CONFIDENTIAL

Domestic Homicide Review Overview Report in respect of:

Mrs A

Marion Wright

Date: 8th October 2013

Contents

Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Mrs A in Lincolnshire in 2012. Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 The purpose of the review is to :-

- Establish what lessons are to be learned from the domestic homicide regarding the ways in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between Agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

1.3 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force on the 13th April 2011. The death of the victim in this case met with the criteria for a statutory DHR in that the victim died as a result of being assaulted by her son in the family home.
Home Office criteria : "A review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse, or neglect by :

a) A person to whom he or she was related or with whom he or she was or had been in an intimate relationship". It is recognised that a domestic abuse incident which results in the death of a victim is often not a first

attack and is likely to have been preceded by psychological and emotional abuse and possibly other physical attacks.

1.4 This review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from many different Agencies for their contribution to the review and for their significant time, openness and commitment.

1.5 Domestic Homicide Review Panel Members.

Tony Blockley	Independent Chair of the Review
Marion Wright	Independent Overview Author
Nicky Dewhurst-Vickers	Addaction
Danielle Burnett / Cathy Sheehan	East Midlands Ambulance Service
John Latham	Lincoln City Council
Tony McGinty	Lincolnshire County Council
Michelle Johnstone	Lincolnshire Community Health Service
Rick Hatton	Lincolnshire Police
Peter Adey-Johnson	Lincolnshire Probation Trust
Jan Gunter	NHS Lincolnshire Primary Care Trust
Liz Bainbridge	Lincolnshire Partnership NHS Foundation Trust
Karen Shooter	Lincolnshire County Council Domestic Abuse Manager
Natalie White	Lincolnshire County Council Domestic Abuse Project Officer
Toni Geraghty	Legal Adviser
Mandy Cooke	Lincolnshire County Council Adult Safeguarding

Glen Garrod	Lincolnshire County Council Adult Safeguarding
Ben Leach / Lisa Blewitt	United Lincolnshire Hospital Trust
Nick Hall	Victim Support

1.6 To reinforce the impartiality of this report it is confirmed that the Independent Chair and the Independent Overview Report Author have not previously been employed by any agency in Lincolnshire and therefore have not had any direct involvement in the case. Neither have they had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair is a retired Detective Chief Superintendent of Police who had responsibility for all major and serious crime including homicide. He has widespread experience in reviewing homicides, in commissioning Serious Case Reviews, and has previously chaired and written Domestic Homicide Reviews. The Independent Overview Report Author is a retired Assistant Chief Officer of Probation with 33 years experience. She had strategic lead for Public Protection including Domestic Abuse. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and Domestic Homicide Reviews.

1.7 Both the agency review panel members and the Individual Management Review report authors who have provided the agency evidence considered by review are independent from any direct involvement in the case or direct line management of those involved in providing the service.

1.8 In line with the National Domestic Homicide Review Guidance the decision was taken to undertake a DHR within 4 weeks of the homicide. The Home Office were notified of the decision on the 31st October 2012. The first review panel meeting took place on 10th December 2012. Given that the alleged perpetrator, at that stage, denied the charge of murder, the review process was temporarily paused until after the conclusion of the criminal trial. This eventually took place in October 2013 and the outcome was that Mr B was found guilty of murder and sentenced to life imprisonment. The review process was immediately resumed.

1.9 The view of the review panel was that to interview the perpetrator and other family members prior to the conclusion of the legal proceeding was inappropriate. However, any lessons to be learnt by Agencies regarding practice, which required immediate attention, were taken forward by the Agencies without delay.

1.10 Following the conclusion of the criminal proceedings which resulted in Mr B being sentenced for murder contact was offered to identified family members and others who could provide information and may wish to have their voice heard within the process.

1.11 Parallel Processes include the Criminal Trial and Coroners Inquest. Appropriate liaison has and will be undertaken to inform the DHR process. Whilst a Mental Health Homicide Review may have been completed in such circumstances, the fact that a DHR has been undertaken is considered to be sufficient in terms of providing learning and recommendations for improvement via a multi agency review with independent scrutiny, chair and author. As a result of this review, all agencies have considered practice lessons learned and improvements where necessary for the future.

1.12 Circumstances that led to the review being undertaken

On 12th October 2012, the Police were alerted by the Ambulance Service who had responded to a careline alarm activation that the victim, Mrs A, was being taken to hospital with a head injury. The Ambulance Service suspected that the injury was not a result of an accident. Sadly, Mrs A died later that day in hospital. Mr B, the son of Mrs A, and of the same address, was arrested and the CPS made the decision to charge him with her murder. On the 31st October 2012, the chair of Lincolnshire Community Safety Partnership considered the case with other Agencies who had contact with the family and concluded that the case met the criteria and justification for a Domestic Homicide Review. The Home Office were notified accordingly.

1.13 Scope of the Review

The scope of the review will include information available on Mrs A, the victim, Mr B , the perpetrator and victims son, and Mr C , the now deceased husband of Mrs A and stepfather of Mr B. The time frame of the review was agreed to be between October 2006 and October 2012. However, if any agency felt there was relevant information outside the time period under review, it was agreed that the information should be included in their Individual Management Review (IMR). As well as the IMRs, each agency provided a chronology of interaction with the identified individuals including what action was taken. The IMRs considered the Terms of Reference (TOR) and whether internal proceedures were followed, whether they were adequate and made conclusions and recommendations from the Agencies perspective.

1.14 Terms of Reference for the Review

Key issues identified by the panel:-

a) Information gathering and sharing.
b) Risk identification.
c) Risk analysis.
d) Risk Management.
e) Competences, Training and Management accountability.
f) Consideration and compliance with Agencies and Multi-Agency domestic abuse policies and procedures.
g) Accessibility of services and equality and diversity.

In order to address the key issues above, the IMR authors were charged with answering the questions set out below in the terms of reference and providing analysis.

1.14.1 Were practitioners sensitive to the needs of the victim and the alleged perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?

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

1.14.2 Did the practitioners seek, and were given, appropriate levels of supervision, advice and guidance during the decision making process.

1.14.3 Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

1.14.4 Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used in the case of this victim and perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse?

