Domestic Homicide Review
Safeguarding Adult Review
Peter, Ron, and Judith

(Anonymised names)

Overview Report

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October 2021

The Safer Lincolnshire Partnership and Lincolnshire Safeguarding Adult Board would like to express their sincere condolences to Ron and surviving family members regarding the loss of Peter and Judith.

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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 this are unknown.

1.2 The Safer Lincolnshire Partnership agreed that the death of Peter met the criteria for a Domestic Homicide Review on 15th November 2016. This was in line with guidance issued under section 9(3) of the Domestic Violence, Crime and Victims Act 2004[i]. The Act states: "'*Domestic Homicide Review*' *means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he or she was related or with whom he or she was or had been in an intimate personal relationship or a member of the same household".*

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims through improved intra- and inter-agency working.

1.4 There was also agreement that Peter and his parents' circumstances met the criteria for undertaking a Safeguarding Adult Review (SAR). The Care Act 2014[ii] states that Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in their area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. It also states that if an adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked together more effectively to protect the adult then a review should also take place in such circumstances.

1.5 The purpose of having a SAR is not to reinvestigate or to apportion blame, undertake Human Resources duties or establish how someone died. The purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures both multi-agency and those of individual agencies;
- To inform and improve local inter-agency practice;
- To improve practice by acting on learning (developing best practice).

Purpose, Scope and Terms of Reference

1.6 The decision was made that this would be a combined DHR and SAR is guided by:

- The processes outlined in the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[iii];
- Learning from other Domestic Homicides Reviews and Safeguarding Adult Reviews across the UK;

- The cross-government definition of Domestic Abuse (April 2013)[iv];
- The Care Act 2014[v].

1.7 Terms of reference were agreed at the first panel meeting on 10th January 2017. These were:

- 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.
- Were practitioners 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?
- 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?
- 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?
- 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?
- 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.

Chronologies and Internal Management Reviews (IMR)

1.8 Agency chronologies and individual agency Internal Management Reviews were commissioned and received from all involved agencies. The family had considerable involvement with services from 1997 when they moved to live in Lincolnshire. A large amount of information was collected and reviewed over a wide scope period, but a more in-depth review was completed of the period March 2014 to August 2015 due to significant increase in incidents prior to the fire. Internal Management Reviews were received from all the involved agencies:

Agencies that provided an IMR:

- 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)

1.9 These agencies also produced recommendations and action plans and these plans were actioned whilst the SAR/DHR was ongoing. The Chair, Author and Panel would like to thank all the Authors of the IMRs for their hard work and for responding to the many queries that arose during the period of the review. Sincere thanks also go to the frontline professionals from a range of organisations and agencies that have cooperated and assisted with the review, as well as those staff who supported the review from an administrative perspective.

Domestic Homicide Review/Serious Adult Review Panel

1.10 A SAR/DHR review panel was convened and membership is set out below:

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

1.11 The panel met for the first time in January 2017 to consider the terms of reference. Meetings were held to receive and critique the IMRs provided by all agencies. The panel assisted with the analysis of the core themes and evaluated and commented on drafts of the SAR/DHR report. All members of the panel have been fully committed to the SAR/DHR process and have provided insights about the work of their agencies and robust challenge. The Chair and Independent Author would like to thank them for their contribution to the review process. This report has also been reviewed by a representative of age UK.

Chair of the SAR/DHR panel, Author of the overview report

1.12 Jane Wiffin was the Independent Chair and the Author of this SAR/DHR report. She has been trained in the process prescribed by the Home Office to conduct Domestic Homicide Reviews and trained to conduct Safeguarding Adult Reviews. See Appendix One for biographical details of the Author. She is independent of all agencies having never had any association with the agencies or organisations involved with Peter, Judith or Ron.

1.13 The Chairing was supported by Heather Roach the LSAB Independent Chair of the Reviews and Learning Group[1]. Heather has been trained in the process prescribed by the Home Office to conduct Domestic Homicide Reviews. See Appendix One for biographical details of the Chair.

Statement of ethos

1.14 The SAR/DHR was conducted in the spirit of openness and fairness that avoids hindsight bias and any bias toward any one agency or individual involved.

Confidentiality and Dissemination

1.15 Prior to publication details of the review and the report have been kept confidential. The findings of this Review are restricted. Information was available only to participating officers/professionals and their line managers, until after the Review has been approved, for publication, by the Home Office Quality Assurance Panel.

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

Equality and Diversity

1.16 The review adheres to the Equality Act 2010[vi]. The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 (i.e., age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation). The issue of disability is addressed through the terms of reference and discussed in the themes. The SAR/DHR also considered the recognition and response of the multi-agency network to aspects of Judith and Ron's age; no other factors were of concern or relevance to the circumstances of the Review.

Parallel Processes

1.17 The inquest regarding Peter and Judith's deaths was completed before the SAR/DHR was started. The Coroner concluded that Peter's death was accidental. A narrative judgement was given regarding Judith's death and in summary said that she died from the injuries received in the house fire; the fire was caused by her deliberately, but her intentions for doing this were unknown. There are no other parallel processes.

Family Involvement

1.18 The Independent Overview Chair/Author and the Lincolnshire Safeguarding Adults Board Manager met with Ron on two occasions at his home. Sadly, one of Peter's brothers died during the review period and, although contact was attempted, his other brother did not respond. Ron said that relationships with the grown-up son's had been extremely conflictual, and they had little contact over the last 30 years; Ron said he could not provide any further information about them or their views. Neither Ron nor Judith had any other family apart from a daughter who was adopted by another unrelated family at birth. The panel considered contacting the daughter to enable her to provide information and reflections to the Review; however, because she was never part of this family unit, she had no contact with David or the other brothers, and the few sporadic telephone calls and recent visits were conflictual and distressing it was decided that contact could cause further distress therefore contact was not made with her**.**

1.19 Ron described Peter as "*a beautiful little fella*" who Judith and he "*loved to bits*". The focus of their lives had been caring for Peter and Ron believed that no professional could match the care they had provided. He reported that there were many times in the past when he believed that Peter had not been looked after properly by external agencies and that this had caused him to be reluctant to accept help and was distrustful of professionals. He said that he was often hostile to professionals and dismissive of their suggestions. He said that he and Judith still felt resentful, that this meant they had to cope alone, and this had been difficult for both himself and Judith. Ron could not think how professionals could have done things differently. He did reflect that it was sometimes confusing to understand the role of people who visited the family home whom he did not know, and this caused suspicion and lack of trust. Ron did not want to talk about allegations of Domestic Abuse, saying it was not an issue, refuting that he had been abusive to Judith or that Judith had been abusive to him. He also said that the concerns expressed by Judith regarding scam mail were incorrect. Sadly, the Review has not been able to find anyone else who knew Judith in order to understand her world.

1.20 Contact was made with the Day Centre that Peter attended. Peter was remembered fondly by those who still work there. He was known for listening to records and the radio, going out in the car/taxis and using the hydrotherapy pool.

2 FAMILY BACKGROUND

The Family are white/British.

2.1 Ron and Judith started a relationship in their teenage years, and they had a child before they married, who was adopted at birth by an unrelated family, which Ron reported was due to both of their parents' disapproval of their relationship. Judith and Ron subsequently married and had three further children who were all boys. The siblings of Peter both had mild Learning Disabilities and moved from home in early adulthood. Ron reported complex and difficult relationships with both siblings. Ron and Judith (but not Peter, or the brothers) had some brief contact with the adopted daughter when she was an adult with a family of her own, but Ron reported that contact has now ceased due to conflict.

2.2 Peter was diagnosed with a rare genetic disorder in early childhood and this meant he had profound physical and intellectual disabilities and also a number of health difficulties. He communicated non-

verbally, was a wheelchair user and required all of his personal needs to be met including assistance with continence needs and personal hygiene. He required constant supervision and almost 24-hour care.

2.3 Peter had attended a residential school for children with Learning Disabilities from the age of five and moved to a new school for his secondary education. He then attended a Training Centre at the age of 19. After this he attended a Day Centre in Yorkshire for the next 10 years.

2.4 Ron worked as a long-distance lorry driver and Judith was a full-time carer to Peter. Ron said during this Review that they were isolated, had little contact with their extended family, and had few friends and little contact with the community. Ron explained that their focus had been on looking after Peter and this left little time to do anything else.

Historical Professional Involvement with the family

2.5 This is a brief summary of the historical professional contact that Peter, Judith and Ron had with professionals prior to the time under Review. It is provided for context and to give an overview of recent history. It does not include the detail of all decision making and professional actions and therefore no commentary is provided.

2.6 The family moved to Lincolnshire in 1997 when Peter was aged 30, Judith aged 52 and Ron aged 55. Ron retired from work due to ill health at this time. Their two other son's had grown up and left home at this point and agencies in Lincolnshire never met them. Peter attended a local Day Centre provider for three days a week and on a regular basis stayed overnight to give him a break and to provide some respite to his parents from their caring responsibilities. This Day Centre stopped providing short breaks/respite care due to budget cuts in 1999; alternative provision was offered, but declined by Judith and Ron. Peter had one further period of a short break/respite[2] care in 2001, which he was said to have enjoyed; after this he had no further overnight stays due to practical difficulties, concerns from his parents about the quality of care he was provided with, disputes between the parents about what was best for Peter and threats by both parties to move and take Peter with them.

2.7 In 2005 Peter's Day Centre sought to instigate an assessment to enhance his non-verbal communication skills, but his parents did not feel able to engage with this. There were reports of conflict between Judith and Ron described as pertaining to the care Peter required.

2.8 During this time Peter was provided with regular social work support; he was also seen routinely by the Consultant Learning Disability Psychiatrist to address concerns about his agitated behaviour.

2.9 The first report of Domestic Abuse in Lincolnshire (it is not known whether there had been any previous incidents of Domestic Abuse before their move) was received in 2006 when the police were called to the family home because Judith had alleged that Ron had been domestically abusive to her. Ron alleged that Judith had attacked him. This was risk assessed and did not meet the threshold for further action;

2.10 In 2009 the Day Centre felt they could no longer meet Peter's complex care needs and he moved to a new Centre. The staff who looked after him adapted their communication style and felt Peter understood most things that were said to him, though he did not recognise pictures or use Makaton. He built relationships with staff and his peers who attended the Centre alongside him. He was able to indicate activities he would like to do and was often smiling and laughing. There were concerns that he showed his anxieties and frustrations through head-banging and the staff were not always able to work out what this meant or what to do to help. A report at the time said Peter "*appears to be very happy and settled (…) he enjoys the environment and appears to have an appropriate peer group with whom he interacts well with and attends activities with*".

2.11 In 2008 a safeguarding alert was received by Adult Social Care Safeguarding Team (Adult Safeguarding Team)[3] from the allocated Social Worker from Learning Disability Adult Social Care Team (Learning Disability Team)[4]. This alert highlighted concern about the parents' poor mental health which was said to have been exacerbated by their caring responsibilities and conflict between them. At this time both parents talked about the significant impact on their lives of their caring responsibili-

[2] The term 'short breaks' (also known as respite) is used to describe the time off that family carers and people with a learning disability receive. This can take different forms such as holidays, residential care or the provision of alternative carers.
[3] See pages 16-19 for a description of this service.
[4] See pages 16-19 for a description of this service.

ties and Ron talked of not trusting professionals locally. The Safeguarding Team concluded there was no need for further action, and they offered the parents support if they needed it. The Adult Learning Disability Social Worker (LDSW) continued to support Peter and his parents. Later, in May 2008 Ron was assessed by the Older Age Community NHS Mental Health Team (OACMHT)[5] as suffering from chronic stress and he said he was worried about his wife who had taken an overdose the year before but would not accept help. Ron was advised to seek help from the GP who was informed about this consultation; Ron did not seek any further support.

2.12 In 2009 Ron called the Police alleging that Judith was threatening to kill him, and to kill herself. The Police went to the home and Judith initially said she would kill Ron one day because she hated him, but then said she would never carry out this threat. Ron also felt that Judith would not carry out this threat, and the Police assessed that this incident was caused by the pressures of caring for Peter. Peter was seen and was well; Adult Social Care was informed of this incident.

2.13 Peter stopped attending the Day Centre in 2011 because the family moved, there were transport difficulties, the parents reported they were anxious about the quality of care Peter received and there were disputes between Judith and Ron about what was best for Peter with both threatening to move and take Peter with them. The records at this time suggest that this lack of outside contact put a strain on family relationships.

2.14 In 2011 the Ambulance Service was called because of a possible overdose by Judith; she had taken some Diazepam[6] she said to get a good night's sleep. Her physical wellbeing was checked but she refused to go to the Hospital; advice was provided. Judith refused all offers of help.

2.15 In June 2012 Judith contacted the Adult Care Safeguarding Team to report that Ron was subjecting her to verbal and mental abuse, but not physical abuse. She was signposted to Domestic Abuse agencies but did not contact them. There is no evidence that her reluctance to seek Domestic Abuse support was explored or understood at this time. In the same month Judith took a small overdose of tablets; she did not need to go to Hospital. She had written a suicide note which said that she would also take Peter's life because she did not want to leave him to suffer in residential care. When Judith was questioned by the Police she said she would not hurt Peter, and that this was a cry for help; she was once again signposted to specialist support services but did not make contact with them. There was no connection made by services between Judith's suicidal ideation and Domestic Abuse. Something that was discussed in the analysis section.

2.16 In the same month Judith contacted the Mental Health Crisis Team to say she needed help because she had made a small fire in the house; it is not clear whether she had lit this. She reported ill health, caring responsibilities and a difficult relationship. Ron said the fire was small, that Judith was not at risk and it was a cry for help. This incident was not referred to Lincolnshire Fire and Rescue Team for a home safety check[7].

2.17 Then, two days later, Judith took another small overdose of medication after what was described as a physical altercation with Ron and there was a minor injury. Judith was taken to Hospital overnight where she was assessed; the conclusion was that there were no mental health concerns and she returned home. A safeguarding referral was made to Adult Care Safeguarding Team regarding the overdose and concerns about possible Domestic Abuse. This referral was said to not meet the threshold for safeguarding action but a Social Worker from the Learning Disability Team met with both parents and offered further support, which they declined. There was no evidence that consideration of meeting with the parents together, to discuss Domestic Abuse, was not appropriate and that the Social Worker needed to talk to Judith on her own and explore the barriers for her feeling able to seek support. Two days later the Ambulance Service received a call from Ron reporting that Judith had taken another overdose. When the crew attended, Judith was described as hostile and Police support was requested; the Police attended, but the situation then calmed. Judith was taken to the Hospital. She was found to be well, but the Hospital were not made aware of the ongoing concerns about Domestic Abuse therefore no support was offered regarding this. This further connection between Judith's suicidal ideation and her experiences of being domestically abused was missed.

[5] See pages 16-19 for a description of this service.
[6] Diazepam, first marketed as Valium, is a medicine of the benzodiazepine family that typically produces a calming effect.
[7] The incident of the fire took place in 2015. At this time Lincolnshire Fire and rescue service (LFR) had limited partnerships with other agencies regarding home safety checks. There have been significant changes since this time with LFR; a team of fire safety advocates visit vulnerable residents across the county. A number of service level agreements and partnerships have been developed with agencies and the awareness of what LFR can offer and why it is important has increased as a consequence.

2.18 At the beginning of 2013 Ron was admitted to Hospital after collapsing in the community. He spent some time in and out of Hospital and the Hospital staff were concerned about the impact on Judith of looking after Peter and visiting Ron. They sought support from the Learning Disability Team; an assessment was completed, and respite care/short break was offered but refused by Judith and Domiciliary Care accepted. A Carers Support Assessment was completed and a small budget for carers breaks, and days out was agreed. The Carers Team also became a point of contact for Judith and Ron.

2.19 Six months after the Domiciliary Care started, there were tensions between Judith and Ron about their reliability and some confusion about when they were due to attend. This led to no further Domiciliary Care being provided.

2.20 In mid-2013 a new LDSW was allocated to Peter and would be his Social Worker until his death. The LDSW shared the assessment completed by the previous Social Worker as part of Peter's Annual Review with Judith, who was angered and offended by its content. Judith said she was unhappy that the assessment contained some health inaccuracies about Peter and she complained about the conclusion which said that her fragile mental state could lead to a high risk of Peter being neglected. The relationship between Adult Social Care Services and the parents had been difficult in the past but from this point in 2013 onwards the contents of this assessment impacted negatively on Judith's attitude to Adult Social Care and the services they offered Peter. There was no connection made between Judith's on-going disclosures of Domestic Abuse and her mental health, including suicidal ideation. Judith said she felt criticised as a mother; she might also have felt that professionals were not recognising that she was a victim of Domestic Abuse.

2.21 Towards the end of 2013 the Police were called because there was an allegation that Judith had slapped Ron and, in retaliation, he had pushed Judith during an argument about scam mail. Support was offered and declined. Ron told the LDSW he was worried about Judith not accepting help, taking overdoses, and attempting to commit suicide. Judith reported in the next few days that she was being locked in the house and that there were many arguments between the couple. Judith also rang the Domestic Abuse service to say she had taken some of Peter's tablets because she was struggling to cope with Ron but refused support and a refuge place. This call was shared with the LDSW who made a safeguarding referral which, however, did not meet the threshold for safeguarding action. The LDSW visited to offer support and alternative accommodation which was not accepted. There was by now, a clear history of Judith telling professionals that she was being domestically abused by Ron but feeling unable to use the offered support. There is no evidence that the reasons for this were explored. This could have been an opportunity to think about what other support was available that would best support her needs. This could include befriending and support services such as those provided by Age UK locally; a third sector organisation could have offered support to Judith if she would have found this appropriate.

2.22 At this time an Adult Care Risk Assessment and Management Plan was completed by the LDSW because the parents would not accept any services to support them or Peter and there was considerable conflict. Although concerns were expressed in this risk assessment about possible physical, psychological, and emotional abuse due to the relationship difficulties of the parents. Professionals also felt that Peter was happy at visits, showing no sign of distress, was well looked after and the parents were observed to be very caring towards him. The LDSW was clear that their role was to support Peter and ensure his safety and well-being, as well as building a relationship of trust with Judith and Ron.

3 THE REVIEW PERIOD:

There were many professionals involved during the period under Review and the table below provides an overview of this as well as a description of the role of the different professionals in each agency.

Chronology of Professional Involvement: March 2014 - August 2015		
Agency	**Team and their role; described in the current tense as all continue to provide services**	**Involvement during the time under review**
Lincolnshire	**Learning Disability Consultant Psy-**	Peter was seen regularly to monitor his

Partnership NHS Foundation Trust	**chiatrists**	mental health and prescribe medication to calm him down and aid his sleep.
	Learning Disability Acute Liaison Nurses; the service offers specialist health support to people with Learning Disabilities.	Peter was seen by the nurses to prepare him for health treatments.
	Learning Disability Occupational Therapy Service; this service provides assessments of the daily living skills of adults with Learning Disabilities and promote their independence.	An Occupational Therapy Assessment was carried out on one occasion regarding the bathroom and the need for hoists to enable Peter to be bathed safely.
	Crisis Resolution and Home Treatment Team; community-based team that provides quick access to assessment and treatment for individuals experiencing mental health crisis.	Judith was seen periodically for assessment in response to her overdoses of medication.
	Older Adults Community Mental Health Team (OAMHT); team that provides specialist services to adults aged 65+ presenting with complex mental health problems.	Judith was assessed and advised by a community psychiatric nurse from this team in 2014.
	Hospital Intensive Psychiatric Support Service (HIPS); service for all adults accessing A&E services which provides mental health assessments.	Judith was assessed and advised by this team on one occasion.
South West Lincolnshire Clinical Commissioning Group	**GP services**	Peter saw the GP as required; Judith was registered with the same GP and visited the surgery regularly and the GP undertook home visits.
	GP services	Ron had his own GP who he visited periodically.
Lincolnshire Specialist Continence Service	**Community Nurses**	They provided resources and care and support to Peter; and his parents regarding continence and would visit every 6 months.
Lincolnshire County Council	**Adult Care Learning Disability Teams;**	Peter had the same Adult Learning Disability (ALD) Social Worker throughout the Review period who visited him either fortnightly or weekly. The Social Worker's Manager also visited on a regular basis. When the Social Worker was on leave other staff visited. He was also seen by the Maximising Independence Worker.
	Safeguarding Adults Team; this was a centralised resource that provided advice and support about the criteria for initiating safeguarding procedures undertaking all safeguarding enquiries	A number of Safeguarding Social Workers were involved during the time under review but none met either Peter or the parents; a Safeguarding Social Worker

	and leads on protection plans. This has now changed with the implementation of the Adult Care Safeguarding Policy and Procedure in 2017 and now keyworkers form the Learning Disability and other teams are much more involved in safeguarding enquiries and where appropriate take the lead for these enquiries. At the time of the Review, it was the working culture that this team completed DASH[8] risk assessments for all Adult Care Teams. This has now changed and the DASH risk assessment is completed by the appropriate Practitioner/Keyworker who will then (where appropriate) refer on to the Adult Social Care MARAC[9] representative.	did speak to Judith on the phone.
	Adult Emergency Duty Team; undertakes mental health assessments and responds to urgent requests for Adult Social Care intervention which require action before the next working day.	Judith and Peter both had telephone contact with this team during the many crises they experienced.
	Carers Team; offers carers information and advice, signposting to other organisations and assessment of needs. This support was provided through a customer care centre telephone line. Assessments were carried out face to face. Carers were provided with a personal budget administered through direct payment.	Judith and Ron were seen by the Carers Team for an assessment.
Lincolnshire Police	**The Force Control Room (FCR);** handles calls from the public, and if appropriate, dispatch Police officers to incidents. **Neighbourhood Policing Team;** operational Police Officers from this team respond to and investigate incidents of Domestic Abuse and other concerns. **Public Protection Unit;** single point of contact for all child and adult safeguarding referrals.	Judith and Ron contacted the Police on a regular basis.
East Midlands Ambulance Service (EMAS)	**EMAS**; provides emergency 999 and urgent care services across the East Midlands region. When a member of the public or a professional calls the	Judith and Ron called the Ambulance Service on a number of occasions and Judith was transported to Hospital by ambulance**.**

[8] Domestic Abuse Stalking & Honour based violence.
[9] Multi-Agency Risk Assessment Conference

	Ambulance Service they are assessed by a call taker to determine the most appropriate response/need for an ambulance. An ambulance crew will be dispatched where considered necessary and a care pathway agreed.	
West Lincolnshire Domestic Abuse Services (WLDAS)	**WLDAS;** a voluntary sector organisation that offers support to women, men, children and young people who are or who have been affected by living with or experiencing Domestic Abuse.	Judith had one contact with this agency which was a self-referral via a telephone call. She terminated the call and said she did not wish for any further support.
United Lincolnshire Hospitals NHS Trust		Judith, Ron and Peter all had contact with the trust through various departments

Chronology of Professional Involvement: The months prior to Peter's death	
Ages: Peter: 47 Ron: 72 Judith: 68	
2014	
6th March	The LDSW discussed with Ron and Judith their concerns about the recent deterioration in Peter's behaviour. This deterioration was reported by Ron and Judith to be as a result of a chest infection. Peter was described as unsettled, disengaging from the family, hitting, and slapping and displaying high levels of self-injurious behaviour. It was agreed that a referral would be made to Consultant Psychiatrist One who had last seen Peter six years earlier. There were some administrative difficulties which meant there was a delay in the appointment taking place.
6th March to 17th April	The LDSW visited Peter three times over the next six weeks and was worried about the angry exchanges between Ron and Judith and the impact this might have on Peter. Ron and Judith talked about their worries and shared concerns about financial issues. The LDSW reminded them that they were primarily visiting to see Peter and ensure he was happy and well. There was no evidence the worker considered what Judith and Ron needed in their own right. Judith has already reported a long history of Domestic Abuse dating back at least eight years. Both parents had extensive caring responsibilities which were long standing and both were older persons.
17th April	The LDSW visited Peter and was concerned that he was quiet and did not acknowledge their presence as usual. Ron said he was angry because of a delay in a psychiatrist appointment being provided.
24th April	The LDSW visited and Judith asked for the contact details of the Adult Social Care Safeguarding Team because she was worried about Ron keeping post from her and controlling her. Judith reported an argument with Ron that was so bad that she saw Peter hide under the duvet. The LDSW asked Judith if she was scared about either the safety of Peter or herself and she replied "*yes and no*" but declined either a short break/respite care for Peter or a place of safety for her. Judith was provided with the contact details of both the local Domestic Abuse Service and the Adult Care Safeguarding Social Workers; the LDSW also informed the Adult Safeguarding Team about what had happened and urged them to expect a call from Judith. The LDSW asked for the telephone call to be taken by the same Safeguarding Social Worker Judith had seen earlier in the year to ensure continuity of care.

