Safer Lincolnshire Partnership

Domestic Homicide Review & Safeguarding Adult Review

Peter, Ron, and Judith (Anonymised names)

Incident Date – August 2015

Executive Summary

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Dated October 2021

Contents

1. Introduction: The Circumstances which led to this Domestic Homicide Review (DHR) and Safeguarding Adult Review (SAR)

1.1. This report of a Domestic Homicide review and Safeguarding Adult Review examines the agency responses and support provided to Peter, a resident of Lincolnshire prior to his death in 2015. Peter had lifelong profound disabilities and lived with his parents Judith and Ron. Peter had long-term involvement with a range of professionals and agencies. He was aged 48 when he died as a result of a fire at his home to which the Lincolnshire Fire and Rescue service were called. Peter was rescued from the fire, but he suffered severe burn injuries and smoke inhalation and was taken to hospital where he died two weeks later. Ron, his father, made his way out of the home and was treated for smoke inhalation and has made a full recovery. Judith, Peter's mother, could not be recovered and died in the house as a result of severe burns and smoke inhalation. The Fire and Rescue Service and Police investigations concluded that the fire had been started by Judith, but her intentions in doing so are unknown.

2. Process of the combined SAR/DHR

2.1. The Safer Lincolnshire Partnership and local Safeguarding Adults Board agreed that the harm and abuse suffered by Peter and his parents met the criteria for a combined Safeguarding Adult Review and Domestic Homicide Review (SAR/DHR). Terms of reference were agreed, a panel convened and an Independent Chair and Author was commissioned. All agencies involved with Peter, Judith and Ron were asked to provide a chronology of their involvement from March 2014 to August 2016, the date of the critical incident. Summary background information was also sought. All involved agencies also provided Internal Management Reviews (IMRs) which provided an analysis of practice and single agency recommendations.

2.2. A panel of senior representatives from all involved agencies was convened that met to review the IMRs, to contribute to the overall analysis and to the report and its recommendations.

3. Contributors to the Review

3.1 All individuals of the following agencies who contributed information to the Review were confirmed as having no contact or involvement with Peter, Ron or Judith and deemed independent, submitted various forms of details depending on their agency contact with the subjects of the review, which included Internal Management Reviews (IMR), agency reports and key pieces of information.

- East Midlands Ambulance Service
- Lincolnshire Community Health Services
- Lincolnshire County Council
- Lincolnshire Fire and Rescue Services
- Lincolnshire Partnership NHS Foundation Trust
- Lincolnshire Police
- Lincolnshire GP
- United Lincolnshire Hospital NHS Trust
- Ending Domestic Abuse Now in Lincolnshire (EDAN Lincs)
- Age UK

4. The Review Panel members

4.1 The Review Panel convened to support the SAR/DHR process, consisted of senior individuals from the agencies who previously had contact with Peter, Ron and Judith but had not had any contact with or had been involved with the review subjects. The Panel met seven times during the Review, initially to appraise the information gathered to ensure accuracy and subsequently to approve the report drafted.

Title	Agency represented
Assistant Director - Specialist Adult Services - Adult Care	Lincolnshire County Council

Adult Safeguarding Lead	East Midlands Ambulance Service
Named Professional Safeguarding Adults	United Lincolnshire Hospital NHS Trust
Consultant Nurse Safeguarding & Mental Capacity	Lincolnshire Partnership NHS Foundation Trust
Head of Safeguarding Adults	South West Lincolnshire Clinical Commissioning Group
Group Manager Prevention & Protection	Lincolnshire Fire and Rescue Services
Quality Auditor & Serious Case Review Author	Lincolnshire Police
Head of Safeguarding	Lincolnshire Community Health Services
Senior MARAC	EDAN Lincs
Safer Communities Manager	Safer Lincolnshire Partnership
Board Manager	Lincolnshire Safeguarding Adults Board

5. Chair and Report Author

5.1. Jane Wiffin, a Social Worker by profession with over 20 years' experience, was commissioned as the Independent Chair and Report Author. She is an experienced reviewer, has completed the training to undertake a DHR and SAR and is independent of all agencies locally. She was supported in this role by Heather Roach, an ex-Deputy Chief Constable with over 25 years' experience in the Police Force, who is the LSAB Independent Chair of the Review and Learning Group[1].

