North Worcestershire
Community Safety Partnership

Domestic Homicide Review

Into the circumstances of the death of a man 'Steven'

June 2016

Independent Chair

Ivan Powell

June 2018

2 PREFACE

2.1 The report Chair and the panel members would like to express their sincere condolences to the family and friends of Steven. The Chair is grateful to Steven's son L and Steven's sister N for sharing their personal memories, some painful, to explain why Steven's life took the course it did, and to family friend B who also contributed to the review.

2.2 For the purposes of this report the victim will be referred to as Steven and the alleged perpetrator Jenny, further explanation is given under section 4 confidentiality (paragraph 4.1 page 5).

2.3 The Chair's gratitude is extended to the professionals, agencies and panel members who dedicated their time and tenacious attention to detail throughout the Domestic Homicide Review

2.4 This report of a Domestic Homicide Review examines agency responses and support given to Steven, a resident of Worcestershire prior his death on 13th June2016.

2.5 West Mercia Police notified North Worcestershire Community Safety Partnership of the homicide on 28th June 2016, however, the DHR process did not commence until the 8th December 2016 when Jenny was charged with the murder of Steven. The DHR sub-group met on 11th January 2017 at which time, having considered the circumstances they commissioned a Domestic Homicide Review.

2.6 A letter of notification was sent to the Home Office on 13th January 2017.

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

The circumstances that led to the Domestic Homicide Review

2.8 At the time of his death Steven was living with Jenny at her home, a one bedroomed flat, in Worcestershire. No one else lived with them. Their relationship had started in early February 2015 but no definitive date can be established. They lived together at other Borough Council owned properties throughout their relationship moving to this last address in the last week of February 2016.

2.9 In the early hours of 13th June 2016 West Midlands Ambulance Service received a telephone call and attended the home address, subsequently asking for Police attendance.

2.10 Steven was found deceased lying beneath a duvet on a mattress which was on the living room floor of the property. At that time the death was not identified as suspicious by attending police officers.

2.11 Steven was removed to a local undertakers and Jenny was taken to her sister's (C) home.

2.12 During the early afternoon of 13th June 2016 C attended her local police station and reported that Jenny had made certain comments to her concerning Steven's death.

2.13 On Tuesday 21st June 2016 a post mortem examination of Steven's body was commenced.

2.14 As a consequence of the initial post mortem findings and the information provided to the Police by C, Jenny was arrested on suspicion of the murder of Steven on Tuesday 21st June 2016.

2.15 The post mortem identified that the causes of Steven's death were:

- 1a Raised intracranial pressure (increased pressure in the skull surrounding the brain);
- 1b Sub-Dural haematoma (a localised collection of blood outside the blood vessels in this case around the Sub-Dura between the skull and the brain).

2.16 The conclusion was that the Sub-Dural haematoma was complicated by increase in intracranial pressure and ischemia (restriction of blood supply to tissues, causing a shortage of oxygen).

2.17 Jenny was formally charged with Steven's murder on 8th December 2016 and remanded to prison.

2.18 In December 2016 whilst in prison staff recommended that Jenny should be the subject of assessment and so she was placed on the mental health and learning disability wing of the prison.

2.19 In mid-June 2017 Jenny was placed in a specialist hospital in Northamptonshire for assessment funded by NHS England Specialist Commissioning. She was diagnosed as having a learning disability.

2.20 During the criminal investigation and post charge in accordance with The Criminal Procedure (Insanity) Act 1964, as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 and as amended by The Domestic Violence, Crime and Victims Act 2004, Jenny was found not fit to stand trial before the Crown Court.

2.21 The Crown Prosecution Service decided that Jenny should stand before a 'findingof fact' hearing in accordance with legal guidance[1].

2.22 Jenny appeared before Birmingham Crown Court for the jury to decide whether or not she committed the actus reus[2] of murder, namely unlawful killing. The jury did not have to consider her mens rea[3].

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[1] cps.gov.uk/legal-guidance/mentally-disordered-offenders

[2] The physical element in the commission of a crime, in this case the act of unlawful killing.

[3] The mental element in the commission of a crime, a person's awareness that his or her conduct is criminal.

2.23 The first trial concluded in mid-October 2017 as the jury were unable to reach a verdict.

2.24 The second trial concluded at the start of November 2017 when the jury's verdict was that Jenny had not committed the unlawful killing of Steven.

3 TIMESCALES

3.1 In February 2017 an independent person was appointed to chair the DHR Panel and to be the author of the overview report.

3.2 The review began in February 2017 and concluded in June 2018. Home Office guidance[4] requires DHR's, where possible to be completed within six months of the commencement of the review.

3.3 At the time of his death Steven had become isolated from his family and friends. He was also out of work. It therefore took an extended period of time to inform the review from Steven's perspective.

3.4 The completion of the review was also delayed by the criminal trial process, but more particularly within that, the need for Jenny and her sister, a witness in Jenny's court hearing, to be given the opportunity to contribute to the review process.

3.5 In addition the criminal investigation was extended by the psychiatric assessments of Jenny.

4 CONFIDENTIALITY

4.1 In order to comply with the Home Office Guidance[5], and to protect the identity of those involved, but to ensure the report is personalised, pseudonyms have been used to identify the victim and the alleged perpetrator. Additionally familymembers and a family friend who contributed to the review have also been identified by pseudonym in agreement with them. The people referred to in this report will be known as:

1. Victim – Steven
2. Alleged Perpetrator/Steven's partner – Jenny
3. Victim's son – L
4. Victim's sister – N
5. Alleged Perpetrator's sister – C
6. Family friend - B

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 Page 35
[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 Page 35

5 TERMS OF REFERENCE

5.1 The review will consider agencies contact/involvement with Steven and Jenny from 1st February 2015 until the date of Steven's death, 13th June 2016. This period has been agreed by the panel members as it is the entire duration of the relationship between Steven and Jenny.

5.2 The review specifically examines the circumstances under which Steven took sole control over their collective welfare benefit payments and therefore had full financial control within the relationship. Steven's compulsion to drink caused him to spend significant amounts of money to support his alcohol dependency at the expense of Jenny's welfare. In addition Jenny's needs made her more vulnerable to coercive and controlling behaviour.

5.3 These factors made this review particularly challenging and panel members endeavoured to ensure that whilst these matters were addressed Steven was central to the review.

5.4 Some aspects regarding Jenny were outside of the date parameters for the review however, agencies still considered the learning and whether any recommendations were required from their agency; implementing the necessary actions where appropriate. IMR authors and panel members exercised their professional judgement to identify the learning from her previous experiences and whether any action was required from single agencies, but of relevance to this review.

5.5 The purpose of the review 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, howand 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 inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

5.6 The full Terms of Reference are included at Appendix A, and were a standing agenda item on every panel meeting to ensure flexibility of approach in identifying learning opportunities.

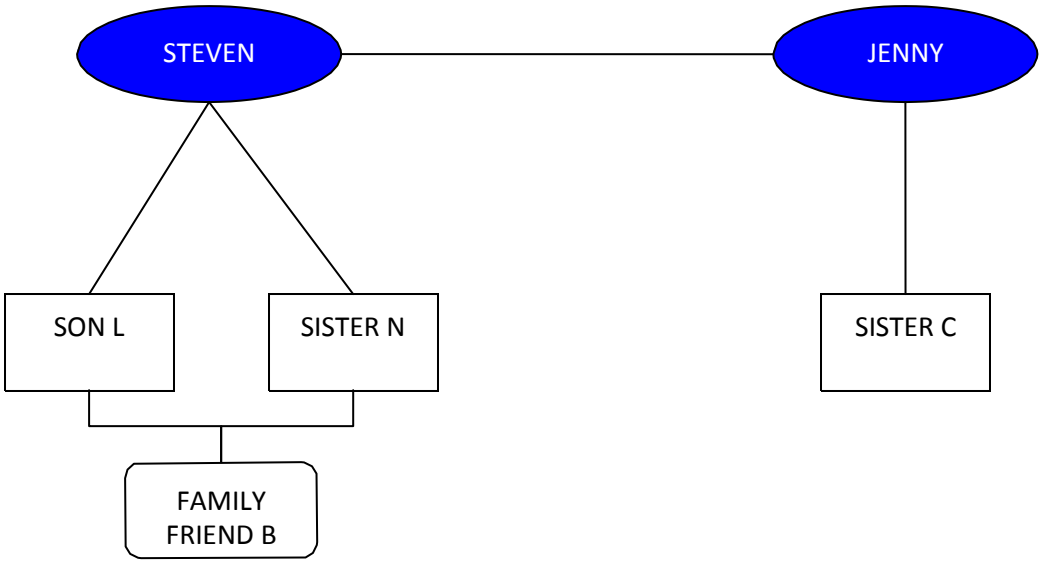
6 METHODOLOGY

6.1 The Overview Report has been compiled from and analysis of the multi-agency chronology, the information supplied in the IMRs and supplementary reports.

6.2 The review process benefitted from the contribution from Steven's family andfamily friend.

7 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURSAND WIDER COMMUNITY

7.1 Family members and friends who contributed to the review.



7.2 The Chair met with Steven's son (L) and his partner at a local police station in February 2017. He was supported in the meeting by two advocates from the organisation Advocacy after Fatal Domestic Abuse (AAFDA), one remained the family's advocate throughout the review. L was provided with the leaflets from the Home Office and AAFDA concerning the conduct of DHR's.

7.3 During this meeting the terms of reference were discussed and L was giventhe opportunity to offer his comments.

7.4 L and N have been updated by the Chair throughout the progress of the review. An arrangement had been made for L to attend the DHR Panel Meeting in June 2017 however he could not attend at short notice for personal reasons. The AAFDA family advocate has been fully engaged throughout by the chair. L was provided personally with a copy of the report by the Chair. He was supported in considering it by the AAFDA advocate but did not wish to contribute further to its content.

8 CONTRIBUTORS TO THE REVIEW

8.1 The following agencies were asked to prepare chronologies of their involvement with either or both of Steven and Jenny, carry out Individual Management Reviews and produce reports:

- Change, Grow Live (CGL) - (substance misuse treatment provider)
- NHS Redditch and Bromsgrove and NHS South Worcestershire Clinical Commissioning Groups (CCG) on behalf of the GP practices involved
- Redditch Borough Council (RBC) Housing Services
- West Mercia Police
- West Mercia Women's Aid
- Worcester Hospitals Acute NHS Trust
- Worcestershire County Council Directorate of Adult Services

The following agencies also contributed to the review by providing information on specific areas by direct contact with the Chair.

- Department of Work and Pensions (DWP)
- St. Paul's Hostel, Worcester

9 REVIEW PANEL MEMBERS

9.1 In accordance with the statutory guidance a DHR Review Panel was established to oversee the process of the review. Members of the panel and their professional roles were:

- Sue Coleman, Chief Executive Officer, West Mercia Women's Aid
- Sarah Cox, Quality and Safeguarding Services Manager, Worcestershire County Council
- Ellen Footman, Head of Safeguarding, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG
- Martin Lakeman, Advanced Public Health Practitioner, Worcestershire County Council
- Julie Payton, Work Coach, DWP
- Vikki Reay, Detective Chief Inspector, West Mercia Police who following her retirement was replaced by Simon Mason, Detective Inspector, Warwickshire Police
- Christina Rogers, Head of Safeguarding, Worcestershire Acute Hospitals NHS Trust
- Liz Tompkin, Redditch Borough Council, who was replaced by Judith Willis
- Steve Tonks, Detective Chief Inspector, West Mercia Police
- Charlie Twinn, Black Country Regional Quality Assurance Lead, Change, Grow, Live (CGL) (substance misuse treatment provider)

9.2 None of the panel members had direct involvement with the individuals involved in this case, nor had line management responsibility for any of those involved.

9.3 The panel met on four occasions.

9.4 The panel was supported by a DHR Administration Officer from Worcestershire County Council, Public Health.

9.5 Expert advice to the panel on alcohol dependency syndrome was provided by the organisation Change, Grow, Live.

9.6 The panel enlisted Mrs Caroline Kirkby, Transforming Care Lead Commissioner Worcestershire County Council as the specialist advisor on learning disabilities. Mrs Kirby had not previously had any contact or involvement with Jenny prior to the review commencing.

9.7 The Transforming Care Programme is the NHS England strategy to transform care for people with learning disabilities and/or autism who have a mental illness or whose behaviour challenges services. It seeks to ensure that people with a learning disability and/or autism in hospital who could be supported in the community are discharged into a community setting as soon as possible.

9.8 One key element of the Programme is for individual's to whom it applies to bethe subject of a Care and Treatment Review (CTR). The CTR process was chaired by a member of NHS England as Jenny's placement was commissioned by NHSE specialist commissioning. Mrs Kirby as the lead complex needs commissioner for Worcestershire, was responsible for visiting Jenny in hospital on 23rd August 2017 to participate in the CTR.

9.9 The panel did not feel that Mrs Kirby's contact with Jenny detracted from her independence, in fact it proved that her meeting with Jenny added significant value to the review process.

9.10 The review benefitted from the provision of information to the Chair by the Chief Executive Officer of the hostel in Worcestershire, concerning Steven's time as a resident at the hostel.

9.11 The Chair also consulted directly with and is grateful for the time and expertisegiven through telephone conversations by Mr Keith Smith, Head of Consultancy, British Institute of Learning Disabilities, Professor Erica Bowen, Professor of Prevention of Violence and Abuse at Worcester University and Mrs Judith Vickress, Safelives.

10 AUTHOR OF OVERVIEW REPORT

10.1 The Independent Chair and Author, Mr Ivan Powell, was appointed in February 2017. He is a former senior police officer and a nationally accredited senior investigating officer having retired in April 2014. He has attended the Home Office accredited DHR chair and report authors training delivered by AAFDA.

10.2 He is the Independent Chair of two Local Safeguarding Adults Boards, (commencing September 2015 and June 2016 respectively), and a Local Safeguarding Children's Board, (commencing December 2016), none of which are in Worcestershire.

10.3 Prior to this review he had no involvement either directly or indirectly with the family and individuals involved.

11 PARALLEL REVIEWS

11.1 The panel were aware that the following parallel proceedings were being undertaken:

11.2 Her Majesty's Coroner opened an inquest in July 2016. Following the conclusion of the court proceedings H.M Coroner decided that there was no necessity for the inquest to be resumed and he informed Steven's family.

11.3 The circumstances of this case required Worcestershire Community Safety Partnership to engage in dialogue with Worcestershire's Safeguarding Adults Board. The decision was for the review to be commissioned as a DHR, but with an expectation on the part of Worcestershire's Safeguarding Adult's Board that the interests of that board would be taken into account during the review.

11.4 The Chair ensured appropriate dialogue throughout the progress of the reviewwith the Independent Chair of Worcestershire's Safeguarding Adult's Board. Additionally DHR panel member Sarah Cox chairs the Case Review Sub-group of that Board.

11.5 The review was conducted alongside criminal proceedings and was therefore proceeded with an awareness of the disclosure issues that may arise. There was a need for direct dialogue between the Chair and the police senior investigating officer to explore whether Jenny's personal circumstances and her previous experiences might have a bearing on the criminal investigation. This had already been appropriately actioned by West Mercia Police. The senior investigating officer also requested that Jenny and her sister should not be spoken to by the Chair until after the criminal process had concluded.

11.6 In October 2017 the Community Safety Partnership, formally notified the Home Office of a delay and the reasons in the review process.

12 EQUALITY AND DIVERSITY

12.1 The review process was cognisant of the nine protected characteristics under the Equality Act 2010 of:

Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

12.2 The Equality Act 2010 states that a person has a disability if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day to day activities.

