Report of the Domestic Homicide Review and Safeguarding Adult Review Joint Panel into the death of Walter

Independent chair: Elizabeth Hanlon
Independent report writer: Deborah Klee

February 2018.

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Main Report

PART ONE

1.0 Introduction

1.1 In order to ensure anonymity the following pseudonyms have been used to identify persons referred to in the report. Mother, father, child, neighbour have the normal meaning associated with them.

Name	Age at time of the fatal fire	Relationship
Walter	78	Victim
Sarah	43	Perpetrator
Tom		Partner of perpetrator

1.2 Address 1 is the address of Walter where the fatal fire ended his life Address 2 is the address of premises owned by Sarah. This is where she lived with Tom prior to moving in with Walter.

2.0 The Review Process

2.1 The purpose of a Domestic Homicide Review (DHR) is to:

a) 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;

b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency work.

e) It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximized both locally and nationally.

2.2 This review arose from a fatal fire caused by an arson attack. The victim died at the scene of the fire. A Post Mortem examination concluded that the victim's death had been due to the inhalation of fire fumes. The perpetrator lived with the victim and has since been convicted of intentionally causing the fire with an intent to endanger the victim's life.

2.3 The circumstances of the death of the victim fulfil the criteria of Section 9 (3)(b) of the Domestic Violence, Crime and Victims Act 2004 in that the violence appeared to be perpetrated by a member of the same household as himself. The members of the review panel express their condolences to the family and friends of Walter who died as a result of this fatal fire.

2.4 This Domestic Homicide Review (DHR) has been conducted in accordance with statutory guidance[1] under section 9(1) of the Domestic Violence, Crime and Victims Act 2004. The review examines the period from 6th August 2014 to the time of Walter's death. The panel has determined that there were no ethnicity, culture, faith, sexual orientation, disability, gender or other diversity issues that had a bearing on agency involvement in respect of this Review.

2.5 The key reason for undertaking a domestic homicide review (DHR) is to facilitate lessons to be learned when a person is killed as a result of domestic violence. To enable these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of these tragedies happening in the future.

2.6 The Essex Safeguarding Adults Board found that this case also met the criteria for a Safeguarding Adult Review under The Care Act 2014. The Care Act Statutory Guidance[2] (14.133), states that 'Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult dies as a result of abuse or neglect, whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult.' The definition of abuse in this guidance includes domestic violence, psychological abuse and financial or material abuse. It applies to people with care and support needs. Both the victim, and the perpetrator were in need of care and support services.

2.7 The purpose of a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and applied to prevent similar harm occurring again. The Care Act does not require the SAR report to be published but it must be referred to in the SAB annual report.

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[1] *Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews,* December 2016, Home Office.

[2] *Care and Support Statutory Guidance*

2.8 It was agreed by the review panel[3] that the DHR and SAR would be combined as a single review. Following this recommendation a decision was made to appoint a different independent overview report writer with a safeguarding adults background who had the relevant experience in carrying out SAR's. The chair of the panel had a background in carrying out DHR's.

2.9 We would like to thank all of the panel members and their respective agencies who participated in this review process for their contribution to the formulation of this report. Particular thanks go to the family of Sarah, for sharing their recollection of how agencies worked together to support Sarah. In doing so, they have supported the learning and development by agencies working with other adults at risk in Essex.

2.10 **Panel membership**

Name	Position/organisation
Adam Waller-Toyne Team manager	One Housing
Chief Inspector Ian Cummings	Essex Police
Kim Spain	Essex County Council
David Williams	Essex County Council
Jane Whitington Safeguarding adult lead	North East Essex Clinical Commissioning Group (NEE CCG)
Lisa Hobson DHR Support	Colchester Borough Council
Lisa Poynter Lead for adult safeguarding	Anglian Community Enterprise (ACE)
Mel Arthey Clinical specialist safeguarding	Essex Partnership University NHS Foundation Trust
Melanie Rundle Community safety manager	Colchester Borough Council
Michelle Williams Domestic Abuse Co-ordinator	Essex County Council
Paul Bedwell ESAB Board Manager	Essex County Council
Liz Varcoe	Essex County Council
Ruth Cherry-Galal	Colchester Women's Refuge[4]
Val Degiorgio Team manager	Essex County Council Adult Social Care
Liz Hanlon	Independent Chair
Deborah Klèe	Independent Overview Report Writer
Amanda Canham	Essex STaRS substance misuse services within Essex Partnership

[3] DHR panel meeting 06/02/2017

[4] From 23rd October 2017 Ruth Cherry-Galal worked for Safer Places.

	University NHS Foundation Trust.

Timescale

2.11 The review began in November 2016. However, a trial date was set for Sarah, who was charged with Murder and Arson with intent to endanger life, for 26th February 2017. The preparation of Individual Management Reviews (IMRs) was therefore delayed until after the trial. This had an impact on the length of time taken to complete this review. The Chair of the panel met with the Senior Investigation Officer from Essex Major Crime unit and following a discussion with the Crown Prosecution Unit a decision was made to continue with the review process but that witnesses were not to be interviewed until after any court cases. The panel meeting re started on the 28th June 2017. Four panel meetings took place between the end of the court case and the completion of the report in February 2018. A learning event took place on the 11th August 2017. The reports were presented to the Essex Safeguarding Adults Board and the Colchester Safer Partnership in January and February 2018.

Confidentiality

2.12 The findings of this Review remained confidential during the review process. Information was available only to participating officers/professionals and their line managers until the report was approved for publication by the Home Office Quality Assurance Group. The Home Office Quality Assurance Group letter of approval is attached at Appendix D and any suggested amendments referred to in that letter have been considered and included within this final report where considered appropriate.

2.13 Information discussed by the agencies' representatives within the DHR Panel meetings is strictly confidential and Panel Members were made aware that information must not be disclosed to third parties without the agreement of Panel members. At the beginning of each meeting, panel members were requested to sign a confidentiality clause.

Safer Colchester Partnership (SCP)

2.14 After the death of Walter Essex Police notified the Chair of Colchester Community Safety partnership that Walter's death had occurred within their Council's area. A decision was made that the death fitted the criteria for a Domestic Homicide Review and on 12th September 2016 the Home Office was notified that a Domestic Homicide Review Panel (DHR) would be established.

Essex Safeguarding Adult Board (ESAB)

2.15 During the first meeting of the DHR panel on the 21st November 2016 it was identified that the death of Walter might meet the criteria for a Safeguarding Adults Review and as such was referred to the ESAB. The Independent Chair made the decision that the case met the criteria for a

Safeguarding Adult Review[5]. Following discussions with the chair of the DHR a decision was made for a SAR to be undertaken alongside the DHR following the Care Act guidance (14.145) for the review to be commissioned jointly and a joint approach used to minimize duplication.

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Panel Chair

2.16 Liz Hanlon was appointed Independent Chair by Colchester CSP. She is a retired senior police officer who worked for Hertfordshire constabulary for 32 years. During her time as a police officer she had no dealings with Essex Police and had not worked with any of the partner agencies who made up the panel membership. Since retiring in 2015, she has chaired and written several DHR's and partnership reviews for both Hertfordshire and Essex as an independent consultant. Liz is currently the chair of the Hertfordshire Safeguarding Adults board. She is independent from any of the agencies involved in this review.

Report Author

2.17 Deborah Klée the overview report writer is also independent from any of the agencies involved in this review. Deborah worked for Essex Rivers NHS Trust, now Colchester Hospital University NHS Foundation Trust, as a Directorate Manager from 1994 – 1999. Deborah is the Independent Chair of Sutton Safeguarding Adult Board. As an independent consultant Deborah has experience of writing a number of SAR overview reports and Chairing SAR panels. Deborah previously worked in senior positions at the Audit Commission and Healthcare Commission. Prior to this she worked for 20 years in the NHS as an occupational therapist and executive manager. www.deborahklee.org.uk

Parallel Reviews

2.18 Notification was sent to the Coroner of the DHR on 17th October 2016. An inquest has not taken place. A trial took place from the 26th February 2017 for Sarah who was charged with Murder and Arson with intent to endanger life. Sarah has since been convicted and is serving a prison sentence.

Circumstances leading to the review

2.19 Essex Police received a call from Essex Fire and Rescue service reporting a fire with persons trapped at address 1. A police patrol car was passing this address at the time of the call and so the police were the first emergency service at the scene. Police officers were informed by members of the public that a person was trapped within the premises – a one-bedroomed ground floor flat. Police officers attempted to enter the premises but were beaten back by flames. Fire fighters then arrived and using breathing apparatus entered the premises by the front door. Walter was discovered on the floor of the living room, which he had been using as his bedroom. Walter was rescued from the premises by the fire crew and CPR and treatment commenced at the scene. Sadly, despite the

[5] ESAB Safeguarding Adults Review Policy Section 3

best efforts of paramedics and the fire crews Walter was declared dead at the scene.

2.20 At the time of Walter's death it was identified that he had been living with a female, Sarah, who was described by people as his Grandaughter. During the Police investigation it became apparent that Walter and Sarah were not related but that they had been living together. Walter had told several agencies that he was looking after Sarah as a result of his dead wife's wishes, however this does not appear to be the case. It appears that Walter and Sarah became friends after she moved in with neighbours and was introduced to him.

2.21 Enquiries made by police officers during the course of that morning established that Sarah had been in the premises at the time of the fire and as a result of initial findings at the scene the fire was declared as suspicious.[6] Sarah was arrested the same day and was later convicted of Murder and Arson with intent to endanger life.

2.22 Both Walter and Sarah were actively being supported by care and support services over a substantial period of time. Walter had Diabetes, Macular Degeneration, and a heart condition. Sarah was being treated for substance misuse.

Scope of the review

2.23 On 6th February 2016 the Panel considered draft Terms of Reference prepared by the Chair and Overview report writer and after revision, adopted the following Terms of Reference:

(1) In conducting the Domestic Homicide Review into the death of Walter, the Panel shall have to regard to:-

(a) The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (7) and the recommended Home Office security provisions (2); and

(b) The Essex Domestic Abuse Strategy Group - Domestic Homicide Reviews Guidance (3).

(2) The Panel would conduct the review on the basis that Walter was murdered at the victim's home address of address 1. A family friend Sarah has been charged with the murder. Sarah was introduced to people by both Walter and Sarah herself as his granddaughter, however there does not seem to be a family link.

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[6] Athena Investigation 42/113745/16 and Essex Police IMR

(7) Home Office "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" (December 2016)

(2) Full personal details will be provided to Panel members for meetings, but any published or shared documentation will be redacted or anonymised as appropriate

(3) Safer Essex "Domestic Homicide Review Guidance" (May 2015)

(4) IMR "Individual Management Review"

(3) The Panel was asked to establish the nature of the relationship between Walter and Sarah prior to his death, and the manner of Walter's death would be confirmed. The panel would establish the relationship between Tom who has been identified as Sarah's boyfriend and what his relationship was with Walter.

(4) The Panel would review the Scoping Exercise and chronologies in order to determine which agencies, organisations and individuals should be requested to submit an IMR [(4).]