1.14.5 Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

1.14.6 Is there evidence that historical information was analysed to provide an holistic assessment of risk?

1.14.7 Did the agency comply with domestic abuse protocols agreed with other Agencies, including any information sharing protocols?

1.14.8 Was inter and intra-agency communication efficient and effective?

1.14.9 What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

1.14.10 Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries

made in the light of the assessments, given what was known or what should have been known at the time?

1.14.11 When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other Agencies?

1.14.12 How accessible were the services for the victim and alleged perpetrator?

1.14.13 What was known about the alleged perpetrator? Had MAPPA been considered?

1.14.14 Had the victim disclosed to anyone and if so, was the response appropriate?

1.14.15 Was the information recorded and shared, where appropriate?

1.14.16 Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families?

1.14.17 Was consideration for vulnerability and disability necessary? Was the victim a 'vulnerable adult' in line with the official definition of a vulnerable adult?

1.14.18 Have there been any other similar cases in recent years and are there any lessons that could have been learnt?

1.14.19 What effective practice can be passed on to other organisations?

1.14.20 To what degree could the homicide have been accurately predicted and prevented?

1.15 Methodology

The review panel was convened by the Lincolnshire Community Safety Partnership and included representatives of the relevant Agencies, the independent chair and the report

author. The review panel commissioned a chronology and IMRs from each agency. As the review progressed it became apparent there were other Agencies who had had contact with the family and whilst they did not complete a full chronology and IMR, they were contacted to consider any relevant information they may have had. There was no relevant information to be included.

1.16 A total of 5 meetings were held with the review panel. Firstly, to agree the Terms of Reference and commission the IMRs. Secondly, to give feedback on the content of the chronology and IMRs and seek clarification. The third meeting was also attended by the IMRs report authors and enabled agencies to present their information and give time for others to ask questions and make comment. The fourth meeting was to consider the draft overview report in order to ensure it accurately reflected the information provided by the Agencies in a full and fair way. The fifth meeting discussed the Executive Summary and the Action Plan.

1.17 In order for Agencies to prepare their contribution, they were asked to consider contact and practice in providing a service, measured against agency policies and procedures and to identify any shortfalls or indeed where current policies or procedures required improvement. Agencies sourced and reviewed a wide range of information from a variety of systems and interviewed members of staff known to have had involvement with Mrs A, Mr B, and Mr C.

1.18 The Agencies completing IMRs and the profile of their involvement with the family are as follows:-

- Lincolnshire Police who responded to calls for assistance from family and neighbours between October 2006 and October 2012.
- Addaction, a specialist substance misuse treatment organisation, who provided a service to the perpetrator between October 2006 and October 2012.
- City of Lincoln Council who provided housing for the subjects of the review between 1986 and 2012. They also provided the monitoring service for community alarms (Lincare).
- East Midlands Ambulance Service who responded to emergency calls between December 2006 and October 2012.

- Lincolnshire Community Health Service who provided a community nursing service between June 2010 and October 2012.
- Lincolnshire Partnership NHS Foundation Trust (LPFT) were involved with the family in providing mental health assessments to Mrs A, Mr B and Mr C at different times prior to and during the review period, LPFT also provided historical drug and alcohol services to Mr B, via Lincolnshire Drug & Alcohol Services (LDAS) which was a partnership with Addaction but in April 2012 the partnership split into two independent agencies. A number of service users were randomly selected to be transferred from LDAS to Addaction as part of the commissioning agreement. One of these service users who was transferred was Mr B. This took place on the 29th March 2012.
- Lincolnshire County Council Adult Care whose primary purpose in this case was to work with Mrs A and Mr C to provide support, through a range of services, to live independently. They were involved between 2006 and 2012.
- Lincolnshire Probation Trust who supervised Mr B when he was subject to court orders in 2007 and 2009.
- Lincolnshire Primary Care who provided a general practice service to the subjects of the review during the time period 2006 to 2010.
- United Lincolnshire Hospitals NHS Trust who provided hospital treatment at different times between 2006 and 2012.
- Victim Support who made contact with Mrs A on occasions following referrals by police between 2008 and 2011.

1.19 In preparing the overview report the following documents were referenced:

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

Home Office Domestic Homicide Review Toolkit Guide for Overview report writers.

Call an end to Violence Against Women and Girls H.M. Government published 25th November 2010.

Joint Protocol for Multi Agency Public Protection Arrangement (MAPPA) and Multi Agency Risk Assessment Conference (MARAC) Lincolnshire 2009.

Lincolnshire Multi Agency Risk Assessment Conference Guidance and Operating Procedures.

Lincolnshire Domestic Abuse Strategy 2007 – 2010.

Lincolnshire Police and Domestic Abuse Partners Information Sharing Agreement.

The Home Office Report on the coordinated community response to domestic violence in Lincolnshire 2012.

The Mental Capacity Act 2005 Code of Practice.

The United Kingdom Parliament Mental Capacity Act 2005 Select Committee (Lords) Update.

1.20 Where confidential information has been detailed in relation to Mrs A, Mr B & Mr C it has been gathered and shared in the public interest and in line with the National Guidance for the conduct of DHR.

1.21 The Victims nephew, the ex wife of the nephew, the next door neighbour a paid carer and the perpetrator were written to offering them the opportunity to contribute to the review.

1.22 Once the draft overview report was completed family and perpetrator were contacted so that they had the opportunity to see to the report and comment on the content before publication.

1.23 Subjects included in the scope of the DHR

Victim	DOB	Relationship
Mrs A	30.06.1940	Mother of perpetrator
Perpetrator		
Mr B	23.04.1974	Son of victim
Key family member		
Mr C (Deceased)	27.06.1921	Husband / Stepfather
Known connected relationships		
Mr D	12.01.19.71	Nephew of Mrs A
Mrs E	25.02.1973	wife of nephew of Mrs A
Child 1	25.10.1997	Son of nephew of Mr A
Carer 1		Carer to Mrs A
Carer 2	08.10.1970	Carer to Mrs A

1.24 Family involvement

The panel would like to thank Mr D, family member, for his contribution to the review and for helping to achieve a more complete understanding of what happened and why. Mr D reported that Mrs A and Mr B had a very strong and unconditional bond. He described Mrs A as a very shrewd capable woman, she was the eldest child in her family and the matriarch, she was used to telling others what to do. In Mr D's view Mrs A did not see herself as a victim and would have considered that she was in full control of her life and situation.