6. Family Involvement

6.1. The Independent Chair/Author and the Lincolnshire Safeguarding Adults Board Manager met with Ron on two occasions. Ron provided information about family history and circumstances, but he found it hard to reflect on professional support as this was something he felt was an intrusion into family life and that no one could provide Peter with the same care as he and Judith did. Sadly, one of Peter's siblings died during the review process and although contact was sought with the other sibling, this was not successful.

7. Terms of Reference for the Review

7.1 To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to Peter, Judith or Ron, or given rise to other concerns, or instigated other interventions; whether appropriate professional curiosity was exercised by professionals and agencies working with the individuals in the case regarding this historical context.

7.2 Were practitioner's sensitive to the needs of Peter, Judith and Ron, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations? Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly implemented?

7.3 When, and in what way, were Peter, Judith and Ron's wishes and feelings ascertained and considered? Were Peter, Judith and Ron informed of options/choices to make informed decisions and were they signposted to other agencies and how accessible were these services to the subjects?

7.4 What were the key points or opportunities for assessment, risk assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known, or what should have been known at the time?

[1] This group receives Significant Incident Notification Forms and assesses next steps in terms of SARs.

7.5 Were any issues of disability, diversity, culture, or identity relevant? For example, did agencies consider whether Peter had the capacity to consent to his own care package and consider whether the care package was in his best interest and whether it was considered if he was being deprived of his liberty?

7.6 To consider whether the role of the carer was fully identified for both parents and the impact of their age and physical health problems was identified and any consequent impact for Domestic Abuse was recognised.

8. Summary Chronology of The Review Period: April 2014 to August 2016

8.1. Ages: Peter: 47, Ron: 72, Judith: 68

8.2. During the whole review period an Adult Learning Disability Social Worker (LDSW) visited very regularly to see Peter and to discuss the many crises with Judith and Ron. The LDSW also had regular contact with all other agencies.

8.3. In April 2014, Judith contacted the LDSW and reported feeling controlled by Ron. She asked for the contact details of the Adult Safeguarding Team. The LDSW tried to facilitate this contact, but there was some confusion and Judith rejected any further support. Judith then took an overdose of tablets. The ambulance crew who attended found a suicide note where Judith threatened to take her own and Peter's life. The Police were called.

8.4. Judith was taken to Hospital. It was concluded that this incident was a cry for help, there were no mental health concerns emerging from the assessment at Hospital and no need for further Police enquiries. Judith returned home and support from the LDSW was increased.

8.5. The next day, Judith took another overdose. She told the ambulance crew that she had not intended to kill herself but was unhappy with her volatile relationship with Ron. She was seen by a Community Psychiatric Nurse and repeated the concerns about Ron. The assessment showed no mental health concerns and Judith returned home. She also reported concerns about Ron to the GP and the LDSW. Judith told professionals that she was stressed and not being provided with enough support

8.6. The LDSW and their Manager agreed that a Strategy Meeting was required. This was planned for two weeks later. This took place, but because the Learning Disability Team did not undertake safeguarding activities this was named a Multi-Disciplinary Meeting. This meant that the Police did not attend and Mental Health Services had ceased contact with Judith by this time. At this meeting it was agreed there was no need for safeguarding enquiries, that support would increase and there would be a review in six weeks' time. This did not take place because circumstances were considered to be more settled.