(5) In the light of information arising from (4) above, the Panel was asked to consider whether such practitioners or agencies, including public service and commercial agencies;

- need to increase their own levels of awareness and information gathering across agencies to assess risk and provide a coordinated response;
- were appreciative of and sensitive to the needs of Walter; and
- were knowledgeable about potential indicators of domestic abuse, including financial abuse, and aware of actions they could take if such concerns had arisen.
- The Panel will; gain an understanding of what domestic abuse, either physical, emotional or financially Walter suffered, if any, within his home environment;
- establish the appropriateness of agency responses to Walter - both historically and immediately prior to his death;
- understand if and how agencies assessed risks within the family household settings;
- understand how intelligence and information is shared across safeguarding children and young persons, adults and domestic abuse to assess and respond to risk;
- determine if and how agencies assessed needs for care and support;
- establish whether single agency and inter-agency responses to any concerns about Walter were appropriate;
- identify good practice that was in place;
- establish how well agencies worked together and identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic violence is a feature;
- consider whether appropriate and timely safeguarding adult procedures were put in place for both Walter and Sarah and;
- determine whether a person-centered approach was taken to understand the outcomes that Walter wanted and to facilitate this e.g. family conference, mediation and making safeguarding personal.

(6) The Panel was asked to consider the role of any practitioners or agencies that had not come into contact with Walter and Sarah that might reasonably have been expected to do so.

(7) The scope of the DHR was been extended, following consultation with Essex Adult Services to include any vulnerabilities identified by agencies surrounding Walter. It was considered important that the review understands and analyses, from a multi-agency perspective, Walter's overall vulnerabilities, his capacity to care for himself, his level of independence and his ability to manage his identified health issues, both physically and emotionally.

(8) The Panel was asked to consider which members of Walter's family or friends should be asked to contribute to information gathering, and how that would then be managed. The Panel was asked to establish whether:

(a) Walter had made any disclosures to family or friends in respect of the state of his relationship with Sarah.

(b) Sarah had exhibited any tendency towards domestic abuse (including financial abuse) towards Walter.

(c) Whether there was any previous family background to indicate that Walter was vulnerable to abuse.

(9) The Panel was asked to seek Information in respect of the background and any previous convictions of Sarah and whether or not she had ever been subject to Multi Agency Public Protection (MAPPA) Arrangements or Domestic Violence Perpetrator Programs (DVPP).

(10) The Overview Report was to be written by the nominated Review Panel Report Author who would, subject to the agreement of the Panel Chair, submit a draft to the Panel for its consideration. The Report would set out the extent, from the findings of the review, whether there are improvements that could be made in the way in which relevant agencies and organisations could work individually or together to safeguard future potential victims. The Panel would also consider whether further information should be made available in the public domain for the benefit of family or friends who have concerns relating to potential abusive relationships.

(11) Subject to (10) above the Panel would identify any changes in policies and procedures arising from the lessons learnt, make recommendations and will, through an agreed Action Plan, establish timescales for their implementation and identify what is likely to change as a result.

(12) The Panel would, once it had agreed the final report, submit it to the Colchester District Community Safety Partnership for its consideration. The Partnership would be requested to consider the content of the report, the recommendations and the associated Action Plan. When the Partnership is satisfied with the report, it will be requested to:

(a) submit the report to the Home Office;

(b) consider whether, prior to the Home Office response, there are issues that should be brought to the immediate attention of Safer Essex; and

(c) consider which agencies, organisations or individuals should receive a copy of the report and the degree to which its findings should be made public, following the approval of the report by the Home Office.

2.24 The Panel accepted that the Terms of Reference could change after meeting with family and friends or at any point in the gathering of information, if new information came to light.

Review methodology

2.25 This Review has followed the statutory guidance issued for the conduct of DHRs. A total of 53 agencies were contacted to check for any involvement with the parties concerned in this Review. There were 39 nil returns, a total of 14 agencies responded with some level of involvement with the victim and/or the perpetrator.

2.26 Agencies were asked to give chronological accounts of their contact with Walter and Sarah. The DHR covered in detail the period from 6th August 2014 when an Iceland worker contacted the police to report suspected financial abuse of Walter through to the time of Walter's death. However some agencies also provided additional historical context where appropriate. Appendix A details all the organisations that were requested to co-operate with this Review.

2.27 Following receipt of the information the Review Panel considered whether an Individual Management Review (IMR) was required. A total of eight IMRs were requested from the following agencies:

- Essex Police
- Essex County Council Adult Social Care
- CDS Housing
- One Support
- Open Road/STARs[8]
- Colchester Women's Refuge
- Anglian Community Enterprise
- North Hill Medical Practice

2.28 Other organisations contacted for information included:

- Safer Places
- Power – an advocacy service
- Essex County Council Children and Young People's service
- Walter's pharmacy

[8] Open Road and STARs are teams that worked with Sarah as part of Essex Partnership University NHS Foundation Trust.

- Colchester Walk-in Centre
- North East Essex Diabetic Service (NEEDS)
- Colchester Borough Council Zone team Helpline.

2.29 The Panel agreed[9] that the Chair and Report Writer would contact the following friends and family to find out more about the lives of Walter and Sarah, particularly in the period covered by the scope of the review.

- CF (Walter's friend)
- JH (Walter's friend)
- Sarah's parents
- Sarah's oldest daughter
- Sarah.

2.30 An email was sent to Sarah's father requesting a meeting with Sarah's parents and eldest daughter on 11th July. Police advised that Sarah's father preferred contact with the family to be made through him. In correspondence dated 11th and 14th July the purpose of a DHR was explained, the confidentiality of this report and a list of the organisations involved. Sarah's father requested the meeting took place on 8th August between 6-7pm at his family home address. The meeting took place as planned. The DHR Chair and Overview Report writer attended this meeting. Both of Sarah's parents were present and Sarah's older daughter. The Chair of the panel later visited the family of Sarah to go through the overview report with them. They acknowledged the thoroughness of the review and the report and agreed with the recommendations. They were pleased that the report had highlighted that Sarah was a vulnerable adult in her own right.

2.31 A letter addressed to Sarah was sent c/o the Prison Governor, on the 9th August Sarah replied through her parents. Sarah's father informed us by email dated 14th August that ' Sarah had written to her mother to say that she has no wish to participate in any meetings or discussions in the homicide review'. As a result of this email no further contact was made with Sarah.

2.32 The contact CF who was named as a friend of Walter in the police chronology was not contacted. It came to light at a Practitioner's Learning event that CF had no recollection of Walter when a PCSO met him whilst on traffic duty. The same PCSO had spoken to CF in Walter's flat but CF denied ever having visited the flat or having any contact with Walter. The integrated chronology states that Walter had only known CF for three weeks when he was staying at the flat.

2.33 The police provided contact details of L. L had come forward as Walter's next of kin to arrange his funeral. L was not related to Walter but had known him for a number of years. An email was sent to L on 19th July requesting a telephone interview. L did not respond to this request so it was followed up with a telephone call on 28th July. The purpose of a DHR

[9] Minutes of panel meeting 28th June 2017

was explained and the confidentiality of information shared. L agreed to talk to the overview writer and an interview was conducted by phone on this date. L provided details to the overview writer regarding her relationship with Walter and Sarah. She stated that she had known Walter for some time as she used to drink with him at the local pub. She had a friendship with Walter which involved her looking after Walter on occasions as he used to sleep on her sofa after they had been out drinking for the night. L described knocking on Walters door on one occasions to be greeted by Sarah and informed that Walter didn't need her any more (L) as he now had her (Sarah). L was not aware of any issues of abuse within the friendship between Sarah and Walter.

2.34 JH was also identified as a friend of Walter's. The police statement was read by the chair and report writer and a decision was taken not to make contact with him as it did not appear that this was a close relationship.

2.35 Additional documentation was requested and provided including:

- The Essex Police *Officer's Guide to Vulnerability*
- Safeguarding enquiry reports for Walter.

2.36 A Partnership Learning Review (PLR) event was facilitated with staff who had direct involvement with Walter and/or Sarah. The purpose of this event was to understand the environment that staff members were working in at that time and the reasons for their actions. This was to help to identify some of the underlying systems that could have contributed to practice. The PLR event is a requirement of the ESAB Safeguarding Adult Review Procedure. Nineteen staff members attended the PLR event representing 6 organisations. The output from the PLR event informed the findings of the review.

2.37 The Review Panel met on four occasions. I

- Meeting one – To set up the DHR/SAR and agree organisations to be contacted for a chronology.
- Meeting two – To review the integrated chronology and agree organisations required to submit an IMR. The Terms of Reference were discussed at this meeting and later agreed.
- Meeting three - IMR writers to present their reports and answer questions from the Panel.
- Meeting four – To discuss the draft report.

Individual Management Reviews

2.38 The purpose of the Individual Management Review (IMR) is to:

- Enable and encourage agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and Identify examples of good practice within agencies.

2.39 The Independent Chair and Overview Report Writer guided the IMR authors through the process for the development of each IMR, as follows:

- Securing agency records;
- Commissioning IMRs;
- Gaining consent to view records;
- Drawing up a chronology;
- Conducting a desk-based review which investigated the agency's involvement relative to the agency's policies and procedures; relevant partnership / multi-agency policies and protocols; professional standards and good practice; and national and local research and evidence-based practice;
- Conducting interviews with relevant staff;
- Writing the IMR including analysing the information and making recommendations;
- Ensuring the report is quality-assured through the process of counter-signing by a senior accountable manager; the same guidance includes advice on:
- Conducting parallel investigations of disciplinary matters and complaints which will not be reported which are internal agency matters;
- Providing feedback and debriefing to relevant staff;

2.40 IMR authors were informed of the primary objectives of the process, which is to give as accurate as possible an account of what originally transpired in the agency's response to Walter and Sarah and to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors were encouraged to propose specific solutions, which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or experiencing domestic abuse.

2.41 Agencies each prepared a chronology of their agency involvement and significant events during the specified time period. These chronologies were analysed by the Review Panel.

2.42 IMR authors produced a first draft of their reports which were quality assured within their own organisations through the signing-off process. These IMRs were then analysed by the Review Panel and discussed with the authors at a review panel meeting. Copies of IMRs had been circulated to all the panel members prior to these meetings and panel members were able to cross-reference significant events and highlight missing information. Authors then reviewed their IMR's, which were again supplied to the review panel for a further review meeting. Authors then produced final reports. The draft overview report was discussed with the review panel and agreed at a further meeting when the final draft was presented.

2.43 All of the 9 protected characteristics of the 2010 Equality Act were considered by the writer, professionals learning event and panel. The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

2.44 Age – there was a big age difference between Walter and Sarah. Their relationship appeared to be mutually receptive in that Sarah would offer companionship for Walter but that he would also look after and support her. There does not appear to have been any identified issues surrounding Walter's age.

2.45 Disability- Walter had several medical illnesses which required health intervention, the most striking being diabetes which required monitoring. It appeared throughout the review that Walter was well looked after by health professionals for his diabetes. Sarah had a long-term history of drug misuse and was receiving active treatment up until the time of Walter's death.

PART TWO

3.0 The Facts

3.1 The facts are described in the case summary, background information on Walter and Sarah and the key events below.

Case Summary

3.2 At the time of his death Walter was living in social housing -a one bedroomed ground floor flat. Social housing is housing provided by the council through a housing provider.

3.3 Walter was the tenant of the property. Sarah had been staying with Walter since December 2012. Sarah slept in the bedroom and Walter slept in the living room on a sofa-bed.

3.4 Walter and Sarah described themselves as grandfather and granddaughter. Walter explained to all of the professionals he came into contact with, that his wife had asked him, before she died, to take care of Sarah. Walter also described Sarah as his carer.

3.5 Concerns were first raised that Walter might be experiencing financial abuse in August 2014, when an Iceland worker contacted the police. Although a safeguarding referral was made and financial abuse substantiated, Walter did not want any intervention. Walter was assessed as having the mental capacity to make this decision.

3.6 Between August 2014 and September 2016 a number of professionals became concerned about the situation. Six safeguarding referrals were raised surrounding his contact with Sarah and her partner Tom and subsequently closed for the same reason that Walter understood the risks associated with his unwise decision not to take any action against Sarah or ask her to move out. As he had the mental capacity to make this decision, the safeguarding referrals were closed on each occasion. However, adult social care referred Walter to One Support for his general housing and support needs.