Whilst Mr B cared for his mother, it was recognised he was not capable of providing her with the care and support she needed. This was in part due to his drug and alcohol use and his own health problems. Also, he did not have the skills to cook and provide the domestic care necessary. Mr D wanted Mrs A to go and live with him on her return from South Africa in late 2011, she would not hear of this and insisted on returning to live with her son.

Despite being aware of Mr B's limitations as a carer for Mrs A "I knew he wasn't up to the job", Mr D who visited Mrs A regularly states he was unaware of any physical and financial domestic abuse. When he was asked if he considered agencies could have done more, his view was that no agency could have done more. If Mr D did not recognise the difficulties his view is that it was unlikely that others would have been unable to.

By agreement with Mr B arrangements were made to interview him in Prison. However, on the advice of his legal representative Mr B cancelled the meeting in advance of the scheduled appointment.

Despite letters being sent, no other family member, neighbours or carers responded to requests to contribute to the review.

2. The facts

2.1 At the time of the murder Mrs A & Mr B lived in the family home, a two bedroomed 1st floor maisonette owned by Lincoln City Council. The family had been tenants of this property since 1986, having moved from Cape Town, South Africa in 1984. For the first two years they had lodged with Mr C's son in Lincoln. The couple then separated in 1991 and Mrs A left taking her son Mr B with her. Mrs A was allocated an alternative tenancy in Lincoln. Despite the separation Mrs A and Mr B remained closely involved in the care of Mr C as his health deteriorated. He died in July 2010 having fallen down the stairs. Mrs A officially moved back to the family home in October 2010 following the death of her husband.

2.2 Piecing various strands of information together it would appear with hindsight that Mrs A spent most of her time at the home address even when she was registered as living elsewhere. Mr B officially moved back to the address in 2003.

2.3 The circumstances of the homicide were that Mrs A was largely bedbound suffering ill health, due to heart and respiratory related illness. Following her last discharge from hospital on 14th August 2012 a Lincare careline was fitted. This allowed her to call for help if she was alone and in need.

2.4 At 5.16am on 12th October the Lincare alarm button was pressed, initially the information given was that Mrs A had fallen and banged her head and was vomiting. Her son was known to be present but would not talk on the phone. The ambulance was called and attended. Given her injuries and the comments she made about her son it was considered she may have been the victim of assault. The Police were informed by the ambulance crew. Mrs A's condition quickly deteriorated to the point she stopped communicating. She was transferred to hospital but sadly died at 15.45pm that day.

2.5 Mr B was arrested on the morning of the 12th October at 7.50am and was taken into custody. Following advice from the Crown Prosecution Service Mr B was

charged with the murder of his mother at 20.17 on 13th October 2012. The Trial of Mr B took place in October 2013; he was found guilty of murder and sentenced to life imprisonment.

2.6 The post mortem examination of Mrs A revealed a number of impacts to Mrs A's head and face around and above the eyes, which it recorded could have been caused by direct blows with a blunt object which could have been a fist. The cause of death was established and recorded as:-

1) A) Brain trauma and bilateral subdural haematoma. (The latter exacerbated by anti-coagulation therapy) due to or as a consequence of
B) Multiple blunt impacts to the head.

It is recognised that anti-coagulation treatment will always increase risk of bleeding to those who use it to assist with other health problems.

2) Ischemic and valvular heart disease.

A coroner's inquiry was opened and immediately adjourned awaiting the outcome of the criminal investigations and trial.

3. Narrative chronology

Background

This report has been informed by a full combined chronology of multi-agency contact during the time period. There is a chronology of significant events attached at Appendix 1.

3.1 Mrs A and Mr B were mother and son. Mr B was the only child born to his mother in Cape Town, South Africa. His father died of a heart attack when he was 6 years old. Mrs A returned to work managing her own business and her son was sent to board at the Christian Brothers College. In 1983 Mrs A met Mr C on holiday in England. Mr C was of Polish origin. They returned to South Africa and married coming back to live in Lincoln in 1984.

3.2 It is reported that Mr B did not get on with his stepfather and did not settle in School in England. In 1987 aged 13 years Mr B attended Court charged with burglary and shoplifting. In 1988 Mrs A refers Mr B to Social Services requesting he be taken into care as she was unable to control him and was concerned about his offending behaviour. Mrs A's marriage is reported to be failing at this time.

3.3 A psychiatric report relating to Mr B identified behaviour problems. These began in South Africa and became worse in England. He allegedly had problems relating to his stepfather but had an excellent relationship with his mother. School described him as emotionally unstable and aggressive and that he had not developed internalised systems of control.

3.4 In August 1988 he was made subject to a Court Order to Lincolnshire County Council and placed in a residential school in Sussex. In June 1991 his parents separated and Mr B returned to live with his mother until he was sent to a Young Offenders Institute in 1992 for 3 years.

3.5 Mr B has a history of offending behaviour and is well known to Lincolnshire Police. He has 27 convictions for a total of 55 offences including:-

2 assault against a person
6 offences against property
2 fraud and kindred offences
24 theft and kindred offences
3 Public Order Act offences
6 offences relating to police / courts / prison
5 drug offences
7 miscellaneous offences.

3.6 Mr B was known to use alcohol in excess and to be an intravenous drug user. His behaviour was difficult and he could be aggressive and threatening. He was a non-complier with treatment for his drugs and alcohol and did not comply with Court Orders. He had health problems relating to frequent and persistent

abscesses and wound infections associated with the injection sites for illicit drugs.

3.7 Mrs A had been in poor health for many years. It is noteworthy that she had a very strong family history of coronary heart disease (CHD) her father, brother and sister all died from CHD at a comparatively young age. Additionally her life style was poor. She was a smoker and had been morbidly obese. She suffered from significant cardiac and respiratory disease and was on multiple prescription medicines when she died. She was housebound and largely bed ridden. Latterly she received healthcare from community nursing staff and carers. Her son was her main carer although she had from time to time employed other private carers said to be friends of her son.