12.3 Steven was recognised by those agencies with whom he was engaged as being vulnerable by virtue of his personal circumstances. There was clear evidence of his GP being flexible with appointment regimes and proactive in encouraging him to access alcohol treatment services. It was not felt by the review panel that Steven had a disability, although the panel were cognisant in considering service responses that on occasion Steven's cognisance may have been impaired as a consequence of his level of alcohol consumption. Steven had been assaulted and lost the sight of one eye in September 2012.

12.4 Jenny had been placed on the Learning Disability Register by her GP in November 2009 and had appropriately been the subject of an assessment under the process formerly known as 'Fair Access to Care Services' (FACS), having moved to Worcestershire in 2012. (FACS was wholly replaced by the Care Act 2014).

12.5 The review was therefore conducted being particularly cognisant of disability.

13 DISSEMINATION

The following agencies will receive a copy of the DHR report and executive summary:

- Bromsgrove District Council
- Hereford and Worcester Fire and Rescue Service
- National Probation Service
- NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG
- Redditch Borough Council
- Warwickshire and West Mercia Community Rehabilitation Company
- West Mercia Police
- Worcestershire County Council
- Wyre Forest District Council

14 BACKGROUND INFORMATION

Background History

Steven

14.1 At the time of his death Steven was residing with Jenny. Before that, between October 2013 and February 2015 Steven had been resident at a hostel in Worcestershire. He also had some history of being street homeless and was alcohol dependent.

14.2 Prior to this Steven and N lived with their mother together with their disabled uncle, their respective partners and Steven's son L, and N's two children.

14.3 N described Steven as a loving and supportive brother and uncle.

14.4 She also explained that Steven had a drinking habit, not helped by the fact thather partner did too. This was to escalate out of control over time.

14.5 N arranged for the Chair to meet with a family friend B who moved in with thefamily as an older teenager and lived with them for a number of years. She explained that from her perspective Steven had always been a heavy drinker bordering on being alcohol dependant and that Steven would often demand money from his mother to support his drinking.

14.6 Steven and his partner separated when L was approximately four years old. N explained that L would come and stay with them at the weekend after the separation.

14.7 L explained to the Chair that he did remember having a relationship with his father up until he was about 8 years of age. He recalled he stopped seeing his fatherwhen he described his father's behaviour as being scary to him. He reflected that he recognised now that his father had been drunk rather than posing any threat tohim.

14.8 In 2000 Steven and N's mother became terminally ill. Steven took this particularly hard and started to drink increasingly heavily, N describes this as the cause of him becoming alcohol dependent. B recalls that in her view he was already alcohol dependant but the loss of his mother hit Steven particularly badly and this madethe situation worse.

14.9 Mr Twinn from CGL gave the following overview of alcohol addiction to the panel.

14.10 There are a variety of theories concerning the nature of addiction, but what most theories agree on is the following four statements which are applied to alcohol.

- Addiction to alcohol is an overwhelming compulsion to drink alcohol, despite negative consequences.
- When suffering from addiction the individual will have impaired ability to stop.
- When suffering from addiction to alcohol, motivation for other normal behaviours decreases
- Relapse is common

Many people suffering from addiction, who drink alcohol on a daily basis will also develop a physical dependency. This is when the body requires alcohol tofunction. When a person who is dependent on alcohol, suddenly stops drinking they are likely to suffer some or all of the following symptoms.

- Agitation, anxiety, headaches, shaking, nausea and vomiting
- Disorientation, hand tremors, seizures
- Insomnia, high blood pressure, tactile, auditory and visual hallucinations, high fever and excessive sweating, delirium tremens.

The combination of both addiction and dependence on alcohol often leads to a dysfunctional and unhealthy lifestyle. Alcohol may become the predominant motivatorin life replacing the need to eat, sleep, form relationships or work. It is therefore common that the individual becomes socially isolated with increasing physical and mental health complications.

14.11 Steven and N's mother died in 2001, their uncle dying a year later.

14.12 Ultimately N and Steven lost the tenancy on their home.

14.13 Steven started lodging with friends but eventually he became homeless.

14.14 N maintained occasional contact with Steven by mobile telephone. She was aware that at one stage in about 2011 he was living in hostel accommodation in Coventry.

14.15 He would occasionally be seen by people who knew N in and around the local area often in a public house or at a parade of local shops asking for spare change from passers-by, and they would let her know he was okay.

14.16 Steven visited N on infrequent occasions.

14.17 Steven's son L explained that he occasionally saw his father whilst in the local town centre, but he only spoke briefly to his father and only on occasions where L felt he was not too drunk.

14.18 The review was unable to identify any other friends or family members who were able to report on either recent contacts with Steven or the relationship between him and Jenny.

14.19 For this reason the following are a description of Steven's circumstances as he reported them to agencies himself. As such they are recorded as facts and are not subject to analysis. Some are outside of the date parameters for the review but it is felt helpful to record Steven's experiences.

14.20 Between September 1996 and October 2015 Steven had attended Accident and Emergency Departments in Worcestershire on 79 occasions and between January 2010 and June 2014 Steven had been admitted to hospital on 8 occasions.

14.21 A number of his attendances at hospital were as a consequence of him being assaulted whilst homeless. Some were very serious assaults including an incident where he was struck with a bat and sustained a broken jaw, an incident where he was beaten by four men and an incident where he lost the sight of one eye as a consequence of an attack with a nail or a knife.

14.22 Given Steven's loss of contact with his sister it is felt important to record that following his attendance at hospital in December 2012 he named her as his next of kin.

14.23 November 2011 Steven told Accident and Emergency staff that he 'was living on the streets at present'.

14.24 December 2011 Steven told Accident and Emergency Department staff at the hospital that he ''was living on the streets and had begun taking alcohol when his partner left him for his best friend and his mother died 11 years ago. Since this time Steven reports to have lost contact with his son and his sister''. The entry concluded that ''Patient acknowledges he has a serious alcohol problem and wants help''. (It

was arranged for Steven to be discharged to a placement where he would receive treatment for his alcohol dependency and he was referred to the Alcohol Liaison Service).

14.25 February 2013 having gone to Accident and Emergency as a victim of an assault Steven told staff he was 'living on the streets'.

14.26 April 2013 Steven told a housing worker that he had been living in a tent locally for the past 6 months. He also explained that before being street homeless he used to have a flat locally and then in Coventry.

14.27 12th November 2013 he told his GP that 'he was drinking a bottle of vodka most days'.

14.28 19th November 2013 he told his GP that he 'walks the streets in the day and was worried about his drinking'.

14.29 By January of 2014 Steven was on a new medication regime. He said his worries had improved, he now felt brighter and his sleep had improved. He was seen frequently by the GP until June 2015, when he moved to a neighbouring local area.

14.30 Steven accessed a hostel in Worcestershire between October 2013 and February 2015.

14.31 In many cases the individuals accessing the hostel had drug or alcohol addiction, in Steven's case his alcohol addiction.

14.32 The hostel provided single room accommodation for residents and had key workers who worked with residents to encourage engagement with treatment services, and to develop other skills such as working as a kitchen assistant.

14.33 Some costs were met by an individual's housing benefit. Individuals were also expected to make a payment in respect of communal heating and lighting and food costs, which although not strictly rent, was referred to within the hostel procedures as 'rent' and therefore 'rent arrears' when they occurred. At the time Steven accessed the hostel the 'rent' was £36 per week.

14.34 The CEO of the hostel remembered Steven well and would often see him buying or drinking canned beer locally. He said that when Steven was not influenced by alcohol he was pleasant, with humour and able to recognise his alcohol addiction was chronic.

14.35 The CEO reported with regard to Steven's alcohol addiction that there were many key work notes where staff noted that Steven was not engaging. There were a small number of entries which noted his wish to cut down or stop drinking.

Jenny

14.34 The Chair is grateful to Jenny's Sister C for her contribution to the review. Whilstshe declined to meet with the Chair, she engaged in a number of telephone conversations.

14.35 December 2017 Jenny was spoken to by her Social Worker and invited on the Chair's behalf to contribute to the review which she declined. The Social Worker explained that Jenny was clearly anxious even talking about the subject.

14.36 Jenny's contact with agencies in Worcestershire dates back to 2012.

14.37 It was evident that all of the agencies involved with Jenny on each and every occasion of their contact with her regarded her as being in vulnerable circumstances.

14.38 Jenny's GP recorded in 1996 that she had sustained a brain injury at birth. Her sister recalled that Jenny had been born at home and during the birth had suffered froma lack of oxygen to her brain. Jenny grew up and lived with her mother in Birmingham. Jenny's sister recalled that their mother was Jenny's carer and in particular she managed her financial affairs.

14.39 There were also two references on Jenny's GP records to her having learning difficulties.

14.40 She was entered onto the Learning Disability Register by her GP in November 2009. Jenny had not been diagnosed as having a learning disability prior to her assessment in Northamptonshire in 2017.

14.41 In 2011 Jenny's mother moved to a residential care home and Jenny relocated to Worcestershire where she initially lived with her sister.

14.42 Agency records on information given by Jenny's sister differ slightly, however the essence was that Jenny was unable to read nor write, had the mental age of a ten (or thirteen) year old, had a learning disability and/or difficulty and that Jenny did not understand the value of money. Despite the inaccuracy of the statement that 'Jenny had learning disabilities' (as she had not been diagnosed) it was information which passed between agencies, in particular to the borough council housing services and the Police.

14.43 Jenny living with her sister was unsustainable and in October 2012 Jenny presented as an emergency situation for the Borough Council's housing options team who worked on the premise that Jenny had a learning disability and provided Jenny with permanent accommodation in discharge of their duty under the provisions of the Housing Act 1996 Part VII (as amended).

14.44 The Worcestershire Community Learning Disability team assessed that Jenny did not meet their criteria for support as she did not have a significant learning disability.

14.45 October 2012 Jenny was visited by a learning disability nurse and a second worker from the Worcestershire Learning Disability Team who following discussion with a

manager, concluded that Jenny's needs could be fully met with the support of the housing department. It was recorded that the housing worker was informed of the outcome of the visit.

14.46 December 2012 Jenny was the subject of a needs assessment by Worcestershire Council Adult Social Care. It was recorded that she was happy and managing independent living and a referral was made for Community Support Services to support her to prevent social isolation and to find meaningful activities for her.

14.47 In early 2013 differing agencies started to reflect their concerns regarding aspects of Jenny's relationship with a new partner.

14.48 This culminated in a strategy meeting held in February 2013. As an action from this meeting social worker (SW1) completed a Mental Capacity Assessment to assess Jenny's understanding of the risks involved in engaging and continuing to engage in the relationship. The outcome of the assessment was that Jenny had capacity and wanted to continue with the relationship and was making 'unwise decisions'.

14.49 The recorded view of the social worker was that Jenny did understand that her family and professionals were concerned about the relationship.

14.50 Between May 2013 and January 2014 there were numerous entries on case records held by social care, housing and Jenny's GP which continued to show that agencies remained concerned that Jenny was in a vulnerable situation.

14.51 August 2013 GP1 spoke with SW1 at length regarding Jenny and hervulnerabilities. The social worker asked for the GP to be aware of Jenny being the victim of physical abuse.

14.52 January 2014 Jenny's case was closed by SW1 the rationale being that the risks had reduced as Jenny had moved away from perpetrator (named) but continued with their relationship. Jenny declined support suggestions and her sister continued to support with finances, shopping, letters and bills. Jenny occasionally attended the Connect drop in sessions as and when she wanted to. The police and Jenny's sister were in agreement that SW1 could close the case.

14.53 The details of the ongoing contacts with Steven and Jenny follow in the chronology.

15 CHRONOLOGY

15.1 The Chief Executive Officer (CEO) of the hostel where Steven was living reported that there were entries in Steven's key work notes around mid-April 2014 which described his wish to access the hostel dry house and made reference to liaison regarding detoxification treatment, however he identified that there was no record or evidence of any treatment taking place.

15.2 The alcohol dependency treatment provider for the parameters of the review in Worcestershire was Change Grow Live (CGL) who operated under the local project

title of 'Pathways to Recovery'. As a consequence of commissioning decisions they are no longer the current provider.

15.3 CGL transparently reported gaps in their service in the few months prior to the date parameters of the review. Given Steven's alcohol dependency they have been included as they are considered to be relevant to the review process and related learning.

15.4 October 2014 GP6 referred Steven to the alcohol dependency treatment provider, recording that Steven was drinking a bottle of vodka a day and his liver function test was abnormal.

15.5 Between 8th October 2014 and 16th January 2015 Steven was seen regularly at the GP practice by a number of different GPs. On 19th November 2015 the GP recorded that Steven said he was engaging with the alcohol dependency treatment provider. Enquiry with the provider concluded this was not the case.

15.6 The CGL IMR author reported that with regard to the referral of 3rd October 2014 from Steven's GP there was no record of contact made by CGL with Steven to offer an appointment, and no record of acknowledgement or receipt of the referral from CGL to the GP.

15.7 October 2014 when Steven had missed his appointment for triage, the CGL team leader gave instruction for the worker to contact the hostel (Steven's address) to arrange a further assessment. The IMR author reported that when it became evident that Steven had not attended his triage contact should have been made with the hostel to ascertain his wellbeing (CGL did not have a phone number for him). The referring GP should have been made aware that Steven had missed his assessment and the details of the follow up appointment given.

15.8 A further appointment was made for Steven to attend a triage assessment on 3rd November 2014, however the IMR author identified that there was no evidence of how this appointment was communicated to Steven.

15.9 Steven did not attend the triage assessment on 3rd November 2014. The IMR author identified that there was no record to indicate that Steven missed this appointment, no record of any action to ascertain the wellbeing of Steven and no evidence of any attempt to engage Steven.

15.10 In early November 2014 CGL closed Steven's case as 'Referral only – Client did not engage '. The IMR author reported there was no evidence of Team Leader oversight of this closure, nor evidence of any correspondence with Steven or his GP to inform them that the case was closed or how to re-refer.

15.11 10th December 2014 CGL received a further referral letter from Steven's GP requesting a service for Steven. The IMR author identified that there was no evidence of acknowledgement of this letter and no evidence that this referral was acted on by CGL.

15.12 February 2015 the hostel considered Steven to have left. Key work notes for the period 17th to 28th January 2015, showed that he had failed to turn up to his Key Work sessions and was in rent arrears.

15.13 February 2015 CGL closed Steven's case as he had missed two consecutive triage assessments. The IMR author reported that there was no evidence of the two triage assessment being offered or any follow up, nor evidence of management awareness of escalating risks which could be inferred by the GP writing a second time to refer him. On 9th February 2015 it was recorded "letter posted out", again the IMR author identified that there was no record of who this letter was sent to or what the contents were.

15.14 Neither the CCG on behalf of the GP practice nor the hostel on behalf of Steven were able to confirm receipt of this letter. Given the findings by the CGL IMR author regarding lack of formal acknowledgements with Steven's GP practice it is most likely that this letter was sent to Steven at the hostel address.

15.15 23rd February 2015 Steven had an interview with a housing worker from the local borough council when he requested food and accommodation. He explained he had been sleeping in the local bus station. Steven declined the offer of available hostel accommodation in Birmingham. Steven was not provided with any food as he was not a local resident. The housing worker did however speak with the administration team at Steven's previous hostel who instructed the officer to send in a referral and negotiate return based on management discretion (given Steven's rent arrears).

15.16 This referral was duly sent. Additionally Steven was not due to receive his employment support allowance payment until 27th February 2015 and so the housing worker agreed to provide him with his travel fare to the hostel.