8.7. Peter was seen by his Learning Disability Psychiatrist because of the parents' concerns about his deteriorating behaviour. The Psychiatrist asked about home life and was told about conflict and dispute at home by Ron. The Psychiatrist queried if this could be a contributory factor to Peter's unsettled behaviour. At the next appointment in June 2014, Peter was seen by a different Psychiatrist and he was prescribed medication for his unsettled behaviour. There was no further discussion of the impact of domestic abuse at home.

8.8. In August 2014, Adult Social Care undertook a review of Peter's care plan. Judith and Ron refused all services. They were supported by the Carers Team at this time and received a small direct payment grant for social activities.

8.9. At the end of September 2014, mother was diagnosed with cancer. She received care and treatment over the next nine months, was noted to be anxious and worried, and support was provided. She made a full recovery.

8.10. In January 2015, Judith contacted a local Domestic Abuse service to report that Ron had been mistreating Peter and was abusive to her; she terminated the call without accepting support. This service contacted the LDSW and a safeguarding response was considered but agreed not to be necessary.

8.11. February 2015 was an unsettled time. Ron told Police that Judith was threatening to kill herself and Peter; he refused to make a complaint. He also said the family were unsupported but said there was no need for further action. Judith told the LDSW that Ron had said he would rather kill Peter than allow him to be placed in a care home.

8.12. In March 2015, Judith told the Police that Ron had threatened to hit her but refused any support. Ron also made allegations that Judith had been abusive to him.

8.13. In May 2015, Judith phoned the Mental Health Team in a distressed state reporting that Ron was behaving in an odd way and threatening to take Peter away to live somewhere else. She refused support. Over the next few weeks Judith spoke about concerns regarding Ron sending money in response to scam mail and she was advised to seek support from the Citizen's Advice Bureau (CAB). Ron also reported concerns about Judith's behaviour towards him.

8.14. In July 2015, Judith reported that she had taken an overdose of tablets because of Ron's abusive behaviour. She was taken to hospital by the Ambulance Service and assessed by the Mental Health Team who concluded carer stress. The Ambulance Service made an adult safeguarding referral. This was accepted but delayed due to capacity issues. Judith was offered support.

8.15. In August 2015, there was extensive planning for Peter to have dental treatment. A comprehensive care plan was completed by the Learning Disability Acute Liaison Nurse (LDALN). The LDALN was concerned when Judith became anxious about the forthcoming treatment and suggested that she provide Peter with some of her tablets to sedate him. The LDALN made a safeguarding adult referral. An appointment was made by the Local Authority Adult Safeguarding Team to discuss the two recent referrals but this was planned for the day after the fire.

9. Key Issues Arising from the Review

9.1. There are six emerging themes arising from the circumstances of Peter, Judith and Ron:

- Working effectively to assess and address Domestic Abuse and its impact on the needs of adults with care and support needs.
- Effective adult safeguarding.
- The application of the Mental Capacity Act 2005 and ensuring decisions are made in the best interest of individuals with care and support needs.
- Ensuring that adults with care and support needs are enabled to communicate effectively and their communication style is maximised.
- Ensuring that the role of carers, for adults with care and support needs, is fully identified supported and its viability in terms of the needs of the individual and the impact on the well-being of the carers evaluated.
- The importance of effective information sharing, multi-agency risk analysis and coordinated action to address the safety and safeguarding needs of adults with care and support needs and adults who are vulnerable.

Working effectively to assess and address domestic abuse and its impact on the needs of adults with care and support needs.

10. Conclusions and Lessons Learned

There are a number of key gaps in practice which emerge from the analysis of the professional response to Domestic Abuse for Peter, Judith and Ron which have implications for wider adult safeguarding practice:

10.1. It is the responsibility of all professionals to identify Domestic Abuse and provide opportunities for victims to talk about the abuse they experience and move the discussion beyond "*difficult or volatile relationships*". Although the evidence from the management reviews and further inquiry as part of the SAR/DHR process suggest there was management oversight and supervision across the professional network, this did not pick up the need for a critical and reflective analysis of what "*difficult or volatile relationships*" actually meant and requires robust challenge as possible euphemism for Domestic Abuse, and there should always be a DASH[2] completed.