3.7 A number of professionals were involved in providing care and support to Walter as he had multiple health conditions including diabetes, macular degeneration[10] and a heart condition. Community nurses visited Walter daily from January 2016 to check Walter's blood glucose levels. A support worker from One Support visited Walter several days a week from June 2016 and formed a close working relationship with Walter. A community nurse became concerned in July 2016 that lack of food, as a result of financial abuse, was lowering Walter's blood glucose levels. This led to one of the safeguarding referrals. A further safeguarding referral was made in August 2016 by community nursing as Walter had lost a significant amount of weight.

3.8 Although the safeguarding referrals were closed for the reasons given in 3.6 care and support staff worked together to ensure Walter had food. Food banks and on one occasion a small donation from a local charity were accessed on Walter's behalf.

3.9 The GP also made a safeguarding referral when it was discovered that Sarah was believed to be obtaining medication prescribed for Walter to use or sell as it had a market value for drug dealers.

3.10 When Walter contacted the police to report the theft of his bankcard by Sarah in December 2013 and then withdrew his allegation claiming it was a misunderstanding, a PCSO became involved. Concerns raised by the PCSO to adult social care led to a community care assessment and assessment by community nursing.

3.11 Adult social care's safeguarding function, community nursing, the GP practice, the police and One Support, all worked closely with Walter over a period of two years. Although Walter would not agree to any action that would have a negative impact on Sarah, he allowed his support worker, community nurse and social workers to support him the best they could and to minimise his risk of harm.

3.12 In September 2016 Walter told his support worker that he was thinking of getting a court order against Sarah. It is likely that Walter told Sarah he

[10] Macular degeneration is an eye disease that interferes with vision affecting the person's ability to read and see objects clearly.

would be giving up his flat to move into sheltered accommodation hours before Sarah set light to a piece of furniture that she had moved into the centre of the room.

3.13 The Fire and Rescue Service were called to a fire at Walter's address. Police and Fire and Rescue responded immediately. Walter was rescued from the premises by the fire crew and CPR and treatment commenced at the scene. However, despite the best efforts of the fire crew and attending paramedics Walter was declared dead at the scene.

3.14 A Post Morten examination concluded that Walter's death was a result of inhalation of fire fumes.

3.15 Sarah was charged with the offences of arson with intent to endanger life. Sarah was sentenced to 12 years imprisonment in relation to manslaughter and 8 years in relation to the arson to run concurrently with the manslaughter conviction.

3.16 The Coroner was advised of the death of Walter. The Corner determined that an inquest would not be held and the death has been formally registered with the Registrar.

Background information Walter

3.17 Walter was born in Plymouth on a ferryboat. He was in the Navy for many years. L said that Walter was a 'ladies' man'. He enjoyed the company of women and could be very charming. We understand that he was married five times and had six children. There are different reports on whether any of his wives or children are still alive. Nobody from Walter's family came forward following the report of his death. The police tried to contact any living relatives but were unsuccessful in identifying anyone. Walter's friend L came forward and agreed to be considered Walter's next of kin (NOK). L arranged Walter's funeral.

3.18 Walter was described by his friend L as 'fun loving' and a man who 'would do anything for anybody.' Walter described himself on more than one occasion as 'a big softie.' Practitioners at the Learning Event said that Walter seemed to genuinely care about Sarah and wanted to keep her safe. It isn't entirely clear what his motivation was. Sarah was not Walter's granddaughter. His friendship with Sarah commenced after Walter had any contact with his wives. The story that Walter's wife asked him to look after Sarah was not believed to be true. Walter's friend L believed that Sarah was once fostered by Walter's wife – this has been found to be untrue. It is believed that Walter got companionship from living with Sarah. Although Sarah abused Walter, he remained loyal to her until his death. Walter described Sarah as his carer.

3.19 Police records show an association between Walter and Sarah as early as April 2009 when police stopped a VW Golf owned by Walter. Sarah

and others were in the car. At this time police recorded that the officer believed that Sarah was taking advantage of Walter.

3.20 Sarah did not move into Walter's flat until December 2015. Up until this date Sarah had been living in a house bought for her by her parents. Sarah's partner Tom lived with Sarah but was violent towards her. When Sarah experienced a physical assault from Tom she moved out of her home and into Walter's flat. However, practitioners at the Learning Event commented that Tom was usually in Walter's flat when they visited.

3.21 The PCSO who worked with Walter told the Practitioner's Learning event, that a neighbour of Walter's who attended his funeral told the PCSO that drug dealers had used Walter's address long before Sarah moved in with him. This information fits with Sarah's parent's recollection of how Sarah met Walter. They said that a mutual friend who was a drug user and stayed at Walter's from time to time introduced Sarah. The neighbour at the funeral claimed that a well-known drug dealing family had been using Walter's flat as a drug den from 2009.

3.22 In the years before Sarah moved in with Walter he was a frequent visitor to the local pub. Walter was popular with locals and was known to stay on friends' sofas when he'd had too much to drink. This was how he met his friend L. Walter enjoyed the company of younger people rather than his own age group. Social workers tried to persuade Walter to join social activities and clubs so that he did not have to rely on Sarah for company, but Walter was not interested.

3.23 Walter was described by those who knew him as 'macho'. He would not want to appear weak. When asked whether he was afraid of Tom who could be very intimidating with his violent outbursts, Walter said he wouldn't let Tom or anyone else 'lay a hand on him.' He said, 'they wouldn't dare.' Although Walter experienced financial, emotional and psychological abuse and damage to his property, there were no reports of physical abuse to Walter by Sarah or Tom.

Background information Sarah

3.24 Sarah was brought up in a loving and supportive family. She is described by her family as 'kind', 'caring' and 'determined'. Sarah's daughter says that her mother is very resourceful and if she sets her mind on something she will find a way to achieve her goal.

3.25 Sarah married her first husband when she was twenty-five. Sarah did not take drugs until she met her husband who was a drug user. Their first daughter was born in 1995, followed five years later by a second daughter.

3.26 Sarah's father bought Sarah and her husband their first home, a semi-detached house, in the same locality as her parent's home. The house was in Sarah's name. Sarah took significant loans against the mortgage

to help fund her husband's use of drugs and her parent's suspect her own use of drugs, which started around this time. Sarah's husband wanted his name on the mortgage as well as Sarah's and Sarah eventually agreed to this.

3.27 Sarah's marriage broke up. Soon after this Sarah became involved with Tom who was also a drug addict. Sarah's children were 6 years old and 3 years old at this time. Sarah's house had been repossessed to pay her debts and so she lived with Tom on a housing estate.

3.36 Sarah's parents kept a close eye on Sarah and their grandchildren providing as much support as they could. Sarah's daughter describes the relationship between her mum and Tom as 'volatile'. Despite the difficult home circumstances Sarah kept up a well-groomed appearance and sent her children to school looking respectable and well cared for. The school and social services did not suspect any risk of harm or neglect of the children.

3.37 In 2005 Sarah's parents applied for legal guardianship of the children. This was a difficult decision for them as they did not want to take their grandchildren away from their mother. Social services did all of the checks and agreed to the guardianship. There has been no contact with Sarah's parents from children's social services since that time. The children were 7 years old and 4 years old when they moved in with their grandparents.

3.38 From 2005 Sarah received care from NEEDAS the North East Essex local Drug and Alcohol Team[11]. At that time Sarah admitted to using Cocaine. Sarah also attended a community support group for people who misuse substances.

3.39 Sarah was known to the police for petty crimes- theft from shops, obtaining money under false pretences and on one occasion breaking and entering a house and stealing a handbag. Sarah was also the victim of crime as drug dealers sought recompense for unpaid drug debts.

3.40 Sarah's father provided a house for Sarah for which he had the freehold. Sarah's parents wanted to give Sarah and Tom the opportunity to turn their lives around and did not think that they had much of a chance whilst living on the housing estate. Sarah and Tom moved into the house saying that they were no longer taking drugs.

3.41 Sarah was a victim of domestic violence from her partner Tom. Sarah reported this abuse to the police and was referred to a Woman's refuge. The Refuge referred Sarah's case to the MARAC (Multi Agency Risk

[11] NEEDAS became STARs (Essex Specialist Treatment and Recovery Service) in February 2014.

Assessment Conference).[12] Noted in the MARAC minutes, information received from the STARs nurse and the support worker from the women's refuge that Tom had been given notice to move out of the home address by June 25th 2015. It has been shown in the IMR's that support was given to Sarah by agencies at the time of the domestic incident and that agencies believed that as Tom was moving out of the home address that Sarah would be safe.

3.42 When Sarah experienced a physical assault by her partner Tom, she moved out of their house to stay with Walter. This was not known to agencies at the time who believed that Tom had moved out of the home address. It was Sarah's father's intention to evict Tom so that Sarah could move back home. However, Tom claimed that the Council advised him to wait until he received an eviction notice or he would be making himself homeless. Information was received by the STAR's nurse that Sarah and her daughter thought that making Tom homeless would make the situation more volatile.

3.43 Sarah has a very supportive family who were doing everything that they possibly could to support her and help her get her life back on track. They accept that services could not help Sarah unless she was willing to help herself. However, the tremendous support network that Sarah had and her own resourcefulness were not used to help achieve the outcome that Walter wanted – for Sarah's needs to be met as well as his own. Professionals working with Sarah and Walter did not have any contact with her parents and very little with her adult daughter AB.

Key Episodes

3.44 The key episodes that follow are a narrative chronology drawn from the integrated chronology. They are presented in chronological order. Comments in italics are the author's reflections.

Key episode one - First alert of suspected abuse – financial.

3.45 6th August 2014 - The first safeguarding alert for Walter was raised following an Iceland workers call to the police. *The panel were unable to gain any further information surrounding the worker nor were they able to identify how the worker gained her understanding of adult safeguarding.* Financial abuse was reported. The police referred this to adult safeguarding.

3.46 A social worker visited Walter on two occasions unannounced. Walter was in on the second occasion. He did not want to proceed with a safeguarding enquiry. The social worker had no reason to doubt that Walter had the capacity to make that decision. The social worker

[12] A regular local meeting of professionals to discuss high risk domestic violence cases and co-ordinate the response.

discussed this case with his/her supervisor. The safeguarding case was closed on 5/9/2014. The conclusion was that the safeguarding concern was substantiated. However, Walter chose to give money to Sarah and had the mental capacity to make that decision. Contact details of adult social care and adult safeguarding were given to Walter. He was given advice on how to manage his situation and suggestions of alternative housing options. The police asked their PCSO to continue to patrol the area.

Key episode two – Walter reports theft of bankcard by Sarah

3.47 13th December 2014 – Walter phoned 999 stating that his adopted granddaughter, Sarah had arrived at his home address at 03:40hrs that morning and had asked to stay. He then discovered that his bankcard was missing and that £259 had been removed from his Post Office account.

3.48 Police attended the incident and took the initial report from Walter regarding the theft but Walter was feeling unwell and an appointment was made for him to attend Colchester Police Station on 16/12/2014. When Walter attended this appointment he explained to police officers that the matter was all a misunderstanding and that Sarah had returned the money the following day, not knowing that he had contacted the police. The incident records that the officer was satisfied that Walter was not being coerced in anyway and no offences had been committed the incident was closed.

Key episode three – concern raised on misuse of medication prescribed to Walter

3.49 3rd August 2015 - Walter was seen in his GP practice with Sarah. Walter reported a history of chest pains over the past two days. Walter said that he had been taking his sisters Pregabalin for weeks and it had helped. The GP prescribed [13]Pregabalin.