15.17 There is no record of Steven attending or contacting the hostel.

Steven and Jenny's Relationship

15.18 No definitive date can be established for the start of Steven and Jenny's relationship, however during a home visit to Jenny in February 2015 by Local Police Officer (LPO) 1 and the Borough Council anti-social behaviour (ASB) Coordinator, Steven was at the flat. The purpose of the visit was to talk to Jenny regarding neighbours reports of arguments coming from her flat, and about her welfare.

15.19 The officers established that Steven had been staying at Jenny's flat for the last week. He stated they had argued because Jenny had locked him in her flat. Jenny confirmed that she had locked him in the flat because she didn't want him to leave. At this point Steven left the flat.

15.20 Jenny explained that she had met Steven by the church in the town centre and that she didn't know anything about him.

15.21 The officers told Jenny that neighbours had reported that her boyfriend had moved in about 3 weeks previously.

15.22 Jenny was asked about her benefits, and specifically if she was giving money to Steven. She said that Steven had his own money and that he put her spare money in a saving pot. The officers asked her to show them which she did to find the pot was empty.

15.23 The officers explained to Jenny that they considered her to be vulnerable and had concerns regarding her welfare. They also explained that her neighbours had reported being fearful about what was happening at her flat.

15.24 Jenny specifically asked if Steven could still come to the flat. She was told that he could but that ''if there were further problems the Police could consider a Domestic Violence Protection Order (DVPO) against Steven to ban him from visiting''. Jenny was also told that her tenancy could be at risk.

15.25 Following this visit the Housing Locality Leader allocated a Home Support Worker (HSW) to carry out welfare checks with Jenny.

15.26 The ASB Coordinator formally informed housing benefits colleagues that Steven was living with Jenny at the address, which had implications for housing benefit payments reported on later, but had the immediate impact of causing Jenny's housing benefit payments to be suspended. (This is the subject of analysis at section 16.8.62 – 16.8.81 pages 52 - 54)

15.27 In mid-April 2015 the housing benefit department sent out a letter to Jenny informing her that her housing benefit had been suspended as she needed to declare Steven as being resident at the address.

15.28 Mid-April 2015 neighbours called the police to Jenny's flat reporting an argument. They did not attend for four hours by which time the house was in darkness and the officers could not get a response from inside. The Police IMR author was unable to establish why there was such a delay in the police response.

15.29 21st April 2015 officers from the police safer neighbourhood team (SNT) re-visited Jenny and Steven which was good practice. They were spoken to independently and denied any incident occurring stating that they were playing loud music.

15.30 A Domestic Abuse Stalking and Honour based violence (DASH) risk assessment was completed although the IMR author reported that it was not clear to whom the assessment related. All of the questions on the assessment were answered in the negative.

15.31 LPO 1 re-opened a pre-existing Risk Management Plan (RMP) in respect of Jenny, which had been in place between 5th February and 13th March 2013 during her previous relationship. In re-opening the RMP LPO 1 stated that she considered Jenny to be vulnerable and referred to her previous relationship when her ex-partner had taken money from Jenny which resulted in her begging and stealing from the local church.

15.32 LPO 1 identified that Jenny had met Steven about two weeks previously and he had moved in. LPO 1 noted that the relationship bore the same risk traits as her previous one. The officer recorded that Steven was homeless and she considered he may be taking advantage of Jenny's situation. She recorded that the flat was very untidy when it had previously been well kept. LPO 1 also made reference to the anti-social behaviour which posed a risk to Jenny's tenancy.

15.33 By mid-May Jenny had accrued three weeks of arrears at her flat. On 18th May 2015 LPO 1 and the ASB Coordinator attended Jenny's current address where they met Jenny's sister C. Jenny was not present despite being asked to be in attendance. C held a key and they entered the property which was found to be messy. C outlined her concerns about her sister's relationship with Steven. C said that she was not able to pay her sister's rent and explained that it was becoming increasingly difficult to see Jenny and that Jenny did not want to engage with support agencies any more.

15.34 12th May 2015 Jenny attended the Town Hall and was given a food parcel when she stated that she had no food. She told the housing worker that she did not want her sister to know she had done this because she was afraid of her sister's husband.

15.35 19th May 2015 LPO 1 saw Jenny and asked her why she had not attended the meeting at her flat. Jenny apologised saying she forgot; and that she was going to sort her benefits out as she was worried about losing her home.

15.36 By 29th May 2015 Jenny had not actioned the requirements from the housing benefit department and her housing benefit was cancelled.

15.37 3rd June 2015 Jenny again attended the Town Hall asking for a foodbank voucher, which on this occasion was not issued.

15.38 11th June 2015 a housing support worker made a referral to Adult Social Care in respect of Jenny. He outlined that Jenny was vulnerable and at risk of being evicted. He explained how she had met Steven who had moved in and that he was a heavy drinker. He also explained that because Jenny had not registered him as living with her, housing benefit had been stopped and she was in arrears.

15.39 He also told Adult Social Care that Jenny's sister helped manage finances but the rent was not being paid. Additionally that Jenny had been seen begging on the street, had asked housing for food parcels, had sold her vacuum and had been trying to sell her iron.

15.40 He articulated their difficulty in engaging with Jenny and that her flat was verydirty when it had previously been immaculate. Adult Social Care endeavoured to make contact with the Borough Council regarding this referral but were unable to do so for ten days.

15.41 12th June 2015 LPO 1 spoke to Jenny who was waiting for her sister to arrive with her weekly shopping. She stated that she was still in a relationship with Steven and that the accrued arrears had still not been cleared and were mounting.

15.42 14th June 2015 a Police referral was received by Adult Social Care. This was recorded in their agency chronology but not included on the Police IMR or chronology.

15.43 The referral detailed the officer's general concerns about Jenny's vulnerability, the circumstances of her relationship with Steven and reports of arguments occurring.

15.44 Adult Social Care responded to the Police by letter within which they stated that after their consideration of the facts there were no apparent eligible social care requirements for Jenny and as such they would be taking no further actions at that time.

15.45 22nd June 2015 a Worcestershire County Council Access Centre Worker spoke to the Adult Safeguarding Team duty Social Worker who advised there were no adult safeguarding concerns within the initial information provided on 11th June 2015 by housing.

15.46 25th June 2015 Adult Social Care telephoned housing services regarding the above referral during which housing services outlined further concerns about Jenny's vulnerability and lack of engagement with their service. The Housing Support Worker again identified that Jenny was putting her tenancy at risk. After discussing the situation the housing worker agreed that no further action was needed.

15.47 26th June 2015 Steven told GP 8 that he was engaging with the alcohol treatment provider. Enquiry with the provider concluded this was not the case. Steven also said that he had moved a nearby town. Steven was given his 'fit note' and advised to register with a local GP which was good practice by GP 8.

15.48 5th July 2015 Police were notified of an incident at Steven and Jenny's address where a female was screaming and shouting at her boyfriend to get out. The person reporting stated that the couple in the flat had been arguing for over an hour and that the boyfriend was called Steven and had a drink problem.

15.49 Police attended within ten minutes by which time the address was silent. The officers spoke with Jenny and Steven. The officers recorded that Jenny was a vulnerable adult with learning difficulties and that Steven was drunk. He was removed by Police and taken to a local address.

15.50 Steven and Jenny were given the opportunity to be referred to alcohol treatment services but both declined. The Police did however make referrals to Adult Social Care and Women's Aid. It was not reported whether consent had been secured for these referrals.

15.51 The Police Domestic Abuse Unit later considered the case but concluded that as referrals had already been made and a risk management plan was running there was no need for a further vulnerable adult referral. The Police IMR author reported that under current arrangements an additional vulnerable adult referral would have been made.

15.52 The Police made the referral on 7th July 2015 and on 8th July 2015 it was recorded as a safeguarding concern by Adult Social Care.

15.53 7th July 2015 a Housing Support Worker contacted Adult Social Care to pursue the referral made by them on 22nd June 2015. This showed that despite theagreement reached and recorded on 25th June 2015 between housing and Adult Social Care that no further action would be taken, there was a misunderstanding between both parties on the outcome.

15.54 16th July 2015 the adult safeguarding team had a telephone discussion with the Police Harm Assessment Unit (HAU). During the conversation it was confirmed that from the police perspective Jenny had not engaged in the police investigation and had indicated that she wished to remain in a relationship with Steven. The adult safeguarding team closed the section 42 enquiry recording Jenny had not been highlighted as having any concerns regarding her capacity and had declined any support to the incident and did not under any circumstances wish to pursue charges towards her partner insisting that she wished for him to return to the home environment.

15.55 27th July 2015 a housing options worker spoke to an Adult Social Care Worker regarding Jenny as she had been living in bushes by the Town Hall.

15.56 Within the discussion reference was made to the existence of an injunction in respect of Steven as a consequence of which he was not allowed to return to Jenny's home for 28 days. The Housing Worker said that Jenny would not engage, had not consented to a referral and had declined support from the Police regarding domestic abuse. The Housing Worker was informed that case would be closed by Adult Social Care.

15.57 The information regarding the existence of an injunction can only have been with regard to a domestic violence protection notice which had not in fact been pursued through the court process, (further analysed at 16.6.18 – 16.6.20 page 38). This showed learning regarding a need for information to be shared and recorded accurately between agencies and a need to improve multi-agency understanding of the DVPO/N process.

15.58 27th July 2015 a patrolling police officer spoke to Jenny at a local bus-stop. The officer recorded a police vulnerable adult incident stating Jenny was a vulnerable adult, had learning difficulties and had been sleeping rough in the town centre. The officer took Jenny home and checked the property which was good practice. Her home was in good order and the fridge and cupboards were stocked with food. The officer recorded his concern that Jenny's mental health may be in decline and that she required intervention from agencies better placed to provide the care and support she needed. Contact was made with the housing locality team at the Borough Council and they were informed of the concerns of the Police. A police harm assessment unit referral was also made.

15.59 18th August 2015 Steven went to the Town Hall seeking a food parcel. The Housing Options Worker explained to Steven that according to their records he was on Jenny's housing benefit claim. He withdrew his request for a food parcel and was transferred to the benefits department to discuss his housing benefit claim.

15.60 25th August 2015 the ASB Co-ordinator and Home Support Worker conducted a welfare visit to Jenny. Steven was present. Jenny explained she would like to move to get away from her neighbours.

15.61 They were again told that as they were now living as a couple they would need to re-arrange their Employment Support Allowance (ESA) jointly as well as their housing benefit. Jenny told the officers that she now had her own bank account. Steven agreed that they would visit the Town Hall to see what they had to do. He said that they had to ask for a food parcel the previous week as Jenny's sister had been away and not provided food.

15.62 August 2015 a neighbour of Jenny called Police to report a couple arguing inside the neighbouring property.

15.63 Police attended the property within ten minutes. Initially they could not get a response but when they spoke to Jenny she denied that she had been arguing and she blamed it on neighbours as they were trying to get them moved out. Attending police officers reported that they were satisfied that a domestic incident had not occurred and that it was part of ongoing neighbour complaints about the anti-social behaviour displayed by Jenny and Steven and the casual visitors to the address, but they did complete a DASH risk assessment with Jenny who declined to answer any questions. The fact that officers completed a DASH assessment would appear to confirm that they believed a domestic incident had occurred despite concluding it was part of the anti-social behaviour problem. The risk was deemed to be medium.

15.64 1st September 2015 a referral was submitted to the Harm Assessment Unit and an automated referral was sent to Safeguarding Adults.

15.65 Adult Social Care have no record of this referral. The police did not reporta conclusion of the referral.

15.66 1st September 2015 the ASB Coordinator and Home Support Worker visited Jenny and Steven when they confirmed they were registered to move. Steven confirmed they had been to the Council regarding their ESA claims.

15.67 7th September 2015 the then Head of Housing of the Borough council chaired a 'Vulnerable Adults' meeting in respect of Jenny following a referral from adultsocial care.

15.68 This meeting had developed under Community Safety Partnership work. Thepurpose of the meeting was to try and resolve issues relating to individuals in a multi-agency arena. It was not constituted to address 'adult safeguarding' as defined by the Care

Act 2014. Adult Social Care were not in attendance at the meeting and were unable to find reference to the action recorded below.

15.69 The meeting minutes recorded concerns for Jenny's mental capacity and her history of being a victim of domestic abuse. Jenny at the time was thought to be in a relationship with Steven. Jenny had been found sleeping in bushes with him and he was believed to be taking her money that she was given by her sister each week. Home Support Workers were visiting Jenny every week and meeting with Locality Officers on a Tuesday morning.

15.70 The agreed action was to refer to the triage team and Adult Social Care services were to check information held. (The case was removed from the Group at the next meeting on the 19th October 2015 as it was felt as Home Support and Borough Council locality officers were meeting with Jenny regularly this was sufficient at the time).

15.71 September 2015 the ASB Coordinator and Home Support Worker visited Jenny and Steven at home. Jenny confirmed that she now had a bank account of her own and was going to deal with all of her bills and Steven also confirmed that his money would be paid into Jenny's bank account.

15.72 The officers did discuss with Jenny whether she would be able to manage her finances as her sister normally looked after her bills. Jenny's further requests for food parcels formed part of this discussion. It was agreed that Jenny and Steven would discuss this further with Jenny's sister. Jenny's application for a housemove was also discussed.

15.73 10th September 2015, because of the concerns of the officers of financial abuse being indicated by the number of requests for food parcels and reports of her being seen street begging, a telephone call was made by the borough council staff to the Adult Social Care Safeguarding Team. This was not recorded on the Adult Social Care system and so it could not be established if it occurred and if so what the resultant outcome was.

15.74 22nd September 2015 the ASB Coordinator and Home Support Worker visited Jenny at home when she told the officers that her sister had stopped her having a bank account and she now had no money. The officers helped Jenny understand a letter from DWP regarding her ESA claim. Jenny was reluctant for the officers to help complete the enclosed claim form so they encouraged Jenny to go to the Citizens Advice Bureau (CAB) for help and advised her to take Steven with her too so that he could include his details. Jenny agreed to do so and also to see a Housing Benefit Worker as her housing benefit had stopped.

15.75 29th September 2015 the ASB Coordinator and Home Support Worker visited Jenny and Steven at home. Jenny told the officers that she had been to the Town Hall to try and complete the ESA form but had been told that she needed to see the CAB for help. They told her to do so that day. Jenny also said that her sister would no longer

do her shopping. Jenny confirmed she did not have a bank account and that she would get her money paid into Steven's Post Office account. The officers were concerned about this decision and discussed it with Jenny.

15.76 3rd November 2015 the Home Support Worker visited Jenny at home who explained that her benefits were now sorted out.

15.77 10th November 2015 the ASB Coordinator and Home Support Worker visited Jenny at home to discuss further complaints of noise nuisance being made from neighbours and a fire brigade call out. Jenny was formally warned that she was in breach of her tenancy agreement. The officers also discussed Jenny's financial position with her which she said was sorted out.

15.78 Jenny left at the same time as the housing workers, who then witnessed her meeting Steven; there being a brief but loud verbal altercation between them and it appeared to the officers that Steven was drunk.

15.79 17th November 2015 the ASB Coordinator and Home Support Worker visited Steven and Jenny at home. Steven was very intoxicated. They were spoken to about rent arrears which had accrued because of the delay in them not claiming for benefits and also about outstanding utility bills.

15.80 19th November 2015 the ASB Coordinator and Home Support Worker visited Jenny and Steven at home and helped them with their finances and payment arrangements.