3.8 Mr C was latterly in poor health. He had prostate cancer diagnosed some years previously. He had received regular treatment for this. He was diagnosed with dementia which was worsening and as a consequence he was very forgetful and could, on occasions, be aggressive to his wife. Records indicate he was separated from his wife although they were living together at the time of his death.

3.9 Mr C had a son prior to his marriage to Mrs A however it would appear he was not involved in the family during the period of review.

3.10 In 1998 Mrs A's nephew and his wife and young son came to live with her from South Africa. Whilst her nephew and Mrs A became joint tenants of one Council property it is unclear for how long they actually lived together. Her nephew was identified as her next of kin when she was admitted to hospital in 2012 and was also identified as managing her financial affairs. The nephew's wife played a key role in reporting abuse to police prior to 2009, when it would appear, she and her son moved away to live elsewhere.

3.11 At different times private carers are referred to as being paid to look after Mrs A. Suggestions were that they were men of Polish extraction who Mr B may have met through his criminal activity.

3.12 There is a history of domestic abuse in the relationship between Mrs A and her son Mr B. There were also allegations of Mr B being abusive to his stepfather before his death in 2010. The abuse to his mother included financial abuse, using threatening and aggressive coercive behaviour to obtain money for drugs and also evident was emotional, psychological and physical abuse. The evidence comes from allegations and convictions for smashing furniture, windows, doors, refusing entry to carers, shouting and threatening, attempts to force feed, pulling of hair, hitting and punching. This pattern of behaviour designed to achieve power and control over his mother and at times his stepfather was first recorded in 2003.

4. Chronology of significant events

This section describes the significant chronology of events identified as of interest in this review. It includes information about events beyond the time frame agreed when these were seen as relevant to the review. The chronology of significant events is attached at appendix 1.

Synopsis of Chronology

4.1 The chronology of contact and services provided to this family from a large number of Agencies revealed that Mr B's behaviour was identified as being problematic and aggressive from an early age. His mother struggled to cope with him as a child. He was made subject of a Care Order and lived in residential care for a period. He has a long history of offending, alcohol and drug use. He returned to live with his mother when she separated from her husband in 1991.

4.2 There is a history of domestic abuse with Mr B using threatening and aggressive behaviour towards his mother and on occasions his step father to gain money to buy drugs and alcohol. When his mother did not provide the money he wanted he would physically assault her by pulling her hair and hitting her predominantly in the face and on the head. The abuse would fit several criteria included in the definition of domestic abuse i.e. financial, physical, emotional and psychological.

4.3 There was a significant volume of identifiable abuse between 2006 and 2009 with 63 incidents recorded by Police. This declined in regularity after 2009 until Mrs A's death in 2012. It is likely from comments made by family members that there was much more abuse in 2006 / 2008 that went unreported. Not all offences reported resulted in Mr B being charged and convicted. The Occupation Order which was in place between 2007 and 2009 did not appear to deter him, he was sent to Prison for 6 months for breach of this Order in January 2009.

4.4 Whilst Mrs A complained about the abuse at the time she would often withdraw the complaint and her support for action to deal with it robustly. Often, instead, she requested help for her son in relation to his alcohol and drug use. It is recorded that she wanted the abusive behaviour to stop but she described that she could not be sufficiently assertive and consistent to take the necessary action herself. With hindsight it would appear that Mr B was very successful in using coercive and controlling behaviour to ensure his mother would not withdraw her involvement with him. During 2009 and 2010, the abuse apparently reduced this was in part due to Mr C and Mrs A living away from the family home. Mr C died in July 2010 following a fall down the stairs.

4.5 In 2011 Mrs A went to South Africa in January and did not return until November. Mrs A's already poor health deteriorated and in 2012 she spent several weeks in hospital. On her discharge she had Home Support Workers (HSW) twice daily. Despite this conditions at home were poor with little food and home comforts and a constant stream of her son's associates visiting the flat. Several Agencies were involved. Mrs A's wishes fluctuated between wishing to be at home and wanting to go into residential care, these options were never fully explored with her. However, it is recorded that, her nephew and son did not want her to go into residential care despite her requests. Sadly she was assaulted by her son whilst in bed during the early hours of the 12th October 2012 and died the same day as a result of her head injuries. Mr B was convicted of her murder in October 2013 and sentenced to life imprisonment.

Analysis of Involvement:

5. Individual Management Reviews

In this section practice is analysed and evaluated against policy and procedure via the individual management reviews. Further analysis takes place in the next section directly answering the terms of reference questions.

Lincolnshire Police

5.1 The Police review was undertaken by the East Midlands Special Operations, Regional Review Unit. Research was undertaken within a variety of Police systems to gather information. That research identified 158 separate events involving Mrs A, Mr B or Mr C. The reviewing officers have examined all of those incidents. 64 of which were domestic abuse. Lincolnshire Police Force policies, procedures and processes were considered, however, interviews were not conducted with Police Officers who attended specific incidents but an interview was conducted with the Domestic Abuse Officer who had had a lot of involvement with the family.

5.2 The Force operates a system of graded response when dealing with incidents. The grading given and the response provided depends upon the seriousness, nature and circumstances of each incident. Incidents are currently graded as urgent, priority, routine or non-attendance. Information provided demonstrates incidents were generally graded appropriately, the majority were graded as urgent and response times were good.

5.3 A critical register marker was placed on the family home address on the 24th November 2006 following incident 342 on the 1st October 2006 when Police were called by neighbours who reported windows and the door at the family home being smashed. The victim also reported that the suspect had "gone berserk". Police Officers attended and arrested the suspect Mr B for criminal damage and for assaulting a Police Officer by deliberately smearing blood on him from his cut wrist.

5.4 The marker placed on the critical register at the time identified Mr B as "violent, very unpredictable and a known drug user, thought to be a hepatitis and possible HIV sufferer and will deliberately smear Officers with his blood. He has previously used household items as weapons". The critical register was subsequently updated and used to provide information about Mrs A and Mr C's vulnerability and the risk Mr B presented to them e.g. 23rd April 2007. The critical register was updated saying "occupier Mrs A a vulnerable elderly female has previously been assaulted by Mr B an alcohol and drug user, if call received urgent response required".