3.50 13th August 2015 - Sarah phoned Walter's GP and said that WALTER had been taking 200mg Pregablin, but had run out and was experiencing a lot of pain in his legs.

3.51 5th October 2015 - Sarah requested more Pregablin 200mg tablets, when it was only issued on 21/9. There is some discrepancy regarding the amount of tablets that WALTER was taking. Sarah said he took four tablets, three times a day however Walter said he took three tablets three times a day. Sarah was very reluctant for Walter to speak and took the phone from him. Pharmacy told the GP that Walter was having medication too often.

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[13] Pregabalin is marketed under the trade name of Lyrica. It is a medication used to treat epilepsy, neuropathic pain, fibromyalgia and generalized anxiety disorder. It has a street value as it enhances the effect of recreational drugs and alcohol.

3.52 14th October 2015 - Walter's GP saw a man who called himself Walter's grandson, believed to be Tom, and the GP explained that as Walter was using too much pregabalin at maximum dose and it was potentially dangerous that blister packs would be set up.

This is the day after there was an aggravated burglary into Sarah and Tom address when a Play Station had been stolen. Police reports conclude that this was probably as a result of a debt owed by Tom and Sarah to drug dealers. Was Tom trying to raise income to repay a debt?

Key episode four – concern insulin not being managed.

3.53 11th November 2015 - Following two admissions to accident and emergency in one week due to Walter collapsing as a result of hypoglycaemia, a request for a social care assessment was passed to a social work team from the hospital social worker. The social worker was concerned that Walter was not managing his insulin and it may be due to Walter not eating properly. On 17th November the duty worker JL made contact with a practice nurse to gather more information. Walter's case was allocated to a social worker (JL) on 7th December 2015.

3.54 12th November 2015 - Adult social care shared their concerns regarding Walter not managing his insulin with Walter's GP. As a result a district nurse visited Walter on 13th December. The district nurse needed to know the doses Walter was taking, but nobody was home. The district nurse reported back to the GP who had also been unable to contact Walter or Sarah. The GP reported that he would refer back to community nursing again if the need remained.

3.55 26th November 2015 Walter required paramedic input due to a hypoglycaemic event. He had taken his insulin prior to attending an out patient appointment but had not eaten. Again this was followed up by community nursing but once again they could not contact Walter and so asked the GP to review Walter as soon as possible. A follow up appointment was eventually made with community nursing on 20/1/2016.

Key episode five – concern raised by PCSO re living conditions and safeguarding concerns.

3.56 19th December 2015 - Sarah phoned the police to say that she was now living with Walter and that Tom had attended the premises trying to get her back. She reported that Tom had assaulted her on 7/12/15. Sarah sounded confused on the phone. Police records prior to this incident observed that Sarah had mental health issues. When the PCSO visited Walter's address to check on Sarah she was not in but the PCSO spoke to Walter. As a result of this visit the PCSO made a referral to adult social care regarding Walter as he seemed to be in poor health. The PCSO did not send a safeguarding alert (SETSAF).

3.57 5th January 2016 - Walter was seen by his SW and PCSO in a joint visit *and* a social care assessment started. Walter reported incidents with his granddaughter, and said that police had been involved. The PCSO advised that when she had previously been to Walter's property, glass had been smashed and there was blood on his front door due to a domestic violence incident between Sarah and Tom. The police in relation to this incident between Sarah and Tom made a Domestic Abuse referral.

3.58 As a result of this joint visit a referral was made to the community matrons' service requesting a joint visit with the social worker due to concerns over how Walter was managing his activities of daily living[14] and his blood glucose levels. The social worker said that Walter would be happy for the community nursing team to support him in managing his insulin. The community matron discussed Walter with the community nursing lead to report a potential risk to staff based on the volatile relationship between his granddaughter and her partner. Police checks were carried out on Sarah and Tom.

3.59 4th January 2016 – A safeguard concern was raised by WALTER's social worker for financial and material abuse. The alleged perpetrator was Sarah.
This was closed on 6th June 2016 see 3.58.

3.60 6th January 2016 - The PCSO received information that Walter disclosed to police on 21/12/15 that Sarah and Tom smashed up his bed, put his wardrobe in the front garden and damaged his property. Walter refused to give a statement and said he would not support a prosecution. The police investigation was closed on 16/1/16.

This would not have met the criteria for a Domestic abuse referral due to the fact that neither party were related to each other. The PCSO knew at this time that Sarah was not Walter's granddaughter as previously identified.

Key episode six–Walter's friend R raises concerns.
Linked to key episode five.
3.61 In January 2016 a friend of Walter had been staying with him (R). When R left he asked a friend of his C to stay with Walter to keep an eye on him. Information had been received from the Police that showed that R was only an acquaintance of Walters and that he used to visit Walter on occasions but that they had a limited friendship. The PCSO at the learning even stated that she had met R at a separate incident and had mentioned Walter, R had no recollection of being at Walters address. IC had only known Walter for 3 weeks when the social worker visited. Police checks didn't find any concerns regarding C.

[14] Activities of Daily Living or ADLs are activities such as, getting out of bed, getting dressed, preparing a hot meal or drink.

3.62 8th January 2016 – An Essex Police incident regarding a concern for safety was created following a visit to Walter by the PCSO. Whilst at WALTER's address she spoke with a friend of Walter who stated that Sarah and Tom had been turning up at Walter's address every Saturday; causing damage and taking money from him. The friend also stated that Sarah had told Walter that she wanted to move into his home. The friend was extremely upset and frustrated that Walter was being taken advantage of and threatened to take action into his own hands.

Key episode seven – daily visits by community nurses commence.

3.63 11th January 2016 Walter was visited by two community nursing staff, visits commenced to collate blood glucose profile for a diabetic clinic appointment on the 20th January. Regular visits were undertaken daily from this point forward by the community nursing team for diabetes care.

Key episode eight – housing officer and social worker joint visit.

3.64 11th January 2016 - A housing officer made contact with Walter's social worker and arranged a joint visit to Walter's property on Tuesday 26th January 12pm. The housing officer was concerned about Walter's living conditions and shared some of the same concerns previously raised regarding safeguarding. The purpose of the visit was to inspect the repairs carried out to Walter's property following a water leak and discuss how security could be improved and the upkeep of the property maintained.

3.65 Walter was referred to One Support[15] as a result of this joint visit. The housing officer noted that Sarah was living at the address. *The housing officer would not have been able to evict Sarah. Walter was breaking his contract with housing by having Sarah live with him in a one-bedroomed flat. However, the housing officer would have had to evict Walter if they were to take action and this was not considered to be in Walter's best interests.* Repairs were noted for action.

Key episode nine – alert on medical notes re misuse of medication.

This links with key episode three

3.66 21st January 2016 - Walter was seen in the GP practice with Sarah. An assessment was made of his general health and recorded. Walter was advised about the over-use of Pregabalin. Tom and then Sarah started demanding gabapentin[16] (a drug increasingly used for recreational use as it gives a 'legal high'). Sarah constantly spoke over Walter leading the GP to suspect that both Gabapentin and Pregabalin were being diverted. On 22nd Jan 2016 an alert was placed on Walter's notes for staff to speak to Walter's GP or Dr H before any further issues of Pregablin or Gabapentin were prescribed. *The GP who saw Walter on this occasion had a good understanding of substance misuse and immediately understood the significance of Sarah requesting these drugs.*

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[15] One Support is a housing related, floating support service.

[16] http://www.brainprotips.com/gabapentin-recreational-use/)

Key episode ten – Community care assessment

3.67 8th February 2016 - A joint visit to Walter by two social workers They were unable to discuss freely due to presence of Sarah. Part one of a social care assessment of need was completed. This noted that sensory and Assistive Technology assessments would be needed due to Walter's difficulties with seeing oven dials and clock, transferring from armchair and bed and tripping on the step at his front door. He also needed [17]Careline, once a landline was in place. The Careline was to be linked to a gas detector as Walter previously didn't turn the oven off properly and the property started smelling of gas. The assessment also stated the need for housing repairs, obtaining bedroom furniture, monitoring medication and ongoing support with diabetes and eating patterns.

Key episode eleven- Sarah trying to obtain Pregablin but declined.

Link to key episode three and key episode nine

3.68 25th February 2016 - GP notes state that Walter phoned to say that he had lost his prescription on the bus. WALTER was not seen. A new prescription was issued. *The notes do not say what the medication was. The GP who made this entry was not known to the surgery and is likely to be an out of hours doctor.*

3.69 2nd March 2016 - Sarah phoned the GP practice requesting more Pregablin but this was declined by reception staff. The GP discussed with the social worker the safeguarding concerns on the misuse of Walter's medication. The GP said that he would request Walter to come in for a 'routine review' and would see Walter alone to discuss alternative pain relief.

Key episode twelve – ongoing intervention and care.

Link to Key episode ten.

3.70 3rd March 2016 - Supervision discussion on Walter's completed social care assessment took place. The social worker noted that it was difficult speaking to Walter alone due to Sarah living back at property. A plan was made to visit Walter the next week and take him out so that the safeguarding enquiry could be completed.

3.71 4th March 2016 - Walter admitted to the community nurse that he was having falls. On the last occasion he fell outside and landed on both elbows. He had not been able to shave since and was unhappy that he had grown a beard. Walter agreed for Ensure shakes[18] to be requested from his GP, as he appeared to have lost weight.

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[17] An alarm system to summon help if for example Walter were to fall over.

[18] A food supplement drink

3.72 8th March 2016 - Visit to Walter by his social worker in an attempt to see Walter on his own, but Sarah was present and Walter wanted her to stay. This happened again on the 5th April 2016 when Sarah was present.

3.73 11th April 2016 – A supervision discussion between Walter's social worker and her supervisor concluded that the Community Care Act Assessment had been completed. Referrals to the sensory team, and One Support had been completed.

3.74 13th May 2016 Sensory Service. The sensory service recorded that they had provided a Doro photo phone[19] and a Talking clock. A letter had been sent to the GP to request referrals for Walter to the eye clinic and low vision clinic. Bumpons[20] were provided for the microwave. Referral made to Fire service for oven cleaning. A referral was made to the library service for a volunteer to deliver talking books.

3.75 18th May 2016 Walter was seen by the Falls service for assessment and appropriate intervention.

Key episode thirteen – safeguard closed.

Link to key episode five

3.76 6th June 2016 – A decision was made in a supervision discussion for Walter's safeguarding enquiry to be closed. The records state 'Financial or Material Abuse Substantiated – Risk Reduced. Domestic Abuse Substantiated – Risk Reduced. Walter satisfied with the outcome. Overall conclusion – Investigation ceased at individual's request.' There was an action to review in 6-8 weeks time the outcome of the advice and information provided to Walter.*This safeguarding referral was commenced 4th January 2016 (3.58).*

Key episode fourteen – One Support commences

3.77 20th June 2016 – The first visit by Walter's support worker from One Support. Sarah and Tom were both present. They were moving the large TV from the front room where Walter watched it into Sarah's bedroom. Walter was left with a small TV, which he could not see. The Support worker called Walter's GP and made arrangements for Walter's medication to be collected by Walter from a nearby pharmacy and for the medication to be provided in blister packs. Prior to this the medication was being delivered to Walter's home address but Sarah cancelled it. Walter could not read the instructions due to his visual impairment.

[19] A telephone for the visually impaired that has big buttons and picture dialing.

[20] Bumpons are brightly coloured, raised, dome-like rubber disks that are self-adhesive. They are used to mark equipment and settings on microwaves and other white goods to assist the visually impaired.