10.2. This case highlights that not all professionals feel enabled to have these difficult and sensitive conversations particularly with adults who lack trust in professionals and who are hostile at times and dismissive of professional support as in this case.

10.3. The increased vulnerability of adults with Learning Disabilities of Domestic Abuse and their lack of recourse to protection was not recognised. The recognition of the category of 'Domestic Abuse' in the 2014 Care Act now means all agencies including Domestic Abuse Workers, Health, Social Care, Education, Police and Support Services need to be able to recognise signs of Domestic Abuse in households or situations where disabled adults are present.

[2] Domestic Abuse Stalking & Honour based violence.

10.4. There was a lack of action or planning to address perpetrator behaviour and consider the risks posed to others and the safety of an adult with care and support needs.

10.5. There was also a lack of recognition of the impact of an adult with care and support needs living with Domestic Abuse and the likely impact on both their physical and emotional well-being.

10.6. There was a lack of recognition that Judith's identity as an older person was recognised as a barrier in the context of Domestic Abuse. Connections were not made between suicidal ideation and action by Judith and the corrosive impact of long-term Domestic Abuse.

10.7. There is evidence here of gender bias with a lack of recognition and support to men who make allegations of Domestic Abuse and understanding whether these are genuine incidents or counter allegations in the context of their own abusive behaviour.

10.8. The SAR/DHR highlights the importance of good quality and effective supervision to enable professionals to undertake this complex task.

11. Recommendations

11.1. Recommendation 1:

All professionals should be equipped to identify Domestic Abuse and have the appropriate tools and guidance to do so. This SAR/DHR highlights the need for the Safer Lincolnshire Partnership to work with the Domestic Abuse Sub-Group and partner agencies to assure itself that all practitioners are equipped to:

- Have sensitive conversations and are able to engage and manage victims who are complex, and hostile including those who are older and have caring responsibilities;
- Understand and address the effects of Domestic Abuse on all members of the household particularly those who are vulnerable, including children and adults with care and support needs, and those who communicate non-verbally;
- Understand the complexity of Domestic Abuse, recognising that men can be the victims of abuse and that women the perpetrators and that at times these co-exist;
- To have an understanding of the different types of Domestic Abuse to enable an effective analysis and the appropriate response;
- Are provided with appropriate supervision to undertake the complexities of the task.

Effective adult safeguarding.

There are policies and procedures in place in Lincolnshire to ensure that adults with care and support needs are effectively safeguarded but these were not always used effectively regarding Peter. This was in part due to organisational pressures on the Safeguarding Team during the time under review. This Review of his circumstances and those of his parents raises some key issues which have implications for wider adult safeguarding practice and these issues are addressed in the following recommendations.

11.2. Recommendation 2:

The LSAB should assure itself that multi-agency safeguarding arrangements are effective and in particular that:

- Information is shared appropriately and in a timely manner between agencies to inform decision-making in accordance with LSAB Safeguarding Adults Policy, Procedure and Process 2017;
- LSAB Policies and Procedures are reviewed to provide clear guidance about Strategy Meetings to ensure clarity of purpose and agency responsibilities;
- LSAB should make it clear who can convene a Strategy Meeting/discussion;
- LSAB should seek assurance that partner agencies have in place processes whereby those responsible for making safeguarding referrals have good quality and reflective supervision to enable professionals to undertake the complexities of responding to safeguarding concerns.

11.3. Recommendation 3:

This SAR/DHR has highlighted the need for clarity about the thresholds for acceptance of a safeguarding referral and the importance of feedback about next steps and proposals for other action if the referral is not accepted. There is now a process in place where feedback is provided to a referrer when a referral to adult safeguarding does not meet the criteria for a S.42 enquiry including the rationale for decision making,

feedback about the quality of the referrals and whether any further information was needed to make a decision and recommended for follow-up. There is now a process in place to ensure that feedback is provided and openness for challenge.