25th April	The next day, Judith telephoned the Safeguarding Social Worker and was told they were not available and that the file regarding her family was closed. Judith was angry and spoke to the LDSW who tried to explain there had been a misunderstanding and that they would ensure that it was sorted out. Judith refused help and said she would sort things out for herself. Five minutes later Ron called the LDSW saying he was worried about Judith whom he said was not well, and that she was talking about moving to a refuge and Peter to residential care. The LDSW could hear Judith shouting in the background that she would act in the way that she had been described in the assessment completed the year earlier as a "*neglectful mother*". She shouted that she was going to take some tablets and bleach. The LDSW tried to offer support and calm the situation down without success. The LDSW phoned the GP who phoned Ron. Ron was verbally abusive and said that Judith was asleep on the sofa. The GP phoned an ambulance. The ambulance arrived and Judith confirmed she had taken tablets which she said she had saved up for Peter because he was "*better out of this world because nobody helps him*" and a suicide note was found which said that Judith intended to kill herself and Peter. Judith refused to be medically examined, was verbally abusive to the ambulance crew who called the Police. Judith was arrested on a charge of threats to kill and taken to the Hospital. After discussion within and between agencies the charges were dropped because the threats were believed to be a cry for help because of the long-term and onerous caring responsibilities for Peter. Ron also reassured the Police that Judith cared deeply for Peter and would never harm him. Judith was assessed as physically well and seen by the Hospital Intensive Psychiatric Services (HIPS). They found no evidence of mental health illness and concluded that caring for Peter had impacted on her mood and that there were additional pressures caused by relationship difficulties with her husband. They concluded that there was no further role for Mental Health Services, and this was communicated to the Police and the Emergency Duty Team (EDT) because it was Friday evening. EDT contacted Ron to ask about Peter's wellbeing and Ron confirmed that he was looking after him and that he was well. The EDT also provided email feedback about this incident to the LDSW.
26th April	The next day, Judith rang the HIPS Team to ask about whether she had been sectioned[10] and whether she might be provided with any support; she was told that the team believed she did not need Mental Health Services. Judith also expressed unhappiness at the way she had been treated by the Police but dismissed the offer of any help to make a complaint. Judith phoned the LDSW, who answered even though it was a Saturday and a non-working day. Judith reported unhappiness at the way she had been treated by the Police and the LDSW said she would visit on Monday 28th April. The Police reported to the EDT that they remained worried about the potential threat posed by Judith to Peter and the Police also telephoned the Hospital Ward. There were a number of conversations between the LDSW, their Manager, EDT and the Police about next steps. There was a discussion about the need for a Strategy Meeting, which did not take place, and EDT offered to visit. The LDSW confirmed to the Police that they had arranged a meeting with Peter, Judith, and Ron at home; a joint visit was discussed, but after some further discussion this was considered not necessary. Ron was spoken to twice by EDT and said he was caring for Peter and he said that Peter's LDSW had agreed that Peter should stay at home because moving him would be too distressing.
27th April	In the early hours of Sunday morning, Judith phoned EDT and said she did not want to live with her husband anymore and he had been hiding both her own and Peter's medication. Contact was made with Ron who confirmed he had hidden the medication to prevent Judith

[10] These were Judith's words so it is not clear exactly what she meant but it is likely that she meant being admitted to hospital under the Mental Health Act 1983.

	taking another overdose. When Judith was spoken to, she said the EDT Worker was on her husband's side. Ron phoned EDT mid-morning on the same day to report that Judith was planning to ring the Mental Health Crisis Team to have him taken away because he was Schizophrenic and said he was concerned about what would happen to his son. He was said to be very distressed but was reassured that the LDSW was visiting the next day and would sort this out.
28th April	The LDSW discussed the current family circumstances with their Manager on Monday morning. They agreed that there remained concerns about Peter's safety and that there would be a need for increased monitoring of his wellbeing. It was acknowledged that there was a balance to be struck between Peter's stability because he had been well cared for by both parents for a very long time, with the need for safety. They decided to discuss this with the Adult Social Care Safeguarding Team after the home visit. The LDSW and their Manager visited, and Judith said she did not want to discuss what had happened over the weekend. She was told that Adult Social Care had a responsibility to ensure Peter's safety and wellbeing which might mean Peter moving but primarily the team wanted to provide help and support. This offer was not accepted by Judith. The Adult Social Care Safeguarding Team were told there was no need for a safeguarding referral at this time as increased monitoring in the form of home visits were planned. That evening Judith took another overdose of tablets. An ambulance was called and Judith told the crew she had not intended to kill herself but was unhappy with her husband. She was taken to Hospital where she reported a deteriorating relationship with her husband due to the strain of looking after their disabled son. She said she felt low but reported no delusions or suicidal thoughts or intent; she reported that this was a cry for help to get more support for her son. She was assessed as medically well and it was agreed that she would be assessed by the Older Adults Community Mental Health Team (OACMHT) the next day. The Social Worker and GP were both informed of the Hospital admission, and both said they would visit after Judith had been assessed. Judith was discharged home.
29th April	The OACMHT Community Psychiatric Nurse (CPN) visited the next day and met with Judith and Ron. Judith spoke about wanting to get away from her husband to whom she had been married for 51 years. She was asked if she would like to speak without Ron present, but she said she did not want this. The CPN noted that Judith and Ron argued throughout the interview and Ron talked about moving away with Peter for whom he said he now fulfilled all the caring responsibilities. Judith said she was not feeling depressed and did not have any current suicidal thoughts. The CPN discussed the assessment interview with Psychiatrist One and reported that Judith was not mentally ill but there were long-standing relationship difficulties between Judith and her husband and there was no role for the OACMHT. The LDSW and GP were informed of this decision. The GP visited and Judith said she had no further plans to take an overdose, did not want to die and was not depressed; she said that her problems were caused by long-term relationship difficulties with Ron.
30th April	The LDSW discussed the current circumstances for Peter with their Manager who talked to the Local Authority Legal Advisor. It was agreed that there was a need for a Strategy Meeting/discussion[11] which would include the GP, the CPN, Police and the Adult Safeguarding Team. It was agreed that the meeting needed to be called a Best Interest Meeting[12] because only the Safeguarding Team could convene a Strategy Meeting.[13] A date

[11]A Safeguarding Strategy Meeting may be called where an allegation or disclosure of abuse has been made. This decision is based on information/evidence available. It is an inter-agency forum to plan the process of the investigation.

[12] A best interests meeting may be needed where an adult (16+) lacks mental capacity to make significant decisions for themselves and needs others to make those decisions on their behalf. Mental Capacity Act 2005 https://www.scie.org.uk/files/mca/directory/best-interests-meetings-guidance.pdf?res=true

[13] A Safeguarding Strategy Meeting may be called where an allegation or disclosure of abuse has been made. This decision is based on information/evidence available. It is an inter-agency forum to plan the process of the investigation. The Strategy Meeting could only be called by the Adult Safeguarding Team because they were responsible for adult safeguarding in Lincolnshire.

	was set for two weeks' time because of diary commitments. The LDSW invited the Police, but this was followed up by a call from the Adult Care Safeguarding Team who told the Police there was no role for them because the parents generally looked after Peter well and current concerns were about the parents' relationship. The LDSW was informed about this decision.
1st May	The LDSW visited Peter and his parents. This was recorded as being a difficult meeting and Judith described in the records as either unwilling to speak or laughing hysterically. Judith and Ron were described as arguing throughout. Ron said he did not want Peter to go into residential care and said he would rather take Peter's life. The LDSW challenged Ron about this. Judith said that Ron wanted "*her sectioned or dead*" and she refused to accept food from him in case it was poisoned. Judith said she had taken some of Ron's tablets because "*he had driven her to it*". Ron said he could do nothing right. Judith asked what she needed to do to be sectioned, and the LDSW said that the CPN had assessed that she had no mental health difficulties. Judith also reported that she thought she might have cancer but did not want to see the doctor; she was strongly advised to do so. When the LDSW left Judith telephoned the CPN and said that she had "*a turn today*" and "*turned a little bit violent*" and she questioned if they could section her. She reported that she had seen two Social Workers who told her that she did not need sectioning. Judith said that her husband made her angry and continually argued with her. She denied any feelings of depression or suicidal thoughts; was offered a home visit by a CPN but declined saying she would be ringing her GP. The CPN phoned the LDSW and they discussed the current circumstances. The LDSW said they were worried about some of the things Judith said but that their focus was on Peter. The LDSW queried the criteria by which Judith was judged not to have any mental health difficulties. They were reassured that there had been a robust assessment. Judith also rang the GP to say that she felt like she needed sectioning and the GP visited that afternoon. The GP found Judith to be much calmer and she said her main problems were the breakdown of the relationship with her husband and caring for her disabled son for 40 years. She said she did not want any further Crisis Team input at present as she had calmed down.
3rd May	Ron phoned the Police to report that he had collected Judith's pension and other monies because she was unwell. He said he had brought the money back and left it for her; she had said it had gone missing. When the Police arrived, they noticed the money on the table. A DASH risk assessment[14] was completed and graded as *standard*[15]. Judith reported feeling better after the incidents of the last week with support from Adult Social Care and the Crisis Team. Ron said he still wanted to leave his wife and take Peter back to the place where they used to live. Peter was seen by the Police Officer and was well. Adult Social Care Duty Team was informed about this incident.
7th May	Peter was taken by Ron for a planned appointment to see Psychiatrist Two about the concerns regarding Peter's deteriorating behaviour. Ron described Peter as pushing, pinching, and biting the parents and stated that this started six months earlier when Peter broke his foot. Ron provided information about Judith's recent overdose attempts and the deteriorating relationship between them; he said they received no support from services or family. Psychiatrist Two asked if Ron thought that Peter might be responding to conflict between Ron and his wife, and Ron agreed that Peter went to his bedroom and got into bed when there was a lot of shouting. Ron refused the offer of short break/respite care and also refused further review by Learning Disability Care Health Nurse (LDCHN). A referral was made to the Occupational Therapy Service regarding difficulties with getting Peter in and out of the bath (the parents had refused equipment for this) and a letter was sent to

[14] Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) is a risk identification and assessment and management model https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009.pdf

[15] DASH initial risk classification

	the GP regarding the appointment. The Occupational Therapy assessment was completed but Ron and Judith refused to have any adaptations to the bathroom suggesting they were unnecessary. Judith told the LDSW that Peter had not been seen by Psychiatrist Two because Ron was late. This was contradicted by Ron a few days later when he told the LDSW that he was unhappy because they had seen a new Psychiatrist (Three) and they needed a further appointment with Psychiatrist Two because of ongoing concerns about Peter's behaviour.
12th May	Judith telephoned EDT to report that Peter had pushed past her in the kitchen, and she had hit him with a wet dishcloth. She felt she needed to report it as a safeguarding concern. It was agreed that this would be discussed at the forthcoming Best Interests Meeting.
15th May	The LDSW visited Peter in the morning before the Best Interest meeting to see how he was and the parents reported that he was becoming more aggressive. The minutes of the meeting describe this as a Multi-Disciplinary Meeting and not a Best Interest Meeting as intended (though this started out as a need for a Strategy Meeting). There is no record as to why the purpose of the meeting was changed. This meeting was also not multi-disciplinary; it was attended by the LDSW, her Manager, and an Adult Care Safeguarding Social Worker. There was confusion about Police attendance (they had been told they were no longer needed by the Adult Safeguarding Team but that was not clear in the discussion had on the day) and the CPN had declined the invitation because their service was no longer involved with Judith. The GP sent apologies but provided a report. All the current concerns and recent history were discussed; the conclusion was that Peter had been well looked after by his parents for a long time, all his needs were being met and Judith and Ron loved him. It was agreed that there was no evidence to support the need for Peter to move from home, and a decision was made not to progress to safeguarding enquiries. Judith's allegations of Domestic Abuse supported by what the LDSW had seen were not sufficiently discussed and the connections to recent suicidal behaviour not made. The LDSW would continue with the high level of visits, to monitor Peter's circumstances and to continue to try to engage Judith and Ron and encourage them to accept additional support. A review of progress was agreed for six weeks' time.
22nd May	The LDSW visited Peter who did not appear very happy. They thought that Peter indicated that he was distressed but without any tears; the LDSW recorded this as "dry crying[16]". Judith said that Peter dominated the kitchen and would be aggressive pinching and pushing. The LDSW wondered if this aggression was related to Dementia or Alzheimer's. The LDSW noted over the next few visits Peter seemed happier and the household was calmer.
26th May	Judith phoned the Police after a row with Ron where he left and took Peter with him. She said she was worried because Ron had a blackout whilst driving a year earlier. She telephoned the Police back 15 minutes later to report that Peter and Ron had arrived home safely. The Police visited the next day to ensure that Peter was safe and well.
4th June	Peter was reviewed by Psychiatrist Two and Ron reported an increase in Peter's aggression and agitation. Ron thought medication would help and Peter was prescribed Risperidone[17]. A week later, Judith told the LDSW that the medication was not working for Peter and that she had taken him off it. A Psychiatric Review was agreed for four weeks' time where the possibility of Peter being admitted to hospital for assessment would be discussed.

[16] The LD social worker thought that Peter looked upset and was exhibiting distress without tears.

[17] Risperidone is an antipsychotic medication is used to treat schizophrenia, bipolar disorder, and irritability associated with autism.

24th June	The LDSW and their Manager agreed to cancel the planned Best Interests Review Meeting because Peter and the parents' circumstances seemed more settled. This was communicated to the Adult Social Care Safeguarding Worker. The LDSW had completed the tasks agreed at the last meeting; they had contacted the last Day Centre that Peter attended, and they reported that he had been disruptive at times. Judith had been signposted to a support group; the fact that she had not felt able to make use of this support or any other services was not discussed, or possible reasons why explored as part of an analysis of the whole family circumstances. The continued high level of visiting was to continue.
9th July	The LDSW visited Peter with the Maximising Independence Worker and there was a discussion about what Peter could do during the day to occupy him. It was agreed the Maximising Independence Worker would seek out some information and proposals.
13th August	The LDSW accompanied Ron to the next outpatient psychiatric appointment. Peter was described as continuing to be agitated, not sleeping, and no longer smiling; the possibility of depression was discussed. Psychiatrist One recommended the medication Trazadone, an anti-depressant with strong calming properties. Judith rang two weeks later to say that the medication had helped, that Peter was sleeping better and remained active and generally happier in the day.
21st August	The LDSW carried out the yearly Review of Peter's support plan. Peter, Judith, and Ron were present. The parents refused any further support services and the LDSW explained that her role was to visit Peter to see that he was OK. Judith and Ron said they were happy to have the regular visits.
30th September	Judith was diagnosed with cancer. Over the next few months, she attended a number of Hospital appointments and received treatment. The Hospital noted that she was anxious and offered her support. They also suggested that the parents needed more support with Peter, which they declined. Judith made excellent progress with her treatment. The LDSW also provided support and adapted visiting times in sensitivity to Judith's circumstances.
1st October	Peter was brought by Ron to be reviewed by Psychiatrist Two; Judith was unwell and so could not attend. The LDSW also attended. Ron reported that Peter was generally happier although the Learning Disability Acute Liaison Nurse (LDALN) thought Peter seemed agitated on the day and the LDSW believed Peter appeared upset. Ron said he thought this might be because Peter's mother was unwell, and he explained that Peter easily picked up on the atmosphere at home which had been recently quite unsettled. It was agreed that Peter would continue on the same medication and this would be reviewed in four months' time. Ron told the LDSW that Judith had been diagnosed with cancer and the LDSW said they would visit the next day and at this visit, further support was again discussed but refused. The LDSW adapted their visiting times in sensitivity to Judith's circumstances.
8th October	The LDSW visited Peter who seemed happy; he smiled and laughed a lot. Judith said that he had started to "*wail*" and had become uncooperative when having his continence pads changed. The LDSW noted that Peter seemed quite cooperative and calm during the visit. Judith discussed her worries about how Ron would cope with bathing Peter whilst she was having her cancer treatment and she was reassured that there could be support put in place. Judith said she would think about this.
10th October	Judith contacted the Carers Team because she wanted to let them know there were current concerns about her health and her Doctor had indicated that there was a serious problem. Judith said she knew that she could contact them at any time.
November	Judith received treatment for cancer and there was discussion about the need for ongoing sensitivity regarding the weekly social work visits. A residential placement was sought for

	Peter in case it was required.
2015	
21st January	The LDSW visited Peter who appeared well looked after and occupied with playing with his records. He smiled in acknowledgement of the Social Worker. The parents reported that Peter could still be a bit of a "*handful*" but they had an appointment with the Psychiatrist the next day, which they were unsure whether they would attend; there is no record of this appointment. Judith reported that she was refusing the next stages of the cancer treatment. She was advised to speak to the Doctor in charge of her care.
28th January	Judith telephoned West Lincolnshire Domestic Abuse Services (WLDAS) a voluntary sector Domestic Abuse Team to report that Ron had been manhandling Peter and locking him in the bedroom. She provided no further details and declined support. WLDAS were concerned and because Judith had shared details of her caring responsibilities, they rang Adult Social Care and established that Peter had an LDSW. WLDAS spoke to the LDSW and reported the phone call from Judith which had been terminated because Ron had returned home. The WLDAS Worker gave advice about assessing risks and offered to undertake the DASH risk assessment with Judith when she was not with Ron. The LDSW telephoned Judith back. Judith said that Peter was safe and she wanted no action taken. The LDSW said there would need to be a referral to the Adult Safeguarding Team; Judith refused a home visit and put the phone down. The LDSW discussed this incident with the Adult Safeguarding Team and it was agreed that the former would do a home visit the next day and assess the situation before next steps were agreed. The LDSW visited and Judith was both angry and rude. Ron was seen, he denied all the allegations and said that he and Judith had been having an argument about Day Care for Peter, which Ron wanted, but Judith did not. Peter was seen and appeared well. The LDSW contacted the Adult Safeguarding Team to report that Peter was not being harmed and home visits would now happen weekly rather than fortnightly. Judith telephoned the LDSW the next week to apologise for being rude and said that Ron would never intentionally harm Peter but managing his care was difficult. Support was again offered and declined. It was agreed that home visits to see Peter would increase again to weekly.
1st February	Judith rang EDT to report that she was finding it hard to cope with her husband's behaviour which she described as erratic; Judith said she thought he had mental health problems. Judith said that Ron was refusing to accept that they both needed help with Peter. This information was shared with the LDSW who was planning to visit that week.
2nd February	The Carers Service phoned Judith who was unable to come to the phone. Ron said it had been a difficult few weeks; they were managing and waiting to hear if Adult Care were going to help with the bathroom. An hour later Judith telephoned the Carers Service back and explained that she was recovering from treatment for cancer; that she received input from Macmillan Cancer Support Service[18] and said she had not found it useful. She said that Ron was misrepresenting the current circumstances, was not coping with looking after Peter and had not told the LDSW the truth. Judith said she had been in bed asleep when the LDSW visited, and they were concerned about Peter who they described as unhappy and always crying. The main issue was described as the problematic behaviour of her husband which had been going on for some time. This information was shared with the LDSW via email. Judith then phoned the LDSW to apologise for being rude at the last visit. She said that

[18] See: https://www.macmillan.org.uk/?gclid=CjwKCAjwzPXlBRAjEiwAj_XTEbrrLidHUDH1zsmn3TFeG4B9FEZ7q2XEst_JlV4IrEF4uaikXYxlNRoCg7AQAvD_BwE&gclsrc=aw.ds

	she was concerned about Ron's behaviour and mental health. Judith said she was upset because Ron pretended that there were no problems and they were coping. Judith said she appreciated the help and suggestions made by the LDSW but most of these had been unsuitable for Peter and although she might consider Day Services there were none that could meet his needs.
5th February	The LDSW visited with the Maximising Independence Worker to discuss the phone call by Judith alleging that Ron manhandled Peter. Ron said that he would never hurt Peter and the LDSW noted the warm and caring interactions between them. Peter seemed settled and was occupied with his records. Judith was agitated and angry with Ron, making comments that he was not a nice person and was nasty to her. The LDSW did not seek to explore these concerns with Judith alone. The parents said they would not have the bathroom adapted to a wet room and again dismissed suggestions of help. Judith followed this visit up with a phone call to the LDSW that afternoon asking for the phone number of the Crisis Team as she said Ron was unstable. She alleged that he had not told the truth at the meeting.
20th February	The LDSW visited Peter and found him sitting in the car listening to music. He smiled at them and seemed happy. Judith reported that she had hit Ron because he had said some nasty things. Ron said he had retaliated by hitting back and said that it was Judith who was violent. The LDSW asked whether Judith had been in contact with the Domestic Abuse service and Judith said they were of no help. This was not explored further. Judith also expressed concerns about Ron receiving scam mail and that he would start sending money off to people again; she showed the LDSW a pile of mail that she had intercepted. The LDSW did not explore this with Ron.
21st February	The next day, Ron went to the local Police station to report that Judith was threatening to kill herself and Peter. He said that Judith had been diagnosed with cancer, was refusing treatment and wanted to die. The Police offered a home visit, which was declined. Ron said he just needed someone to talk to. Peter was in the car and seen by Police Officers. The Police Officer evaluated that there was no current risk.
24th February	Judith telephoned the LDSW Social Worker to report that Ron had said he would rather kill Peter than let "*social services*" take him. Ron telephoned 10 minutes later to say that he had not said this and that Peter was fine. The LDSW visited the next day and was greeted by a happy and smiling Peter who looked well cared for. The LDSW discussed Peter with both parents and noted there was a sense of uneasiness between them; home visits continued over the next few weeks, and although Peter was well and smiling, the tensions between the parents remained.
22nd March	In the early hours of the morning, Judith made a 999 call reporting that Ron was threatening to hit her and had been threatening her all the previous day, bullying her and raising his fists. The Police went to the home, and there were no injuries to Judith; she refused to complete the DASH risk assessment[19]. The Police had no immediate concerns but proposed that a Domestic Abuse Officer (DAO) would contact Judith; this did not happen. The Police Public Protection Unit[20] were informed of this incident but this led to no further action and the LDSW was not informed of this incident.
April	The LDSW continued to visit Peter who was observed to be often smiling and there was evidence that Ron had taken him out or was about to take him out. Tensions between Ron

[19] DASH stands for domestic abuse, stalking and 'honour'-based violence. The DASH risk checklist is an accurate and fast assessment of the danger victims of abuse are available at: http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face

[20] The Public Protection Unit is a dedicated Police resource for the investigation of concerns such as child protection, neglect and abuse, domestic abuse and adult safeguarding.

	and Judith remained and Judith had a number of health appointments during this time.
2nd May	Judith rang her GP and was argumentative on the phone. The GP visited and she had calmed down. Judith said she was feeling unsupported but denied thoughts of self-harm or suicide. The GP liaised with OACMH CPN Two and queried whether anti-depressants might be helpful. The GP asked that the CPN Two liaise with Psychiatrist One.
12th May	The LDSW visited Peter who had just arrived back having been out with Ron in the car. Judith said Ron had to provide all care to Peter and she was worried about the impact on him; she agreed to let the LDSW know if she ever got seriously worried about the pressure on him.
17th May	Judith phoned the Mental Health Team in a distressed state saying that Ron had been acting oddly and threatening to take her son Peter away. Judith said that Ron had been lying to the GP and social services and he was currently seeing a Psychiatrist because he had Schizophrenia and had an appointment on Monday. This was checked and it was found that Ron was not known to Psychiatric Services. Judith said that Ron was due back soon and would unplug the phone. She was asked if she felt at risk of harm and said that he had not been physically abusive to her but was mentally abusive. It was suggested that Judith go to a neighbours or friend's house to allow someone to call her but Judith said that her husband did not let her out and would follow her. The Mental Health Crisis Team said they would call Judith but were not sure when a home visit could be undertaken. The Crisis Team Acute Care Nurse phoned Judith at the end of the afternoon. Judith reported that her husband had been acting oddly and had threatened to move and take Peter away to live with him. She said she did not feel at risk and her husband had an appointment with a Psychiatrist. She was advised to ring the Psychiatric Service and inform them of her concerns. Judith said she regretted taking the overdose two weeks earlier and would never repeat this. The direct number of the Mental Health Crisis Team was provided.
27th May	The phone call to the Crisis Team was shared with the LDSW, but this incident was not discussed at the next visit to Peter. There is no evidence that there was a discussion with Judith about her experiences regarding emotional abuse that had been shared by the Crisis Team. Peter seemed happy and Judith updated the LDSW regarding her medical Hospital appointments.
June	Over the next few weeks, the LDSW visited Peter regularly and he seemed happy and well cared for. Judith attended her own appointments for possible secondary cancer and the medical opinion was that there was no need for chemotherapy at this point.
1st July	The LDSW and another team member visited Peter who was happy playing with special balloons in the kitchen. Judith told the LDSW that her Oncology Consultant had phoned her to say that her tumours were inoperable, and she thought Ron was in denial regarding this and added to her worries about who will care for Peter in the future. The LDSW and colleague reassured Judith that support could be put in place.
6th July	Judith left a message for Oncology staff asking for a telephone call; she had sounded very distressed and had asked if she was going to die. The Oncology Consultant phoned Judith to reassure her and provide information shared during the last hospital visit including that she had made very good progress and the cancer treatment had been completely successful.
13th July	Judith phoned the Carers Team to talk about Ron sending money in response to scam mail and that he was hiding the evidence. She was advised to call the Police but said she thought this would not work.

16th July	At the next home visit to see Peter, Ron spoke to the LDSW about current problems including that he had sent money in response to junk mail and had told Judith that he did not need her to help with caring tasks which had upset her. Ron said he had done this because Judith was not well. The LDSW then saw Judith on her own who confirmed the concerns about Ron responding to junk mail, which she referred to as a long-term problem. She said that Ron was stopping her from fulfilling her caring role and wanted to get rid of her. Judith also said that Ron was not physically harmful but said unpleasant things. Judith confirmed that the Oncology Consultant had told her that her life was not at immediate risk, but she would not accept any further treatment. She also said that she had thought of killing herself this week, "*but as it was happening anyway (because of cancer) she'd let it happen naturally*". That afternoon, Judith made a 999 call and asked for the Ambulance Service. She reported that she had taken an overdose of her son Peter's tablets because she felt unsafe from her husband who was controlling and abusive. She also reported ill health and caring responsibilities. Judith was taken to the Hospital. The ambulance crew made a referral to the Adult Care Safeguarding Team; they also spoke to Judith's GP and requested the GP consider giving advice about Domestic Abuse, a referral to the Substance Misuse Team, a referral to the Mental Health Team and a review of the overall Care Plan. Judith was seen by the Mental Health Crisis Team for assessment. She said that she had taken the tablets as a result of arguing with her husband, and she had become angry and upset. She said she had not had any thoughts of suicide and had rung for help immediately after taking the tablets. Judith was described as calm but a little tearful. The conclusion was that this was an impulsive overdose in response to social pressures with no intent to cause herself harm; therefore, there was no role for the team who organised transport to take her home. A letter was sent to the GP.
17th July	The next morning, the LDSW was informed about the recent overdose and sought advice from their Manager. It was agreed that they would check with the Adult Safeguarding Team about their planned next steps as a result of the referral from the Ambulance Service. The Adult Safeguarding Team said there were no concerns raised about Peter, but about possible Domestic Abuse and they needed to seek Judith's consent to undertake a DASH assessment. The LDSW said they would be visiting and it was agreed that there would be no discussion of the concerns regarding Domestic Abuse because it could impact on the progress of the adult safeguarding enquiry which would be undertaken by the Adult Safeguarding Team. The LDSW visited and asked to see Judith on her own; Judith said this had not been a serious suicidal attempt. She did say that some family members had committed suicide in the past. Peter was seen and appeared well. Ron confirmed that he was providing care to Peter and the LDSW said they would visit the next week. After this visit the LDSW's Manager sought advice from a Senior Manager. It was agreed that there would be a referral to the Adult Services Local Authority Legal Team to seek advice about whether Peter should remain at home or be moved to residential care. The LDSW rang over the next few days and was told all was well.
23rd July	The LDSW visited Peter with a colleague as planned the following week; he seemed well and was playing with his records. The LDSW said that a safeguarding referral had been made and the parents would hear from the team at some point. Judith walked to the car with the LDSW and said that Ron was always angry but was different when professionals were there. She said she felt lonely and had rung the Samaritans but they were "useless". The LDSW suggested finding a group to join and Judith appeared keen to do this.

	The LDSW updated the Adult Safeguarding Team about recent events and asked about the progress of the adult safeguarding process; they were told the referral was awaiting allocation because the team was very busy.
28th July	Judith contacted the Carers Team to report again her concerns about Ron sending money in response to scam mail. The next day two LDSWs visited (they were covering for the allocated LDSW). Judith was confused about who they were and phoned the Carers Team again because she thought these Social Workers were visiting in response to concerns about the scam mail, but they had not mentioned this or discussed Peter being safeguarded. The Carers Team recommended that Judith speak to the post office about the scam mail. Judith raised this issue of scam mail again with the LDSW when they visited that day and said she had not been able to speak to anyone; she said she had intercepted a huge bagful of mail to stop Ron from responding.
3rd – 11th August	There was extensive planning and support regarding Peter having a dental operation with the Learning Disability Acute Liaison Nurse.
11th August	Judith telephoned the LDSW to allege that she had found that Ron was accessing telephone female chat lines and sending money to scam mail remained a significant issue. Judith said that when she raised this with Ron he became aggressive. Judith reported that she managed her own and Peter's finances and therefore, the money Ron spent on scam mail were not currently having an impact on the family finances but she was worried for the future. Judith was advised to discuss this with Citizens Advice Bureau (CAB)[21]. The LDSW asked if Judith had heard from the Safeguarding Adults Team and she said she had not but did not see why this was necessary. The LDSW reiterated that they needed to assess recent concerns. The LDSW proposed that they ring the Safeguarding Team at this point, but Judith said she did not want to. Once again respite care/short breaks were discussed and Judith said she believed that Ron would not allow it.
20th August	The Learning Disability Acute Liaison Nurse One (LDALN) visited to plan for Peter's dental operation in six weeks' time. Judith and Ron were worried about this and reassurance was provided. A comprehensive care plan was developed and a mental capacity assessment of Peter undertaken. Judith talked of her ill health and that Ron was a difficult man, that she had recently taken overdoses and was worried about Peter's care in the future if she or her husband died. The next day, Judith phoned LDALN One because she was confused about the care plan and how to help Peter be calm before coming to the Hospital. It had been agreed that Ron would ask the GP to prescribe medication, but Judith said she was against this decision because it was too difficult to get a GP's appointment and she would give Peter some of her own medication. The LDALN One strongly advised against this, but Judith was not prepared to change her mind. The LDALN One was unhappy about this and spoke to a Senior Nurse. Contact was made with the Hospital Safeguarding Team and a referral made to the Adult Care Safeguarding Team. This referral provided details about concerns regarding attitude to medication, Judith's ill health, recent overdoses and that both parents had mental health problems. The LDSW was also informed about the referral.
21st August	The Adult Safeguarding Team emailed the LDSW regarding the recent safeguarding referral and noted the parent's anxieties regarding the forthcoming operation. The Safeguarding Team asked whether it would be best for the LDSW to discuss the concerns with Judith or whether a joint visit should be undertaken with the Safeguarding Team to reinforce the

[21] Citizens Advice is an independent charity that gives free, confidential information and advice to assist people with money, legal, consumer and other problems. See: https://www.citizensadvice.org.uk/

	concerns or a Best Interest meeting. The LDSW sought advice from their Manager and it was agreed that they would discuss the concerns first with Judith. On the same day, the LPFT[22] Safeguarding Team contacted the LDSW to also ask about the progress of the safeguarding referral. They were informed an appointment had been made by the Safeguarding Team with Judith and Ron on the following day to discuss both recent referrals (which were about different issues).
24th August	In the early hours of the morning the fire occurred, was responded to appropriately, medical care was provided to Peter and Ron and all professionals were informed of this incident.

4 ANALYSIS

Introduction

4.1 The focus of this section of the report is an analysis of the professional response of the professionals and agencies involved with Peter, Judith and Ron. This analysis draws on the IMRs produced by those agencies involved and use the terms of reference as a framework to explore why decisions were made and actions taken or not taken. The Overview Author and Review Panel has made every effort to avoid hindsight bias and have tried to understand the evolving circumstances as they would have been seen by professionals and agencies at the time. The purpose is to establish whether there are lessons to be learned for the future about the way that professionals and agencies work individually and together to safeguard victims, address perpetrator behaviour and safeguard adults with care and support needs. The original terms of reference are outlined at the beginning of this report and these have been amalgamated into six key themes which are outlined below.

Themes	
1.	**Working effectively to assess and address Domestic Abuse and its impact on the needs of adults with care and support needs.**
2.	**Effective adult safeguarding.**
3.	**The application of the Mental Capacity Act 2005 and ensuring decisions are made in the best interest of individuals with care and support needs.**
4.	**Ensuring that adults with care and support needs are enabled to communicate effectively and their communication style is maximised.**
5.	**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.**
6.	**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.**

Theme 1: Working effectively to recognise and respond to Domestic Abuse

4.2 There was a long history of concerns about domestic abuse from 2006 onwards. This SAR/DHR looks in close detail at an 18-month period of time; there is evidence that Peter was both a victim of Domestic Abuse from his parents and also there is evidence of the negative impact of Peter being present when Judith and Ron were domestically abusive to each other. There was a long history of disclosures by Judith of being domestically abused by Ron and also evidence that Judith was domestically abusive to Ron. There were three key issues here:

- The extent to which the Domestic Abuse of Peter was addressed and responded to;

[22] Lincolnshire Partnership NHS Foundation Trust

- The impact of long-term Domestic Abuse on Peter's wellbeing and how well that was responded to;
- Addressing the domestically abusive behaviour of Judith and Ron.

Peter as a victim of Domestic Abuse

4.3 Peter was subject to Domestic Abuse from both his parents. They both threatened to kill him rather than allow him to be looked after by services or move to residential care. This abuse was never sufficiently addressed. Research suggests that adults with Learning Disabilities are at increased risk of Domestic Abuse but less likely to come to the attention of preventive and support services[vii].

4.4 Judith made two threats to take Peter's life and her own life, reporting that she did not believe anyone else could care for him and was worried about his future. The first incident in April 2014 led to Judith being arrested initially for threats to kill. She was subsequently assessed by the Mental Health Team; the conclusion drawn and accepted by those involved at the time was that Judith's actions were a cry for help, caused by the stress of caring for Peter and her difficult relationship with Ron. It was agreed that there would be increased social work visits. There was no discussion about Peter's lack of capacity to keep himself safe given his total dependence on his parents for his care, and therefore what the implications were for his future safety.

4.5 However, Judith took a second overdose the next day and a safeguarding referral was made; this was an appropriate response and would have been an opportunity for all agencies to share current concerns for Peter, review historical information and would have put the current incident into a wider context of the complexities of the family circumstances. The safeguarding referral merged into the ongoing plan for support, and although a Safeguarding Strategy Meeting was proposed, it did not take place. The lack of this Multi-Agency Safeguarding Meeting meant that there was no discussion or analysis of the ongoing risk that Judith might pose to Peter.

4.6 This risk was not recognised because both parents were seen as caring deeply for Peter and feeling stress as a result of their significant caring responsibilities. This was real but there needed to be an evaluation of the risk of Domestic Abuse to Peter. A meeting was planned to discuss the family circumstances but was delayed and by the time it took place the perceived crisis was over, and the focus was on ongoing support. The threats to kill and the risk this posed were not discussed, because this was inappropriately not considered to be a safeguarding response.

4.7 In February 2015, Ron told the Police that Judith was threatening to kill herself and Peter. Ron was offered time to talk, Peter's wellbeing was assured, and Ron said he did not believe Judith actually posed a risk but was seeking help. At the same time, Judith told the Social Worker that Ron had said that he would rather kill Peter than allow Adult Social Care to take him away. Judith reassured the Social Worker that these incidents was due to the pressures they were feeling. Neither Judith, nor Ron was challenged about these threats and what they meant for Peter's safety. Their assertions that the threats were a cry for help were accepted at face value, and the absence of a risk assessment meant the discrepancy between this cry for help and the refusal to accept services was not voiced or explored. The Domestic Abuse risks posed by Judith and Ron to Peter were not sufficiently discussed or addressed; and Judith and Ron were not challenged about the meaning for Peter's wellbeing and safety. Peter's right to safety as an adult with Learning Disabilities was not voiced.

The impact of Domestic Abuse on Peter

4.8 In all the circumstances, where there were concerns about threats to harm and Domestic Abuse, professionals ensured that Peter had not been physically harmed. There was less emphasis on the possible emotional/psychological impact of witnessing or him being aware of the Domestic Abuse and significant conflict between his parents. There is no available research regarding the impact of witnessing Domestic Abuse by adults with profound disabilities. There is only research available regarding the seriously negative impact and harm living with Domestic Abuse causes children and young people[viii] and this has led to the Adoption and Children Act 2002, clarifying the definition of significant harm as being caused by witnessing the ill-treatment of another person such as Domestic Abuse. This research does not speak to the experiences of adults with Learning Disabilities, but given the lack of research in this area, it provides some parallels about the potential impact of witnessing and hearing Domestic Abuse and how seriously this should be taken.

4.9 The core agency was Adult Social Care Learning Disability Team and in 2013 a risk Assessment and Management Plan was developed to address what was described as the parents' volatile relationship

and the likely impact of this on Peter, which was said to be physical, psychological and emotional harm. This was a clear analysis that indicated a need to assess and address the Domestic Abuse and the likely impact on Peter. This did not happen because Judith felt aggrieved by this risk assessment and was unwilling to accept further help and support. This meant the task for the new LDSW was to rebuild the relationship with Judith and Ron and build trust to enable them to access support. This influenced the response to both Ron and Judith over time.

4.10 There was evidence that Peter was experiencing emotional harm as a result of the Domestic Abuse and conflict at home. In April 2014, Judith and Ron were concerned regarding deterioration in Peter's behaviour and that he had become more aggressive at home, slapping and pinching them. An appointment with Psychiatrist One was organised by the Social Worker. At this appointment which was with Psychiatrist Two Ron described arguments at home and the overdoses taken by Judith; the Psychiatrist asked if Peter's behaviour might be in response to this. Ron agreed that Peter did go to his bedroom and get into bed when there was a lot of shouting. The Psychiatrist suggested that short breaks/respite care might be a good idea, but Ron refused this help for Peter. This was a helpful insight from the Psychiatrist, which does not appear to have been shared with the Social Worker, and although the GP was informed of the outcome of this appointment the full detail of the concerns about this was not shared. Ultimately, it was decided that Peter's complex behaviours would be addressed through the provision of medication, and the issue of the likely impact of Domestic Abuse not addressed.

4.11 The possible impact of what was described as conflict at home was discussed at the meeting held in May 2014, but it was agreed that the LDSW would contact the Day Centre that Peter had attended to see if he had been aggressive there. This was done and information that he was aggressive and unhappy at times seems to have been reassuring, rather than a possible reflection that this might reflect historical concerns about Domestic Abuse.

4.12 In May 2014, the LDSW was concerned about Peter and observed that he was "*dry crying*"; it is not clear what this meant but the LDSW believed that he was upset. Judith reported further anger and aggression by Peter. The discussion, however, focussed on whether this might be an indication of the onset of Alzheimer's or Dementia not on the possible impact of Domestic Abuse.

4.13 Peter was seen again in the outpatient psychiatric clinic by a different Psychiatrist and his aggression and unhappiness was again discussed. This time it was considered that Peter might be depressed and different medication was prescribed to address this. Peter was seen again in October 2014, with Ron, the LDSW and the LDHN. Peter appeared agitated and the LDSW thought that he was again "dry-crying" or behaving in a way that expressed distress. Ron explained that this might be because Judith was unwell and he said, "*Peter picks up the atmosphere at home*". There was no further discussion of the potential impact of the Domestic Abuse on Peter.

4.14 The issue of the likely impact of Peter living with constant conflict, abuse and arguments was not sufficiently assessed, analysed or addressed.

Domestic Abuse of Judith by Ron

4.15 There was a long history of Judith telling professionals that she was being domestically abused by Ron dating back to 2006. In the period of 2006 and 2014 these allegations were routinely addressed through Police action to risk assess each incident as it occurred. The risk in each incident was graded as standard using the DASH risk assessment tool and therefore did not meet the threshold for MARAC involvement. There were also three safeguarding alerts in this historic period which included concerns about Domestic Abuse. Judith was signposted to local Domestic Abuse services and support which she never felt able to take up. There was little discussion about why this was and what the barriers were for her. She was at this stage aged 61 and this may have been an opportunity to explore the impact on her as she aged but this was not considered.

The limited pool of research which exists regarding Domestic Abuse and older people suggests that older women's experiences of Domestic Abuse are different from those in the younger age group[ix]. These differences include an older woman's understanding of Domestic Abuse, the potential longitudinal nature of their experiences and that most resources and sources of support are targeted at younger women.

These may all have been issues for Judith, but she was never asked and there was no analysis of the impact of her age on her ability to continue to care for Peter and safeguard herself and Peter. This would continue as a gap in practice throughout the subsequent years.

4.16 There was also a clear pattern emerging from 2006 onwards of Judith having suicidal thoughts and acting upon them. Although she received help and support on each occasion, and her mental health was assessed, no connection was made between her suicidal feelings and her allegations of Domestic Abuse.

4.17 From March 2014 onwards Judith often raised concerns about Domestic Abuse in the context of a crisis or period of heightened tension which was often perceived to be connected to stress related to her caring role for Peter. The focus would be on solving the immediate crisis and not the Domestic Abuse or how they were connected. There would then be periods of calm, where a picture of harmonious family life was observed; Peter always appeared well cared for and was described as happy. This reassured those professionals involved with Judith and there was no further exploration of Domestic Abuse.

4.18 During these crises Judith told many professionals that she had a difficult relationship with Ron including Hospital staff, the ambulance crew and the OACMHT CPN. Appropriately, the CPN asked if she would like to talk without Ron being present but Judith declined. Judith also saw the GP and then the LDSW and told both about relationship difficulties with Ron. The consensus of professional opinion was that the relationship difficulties were likely caused by the stress experienced by Judith and Ron, who were in their 70's, providing full-time care to Peter rather than incidents of Domestic Abuse that needed assessment and action.

4.19 The pattern of Judith talking to professionals about Domestic Abuse, but then denying feeling afraid and being unable to access support without exploration of why; this classic indicator of Domestic Abuse needed further analysis by the professionals involved with Judith and an exploration of why it was so difficult for Judith to access services.

There was a crisis led approach which meant that concerns about Domestic Abuse got lost and that no collective multi-agency picture was formed. There were no multi-agency meetings convened because once a crisis had been dealt with and the immediate concerns addressed, there was no multi-agency network to call upon.

4.20 The controlling or coercive behaviour by Ron was not sufficiently explored, analysed or addressed. There was considerable evidence that Ron threatened to leave and take Peter away. In discussion with Ron as part of the SAR/DHR Ron talked about his jealous behaviour towards Judith and this caused him to stop carers to come into the home for Peter and, for example, meant that he rejected any work on adaptations to the home.

4.21 In April 2014, Peter's LDSW was concerned about the continued conflictual relationship between Judith and Ron. They tried to discuss this with Judith who was reluctant to talk as she was still feeling distrustful of Social Workers. However, soon after Judith asked the LDSW for the contact details of the Adult Safeguarding Team because she said Ron was controlling her and emotionally abusing her. This was a clear disclosure of Domestic Abuse, which should have been contextualised alongside the available historic information and recent risk assessment. Judith had also asked for help, something she did not often do. This was an important moment and opportunity to get Judith the help and support she needed. Instead of which professional practice went back to the crisis driven approach, reacting to these, not recognising that Domestic Abuse was the heart of the issue.

Ron's allegations of Domestic Abuse by Judith

4.22 There were also allegations by Ron that he was the victim of Domestic Abuse by Judith; he shared his concerns with the Adult Social Care Team and the Police, but not with any other professional. These allegations do not appear to have been taken seriously enough or explored with him further and his experience of Domestic Abuse remains unclear. This was discussed with him as part of the consultation for the SAR/DHR and he did not feel able to discuss this aspect of the past. The Adult Social Care Author reflects in the IMR, produced as part of the SAR/DHR, that there was evidence of gender bias regarding the abuse of men which went unrecognised and this was an influencing factor in recognising Ron's experience of Domestic Abuse. There is clear evidence that men do experience Domestic Abuse and that this often goes unexplored and unaddressed.[x] Perpetrators of abuse often use tactics of counter allegations to perpetuate abuse, leading to professionals interpreting incidents

as situational violence, and mistaking Domestic Abuse as 'relationship difficulties' or 'carer stresses'. This was evident with both Judith and Ron.

4.23 Effective practice suggests that the focus of professional attention needs to be on enabling disclosure, addressing the safety and wellbeing of victims, and addressing the risk posed by perpetrators[xi], an effective analysis of the type of Domestic Abuse being seen and therefore the appropriate response. This is important because Domestic Abuse is a serious issue which affects women[xii], men[xiii] and children[xiv]. There is considerable evidence regarding the negative long-term effects on people's safety, mental health and physical health and wellbeing. Despite this serious impact, there is also considerable evidence that there are barriers for victims in talking about Domestic Abuse, the harm they experience and seeking help. In part, the barrier comes from many adults feeling uncertain about what Domestic Abuse is and the influence of both a sense of shame and the coercive and controlling behaviour of perpetrators. There are particular barriers for adults with care and support needs and whose different communication style has not been enhanced, such as for Peter. It is critical therefore that all professionals support victims to disclose Domestic Abuse, provide the right circumstances to enable this to happen and be prepared to notice when adults with care and support needs are being domestically abused.

4.24 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:

- It is essential, as a result of this SAR/DHR, that thought is given to supporting professionals to have an understanding of the different types of Domestic Abuse to enable an effective analysis and the appropriate response. Within case records there is little analysis of description of the Domestic Abuse, no analysis of coercion and control, emotional abuse or financial abuse.
- 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 means; and requires robust challenge as possible euphemism for Domestic Abuse and there should always be a DASH completed.
- 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.
- 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.
- There is evidence here of gender bias and a lack of recognition that men may be experiencing Domestic Abuse or may be making counter allegations to deflect attention.
- 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.
- 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.
- It is not clear whether Judith's age was a factor because this was not mentioned by those interviewed as part of this SAR/DHR and was only discussed in one agency Individual Management Review. However, it is the view of the Independent Author that Judith's age was a contributory factor in how Domestic Abuse was understood. Research[xv] highlights the significant impact of Domestic Abuse on older women and the many barriers they face in making disclosures. Again, this was not mentioned by any of the IMR Authors who interviewed professionals who were involved, but Judith's circumstances highlight the importance of taking Domestic Abuse in older age seriously.

- There was also a lack of connection made between Domestic Abuse and Judith's suicidal ideas, and actions which should have been robustly addressed and her support needs understood.
- The importance of good quality and effective supervision to enable professionals to undertake this complex task.

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;
- To have an understanding of the typologies of Domestic Abuse to enable an effective analysis and the appropriate response;
- Are provided with appropriate supervision to undertake the complexities of the task.

Theme 2: Addressing Adult Safeguarding Needs

4.25 During the 18-month period under which Peter's circumstances were considered there were four incidents of concern where a safeguarding response was considered but which was either not discussed with the Adult Safeguarding Team or was deemed not to meet the criteria for a safeguarding response. There were three incidents that should have been subject to advice regarding the potential for a safeguarding referral to be made. There were also four incidents where there were direct threats to Peter's safety. It is clear that each incident in the period under Review was treated individually and was not seen as connected incidents or analysed in a holistic way.

4.26 The Guidance in place at the beginning of the SAR/DHR was *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (2000)[xvi]. No Secrets made clear the importance of ensuring that vulnerable adults who are at risk of abuse and neglect receive protection and support. This guidance defined abuse as "*a violation of an individual's human and civil rights by any other person or persons*". It goes on to say that abuse can consist of a single act, may be physical, verbal and psychological; and can occur in any relationship and results in significant harm to the individual. The Care Act 2014 and attendant safeguarding responsibilities was implemented in the six months before Peter and Judith died. The Care Act 2014[xvii] says that Adult Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. The Care Act 2014 requires that each Local Authority must: make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent abuse or neglect, and if so, by whom.

4.27 The first stage of ensuring the safety of adults is to notice abuse. No Secrets and the Care Act 2014 highlight that it is the responsibility of all professionals, as well as family and community members to act on suspicions or evidence of abuse; in Lincolnshire this means discussing concerns with the Safeguarding Adults' Team and evaluating whether a safeguarding enquiry is required through the sharing of all available information. This did not happen when Judith made threats to kill Peter in April 2014. A home visit was undertaken and the LDSW and their Manager were reassured by Judith and Ron that these threats were not real. The Police believed a Strategy Meeting was planned. This would have allowed professionals to step back from the current crisis and evaluate what was known, what was needed to be known; and to signal to Peter and Judith that these incidents were serious and required investigation and an evaluation of the risk posed by Judith.

4.28 Advice was sought from the Adults Safeguarding Team as a result of Judith taking the second overdose. There were no threats to kill, but this was an escalation of serious concerns which matched similar historical actions. This was said not to meet the threshold for safeguarding action; there was multi-agency confusion about this, with the Police still considering that there was likely to be a safeguarding response. A meeting was held, but not under the adult safeguarding procedures and importantly neither Judith nor Ron were informed that it was taking place. This decision was made be-

cause of concern that this would further entrench their distrust of Social Workers. The plan was to continue with monitoring visits; a safeguarding response was required.

4.29 Ron visited a Police station in May 2015 and told Police Officers that Judith had said she would take her own life and kill Peter. In the same month, Judith told the LDSW that Ron would kill Peter rather than allow Adult Social Care to remove him to a residential setting. These were serious threats to Peter's safety and wellbeing. The decision not to make a safeguarding referral was based on a belief that these threats were "*a cry for help*" and indicative of carer stress without evaluating all the available information. Professional judgement needs to be used in all circumstances, but the purpose of a discussion with the Safeguarding Adults' Team is to test the evidence with an open mind and in these circumstances, the referral should have been made and a Strategy Meeting convened.

4.30 There were concerns raised by Judith about Ron manhandling Peter in January 2015 where a safeguarding response was considered, but ultimately the LDSW was again reassured that neither parent intended any harm. The contact with the Adults Safeguarding Team was not made.

4.31 There were two incidents where Judith herself sought to have contact with the Adults Safeguarding Team. One in April 2014, where she reported concerns about Domestic Abuse; this was thwarted by confusion and a second incident where she reported swatting Peter with a wet dishcloth and Judith reported this to the LDSW because she believed this was a safeguarding concern. A home visit was undertaken, and it was agreed that this would be discussed in the meeting in May 2014. In the event, this led to no further action. This second incident, appeared on the surface, to be minor but came soon after the threats to kill and overdoses in April 2014.

4.32 In July 2015, the Ambulance Service made a referral to the Safeguarding Team when Judith reported feeling unsafe with her husband when she had taken another overdose. This referral was accepted, but action was delayed because of workload pressures. The LDSW provided support to Judith during this time, but they were advised not to discuss the Domestic Abuse or explore the risks to Peter because this was the task of the Adult Safeguarding Team. There was a further safeguarding referral made by the LDALN One in August 2015 because Judith had disregarded advice about seeking medication from the GP for Peter's forthcoming dental surgery. This referral was not actioned before the critical incident.

4.33 Ron did not meet the criteria for being a vulnerable adult but there were ongoing concerns that he might be being financially exploited through scam mail. This concern was raised as a concern by Judith historically and raised again by her in February 2015, when Judith said Ron was sending money to scam mail companies and this was causing arguments. In July 2015, Ron talked to the LDSW about his worries regarding scam mail and needing help to address it. Judith also spoke about her growing worries. They were advised to seek help from the Citizen Advice Bureau (CAB), Judith also phoned the Carer Team and they advised talking to the post office. Judith and Ron did not seek advice from either agency and it is unclear if either the LDSW or the Carers Team checked on progress.

4.34 In August, Judith highlighted there had been an escalation, with Ron also allegedly using chat lines. Judith reported that this was not currently having an impact on the family finances (though financial pressures had been discussed) but she was worried that it would do so in the future; she also indicated that this was an additional stress which was impacting on relationships and causing arguments. She was advised to seek advice from CAB. She did not seek advice.

4.35 Scam mail is a serious issue which has the capacity to impact financially and emotionally on individuals. Anyone can fall prey to this kind of exploitation but the old, isolated and vulnerable are most likely to be affected. This concern should have been addressed more robustly. Professionals needed to be more proactive in addressing Judith and Ron's concerns. Lincolnshire Trading Standards is a key resource that can be used now.

4.36 Overall, this was a complex set of circumstances. The safeguarding concerns were evaluated individually in an incident led way, and the concerns were often evaluated in the context of carer stress and the parents caring approach to Peter.

4.37 Current practice can learn from recent guidance from the Association of Directors of Adult Social Services (ADASS) which suggests that professionals evaluate the seriousness of the risk to an adult with care and support needs by considering the intention of the adult about whom there are allegations. Research has suggested that where professionals perceive likely harm as unintentional there can be

a lowering of concerns. This appears to be the case here. The incident focus and analysis of carer stress meant that the potential and likely cumulative impact of risk and harm was not identified.

4.38 Making Safeguarding Personal[xviii] is clear that safeguarding action should focus on the individual about whom there are concerns and establish what needs to happen to establish whether a person is being abused or at risk of abuse. In a number of the safeguarding referrals made, Judith and Ron were able to reassure professionals that they cared deeply for Peter and would not harm him. The purpose of a safeguarding enquiry is to evaluate all the available information from a multi-agency perspective and to take into account the perspective of the adult with care and support needs. Neither of these things happened. The multi-agency network (which was involved at moments of crisis) was not consulted or asked their views and nor was Peter's perspective explicitly taken into account. The next section focusses on the Mental Capacity Act 2005, but in the context of evaluating the need for a safeguarding response there was no explicit discussion of Peter's capacity to take part and given the assessment, would have likely concluded that he lacked capacity at that time to contribute to a safeguarding enquiry, who would best represent his views and needs. There was a clear need for advocacy and possibly an Independent Mental Capacity Advocate.

4.39 In the circumstances where it was decided that safeguarding enquiries were unnecessary, there remained concerns about Peter, Judith and Ron's circumstances which required further analysis of the current risks, discussion and planning. However, the decision not to undertake the safeguarding enquiries meant that there was no multi-agency discussion about what else needed to be put in place; with the exception of what was termed the Best Interests Meeting (which in fact was not a Best Interests Meeting) which concluded that the existing approach was the right one. It is critical, that where concerns are expressed about the safety and wellbeing of an adult with care and support needs, but the threshold for safeguarding action is not met, that the Adult Safeguarding Team contributes to a discussion about what next steps are necessary, including further assessment or an early help plan; something that did not exist at the time. The Safeguarding Team also need to provide feedback to all referrers about why safeguarding action is not necessary. The referrer and any other involved professional should then evaluate whether further challenge is necessary, and ultimately whether the Safeguarding Adult Boards' escalation policy should be used.

4.40 This all exists. The role of the Adult Safeguarding Team is to provide support and advice regarding safeguarding matters to professionals working in Adult Social Care and external partners. Since April 2018, referrers have been provided with feedback about the outcome of referrals and the rationale for decision making. A recent audit undertaken by the Independent Chair of the LSAB suggests that the majority of referrals received by the Adult Safeguarding Team are being assessed appropriately, but in some cases, there was the need for an alternative forum for discussing concerns. There is current work commissioned by the LSAB and Adult Social Care focussing on considering what is currently on offer in respect of early intervention and prevention. Adult Social Care is in the process of developing an approach to intervening before safeguarding enquiries are necessary. Work is also underway to strengthen the use of Strategy Meetings. These are all relevant to Peter's circumstances.

4.41 There are policies and procedures in place 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.

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 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.

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.

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 some 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.

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.

Theme 3: The application of the Mental Capacity Act 2005 and ensuring decisions are made in the best interest of individuals with care and support needs.

4.42 The Mental Capacity Act 2005 (MCA)[xix] outlines people's rights to make decisions and choices; and their rights to have decisions and choices made for them in their best interests if they lack the mental capacity to be able to make these decisions for themselves. The core task for all professionals is to establish an individual's capacity to make a range of day to day and complex decisions through a Mental Capacity Assessment. This assessment must focus on a specific decision at the time it needs to be made. It is critical that there is not a prejudgement made that an individual lacks capacity in all circumstances and therefore a capacity assessment is not needed when new decisions are required. Mental Capacity must be evaluated in all circumstances and recorded where these decisions are complex.

4.43 There were many occasions when there should have been more explicit discussion and recording about Peter's mental capacity. On each occasion, this should have led to discussion about whether he had capacity to make the current decision, at the current time and if not, who should make the decision and what was in his best interests. There were many discussions held by Adult Social Care about the need for a professional to provide Peter with more opportunities to access the community; there were also discussions about whether he would be better off in residential care, how his communication needs could be enhanced and whether he was at risk of abuse and harm. Peter's capacity was assessed in regard to taking part in the annual assessment[23] of his needs, but there was no reflection in the assessment of his capacity within the needs related to personal care, emotional and physical wellbeing, communication and links with the community and how his capacity needs would impact on the completion of the set goals. The guidance in place at the time suggests that the Review should "[e]*stablish whether the outcomes identified in the support plan are being met through current arrangements".* In the section on Community, it is acknowledged that Peter was extremely

[23] This annual review took place before the implementation of the care Act and was undertaken under the "Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care Guidance on Eligibility Criteria for Adult Social Care, England 2010".
https://webarchive.nationalarchives.gov.uk/20130105061723/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113155.pdf

isolated and that the required outcome was for him to be supported to access the community through the use of services being sought. It was not acknowledged that Judith and Ron were not accepting of any services and so were actively preventing this, and many other outcomes, being achieved. This required a more explicit discussion of an assessment of Peter's mental capacity to take part in decisions about his own outcomes and if this was not possible what was in his best interests.

4.44 Peter did not receive an Annual Learning Disability Health Check[xx] from the GP which could have been another opportunity to consider his needs and capacity to make decisions and who would support what was in his best interests. GP practices do not have to offer this service but National Health Service England (NHSE)[xxi] has set a national target of 75% of adults with Learning Disabilities to have an Annual Health Check. The importance of this is underpinned by the Confidential Inquiry into premature deaths of people with Learning Disabilities[xxii] and their finding that this group of adults are at risk of premature death.

4.45 Peter was seen by a Psychiatrist regarding agitation and displaying complex behavioural issues regarding medication were discussed for him. There were concerns expressed about the impact of the parent's conflict and the atmosphere at home but there was no discussion about undertaking a mental capacity assessment with Peter regarding the decision to take the medication.

4.46 A Mental Capacity Assessment of Peter was appropriately undertaken by the LDALN in preparation for developing a care plan and support package for a dental operation.

4.47 In many circumstances, it was accepted that Peter lacked capacity without a formal capacity assessment and that his parents were acting in his best interests. This evaluation did not meet the requirements of the MCA because it was not formally based upon Peter's assessed needs or wishes and feelings.

4.48 If an individual is found to lack capacity, then someone else will need to make the specific decision on the individual's behalf. This individual is known as "*the decision maker*" and can be a family member, partner, friend or professional. In undertaking the role of making decisions on behalf of another, the MCA makes clear that this should be demonstrably in their best interests, based on relevant information about their needs, the views and professional expertise of relevant others; and also, that the needs, wishes and feelings of the individual must be at the centre of decision making (MCA Code of Practice)[xxiii] and the final decision must be based entirely on their best interests. It cannot be based on what others believe their best interests are.

4.49 The MCA Code of Practice makes it clear that any professional involved with an individual who lacks capacity should make sure that a record is kept of the process of working out the best interests of that person including how decision were arrived at, how they align with the assessed needs of the individual, the reason for reaching the decision about best interests and who was involved. There is a clear process where there is uncertainty about what the best interests of an individual might be and this is called the Best Interests Meeting. This meeting must follow the Best Interest Checklist contained in the MCA Code of Practice.

4.50 There was considerable evidence that the parents were not always acting in Peter's best interests despite their care. In May 2014, a meeting was called to discuss the concerns arising from Judith's overdoses and threats to kill Peter. This was initially meant to be a Strategy Meeting but because it was not being convened by the Adult Safeguarding Team it was called a Best Interests/Multi-Disciplinary Meeting. Judith and Ron were not invited, despite being seen as the decision makers for Peter. There are no minutes therefore it is unclear the extent to which this meeting adhered to the Best Interests Checklist. There are actions recorded which are based on Peter's needs and circumstances, but these actions were not reviewed and decisions were not made. This meeting did not address the issue of Peter's best interests and no further Best Interest Meetings were considered or held.

4.51 This was a complex set of circumstances where an adult had considerable care and support needs, and parents who were mistrustful of professionals, and often dismissive and hostile. They explained this as being due to professionals, in the past, not providing appropriate care to Peter and not meeting the high standards they set. There was considerable evidence that Judith and Ron provided good quality physical care, but there were concerns about emotional care, lack of focus on independence and possible abuse. That is precisely why well planned, well-structured Best Interests Meetings were required which were focused on the assessed needs of Peter, drew on all available and relevant information about the whole family circumstances and which had Peter's needs at the centre.

4.52 Peter was an adult when the Mental Capacity Act 2005 was implemented. His parents had been making decisions for him his whole life, and when he turned 18 there would have been no requirement to plan for the transition into adulthood, and consideration of mental capacity and his best interests[xxiv]. The LSAB might want to consider how many adults are living in these circumstances and whether their mental capacity needs are being addressed and their best interests considered by all agencies.

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 CCG, although there is uncertainty about the extent to which these health reviews address issues of mental capacity.

Recommendation 6

LSAB should seek assurance from Adult Social Care:

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

Recommendation 7

LSAB should seek assurance from 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.

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.

Theme 4: Ensuring that adults with care and support needs are enabled to communicate effectively and their communication style is maximised

4.53 All adults deserve to be able to communicate in ways that recognise their unique needs and circumstances, and this is particularly true of adults with care and support needs. Peter had profound Learning Disabilities and was known to communicate non-verbally. It is unfortunate that plans in 2005 to support Peter to learn some specific communication techniques did not go ahead because of Judith and Ron's reluctance to engage with the speech and language service. In 2008, there were

also discussions held within his Day Care setting, that it was important that he was enabled to learn non-verbal communication skills but this was not actioned before he left the Day Care setting and he did not attend any other day activities.

4.54 During the time under review there was a lack of understanding of Peter's communication style, what his profound disabilities meant for the best approach to maximise his non-verbal communication skills and there was no plan to help him develop his communication skills or thoughtful discussion of how best to communicate with him. Professionals did spend time with him. The LDSW always engaged with Peter on every visit, and they tried hard to understand his moods. The care plan and the annual assessment completed in 2014 and 2015 noted his non-verbal approach, which Judith and Ron could understand and interpret some of his moods, but not always successfully and acknowledged that his parents communicated for him. There was no commentary regarding how professionals could communicate effectively with Peter or make sense of how he was feeling. There was no plan noted about how to address this.

4.55 Peter lived in a turbulent household. There were arguments, some violence, the Police and ambulance service arrived often in the early hours of the morning. There was a lack of reflection on what this might mean for Peter and his wellbeing. There was evidence that he was stressed and upset. The LDSW reflected that he was observed to "*dry cry*" on occasions and there was deterioration from April 2014 in his behaviour which had become more unsettled and aggressive. This change was addressed through contact with the Psychiatrist but the solutions were medical ones. He was not enabled to communicate his feelings about life at home and the lack of focus on developing his communication skills meant that this would have been difficult to achieve. He needed a professional to "*stand in his shoes*" and consider what life was like for him, as well as a plan to develop and maximise his communication skills so that he could indicate what life was like from his own perspective.

4.56 The Learning Disability Liaison Nurses (LDLN) were involved with Peter over a period of time to prepare him for medical interventions and ensuring his needs were met. In August 2015, the LDLN took a person-centred approach to support Peter in having a dental operation. A detailed care plan which focussed on Peter as an individual was developed fully, preparing professionals to address his individual needs for care and support. This was effective practice.

4.57 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.

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.

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 and the Care Act 2014.

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.

Theme 5: 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.

4.58 The caring responsibilities of Judith and Ron were significant. Peter needed complete help with all his personal needs, including managing his double incontinence, preparing food which addressed his swallowing difficulties, feeding him, dressing him, washing and meeting his hygiene needs (without the aid of an adapted bathroom as Ron and Judith had refused to accept help with this) as well as shaving. This included addressing Peter's needs in the middle of the night. Peter could not be left unsupervised for long and required some assistance to move around the house. He required almost 24-hour care. The records suggest that many of these tasks were not easy because Peter was not always compliant with this care. Ron and Judith are described as patient and caring in this role. When Ron was interviewed as part of this Review, he said that the role of caring for Peter dominated their lives, left them isolated but that he was not resentful of this. This was a task they had both undertaken for over 40 years. During the time under review they refused all help, and received only a small financial direct payment.