3.78 23rd June 2016 - Walter's Support worker met Walter in town as they planned to open a current bank account for Walter. However, an advisor was not available at the bank and so the application was made later over the telephone. The Support worker was concerned as Walter looked unwell. He had been running errands for Sarah, including returning an item to a shop for a refund. He did not have any money for a bus and had walked some distance. He told the Support worker that Sarah took almost all of his money apart from a small amount he kept for food. Walter said that he had to do their shopping, all of the laundry and clean her shoes. Sarah did nothing for Walter or in the house. If Walter had any money and hid it under his pillow she would take it during the night. He said that Sarah was abusive to him. The Support worker asked if Walter had ever felt in fear of his safety from Sarah or Tom. Walter said he would never allow them to touch him. Walter no longer had a bus pass as Sarah used it and then lost it.

3.79 29th June 2016 – The Support worker visited Walter. Sarah and two males were in the property drinking. Sarah said they were having a party. It started at 8.30am. When alone with his Support worker Walter said he'd had enough and wanted his house back. The Support worker called the DWP with Walter and gave them the new bank details for the current account so the Pension/Pension credit would be paid in from the 11th July 2016.

Key episode fifteen – One Support Safeguarding referral

3.80 30th June 2016 - Walter's Support worker raised a safeguarding alert. An email was also sent to the police with her concerns.

3.81 The safeguarding referral progressed to an enquiry. Arrangements were made with Walter for the social worker to visit him when Sarah was out. At this time the Support worker and the diabetic nurse were the only contacts Walter had with health and social care professionals.

3.82 Walter spoke to the social worker about his five marriages and six children. His daughters would not visit him whilst he was being exploited by Sarah. Walter spoke about what life could be like if he was free from Sarah but he was not yet ready to make the break. *None of Walter's daughters came forward at the time of his death.*

3.83 7th July 2016 - As Walter had mental capacity the safeguarding enquiry was closed, with a note to say that the risk would be reduced through multi-agency monitoring. A risk management plan was put in place regarding medication and being able to access help. The police visited Walter. As no offences were disclosed and social care was to have on-going involvement the investigation was closed.

Key episode sixteen –domestic assault and theft

3.84 17th July 2016 - Walter phoned 999 to report that Sarah had been assaulted by Tom and Tom had stolen Walter's wallet, bankcard and £30 in cash which had been in the possession of Sarah. During the assault Sarah received a black eye. This incident was graded as a High Risk Domestic the officer completed a skeletal Domestic Violence Form. Although both parties were unwilling to engage, Tom was arrested later that day at another location in connection with the assault and theft.

3.85 18th July 2016 - Whilst Tom was in custody Walter and Sarah were revisited by an officer from the Domestic Abuse Investigation Team. On this occasion Sarah agreed to complete the Athena Risk Assessment although both Sarah and Walter maintained the position that they would not provide a statement. The attending officer regarded the risk level to be Medium Risk, a decision agreed by a supervisor. Tom was later interviewed during which he denied the assault and the theft of the wallet, bankcard and money as a result the case was closed.

Key episode seventeen – lack of food lowering blood glucose levels.

3.86 21st July 2016 - Walter informed his community nurse that Sarah had taken money for food and not returned. Walter had not eaten breakfast and had little food in his cupboards. The community nurse sent a safeguarding alert (SETSAF1). There were no changes in Walter's situation since the last safeguarding raised on 30/6/2016 and so the safeguarding referral was closed. The Support worker and social worker were to continue working with Walter and monitor the situation. The district nurse was continuing to visit Walter every day to monitor his blood sugar levels.

Key episode eighteen – telephone landline, gas detector, window repair and fire safety visit.

3.87 22nd July 2016 - Support worker visited Walter to find that his telephone landline was still not working. The Support worker was advised to go back to the property and undo the box so that BT could assist by talking through instructions on her mobile phone. Walter also had his gas card taken so the Support worker called his gas provider and they arranged to send out another card by Monday.

3.88 3rd August 2016 - Walter went to see his Support worker at the One Support offices where Walter applied for a loan for a new television and some clothes. Walter spoke again of his mistreatment by Sarah. Walter's Support worker telephoned Walter's landlord to ask for his window to be repaired as a matter of urgency due to Walter's vulnerability and him living on the ground floor. The landline was expected to be working by the following afternoon.

3.89 4th August 2016 - Social Worker visited Walter to review whether the provision of services and actions following the Care Assessment had met Walter's needs. The social worker wanted to discuss assistive technology solutions but Walter was still waiting for the wiring to be fixed for his landline. Walter agreed to Careline once the landline was working. He

also agreed for a referral to the fire service with regard to a fire risk from condition of his oven.

3.90 8th August 2016 Email to, support worker from social worker updating her of the outcome from the care review. The telephone landline was now working. The social worker said that the gas detector was no longer provided by the Council and he/she would make enquiries to see how else it might be funded.

3.91 15th August 2016 - A home safety visit was conducted by two firemen at the property with Walter. They installed two smoke alarms in the Living Room and Hallway. All areas of concern relating to home safety were mentioned with escape plans and oven cleanliness being discussed in depth. A referral for the fire service's oven clean service was made but was not provided as sadly Walter died.

Key episode nineteen – TH causing a disturbance

3.92 18th August 2016 - Essex Police attended an incident regarding a report of a disturbance at Walter's address. A 999 call was received from JH a neighbour of Walter stating that a male called Tom was outside Walter's home. Tom was very drunk and was banging on a window to the flat and shouting to be let in. The neighbour was concerned for Walter as he was in his 80's and would not be able to deal with this male. Police attended the premises but Tom had left prior to their arrival. Advice was given to Walter and he was advised to call back in the event of Tom returning. The incident was logged as an ASB (anti-social behavior) Nuisance call.

Key episode twenty – dramatic weight loss cause for concern

3.93 18th August 2016 - GP notes record a discussion with Walter's district nurse regarding Walter's dramatic weight loss, 'family members' in his flat taking money and food and selling Walter's medication for drugs. The record says that Walter was reluctant to take any action. However, the district nurse was to discuss these concerns with Walter's social worker. *It has since become apparent that the people referred to were Sarah and Tom and therefore not family members.*

3.94 19th August 2016 – The district nurse was supported by the Community matron to complete a safeguarding referral. The district nurse spoke to Walter's social worker to discuss her concerns and intention to send a safeguarding referral. The district nurse told the social worker that she would have to buy Walter some food due to the risk of hypoglycemia, as there was no food in his flat. The district nurse enquired about food bank vouchers and the social worker said that she would make enquiries.

3.95 23rd August 2016 - During a visit the community nurse spoke to Walter's support worker, who told her she had similar concerns, and had raised a safeguarding alert in the recent past. Consent was obtained from Walter to look in his fridge/freezer and cupboards. There wasn't much more than bread and frozen peas. Weight loss was even more evident as

his false teeth no longer fitted. Walter agreed the food situation is worse round Thursdays, as his visitors had eaten everything by then.

3.96 23rd August 2016 – A social worker phoned Walter to say that safeguarding concerns had been raised regarding a lack of food in his property. The social worker made arrangements to visit Walter when Sarah was out. Walter said that he did not feel as though he had lost much weight and that he had plenty of food now.

3.97 24th August 2016 – The Support worker took a food parcel to Walter. She called Walter just as she got to his property to tell him. He asked for it to be delivered another time. When the support worker called Walter later that day he explained that there was a house full of Sarah's friends when she was about to drop off the food parcel. He said that Sarah's mother had visited the previous day with a pork joint which they had roasted. The Support worker arranged to deliver the food parcel the next day.

3.98 25th August 2016 – The social worker and Support worker visited together to deliver a food parcel. Walter showed them that he already had a lot of food in his fridge-freezer and cupboards following a visit by Sarah's mother. Sarah and her partner Tom were at the property but went into the bedroom. When concern about Walter's weight loss and lack of food was raised, Walter said 'shh' and pointed at the bedroom door. He said loudly to the support worker 'it's good you're taking round this food to everyone you work with now,' so he clearly did not want Sarah and Tom to know that there were concerns about his welfare.

3.99 25th August 2016 - The social worker asked the community nurse to clarify 'In your SET SAF (safeguarding referral) you say that Walter has frequent falls and hypos; do you have any more info on when?' The social worker was not aware of any hypoglycemic events since the district nurses had been visiting daily, neither was she aware of Walter having had any falls that year. The social worker explained that the duty worker was going to arrange vouchers for the food bank. The social worker asked community nursing to monitor the food situation over the coming days and weeks. *This was because they visited daily and it seemed to be the best way of keeping an eye on the situation and helping Walter to access another food parcel if was needed.*

3.100 31st August 2016 – The Community matron spoke to the social worker, after several unsuccessful attempts to speak to someone in adult social care about Walter. The social worker explained that the assigned social worker was away that week. The Community matron advised the social worker she was aware of a current safeguarding enquiry and reported that Walter yet again had no food in his flat The social worker advised he would try and contact some charities and see if food could be delivered to Walter that day.

3.101 31st August 2016 – The district nurse sent a long email to Walter's social worker setting out her serious concerns for Walter's health and well-being. She reported that Walter once again had no food in his cupboards and that she was very concerned for his health due to how little he had been eating. In this email the district nurse explains that nursing notes are kept at Walter's flat, which the social worker can read at anytime. These record all hypoglycemic attacks. The district nurse also told the social worker that she had taken a urine sample to check for toxins that might have contributed to his falls. The district nurse was concerned about Walter being susceptible to broken bones if he fell due to his poor diet. The GP was going to check Walter's blood but in the meantime had prescribed supplements high in calcium and other nutrients.

Key episode twenty-one – Theft of bank cards

3.102 31st August 2016 – The Support worker visited Walter who was very distressed. Whilst he was sleeping the night before Sarah had taken his wallet from under his pillow and removed two bank cards. He had no food as Sarah & Tom had eaten it all. He had no money and was feeling unwell. He discovered the bank cards were missing when he went to the cash point early that morning to withdraw some cash. When he returned home Sarah and Tom had gone out. Walter was so distressed and angry he agreed to the Support worker contacting the police. Walter said he wanted them out - as he could not take it anymore. The police said they were hoping this could be dealt with the same day and that they would be raising a safeguarding alert because of the on going situation and previous incidents. Whilst on the phone to Walter's bank Sarah and Tom returned with shopping bags of drink. Sarah had a Diesel handbag in a bag. Walter shouted at them that they had taken his cards and spent the money. They denied this. Walter told them the police had been contacted.

3.103 The support worker was due to go on leave the next day. She called the zone warden and made arrangements for a £10 donation from the church. The support worker also arranged a food parcel. When the support worker took the food parcel to Walter he said that Sarah had taken the cards in case he wasn't well enough to go out and get his money and that she would give it back to him. The social worker was updated on the situation.

3.104 31st August 2016 - A police unit attended Walter's address and spoke with Walter. The officers recorded that Walter informed them that he had no concerns in relation to Sarah and did not want the police to remove her from the premises. He informed the officers that she would be moving out soon. He confirmed that he was living in the living room and had done so for a couple of years out of choice. He informed the officers that Sarah had used his bankcard as she had felt that he was not well enough and had gone and got some money out of his account in order to buy food for him. He informed officers that he had made an appointment to see his

bank on the following Saturday, with his support worker, to change his bankcard and PIN. The incident was then deferred to 3rd September 2016 for officers to revisit Walter to establish if any further money had been taken from the account and for consideration of the submission of a safeguarding referral. However, on 1st September 2016 an update of the incident stated that arrangements had been made for a follow up enquiry (planned for 3rd September 2016) and that the incident could be closed.

3.105 The officer made it clear in the incident log that she was taking leave and would be unable to follow up the enquiry – so the follow up did not take place.