- The LSAB will need to seek an update from relevant partner agencies regarding the progress of this and seek assurance that it is making a difference to adults with care and support needs.

11.4. Recommendation 4:

Where adult safeguarding action is being considered for an adult with care and support needs and that individual is assessed, at that moment, as lacking capacity to take part or provide a view about their circumstances and wishes, there needs to be reflection about who represents those needs and the possibility of advocacy.

- The LSAB will need to understand what is currently in place to address this and what further action is required from partners.

11.5. Recommendation 5:

Professionals should always consider whether decisions about safeguarding responses in complex cases such as this need to be carried out in a multi-disciplinary way. This did not happen for Peter and there is currently no formal process to allow this to happen. The LSAB will need to consider what process needs to be in place to ensure that where necessary adult safeguarding concerns are considered in a multi-agency context.

The application of the Mental Capacity Act 2005 and ensuring decisions are made in the best interest of individuals with care and support needs.

This review of the application of the MCA 2005 to Peter's circumstances has highlighted a number of issues:

- It appears that some professionals and some agencies perceived Peter to lack mental capacity generally rather than considering each complex decision to be made and his capacity to make that decision at the time it was needed to be made. This meant his lack of capacity was not considered in the context of specific decisions and the issue of what was in his best interests not discussed.
- There are concerns here about the lack of Best Interests Meetings and when one did take place how well it complied with the Best Interest checklist and was based on a multi-agency assessment of Peter's needs. Adult Social Care has undertaken work regarding the importance of Best Interest process, ensuring they are compliant with the Best Interest Checklist and that practitioners use evidence-based tools and frameworks.
- There was an assessment of Peter's mental capacity to engage with the annual assessment and review of care and support needs by Adult Social Care, but the issue of mental capacity in the many areas of need outlined within the assessment was not addressed and therefore there was no focus on best interests in each area.
- Peter was not provided with a Learning Disability Health Review and although this is not a mandatory offer, given national concerns about the unexpected deaths of adults with Learning Disabilities generally, and the complexities of Peter's needs specifically, this would have been a further opportunity to address his needs. Work is underway regarding this by the Clinical Commissioning Group (CCG), although there is uncertainty about the extent to which these health reviews address issues of mental capacity.

11.6. Recommendation 6:

LSAB should seek assurance that:

- The MCA is being applied appropriately by Adult Social Care and that the view that some adults lack capacity overall is challenged;
- That the process supporting best interest decision making in Adult Social Care is clearly understood and effective.

11.7. Recommendation 7:

LSAB should seek assurance partner agencies that:

- The needs of those adults who would have made the transition from children to adults' services before the implementation of the MCA 2005 have appropriate MCA assessments which inform effective future planning.

11.8. Recommendation 8:

The LSAB will need to seek assurance about:

- The progress of the CCG's work around the use of Learning Disability Health Reviews, the extent to which these reviews address mental capacity and they are making a difference to adults with care and support needs.

Ensuring that adults with care and support needs are enabled to communicate effectively and their communication style is maximised.

This SAR/DHR reviewed Peter's circumstances when he was in his late 40s. This appears to have been an influencing factor. There have been huge changes in legislation, policy and practice across Peter's lifetime. The changes should mean that if Peter had been a child or young person during the time under review his right to have his communication needs addressed and enhanced would have been recognised, and there would be action to address parents who prevented this from happening.

Peter had a lifetime of these issues not being addressed. This SAR/DHR is a reminder that professionals need to consider the needs and circumstances of adults who have profound Learning Disabilities, and whose previous care and planning approach might have been predicated on older ideas about what was best practice. The circumstances of Peter are a reminder of the importance of taking a person-centred approach ensuring that their communication style is understood, that this is used to make a direct connection with them and that their communication is maximised through effective care planning and support. Judith and Ron put barriers in the way of this happening for Peter because of their own distrust of professionals. This needed challenging and this highlights the need for services for adults with care and support needs to be person centred and the reluctance of parents or carers to promote independence and wellbeing gently but firmly challenged.