15.81 1st December 2015 during a home visit by the ASB Coordinator and Home Support Worker Jenny and Steven were again given support with their finances and payment arrangements were made. It was also agreed that the Home Support Worker would complete a 'Capability for Works' questionnaire for Jenny. Jenny asked if she could move as she wasn't getting on with the neighbours and it was agreed that this would be pursued after Christmas.

15.82 3rd December 2015 the ASB Coordinator and Home Support Worker visited Jenny and Steven at home and told them that Jenny's questionnaire had been completed and that their Council Tax payments had been arranged.

15.83 16th December 2015 the ASB Coordinator and LPOs 1 and 3 visited Jenny and Steven at home following further reports from neighbours of shouting and swearing and reports of Jenny begging in the street. They were told that they were in breach of their tenancy agreement and that action would be taken if further complaints were received.

15.84 Steven talked about his alcohol addiction and agreed that he would be willing to accept help in the New Year. Jenny denied begging. LPO 1 subsequently made a telephone referral to the alcohol treatment provider.

15.85 24th December 2015 a patrolling PCSO attended a report of Steven and Jenny arguing in the town centre. Both were drunk and were escorted by the officer outof

the town centre precinct. The PCSO made an entry on the risk management plan but a domestic incident report was not created. The IMR author identified that under police process a domestic incident report should have been recorded.

15.86 29th December 2015 Jenny and Steven stopped the ASB Coordinator when they saw him on a local car park to talk about their concerns about being evicted. He explained that this would not happen as long as there were no further complaints about their behaviour.

15.87 5th January 2016 Jenny was visited at home by the ASB Coordinator and LPOs 1 and 3, at which time her health and pending house move were discussed. LPO 1 tried to persuade Jenny to make an appointment with her GP but she refused.

15.88 8th January 2016 LPOs 1 and 3 visited Jenny and Steven at home following the ASB Coordinator informing them of third party reports from residents of shouting and screaming from the flat over the Christmas period. Both Jenny and Steven were spoken to but denied that any arguments had taken place. They immediately said the neighbours 'had it in for them'.

15.89 Jenny was spoken to on her own but maintained there was no issue. LPO 1 was concerned that Jenny may be reluctant to make disclosures and so arranged for the Safer Neighbourhood Team to pay late night attention to the property which was good practice. Checks were subsequently made of the property but no further disturbances noted.

15.90 11th January 2016 Jenny and Steven contacted the Home Support Worker several times by telephone. They were concerned about the Police visiting them at their property about noise complaints as they did not think they were giving their neighbours any reason to complain.

15.91 Jenny was given advice which the officer felt Jenny may not have understood. The officer also noted that Steven was intoxicated during discussions.

15.92 Between 14th January 2016 and 22nd February 2016 Housing Workers conducted home visits to Jenny and Steven on a number of occasions to facilitate their house move, which occurred on 23rd February 2016. During this period Jenny and Steven were given a significant amount of coordinating support by Housing Workers, including the purchase of a new washing machine through the Essential Living Fund. The Benefits Officer also changed over housing benefits and Council tax payment.

15.93 15th March 2016 the ASB Coordinator and Home Support Worker visited Jenny at home. Jenny was very agitated and did not want the officers to stay and help sort her mail.

15.94 21st March 2016 LPO 2 and the ASB Coordinator visited Jenny at home to speak with her about reports of her begging in the town centre.

15.95 26th March 2016 Police attended Jenny and Steven's home following a '999' call from neighbours who reported arguing with lots of shouting and screaming for the past hour.

15.96 Steven initially told the attending police officer that he had been assaulted by Jenny who had struck him upon the hip causing bruising, but later said he did not know how he had sustained the bruising.

15.97 A DASH assessment was conducted with Steven and the risk graded as standard. Steven did not wish to pursue a complaint.

15.98 The case was discussed at the multi-agency 'Every Victim of Domestic Abuse' (EVODA) meeting on 31st March 2016.

15.99 The EVODA meeting was held every Monday to Friday morning to discuss all reported domestic abuse incidents which had occurred the previous evening or over a weekend.

15.100 The purpose of the meeting was to ensure that all information was effectively exchanged between the agencies to ensure the whole picture was understood.

15.101 From a policing perspective all cases assessed as high risk would be allocated to a domestic abuse risk assessment officer (DARO) who would make contact with the victim to discuss safety planning.

15.102 High risk cases would also be referred to Women's Aid and may result in the allocation of an Independent Domestic Violence Advisor (IDVA), but this would not occur if the victim had not given their consent.

15.103 The decision from this multi-agency meeting was that there would be nofurther action.

15.104 The EVODA meeting has now been re-named domestic abuse triage.

15.105 29th March 2016 the ASB Coordinator and Home Support Worker visited Jenny and explained that they may have to withdraw their home support to her as she was not engaging with them. Jenny told the officers that she no longer needed support as she had Steven as support.

15.106 The housing officers remained so concerned about Jenny's ability to manage her finances, and in particular were cognisant of the reports of Jenny begging in the streets, that they made contact with the local policing team to organise a joint home visit.

15.107 13th April 2016 the ASB Coordinator and LPO 2 visited Jenny at home to discuss the reports of her begging. She told the officers that she was going to stop begging and was worried about being arrested. She also stated that she was using her benefitsto buy clothes and food. The officer's checked the flat with Jenny's permission. It was noted that there was very little food in the fridge and freezer. Jenny told the officers

that her benefit money was paid into Steven's Post Office account and that he gave her money to buy food and clothes and to pay for their bills.

15.108 The officers pursued conversations with Jenny regarding her welfare however she said that there was not a problem with her and Steven and that he cooked her meals. Jenny became agitated saying that she wanted to leave the flat.

15.109 LPO 2 advised that he would make an adult safeguarding referral on return to the police station due to concerns of financial abuse from Steven.

15.110 Adult Social Care do not have a record of receipt of this referral. The police were unable to advise on any result of it.

15.111 18th April 2016 Police attended the address following a '999' call from neighbours who reported that Steven and Jenny were arguing. Police attended and found all was calm inside and Jenny and Steven were cooking dinner. They denied arguing saying they had both been drinking and had the TV on loud. The police completed a DASH assessment with Jenny, graded as standard. It was recorded that both parties denied arguing. The previous history of domestic incidents was recorded as a factor. A Harm Assessment Unit referral was made and the matter was discussed at the 'Every Victim of Domestic Abuse' meeting on 20th April 2016. Jenny's declined to give her consent for her referral to domestic abuse agencies. The decision at the meeting was for no further action to be taken.

15.112 19th April 2016 and 21st April 2016 housing officers continued to try and contact Jenny.

15.113 26th April 2016 due to Jenny's lack of engagement it was agreed by the Housing Locality Team Leader that the home support was to be withdrawn.

15.114 3rd June 2016 a further joint visit was conducted by LPO 2, PCSO 1 and the ASB Coordinator to discuss anti-social behaviour reports from neighbours and reports of Jenny begging in the town centre.

15.115 When the officers arrived at the rear of the flat they could hear shouting and arguing. When the officer's went to the front door of the flat it was clear the arguing was coming from within. On knocking the door all went quiet, after knocking several times and a threat from the Police to force entry (for welfare reasons) Jenny answered. Initially both Jenny and Steven denied that they had been arguing. At this point Jenny was asked to speak separately with PCSO 1 in another room.

15.116 Steven, when on his own, said neither he nor Jenny liked the flat and that Jenny wanted to move back to their previous address.

15.117 When Jenny returned to the room she confirmed that she did not like the flatand that she wanted to move back to their previous address.

15.118 They were told that this would not happen because of their history of neighbour nuisance and to give them a new start. They were told that the Police had received

complaints from their new neighbours which confirmed the likelihood that they had been a problem to their previous neighbours also. They were told that if complaints continued the Borough Council would consider eviction proceedings.

15.119 They were also told by the Police that they would be the subjects of the Police RMP. In response Steven specifically asked if it was because the Police thought he was hitting Jenny.

15.120 He was told that it was in respect of reported anti-social behaviour however the Police did outline the possibility of them pursuing a DVPO against him.

15.121 It was agreed that the Police would make a referral to the alcohol treatment provider for Steven and to Social Services for Jenny and LPO 2 emphasised the importance of them engaging with support.

15.122 10th June 2016 LPO 2 contacted and spoke with the Consultant Social Worker in the Triage Intervention Team at which time he explained he had recently made a referral in respect of Jenny through the 'Your Life Your Choice' website.

15.123 He outlined his ongoing concerns regarding Jenny's vulnerability and in particularhis concern that Steven was financially abusing Jenny as he had control over their joint benefits and he was alcohol dependent. The Social Worker asked the LPO if he wanted to report the suspected abuse as safeguarding but he said for now he would just like his concerns passed through to triage and asked if a Social Worker could call him back as soon as possible.

15.124 13th June 2016 Steven's death was reported by Jenny.

15.125 13th June 2016 LPO 2 submitted a vulnerable adult incident outlining the facts that Jenny had now had no access to money and outlined other vulnerability considerations. This was received by ASC on 14th June 2016. Other agencies notably the Borough Council supported Jenny to arrange her finances.

15.126 13th July 2016 a letter from Worcestershire Health and Care Trust was received by Jenny's GP which informed the GP that Jenny had been assessed as lacking capacity for managing her finances.

16 ANALYSIS

16.1 Worcestershire Acute Hospitals NHS Trust

16.1.1 Between September 1996 and October 2015 Steven attended Worcestershire Acute Hospitals NHS Trust Accident and Emergency Departments on 79 occasions, and between January 2010 and June 2014 Steven had been the subject of 8 in-patient admissions to hospital.

16.1.2 The NHS Trust IMR author identified that whilst there was evidence of Steven being offered and at times declining services there did not appear to be a consistent approach to re-offering these services given the high number of A

and E attendances. There were also occasions where alcohol liaison was not evident in his patient records.

16.1.3 There was no evidence in records of questions being asked regarding domestic abuse.

16.1.4 The IMR author confirmed that the Trust have domestic abuse policy and procedures in place and use the DASH risk assessment model, that the Trust is represented at MARAC meetings by named nurses from the Safeguarding Team and Accident and Emergency Department has link nurses who have a specific interest in domestic abuse.

16.1.5 Safeguarding is a standing agenda item on all Trust governance agendas, and domestic abuse has a specific focus at the Safeguarding Committee.

16.1.6 The IMR author also identified that hospital records did not indicate that safeguarding procedures had been considered for Steven, particularly given his high number of Accident and Emergency attendances.

16.1.7 Three single agency recommendations were made by the Trust.

- *Recommendation 1*

Worcester Acute Hospitals NHS Trust to review the number ofprevious Accident and Emergency Department attendances upon admission ofa person and to consider any potential safeguarding concerns.

- *Recommendation 2*

Worcester Acute Hospitals NHS Trust to ensure compliance with NICE Public Health guideline on 'Domestic Violence and Abuse: how services canrespond effectively' (PH50); recommendation 6 (Ensure trained staff ask peopleabout domestic violence and abuse).

16.2 <u>Change, Grow, Live</u>

16.2.1 Whilst Steven was resident at the hostel his key workers generally saw little evidence of him actively trying to engage with treatment providers other than the period between October and December 2014 when he did appear to be willing to engage. Shortcomings on the part of the treatment provider, as reported by the CGL IMR author, must therefore be seen as missed opportunities to engage Steven in treatment.

16.2.2 The CGL IMR author reported that whilst the contacts were outside the timeframe set for the DHR, it was possible that if Steven had engaged with treatment for his alcohol dependence at the time of referral his life may have taken a different course.

16.2.3 At the time of the referral in October 2014 CGL was providing a weekly clinic to the hostel to support and attempt to engage homeless people with drug or

alcohol problems into treatment. However following referral from the GP there was no evidence that CGL used this clinic or the good relationships it had with the support workers at the hostel to attempt to engage Steven.

16.2.4 In December 2014 (one month following the closure of the case by CGL) Steven's GP re-referred him to CGL. At this time Steven was still living at the hostel. The IMR author identified that the second referral from a GP in a short period of time should have highlighted increased risk/concern to CGL. If CGL had picked up on the increased risk and acted upon it by making greater efforts to engage with Steven, then the course of Steven's life may have been altered.

16.2.5 In August 2016 CGL introduced a new 'Engagement and Re-engagement Policy'. This Policy sets out standards expected of all practitioners in all CGL services in response to missed appointments. Practitioners are now expected to always attempt to make contact with the service user during the appointment time if the service user does not attend. If the service user cannot be contacted the practitioner is required to use a decision making matrix to inform what action should be taken, which includes:

- If the case should be escalated internally within CGL.
- If information should be shared with other agencies and if so who.
- If assertive outreach should be actioned.

16.2.6 The IMR author reported that CGL have a policy and toolkit for safeguarding adults, local processes exist for completion of DASH Risk Assessments where domestic abuse is suspected and CGL are a regular member of the MARAC meeting structure. All practitioners receive training on Adult Safeguarding and Domestic Abuse.

16.2.7 The learning from the review of Steven's case pre-dated the introduction of CGL's new 'Engagement and Re-engagement' Policy and therefore no single agency recommendations or action plan is required.

16.2.8 On occasions Steven told his GP that he was engaging with the alcohol treatment provider. Enquiry with CGL confirmed that this was not in fact the case. It is not current practice for the GP to make enquiry with a treatment provider to clarify whether a person is in fact engaged with them. It has been established with the current provider that should someone engage with the service without a direct referral or knowledge of their GP then they would routinely ask the question around the GP and seek to inform the GP with consent. In the case of drugs then this would be done to prevent conflict with subscribing medication.

16.3 Clinical Commissioning Group (GP practice)

16.3.1 Steven first attended his GP practice in October 2013 as a walk-in patient, at that time the practice operated as a Primary Care Walk-In Centre. He remained registered with the practice until his death in 2016.

16.3.2 The IMR author reported that Steven was recognised as having a significant alcohol problem that was affecting his life on a daily basis. His fluctuating mental capacity was recognised in terms of decisions he made whendrinking, however, there were no concerns about his capacity when he came into contact with the practice. Steven's associated mental health problems were also treated (pharmacologically) and he was able to make decisions about his care.

16.3.3 The GP practice repeatedly attempted to help Steven engage with alcohol support services and the practice made referrals to the service in October and December 2014.

16.3.4 The GP practice also continued to send routine health check appointments to the hostel for Steven.

16.3.5 Steven was not considered by the GP practice to be a victim of domestic abuse, but he was recognised as vulnerable due to his homelessness, mental health issues and substance misuse.

16.3.6 The GP practice was used by the hostel residents regularly and an understanding of the many issues that homeless individuals present with would be a regular part of the practices experience of working with this client group.

16.3.7 There is a regular record of "not fit for work" statements due to "alcohol dependence syndrome" being given to Steven, which would have enabled him to claim welfare benefits.

16.3.8 Jenny was not seen by her GP practice for almost two years prior to Steven's death, and so her contacts with the GP are outside of the parameters of the review, however the IMR author did include some elements he felt were of relevance to the review.

16.3.9 Jenny's records indicated that during 2013 the GP had concerns regarding Jenny's relationship with a male who was known to pose a domestically abusive risk to her. The GP did not make a referral to the then adult protection system (now Adult Safeguarding) or domestic abuse services, however in August 2013 the GP did speak extensively to SW1 about the matter.

16.3.10 The GP also referred Jenny in October 2013 to the Learning Disability Team for assessment and support, but no information was recorded regarding the outcome.

16.3.11 The IMR author reported that the GP acknowledged that they would deal with the situation differently now by discussing Jenny's circumstances with the CCG Safeguarding Lead and making an adult safeguarding referral into social care and signposting to domestic abuse support services.

16.3.12 The IMR author provided an overview of the training and information available to GP practices for domestic abuse and adult safeguarding and made the following three recommendations in conclusion:

- *Recommendation 1*

GPs and Clinical Practice Staff in Worcestershire to complete Safeguarding Adults Level 3 Training which includes Domestic Abuse (DA) training.

- *Recommendation 2*

CCG to communicate current Domestic Abuse Guidance to all Worcestershire GP Practices

The IMR author also proposed the followingrecommendation:

- *Recommendation 3*

CCG to audit Safeguarding Adult Level 3 training as part of the CCG Programme of Audit for GP Practices.

16.3.13 The IMR author also passed the following helpful observations:

'GPs are recognised as a key professional in recognising domestic abuse. In many Domestic Homicide Reviews, they were the only professional in regular contact with many victims of domestic abuse. It is an ongoing priority to raise awareness of domestic abuse amongst GP Practice. Enhanced knowledge from education, training and experience still continues to be the major trigger to instigate and support asking about domestic abuse as a 'routine enquiry.

16.4 <u>West Mercia Women's Aid (WMWA)</u>

16.4.1 West Mercia Women's Aid had no involvement with Steven or Jenny until after Steven's death, when following a MARAC meeting held in July 2016, a referral was received by WMWA in respect of Jenny.

16.4.2 Whilst again outside of the date parameters of the review the learning is included as it has current and ongoing relevance.

16.4.3 Jenny had not consented to a referral for Independent Domestic Violence Advisor (IDVA) support as she had not understood what it would entail. Calls were made backwards and forwards between WMWA and the allocated Social Worker but the individuals within agencies kept missing each other and

so a series of messages were left. By the time contact was made with the Social Worker she was no longer handling Jenny's case. It is apparent that given Jenny's reported lack of understanding she would have benefitted from a joint approach between WMWA and Adult Social Care.

16.5 Redditch Borough Council (the Council)

16.5.1 The Council own and provide landlord services for approximately 5800 properties. The management of housing is split into four core functions. Three of those functions are delivered through their three community based teams, each having five Locality Officers.

16.5.2 The Locality Officers specialise in Anti-Social Behaviour (ASB) Management; Tenancy Management and Rent Account Management.

16.5.3 The fourth core function of housing management is the Housing Options Team, who provide the Local Authority duty in respect of homelessness and housing options. Their role is to provide a front line service and meet all people who present with housing needs to the Council.

16.5.4 They also manage temporary accommodation units, where homeless people are placed and supported by a temporary accommodation worker until housed. Once accommodated Housing Locality Workers would provide support if required.

16.5.5 The Housing Options Team at the Council first became aware of Steven in December 2011 following an enquiry from the local hospital after he had been admitted to Accident and Emergency the previous night.

16.5.6 The Council offered to secure a placement in a homeless hostel which Steven declined.

16.5.7 The Council also operate the 'Essential Living Fund' (ESL) which enables people who live in the council district, and who are facing a financial crisis or emergency to secure essential goods or food vouchers, but not cash. It does not cater for anything already covered by benefit entitlements.

16.5.8 ESL is a discretionary and limited fund and council decisions are in favour of people identified as vulnerable and with the greatest needs.

16.5.9 Steven approached the Council on a number of occasions requesting a food parcel and was given this assistance as they recognised his vulnerability.

16.5.10 Jenny first came to the attention of the Housing Options Team at the Council in October 2012 when she presented as an emergency situation.

16.5.11 The Council considered Jenny to have a learning disability and she was provided with permanent accommodation until 22nd February 2016 at which time she was re-housed at her request and provided with accommodation at her new address from that date until 15th August 2016.

16.5.12 Jenny did not apply for joint tenancy in respect of her and Steven, however Steven was recognised by the housing provider as being resident at Jenny's home.

16.5.13 As the sole tenant Jenny was supported during her tenancies by Home Support Locality Workers who provide support to the most vulnerable tenants to enable them to sustain their tenancy. Matters that are outside of housing specialisms are referred to appropriate agencies.

16.5.14 It is not a requirement for social housing landlords to provide this type of support service. The Council designed in this service following transformation work when it identified that typical tenancy functions, such as tenancy enforcement, did not solve problems tenants faced nor did it resolve the impact that some challenging although vulnerable people had on a wider scale. Understanding people's circumstances enabled the council to provide services to help tenants resolve problems to improve individual lives and reduce the demand on other public services.

16.5.15 This approach by the Council is good practice.

16.5.16 Steven became known to the Council Housing Landlord Services in February 2015 when the ASB Coordinator visited the property where Steven was present and Jenny said he was her boyfriend.

16.5.17 There are a significant number of records reflecting the methods and frequency of attempts to engage Steven and Jenny which demonstrated that the Council went beyond what is required of a Social Housing Landlord, and also showed a balanced approach to their welfare when tackling anti-social behaviour.

16.5.18 Steven was considered by housing services to be co-habiting with Jenny and he was provided with advice relating to the management of their joint benefit/finances as well as the tenancy. Both Jenny and Steven were signposted to other agencies including the Citizens Advice Bureau, Housing Benefits and they were repeatedly encouraged to engage with their GP services.

16.5.19 The Council had no policies for domestic abuse nor risk assessment and therefore no processes for risk management for domestic abuse victims or perpetrators. Housing officers did not have the right degree of awareness of 'coercive and controlling behaviour'.

16.5.20 At the time of the DHR the Council's 'Safeguarding Policy and Procedure for Children, Young People and Vulnerable Adults' did not include a definition of a vulnerable adult. Staff applied a common sense approach to who they considered a vulnerable person and/or a person in vulnerablecircumstances.

16.5.21 This Policy is the subject of annual formal review and was last updated in January 2018. It is now compliant with the Care Act 2014 (adultsafeguarding) and Making Safeguarding Personal[6] .

16.5.27 The Borough Council identified the following three single agency recommendations:

- *Recommendation 1*

The Borough Council to produce policy and procedures regardingdomestic abuse, which should include risk assessment and risk management.

- *Recommendation 2*

The Borough Council to provide training in domestic abuse for all home visiting staff relevant to their role.

- *Recommendation 3*

The Borough Council to promote awareness amongst its staff of theadult safeguarding process and escalation procedures.

16.6 West Mercia Police

16.6.1 West Mercia Police had contact with Steven dating back to 1996. Information recorded on Police systems within the time parameters of the review identified his homeless status, his alcohol addiction and the fact that he had been seen on occasion begging in the town centre.

16.6.2 There is no indication that the Police submitted vulnerable adult referrals directly in respect of Steven during the review period although the details of his circumstances were recorded on referrals to Adult Social Care made in respect of Jenny. That is not to say that officers from West Mercia Police, particularly members of the Local Policing Team did not recognise his vulnerability. There was evidence in particular of concerted effort by LPO 2 to persuade Steven to engage in alcohol treatment services. Steven agreed to a referral being made on his behalf in December 2015.

16.6.3 Jenny was considered to be vulnerable by West Mercia Police. The information provided by her sister that 'Jenny had the mental age of a child' was repeatedly reported in the records made when officers attended incidents with Jenny.

16.6.4 'Vulnerable Adult' referrals to Adult Social Care detailed varying factors which included concerns about her mental well-being, her 'mental age', her exposure to suspected domestic and financial abuse and her lack of engagement with agencies.

[6] Making Safeguarding Personal Guide April 2015 Local Government Association and Association Directors of Adult Social Services

16.6.5 In April 2015 LPO 1 revisited Jenny at home following the incident of the previous evening which was good practice.

16.6.6 In reviewing the Police actions the IMR author stated that the DASH had been completed in the absence of either Jenny or Steven. The risk was assessed as standard with the rationale that it was the first reported incident between the two, it was argument only and as Jenny was a vulnerable adult it would be monitored by the Local Policing Team via the risk management plan in respect of her.

16.6.7 The recording of the risk as standard because the circumstances would be monitored by the local policing team would appear to be a mix of the risk assessment process and the risk management procedures which would be put in place in consideration of the risk level.

16.6.8 The previous domestic incidents between Jenny and a previous partner were noted. No consent was recorded to share information with other agencies. A referral to the Police Harm Assessment Unit was made but there was no recorded conclusion.

16.6.9 Following the domestic incident in July 2015 there was clear evidence of a robust investigation by the attending Officer. The Officer also successfully managed to engage Jenny in the DASH risk assessment process which was good practice as it was the only occasion where Jenny's full engagement was secured.

16.6.10 Within the rationale of the risk assessment, the officer recorded that the victim was a vulnerable adult who wanted to resume the abusive relationship and that neighbours and friends had expressed concern.

16.6.11 During the risk assessment Jenny told the officer that Steven had become aggressive when he was drunk; he had pushed her out of bed and forced his thumb against her windpipe. She said he had previously pinched her and spat upon her. He was threatening and she had begun to retaliate by striking him back when he assaulted her. Jenny she said she was upset at the way he treated her but was also upset that he may not come back to the flat, as she wanted to continue the relationship. She added that she feared further violence from him.

16.6.12 The officer concluded the level of risk to Jenny to be medium.

16.6.13 Given the identified risk factors this should have been recorded as high risk. The case should have been referred to MARAC for this reason alone, however given Jenny's vulnerability and Steven's history there were other occasions when the case should have been referred to MARAC under professional judgement.

16.6.14 Although Jenny did not support the investigation the Officer recorded details of Jenny's injuries and secured a witness statement from her neighbour to whom Jenny had disclosed that she had been assaulted by, and was afraid of Steven.

16.6.15 The Officer pursued a victimless prosecution but a charge was not authorised by the Crown Prosecution Service.

16.6.16 In the absence of the opportunity for prosecution, in accordance with policy, the officer then pursued a Domestic Violence Protection Notice (DVPN) in respect of Steven which was appropriately authorised by a Police Superintendent and the case file to support the application for the DVPO was prepared.

16.6.17 The officer's investigation, pursuit of a victimless prosecution and subsequent application for a DVPN/O are recognised as good practice.

16.6.18 In July 2015 the DVPN was served upon Steven.

16.6.19 The enquiry was passed to early-turn officers to re-visit Jenny and pursue the DVPO but the court records report that the application was dismissed as the Police did not attend court. The IMR author was unable to establish why the matter was not presented at court.

16.6.20 The failure by West Mercia Police to monitor Steven's compliance with the DVPN and pursue application for the DVPO was a breach of process and the statutory guidance. This was a missed key opportunity to have put in place multi-agency interventions to protect and safeguard Jenny and to engage with Steven regarding his lifestyle and behaviour, and in particular his alcohol dependency. It should be emphasised that the concept of the DVPN/O process to is take the decision out of the hands of the victim who is trapped in an abusive / coercive relationship and unable to do this for themselves out of fear or failing to recognise themselves as a victim and at significant risk.

16.6.21 The IMR author reported that no consent was given for referral to alcohol treatment services however referrals were made to Adult Services and Women's Aid.

16.6.22 He also reported that the Police Domestic Abuse Unit considered the case but concluded that as referrals had already been made and a RMP was running there was no need for a further Vulnerable Adult Referral. The IMR author helpfully reported that under current arrangements an additional Vulnerable Adult Referral would have been made.

Recommendation 1

- *West Mercia police to provide assurance to partners around notifications of Domestic Violence Protection Orders and to ensure there is a revised programme of training in their application.*

16.6.23 In July 2015 the Adult Safeguarding Team held a telephone discussion with the Police Harm Assessment Unit regarding the referral made in respect of the incident on 5th July 2015.

16.6.24 During the conversation it was confirmed that Jenny had not engaged in the Police investigation and had indicated that she wished to remain in a relationship with Steven. The Adult Safeguarding Team closed the section 42 enquiry recording that Jenny had not been highlighted as having any concerns regarding her capacity and had declined any support to the incident and did not under any circumstances wish to pursue charges towards her partner insisting that she wished for him to return to the home environment.

16.6.25 Regarding the Police action following attendance at the reported domestic abuse incident between Jenny and Steven in August 2015 the Police IMR author reported that the risk assessment process was not sufficiently effective as neither person had contributed to the risk assessment process and the assessment had been conducted from previous records. Hequalified this by reporting that the questions regarding alcohol and mental healthhad been answered in the negative.

16.6.26 The publication of the College of Policing national review into the police service use of DASH is awaited however the Chair made enquiry regarding this case and the national review early findings.

16.6.27 The College of Policing are in the process of piloting a DASH model which has a reduced focus on a 'yes/no' process in favour of more involved discussion and enquiry with victims. It was felt unhelpful by the College of Policing to support a recommendation to seek a DASH related specifically to victims with needs such as Jenny's. This was on the basis that, had there been better understanding of and compliance with the relevant legislation and procedures, then engagement with Jenny could and should have been secured.

16.6.28 The Chair also engaged with Mrs Judith Vickress of Safelives. She explained that Safelives have observed often that police are not always using the DASH risk assessment as a tool to inform their professional judgment as intended but more as a 'tick box exercise'.

16.6.29 Jenny was the subject of a Police risk management plan for 2 separate periods of time, originally put in place because of her vulnerability with her previous partner. It was closed when that relationship ended but re-opened by LPO 2 when she commenced her relationship with Steven. The LPO recorded that Jenny was vulnerable and was being exposed to the same risks with Steven as had existed in her previous relationship.

16.6.30 Entries recorded on this plan related to both anti-social behaviour and domestic abuse incidents. The learning regarding this was that where entries

were made which were reflected as domestic abuse arguments, domestic abuse policies and procedure were not always followed.

- *Recommendation 2*

West Mercia Police to ensure that when Risk Management Plans are in place for combined issues the domestic abuse policy and procedure is always pursued.

16.6.31 On 21st March 2016 LPO 2 and the ASB Officer attended Jenny's address to talk to her about reports of her begging. It was evident that the officers were focussed on Jenny's vulnerability, and that her begging indicated this, but the LPO did not consider the fact that her begging was indicative of her being exposed to coercive and controlling behaviour by Steven.

16.6.32 The officer asked a series of direct questions to establish if she was the subject of any abuse by Steven or the subject of controlling behaviour by him.

16.6.33 The 'no' responses given by Jenny to the direct style of questioning are typical of victims of coercive and controlling behaviour. This is indicative of the fact that West Mercia Police have not suitably trained their staff in understanding the dynamics of coercive and controlling behaviour. West Mercia Police requires officers to undertake a number of National Centre for Applied Learning Technologies (NCALT) packages but none sufficiently cover coercive and controlling behaviour.

16.6.34 IMR author reported that whilst the Police had delivered some training on domestic abuse it was acknowledged that officers have not received specific training on the Section 76 Serious Crime Act 2015 offence of 'coercive and controlling behaviour', which came in to force in December 2015.

16.6.35 He also reported that this case involved many aspects of coercive and controlling behaviour and that officers understanding and approach would have benefited from having a greater insight in to its effects and how a victim may present.

16.6.36 The IMR author also identified that there needed to be an improvement in knowledge of the DVPN/O process.

- *Recommendation 3*

West Mercia Police should equip officers and staff with the required knowledge and understanding of behaviours and legislation in relationto coercive and controlling behaviour.

16.6.37 In 2000 the Department of Health published 'No Secrets'[7] which included the following definition of a vulnerable adult:

[7] No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, Department of Health 2000.

'A vulnerable adult is any person aged 18 years or over who is or may be in need of community care services by reason of mental, physical, or learning disability, age or illness AND is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation'.

16.6.38 In 2012 the then National Policing Improvement Agency (NPIA) published 'Guidance on Safeguarding and Investigating the Abuse of Vulnerable Adults' 2012[8]. That document identified that the guidance applied to the same definition of a vulnerable adult.

16.6.39 In 2012 the NPIA was replaced by the College of Policing as the professional body for the Police service in England and Wales who are responsible for producing 'Approved Professional Practice' (APP) for the Police Service and for the development of training packages in support of APP.

16.6.40 'No Secrets' was repealed with the enactment of the Care Act 2014 on 1st April 2015.

16.6.41 The College of Policing has not produced APP for Adult Safeguarding for the Police Service and reinforces that currently, until it does, Police Services should comply with the NPIA procedures published in 2012.

16.6.42 As a consequence of this position West Mercia Police continue to operate to the definition of Vulnerable Adult which was repealed with the introduction of the Care Act 2014 and their staff are not trained in how to recognise and respond to adult safeguarding episodes when they come across them in accordance with the Care Act 2014 and Making Safeguarding Personal[9]. In addition there exists a lack of understanding regarding the issues of capacity and consent.

- *Recommendation 4*

West Mercia Police to produce a local policy and procedure on Adult Safeguarding given the current absence of Approved Professional Practice.

- *Recommendation 5*

West Mercia Police to raise staff and officer's awareness of the Care Actwith particular regard to adult safeguarding.

16.6.43 The position is compounded by the frequency with which police officers and staff are encountering individuals (vulnerable adults) who display a range of complex needs including but not confined to drugs and alcohol misuse and mental health.

[8] NPIA 'Guidance on Safeguarding and Investigating the Abuse of Vulnerable Adults' 2012 .
[9] Making Safeguarding Personal Guide April 2015 Local Government Association and Association Directors of Adult Social Services

16.6.44 In addition West Mercia Police's current Vulnerability Strategy[10] also encourages officers to take a broad view of vulnerability.

16.6.45 The above three elements result in West Mercia Police personnel in response to certain incident types submitting 'Vulnerable Adult' referrals which record complex needs and vulnerability issues. These are submitted to either Local Harm Assessment Units or Multi-Agency Safeguarding Hubs (MASH), who in turn make onward referrals to partner agencies, including Adult Social Care Services.

16.6.46 It is acknowledged that the current co-location of adult safeguarding staff and police harm assessment unit staff has improved communication and decision making regarding the onward referral of police information to adult social care. However a limitation remains in that whilst this process ensures unnecessary referrals do not progress, no developmental feedback is given to referring staff.

16.6.47 Often those issues which are being identified as matters impacting on an individual's vulnerability are matters outside of the scope of adult social care and/or safeguarding procedures, in particular referrals concerning an individual's mental health, alcohol and/or substance misuse. They alsooften lack acknowledgement of issues of capacity and consent.

16.6.48 Following specific enquiry by the Chair on this point the IMR author reported that the lack of pathways that should be the starting point for this issue.

- *Recommendation 6*

WMP to review the process of referrals to partner agencies following response to incidents involving vulnerable adults.

16.6.49 In April 2018 West Mercia Police appointed a Detective Sergeant with the requisite specialist knowledge and experience in adult safeguarding and related partnership working to a bespoke role to produce local policy and procedure, and to oversee amendments to current training provision.

16.7 <u>Worcestershire County Council Adult Social Care (ASC)</u>

16.7.1 Worcestershire Adult Social Care did not have any contact with Steven.

16.7.2 The learning related to adult social care was with regard to their ongoing involvement with Jenny's case which was generally in response to concerns raised by other agencies. When discussed it was often agreed that no further action by adult social care was required.

16.7.3 Following the referral of Jenny in October 2012 the IMR author identified that with regard to the actions of ASC Community Learning Disabilities Team there was a perception amongst workers that if it was evident that a service

[10] West Mercia Police Vulnerability Strategy 'see past the obvious'

user would not meet the eligibility criteria or there were no apparent social care needs then there was no need to complete a needs assessment. He identified that it was always necessary to complete a proportionate assessment as evidence that the service user has no apparent social care needs.

16.7.4 The IMR author identified the following single agency recommendation.

- *Recommendation 1*

Worcestershire Adult Social Care to ensure that an assessment by the most appropriate team should take place to determine whether a person has eligible needs.

16.7.5 In January 2013 a Support Plan was completed following the Needs Assessment conducted with Jenny. The IMR author identified that whilst this was a positive outcome there were challenges in persuading Jenny to engage with the services offered and made the following single agency recommendation.

- *Recommendation 2*

Worcestershire Adult Social Care to amend the guidance on the risk assessment of people who do not engage with services to include lack of engagement with professionals and disseminate to staff.

16.7.6 In July 2015 in discussion with ASC a housing support worker outlined Jenny's vulnerability and reported a number of areas of concern which included that she and Steven were in the town centre every day drinking and begging. She also said that Steven was very controlling and she wasn't sure if Jenny had mental capacity. She explained that Jenny had a learning disability 'of some kind', but was unable to confirm a diagnosis.

16.7.7 In July 2015 the safeguarding concern raised by SW1 contained information from the referring police officer that Jenny had no access to money, that he was concerned that Steven was influencing and controlling and that he suspected that Jenny was being financially abused and exploited.

16.7.8 In July 2015 a social worker spoke to the housing options worker regarding a previous section 42 which had been closed as Jenny had not consented to police action following a domestic incident. The housing options worker stated there was no need for a Social Care Assessment. Jenny would not engage, had not consented to a referral and was independent with personal and domestic activities of daily living and had declined support from them with her domestic abuse.

16.7.9 In June 2016 LPO 2 contacted the consultant Social Worker to discuss concerns he had raised about Jenny. He detailed that Jenny was a vulnerable adult and explained that her monthly benefits were paid to Steven and he

was concerned whether financial abuse was occurring. He also said Jennyhad been reportedly begging and that Steven was alcoholic. He said they were having difficulty engaging with Jenny. The social worker asked LPO 2 if we wanted to report the suspected abuse as safeguarding but he said for now he would just like his concerns passed through to triage and asked if a Social Worker could call him back.

16.7.10 Whilst it was reasonable for ASC staff to work under the assumption that other agencies had policy and procedures and had appropriately trained their staff on the Mental Capacity Act and the Care Act, including Adult Safeguarding and Making Safeguarding Personal[11] it has been identified that this was not the case.

16.7.11 From the narrative in both the referrals and on occasions conversations with borough council housing and police staff, ASC staff could have reasonably drawn the conclusion that there was a lack of professional knowledge of both care and support guidance and the adult safeguarding process.

16.7.12 Additionally Jenny's needs were assessed by ASC as being met by a combination of support from her sister and the housing support function. During her relationship with Steven it became apparent that these 'protective' factors were being eroded and as such were a substantial change in Jenny's circumstances.

16.7.13 Given these combined factors ASC should have taken a leadership role in conducting a further needs assessment with Jenny and/or direct safeguarding activity.

16.7.14 Learning is also identified from the decision recorded by the Adult Safeguarding Team, Worcestershire Council on 16th July 2015 to close the section 42 enquiry. The rationale was Jenny had not been highlighted as having any concerns regarding her capacity and had declined any support to the incident and did not under any circumstances wish to pursue charges towards her partner insisting that she wished for him to return to the home environment.

16.7.15 It is known that for a range of reasons victims of domestic abuse choose not to engage with either or both of police investigative processes and domestic abuse support agencies. This stance should not be viewed as indicating no consent for adult safeguarding procedures. The Care Act 2014 and MSP outline how individuals should be supported to raise safeguarding concerns and this should have been treated both differently and separately in this case. However, it needs to be acknowledged that the Care Act was

[11] Making Safeguarding Personal Guide April 2015 Local Government Association and Association Directors of Adult Social Services

implemented on 1st April 2015 and made significant changes to adult safeguarding which had implications on practice.

16.7.16 In Jenny's case there was the additional issue of whether she had the capacity to understand what she was being offered and asked to engage with, not only because of her learning disability but also because she was living with coercive control which has an impact on capacity.

16.7.17 Local Government Association (LGA) and Association of Directors Adult Social Services (ADASS) guidance[12] identifies that assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by, or lives with, a family member or intimate partner and is seen to be making decisions which put or keep themselves in danger. Skilled assessment and intervention is required to judge whether such decisions should be described as 'unwise decisions' which the person has capacity to make, or decisions that are not made freely, due to coercion and control.

16.7.18 The guidance also identifies that recent case law has clarified that there is scope for local authorities (using the principle of inherent jurisdiction) to commence proceedings in the High Court to safeguard people who do not lack capacity, but whose ability to make decisions has been compromised because of constraints in their circumstances, coercion or undue influence.[13]

16.7.19 In April 2013 Jenny had been the subject of Mental Capacity Assessment to assess her understanding of the risks involved in engaging and continuing to engage in a relationship.

16.7.20 The fact that no such assessment was conducted with regard to her relationship with Steven should be considered a missed opportunity. The housing officers and police officers had the opportunity repeatedly to consider this aspect but given the learning that their organisational policy and training was lacking in this regard it was unlikely to have happened. Again it may have been helpful if ASC colleagues had undertaken a leadership role and prompted the other agency professionals accordingly.

16.8 <u>Multi-agency procedure and practice</u>

16.8.1 The agencies should have recognised that collectively the events involving Steven and Jenny were indicative of him displaying a pattern of coercive and controlling behaviour towards Jenny, and that because of her needs she was more vulnerable to this form of behaviour.

16.8.2 One aspect of this review were the differing levels of professional knowledge of the relationship between how Jenny's needs were assessed and being met,

[12] Adult safeguarding and domestic abuse - A guide to support practitioners and managers 2013 revised October 2014

[13] DL vs A Local Authority and Others (2012)

how a learning difficulty or learning disability adds complexity and whether the agencies understood how the latter may have impacted on how Jenny responded to officers who were endeavouring to secure her understanding of the possible risks she faced.

16.8.3 Professionals needed an appreciation of how Jenny's needs would have impacted on their attempts to engage her in discussions about those risks and an appreciation of Jenny's ability to understand what she was being asked to engage with, when support services were being offered.

16.8.4 Professionals needed to understand the Mental Capacity Act and in particular whether there would have been benefit in formally assessing Jenny's ability to make certain decisions.

16.8.5 The learning with regard to the police and borough council's lack of policy and procedures and training and awareness for staff on Adult Safeguarding and the Mental Capacity Act has already been identified.

16.8.6 In addition their staff would also have benefitted from an understanding of the role of adult social care, and in particular how individual's needs are assessed and met in accordance with the Care and Support statutory guidance.

16.8.7 Social care recorded that when seeking support for Jenny after her mother had moved to residential care, Jenny's sister suggested that Jenny was able to learn independent living skills.

16.8.8 The panel had the benefit of specialist advice from Mrs Caroline Kirkby. The Chair also consulted with Mr Keith Smith the Head of Consultancy, British Institute of Learning Disabilities (BILD). The aspects explored with them were Jenny's ability to engage with the agencies concerned and her ability to understand the risks they believed she faced.

16.8.9 Mrs Kirby explained that it was unusual for a person to be diagnosed with learning disabilities so late in life, Jenny was 51 years of age at the time of this diagnosis. Her view was based on information available to her at the time of the Care and Treatment Review (CTR). At this time Jenny had been open to the Adult Social Care community team not the learning disability team and their view was Jenny had a learning difficulty. In Mrs Kirby's view Jenny's presentation during the CTR and the social care case notes supported this.

16.8.10 Mrs Kirby advised that current day diagnosis of learning disability of an individual is established during pre-school and school, usually as a consequence of professionals noting that an individual was not meeting expected developmental milestones in childhood. She explained that Health visitors and GPs will look at what age the child is reaching their development milestones, and diagnosis is made via a range of psychological checks. The completed assessments measure against what is considered typical norms for

a child of that age, consideration is given to their level of understanding. As a child gets older the degree of development delay increases, and so diagnosis is usually during childhood. As the ability to progress and meet milestones continues the developmental delay becomes more apparent.

16.8.11 Mr. Smith stated that as Jenny was at school during the 1970's and 1980's the process was not as mature as it is currently and it was therefore possible that opportunities for Jenny to be diagnosed may not have existed. Given the overview of the case provided by the Chair to Mr. Smith he felt there was likely to be some basis for the diagnosis of a learning disability.

16.8.12 He explained that in the event of a person having a moderate learning disability then its presentation may not necessarily be consistent. It may also be that an individual would possess some skills and some abilities and dependent upon their level of motivation to achieve a particular task or goal they may well be able to achieve them.

16.8.13 In terms of communication, people with moderate learning disabilities are likely to present as being much more able than they actually are. It would take particular skill and experience to both recognise this and draw out the relevant aspects of a conversation.

16.8.14 In describing Jenny's circumstances to Mr. Smith he explained that given the high degree of support she was likely to have been given by her mother during her life, when she moved away from her mother, he was not surprised that her needs were then assessed as moderate.

16.8.15 He also offered the opinion, based on the collective experience of BILD, that Jenny having been supported by her mother was probably likely not to have had normal life experiences and possibly not had opportunities to develop areas such as socialisation and pursue hobbies, friendships and relationships.

16.8.16 The specific matter of Jenny not understanding the value of money, as reported by her sister was also examined with him.

16.8.17 Again drawing on BILD's broad experience he explained that often in families where benefits are paid to individuals these can often be absorbed into the household budget, thereby further reducing an individual's ability to learn and develop new skills, in this case the value of money.

16.8.18 Mrs. Kirby explained that it is very common for parents of children with a learning disability to be over protective and as a consequence individuals may not become empowered to develop key life skills for themselves. She used the following analogy. When Jenny's mother moved into residential care Jenny would have been approximately 45 years of age. With no experience of living on her own, managing day to day was likely to be challenging. She would have been likely to have behaved as a teenager might, with limited opportunities and life experiences this can often lead to

boundaries being tested, with little to reflect on. Additionally also again compromising any opportunities to develop new skills, friendships and become independent, all of which would significantly compromise her understanding of risk. It is likely that Jenny given her experiences would become vulnerable, and have limited capability to judge others.

16.8.19 Mr. Smith was also asked to consider Jenny's likely ability to engage in conversations with agencies, in particular Police and Housing Workers concerning her personal circumstances, with their focus being on the potential of her being a victim of domestic and financial abuse.

16.8.20 His view was that it was highly likely that officers engaging in such conversations were likely to have formed the view that given her answers Jenny understood the questions posed. He explained that Jenny would actually be giving answers based on her life experiences and would be giving answers she felt pleased the person posing them as opposed to being the actual answer.

16.8.21 In considering the same points Mrs. Kirby advised that Jenny would be keen to please and likely to answer simply yes or no. She also advised that when Jenny was talking to people she perceived to be in a position of authority she would be likely to try and be quick as she would not wish to prolong the meeting. Jenny would also be likely to feel anxious and scared about what the consequences might be when answering questions and this wouldimpact negatively on the degree of her engagement with agencies.

16.8.22 Mrs. Kirby has not received specific training in the offence of coercion and control but has a working concept of the principles.

16.8.23 She explained that given Jenny's life experiences she would be likely to actively seek out control given her previous dependence on her mother and sister. Jenny's sister and the Home Support Worker both described how Jenny would 'latch on to a new partner', which would appear to concur with Mrs. Kirby's opinion.

16.8.24 This showed that Jenny had a higher degree of vulnerability to coercive and controlling behaviour.

16.8.25 Mrs. Kirby and Mr. Smith both explained that professionals would have to adjust their communications in quite a skilled way to be able to have engaged Jenny fully in their discussions. In general terms people would have to think differently and pose questions in a number of different ways.

16.8.26 They agreed with the Chair's contention that it was probable that Jenny did not understand what in fact she was being asked to engage with, or as a minimum that services were not being explained to her in a way which she understood. The following is only one example of this point but this was clearly recorded by West Mercia Women's Aid concerning Jenny's lack of

consent for an IDVA referral, as 'she had not understood what that would entail'.

16.8.27 In addition to the above the Chair also spoke with Professor Erica Bowen, a Professor of Prevention of Violence and Abuse at Worcester University, to examine the level of understanding currently on the incidence of domestic abuse where learning disability is present.

16.8.28 She too confirmed that Jenny would be likely to respond with 'no' responses to the direct questions on the DASH Risk Assessment, and would answer in ways she believed would avoid people (Steven) getting into trouble.

16.8.29 Professor Bowen explained that there was a lack of international research on the subject, and with no work on perpetrators with learning disability at all.

16.8.30 Professor Bowen also identified that there remains some stigmatisation of people with learning disabilities and that there is a lack of appreciation that people with learning disability want relationships, including physical relationships. She identified that there is no systematic education programme on healthy relationships for people with a learning disability.

16.8.31 It is accepted that these elements are possibly beyond the parameters of this DHR however it is felt by the Chair to be of fundamental importance for this matter to be raised as a matter of significant importance for those agencies who provide domestic abuse services.

16.8.32 During follow up conversations between the Chair and IMR authors from the Police and Borough Council it became apparent that their knowledge of the Care Act, Care and Support statutory guidance, Adult Safeguarding statutory guidance and the Mental Capacity Act was not sufficient to enable them to pursue the elements of clarification required. As a consequence the panel member from the borough council and Head of Protecting Vulnerable People from the Police agreed that there would be benefit in the Chair meetingtheir respective front line staff jointly which occurred in December 2017.

16.8.33 The Chair met with LPO 2, the ASB Officer, the Home Support Worker (HSW) and a Housing Benefits Officer. LPO 2 also reported on other policing activity recorded in the Police RMP.

16.8.34 In addition to the areas outlined above there was also discussion which identified learning about the multi-agency system.

16.8.35 The overriding impression the Chair formed was of frontline staff who were very committed to the work they did, and a recognition and desire to work supportively in this case with both Jenny and Steven. The officers significant commitment and effort both individually and collectively throughout their whole period of working with Steven and Jenny was good practice.

16.8.36 All three home visiting officers recognised that Steven had his own vulnerabilities due to his alcohol dependency and gave a number of examples of talking to him about his alcohol dependency and to try and get him to engage in treatment.

16.8.37 The ASB coordinator described Steven as always being drunk to a degree but that he could still hold conversations on most occasions.

16.8.38 He also explained that Steven was generally trying to look after Jenny subject to the limitations of his ability to do so because of his alcohol consumption.

16.8.39 Steven told him that it was the death of his mother which caused him to become alcohol dependent.

16.8.40 Steven had agreed in December 2015 to be referred to alcohol services by LPO 2. The ASB Coordinator was of the view that this coincided with the fact that he and Jenny were to move to a new home in the New Year and that he potentially viewed it as a fresh start.

16.8.41 The three elements the officers articulated with regard to Jenny were their concerns about her vulnerability, their difficulty in securing her engagement with them and specifically her ability to manage her finances. They gave the examples of her begging, asking for food parcels and trying to sell household goods. The ASB Coordinator also confirmed that he found it difficult to engage Jenny and that often she presented as worrying about being in trouble. They collectively identified their concerns with regard to Steven having sole control of their finances.

16.8.42 LPO 2 also described how both he and his colleagues had found difficulty in engaging Jenny. He reported he tried adjusting his conversational style and asking a PCSO colleague to try to engage with Jenny recognising that as a female officer she may achieve more success.

16.8.43 In terms of partnership working, the discussion confirmed that officers from the police and council housing department did not have a clear understanding on the role of Adult Social Care and they did not understand how Jenny's needs had been assessed and were being met. Whilst it is acknowledged that these assessments were outside of the timescales for this review the content would have formed part of Jenny's case history and arguably would have been of value if shared with partner agencies whowere continuing to work with her.

16.8.44 The HSW first started working with Jenny in February 2013 and gave examples of supporting her to shop, tidy her home and visit her GP.

16.8.45 When first working with Jenny the HSW recalled that at that time Jenny had an allocated Social Worker who explained that Jenny 'had capacity'. The HSW explained she interpreted this to mean that Jenny had the capacity to live

independently which she stated she found challenging as she was working with the information that 'Jenny had the mental age of a 13 year old', could not read, write nor understand the value of money. In addition she gave examples of Jenny's limitations in certain aspects of her daily living activities, including that she did not know how to use a microwave oven, did not understand how to work the heating in her home and could not tell the time.

16.8.46 The term 'capacity' within the context of this review is in regard to Jenny's capacity under the Mental Capacity Act to be able to make specific decisions.

16.8.47 What had in fact been assessed by adult social care was Jenny's ability to live independently.

16.8.48 As part of that assessment social care had taken into account the view of Jenny's sister that Jenny could learn new skills, that Jenny was being supported with her finances by her sister and with her daily living by her sister and the housing support worker.

16.8.49 Had police and housing officers fully understood this they could have discussed any substantial change to these circumstances with adult social care and referred Jenny for a further needs assessment. Police and Housing Workers were working under the misapprehension that either Jenny had an 'allocated Social Worker' or was as a minimum an 'open case', or in the absence of either, that their repeated submission of referrals would result in the allocation of a Social Worker.

16.8.50 In other circumstances officers from the Police and Borough Council should have raised safeguarding concerns.

16.8.51 Police and Council Officers were in fact submitting 'vulnerable adult' referrals to adult social care. In the case of the Police in line with a vulnerable adult definition repealed by the Care Act and in the case of the council a 'common sense' approach to people who are vulnerable.

16.8.52 The Adult Social Care panel member also observed that from her perspective the conversations regarding the suspected abuse of Jenny were separated from the discussions about her care. To have engaged Jenny directly in those discussions would have been beneficial. This should have occurred in line with 'Making Safeguarding Personal'.

16.8.53 It was apparent that the accumulated picture was not fully understood by each of the agencies involved, namely Police, Housing and Adult Social Care.

16.8.54 This manifested itself as a frustration from the Police and Housing officer's perspective, who felt they were making a significant number of referrals articulating their concerns of Jenny's vulnerability and suspected financial abuse, to result in no apparent activity and no feedback to them.

16.8.55 LPO 2 explained that he had commenced in his local policing role in 2015 at which time he had started working to support Jenny and Steven and in conjunction with the colleagues from housing. He was also able to report on his knowledge of them and both his and other policing colleagues' activity recorded in the two Police risk management plans.

16.8.56 He explained that the one risk management plan had been in respect of a generic anti-social behaviour problem presented by a group of street drinkers amongst who was Steven, Jenny was also occasionally present.

16.8.57 The second plan focussed specifically on Jenny's vulnerability and included references to her previous relationship within which she was considered to be highly vulnerable to both domestic and financial abuse. This plan which ran from the periods 5th February to 13th March 2013 and 21st April to 9th June 2015 had 51 recorded visits to Jenny by Local Policing Team members.

16.8.58 He was specifically asked by the Chair if he felt that the risk management plan was focussed on the anti-social behaviour at the possible expense of the understanding of the incidence of domestic abuse. LPO 2 did not feel that was the case and drew reference to the high number of entries regarding Jenny's vulnerabilities and the suspected financial abuse of her together with entries regarding domestic arguments.

16.8.59 Jenny's ability to manage her finances was actively questioned by Housing Workers and Police Officers alike. All three of the LPO, HSW and ASB Coordinator described their concerns and indeed frustrations at not being able to get Jenny to understand her financial risks. The LPO recalls Jenny showing him clothes she had bought with her money to justify her expenditure, but they were clothes from a budget store and he stated that this simply demonstrated she did not understand the value of money. Throughout her life Jenny had been supported to manage her finances by her mother and then latterly her sister.

16.8.60 Had the officers better understood the Mental Capacity Act there would have been an opportunity for them to have liaised with health and/or social care colleagues to establish formally if Jenny had the capacity to manage her finances.

16.8.61 It is however acknowledged that other professionals also had a key role to play in this regard.

16.8.62 ESA, disability living allowance and personal independence payments are all administered by DWP.

16.8.63 Jenny was also in receipt of housing benefit which is administered by the local authority, in her case the local borough council.

16.8.64 Steven claimed ESA between 18th October 2013 and 19th September 2015 (when he was named by Jenny on their joint benefit claim).

16.8.65 Jenny had historically claimed disability allowance and incapacity benefits under the previous system as her related medical assessment had deemed that she had a mental illness.

16.8.66 In December 2012 Jenny was placed onto ESA, with an enhanced payment of disability living allowance and personal independence payments in accordance with the revisions at that time to the benefits system. Jenny was placed into the 'Support Group' classification, which meant that she was formally recognised as having severe health issues and that Jenny would never work. As a consequence she had no need to personally meet with a member of DWP or the job centre.

16.8.67 People who live together have to claim joint rather than individual benefits, whether a tenancy is a single or joint tenancy.

16.8.68 From February 2015 the local borough council considered that Steven and Jenny were living together and as a consequence this triggered the process whereby they had to claim joint benefits.

16.8.69 The Housing Benefits Worker provided clarity on the housing benefits process. It was learned that Jenny would have been sent letters with instructions and a form to complete which she would not have been able to action as she could not read nor write.

16.8.70 Three different members of DWP were spoken to by the chair and as such contributed to the review. However, it is worthy of note that there is no person with lead responsibility for safeguarding that could be identified.

16.8.71 Jenny's sister was her appointee between December 2011 and October 2015 and as such was fully responsible for all dealings with DWP. Enquiry by the Chair with DWP identified that in transferring welfare payments from Jenny's sister to Steven, DWP would have been required to both seek consent from her sister and interview Steven.

16.8.72 Jenny's sister informed the Chair that she had received a letter from DWP informing her that she was no longer Jenny's appointee. In response she had a telephone conversation with DWP who were unable to give any further information.

16.8.73 DWP were unable to provide clarity as records are systematically destroyed at the eighteen month point in time on customer's records.

16.8.74 During enquiry with a differing member of DWP staff the Chair was informed that 'DWP deal with forms not people'. This is included not as acritical comment concerning the staff member, who was endeavouring to be helpful to the review, but to show that there is remaining concern that individual'sin

the ‘support group’ may be subject to decisions being made without DWP being fully aware of their personal circumstances, in particular their needs and abilities.

16.8.75 It is contended that in this case, albeit possibly not overtly, Jenny was asked to make the decision to allow Steven to receive all of her benefit payments and as a consequence Jenny’s ability to make that decision may have been overlooked.

16.8.76 Historically Jenny’s mother and sister had been heavily involved in managing her finances, and indeed DWP had accepted Jenny’s sister as herappointee.

16.8.77 Jenny being seen repeatedly begging and on occasion a lack of food in her home also evidenced concern that she was not managing her finances well.

16.8.78 After Steven’s death Jenny had to be supported to re-arrange her finances. In July 2017 she was assessed as lacking the capacity to manage her finances.

16.8.79 The facts would indicate Jenny’s ability to make the decision to allow Steven to receive all of her benefits and manage her finances should have been the subject of formal assessment under the Mental Capacity Act.

16.8.80 The result was that Jenny’s housing benefits, ESA and personal independence payments, which amounted to approximately £1000.00 per month were wholly paid into Steven’s account.

16.8.81 Payments were made through the ‘simple payments’ processes, being made into a Post Office account from which the account holder can only makecash withdrawals.

16.8.82 The ASB coordinator said that in his view Steven did endeavour more than Jenny to make sure bills were paid. This further confirmed his view that Jenny was not able to manage her finances.

16.8.83 The consequence of the benefits payments being made to Steven was inevitable. His compulsion to drink because of his alcohol dependency syndrome drove him to spend significant amounts of their benefits on alcohol. The linked consequence was the financial abuse of Jenny.

16.8.84 The HSW explained that she and ASB Coordinator did give Jenny and Steven significant assistance to work through the process, but identified that Jenny’s reluctance to engage with them had drawn the process out over an extended period of time, approximately from April to September 2015.

16.8.85 It was identified that Jenny had been telling the HSW and ASB Coordinator she was arranging a bank account for herself when this transpired not to be the case. The HSW offered the view that this was why Jenny had been reluctant to allow them to assist her with the process.

16.8.86 The HSW explained that she tried very hard to get Jenny to understand that she should have her own account as the significant proportion of benefits were hers, and that she feared the risk of Steven spending it on alcohol.

17. CONCLUSIONS

17.1 Steven was acknowledged by his GP practice, the police and housing as being vulnerable because of his social circumstances, his alcohol dependency and his related physical and mental illnesses. He lived variously between friends' houses, hostel accommodation and later in his life was homeless, again reinforcing his vulnerability.

17.2 People described by some agencies as a 'vulnerable adult' often fall between services and are not eligible for longer term engagement and support of statutory services. This particularly applies in the case of an adult who elects not to engage with services, (accepting the circumstances where a lack of mental capacity may be a factor). In Steven's case he was never referred to Social Care for a formal Care and Support Assessment and were such an Assessment to have been conducted the likely outcome cannot be predicted.

17.3 On this aspect the CGL panel member in his capacity as an expert on alcohol addiction suggested that any of the agencies could have referred Steven to ASC Services for a Care and Support Assessment.

17.4 Statutory guidance[14] states that:

A Local Authority must undertake an Assessment for any adult who appears to have any level of needs for care and support, regardless of whether or not the Local Authority thinks the individual has eligible needs.

The guidance states that an adult's needs meet the eligibility criteria if:

(a) The adult's needs arise from or are related to a physical or mental impairmentor illness

(b)) as a result of the adult's needs the adult is unable to achieve two or moreof the specified outcomes, and

(c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being.

17.5 The panel member identified that Steven suffered from alcohol addiction, a mental health problem. As a result was unable to achieve two or more of the specified outcomes, in his specific case;

to maintain a habitable home environment, engage in work or training and maintain family relationships and;

[14] Chapter 6 Assessment and Eligibility Care and Support Guidance issued under the Care Act 2014

there was clearly a significant impact on Steven's well-being.

17.6 The panel member acknowledged some of the challenges this would pose but outlined that most often referrals for a Care and Support Assessment on the outlined rationale would not result in an Assessment of Need or in the provision of support or care. Currently if an individual is engaged in alcohol treatment the service provider will advocate in relation to housing and finances.

17.7 The Adult Social Care panel member identified that the overall assessment would determine the level of impact on well-being thus determining eligibility. It cannot be assumed from the terms 'alcohol addiction' and 'mental health problem' that this would automatically lead to someone being unable to achieve two or more of the specified outcomes.

17.8 It is acknowledged that for either access to treatment services or assessment for care and support an individual would have to be willing to engage and in Steven's case most often he did not engage with alcohol treatment services, but a joint approach with Adult Social Care colleagues may have been a more attractive proposition.

17.9 It was apparent that GP services and the hostel did provide good levels of support to Steven. It was also evident that members of West Mercia Police and Borough Council Housing Services also tried hard to secure Steven's engagement with alcohol treatment services but were unable to get him to do so.

17.10 Jenny was acknowledged as being vulnerable by all of the agencies involved.

17.11 In 2012 a capacity assessment was conducted with Jenny when she was deemed to understand the risks involved in continuing her relationship with her previous partner.

17.12 No formal capacity assessment was conducted with Jenny concerning her understanding of the risks within her relationship with Steven. It was apparent that within this relationship she was not recognising the risks of his behaviour on her welfare.

17.13 There was a lack of clarity on Jenny's status of having either a learning difficulty or a learning disability. The diagnosis of learning disability remains a matter of professional discussion in Worcestershire.

17.14 It was apparent that whilst there was a recognition of Jenny's needs in police and housing officers, and there was a lack of awareness of how to adapt procedural approaches when endeavouring to secure her engagement. This is also linked to the fact that police and housing had not adequately trained their staff on the Mental Capacity Act 2005 with particular regard to the understanding of a need to assess or cause to be assessed a person's capacity to make specific decisions.

17.15 This is of particular relevance given the statement that Jenny is described as 'refusing to engage with services'.

17.16 The time period of the review included 1st April 2015, the date on which the Care Act 2014 was enacted and 29th December 2015 the date on which 'coercion and control' became a criminal offence under the Serious Crime Act 2015. It was established that not all agencies had appropriately trained their staff in this regard.

17.17 Not all agencies understood the role of Adult Social Care to help people to live as independently as possible for as long as possible and that any action with an adult can only be instigated with their consent (accepting where mental capacity may be an issue alternative approaches may be appropriate).

17.18 There was also a lack of understanding of the process of Adult Safeguarding and the fact that where protective intervention may be required, it must be in a way in which the individual affected is empowered to take action themselves, and the least intrusive response for the risk presented is taken.

17.19 As a consequence of the combined lack of understanding this resulted in referrals to Adult Social Care from the police and borough council which were not and could not be acted upon by them. This 'inactivity' in turn manifested itself as frustration from some partner agency staff who were in anticipation of action by Adult Social Care when in fact this was not going to be the case.

17.20 Conversely there were opportunities for Adult Social Care staff to recognise these gaps in knowledge amongst other agencies and to both take and prompt activity accordingly.

18 LESSONS TO BE LEARNED

18.1 The term 'vulnerable adult' is used variously by differing agencies and with no degree of consistency. To use the term 'vulnerable adult' within multi-agency communications is unhelpful, particularly where it's use is for the purpose of referring a 'vulnerable adult' into services when there is no consent for such a referral and/or for matters where no referral pathway exists.

18.2 Jenny not supporting police investigative processes into alleged domestic abuse offences were incorrectly interpreted by adult social care professionals as a proxy for her lack of engagement with the adult safeguarding system.

18.3 There was a lack of knowledge of and clarity on the inter-dependency and inter-connectivity between domestic abuse offences and processes, the Mental Capacity Act, the Care Act (Adult Safeguarding) and Making Safeguarding Personal. Therewas also a lack of awareness of the West Midlands Regional Adult Safeguarding Procedures.

18.4 The Care Act 2014 defines domestic abuse as one of the categories of abuse for adult safeguarding. LGA and ADASS have also produced supportive guidance[15] for frontline adult social care professionals which did not appear to be embedded into current

[15] Adult safeguarding and domestic abuse A guide to support practitioners and managers

working practice. There needs to be local clarity in process and procedures regarding domestic abuse within the context of adult safeguarding settings which should include a protocol between Adult Social Care and West Mercia Women's Aid.

18.5 In this case there was significant contact between agencies but little in the way of actual communication, as evidenced by the Police and Borough Council 'referrals' into Adult Social Care, and the resultant lack of activity by the latter agency and lack of feedback to referring officers.

18.6 There were possible opportunities for shared understanding of Jenny's statusby adult social care with other professionals working to support her.

18.7 There would have been benefit in arranging a professionals meeting to agree common language and a consistent description of the risks the agencies perceived Jenny faced. This would have also provided the opportunity to explore whether Steven having sole control of their finances were presenting a risk to his welfare given his alcohol dependency.

18.8 Taking into account the whole circumstances of the relationship between Steven and Jenny and her vulnerability, she is likely to have met the high risk threshold for MARAC had professional judgment been applied. Had a MARAC referral been made it is likely that this would have been the catalyst for a better multi agency response. MARAC would have looked to reduce the risk to Jenny by creating an action plan that worked to manage the behaviour of Steven. In doing so it is highly likely that this would have led to the identification of the support he may have needed.

18.9 Referral to the MARAC process would result in a referral to the IDVA service. The role of the IDVA is to engage victims into support and coordinate the multi-agency response. Where a victim already has support networks and may be overwhelmed by more support, the IDVA or specialist domestic abuse service would work with the professional with the best relationship with the victim to ensure all advice and support is also considered through a domestic abuse lens. There is a notable absence in this case of any domestic abuse specialism which may have made a considerable difference to support her response to the domestic abuse Jenny experienced.

18.10 As has been reported although a DVPN was issued against Steven, it was neither enforced nor was the Order pursued. The review found that there was a lack of collective multi-agency understanding of the DVPN/O process and the proactive partnership opportunity the DVPN/O process presents.

18.11 The issue of the resilience of agencies to allocate an IMR author varied by agency. The timeliness of responses to follow up enquiries and requests for clarity from the chair was an issue on the part of Worcestershire County Council Adult Social Care, Redditch Borough Council and West Mercia Police. This is not recorded as a criticism but seeks to acknowledge the fact that often review work is tasked to individuals who already have a significant workload.

18.12 In the specific case of West Mercia Police this was further compounded by thefact that IMR work is currently allocated to a review team not all of whom have the right degree of experience to review and report effectively on domestic abuse. This is a matter which West Mercia Police are aware of and are actively addressing through their Head of Protecting Vulnerable People Detective Superintendent.

19 RECOMMENDATIONS

The following are overarching recommendations made on behalf of North Worcestershire Community Safety Partnership:-

National Policing Lead for Adult Safeguarding

- DHR author to write to the National Police Lead for Adult Safeguarding DCC Pilling, Greater Manchester Police to highlight the need to produce Approved Professional Practice on Adult Safeguarding.

Department of Work and Pensions (DWP)

- DHR author to write to the Local Government Association (LGA) who are currently working with DWP for the LGA to seek assurance that governance arrangements exist within the Department to ensure effective policies and procedures are in place in respect of adult safeguarding, domestic abuse and compliance with the Mental Capacity Act 2005.

Worcestershire Forum against Domestic Abuse

- The chair of the Worcestershire DHR sub group on behalf of the North Worcestershire Community Safety Partnership to write to the Worcestershire Office of Data Analytics project who is working on the development of shared systems and/or data. To share the themes and learning from this review to inform the future of data capture and sharing arrangements.

Worcestershire Public Health

- On behalf of the North and South Worcestershire Community Safety Partnerships to develop scope and commission domestic abuse training which seeks to bring together both Children and Adult social care and wider partners, making the links to safeguarding.

West Mercia Women's Aid and Worcestershire Adult Social Care

- To develop a joint working protocol around clients with complex needs that are suffering domestic abuse.

SUMMARY OF SINGLE AGENCY RECOMMENDATIONS

Worcestershire Acute Hospitals NHS Trust

Recommendation 1

Worcester Acute Hospitals NHS Trust to review the number of previous Accident and Emergency Department attendances upon admission of a person and to consider any potential safeguarding concerns.

Recommendation 2

Worcester Acute Hospitals NHS Trust to ensure compliance with NICE public health guideline on 'Domestic Violence and Abuse: how services can respond effectively' (PH50); recommendation 6 (Ensure trained staff ask people about domestic violence and abuse).

NHS Redditch and Bromsgrove and NHS South Worcestershire Clinical Commissioning Groups (CCG)

Recommendation 1

GPs and Clinical Practice Staff in Worcestershire to complete Safeguarding Adults Level 3 Training which includes Domestic Abuse (DA) training and PREVENT.

Recommendation 2

CCG to audit Safeguarding Adult Level 3 training as part of the CCG Programme of Auditfor GP Practices.

Recommendation 3

CCG to communicate current Domestic Abuse Guidance to all Worcestershire GP Practices.

Redditch Borough Council

Recommendation 1

Redditch Borough Council to produce policy and procedures regarding domestic abuse, which should include risk assessment and risk management.

Recommendation 2

Redditch Borough Council to provide training in domestic abuse for all home visiting staff relevant to their role.

Recommendation 3

Redditch Borough Council to promote awareness amongst its staff of the adult safeguarding process and escalation procedures.

West Mercia Police

Recommendation 1

West Mercia police to provide assurance to partners around notifications of Domestic Violence Protection Orders and to ensure there is a revised programme of training in their application.

Recommendation 2

West Mercia Police to ensure that when RMPs are in place for combined issues domestic abuse policy and procedure is always pursued.

Recommendation 3

West Mercia Police should equip officers and staff with the required knowledge and understanding of behaviours and legislation in relation to coercive and controlling behaviour.

Recommendation 4

West Mercia Police to produce a local policy and procedure on Adult Safeguarding giventhe current absence of Approved Professional Practice.

Recommendation 5

West Mercia Police to raise staff and officer's awareness of the Care Act with particular regard to adult safeguarding.

Recommendation 6

WMP to review the process of referrals to partner agencies following response to incidents involving vulnerable adults.

Worcestershire Adult Social Care

Recommendation 1

Worcestershire Adult Social Care and Worcestershire Health and Care NHS Trust to ensure that an assessment by the most appropriate team should take place to determine whether a person has eligible needs.

Recommendation 2

Worcestershire Social Care to amend the guidance on the risk assessment of people who do not engage with services to include lack of engagement with professionals and disseminate to staff.

APPENDIX A

Terms of reference

The Victim:

5.1 Was the victim recognised or considered to be a victim of abuse?

5.2 Did the victim disclose to anyone and if so, was the response appropriate?

5.3 Was this information recorded and shared, where appropriate?

5.4 Were services sensitive to the protected characteristics within the Equality Act 2010 (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity) of the victim and their family

5.5 When, and in what way, were the victim's wishes and feelings ascertained and considered?

5.6 Is it reasonable to assume that the wishes of the victim should have been known?

5.7 Was the victim informed of options/choices to make informed decisions?

5.8 Were they signposted to other agencies?

5.9 Was consideration of consideration of vulnerability or disability made by professionals in respect of the victim?

5.10 How accessible were the services for the victim and the perpetrator?

5.11 Was the victim or perpetrator subject to a Multi-Agency Risk Assessment conference (MARAC) or any other multi-agency fora?

5.12 Did the victim have any contact with a domestic abuse support organisation, charity or helpline?

5.13 Was the victim a social housing tenant? If so was there rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation. Does the Social Housing Landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?

The Perpetrator:

5.14 Was the perpetrator recognised or considered to be a victim of abuse?

5.15 Did the perpetrator disclose to anyone and if so, was the response appropriate?

5.16 Was this information recorded and shared, where appropriate?

5.17 Was anything known about the perpetrator? For example, were theybeing managed under MAPPA, had they received a Learning Disability diagnosis, didthey require services, did they have access to services?

5.18 Were services sensitive to the protected characteristics within the Equality Act 2010 (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity) of the perpetrator and their family?

5.19 Were services accessible for the perpetrator? And were they sign posted to services?

5.20 Was consideration of vulnerability or disability made by professionals in respect of the perpetrator?

5.21 Did the Perpetrator have contact with any domestic abuse organisation, charity or helpline?

5.22 Was the perpetrator a social housing tenant? If so was there rent arrears orfrequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation. Does the social Housing Landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?

Practitioners:

5.23 Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse including coercive control and behaviour and aware of what to do if they had concerns about a victim or perpetrator?

5.24 Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

5.25 Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (for example DASH) and were those assessments correctly used in the case of this victim/perpetrator?

5.26 Did the agency have policies and procedures in place for dealing with concerns about adult safeguarding and domestic abuse? And are these subject to review?

5.27 Were these assessments tools, procedures and policies professionally accepted as being effective?

5.28 Did the agency comply with adult safeguarding and domestic abuse protocols agreed with other agencies, including any information sharing protocols?

Assessments and Decision Making:

5.29 What were the key points or opportunities for assessment and decision making in this case?

5.30 Was there reason to doubt the mental capacity of the victim or the perpetrator and if so was this considered appropriately in order to inform key decisions?

5.31 Do assessments and decisions appear to have been reached in an informed and professional way?

5.32 Did they consider either the victims or perpetrators past criminal history or indicators of risk?

5.33 Did actions or Risk Management Plans (RMPs) fit with the assessment and the decisions made?

5.34 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?

5.35 Were Senior Managers or agencies and professionals involved at the appropriate points?

General:

5.36 Consider the methods and frequency utilised by staff with both the victim and perpetrator in light of their reluctance to engage.

5.37 Are there other questions that may be appropriate and could add to the content of the case? For example, were there any previous lessons learnt from past DHR's that

should have raised practitioner's awareness - housing, community organisations, neighbours , employers etc.

5.38 Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where could practice be improved in your organisation?

5.39 Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

Appendix B

List of Abbreviations

AAFDA – Advocacy After Fatal Domestic Abuse

ASB – Anti-Social Behaviour

ASC - Worcestershire County Council Adult Social Care Services

CCG – Clinical Commissioning Group

CEO – Chief Executive Officer

CGL – Change Grow Live (alcohol dependency treatment provider)

DASH – Domestic Abuse Stalking and Harassment Risk Assessment Process

DHR – Domestic Homicide Review

DVPN/O – Domestic Violence Protection Notice/Order

DWP – Department for Work and Pensions

ESA – Employment Support Allowance

FACS – Fair Access to Care Services (repealed by Care Act 2014)

GP – General Practitioner

HAU – Harm Assessment Unit West Mercia Police

HMP – Her Majesty's Prison

IMR – Individual Management Review

KWN – Key Work Notes (St Paul's Hostel Worcester)

LPO – Local Policing Officer

NHS – National Health Service

NPIA – National Policing Improvement Agency

PC – Police Constable

PCSO – Police Community Support Officer

PVP – Protecting Vulnerable People department West Mercia Police

RBC – Redditch Borough Council

RMP – Risk Management Plan (West Mercia Police)

SNT – Safer Neighbourhoods Team (West Mercia Police)

SW – Social Worker (Worcestershire County Council Adult Social Care Services)

Appendix C

References

In preparing the overview report the following documents were referred to:

The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016.

The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers.

Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.

Appendix D

Professionals involved in the review

Professionals identified within single agency IMR's were included but anonymised withinthe report as follows:

Steven's GPs - 1, 6, 7 and 8

Local Police Officers - LPOs 1, 2 and 3 and Police Community Support Officer - PCSO 1

Borough Council – Anti-social behaviour (ASB) Coordinator and Housing Support Worker (HSW)

Worcestershire County Council Adult Social Care - Social Worker 1 (SW1)

Appendix E

Learning Disability

A learning disability is defined by the Department of Health as a ‘significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood’.

Sometimes the term ‘global development delay’ is used to describe a learning disability. Global development delay describes a condition that occurs between birth and the age of 18 which prevents a child from reaching key milestones of development like learning to communicate, processing information, remembering things and organising their thoughts.

The difference between a learning disability and a learning difficulty in general terms is a learning disability constitutes a condition which affects learning and intelligence across all areas of life, once learning has been optimised this will not change during the life span. Their cognitive ability will prevent and limit the development of new skills. Whereas a learning difficulty constitutes a condition which creates an obstacle to a specific formof learning, but does not affect the overall IQ of an individual, examples include but are not confined to dyslexia or dyspraxia. The individual will be able to develop new skills however will require additional support to achieve and optimise their development.