3.106 1st September 2016 – A social worker telephoned Walter when he said that he could speak on the phone as Sarah was not present. Walter said that he had some food at home, but not enough to last the weekend. Walter told the social worker about the money taken from his account and that the police had been informed, He said that he thought it was Sarah or one of her friends. Walter said that things had got worse and he was thinking of getting a court order put in place. He said that it was difficult for him as his deceased wife's wish was for him to look after Sarah, so he felt that he would be letting down his wife and breaking his promise. *We can only assume that Walter was trying to convey the immense difficulty of breaking away from Sarah without disclosing that he was afraid of her. As an ex-navy man he wanted to appear macho and to admit to being afraid of a woman could not have been easy.*

3.107 2nd September 2016 - A home visit by a social worker with a number of food items bought for Walter to last the weekend. Sarah was present when the food was delivered. The social worker advised Walter that his key (social) worker would be in touch some time early in the following week to speak to Walter about some of the current presenting issues.

Sunday Sept 4th 12.30am Sarah committed arson. Fatal fire resulted in Walter's death.

PART THREE

4.0 Analysis

Good practice

4.1 There are some examples of notable good practice in this DHR/SAR. These are reported first.

4.2 A member of the public, an Iceland worker, recognised that Walter might be experiencing financial abuse and reported this concern to the police. This demonstrates the effectiveness of the Essex Safeguarding Adult partnership in raising the public's awareness of adult safeguarding (3.45).

4.3 When Sarah contacted the police to report an assault by Tom a PCSO carried out a follow-up visit. It was as a result of this visit that the PCSO raised concerns about Walter's living conditions to adult social care.

4.4 When Sarah's domestic violence case was discussed at a MARAC meeting, Walter was identified as a vulnerable adult living within the same household and a safeguarding referral was made to adult social care (3.41).

4.5 Professionals worked closely together with three joint visits noted:

- PCSO and social worker (3.57)
- Community matron and social worker (3.58)
- Housing officer and social worker (3.64)
- Support worker and social worker (3.98).

4.6 Professionals from all agencies involved in providing care and support to Walter was aware that he was experiencing abuse and made appropriate referrals to safeguarding adults. Six safeguarding referrals were made see table one below.

Table one

Date	**Referring agency**	**Date closed**	**Outcome**
6th August 2014	Police	5th September 2014	Substantiated material/financial abuse. Walter did not want to proceed (3.44, 3.45)
5th January 2016	Social worker	6th June 2016	Substantiated material/financial abuse and neglect (3.59, 3.76)
10th February 2016	Police	6th June	This referral was following a MARAC where Sarah was discussed. Walter was already subject to a safeguarding enquiry at this time.
30th June 2016	One Support	7th July 2016	Substantiated material/financial abuse and neglect (3.80, 3.83)
21st July	Community nursing assistant	21st July	Recurring concerns managed via case management (3.86)
23rd August	District nurse	Not completed	Walter died before the safeguarding enquiry was closed.

4.7 The Safeguarding Adult team respected Walter's right to make an unwise decision when he declined any involvement from adult safeguarding. They recorded that Walter had the mental capacity to make the decisions on each occasion. This was in keeping with the Mental Capacity Act.

4.8 When Walter declined intervention by adult safeguarding care and support was put in place to minimise the risk of abuse.

4.9 Walter had a social care assessment (3.67) and a review of his plan of care (3.90) during the period covered by this review. The Care Assessment and Care plan were comprehensive. As well as addressing health needs the Care plan included referral to the fire service for fire prevention checks, obtaining a gas detector, getting a telephone landline installed and access to Careline.

4.10 Adult social care-Safeguarding adults function, Community nursing, GP practice, Police, Housing officer and the One Support worked together to support Walter the best that they could. Walter received daily visits from community nurses and frequent visits from his support worker, who built trusting relationships with Walter.

4.11 The social worker and community nurses working with Walter had regular supervision from their line managers and were able to escalate their concerns, which they did effectively (3.70, 3.73, 3.76).

4.12 The GP practice quickly identified that Walter's prescribed medication was being misused by Sarah and took timely and appropriate action (3.52, 3.66, 3.69)

4.13 When Walter had no food in his house and no money care and support staff were resourceful in meeting his needs. The community nurse and social worker provided food using food bank vouchers (3.98, 3.99). The Support worker and Zone warden obtained £10 from the local church for Walter and delivered a food parcel (3.103). One Support provided a food parcel (3.97).

4.14 The Primary care team referred Walter to the Falls service to investigate why he was experiencing falls. Walter's urine was tested to see if there were toxins that may have contributed to his falls. Walter was provided with prescribed food supplements high in calcium and other nutrients to prevent broken bones from his falls. Walter's urine was also checked to see if he was being given illegal drugs (3.101).

4.15 Walter received comprehensive care and support. Staff worked closely with Walter earning his trust and working within the boundaries that Walter set. They used discretion, checking that he was alone before discussing sensitive issues. This was a complex case where a man who had the mental capacity to make decisions about his care chose to stay living with Sarah despite experiencing daily abuse.

4.16 It is always easier with hindsight to look back and identify what might have been done differently to achieve a better outcome. The DHR/SAR panel and the practitioners involved in the Learning event (11th August 2017) identified areas of learning. These have been grouped under four headings:

- Sharing intelligence and joint decision-making
- Making Safeguarding Personal
- Interface between Domestic Violence and Adult Safeguarding.
- Raising awareness of adult safeguarding

Intelligence Sharing and Joint Decision-Making

4.17 The key events narrative shows that agencies working with Walter worked closely together to share information and concerns. This is demonstrated in the joint visits to Walter (4.5) and information exchanges when safeguarding concerns were raised (4.6).

4.18 However, despite agencies working closely together, there was not a formal process for discussing the case and agreeing a coordinated response to minimise and review risk.

4.19 During panel discussions it was identified that housing were aware of incidents involving Sarah, Tom and Walter taking place at Walters home address. (3.92) Housing stated that as Walter was the named tenant the only action that they could take would be in relation to Walter. This would have resulted in the eviction of Walter and not Sarah or Tom. This was raised as a missed opportunity by the panel who believed that the Housing agency should have held a multi-agency meeting to discuss what was taking place at Walters address and to look at other ways of dealing with the situation. There currently appears to be a gap in the awareness of the housing association who dealt with Walter.

4.20 The Practitioner's Learning Event (11/8/2017) reported that Primary care hold monthly multi-disciplinary team meetings to discuss clients. However, adult social care, care providers and the police are not invited to these multi-disciplinary team meetings.

4.21 There is a clear process for holding a strategy meeting and agreeing co-ordinated support and intervention when an adult is subject to the adult safeguarding process. Walter chose not to participate in the safeguarding process and so did not benefit from this approach. Practitioners explained at the Learning Event that any professional could call a multi agency team meeting to discuss a client at any time. The absence of a formal process for calling a multi-agency team meeting and coordinating care meant that this did not happen as none of the agencies took the initiative and called the meeting.

4.22 The Police IMR found that whilst there were a number of safeguarding notifications made that resulted in a response from both the police and social care, there were a number of occasions where this wasn't the case. This had the cumulative effect of an incomplete picture of the relationship between Walter, Sarah and Tom. This information could have helped inform a joint risk assessment of Walter. The Police IMR identifies these missed opportunities as follows:

- When Walter reported the theft of his bankcard (3.47). If this had been recorded on the Police information system STORM then links would have been made with the safeguarding referral raised four months previous on suspected financial abuse.
- When Police attended a break-in to Walter's address (3.104) reported by Sarah. The Police suspected that Sarah was experiencing mental health problems but did not raise a notification for Sarah or Walter to the Police's SOVA team.
- When responding to a report of aggravated burglary to address 2 (Sarah and Tom's house) Police identified the suspected culprits as two drug dealers who were staying at Walter's address. The Police report comments on Walter's vulnerability but a notification was not raised.
- The Police chronology and IMR refers to an incident when Sarah made a non-emergency call to the Police to say someone had been in her home whilst she had been out and had moved a rubbish bag. She also said that she thought Tom had been setting up bills in her grandfather's name (Walter). The information recorded on STORM was that no offence had been committed and that the matter related to mental health issues. No links were made with earlier reports of suspected financial abuse of Walter.

4.23 Whilst professionals were sharing information regarding Walter this was not seen within the wider context of Sarah and Tom. If information on the domestic violence reported by Sarah and other incidents involving Sarah and Tom investigated by the Police had been shared with professionals working with Walter, a broader picture and subsequent risk assessment could have been achieved.

4.24 The Police did identify a vulnerable adult Walter was living with Sarah when her case was discussed at a MARAC. This resulted in a referral to adult safeguarding. This was a missed opportunity to hold a strategy meeting including professionals working with both Walter and Sarah.

4.25 Despite Walter referring to Sarah as his carer, no carers assessment was completed regarding Sarah or any support offered to her.

4.26 Professionals at the Practitioner Learning event (11/8/2017) suggested that the accepted practice of raising a safeguarding alert when a child is in the household of reported domestic violence could be extended to vulnerable adults. It must be noted, however, that it is often difficult to identify a vulnerable adult but awareness needs to be raised for

professionals to consider the possibility of a vulnerable adult being present in an address.

4.27 A timely multi agency strategy meeting involving all of the agencies providing care and support to Walter and Sarah could have:

- Led to a more person-centred approach in helping both Walter and Sarah achieve the outcomes that they wanted,
- Pooled knowledge and expertise across safeguarding adults and domestic violence to help Walter and Sarah explore the options available to them,
- Assessed the risk to Walter at different stages through the sharing of information and coordinated a response to minimise risk and negotiate potential solutions with Walter and Sarah.

4.28 Making Safeguarding Personal and the Interface between Domestic Violence and Safeguarding Adults explores this further.

Making Safeguarding Personal

4.29 Six referrals were sent to the Safeguarding Adult Team (table one). However, no further action was taken to proceed with the safeguarding process as there was no reason to doubt that Walter had the mental capacity to make a decision and he chose not to continue with adult safeguarding.

4.30 The Safeguarding Team was right to respect Walter's decision albeit considered unwise, as there was no reason to doubt that Walter had the mental capacity to make this decision on each occasion, as set out in the Mental Capacity Act.

4.31 Working with people who have mental capacity, but make unwise choices that threaten their health and well-being, is a challenge for health and social care professionals. Braye, Orr and Preston-Shoot (2011)[21] describe the need to balance a respect for the person's autonomy with a perceived duty to preserve health and well-being. They say research has shown that effective practice resides in the ability to build relationships over time and negotiation with the person.

4.32 Walter's Support worker was working closely with him and had taken time to build a trusting relationship. However, the Support worker was working without strategic direction, as she was not supported by an integrated and effective care management approach to planning, risk assessment and a person-centred approach to positive risk taking.

4.33 Positive risk taking identifies what is important to the person and enables them to recognise the risks of their decision alongside their

[21] *Conceptualising and responding to self-neglect: the challenges for adult safeguarding,* Suzy Braye, David Orr, Michael Preston-Shoot, Journal of Adult Protection, Vol 13 No 4 2011 pp182-193, Emerald Group Publishing.

wishes. Research shows that an approach, which continues a dialogue with the person, enabling them to achieve the outcomes they want whilst recognising and negotiating levels of risk, is often effective (LGA/ADASS 2014)[22].

4.34 The Essex County Council Adult Safeguarding Enquiry form records what the adult's views are on the safeguarding process in their own words. This is good, as it clearly represents the person's wishes. The form then has some options to record the 'Adult's desired outcome.' This is a tick box with an option 'other'. This partly meets the Making Safeguarding Personal guidance[23] to record in the person's own words the outcomes that they want to achieve. However, it misses an important point. Walter's desired outcome was to keep Sarah safe as well as himself. This has been reported in the chronology and IMRs but the outcome Walter wanted was not explored with him and recorded. The three completed Safeguarding Enquiries state what Walter *does not want*, 'the safeguarding process to continue.'