5.5 From the mid 1990's Lincolnshire Police introduced a domestic abuse reporting form P548. It was required to be completed. In June 2007 and in 2010 it was updated to take account of developments and the introduction of the Association of Chief Police Officers (ACPO) Domestic Abuse Stalking and Honour based violence (DASH2009) risk identification, assessment and management module and became referred to as the P548 ACPO DASH.

5.6 The P548's were not completed in respect of many incidents which should have been recognised and recorded as domestic abuse and the quality where completed was variable. Where P548's were not completed the omission should have been addressed by supervisors and the Force Control Room.

5.7 When all actions necessary to respond to an incident have been completed the incident will be closed by the Force Control Room Staff (FCR) it is given a final classification code used for statistical purposes, this is mandatory. The code for a domestic abuse incident is P07, in addition each incident can be given a qualifier code. The qualifier code for domestic abuse incidents is Q06 the qualifier fields are not mandatory. Both the final classification code P07 and the qualifier Q06 are also used to prompt staff in the FCR to post incidents involving DA onto the Public Protection Unit (PPU) Message Group used to bring all relevant incidents to the attention of the PPU.

5.8 Information demonstrates that many incidents which should have been recognised and classified as domestic abuse did not have the final classification

code P07 or the qualifier Q06 applied and were therefore not included in the PPU Message Group to be brought to the attention of the DAO which meant they did not get the attention and input intended by the process. The review identified that there was confusion within the force relating to the process for the DAO's receiving the information via the PPU Message Group. The confusion related to misunderstanding about whether the process was automatic or manual. The outcome of this was that some messages did not arrive on the PPU Message Board and therefore were not picked up by the DAO.

5.9 There was evidence during the review process by Police that investigations following the reporting of a crime in this case were, on occasions, thorough and brought to a positive conclusion but at other times lacked robustness and were not pursued to conviction or were discontinued and did not follow Police policy and procedure in this respect.

5.10 Further analysis of Police involvement is covered under the terms of reference headings provided later in the report.

Addaction / Specialist Substance Misuse Treatment Organisation

5.11 Addaction had four episodes of service provision to Mr B and no episodes of contact with Mrs A or Mr C.

5.12 The first episode 12th October 2006 to the 4th March 2008 there was a series of unsuccessful efforts to engage Mr B to enter into treatment services to address his substance misuse. This was through the Drug Intervention Programme (DIP) following his arrest, Court appearance or release from Prison, they were ultimately unsuccessful due to his unwillingness to enter into treatment.

5.13 Second episode 14th October 2010 to the 15th November 2011. Mr B self referred through Open Access Service for treatment related to misuse of amphetamines and heroin. He was referred onto Lincolnshire Partnership Foundation Trust (LPFT) to receive his treatment within a matter of days of being assessed. On both occasions agreed treatment pathways were followed

and the interaction and onward referrals made by Addaction were entirely appropriate.

5.14 Third episode 29th March 2012 to the 16th August 2012. Mr B was transferred from LPFT to Addaction in March 2012 being one of those client's whose treatment provider was changed following the re-design and restructure of substance misuse treatment services in Lincolnshire. When Mr B was transferred he was in receipt of a methadone prescription to help treat his heroin addiction. The prescription was maintained within National Clinical Guidelines. He proved very difficult to engage within any meaningful psycho-social intervention. He failed to attend appointments with his key worker. To maintain standards for safe prescribing and within clinical guidelines he was maintained on a regime of daily supervised consumption at the dispensing chemist and the taking of this methadone was required to be witnessed by the pharmacist.

5.15 When Mr B failed to collect his prescription on the 16th August 2012 no follow up action was taken by Addaction staff until the 5th September. This is a failing and did not meet the expectation of the Agency procedures. Follow up action should have been taken in a much shorter time frame to establish why the prescription had not been picked up and to check on the wellbeing of Mr B and to attempt to re-engage him into treatment. Procedures have since been changed in relation to this.

5.16 Fourth episode 3rd October 2012 to the 8th October 2012. Mr B self referred to Addaction for treatment related to heroin misuse. Three telephone calls were made to the number given by him for contact, a message was left for him to contact Addaction but no contact was made by Mr B to arrange an assessment of his treatment needs. Actions by staff on this occasion were appropriate and in line with procedures.

5.17 It was apparent Mr B was abusing substances quite dangerously and was probably causing himself significant harm by doing so. On the occasions he did engage he reported issues with his mother Mrs A on five occasions:

- 12th October 2006 Mr B reported during the previous week he had trashed his mother's flat and he was using her money to buy his drugs and as a result he was due in Court on the 10th November 2006.
- On the 15th November 2006 there was a report by a third party that Mr B had again smashed his mother's house up and his mother had reported the matter to the Police.
- On 20th November 2006 a telephone call was made by Mrs A to Addaction staff informing them that Mr B had again caused damage to her flat. The matter had been reported to the Police and Mr B had been arrested for offences committed. Mrs A said that she did not want Mr B back at her flat and sought advice as to how best to achieve this.
- 27th November 2006 a home visit was undertaken to try and engage Mr B in treatment, nothing out of the ordinary was noticed.
- 5th July 2012 when Mr B attended Addaction to collect his prescription he stated his mother was in hospital and that he was visiting her regularly.

5.18 Whilst on three of the occasions above staff were aware of potential domestic abuse, records show that the matters had been previously reported to and were under investigation by statutory Agencies. Nonetheless rather than assuming others were taking the matter forward ,with hindsight, liaison could have been undertaken with the Police to share information about risks presented and a possible referral to Adult Care could have been considered. The fact that Mr B was not engaging in treatment potentially increased his risk and could have been useful information to Police and others in arriving at a holistic risk assessment indicating that a possible multi-agency response was required.

5.19 When Mr B disclosed to Addaction that he had trashed his mother's flat there was no evidence that his inappropriate offending behaviour was challenged. The primary aim of staff at the time was to engage Mr B in treatment, had he engaged with treatment these issues may have been included in a holistic treatment / care package.

Lincoln City Council Housing

5.20 The methodology employed to prepare this IMR included the sourcing and review of documents both electronic and manual from a range of departmental systems employed by the Council. Selected interviews with five members of staff known to have had involvement with Mrs A, Mr B or Mr C were undertaken to clarify or confirm actions taken in response to issues. Discussions took place with The Supporting Housing Manager and the Public Protection Anti-Social Behaviour Manager to clarify where necessary internal policies and procedures.

