVA was discharged home. The NICHE investigation found that 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.

2.66 A LFT AABIT social worker entry dated 21st June referred to a supervision session taking place on the 19th June. The AABIT social worker 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. OLIVER also spoke about a friend who was being very supportive and his contact with his mother, and that she was due to return home on 27th June. The social worker agreed to call again the following week. The recording also referred to enquiring with LA Adult Safeguarding about where the safeguarding alert was but had to leave a message. There was also 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.

2.67 On 23rd June, SW5 contacted the Memory Assessment Team asking for an update. It was noted OLIVER was still waiting for counselling (from Psychological Services) and SW5 suggested that a follow up would be appropriate, suggesting a meeting between AABIT doctor, social worker and OLIVER on 11th July.

2.68 The manager of the Oaks residential unit notes 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.

2.69 LA records state on the 27th June, AVA was discharged home with a care package of three visits per day; although the respite end-date is recorded as 28th June with a local authority commissioned service providing home care from this date. OLIVER reported to SW5 the antidepressants hadn't yet kicked in fully.

2.70 On the 29th June, LFT AABIT social worker attempted to call OLIVER to monitor his mental health but he did not answer his phone.

2.71 On 4 July 2017, the home care Manager emailed the LA Home Care Brokerage Department and SW5 to inform LA about concerns raised by one of the carers (Carer 1) who visited AVA on 30 June, 1 and 2 July 2017 three times per day. These concerns should have reported within 24 hours according to the Homecare Providers' guidance and procedures.

2.72 Carer 1 reported attending the home of AVA for an evening call on the 30th June. 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, slamming doors and throwing things and was being very rude to his mother. This was aimed at AVA. Carer 1 stated that OLIVER made it seem like an inconvenience. 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, to which 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.

2.73 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. The carer stated it was dirty and needed changing. The carer described having to be forceful, taking out the new underwear to change her and that OLIVER 'had a go at her'. The carer also suggested that they change her into day clothes, as she had been in her nightwear since the 30th June. The carer also noted that prior to the previous carers noted AVA remained in the same nightclothes. OLIVER is said to have 'shouted' at her about this. 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".

2.74 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.

2.75 The homecare manager asked for advice via email about steps to follow, in addition to monitoring the situation in the home. The homecare manager also reported that their Quality Officer had visited the previous week to arrange a risk assessment, but OLIVER refused to let her in. There is no evidence that a LA 'concern reporting form' was completed following receipt of this information.

2.76 NICHE interviewed Carer 1 and she said she managed to engage with OLIVER who told her that he had experienced a failed relationship and that everything had gone downhill from there. He felt that by being an only child, there was an expectation that he should have children, that he had let himself down and he had not found a partner. OLIVER told her that, financially speaking, he and his mother had to be together.

2.77 Carer 1 stated that she had at one point informed the homecare provider that she was not willing to continue to provide care for AVA, as OLIVER had shouted at her about putting on clean underwear for AVA. She understood that the homecare provider had reported this to LA, but in terms of her personal concerns, this had not resulted in any action being taken. It was clear OLIVER's behaviour was very concerning and AVA was at risk; however, it remains unclear why this was not responded to.

2.78 At this point there are significant reported concerns. LFT 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.

2.79 On the 6th July at 10:39am, the homecare manager contacted the LA 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, the son stood there and answered all of the questions. The homecare Manager asked for this information to be sent to the appropriate person, as she was becoming very concerned about the wellbeing of AVA.

2.80 On the same day Homecare Package Brokerage emailed SW5 at 10:51am asking for her to respond. Later that afternoon SW5 visited AVA and OLIVER with a care assessor from the ACT North Team. 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 responded saying she often had cold legs and he puts blankets over her for this. He also denied shouting at his mother and said the carers are liars and he did not want them coming back. After explaining they were there to support AVA, he agreed they could come back but he would not speak to them. Also after suggesting a variation to AVA's diet, OLIVER asked if they expected him to do more work and that going to the supermarket would mean leaving his mother for too long. SW5 suggested the carers could prepare breakfast for AVA, which OLIVER accepted. He also agreed to AVA attending a daycentre 2-3 times per week. The recording does not indicate whether AVA was asked about these arrangements or whether she agreed. The final comments state that the care plan is to be revised to include breakfast and lunch preparation and a day centre referral, raising 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.

2.81 Whilst this is not part of the professional chronologies, OLIVER's close friend stated to the NICHE investigator that on Thursday 6 July 2017, OLIVER rang him and was very angry because the LA 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 LA Social Worker were due to visit on Tuesday 11 July 2017 to provide a diagnosis for her.

2.82 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. The response by SP2 was that she had looked at the history and that the long-term concerns were that OLIVER had his own mental health and alcohol issues and had not been coping as a carer; neighbours had heard him shout at AVA and that he had admitted he had caused the injury to the nose by accident. Therefore 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. The notes do not refer to concerns raised by carer two regarding bruising to AVA's legs and arms.

2.83 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 South for an enquiry. It isn't clear why SP2 didn't recommend the same actions, and there does not appear to have been any communication between the two senior practitioners.

2.84 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. Whilst SW5 shared her concerns with SP2 following the visit her desire was to facilitate AVA remaining at home if at all possible. At this point, given the significant concerns and indication of OLIVER' deteriorating mental health, SW5 should have requested he was seen by a mental health practitioner to assess his mental health. OLIVER had a close friend. This could have been a point for SW5 to have spoken with him with OLIVER's consent to try and further understand OLIVER's worries and

concerns and to understand if he felt OLIVER's mental health and wellbeing had deteriorated; alongside making enquiries about extended family and whether they could provide support. This discussion could have extended to AVA and her vulnerabilities. At the point, 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 also a second opportunity to convene such a meeting immediately after the home visit. The reported concerns in the email sent by the homecare Manager were clear, along with her expression of concern for AVA's safety. There was a lack of recognition of the importance of the carer's information by SW5 i.e. the carers were seeing and attending to AVA and OLIVER daily, and witnessing both the deterioration in AVA's wellbeing and OLIVER's mental health.

2.85 LFT AABIT made a call to SW5 regarding a planned joint home visit for the 11th July which SW5 had arranged previously. OLIVER was called to advise him of the visit. OLIVER and the close friend spoke on the phone on the 9th July 2017 about the joint visit and OLIVER is reported to have said, "You know what that means". His friend offered to be there for the planned visit however, OLIVER snapped back a "no point" response. OLIVER's friend tried to offer reassurances.

2.86 AVA and OLIVER were both found deceased by the homecare provider carer on the morning of the 10th July.

3. Overview

3.1 Set out below are the key points of the information provided from the merged chronology and reports for the purposes of this report.

3.2 It is clear that the fraud of over £50,000 which took place in October 2016 had a deeply upsetting and profound impact on both OLIVER and his mother AVA. This, coupled with the deterioration of AVA's health, meant from the perspective of OLIVER there was a huge risk of losing the home that he had lived in all of his life. This appears to have had a significant impact upon OLIVER's mental health, and the relationship between AVA and her son. At this time, AVA was beginning to have memory problems and it was thought had the onset of dementia and Memory Service were involved. An assessment was undertaken on AVA by LA and a package of care offered, however both declined this. In late December 2017, the police were called to the house following reports of screaming. At this point, the police completed a Merlin report highlighting concern for OLIVER's mental health and the burden of caring for his

mother. A social worker was allocated to AVA who visited on the 3rd February to discuss the neighbours' concerns. They both reported all was fine.