4.59 Ron was 72, 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.

4.60 A carer assessment was completed in 2013. This was insufficiently detailed and the attendant plan was not sufficiently focussed on the sustainability of the caring role given the known circumstances of ill health, older age and stress and there was no evidence that there was planning for the future given these circumstances. The existing guidance in place at the time (Prioritising Need in the Context of putting People First 2010)[xxv] advises Adult Social Care departments to grade the *"extent of risk to the sustainability of the caring role*" into one of four categories – namely *"critical, substantial, moderate and low"*[xxvi]. The grading system is a formal determination of the degree to which a carer's ability to sustain that role is compromised or threatened, either in the present or in the foreseeable future by the absence of appropriate support. If the results of a carer's assessment indicate that the carer has needs which pose a risk to the sustainability of their caring role, the Local Authority has a duty to consider whether or not to provide services to the carer. The circumstances of Judith and Ron met the criteria for critical risk of their caring role not being sustained. Although they were offered services and refused, this grading should have been acknowledged, incorporated into Peter's Annual Review and a risk strategy developed.

4.61 This carers plan was not reviewed as would be expected annually and therefore the carers plan could not take account of the emerging issues about Domestic Abuse, fractious family relationships, safeguarding concerns and ongoing ill health, stress and depression. The carer tasks were not analysed in the context of Peter's annual review, which acknowledged that Ron and Judith had refused all offers of support and there was a risk of breakdown of the arrangements but without any sense of a plan to address this.

4.62 Judith did have telephone support from the Carers Team and she reported to the LDSW that she found this useful. It was effective practice that the LDSW, aware of Judith and Ron's reluctance to engage with services, facilitated this relationship with the team by organising a joint home visit.

4.63 Judith and Ron refused all offers of help and support for themselves or for Peter. Peter ceased attending an external provision in 2011. Judith and Ron refused help to adapt the bathroom, dismissing

this offer as unsuitable. They refused contact with wheelchair services. They accepted domiciliary support for a short time in 2013, but there was evidence of them actually sabotaging this by one parent cancelling at short notice and the other parent then thinking that the service was being unreliable; reinforcing their belief that no professional could provide adequate care to Peter. It was proposed that Peter have periods of time in a short break facility, to give him a break and change of scene, something important to develop independence for adults with profound disabilities, and also to give the parents' a break from providing almost 24-hour care. The parents refused to consider Peter attending a short break or day centre facility.

4.64 The stresses of caring for Peter were well known to those agencies that dealt with the many crises that occurred over the 18-month period under review. The Police Officers who attended the family home and spoke to Ron, the Ambulance Service that attended the family home and took Judith to Hospital, the GPs who offered advice about stress and depression and visited Judith on a number of occasions, the Hospital staff who provided medical care to Judith and the Mental Health Team, who when they assessed her, were told by Judith and Ron that they were extremely stressed and overwhelmed by their caring role. This stressful caring role was seen as a causal factor for the suicide attempts by Judith, threats to kill Peter, Ron's often irascible behaviour towards professionals and what was described as the volatile relationship/Domestic Abuse. Judith and Ron told all these professionals that they were unsupported in this task. These professionals did not appear to know that Judith and Ron had consistently and vociferously refused all offers of help. If professionals believed the parents were unsupported and that this was impacting on their well-being and safety of others there should have been more discussion about why this was and what could be done about it.

4.65 It would have been expected that professionals would have sought to ensure that Judith and Ron were provided with the right support, regardless of the time limited nature of their role. Professionals needed to consider the implications of their contact with one individual for the rest of the family, and in this situation, the potential fragility of the caring role. This exchange of information did not happen, and so the discrepancy that although Judith and Ron felt unsupported and overwhelmed, they yet refused services, which was not recognised, discussed or addressed. This discrepancy was something that was hidden and not well understood. Given that it was one of the key issues underpinning the risks to all members of the family it needed to be understood and addressed gently and kindly with parents who genuinely had a significant caring role that they were palpably not coping with.

4.66 The Care Act 2014[xxvii], implemented in April 2015, promotes a whole family approach and current carer assessment is expected to be more 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.

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.

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.

Theme 6: 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

4.67 Information sharing is at the heart of effective safeguarding practice. It is one of the key findings of SARs[xxviiixxix] and DHRs[xxx] nationally. What has emerged from these reviews also is that professionals need to provide an analysis of the meaning of the information they hold, the implications for the safety and wellbeing of the adult about whom they were sharing information and to discuss next steps.

There were occasions across the timeline for this Review where information was not shared. In February 2015, Ron went to the Police station to report that Judith had made threats to kill herself and Peter if "*social services tried to move him*". The Police Officer evaluated that this was a cry for help, and a Police Officer visited the family home and saw Peter. The LDSW, the lead agency working with Peter, was not informed. Judith made a 999 call to the Police in March 2015 reporting that Ron was threatening to hit her. The DASH risk assessment was completed and the Public Protection Team of the Police was informed but the LDSW was not.

4.68 The Oncology Team treating Judith managed her anxieties well, and were aware of her caring responsibilities, but did not discuss these issues with the LDSW as the lead professional. The Carers Team were told by Judith that Ron was sending money in response to scam mail and this was not shared with the LDSW. Psychiatrist Two was concerned in 2014 that Peter's wellbeing was being impacted negatively by conflict at home; this was not shared with the LDSW or any other agency, for example, the GP. The GP was aware that Judith was feeling down and unsupported and discussed this with the CPN from the OACMH team who was no longer involved. Neither shared this with the lead professional, the LDSW. The GP received a call from Judith in May 2014, soon after she had been hospitalised for an overdose and she reported that she needed sectioning. The GP visited and Judith was calm but this information was not shared with anyone. The community nurses who provided continence care were unaware of the concerns and although they were aware from Judith that there had been difficulties, they did not seek to find out any information regarding this.

4.69 As was highlighted in Theme 5 regarding addressing caring responsibilities, many professionals were aware that Judith and Ron reported being stressed in their caring role and they often attributed the crises they experienced, and Judith's overdoses to this fact. Yet this information about them feeling overwhelmed was not shared with others. If it had been, the discrepancy between their stress and their reluctance to accept help could have influenced the analysis of all the professionals who were working with Judith and Ron and might change their understanding of the significant issues facing this family.

4.70 It appears that all these incidents were viewed in isolation and they did not seem sufficiently significant to require them to be shared with others; but if they had been viewed alongside other information already held, they would have highlighted an overall concerning pattern. This is also a key finding from the national analysis of DHRs[xxxi].

4.71 There were many times in which information was shared, but without its meaning being discussed or the implication for Peter or Judith's safety being explored, the risk analysed and the meaning understood in the context of the whole family circumstances. Many professionals were aware from Judith that she found her husband difficult, volatile and she described this as relationship concerns. This information was shared but the meaning for Judith, Peter and Ron and their circumstances was not discussed and the risk not analysed. When Judith phoned the Mental Health Crisis Team (CRHT) to report her husband acting oddly this was shared but not analysed or the exact meaning explored.

4.72 Information sharing when it happened was in the context of each crisis as it occurred. Although each crisis was largely addressed by individual agencies there was no collective or cumulative view formed. When information was shared, it was not in the context of connecting it to recent similar events and agencies did not ask what the ongoing plan was for Peter or Judith. No one agency had a chronology of events, and therefore could not see the patterns within the events that took place.

4.73 This is in part, because most of the professionals involved with the family were only involved to address a moment of crisis. So, the many incidents of concern that took place were not connected to the longer-term plan of support and care to Peter from the Adult Learning Disability Team. However, the GP was in regular contact with Judith, and two Psychiatrists with Peter and Ron. There was very little exchange of information across these three core agencies, although it was effective practice that the LDSW attempted to bridge this gap by attending the Psychiatric appointments for Peter.

4.74 There is also evidence that professionals addressed the needs of the individual seen, without considering the wider risks and needs of the whole family. They were not *thinking family*. This approach to considering the needs of all family members was introduced in 2007. *Think Family*[xxxii] practice nationally was described as the steps taken by children's, young people's and adults' services to identify wider family needs which extend beyond the individual they are supporting. Intervening early with a Think Family approach can help avoid problems escalating to crisis level and reduce the number of families and individuals who need intensive support in the future. This was not established practice across all agencies at the time under review, though was an expectation for some.

4.75 Appropriate information sharing, coupled with an identification of risk, good quality analysis of the meaning of information, a coordinated plan of action which took account of the whole family's needs could have made a real difference to making sense of this complex family situation. Indeed, it would have helped identify more clearly that this was a complex situation that required more multi-agency analysis and this was the responsibility of all involved agencies.

4.76 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.

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.

5. CONCLUSIONS

5.1 The family circumstances of Peter, Judith and Ron were extremely complex. There were long term concerns, spanning at least an 11-year period of Domestic Abuse, safeguarding concerns, worries about the parents' mental wellbeing, health and carer stress for Judith and Ron. They were the main carers for Peter who had significant care and support needs; they had been his carers for the whole of his adult life. Judith and Ron distrusted professionals and were often hostile and dismissive. This made working complex. This distrust and hostility were perceived to be due, in large part, to the very real onerousness of their caring responsibilities and there was professional sympathy and empathy for them regarding this. The LDSW in particular tried extremely hard to build relationships with Judith and Ron as a way of advocating for Peter. Other professionals also tried to engage both parents, including GPs and Mental Health Services.

5.2 What was missing from an understanding of the family circumstances was how entrenched it was and how little change took place. Patterns were repeated over time; the same issues arose over time. The professional response remained the same, despite this lack of change. This meant that Domestic Abuse was not addressed, safeguarding concerns not investigated, carer stress not sufficiently evaluated, the risk of family breakdown not established, Peter's independence and future not assured and his best interests not established.

5.3 The application of the MCA/Best Interests in the appropriate manner (including reviews) could have led to Judith and Ron being formally challenged about their beliefs and care of Peter. It could also

have led to proper identification and supportive challenge around domestic violence issues. This could have led to longer term planning, considering their complex family dynamics. A good analysis of the corrosive impact of Domestic Abuse would have depended on professionals understanding of the family circumstances, including being interested in why the adult son's no longer visited. Adopting a more holistic "*think family*" approach could have facilitated more information sharing, a greater analysis of risk, support to each professional and a coordinated approach.

5.4 These concerns could have been addressed through supervision and management oversight. The IMRs produced as a result of this SAR/DHR did not highlight any concerns about management oversight and supervision and this was explored through the review process. Yet, the complexity of the family circumstances was not picked up and those professionals working directly with Judith, Ron and Peter were left trying to manage this.

5.5 All these issues have been picked up in the agency IMRs and through the six key themes highlighted. There is never one driving factor when considering an adult's circumstances in the context of a SAR/DHR. It is the coexistence of a number of factors which impact negatively, and which need to be addressed to improve adult safeguarding and the response to Domestic Abuse.

Postscript:

5.6 This SAR/DHR highlights concerns regarding the intersection between adult safeguarding and Domestic Abuse which left Peter, Judith and Ron's needs not fully met. This was the practice landscape some years ago. Safeguarding and Domestic Abuse practices in Lincolnshire have been developed over the last few years, particularly the interaction between both areas. At an operational level Safeguarding Adult Practitioners are fully engaged in the MARAC process and there are clears lines of accountability within that service area, all relevant practitioners undertake Domestic Abuse training and engage in regular briefings, updates and training sessions. Adult Safeguarding and Social Care Practitioners attend and contribute to project development groups and are heavily involved in the implementation of new initiatives. At a strategic level adult safeguarding are members of the Domestic Abuse partnership and engage in the completion of strategic audits where needed. The Safeguarding Children's Partnership Manager, Adult Board Manager and the Domestic Abuse Lead meet on a regular basis to ensure practices are aligned, clear to all partners and that safeguarding is approached holistically. In addition, Lincolnshire introduced the Public Protection Board which is an overarching group that brings together the three separate boards in Lincolnshire and several partners, in order to ensure everyone is working together to support the safeguarding agenda.

APPENDIX

Jane Wiffin - Bio:

Jane Wiffin is a Social Worker by profession. She has over 20 years' experience of practice across children and adult services. She has been an Independent Author and Chair of Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews for the last 20 years. She has completed 92 reports, the majority of which have been published. She has undertaken the SCR Training delivered by the Tavistock Centre and is also an accredited SCIE Learning Together Reviewer. She has completed the Home Office DHR training.

Jane is also a trainer and policy adviser with a specialist interest in child and adolescent neglect, its impact across the life course and trauma informed approaches to child and adult safeguarding. She has also been involved in policy development and training around Domestic Abuse.

She is completely independent of all services in Lincolnshire and has never worked for any agencies involved in the SAR/DHR.

Heather Roach - Bio:

Heather Roach was a former Police Officer and retired in 2016 as a Deputy Chief Constable. In this role she was a Strategic Lead for Safeguarding and all crime related issues. She now chairs the Review and Learning Sub-Group and is the Independent Deputy Chair for the Lincolnshire Safeguarding Adults Board.

Heather has completed the Home Office DHR training.

REFERENCES

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