5.21 Whist having an alternative address since 1991 Mrs A returned to the family home officially in October 2010. However it is clear that she lived at the family home on a regular basis between 2006 and 2012, the period of this review.

5.22 At various times Mrs A had "succession of lodgers staying at her alternative address". Her nephew, his wife and son came from South Africa and became joint tenants in 1998. It would appear the nephew moved out in 2003 and his wife and son sometime in 2009. At other times carer 2 and another person resided at Mrs A's address.

5.23 There was an allegation that Mrs A sub-let her Council property. Attempts were made to investigate this but the allegation was denied by Mrs A. In undertaking the investigation Housing Officers had contact with the Police on the 22nd June 2009. Also, when Mrs A indicated her intention to move back to the family home, housing staff contacted the GP as they were concerned such a move may be detrimental to her health. Concern was also expressed that Mrs A may be seeking to move simply to enable her son to retain the occupancy of the family home. However overall there was a lack of sharing with and receiving information from other Agencies.

5.24 Mr B had right of succession to the original family home but whilst he was a single occupant he could have been asked to move to smaller accommodation as he was under occupying the property. When his mother moved to live with Mr B

this removed the under occupancy. The joint tenancy was granted albeit reluctantly on the 1st November 2010 to Mrs A and Mr B.

5.25 Staff witnessed nothing to suggest that Mrs A's decision to move to live with her son, following Mr C's death, was made other than through her own free will. Nor was it considered that she was in anyway coerced into moving to live with him although this was not specifically explored with her.

5.26 When Staff were concerned the property was physically unsuitable for Mrs A, an opportunity was missed for referral to Adult Care. An assessment of the need for any adaptions to the property may have triggered a full assessment of the risks of Mrs A moving back to the family home.

5.27 Much of the contact between this family and housing related to noise nuisance and disturbance and repairs to the property. However, there is a note on the file relating to June 2007 that says "tenant is vulnerable and son has been abusing him" this followed information from Adult Care following a request to change the locks at the property. Whilst there was no record of evidence of physical injury to Mr C consideration was not given to a safeguarding referral. However, an opportunity for referral of Mr C to Adult Care as a vulnerable adult for a full assessment of his care and support needs was missed.

5.28 On the 14th December 2009 Mr B appeared in Court for breach of his Community Service Order and was made the subject to a Curfew Order to the family home between 7pm and 7am. He was said to live alone at the property and Probation referred to the assault on his parents. It was established by Housing that Mr C was still living at the family home. No further checks were made by Housing with Probation or Police to verify the whereabouts of Mr C equally there appears to have been no contact from Police, Probation or Adult Care to verify the position regarding Mr C's tenancy and occupancy of the property.

5.29 On the 23rd December 2010 Mrs A advises the Housing Benefit Team that she wishes her nephew to be authorised to deal with her financial affairs and confirms this in writing.

5.30 The City Council Housing identified two other service failures, one relating to a letter that had been received from an O T about moving to ground floor accommodation that was not responded to and filed away. Secondly, that the referral for Lincare Monitoring Service in August 2012 indicated that Mrs A's nephew had Power of Attorney. This should have been verified and a copy obtained for the City Council's records but no checks were made. Whilst there were failures neither had a direct bearing on the domestic abuse in this case.

East Midlands Ambulance Service [EMAS]

5.31 During the compilation of the IMR the author consulted various records and systems. Three staff members were interviewed that attended Mrs A on three occasions at the home address and the Locality Quality Manager was also seen. The analysis of involvement focuses on six specific episodes of service provision dated 5th December 2006, 7th March 2007, 29th April 2007, 14th October 2010, 17th August 2012 and the 12th October 2012 and will draw upon further evidence from six additional attendances all for medical reasons.

5.32 Evidence shows that all emergency calls were responded to as priority calls and were categorised as a red response, the fastest.

5.33 On the 5th December 2006 records indicate that Mrs A had been upset by her aggressive son and Police were required to calm the situation. There were no injuries recorded and Mrs A declined to be conveyed to Hospital. There is no evidence of a safeguarding referral and a limited holistic assessment.

5.34 Mrs A was attended in response to a call regarding assault by her son on the 7th March 2007. She had been hit in the left eye causing bruises and swelling. Mrs A refused treatment and refused to go to Hospital. As an adult with capacity Mrs A was able to make the decision to remain in her own home and potentially

remain at risk. However, a clinical assessment should have been completed if the crew had consent and the Police should have been informed or requested to attend. On this occasion the Police were in attendance. A safeguarding referral to share information with the Local Authority about concerns would now be expected although it was not a clear expectation in 2007.

5.35 On the 29th March 2007 an ambulance attended having been called by Mr B asking for his mother to be checked out. On arrival Mrs A said she had no need for the service and her son was a drug user and called when being on a high with drugs. She was happy for the crew to leave without intervention. EMAS now have procedures in place to ensure that support is provided to patients and others on the scene who may require safeguarding or support with drugs and alcohol abuse. These procedures were not in place at the time.

5.36 On the 14th October 2010 attendance was identified for breathing problems. Mrs A declined being conveyed to hospital but was appropriately referred for a follow up visit with an Emergency Care Practioner(ECP). The ECP contacted the Emergency Operation Centre (EOC) and informed staff that a flag should be placed on the location "a heroin addict who liked to hold people hostage in the past". It was stated that an incident form would be completed and the paramedic team leader was to be informed. There is no evidence that this occurred. The author of the IMR was unable to ascertain where the information regarding the flags was sourced. There is no record of the ECP or crew assessing the risk that a potential drug addict and dealer may pose to Mrs A. There is no record that Mr B was a carer for Mrs A. Following the ECP spending 1 hour 35 minutes with Mrs A she gave consent and was conveyed to hospital.

5.37 The ambulance service attended the address on the 17th August 2012 due to Mrs A having a fall. There is no evidence to suggest that staff had concern in relation to domestic abuse. Staff recommended that Mrs A was conveyed to hospital however she declined. It was confirmed that Mrs A identified Mr B as her carer. Attending staff were not aware of the flag on the property as information was not shared between the control room and attending staff about the risks presented by

Mr B. The risk marker process was not acceptable practice and did not take account of Mrs A's needs or utilise other information.