3.3 Such was the impact of the fraud and the changes in role for OLIVER as a carer for his mother he (under the influence of alcohol) attempted suicide on February 5th 2017 by taking a knife to his throat. At this point, he was drinking alcohol regularly and heavily, according to health records and his close friend who reported OLIVER used alcohol to self-medicate. This should have been considered as a risk issue in its own right.

3.4 Following OLIVER's attempted suicide; OLIVER was sectioned under the Mental Health Act and remained in hospital for a period of three weeks. AVA was also hospitalised due to her level of vulnerability and distress. Unfortunately, AVA was discharged home the same day without a clear plan and to her home which still had the remains of the blood from the suicide attempt in the bathroom. OLIVER's close friend had been liaising with the hospital and alerted them to her needs and the state of the home suggesting she should not be discharged home. The discharge of AVA seemed purely down to a lack of coordination and planning between the hospital, the community health services and the LA. AVA was quickly re-admitted later that evening, eventually being placed into a respite care home. A LFT CTT Sec 42 safeguarding enquiry into AVA's discharge about what went wrong concluded that AVA's mental capacity should have been fully demonstrated in the assessment. It was stated through a further assessment that '*AVA's physical and emotional wellbeing was compromised….and she could not retain information'* and concluded that the trauma brought about psychological changes and affected her '*capacity'.* However, the Sec 42 enquiry did not set out a plan or conclude that a multi-agency meeting should be held to discuss the future safety and welfare of AVA and future support to OLIVER.

3.5 OLIVER remained in hospital. He spoke of a history of suicidal thoughts but had never acted on them. He spoke of his own father's suicide in 2005. He also spoke of drinking heavily. The attempted suicide was noted to have been connected to the fraud he had suffered. He did not present as depressed or a risk to others and was not prescribed antidepressants. He was prescribed Thiamine in relation to his alcohol problem. OLIVER stated he regretted the suicide attempt and the distress he had caused. He wanted to return home and care for his mother. Memory Service attempted to Liaise with the hospital ward OLIVER was on to raise concerns about OLIVER resuming care of AVA. These attempts failed and the Mental Health Consultant responsible for OLIVER

stated he was unaware of the concerns or any attempts to contact him. Communication between these two key services failed at this critical point, which was a missed opportunity to discuss the complexity of the situation and for a single professional to be appointed to oversee a plan for both OLIVER and AVA.

3.6 OLIVER was discharged from hospital on 28th February. AVA was discharged home nine days later. The allocated LA social worker SW2 returned from an extended period of leave four days after this and expressed concern that AVA had returned home to be cared for by OLIVER, given that he had made such a serious attempt on his life. Whilst a care package was in place for AVA there was no multiagency plan in place. Professionals from LFT HTT and LA appeared to be responding to arising issues on a day by day basis. SW2 arranged for a joint visit with LFT HTT. The joint visit concluded that at this point the home situation seemed to be settled. AVA seemed well cared for and OLIVER spoke of having insight as to why he attempted suicide. OLIVER stated he had been overwhelmed with his mother's dementia. His appearance however was unkempt and dishevelled. He reported he was not drinking alcohol and was keen for the psychology to service to begin working with him. Despite the failings prior to this and questions as to the speed of OLIVER's recovery, it appeared to the professionals that the home situation was stable at this point. However, I would suggest the complexity of the circumstances and their individual needs and issues was not recognised.

3.7 On 25th March, some eight days later, the home care service going into the home for AVA requested an urgent review due to OLIVER's behaviour by being controlling of AVA food, shouting at her causing AVA distress and not allowing her underwear to be changed. OLIVER also cancelled an MRI scan for his mother and was irate when doing so. AVA reported she was concerned for her son and that he may try to take his own life. HTT carried out a joint assessment. The conclusion was that OLIVER was irritable as he had a cough. There were no signs of deterioration and OLIVER was adamant there was nothing to worry about. There is no record as to why AVA had been so worried for her son's mental health. OLIVER did not want HTT to become involved again. Alongside this, AVA was advised by LFT HTT to call the police if needed. This is concerning in the context of whether AVA had the capacity to know or understand when she may need to do this.

3.8 A few days later a neighbour wrote a letter to the Multi Agency Safeguarding Hub (MASH) raising concerns about swearing, screaming and banging alongside bizarre noises being heard. They also reported

hearing OLIVER threaten to kill his mother. They wanted something done. Checks were completed and HTT reported that arguing was their usual pattern of behaviour. The neighbour was advised to call the police if there were further concerns.

3.9 LA SW6 raised concerns about the circumstances and lack of response with her Service Manager, who in turn liaised with the LFT AABIT Senior Social Worker. The communication (via email) initially appeared to be tense as AABIT stated they had done all they could; although later agreed to carry out a review of OLIVER's current mental state, although a home visit did not take place. She clarified that unless OLIVER was suicidal he would not meet the criteria for crisis intervention which is provided by HTT. In other words, he would not receive a service unless he was in crisis and the assessment did not evidence this. The situation regarding how to respond to the circumstances for AVA and OLIVER seemed to cause stress and pressure for AABIT and LA, with no obvious answer in how to deal with this.

3.10 SW7 and ACT South Team Manager carried out a home visit the following day on 30th March. The visit did not identify any specific concerns and OLIVER gave an explanation for the shouting and screaming i.e. his mother had wax in her ears. At this point, it isn't clear what was to be achieved in the visit. The intention of the Service Manager and SW6 was positive as they raised concerns with MH services and requested HTT involvement which was refused at this point. What is clear is the mental health services were only able to deal with specific MH needs, aimed primarily at those individuals in crisis. Alongside this, the Team Manager also noted that the 'South Team had not visited for a while', clearly indicating her concern. At this point OLIVER was still waiting for an appointment with Psychological Services.

3.11 An adult at risk evaluation record (31st March) noted the neighbours' concerns and the history concluding that; section 42 threshold was met for AVA due to her care and support needs and the risk of abuse, and an enquiry was to be undertaken. Unfortunately, SW2 was leaving the employment of LA. The case was transferred to SW5. At this point, the risks and concerns were passed to another professional to respond to. This was a missed opportunity for LA to convene a strategy/multiagency meeting to consider the complexity of the situation and the concerns that didn't seem to be able to be addressed. This would also have been good practice and extremely helpful for AVA and OLIVER, alongside the newly appointed social worker and her manager.

3.12 On the 4th April, the police investigating officer regarding the fraud completed a Merlin report and referred directly to LA and LFT HTT expressing their concerns about OLIVER's mental health having visited the home in relation to the investigation. Whilst HTT responded and carried out a home visit, there were no specific mental health concerns noted other than his fluctuating mood. OLIVER refused any support from HTT, instead saying he would wait for the psychological appointment. There was no intervention from LA which, given the recent concerns, should have prompted a home visit. HTT notified LA that Sec 42 was not met for OLIVER, and LA were informed for '*information as they were supporting mother'*. Despite the regular reporting of concerns and safeguarding issues that had arisen over previous months, neither agency appeared to consider the overall circumstances and the many risk indicators; 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.

3.13 Going forward OLIVER requested a reduction in care via email, followed by the neighbour contacting LA due to their concerns about the screaming, shouting, and banging noise late at night, and concern for the welfare of OLIVER and AVA. Approximately two weeks later, SW5 visited the home in order to complete the section 42 enquiries. SW5 recorded a relatively positive picture with both presenting as well, OLIVER explaining the reasons for the shouting and AVA stating she no longer needed the re-ablement package, as she wanted to remain as independent as possible. The recordings do not indicate any discussion about earlier concerns raised by the neighbour, or the issues raised by the home care service. There is no indication of whether AVA had the mental capacity to understand her needs and the risks possibly posed to her. It is concerning that; it took so long for the visit and the enquiry to take place. There is a question as to whether SW5 had a good understanding of the circumstances and history of AVA and OLIVER, and whether SW5's direct, line manager also had that understanding. In my view, the visit and the recording of the visit does not meet the standard required for a section 42 enquiry.

3.14 From the 28th April until the 25th May, there appeared to be no professional involvement or interaction with either AVA or OLIVER. On the 25th May, SW5 and the Acting Team Manager carried out a home visit.

Both OLIVER and AVA appeared to present a united front. Nothing of concern was noted (apart from OLIVER's self-neglect) and OLIVER reassured both that if he felt low he would ring the mental health team. It wasn't clear at this point if this was a further visit related to the section 42 enquiry or if the enquiry had been closed.

3.15 The police were called on May 30th again by a neighbour due to shouting being heard. OLIVER provided an explanation about an incorrect takeaway order, which was accepted by the police. A police Merlin was completed regarding OLIVER but not AVA. A further call to police came the following day from a builder working next door, due to hearing a woman screaming. The explanation was that AVA had been using her fingers to evacuate her bowls and OLIVER had pulled her hand to stop her putting her hand in her hair. AVA was stated to have said OLIVER had slapped her face. AVA was then said to be agreeing with OLIVER's explanation. OLIVER was seen and assessed by a member of LFT ACAT, whilst AVA was admitted to a care home for two weeks respite. The police at this point completed a Merlin on OLIVER regarding the incident and did not consider this to be a domestic abuse incident, resulting in no report being submitted regarding AVA. Whilst the officers later explained in interview that the original recording was '*inaccurate wording'* as AVA was agreeing with her son's explanation; AVA was heard to be screaming loudly enough for the builder next door to hear and be concerned. In my view it is not unreasonable to form the view that at the very least OLIVER had handled her roughly. She was at risk in these circumstances due to OLIVER's increasing anger and agitation in dealing with his mother, and due to his difficulty in coping with her care needs and his feelings of being overwhelmed, as reported by the LFT ACAT worker following her assessment of OLIVER. Had this been reported as a domestic abuse incident, there may have been potential to refer to the MARAC and whilst the threshold for MARAC may not have been met, agencies involved would have been alerted to concerns, providing an opportunity for a multi-agency response to be formulated. The Merlin referral regarding OLIVER was evaluated via MASH, and it was concluded that section 42 criteria was not met for OLIVER as his needs related to his mental and emotional difficulties. Had a police Merlin been completed in relation to AVA, there was potential that the criteria for section 42 would have been met and a further opportunity for a multi-agency meeting and response.

3.16 The LFT ACAT assessment completed on the 31st May found OLIVER to have low mood, having daily suicidal thoughts and a deterioration in his mental state. He was drinking large amounts of alcohol again. Efforts were made to complete an assessment jointly with AABIT,

however this was rejected, leaving a team that had high caseloads as an assessment and short intervention service, to support OLIVER.

3.17 At this point OLIVER was not coping with the care of his mother; with daily suicidal thoughts and a deteriorating mental state. He was increasingly drinking alcohol and was known at least to roughly handle his mother. AVA's capacity to make informed choices and be able to understand the potential risks to her was not clearly assessed. The delay in submitting the safeguarding alert by LFT ACAT (due to seeking consent from AVA) meant that the crisis had passed and that a further opportunity to focus on the complexity of this situation was missed.

3.18 A home visit that took place on 6th June by SW5 revealed that OLIVER was self-neglecting, and that the Care Home had raised significant concerns about his personal care and the smell from him and his clothing when visiting his mother. OLIVER remained resistant to having carers in the home for his mother, but was in agreement to be prescribed antidepressants. The expectation that OLIVER should complete a carer's assessment alone was unrealistic and also unprofessional given the serious issues regarding OLIVER' mental health. OLIVER required an assessment in his own right.

3.19 Since OLIVER's attempted suicide in early February, the NICHE investigation found there had been no Consultant Psychiatric review of OLIVER (a period of four months) despite there being a further treatment episode; their expectation being OLIVER to have been reviewed by the LFT HTT Consultant Psychiatrist.

3.20 When SW5 visited AVA at the residential home a week later, it was noted she was confused and did not remember SW5. AVA was seen to be anxious, worried and concerned for her son and thought the incident had occurred the previous night. She was unable to retain information about carer arrangements, and wanted the social worker to speak to both her and her son, as she didn't want to upset him. SW5 should have considered assessing AVA's mental capacity at this point and considered what AVA's worries were based upon. SW5 also suggested to OLIVER that if the police were called again, AVA would be placed permanently into a home. This was then repeated to them both in terms of if they wanted this to happen to which both stated they did not. This was an inappropriate and unprofessional question to ask two vulnerable adults within a complex and risky situation.

3.21 A week later OLIVER and AVA were seen to be arguing for a period of 30 minutes in the residential home. It wasn't known what they argued about. SW5 was informed and was to inform her manager, but in any event concluded this was a one off event and AVA would return home to the care of her son. The same day OLIVER informed SW5 that the antidepressants had not 'kicked in' and he had completed as much of the carers form as he could. The NICHE investigation concluded that OLIVER's needs as a carer was not adequately assessed and that leaving OLIVER to complete the form was not an adequate response to the situation. It was known to SW5 and the LFT AABIT social worker that both OLIVER and AVA were resistant to having the care package in place and needed persuading. The workers agreed to keep in touch. SW5 arranged a follow up meeting with the Memory Service and the AABIT Consultant for 11th July. On the same day, the residential home manager noted AVA's extremely repetitive behaviour and anxiety about her situation and about what was happening next.

3.22 AVA was discharged home on the 27th June with a care package of three visits per day. One week later, on July 4th, the homecare provider manager raised concerns with LA concerning visits on the previous three days. The first day AVA was found crying and shaking feeling very cold around her legs. An ambulance was called to which OLIVER responded negatively shouting and slamming doors. Eventually due to the length of time the ambulance was taking and the situation having calmed down, with AVA feeling a little better, the ambulance was cancelled. The following two days saw AVA's eating pattern to be limited and controlled by OLIVER. OLIVER was also extremely resistant to AVA having her underwear and outerwear changed. AVA seemed to have to remain sitting in the same chair, and whilst the carer successfully changed AVA from night to day wear, OLIVER changed her back to the same used nightwear on her return visit. The carer found OLIVER difficult and at one point had asked not to remain as the carer.

3.23 On the 6th July, Carer 2 was in attendance and noticed bruising to AVA's arms and legs. When asked how they had occurred OLIVER spoke for AVA saying they didn't know. AVA seemed extremely confused and frightened. Carer 2 questioned the bruising to AVA's legs and OLIVER stated they happened when dressing his mother. The homecare provider manager reported these issues, expressing significant concern for AVA's wellbeing. SW5 and a care assessor visited on the same day in response to the concerns. OLIVER's response was to deny he had been shouting at his mother and about her limited eating. OLIVER called the carers liars, and said he did not want them back in the home. The response by SW5

and the care assessor was to make some changes to the care package for the carers to prepare her food. SW5 was at this point considering a residential placement for AVA. The following day (7th July), SW5 contacted senior practitioner 2 to discuss a small bruise to the side of AVA's nose, and stated AVA could not comment on how it happened due to her dementia but OLIVER had explained it was an accident. SW5 was clearly concerned. The discussion concluded to put in extra support rather than separate mother and son, and to monitor for any further injuries. Later the same day Senior Practitioner 1 reviewed the safeguarding alert submitted by SW5, and concluded in her recording that Section 42 threshold was met and an enquiry should take place linking with mental health who have had experience of family relationships ending in Safeguarding Adult Reviews (SARs). It is important to note that there is no mention by SW5, SP2 or SP1 in the recordings of the bruising concerns raised by carer 2. At this point 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 to consider whether protective action was required, as AVA was potentially suffering domestic violence and was described by SW5 as unable to provide any explanation due to her dementia.

3.24 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. AVA also had an itchy back which the GP prescribed antihistamines. The GP did not report any safeguarding concerns. The GP has stated that from their perspective they had no concerns and were satisfied with the explanation given. However, had there been mutli-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.

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

4. Health Services

4.1 Although the medical decision to discharge AVA was taken by the hospital, there was a lack of coordinated discharge planning between the hospital, the LFT CCT and LA. The NICHE report notes that 'The Hospital Medical Team' recognised this and on 7 February 2017, an incident form and a safeguarding alert was raised as a result.

4.2 The capacity assessment undertaken as part of the safeguarding alert completed by the Hospital on 6 February 2017, when AVA was admitted, indicated that AVA had capacity to decide about her own safety. However, at the point of discharge home, AVA's capacity had not been formally assessed by the LFT CTT. The LFT 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*". A comprehensive capacity assessment was completed thereafter on 9 February 2017 by LFT CCT.

4.3 In spite of the evidence (National Confidential Inquiry into Suicide and Homicide by Patients with a Mental Illness; Annual Report 2017) that risk is consistently associated with alcohol abuse, there was a lack of professional ownership of OLIVER's alcohol problem from the initial identification of this in hospital. 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. It is understood that self-referral to the alcohol services is preferred, however the service accepts referrals from professionals in health, education and social care.

4.4 HTT asked LFT AABIT to undertake a joint assessment with them on 2 June 2017, however we were told that LFT AABIT declined due to lack of resources. This as unfortunate, and a service delivery problem, as this would have provided an opportunity for a joint view and assessment and might have resulted in a different outcome as a result.

4.5 The assessment of OLIVER undertaken by LFT ACAT on 2 June 2017 did not reference his previous history of self-harm or provide any indication that the fact that he was drinking alcohol again may increase risk to himself or others.

4.6 There should have been professional challenge about decisions made by LFT ACAT. This made LFT AABIT appear to passively receive the decision that OLIVER would not be taken on by LFT HTT, rather than challenging this decision.

4.7 The NICHE investigation found there was a service delivery problem associated with the risk assessment and management training

requirements. Staff interviewed by NICHE stated there was an electronic system in place to tell them when their training was due and this was regularly reviewed by the team manager; however although they said they had received risk training they were not clear as to whether this was mandatory, and how often they should receive this.

4.8 The NICHE report also found there was no consideration made by LFT services, as her carer, to refer the situation involving AVA and OLIVER to the Multi-Agency Risk Assessment Conference (MARAC).

4.9 The NICHE investigation found that the LFT Memory Assessment Service did not view their assessment of AVA as being undertaken within a complex situation. It would have been helpful to have discussed the complex circumstances in which they were assessing AVA in the weekly multidisciplinary meeting.

4.10 There was a care delivery problem in that the application of CPA (Care programme Approach) was not considered for OLIVER, in line with the LFT CPA policy at the point of discharge from the Hospital to the LFT HTT. The appointment of a care co-ordinator would also have ensured that he had his needs assessed as a carer.

4.11 There was a lack of clarity in OLIVER's first episode of care, as LFT HTT were not clear about why they were working with him, other than because it was routine monitoring after discharge from the Ward with no detailed crisis plan for OLIVER.

4.12 The LFT AABIT Social Worker made reasonable efforts to follow up OLIVER between the 21 June 2017 and the date of his unexpected death on 10 July 2017 given the remit of the LFT AABIT and the fact that 'follow up' requirements had not been stipulated. However, there was no evidence of a care plan or a LFT AABIT team decision about the intervals for monitoring OLIVER.

4.13 Overall, OLIVER had no Consultant Psychiatrist review and only one medical LFT HTT contact, in spite of two treatment episodes and three referrals. Given this, and the risk history of OLIVER, the NICHE investigation would have expected him to be reviewed by the LFT HTT Consultant Psychiatrist.

4.14 There was a missed opportunity following advice from the LFT Safeguarding Advisor of the possible discharge of OLIVER from the Ward. The LFT 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 LFT Ward Consultant Psychiatrist on 23 and 27 February 2017.

4.15 There was a missed opportunity on 30 March 2017, after the LFT HTT were notified following a neighbour contacting the MASH about concerns about OLIVER's mental health. LFT HTT did not reassess OLIVER and the records indicate that the police should be called if there were any further concerns by neighbours.

5. LA Adult Social Care

Mental Capacity

5.1 AVA's capacity was assumed on her discharge from Hospital on Feb 6th 2017. This decision was reviewed as part of the CTT Sec 42 enquiry on the 7th Feb On the 9th Feb, in a comprehensive capacity assessment completed by LFT CCT, AVA was deemed not to have capacity due to the distress and anxiety following the attempted suicide of her son. AVA's capacity had not been assumed whilst in the first residential placement as a standard deprivation of liberty application had been submitted by the care home manager, which was approved by the Section 12 approved Doctor. Senior Practitioner 1 found that the 'Best interest' requirement was met and that it was recommended to deprive AVA of her liberty for a period of three months. This would have been reviewed at the point a decision was made to discharge AVA home. There is a 21 day period for DoLs to be approved but due to a backlog in the system, the application wasn't viewed until after AVA was discharged home. Whilst DoLs does not indicate that AVA should not have been discharged home, the decision to apply for DoLs for a 3 month period indicated that the Manager of the residential home, Sec 12 Doctor and SP 1 were sufficiently concerned regarding AVA's mental capacity and her best interests, in the context of OLIVER' attempted suicide and the impact of this upon AVA. This should have been a trigger for further thinking about mental capacity issues and risk, as part of the decision making to support the return of AVA home. LA have had a significant increase in DoLs applications: 2015/6 there were 560 applications; March 2017 there were 1207 applications and from April to November 2018 there have been 1126 applications. This has put significant pressure on LA capacity.

5.2 SW4 is recorded as assessing AVA's mental capacity on 23rd February, and again on 6th March. The NICHE investigation found that neither assessment fully demonstrated the rationale for assuming AVA had 'capacity' to understand potential risks. AVA returned home with a care package on the 9th March, and remained there until 31st May when the police were called to the house. OLIVER's mental health was assessed by LFT AABIT. AVA agreed to being admitted to the second care home. SW5 visited AVA in the care home on the 12th June. It was

noted she was 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.

5.3 On the 7th July, following concerns raised by Carers 1 and 2, SW5 carried out a home visit. Following this, SW5 alerted SP2 to a bruise to AVA's nose. SW5 wanted to know if the injury constituted a 'safeguard'. SW5 stated AVA was unable to say how the injury occurred due to her dementia and that she exhibited limited capacity. SW5 wanted to uphold AVA's wish to remain at home for as long as possible but was considering residential care. AVA may have wished to remain living at home. However, it appears SW5 did not consider whether AVA was expressing this wish under coercion from her son, in the context of domestic abuse. The NICHE investigation reports that SW5 and her Interim Team Manager had no concerns about AVA's capacity in the period of their involvement. The records indicate this is the case as there was no mental capacity assessment considered or completed during their involvement.

Safeguarding and Adult Risk Evaluation Section 42

5.3 There were three clear points where LA undertook Adult at Risk Threshold Evaluations. The first was on the 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 LA 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. There was no record of any formal safeguarding 'enquiry' report on LA records. The NICHE investigation reviewed the records and found the documentation confusing and unclear, with SW5 stating that the previous plan of 7th March was ongoing with no changes. They were informed that the safeguarding and review plan (protection plan) was in fact a support plan, as it was not put in place as a result of a formal safeguarding concern.

5.4 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. The concern was raised by police via a Merlin report regarding OLIVER. The evaluation of the risk was related to OLIVER's mental health needs, he had not suffered harm and the criteria for Sec 42 was not met; effectively closing down the concern without wider consideration of AVA and her needs and potential future risks. At this point

AVA was in the second care home and therefore she was not considered to be at risk.

5.5 On 7th July, following two separate concerns raised by Carers 1 and 2, Senior Practitioner 1 reviewed the concerns raised and stated on the LA records that there was a large body of concern for AVA as a result of the difficulties OLIVER was experiencing. There is reference to the bruise on her nose, that she '*suffers from dementia and does not have the capacity to make decisions about keeping herself safe when living with him'* (OLIVER). SW5 had stated to SP2 that AVA was unable to say how the bruise occurred due to her dementia. 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 as to the type of bruising seen. At this point OLIVER's mental health required assessment and there was a clear opportunity to request this given the reported concerns about his controlling behaviour, aggression and deterioration in the home situation. AVA was seen to have bruising, and was unable to speak directly with carers as OLIVER was preventing this by speaking for her. She also appeared confused, frightened and withdrawn. Alongside this, the social worker's view was that AVA had limited 'capacity'.

5.6 The above instances were missed opportunities to consider the possibility of domestic abuse, to work collaboratively with LFT to have multiagency professional communication via telephone consultations and meetings, to develop joint planning to support OLIVER and safeguard AVA. There was a missed opportunity for OLIVER to have a further mental health assessment given his behaviours and the concerns raised by carers about this.

6. Metropolitan Police

6.1 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.

6.2 On the 31st May, a builder working at the premises next door to AVA and OLIVER called police due to hearing a female scream. 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. They concluded that the incident regarded two

vulnerable adults who both had safeguarding and care needs. The attending officers spent over two hours at the home building rapport with both AVA and OLIVER, and had previously attended the home. They sought support from the appropriate agencies and also sought guidance from their line manager, who supported their decision. A Merlin was completed in respect of OLIVER only.

6.3 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. Whilst the officers explained that the original recording was 'inaccurate wording', as AVA was agreeing with her son's explanation, AVA was heard to be screaming loudly enough for the builder next door to hear and be concerned. My view is that 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. Officers completed one Merlin report in regard to OLIVER and not AVA, which might suggest they had not fully recognised any potential risks to AVA from OLIVER. This was a further missed opportunity.

7. Domestic Abuse

7.1 This domestic homicide report has focused on the complexities of the relationship between OLIVER and AVA as far as possible, given that they had little contact with anyone outside their relationship as mother and son. The report has also considered the complex care, treatment and support services involved with OLIVER and AVA and the challenges for them both to have their individual needs fully met. The report has considered incidents which raised concern for professionals regarding possible domestic abuse perpetrated by OLIVER towards AVA. This section of the report will consider critical factors which potentially relate to their untimely and tragic deaths.

7.2 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. Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship (the Statutory Guidance cites the following cases - Curtis [2010] EWCA Crim 123 and Widdows [2011] EWCA Crim 1500*).* 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 report 'Multi-Agency Risk Assessment Conferences data does not include this age bracket, figures show that only 3% of victims aged 60 or over are accessing (independent domestic violence advocate) IDVA services supported by the MARAC model'. They raise concern that domestic abuse in older people is not recognised by professionals. It is within these definitions that OLIVER and his behaviours will be considered in this report, along with potential offences of violence and neglect.

7.3 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' in terms of it not being a single incident. It states that it is 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 outlined in the following way:

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

Coercive behaviour is 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, these relate 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), bruising to parts of AVA's body possible attributed to assaults or neglect. 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.

7.3 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. The caller stated this was a regular occurrence, although the details were never established with the neighbour. On this occasion, the officers in attendance found OLIVER appearing to be having convulsions. An ambulance was called although later cancelled as OLIVER said he would see his GP the following day. Officers noted in the police Merlin report that AVA spoke over OLIVER and both said the arguing was about the substantial amount of money lost through the fraud. The reporting officer also provided detailed opinion that OLIVER's health was in decline due to the stress of losing the money, as well as the burden of caring for his mother. 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. Two days later OLIVER attempted to take his own life and following this, a 'Section 42' Adult at Risk Evaluation (where there is concern that an adult is potentially at risk from abuse or neglect) was undertaken and the threshold was considered to be met. The LFT CTT SW undertook the assessment, identified 'inappropriate discharge planning' and completed a mental capacity assessment. However, multi-agency future safety and welfare planning for AVA and support for OLIVER were absent.

7.4 The second noted incident and concern was reported by the initial respite provider attending to AVA in the home on 25th March. This followed the discharge of AVA on the 9th March to the care of OLIVER who had been discharged from hospital on the 28th February. 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. AVA expressed concern OLIVER was going downhill and may try to take his own life. This was reported to LA requesting an urgent review.

7.5 LFT HTT agreed to carry out an assessment (27th March 2017) of OLIVER which did not show signs of deterioration in his mental health. OLIVER was seen to be dishevelled with outgrown hair and beard and

smelling strongly. They advised AVA to call the police if needed. 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 LA 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. They wanted something done. These concerns were not followed up with the neighbour other than to advise they call the police if there were further concerns.

7.6 On the 30th March, duty SW6 discussed her concerns regarding the situation with her Service Manager. This related to the response from HTT that OLIVER and AVA regularly argued and this was 'their usual pattern of behaviour'. SW6 was also concerned about the neighbour's fears. It is concerning that, the HTT professional did not consider the wider context regarding the risk of domestic abuse to AVA from OLIVER. The Service Manager took these concerns up directly with the Senior Social Worker, who was also the team lead for domestic violence and a MARAC representative. The Service Manager questioned the assumption that AVA could summon help if required and stated that she would discuss a referral to MARAC with AVA's social worker. The Senior Social Worker did not offer any advice regarding these points, however did question '*what were they expected to do'* and they *'had done all they could'*. It is important to note that this communication took place via an email exchange. This is a significant point in the chronology and one has to question what experience and training the Senior Social Worker had in their role as lead for DV and MARAC representation. By this point, SW2 had left LA and the case was allocated to SW5. SW6 completed a Sec 42 Adult at Risk Evaluation stating threshold was met and a Section 42 enquiry was to take place. Unfortunately, there is no evidence of a specific discussion with the allocated social worker regarding a referral to MARAC. This would have been appropriate and was a further missed opportunity.

7.7 By this point the indications are that OLIVER was deteriorating in his mood and mental health given his behaviour and appearance in terms of poor self-care. 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 'controlling or coercive

behaviour'. Had this been considered, there was opportunity to investigate any concerns and actions taken to attempt to assess the home situation and minimise risk.

7.8 The third incident took place on the 31ST May. On the 30th May, a neighbour contacted police due to hearing a disturbance late in the evening. On attendance OLIVER reported he had been given the wrong take away order so was shouting about this. The police officers completed a Merlin reporting that OLIVER would benefit from support from HTT. The following day (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 by the officers and appropriate actions taken.

7.9 OLIVER was assessed by LFT AABIT the same evening. It is noted by the AABIT professional that it was unclear if OLIVER had been aggressive towards AVA and that OLIVER had consumed a lot of alcohol. They recommended completion of an incident report and a safeguarding alert. The HAABIT professional delayed submitting the safeguarding alert in order to seek consent from AVA. The NICHE investigation considered that the need for consent could have been overridden, given the circumstances. The recording is not explicit in suggesting OLIVER was aggressive although raised a concern that he could have been. This left the situation unclear as to what the AABIT worker was concerned about. Overall, the police and mental health services missed an opportunity to raise concerns regarding possible domestic abuse, which was compounded by a lack of intervention from SW5 LA. AVA was admitted to a Care Home. During the following weeks, OLIVER was prescribed and had started taking anti-depressants.

7.10 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. OLIVER was reported to be dishevelled and smelling strongly. As the time drew closer to AVA's discharge home, OLIVER stated to the AABIT worker that he and his mother did not want the care package being suggested and he was reminded about his previous breakdown due to the stress and pressure he felt as his mother's carer. It is important to note that by this time

OLIVER had been waiting for approximately 5 months for treatment through Psychological Services.

7.11 Fourth incident. AVA was discharged home on the 27th June 2017. On 4th July, the Home Care Provider reported to LA 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. The situation eventually calmed down and the ambulance was cancelled. Over the following two days the carer noticed AVA' eating pattern which consisted of 2 biscuits with tea for breakfast, shop bought sandwich for lunch and 2 biscuits with tea in the evening. OLIVER stated he bought take-outs later in the evening. The carer also noted that OLIVER 'fought' with her about changing AVA's underwear and AVA had remained in the same nightwear. AVA did not seem to have any say in this and referred constantly to OLIVER for his view. On the 2nd July, the carer noticed a bedsore. No action is reported to have been taken. This was a strong indication of controlling behaviour, isolation and neglect.

7.12 Fifth incident. On the 6th July, the homecare provider manager again contacted LA 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. When asked where they came from, OLIVER was reported to speak for AVA stating they did not know where they came from. He also told them not to feed his mother and that he would do this. Later that day SW5 and a Care Assessor visited AVA and OLIVER. The issue of AVA being cold and upset, being shouted at and her eating pattern were discussed. OLIVER denied shouting at the carers and said they were liars. There is no mention in the records of the bruising seen on AVA. It was agreed to change the care package to include food preparation. It was also noted to raise a safeguarding concern regarding bruising to AVA's nose. This is a further missed opportunity to consider the family situation in the context of wider domestic abuse issues.

7.13 The sixth incident. The following day, SW5 spoke with Senior Practitioner 2 and discussed the concerns regarding the bruise seen on AVA's nose; there is no mention of the other bruising seen by carer 2 or of OLIVER's aggressive and controlling behaviour. SP 2 recommended a Sec 42 Enquiry take place.

7.14 In my opinion 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. Mental health services should have been contacted to carry out a further mental health assessment and AVA should have been placed into a care home to safeguard her whilst a multiagency conference took place to formulate a protection plan. A further Sec 42 enquiry was not going to make any difference to the immediate presenting issues and risks.

8. Analysis

8.1 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. 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 multi-agency 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. Alongside this the issue and concept of domestic abuse appears to have been unseen by all professionals. There were significant numbers of professional services and individual professionals involved at varying points in time between January and July 2017. The Safe Later Lives report (2016) refers to adults over 60 years who are suffering DV are a 'hidden group' and refer to 'systematic invisibility'. One of the challenges is the fact that victims are rarely alone due to their care needs and therefore there is less opportunity for professionals to speak with them or for victims to speak up. It also requires professionals to know how to discuss domestic abuse.

8.2 From AVA's perspective, there were six LA social workers involved with two specifically allocated SW2 and SW5; one Service Manager; two Team Managers; two Senior Practitioners; a number of homecare providers and respite carers and a homecare provider manager. From LFT services, one consultant Psychiatrist Memory Assessment Service; Locum Consultant Psychiatrist Memory Assessment Service; Clinical Lead for the Memory Service; Senior Social Work Practitioner Older Adult Team; Hospital Mental Health Liaison Nurse and Re-ablement and Community Services Social Workers and GP. Alongside this were two care home episodes with two managers and various staff involved in her care. It is difficult to imagine what the experience of this number of services and professionals was for AVA.

8.3 From the perspective of OLIVER there were three levels of service including the Hospital based Consultant Psychiatrist; two community

based Consultant Psychiatrists for the Community Home Treatment Team (HTT) and the Access, Assessment and Brief Intervention Team (AABIT); Community Psychiatric Nurse HTT; Locum Community Psychiatric Nurse HTT; Team manager AABIT; Clinical Lead and Senior Social Worker AABIT; Social Worker AABIT; LFT ACAT professional and GP. Outside of this was the Psychology Service OLIVER was expecting to engage with, and the substance misuse service it was hoped he would engage with. It is equally difficult to see how OLIVER experienced this number of services and professionals involved in his life.

8.4 On the basis of this information, it seems there had been and was an overwhelming amount of involvement of service professionals, each with their own roles and responsibilities, working within specific frameworks and requirements. Communication and understanding of the roles and responsibilities is critical to each of the key professionals involved. More importantly, the awareness of the complexity of the relationship between AVA and OLIVER, their individual needs and the risks associated with those needs, required a common understanding and response. In this case, due to the lack of professionals consistently adhering to guidelines, policies and procedures including safeguarding; care planning; risk assessment with an awareness of and focus on potential domestic abuse, as well as management oversight and supervision, their needs became lost in the complexity of those charged with ensuring their rights to a quality service were met.

8.5 Without a lead professional allocated it is understandable that the situation became confused between agencies. No one professional had built a relationship with either AVA or OLIVER. Communication was critically lacking in this case between individuals and within and across agencies. The structure of mental health services appeared fragmented, with each element focusing on its own function rather than the patient's needs, which were lost sight of in this case. Management oversight and quality supervision was required at regular intervals and in line with each agency's procedural guidance to ensure quality assessments, clear planning and effective communication took place. This review has not found evidence of this.

8.6 Recognition of the key issues for AVA and OLIVER was lacking. Had clear and specific assessments been completed, recorded and shared within a multiagency forum using the appropriate tools and frameworks, there would have been clear and comprehensive understanding of need and response to domestic abuse and risk in terms of both AVA and OLIVER as individuals. This includes: completion of comprehensive section 42 enquires using the guidance set out by LA; clear mental health

assessments and reviews carried out and delivered by the appropriate services; specific, measurable, achievable and timely planning; and adherence to the MCA Mental Capacity Act 2005 assessment using the five principles at the times when there was concern. Elements that were overlooked or not considered as relevant due to the lack of a holistic picture were OLIVER's obsessive compulsive behaviours, which by the end appeared to be significantly impacting on the safety and wellbeing of AVA and should have been considered in the context of domestic abuse. Alongside this, OLIVER's significant self-neglect was evident but wasn't considered in terms of his mental health needs and deterioration. Further to this, had OLIVER been able to access Psychological Services which he was referred to, this could have potentially alleviated his mental health challenges and needs; however there were clear resource issues with the demand exceeding available provision. OLIVER's alcohol addiction history was also overlooked; although it was deemed to be the main factor in his suicide attempt, the expectation was for OLIVER to self- refer to alcohol services. Alcohol is also a key factor in domestic abuse according to the British Journal of Criminology Dec 2019, which references findings of DHRs and SCRs where women and children have been killed linking a 'toxic trio' – mental health; alcohol problems & domestic abuse. Alongside this, the National Inquiry into Suicide & Homicide, mental illness Annual Report (2017) outlies much of the risk relates to existing drug/alcohol abuse. OLIVER began to use alcohol again prior to his second mental health assessment. Unfortunately, this was not picked up as a significant issue.

8.7 Finally, the critical issue of identifying and responding to domestic abuse which appeared to be unseen by professionals could have made a significant difference to the care and safeguarding of AVA, and the response and treatment for OLIVER. OLIVER's character was not clearly understood, although within the recording and completion of the DHR reports there are indicators of how he responded to stressful and traumatic events. When OLIVER's father took his own life, not only did he have to deal with the loss and distress of a parent taking their own life but he also found his father hanging in the garage. The close friend reported that OLIVER suffered a period of severe stress and this manifested in his work place. OLIVER was suspended from his job in a residential unit after threatening a service user and was later dismissed. Later he began working in a school but is described as having his contract ended potentially following an incident in the school. From then on, OLIVER did not have any employment. Alongside this, the fraud of over £50,000 had a profound impact on OLIVER which seemed to lead to deterioration in his mental health. From the information available, there is no evidence of

a full and comprehensive assessment of OLIVER setting out his characteristics; beliefs, values and behaviours, which would have informed potential risks and planning for those. The involvement of mental health services was significant and had there been a joined up approach, setting out a comprehensive understanding of OLIVER's needs, there was potential to share this across the key agencies involved.

8.8 The recordings over the 6 month period of significant professional involvement indicate that OLIVER could be at times difficult to engage, with fixed ideas, obsessive behaviours and quite closed; and at other times, he was cooperative, insightful and open; however the positive aspects were few and infrequent. OLIVER acted aggressively towards care staff and other professionals at times, and was highly resistant to carers and professionals coming into the home and being involved in his mother's care. OLIVER also spoke with different professionals and carers about his fear of losing his home and this became a particular pressure when he became more and more responsible for his mother's care. The evidence suggests that OLIVER had an alcohol addiction problem, which was seen to be a critical factor in his attempted suicide in February 2017. He also was described by his friend as having developed a nocturnal routine.

8.9 OLIVER struggled to take on the role of carer for his mother and I suspect AVA had been his significant carer for all of his life. The role reversal is likely to have taken a significant toll on both OLIVER and AVA in their relationship, and is a factor that should have been taken into account. Family members described OLIVER as being 'odd', an 'unusual character', and seen to be a troubled individual, affected by the death of his father in 2005. OLIVER was also reported to have suicidal thoughts from around the age of 14yrs. However, by his two friends he was described as 'kind' and 'decent' and a 'best mate'.

8.10 OLIVER was seen to have mental health difficulties. Alcohol was considered to have been the key factor in his suicide attempt. In terms of treatment for this, he was referred to Psychological Services. Unfortunately, he was not able to access this due to lengthy waiting times. Following his discharge from hospital, the expectation was that he should self-refer to alcohol services but he did not do this.

8.11 The relationship between OLIVER and his mother AVA appeared to be close, but in the final months, OLIVER described his frustration and irritation with his mother needing his support, and the impact of the dementia on her behaviours. The chronology of events regarding potential domestic abuse in terms of coercive control include: OLIVER attempting

to control AVA's needs by insisting she come home to be cared for by him, and at the same time becoming frustrated and angry with her due to her needs; his persistent anxiety about losing his home should AVA go into a care home; his resistance of the attendance of carers into the home and the more extreme behaviours of not allowing her to be washed or have her clothing changed, alongside food restrictions; his refusal to communicate with AVA in front of carers and ignoring her attempts to communicate with him; and his insistence that she remain in the same chair indicated not only his deteriorating mental health but his abusive control over AVA, including potentially withholding food and fluid as a means of controlling her personal care needs (Safelives, 2016). Professionals seemed unaware of this as a potential risk to AVA. Importantly, in the last few days of their lives AVA was clearly suffering and was described as confused and frightened, alongside having bruising seen on her body. No one can say at this stage how they occurred but it is not unreasonable to suggest they could have been either inflicted through assault by OLIVER upon AVA, or through her struggling to care for herself due to being neglected and left alone by OLIVER.

8.12 Throughout this six month period, AVA remained loyal and supportive to her son. However, her capacity to understand any presenting risks was diminished through her dementia and some of the stressors she experienced through OLIVER's attempted suicide, alongside anxiety about what the future held for her. AVA was unable to recognise the risks she faced and it appears she was coerced into going along with OLIVER's wishes, both in terms of her returning home to his care, and being unable to protect herself at certain points where she is likely to have been either assaulted or neglected. Professionals failed to recognise the potential coercive control and abuse. AVA's right to decide where she should live and particular perceptions of her 'capacity' to make decisions appeared to override the presenting risks. 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 situation which was multi layered and 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.

9. Conclusions

9.1 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 (SW2; SW6; Service Manager LA; SP1; SP2; Memory Service Consultant; Hospital Mental Health Liaison Nurse; Metropolitan Police officers). There were also events when those directly in the frontline reported very clearly matters that were of concern (Residential Home Managers; Carer 1; Carer 2; Homecare provider's manager). Had these events been 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.

9.2 Were professionals to have had a clear awareness and understanding of the complexities of domestic abuse of the elderly, including by close family members who are carers (Home Office Statutory Guidance 'Controlling or Coercive Behaviour in an Intimate or Family Relationship' December 2015; Safelives Spotlights Report: Hidden Victims 2016) and 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.

9.3 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 OLIVER and AVA by the agencies involved.

9.4 AVA's niece's description of her background presents a picture of a kind and capable woman 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.

9.5 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.

9.6 OLIVER had his own life challenges particularly following the death of his father in tragic circumstances. Friend 1 has recently stated that OLIVER took on some caring responsibilities for his mother and believes this impacted on OLIVER's social outlets and friendships. He struggled in his work settings, described a sense of failure in his personal life and following the fraud of a considerable amount of money, 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. Caring responsibilities in the role of 'carer' are challenging in the best of circumstances. OLIVER's own issues further magnified those challenges. The evidence indicates that OLIVER was abusive to his mother compounded by his alcohol use and mental health problems. It is likely that 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.

10. Lessons to be learnt

10.1 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.

10.2 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, AABIT caseload management is a challenge that requires focus.

10.4 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.

11. NICHE Recommendations for LFT, LA and Homecare Provider

11.1 NICHE set out a number of recommendations for Health and Adult Social Care agencies and these have been responded to by each agency. The Metropolitan Police also made recommendations via the Individual Management Review.

LFT recommendations

Recommendation 1

LFT must review their procedures for domestic violence against the 2016 NICE Quality Standard (QS116) 2016 and seek opportunities for specific multi-agency training in how to identify and respond to domestic violence, including the role of MASH and MARAC, and use the learning from this independent investigation to prevent recurrence.

Recommendation 2
LFT must review the partnership arrangements with local Hospitals, and between substance misuse services and the LFT inpatient and community services. This is to ensure that discharges are coordinated appropriately with local hospitals where there are mental health concerns, and with regards to substance misuse services that risks associated with co-morbidity are recognised and responded to as an area for joint working.

Recommendation 3
LFT must review the high-risk report process to provide assurance that staff understands how this can offer support, management advice and senior oversight, and to provide further assurance that the absence of a high-risk report is not a recurring theme in serious incident investigations.

Recommendation 4
LFT must provide assurance that the requirements for assessing capacity, safeguarding, risk assessments, care plans and crisis plans are in place, up to date, and meet the quality standards set.

Recommendation 5
LFT must address the issues associated with the professional relationships between AABIT, ACAT and HTT and review the resources and operational arrangements between the AABIT, ACAT and HTT to ensure that they are able to undertake, where relevant, joint assessments and escalate concerns.

LA recommendations

Recommendation 1
LA must review their procedures for domestic violence against the 2016 NICE Quality Standard (QS116) 2016 and seek opportunities for specific multiagency training in how to identify and respond to domestic violence, including the role of MASH and MARAC, and use the learning from this IMR to prevent recurrence.

Recommendation 2
LA must seek assurance that the policy requirements for assessing capacity, DoLS, safeguarding, care support planning and carer's assessments are in place and meet the quality standards set.

Recommendation 3

LA must seek assurance that all appropriate staff receive MCA initial and refresher training and that this training impacts on day to day practice in terms of the application of defensible practice.

Recommendation 4
LA must ensure that the expertise of the Safeguarding Adults Team in relation to both MCA and safeguarding is promoted and a system for review of complex cases and, or cases where a number of safeguarding alerts have been raised is formally considered for development.

Recommendation 5
LA must ensure that opportunities are sought to expand the adult social care understanding of mental health issues through further promotion of joint working and by using the learning from this IMR.

Homecare Provider recommendations

Recommendation 1
Homecare Provider must ensure that an appropriate policy is in place for adult safeguarding, aligned with LA Safeguarding Adults Protocol and the London multiagency adult safeguarding policy, and assurance sought that staff understand the correct procedures for timely reporting and recording of concerns.

Recommendation 2
Homecare Provider must ensure that an appropriate operating and escalation procedure is in place for adult support initial and risk assessments and that assurance systems are in place to demonstrate that this is embedded in practice.

Metropolitan Police Recommendations

Recommendation 1 - Local level
It is recommended that BOCU SLT dip sample ACN Merlin reports to ensure compliance in documenting reports for each individual where vulnerability has been identified using VAF (vulnerable adult framework) and re-inforce this by communicating this message to staff.

Recommendation 2 - Local level - BOCU Senior Leadership Team (SLT)
It is recommended that BOCU SLT debrief the attending officers involved in this investigation to remind them of the importance of documenting non

crime DA CRIS investigations and to complete ACN Merlin reports for each individual where vulnerability has been identified using VAF (vulnerable adult framework).

DHR Local & National Policy and Practice Recommendations

1. Domestic Abuse Governance Boards (Local Authority Community Safety Partnership) to monitor referrals and engagement of older people with domestic abuse services and action plan accordingly.
2. Local Authority 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. Local Authority Adults Safeguarding Board to oversee and ensure professional development and training programmes regarding safeguarding and domestic abuse are in place; which are purposeful and set out how to apply the learning and understand what the barriers are for implementing change and can be applied systemically across the partnership.
4. LA Adults Safeguarding Board 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.
5. LFT and LA 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. Implement a multi-agency domestic abuse training programme for LFT Health Services specifically Mental Health Services and LA Adult Social Care that addresses aspects of domestic abuse including adults who require care in the home by a family member.
7. 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.
8. 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.

9. Clinical Commissioning Group to enhance General Practitioner Training with regard to domestic abuse of older people.
10. 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.
11. That 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.
12. That LA and all agencies should ensure that there is effective managerial involvement in the case transfers between staff, particularly agency staff, to ensure that there is the continuity of understanding and that the key issues do not become lost at the point of case transfer.

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Deprivation of liberty (DoLs) https://wwwscie.org.uk/mca/dols/

Carers Assessment Guidance https://www.thinklocalactpersonal.org.uk

Care Programme Approach 1993 www.bjmp.org

Multi Agency Safeguarding Hub (MASH) https://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/files/adult-safeguarding-practice-questions.pdf

Multi agency risk assessment conference (MARAC) www.safelives.org.uk

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Crime report information system CRIS Metropolitan Police Service. Standard Operating Procedure (SOP) and toolkits. Authorised Professional Practice Toolkits.

Independent Domestic Violence Advisors (IDVA) www.ccrm.org.uk