11.9. Recommendation 9:

The LSAB should assure itself that:

- All partner agencies promote the rights of adults with care and support needs and all those covered by the Care Act 2014 to have their communication skills enhanced ensuring a person-centred approach.

And,

- Partner agencies enable all practitioners to feel confident to challenge parents/carers around the rights of adults with care and support needs to have their communication enhanced.

11.10. Recommendation 10:

- The LSAB should assure itself that all partner agencies ensure that adults who are described as lacking communication should have an advocate in line with their Human Rights.

11.11. Recommendation 11

The LSAB should ensure that:

- All partner agencies have enabled professionals to be equipped to work with adults/families who are hard to engage, and that this is always challenged in the best interest of an adult with care and support needs.

Ensuring that the role of carers for adults with care and support needs is fully identified, supported and its viability in terms of the needs of the individual and the impact on the well-being of the carers evaluated.

The caring responsibilities of Judith and Ron were significant. Peter needed complete help with all his personal needs. Ron was 72 and had some health problems and sought help from his GP for depression. Judith was 69, had significant health problems including a diagnosis and successful treatment for cancer; she also talked of feelings of depression and stress and described this stress as being a contributory factor to her taking of overdoses.

The Care Act 2014[i], implemented in April 2015, promotes a whole family approach and current carer assessment that are expected to be holistic. They are required to draw on assessments of individuals

undertaken by other agencies and consider the implications for the provision of care. It is a requirement that the risks to carers of sustaining their caring role is always established, evaluated and planned for. The wellbeing of all family members should be considered, and account taken of whether the needs and circumstances of one member of the family are impacting on the well-being of other family members.

The review of addressing the caring responsibilities of Ron and Judith has highlighted a number of concerns which are addressed through the recommendations.

11.12. Recommendation 12:

The carer assessment of the complex circumstances of Judith and Ron was not sufficiently robust and did not address the contradiction between the carer stress they experienced and their reluctance to accept services. It was not updated or reviewed.

- Carers assessments are now subject to quality assurance audits and the LSAB will need to seek assurance that this is making a difference.

11.13. Recommendation 13:

The LSAB will need to seek assurance from ASC that:

- Carer assessments are included in the annual review of an adult with care and support and that these have future planning embedded within them and a risk assessment regarding the sustainability of the caring role using existing frameworks.
- The LSAB will need to be reassured that this is being addressed through audit and the best interest work referred to in Theme 3.

The importance of effective information sharing, multi-agency risk analysis and coordinated action to address the safety and safeguarding needs of adults with care, and support needs and adults who are vulnerable.

The review of information sharing and risk analysis for Peter, Ron and Judith suggests that:

- There remain times where agencies do not always understand their information sharing responsibilities in the context of adult safeguarding and the importance of considering their information, although seemingly not significant, may well be when considered alongside other sources of information;
- There is evidence that agencies did not always recognise their Think Family responsibilities;
- That information has become about flat information exchange, rather than a process whereby there is a clear risk analysis undertaken and the meaning for the information is explored in the context of agency expertise and the needs of the adult about whom it is being shared;
- Professionals who share information do not always seek information about next steps and consider what role they can play in a coordinated and planned approach;
- There is no routine use of chronologies to understand patterns and consider the impact of cumulative events and likely harm.

11.14. Recommendation 14:

LSAB should invite agencies to consider:

- The importance of developing a formal multi-agency approach around “think family” to take a more holistic approach to the identification and management of risk ensuring patterns of behaviour can be identified, and incidents are not dealt with in isolation and that complex family needs are addressed.

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[i] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted