Domestic Homicide Review/ Safeguarding Adult Review: Executive Summary

‘Peter’

Died March 2018

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June 2021

Contents

1.The Review Process.....3

2. Contributors to the Review.....4

3. The Review Panel members.....5

4. Author of the Overview Report 6

5. Terms of Reference for the Review 7

6. Summary Chronology.....9

7. Key issues arising from the review 11

8. Conclusions 12

9. Lessons to be learned 14

1.The Review Process

This summary outlines the process undertaken by Salford Community Safety Partnership domestic homicide review (DHR)/ safeguarding adult review (SAR) panel in reviewing the homicide of Peter, who was a resident in their area.

The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

Name	Age at time of death	Ethnicity	Relationship	Address
Peter	55	white British	Victim	Salford
Matthew	n/a	white British	Peter's brother	Salford
Daniel	n/a	white British	Peter's brother and carer	Salford
The Perpetrator	45	Irish	Perpetrator	Same address as Peter - Salford

Criminal proceedings were completed in October 2018: the Perpetrator was convicted of murder following trial. He was sentenced to Life, to serve a minimum of 15 years.

The process began when the Salford Safeguarding Adult Review Panel agreed that a Safeguarding Adult Review (SAR) should be conducted in April 2019. At the first Panel meeting in June 2019, it emerged that the Perpetrator had been living with Peter following the Perpetrator 's release from prison in December 2017 and was therefore a member of the same household as the victim so that the incident potentially met the criteria for a Domestic Homicide Review. This was referred to the Community Safety Partnership (CSP) and the CSP agreed that the incident met the criteria for a DHR and notified the Home Office on 9 July 2019. The review was conducted as a joint DHR/ SAR.

All agencies that potentially had contact with Peter and/ or the Perpetrator prior to the point of Peter's death were contacted (15 in total) and asked to confirm whether they had involvement with them. Twelve agencies confirmed contact with the victim and/or perpetrator and were asked to secure their files.

2. Contributors to the Review

Agency	Abbreviated as	IMR in respect of Peter	IMR in respect of Perpetrator	Other contribution
Adult Social Care	ASC	-	-	Single agency report
Cheshire and Greater Manchester Community Rehabilitation Company[1]	CGM CRC	-	√	-
ForHousing (formerly City West)	-	-	-	Single agency report regarding Peter
Greater Manchester Fire & Rescue Service	-	-	-	Information
Greater Manchester Mental Health Incorporating information from Achieve	GMMH	√	√	-
Greater Manchester Police	GMP	√	√	-
Housing Options Service (Homelessness)	-	-	-	Information
North West Ambulance Service	NWAS	√	√	-

[1] CGM CRC is a provider of probation services to adult offenders and operates under contract to the Ministry of Justice.

Salford City Council Client Affairs	SCC Client Affairs	√	-	-
NHS Salford Clinical Commissioning Group	CCG	√	√	-
Pharmacy	-	-	-	Additional information
Salford Royal NHS Foundation Trust	SRFT	√	√	-

Individual Management Review authors were independent of any direct involvement with or supervision of services involved in this case.

3. The Review Panel members

Name	Organisation	Job Title
Alison Troisi	GMP	DS Serious Case Review Unit
Carol Marsh	GMMH	Operational Manager Achieve
David Chambers	GMMH	Operational Manager
Emma Hinchliffe	GMMH	Service Manager
John Fenby	GMMH	Professional Lead for Social Care
Judd Skelton	Salford Council/CCG	Assistant Director Integrated commissioning
Laura Forsythe	CCG	Specialist Nurse Adult Safeguarding
Elizabeth Walton	CCG	Designated Nurse Adult Safeguarding
Janine Mellor	Adult Social Care	Principal Manager
Rebecca Flynn	Salford CRC	Risk & Public Protection Operational Lead

Michelle Hulme	Salford Safeguarding Adults Board	Training and Development Officer
Rob Grigorjevs	ForHousing	Tenancy Support & Sustainment Manager
Roselyn Baker	Salford Council	Principal Policy Officer
Stephanie Whitelaw	SRFT	Assistant Director of Nursing
Susan Mary Benbow	Older Mind Matters Ltd	Independent Reviewer / Author

The Review Panel met on the following dates:

13 June 2019 (as a SAR Panel, then expanded once the review became a DHR)

24 September 2019

12 December 2019

25 February 2020

6 May 2020 (by Microsoft Teams)

23 June 2020 (by Microsoft Teams)

All panel members were independent of any direct involvement with or supervision of services involved in this case.

4. Author of the Overview Report

The Reviewer/ Author of this report is by professional background a psychiatrist and systemic therapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands and undertook consultant roles in Manchester and then Wolverhampton until 2009 when she retired early from her NHS roles and started to develop a portfolio career in independent practice. She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past. She has no connections or ties of a personal or professional nature with the family, with the Community Safety Partnership, or with any other agency participating in this review.

5. Terms of Reference for the Review

5.1 The purpose of this DHR/ SAR is to:

• Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse.

• Identify clearly what those lessons are, both within and between agencies; how those lessons will be acted on, within what timescales and what is expected to change as a result.

• Apply these lessons to service responses including changes to policies and procedures as appropriate; and

• Assist in the prevention of future domestic homicides through improved intra and inter-agency working to domestic abuse victims and their children.

• Determine what agencies could have done differently that could have prevented harm or death and that might prevent similar harm in future.

In addition, the following areas were to be addressed in the Internal Management Reviews and the Overview Report:

1. The victim had no known contact with any specialist domestic abuse agencies or services. Could more have been done to inform local residents about services available to victims of domestic abuse?

2. Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator to the victim.

3. Whether there were any barriers experienced by the victim or family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should he have wanted to.

4. Whether there were any warning signs and whether opportunities for triggered or routine enquiry and therefore early identification of domestic abuse were missed.

5. Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or the alleged perpetrator that were missed.

6. Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim or perpetrator.

7. Consider the potential role of safeguarding processes and section 42.

8. Consider assessment and risk management/ responsiveness after Peter had raised concerns.

9. Consider the possible role of coercion and control.

10. Consider how well coordinated were the services that were working with Peter and how might services have been better coordinated.

11. Consider financial abuse and how services addressed potential risks.

12. How was the Mental Capacity Act relevant and applied in practice.

13. Identify any good practice.

14. Consider any other information that is found to be relevant.

15. Consider whether there was evidence that Peter was self-neglecting, the response by agencies and the impact of this.

5.2 The Time Period under Review

The time period under Review was agreed as the 12 months leading up to Peter's death in March 2018 plus any relevant information falling outside this time frame.

5.3 Publicity/ Media issues

• Media and publicity meetings were to be held as necessary.

• All requests for information were to be dealt with by Salford Council's Marketing and Communications Team.

• Any materials published and their contents were to take proper account of privacy/confidentiality considerations and be subject to advice.

5.4 Other issues

• Legal Issues – Individual agencies were free to seek legal advice in relation to their agency's IMR however this was not to hinder agreed timescales.

• Timescale - The Home Office was informed of the intention to conduct a DHR in this case. The guidance requires that the first review panel must be held within a month of this date and that the whole process should be completed within 6 months.

• Anonymisation of Family Names - For the purpose of the Overview Report, it was agreed that the victim would be referred to as Peter and the perpetrator as the Perpetrator.

• Anonymisation of Staff – Staff were anonymised in IMRs and the Overview Report.

6. Summary Chronology

6.1 Summary of events

Peter was a single white British man, aged 55 when he died in 2018. He had been dependent on alcohol since early adulthood. He had six psychiatric admissions since 2006 thought to be related to alcohol misuse, the latest being in April 2017, and he had been given a historic diagnosis of schizophrenia. The diagnosis of schizophrenia was later revised, as the psychotic illnesses were thought to be secondary to alcohol use. In May 2010 neuropsychological assessment showed cognitive difficulties thought to be related to alcohol misuse which affected his ability to retain verbal information and to make some decisions. In April 2016 there was a safeguarding investigation following allegations of possible financial abuse. Peter was assessed as lacking capacity to manage his finances and Salford Council became his appointee.

Following this he continued to drink heavily. Community Mental Health Team (CMHT) professionals were involved and professionals' meetings were held. In the months leading up to Peter's death there were concerns that he was being abused/ exploited by others who were taking money from him and taking advantage of him in other ways. There were also concerns about self-neglect. On his last contact with his care coordinator, Peter referred to a man staying at his flat that he did not want to be there (possible 'cuckooing'), but refused to agree that the care coordinator could contact the Police. He agreed that the locks could be changed.

In March 2018 (three days after agreeing that the locks could be changed but before this was done) a 999 call to Police reported that Peter had been found dead at his home address. In April 2018, Home Office Post Mortem was carried out and the conclusion of the examination was that Peter had died as a consequence of internal bleeding caused by severe internal abdominal injuries caused by blunt force trauma. Subsequently a suspect was identified and charged with murder. The suspect was the man staying at Peter's flat and referred to during the care coordinator's visit.

It later emerged that the Perpetrator had been living at Peter's address for 2-3 months prior to the murder. At times practitioners visiting the address had been aware of other people being in the flat, with or without Peter being present, but it had not been clear what their status was.

6.2 Background

> *The information below is taken from a statement made by one of his brothers and is included with his consent.*

Peter was the second youngest of eight brothers. His father was a labourer and his mother a housewife. The brothers all completed their education with no major problems. At school Peter was said to be popular and to have lots of friends. The brothers were brought up Catholics, attended church every Sunday and all completed their Holy Communions. They were brought up as a close-knit family and remained close as adults.

When he left school at the age of 13, Peter got a job in an appliance shop where he learned how to fix various appliances. He worked there for a few years and, whilst there, made two good friends with whom he remained friends until he died. After this job he did various labouring jobs, but engaged in no long-term periods of employment.

After having a few short-term girlfriends, Peter met the woman who became mother to his two children. They were in a relationship for around 6 or 7 years. When they broke up, Peter moved back to live with his mother, but had contact with his children for a couple of years after the breakup. About a year after the relationship ended, he started drinking and, as his drinking increased, he stopped contact with his children, and had not seen them for some years prior to his death.

Peter is described by family as gradually becoming an alcoholic and, alongside that, developing other medical issues, including a psychotic illness and dementia. His mother was a strong woman and she managed to keep him from drinking for around 10 years. She managed his money and ensured he took his medication at the right times as he was unable to do this himself. Eventually she had a stroke and needed care. She died in early 2014. Peter and another brother (Matthew) were living with her at the time, and both were re-housed after her death.

Once he had control of his own finances, Peter started drinking again. One brother (Daniel) became Peter's carer, managed his money, tried to supervise his medication, took him to appointments, clothes shopping, on a weekly shop, and made sure he had food, tobacco, and spending money. It is reported that Peter would forget to buy food if it wasn't bought for him and that he would forget what time and day it was. Daniel bought him a few mobile phones which he would always end up selling to finance his drinking habit.

Around four years ago Peter was referred to a Community Mental Health Team (CMHT) by his doctor and was allocated a mental health worker. He would attend the CMHT base regularly to collect his money and meet the worker. Salford City Council took over management of Peter's finances and Daniel reports that he found this a great help, though he felt that Peter was given too much money per week for his alcohol.

Peter is described by family as a quiet man with a big heart who would do anything for anyone, but this left him open to manipulation by people he considered friends. These so-called friends would go to his flat when he got his money and drink beer with him and, when he didn't have money, they would buy him alcohol. He could never remember who he had borrowed from, so he was an easy target to extract money from. He would let people stay at his place if they were struggling for somewhere to stay, including his friend who became the perpetrator of his murder.

7. Key issues arising from the review

7.1 Domestic abuse, coercion and control

- Peter's situation did not fit with many practitioners understanding of domestic abuse and is more readily understood as involving coercion and control and exploitation of a vulnerable person.
- Practitioners working with Peter were aware of aspects of his exploitation by so-called friends but regarded it as consensual.
- Peter was regarded as living a 'risky lifestyle'. This raises the question of how far his vulnerability was seen as resulting from 'lifestyle choices'.
- There were missed opportunities to initiate a safeguarding process.
- A safeguarding process could have introduced a broader community safety perspective

7.2 Safeguarding issues

- There were missed opportunities to initiate safeguarding processes.
- The acute Trust frequent attenders' process could have led to a safeguarding response.
- The financial/ economic exploitation could have led to a safeguarding response
- The documented self-neglect could have led to a safeguarding response
- The rationale throughout amongst those working with Peter appeared to be that practitioners' meetings were being held and that safeguarding "would not add anything".
- The absence of information sharing meant that primary care involvement was lacking.
- Safeguarding offers a multi-agency structure that may open up possibilities that otherwise might not be considered.

7.3 Legal issues

- Peter's circumstances might have excluded him from some housing options as he would have been deemed to be adequately housed
- A safeguarding protection plan (had one been in place) might have opened up other housing options
- No evidence of stigmatising practices on behalf of practitioners was found - they showed commitment to working with people in complex and difficult circumstances.
- However, it is possible that risk was tolerated by practitioners as it may have been seen as a "lifestyle choice" and that this was a factor in the failure to consider safeguarding.
- Peter had complex needs that would be likely to have indicated a need for formal mental capacity assessment on a number of occasions.

7.4 Risk and multi-agency working

- It is possible that when someone stops buying alcohol for people exploiting them (that they have formerly bought alcohol for) this increases their risk.
- It is possible that in working long-term with chronic ongoing risks practitioners develop a 'tolerance' of those risks – the advantage of multiagency working is that it gives practitioners access to other perspectives on what is happening.
- There are ways in which multi-agency working could be better coordinated and communication improved.
- Initiating safeguarding processes offered one possible way of attempting to mitigate some of the risks to Peter but it is impossible to know what difference it might have made.
- Practitioners are not always aware of what tools and powers other agencies such as Housing can utilise to protect their tenants.
- Practitioners appeared to lack clarity regarding housing options.

7.5 Good practice

- Examples of good practice within various organisations were identified in this Review.

7.6 Other relevant issues

- There were missed opportunities in relation to the Perpetrator's support and supervision after his release from custody
- Peter's case involves parallels with other SARs where alcohol was identified as a significant factor and that there may be additional learning from bringing cases together to draw out common themes

8. Conclusions

8.1 The Review has not identified any opportunities to predict Peter's death and the only opportunity to prevent it would have been if Peter had moved from his address following the disclosure to the care coordinator that a man was staying at his flat and he did not want this person to be there or if an injunction had been obtained to exclude the Perpetrator (but this could have increased the risk).

However, given the fact that the care coordinator had no knowledge of the Perpetrator and no reason to assign urgency to the situation, it is unlikely that Peter's death could have been prevented.

8.2 Earlier interventions via safeguarding or possible change in accommodation could have mitigated some of the ongoing risk but it is impossible to know what difference this might have made.

8.3 Peter's situation did not fit with many practitioners' understanding of domestic abuse.

8.4 There was evidence that Peter was being exploited financially by so-called friends. Practitioners working with Peter were aware of aspects of his exploitation by so-called friends but regarded it as consensual. The financial exploitation could have led to a safeguarding response.

8.5 There was evidence that Peter was subject to coercion and control by so-called friends and, towards the end of his life, by the Perpetrator. The coercion and control could have led to a safeguarding response.

8.6 There was evidence of self-neglect over a long period prior to the homicide. The documented self-neglect could have led to a safeguarding response.

8.7 Peter's frequent attendances at the Emergency Department could have led to a safeguarding response in line with the acute Trust frequent attenders' process.

8.8 There were missed opportunities to trigger safeguarding processes.

8.9 Safeguarding offers a multi-agency structure that may open up possibilities that otherwise might not be considered. It is possible that, in working long-term with chronic ongoing risks, practitioners develop a 'tolerance' of those risks. The advantage of multiagency working is that it gives practitioners access to other perspectives on what is happening.

8.10 Practitioners are not always aware of what tools and powers other agencies such as Housing can utilise. This is another advantage of the multi-agency structure of a safeguarding response.

8.11 Peter's circumstances may have excluded him from some housing options.

8.12 Practitioners appeared to lack clarity regarding housing options.

8.13 No evidence was found to suggest stigmatising practices on behalf of practitioners - they showed commitment to working with people in complex and difficult circumstances. However, it is possible that risk was tolerated by practitioners and may have been seen as a "lifestyle choice": this may have been a factor in the failure to initiate safeguarding processes.

8.14 Peter's complex needs would suggest that a formal mental capacity assessment would have been appropriate on a number of occasions.

8.15 There were missed opportunities to intervene in relation to the Perpetrator's support and supervision after his release from custody.

8.16 Peter's case involves parallels with other SARs where alcohol was identified as a significant factor and there may be additional learning from bringing cases together to draw out common themes.

9. Lessons to be learned

9.1 Concerning domestic abuse

Practitioners' understanding of domestic abuse may not include situations where people are members of the same household but neither intimate partners nor family members.

People living a 'risky lifestyle' and being exploited by so-called friends might be regarded by practitioners as making choices.

9.2 Concerning safeguarding

Safeguarding processes might not be initiated in some complex circumstances, particularly those involving alcohol or substance misuse and including, perhaps, situations that are regarded as 'consensual' or resulting from 'lifestyle choices'.

In complex and often longstanding circumstances, safeguarding should be initiated when appropriate since it brings in a multi-agency structure that supports practitioners and opens up other perspectives and possibilities for intervention.

The involvement of Housing may allow access to their powers to make timely interventions.

9.3 Concerning legal issues

Formal mental capacity assessments may be indicated and appropriate in people with fluctuating capacity related to alcohol/ substance misuse.

Relatively young age might limit consideration of housing options normally focused on older adults, despite the fact that they may be appropriate in situations of accelerated ageing.

9.4 Concerning risk and multi-agency working

Ways of better coordinating multi-agency working and communication exchange were identified during the Review.

When working long-term with people in risky settings and with ongoing established risk practitioners are at risk of developing 'tolerance' of those risks and need access to a forum where they can draw on other perspectives and expertise – this might be available using safeguarding processes when that is appropriate.

10. Recommendations from the review

10.1 Multi-agency recommendations

The Community Safety Partnership and the Safeguarding Adults Board to seek assurance from all relevant agencies that they have regard to the multi-agency recommendations listed below:

Practice recommendations

(1) Adult safeguarding referrals should always be made when there is a concern a person may be at risk of harm from abuse or neglect. This promotes wider multi-agency involvement and information exchange between partner agencies, and may open up options that further inform decision-making and practice.

(2) Agencies to review no reply policies and ensure that they are fit for purpose and include escalation routes. This aims to address the importance of regular and timely care coordination visits in accordance with the presenting needs of service users.

(3) To investigate with housing providers what housing options are available in these circumstances and what the process is to apply.

(4) To investigate how practitioners working long-term with people with ongoing established risk might have access to a forum where they might draw on other perspectives and expertise if clients do not meet the threshold for a Section 42 enquiry.

(5) Practitioners to be reminded to ask about the tenure of service users and to involve social landlords where possible: if it is a social landlord there are a range of people, services and expertise that can add value in terms of solving issues and taking remedial action.

(6) Salford Safeguarding Adult Board to formulate a Seven Minute Briefing (or similar) to concentrate the key learning points into an accessible format. This should be disseminated to all qualified staff at each partner agency.

Safeguarding recommendations

(7) Staff involved with adult safeguarding enquiries should:

a. Understand when abuse and / or neglect may result in the need to consider urgent interventions such as a change of accommodation,

b. Be able to identify potential options in the context of relevant legal frameworks,

c. Understand the importance of promptly formulating and implementing an appropriate interim protection plan once an adult safeguarding referral has been raised.

(8) SSAB website to be updated to include more information about different services, tools, and raising awareness of legal powers partners may have when dealing with different situations.

Training recommendations

(9) The delivery of a be-spoke training package to key staff across partner agencies aiming to address the agreed learning points from this case in relation to: the operation of adult safeguarding procedures, risk assessment / management and mental capacity issues with specific reference to those people presenting with alcohol addiction and/or subject to exploitation and/or coercion and control, and including when Police should be consulted in relation to a crime.

(10) Training/awareness raising on how to access/navigate the system for applying for housing and on what housing options are available.

(11) The key learning points from this case to be incorporated into existing training packages at each partner agency.

(12) Mental Capacity Act training to include how excessive alcohol use and withdrawal from alcohol may impact upon mental capacity; the likelihood of fluctuating capacity in relation to key decisions such as care, treatment, residence etc in these situations; and how coercion and control might influence decision-making.

Policy recommendations

(13) Salford Safeguarding Adult Board to ensure local adult safeguarding policy, procedures and guidance incorporate the key learning points so staff can be fully supported in their practice.

(14) Ensure that staff are fully aware of the different ways that formal appointeeship can be implemented in order to protect a person's finances. This may include consideration of a commissioned package of care to ensure essential items are bought.