4.35 The outcome to keep Sarah safe from harm and her needs met, could have been discussed and negotiated with Walter. It may have been possible to explore some options, had a family conferencing approach been used for example. This approach brings together the people around the person who is at risk and draws on the assets that they bring to help find possible solutions. Sarah's daughter has said that her mum is determined and could always find a way to achieve what she wanted. Sarah's family shared Walter's desired outcome to keep Sarah safe and wanted her to move back into the house they had provided for her. By involving the organisations supporting both Walter and Sarah, as well as family and friends, then more creative options could have been explored with Walter.

4.36 It is possible, and some practitioners who worked with Walter and Sarah consider it likely, that Walter and Sarah would not have participated in a family conference or similar approach. Although that might well be the case there is learning here for future cases where a person-centred approach to positive risk taking, working with the person to continually balance their desired outcomes with negotiated levels of risk, and creatively exploring how those outcomes could be met whilst reducing risk, could be effective.

4.37 The panel felt that there was a missed opportunity in engaging with Sarah when considering Walter's care needs and safeguarding concerns. However this could only have been done with Walter's permission.

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[22] *Making Safeguarding Personal: Guide 2014,* LGA/ADASS

[23] *Making Safeguarding Personal: developing responses and enhancing skills,* Jill Manthorpe, Deborah Klee, Cathie Williams, Adi Cooper, Jouranal of Adult Protection, Vol 16 No 2 2014 pp96-103, Emerald Group Publishing.

Interface between Domestic Violence and Safeguarding Adults

4.38 There is considerable overlap in legislation regarding Domestic Violence and Safeguarding Adults. The Home Office made changes to the definition of Domestic Violence in 2013 to include; psychological, physical, sexual, financial, emotional abuse and so called honour-based violence. It includes violence against family members as well as intimate partners.

4.39 The Care and Support Guidance of the Care Act 2014 expanded the definition of safeguarding adults to include; physical abuse, domestic violence, including so called honour based violence, psychological abuse, sexual abuse, financial abuse, modern slavery, discriminatory, organisational abuse, neglect or acts of omission and emotional and self-neglect.

4.40 When the Police first attended Walter's flat (address 1) and spoke to Walter about the concerns raised by the Iceland worker regarding financial abuse (3.44), the Police established that Sarah was not Walter's granddaughter.

4.41 The definition of domestic violence[24] is, 'Any incident or pattern of incidents of controlling, coercive, threatening behavior, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of age or sexuality.' Domestic violence includes financial abuse and emotional abuse.

4.42 The Police were correct in not following the procedure for reporting Walter as a victim of domestic violence and quite rightly referred him to the Safeguarding Adult Team and the Police SOVA team. However, there was an opportunity for the safeguarding adults team to benefit from the expertise of domestic abuse agencies in the risk assessment and management of abuse.

4.43 There are also a number of legal actions and sanctions (criminal and civil) that can be used in adult safeguarding and domestic abuse. Sarah was a victim of domestic abuse. By bringing together the expertise of adult safeguarding and domestic abuse services, a wider ranger of social work and legal options could have been explored in achieving an outcome that was acceptable to Walter.

4.44 The Local Government Association and ADASS have produced helpful guidance on adult safeguarding and domestic abuse [25]. This guidance

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[24] *Call to end violence against women and girls,* Home Office, November 2010

[25] *Adult safeguarding and domestic abuse – a guide to support practitioners and managers. LGA and ADASS Second Edition 2015.*

recommends that there are clear local arrangements between safeguarding adult boards, community safety partnerships and the local safeguarding children's board. The Southend, Essex and Thurrock Safeguarding Adult Guidelines (March 2017) states at 5.6.28 that any adult experiencing domestic abuse must be subject to the Domestic Abuse, Stalking and Harassment (DASH) risk model. Clear links are made between safeguarding adults and domestic abuse in a flow chart. However WALTER did not meet the criteria for domestic abuse.

4.45 These considerations of potential levers for change emphasise the advantages of considering options when drawing on the experience of domestic violence cases as well as adult safeguarding. A multi agency approach involving all partners working with Walter and Sarah may have identified a wider range of solutions.

4.46 Further considerations could have been used by agencies regarding the removal of Sarah from Walter's property. An injunction keeping her away from his home address could have been obtained through the courts; however, this again would have had to come from Walter in relation to his decision-making. It is felt that had Walter ultimately made that decision then agencies involved with him would have helped and supported him through this process.

4.47 It has previously been identified that the rental agreement for the property was in Walter's details and as such enforcement could have been taken against Sarah in removing her from the premises.

4.48 Walter did not benefit from the safeguarding adult process as he refused this service and was considered to have the mental capacity to make this decision. Sarah might have been considered for adult safeguarding as she was receiving care and support services as a result of substance misuse and was experiencing domestic abuse. However, the safeguarding adult team representative at the Practitioner Learning Event explained that Sarah was able to protect herself and therefore would not have met the criteria. In considering the safeguarding adult responses to both Walter and Sarah there are lessons to be learnt drawing on the LGA/ADASS guidance (2015).

4.49 When Walter made, what was considered an unwise decision, to refuse safeguarding services then this decision was respected as there was no reason to doubt that Walter had the mental capacity to make that decision. The experience of domestic abuse agencies is that, 'an apparently unwise decision may be the result of coercion on controlling behaviour by another person (LGA/ADASS 2015). The guidance goes on to say that, 'When a person appears to be choosing to stay in a high-risk abusive relationship then careful consideration must be given to whether

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https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf

they are making that choice free from the undue influence of a person who is causing them harm. It may be that the relationship is more important to them than the harm that is being done. Perhaps more so if the harm is not life-threatening.'

4.50 Case law has challenged whether a person truly has the mental capacity to make this decision when experiencing the controlling behaviour of another person (see DL vs A Local Authority and Others 2012)[26]. It has been determined that there is scope for a Local Authority to commence proceedings to the High Court to safeguard people who do not lack capacity but whose ability to make those decisions has been compromised as a result of constraints in their circumstances including coercion and undue influence (LGA/ADASS 2015).

4.51 The safeguarding adult team would have benefited from the expertise of domestic abuse agencies in the risk assessment and management of Walter's case. The assessment of mental capacity to make a decision about intervention in this case, which is very similar to a domestic violence case, requires skilled assessment and intervention. Safe enquiries should be made i.e. asking the right questions in a safe place and providing information and support to help the victim explore all of the possible options available to them.

4.52 Although Walter was considered to have mental capacity he might have benefitted from the support of an advocate to help him understand and consider his options.

4.53 Sarah was not considered for safeguarding adult services when she experienced abuse by Tom. A safeguarding referral was made for Sarah by an ambulance crew who attended Open Road on 15th March 2016[27] as it was suspected that Sarah and two other adults had been drinking and taking a high called Spice. This referral was closed on receipt, as there was no alleged abuse. It is easy to dismiss safeguarding referrals regarding people who misuse substances, as an assumption might be made that they are able to defend themselves and have mental capacity. However, people who misuse substances are likely to experience fluctuating mental capacity.

4.54 LGA/ADASS guidance (2015) alerts us to the danger of making assumptions about particular service users and highlights people who misuse substances. This guidance says that, 'substance misuse by the victim may make it difficult for them to accurately assess the risk posed to them, as it may dull their perception.'

4.55 Sarah was also a victim. Both Walter and Sarah were complex cases that needed the expertise of domestic abuse and safeguarding adult

[26] http://www.bailii.org/ew/cases/EWCA/Civ/2012/253.html accessed 13/09/2017

[27] Adult Social Care ECC chronology.

teams. These two teams, working with both cases, would have had access to a wider range of tools, resources, expertise and information to enable Walter and Sarah to consider the options available to them.

Raising awareness of adult safeguarding

4.56 Preventing as well as responding to the abuse and neglect of vulnerable adults requires professionals and the general public to have an understanding and awareness of the different types of abuse and neglect. Good practice above has identified public awareness of financial abuse in particular the actions of the Iceland supermarket worker which had a significant impact and professionals' awareness of when to refer a vulnerable adult for safeguarding. However, this review found that there were some aspects of adult safeguarding where awareness could be improved:

- Cuckooing – the use of vulnerable adults homes as drug dens
- The misuse of prescribed medications such as Pregabalin
- Police awareness of when to raise a safeguarding concern to the police safeguarding triage

Cuckooing

4.57 Cuckooing vulnerable adults homes to use as drug dens or as part of County lines exploitation (see 4.20) is becoming an increasing problem. The Guardian reported on the increase of vulnerable adults homes being used by drug dealers.[28] '(It is) largely in response to the widespread closure of crack dens under powers given to local authorities a decade ago.'

4.58 Vulnerable adults are groomed with offers of sex and/or drugs in exchange for accommodation. The gangs identify vulnerable adults who do not have friends and family. They are often lonely and known to indulge in drink, drugs or sex. Walter was a regular visitor to his local pub where he spoke openly about his past relationships with women. A friend (L), interviewed as part of this review, knew Walter from the pub.

4.59 County Lines[1] – or 'Going County' is the police term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated phone lines. Gangs use children and vulnerable adults to move drugs and money[29].

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[28]Observer https://www.theguardian.com/society/2010/oct/03/homeless-gangs-cuckoo (accessed 18/8/2017)

[29] *Criminal exploitation of children and vulnerable adults: County Lines guidance,* Home Office July 2017 http://cdn.basw.co.uk/upload/basw_81753-1.pdf (accessed 18/8/2017)

4.60 The National Crime Agency (NCA) researched where County Lines activity typically took place.[30] It is interesting to note that 42% of reported activity was in coastal towns, rising to 52% when the coastal area was close to a town. Sixty-five percent were in areas with decent transport links to London.

4.61 With hindsight, it is evident that Colchester is a prime location for County Lines or Cuckooing and that Walter was a likely victim given his situation. However, this suspicion did not come to light until a neighbour mentioned to the PCSO attending Walter's funeral, that a local drugs gang had been using Walter's home for some time before Sarah moved in with Walter. Whilst this is hearsay and has not been fully substantiated, the potential risk to Walter is evident and therefore considered to be relevant to the lessons learnt from this review.

4.62 Walter always explained his relationship with Sarah, saying the same thing to all of the staff he came into contact with. The rehearsed way that Walter relayed this information without being asked did raise some suspicion in staff that worked with Walter, but they were not looking for Cuckooing or County Lines activity. There was some suspicion that Walter was being given drugs against his will. The community nurse asked Walter's GP to check a urine sample for drugs. Although the urine sample did not show any evidence to this effect, the GP reported that the urine seemed diluted and may have been tampered with before it was tested.

4.63 The Police IMR reports that when there was an aggravated burglary to Sarah and Tom's home (address 2) (3.51) that the investigation found that the burglary was committed in all probability by two identified drug dealers who may have been staying at Walter's flat from where they had been dealing drugs. Although a note was made within the Police incident log that Walter would appear to be 'quite vulnerable', there was no mention of Cuckooing or an understanding of this practice.

4.64 If the general public had been aware of Cuckooing, the signs to look for and how to report concerns confidentially, then the police and adult safeguarding would have been made aware of Walter's vulnerability at an earlier stage. The neighbours did apparently know the situation but did not report their concerns. The Safeguarding Adult Board has done a good job of raising public awareness of adult safeguarding. This now needs to extend to Cuckooing and county lines.

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[30] *NCA Intelligence Assessment, County Lines, Gangs, Safeguarding,* National Crime Agency, 12/8/2015 http://www.nationalcrimeagency.gov.uk/publications/620-NCA-Intelligence-Assessment-County-Lines-Gangs-and-Safeguarding/file (accessed 18/8/2017)

4.65 The Police, Community nurses, Social workers and Walter's Support worker made many visits to Walter's address. If they knew what to look for and were aware of the risks of Cuckooing they may have understood the situation better. The Home Office guidance recommends a process for reporting concerns, sharing information and discussing at a Partnership meeting to agree actions.

The misuse of medication

4.66 Walter's GP practice quickly identified that Walter's prescription for Pregabalin was being misused by Sarah and appropriate action was taken to review Walter's medication and a note made to stop further prescriptions. The GP explained at the Practitioner's Learning event (11/8/2017) that the GP concerned had worked in substance misuse and was aware of the potential misuse of this drug.

4.67 Public Health England published guidance on the prescription of Pregabalin and Gabapentin in December 2014[31] recommending that prescribers take a proportionate risk benefit assessment prior to prescribing these drugs or repeating prescriptions. When Walter's GP first prescribed Pregabalin because Walter said he had tried his sister's medication and it had helped him he did not adhere to the guidance from Public Health.

4.68 The GP practice concerned believe that there is a lack of awareness amongst GPs locally and nationally on the risks of misuse of Pregabalin.

4.69 The Chair of the Advisory Council on the Misuse of Drugs (AMC) wrote to the Home Office on 14th January 2014[32] recommending the control of Pragabalin and Gabapentin as class C drugs.

4.70 Since Walter's death awareness has been raised within the GP practice concerned on the potential misuse of Pregabalin. GPs across Essex need to be reminded of Public Health England's Guidance on prescribing Pregabalin.

4.71 North East Essex Clinical Commissioning Group (NEECCG) medicines management team has already taken action to raise awareness on the potential misuse of Pregabalin and Gabapentin with prescribers and GP practices.

4.72 The Public Health and NHS England paper on the Advice for prescribers on the risk of the misuse of Pregabalin and Gabapentin was circulated to all the GP practices and prescribers in the North East Essex

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[31] https://www.gov.uk/government/publications/pregabalin-and-gabapentin-advice-for-prescribers-on-the-risk-of-misuse (accessed 18/8/2017)

[32] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491854/ACMD_Advice_-_Pregabalin_and_gabap (accessed 18/8/2017)

area when it was published in 2014.

4.73 In September 2016 North East Essex Clinical Commissioning Group (NEECCG) Medicines management team devised a useful 'update on a page' on the risk of abuse with Pregabalin and Gabapentin. This was circulated to the GP practices and prescribers in the North East Essex area.

4.74 In Nov 2016 NEECCG put an article in the GP Newsletter highlighting again that Pregabalin and Gabapentin can lead to dependence and may be misused or diverted. The newsletter highlighted that it is local prison policy that prisoners who require Pregabalin need to have evidence that this has been prescribed by a consultant prior to coming into prison so that this can be continued whilst under their care.

Police awareness of when to raise a safeguarding adult alert

4.75 The integrated chronology shows that the Police sent a safeguarding referral to adult social care following the concern raised by an Iceland worker (3.45).

4.76 The recognised process at that time (subject of Force Policy[33] and contained within the Officer's Guide to Vulnerability) for Police generated notifications was for the Officers or Police Staff to complete a safeguarding referral (SETSAF1) and forward it to the relevant agency and to also forward a copy to SOVA. The Police IMR explains that as a result SOVA would be able to assist the notifying officer/staff with advice and additional intelligence concerning the person and assist with the coordination between partner agencies.

4.77 This review found that there was only one occasion when this process was followed and that was the first incident (3.45). The panel identified that there was a missed opportunity for a safeguarding referral to be made to adult services after the incident of a reported theft by Walter against Sarah. A PCSO did raise concerns regarding Walter's living conditions with adult social care (3.56). This led to a joint visit between the PCSO and social worker. The social worker subsequently sent a safeguarding referral to adult social care.

4.78 If the Police had followed their own procedure when any concerns were raised regarding Walter's vulnerability and suspected abuse then intelligence could have been gathered more effectively to assess risk. This is discussed more in the next section- Sharing Intelligence and Joint Decision-Making.

4.79 Since Walter's death the Police have formed the Adult Triage Team (ATT) formally SOVA who sit within the Operations Centre. This team works with operational staff to advise and assist in the coordination of the Police and partner agencies response to vulnerable adults. The team includes a social worker for adults and a part-time mental health worker.

[33] Policy and Procedure B1407 Safeguarding Vulnerable Adults

4.80 The introduction of the Adult Triage Team should improve the flow of information and co-ordination. However, it will only be effective if the Police are aware of when and how to raise safeguarding concerns

PART FIVE – LESSONS LEARNT

5.0 Conclusion

5.1 This DHR/SAR found many examples of good practice. The staff caring for Walter were resourceful and innovative in finding ways to support him in difficult circumstances. The cash donation sought from a local church, food bank vouchers and assistance in installing a landline telephone and Careline, are just a few of the many examples highlighted in section 4.

5.2 Professionals and the public demonstrated that they knew when and how to refer to safeguarding adult services. The exception to this was the Police who did on occasions fail to identify the need to alert safeguarding concerns to the Police SOVA team and safeguarding adults. The Police have taken action since the commencement of this review to address this by establishing an Adult Triage Team (formally SOVA) to provide advice and assistance in the co-ordination of the Police and partner agencies response to vulnerable adults.

5.3 When Walter refused safeguarding adult intervention his wishes were respected, as he was deemed to have the mental capacity to make that decision. Adult Social Care instead put in place a comprehensive care plan to minimise risk and to support Walter. This included daily contact with a support worker who developed a close working relationship with Walter built on trust.

5.4 The Community nursing service also provided daily input to monitor Walter's blood glucose levels. The Primary care team addressed Walter's health care needs including an investigation into the cause of Walter's frequent falls.

5.5 The health care and support staff working with Walter worked closely together, sharing information through joint visits and referrals across agencies.

5.6 However this was a particularly challenging case involving an elderly man who had mental capacity and made what were considered to be unwise decisions and a woman who misused substances. Both Walter and Sarah were victims of abuse.

5.7 The definitions of domestic abuse and adult safeguarding have recently changed (2013 Home Office changes to domestic abuse definition and Care Act Statutory Guidance 2014). There is now a much wider remit

recognising the impact of self-neglect, domestic abuse, people trafficking, modern day slavery, honour based violence and female genital mutilation on vulnerable adults.

5.8 These are relatively new challenges for Safeguarding Adult Boards. Since the Care Act, new guidance has been developed to assist boards but the complexity of cases, particularly when a person has mental capacity but makes unwise decisions, has resulted in legal challenges leading to new case law[34].

5.9 Walter was not subject to an adult safeguarding strategy meeting as he refused to participate in the safeguarding process. In the absence of the safeguarding process there was not a formal system for partners to share intelligence and information and to jointly assess and respond to risk. Any professional could have initiated a multi-agency team meeting but without a clear protocol nobody took the lead for arranging a meeting. There are examples of SABs that have established systems to respond to similar cases where a person with mental capacity refuses services. This includes people who self-neglect. See Shefffield *Vulnerable adult risk management system and Sutton Community MARAC procedure* for examples.

5.10 During panel discussions it was identified that housing were aware of incidents involving Sarah, Tom and Walter taking place at Walters home address. Housing stated that as Walter was the named tenant the only action that they could take would be in relation to Walter. This would have resulted in the eviction of Walter and not Sarah or Tom. This was raised as a missed opportunity by the panel who believed that the Housing agency should have held a multi-agency meeting to discuss what was taking place at Walters address and looked at other ways of dealing with the problem. A multi-agency team meeting that included agencies working with Walter and Sarah could have resulted in a better understanding of the situation and the options available. It would have drawn on the expertise of domestic abuse agencies as well as safeguarding adults. A wider range of legal and social work options may have been explored.

5.11 Walter had the mental capacity to make a decision but he should have had the information on all of the options to help him to achieve the outcome that he wanted. Throughout this case Walter was consistent in his wish to care for Sarah and to maintain her friendship. Making Safeguarding Personal guidance and best practice[35] suggests approaches to enable a person to achieve outcomes such as maintaining

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[34] http://www.lgo.org.uk/assets/attach/2231/Report-11-010-604-Bedford-Borough-Council-22.05.2014.pdf accessed 14/09/2017

[34]http://www.bailii.org/ew/cases/EWCA/Civ/2012/253.html accessed 13/09/2017

[35] https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

a relationship with a perpetrator whilst managing the situation to reduce risk; for example, family conferences, mediation and negotiation on a wide range of options.

5.12 When considering how a person's needs and strengths might help them to achieve their desired outcomes, they should be considered within the context of their friends, family and the wider community. This means working across the perceived boundaries of domestic abuse, safeguarding adults and safeguarding children and young people. This case has demonstrated this well. The need to share information, intelligence and expertise is crucial to safeguard vulnerable adults, children, young people and woman experiencing violence.

5.13 Although this case has focused on domestic abuse, safeguarding and the practice of cuckooing, there are other areas where staff from all sectors and the general public need to have increased awareness. Local authority staff, businesses and professionals go in and out of people's homes and with an increased awareness may notice and report concerns regarding other aspects of safeguarding such as, human trafficking, modern day slavery and so called honour-based violence.

6.0 Recommendations

6.1 The key learning from this review is for a multi agency approach to sharing information and jointly assessing and responding to risk when a person has mental capacity but makes unwise decisions. This learning will benefit people who self neglect as well as vulnerable adults who experience domestic abuse.

1. Southend, Essex and Thurrock Safeguarding Adult Boards to revise the SET safeguarding adult procedures to make it explicit that there is a formal process for agencies concerned about safeguarding risks for an adult with needs for care and support to convene a multi agency meeting. This meeting should have representation from all partners involved who can share information and develop an action plan.

2. Southend Essex and Thurrock Safeguarding Adult Boards to review the Safeguarding Enquiry form (SETSAF1) and guidance so that the person's desired outcome is recorded in their own words and the significance of this is understood by practitioners.

3. The Essex Safeguarding Adult Board to ensure appropriate training and development is provided by its partners to increase practitioners' understanding of Making Safeguarding Personal, while working with people who have mental capacity but make what others may consider unwise decisions and people with fluctuating capacity, for example,

people who misuse substances. This recommendation is to include external partners such as housing associations.

4. NHS England and North East Essex Clinical Commissioning Group to further to raise awareness on the potential misuse of prescription drugs particularly Pregabalin and Gabapentin with GP practices and prescribers across Essex including circulation of the Public Health England guidance.

5. Police – To provide assurance to the Essex Safeguarding Adult Board that the arrangements put in place since WALTER's death are sufficiently robust to collate police information to get a complete picture of adults at risk and appropriate triage in considering referrals for adult safeguarding.

6. Southend, Essex and Thurrock Domestic Abuse Board to revise the MARAC referral form to require all members of the household to be named, to ensure MARAC can include them in their considerations.

7. The Safeguarding Adult Board, and Children's Safeguarding Board to raise awareness of Cuckooing and County Lines, exploitation of children, young people and vulnerable adults with the general public and professional staff.

8. The Safeguarding Adult Board to run an awareness campaign surrounding adult safeguarding specifically targeting supermarket workers and other retailers.

9. The Safeguarding Adult Board and Essex Domestic Abuse Board to develop effective and clear links and arrangements in working with adults with care and support needs who experience domestic abuse,

10. The Home Office to consider aligning the Domestic Abuse definition and the definition of a Domestic Homicide Review.