5.38 Due to the potential that her main carer was under the influence of a substance on the 17th August it would be expected now that there was a safeguarding referral, this did not occur. Since 2010 ambulance staff should be able to recognise indicators of safeguarding need and escalate issues appropriately. When the ambulance arrived on the 17th August 2012 they could not gain entry as the door was locked and Mr B did not have a key. The Police were called to gain entry.

5.39 On the 12th October 2012 staff attended Mrs A following a call from her care line to report she had fallen. Staff engaged Mrs A attempting to ascertain how she had got her injury. The history of the injury did not appear accurate and she deferred to her son to explain. During the attendance Mrs A's ability to communicate deteriorated as had her physical condition and it was considered she no longer had capacity and in her best interest staff conveyed her to the emergency department at the hospital. The ambulance crew indentified indicators of domestic abuse and consequently informed the Police and hospital of their concerns. During attendance at the property on the other occasions during the review period staff attended Mrs A in relation to her long term condition and there is no evidence that staff suspected domestic abuse.

Lincolnshire Community Health Service (LCHS)

5.40 The IMR was conducted by obtaining all relevant LCHS records on Mrs A and Mr B, there were no health records identified for Mr C for the relevant period, this is likely to be due to the fact that he was deceased. Until the transfer of service to Lincolnshire Partnership Foundation Trust on the 2nd July 2012, the Needle Exchange Service was provided by LCHS. The records relating to this period were requested. Interviews took place with four members of nursing staff who provided service delivery. The Senior Practitioners with most involvement with the case who would be expected to scrutinise / advise and supervise junior staff were also interviewed.

5.41 Mrs A had a medical diagnosis requiring nurse assessment and intervention documented from the 25th June 2010 to the 23rd February 2012. On the 22nd September 2010 Mrs A was visited at home to complete a Health Needs Assessment. At that time Mrs A lived with a full time employed carer and had a Social Worker. Whilst there was a detailed record of health needs, there was only minimal information regarding social circumstances. There was no detail of the full time carer and the Social Worker contact was not referred to in the appropriate place in the record. Overall recording was identified as requiring improvement. In March 2011 the nurse attempted to contact Mrs A, she was informed by her son that she was away in South Africa and would be back in a few weeks. On the 1st April 2011 there was an unsuccessful attempt to contact her and then on the 12th May 2011 there was a record saying discharged from care.

5.42 There was no further intervention or record of planned discharge from LCH Services taking place to evaluate if this patient had any outstanding health needs. The service discharge did not meet organisational expectations.

5.43 Mr B had a history of drug use. A medical condition developed on both legs which required regular assessment and dressings. As Mr B was non-compliant with attendance for treatment at the GP surgery he was referred and treated by the Community Nursing Service within the home. On the 8th December 2011 a scanned risk assessment form completed by a District Nurse Case Manager contained information advising to visit at home in pairs. This warning related to risks to staff. The recorded description of the risk was that "Mr B was a known drug user with leg ulcers not known to be dangerous but home circumstances may be threatening. Visit in pairs and ensure whereabouts are known to the team." However there was no observation of poor care towards his mother, to the contrary staff witnessed a positive relationship.

5.44 From the 1st January to the 31st March 2012 there was a total of twenty nine home visits to Mr B by fourteen different practitioners from the Community Nursing Team for assessment and treatment. On the 10th February 2012 Mr B admitted he had used drugs. The implication of this practice on his health was

discussed with Mr B as well as the impact on his ability to care for his mother whilst under the influence of drugs. He was advised to contact his support worker at Addaction. There was no recorded observation of poor care or abuse directed at Mrs A or anyone caring for her.

5.45 There is no record of liaising with the GP to share relevant information and no communication with the support worker at Addaction. There is also a lack of professional curiosity or clarity about the request for a methadone prescription for his mother and there appears to be an acceptance of his behaviour and a lack of professional challenge.

5.46 Between the 1st April 2012 and the 30th June 2012 there were thirty four home visits three of which were no access and ten different practitioners visited during this time. At a home visit on the 27th June 2012 Mr B stated he had taken drugs for two days and had been drinking heavily and when nurses visited he was sitting drinking.

5.47 Whilst appropriate advice was given regarding Mrs A being ill in bed there was no evidence of professional curiosity or further enquiries relating to this episode.

5.48 During the period the 1st July 2012 to the 15th October 2012 there were twenty three home visits and ten no access visits. Fifteen different practitioners visited the house to provide the service. There was no explanation for the increase in no access visits. At a no access visit on the 23rd July 2012 Mr B left a note saying he was visiting his mum in hospital. There is no information about this hospital admission or discharge in Mrs A's health record.

5.49 At a home visit on the 17th September 2012 Mr B was drinking heavily and on drugs and getting verbally abusive. His mother was trying to advise him but he would not listen. Due to three no access visits Mr B was not seen again for fourteen days until the 1st October 2012. On the 11th October 2012 at a home visit he reported he had been drinking and taking drugs that morning, he was being non-compliant with treatment.

5.50 The number of no access visits increased which meant input and possible positive outcomes for Mr B reduced. He became increasingly non-compliant with treatment. He reported use of drugs and alcohol and he was verbally abusive, at the same time he reported his mother's ill health. However, there is no documented risk assessment or management plan or any analysis of how this impacted on the care of his mother or how Mr B was coping with activities of daily living. There is no recorded liaison with the GP or Addaction or referral to other Agencies. This was a missed opportunity.

Lincolnshire Partnership NHS Foundation Trust [LPFT]

5.51 The Trust combined the IMR and the Trust internal investigation in terms of gathering information. All electronic and paper records held by the trust were obtained and reviewed in relation to Mrs A, Mr B and Mr C. Interviews were conducted with three staff in relation to Mrs A and a separate group of four staff in relation to Mr B. Three staff were specifically interviewed in relation to Mr C. In relation to Mrs A the date of contact falls between the 21st August 2012 and the 9th October 2012. The period of assessment spanned seven weeks and involved two face to face contacts.

5.52 The first contact was an assessment in hospital where Mrs A failed to engage. The second contact was in her home environment when visited by the Community Psychiatric Nurse for re-assessment of her needs on the 19th September 2012. A further appointment was made for the 14th November 2012 to see a Consultant Psychiatrist for further assessment, however she died before this appointment. When undertaking the home visit the CPN saw evidence of a carer's book in the home and checked this with permission in order to see if there are any concerns / risks contained within it from other visiting Agencies perspective. There were none listed. The contact with Mrs A was in the early stages of assessment and presented nothing to staff that was out of the ordinary. Therefore, they did not consider the need to liaise directly with the carers and other Agencies to share / gather information, to do so may have ensured a more holistic assessment.

5.53 As part of the assessment the Trust has a specific adult safeguarding screening tool which requires staff to ask the service user if they have ever experienced physical, sexual or emotional abuse at any time (Department of Health 2008). Neither of the practitioners from the Older Adults Team completed the screening tool, this was an omission in terms of procedure, however they did ask alternative questions and demonstrated evidence of robust risk assessment.

5.54 The contact with Mr B can be broken into three episodes of care by LPFT Drug and Alcohol Services/LDAS. Episode one the 1st September 2007 to the 2nd October 2007, Mr B makes contact with LDAS but fails to attend two separate appointments for assessment. His case is closed.

5.55 Episode two the 14th October 2010 to the 11th January 2011. In this episode Mr B attended and was assessed he was accepted for treatment and was noted to have physical complications as a result of intravenous drug use. There were two telephone contacts answered by Mrs A for the sole purpose of passing on information to engage Mr B. He was discharged from service after repeated attempts to contact him proved unsuccessful.

5.56 Episode three the 1st December 2011 to the 11th April 2012. Mr B was assessed again. He was requesting methadone to help him withdraw from heroin and amphetamine use. His physical health was still of concern. He was transferred from the care of LDAS to Addaction at the end of this period due to a restructure of drug and alcohol services in Lincolnshire. Specific analysis in relation to this takes place under the terms of reference questions.

5.57 There was a contact that is worthy of note that occurred outside the time frame for the review. In 2004 Mr B was seen by a Consultant Psychiatrist. The urgent assessment considered Mr B had a personality disorder with impulsive and dissocial traits. Mr B disclosed many convictions but his GP considered that there was minimal evidence of violence in recent years. Liaison between his referring GP and a Consultant Forensic Psychiatrist resulted in a decision that the best line of treatment was a further in patient detoxification for his drug and alcohol use which was arranged via his GP. Mr B described some psychotic

symptoms which were assessed as being related to the drug and alcohol use. There was no further contact from the GP for further mental health input.

5.58 In relation to Mr C the dates of contact that fall within this time frame are from the 15th February 2007 to the 16th July 2010 whereby the trust was informed of his death which had occurred on the 12th July 2010. Mr C had been referred to the Older Adults Community Mental Health Team in Lincoln due to worsening memory problems. He is assessed at home by the team. Mrs A is recorded as being separated from Mr C but spending an increasing amount of time at the property to support him. A referral to Adult Care is made.

5.59 Mr C is then seen frequently by the CPN and has reviews of his mental health and medication prescribed by a Consultant Psychiatrist. He also receives support from a Community Support Worker and an assessment by an Occupational Therapist. It is during this episode of care that the main concerns around abuse take place. This is in relation to assault on Mrs A by Mr B in March 2007 and the threat with a knife against Mr C in June 2007. Mr C is diagnosed with dementia and is transferred in line with guidelines to the memory team within the Older Adult Community Mental Health Team. There are no more episodes of abuse noted within the records before Mr C's death on the 12th July 2010.

NHS Lincolnshire Primary Care Trust [LPCT]

5.60 All available General Practice (GP) case notes for the identified patients were reviewed. The patients were seen by numerous health professionals within the period of the review. The actions of no single Practitioner stood out to the IMR author who felt it was not therefore necessary to conduct staff interviews.

5.61 Despite very poor health due to heart disease and being on multiple prescription medicines Mrs A was an infrequent attender at the Practice. There were also few home visits. In total she had fewer face to face consultations with Practice staff than would normally be expected for a patient of her age and a lot fewer than would be expected for someone which such significant morbidities. She

received care from Community Nursing Staff and from specific Community Respiratory Nurse which is covered in information from LCHS.

5.62 Mr B was a frequent attender at his General Practice, he was dependent on drugs and alcohol and was hepatitis B and C positive and had persistent abscesses and wound infections associated with injecting sites of illicit drugs. He changed GP practice a number of times and was well known regarding his chaotic lifestyle to a number of GP's. He had tried to obtain, by deception, prescribed drugs which have a street value. He was clearly a very complex and difficult patient.

5.63 Within his record there is evidence of his referral to LPFT and drug and alcohol services in Nottingham in 2004 which is outside the time frame for this review. This was identified through correspondence between the GP and Consultant Psychiatrist regarding detoxification management.

There is no documentary evidence that Mr B was managed according to the Consultant Forensic Psychiatrist recommendations in July 2004. Mr B had a number of episodes of incarceration in Her Majesty's Prisons which would explain gaps in the record.

There is much evidence of subsequent and ongoing engagement between Mr B and his GP practice regarding the care of his ulcers and associated complex health care needs.

5.64 Mr C was in poor health at the end of his life, having had prostate cancer and dementia which was worsening. He could, on occasions, be aggressive to his wife and records indicate that although separated they were living together at the time of his death. Mrs A, Mr B and Mr C were registered at different Practices at different times. There is no record of a referral to any other service that was triggered by the actions or behaviours by their relatives. Despite recording of verbal aggression and an allegation Mr C attempted to hit Mrs A with his walking stick, actions in response to this behaviour were limited. There is no record of any physical injury to Mrs A within her GP notes and no entry that she

had complained about the actions or behaviours of her son Mr B. Further analysis relating to the terms of reference will be covered in that section.

Lincolnshire Probation Trust [LPT]

5.65 In order to prepare the IMR and chronology the IMR author has read all documented records and Court reports which were prepared in relation to contact with Mr B and still held by the service. No specific staff member has been interviewed in relation to the review. There were two episodes of service provision which both commenced as pre-sentence report requests, leading to the making by the Court of Community Orders. These occurred in 2007 and 2009, both led to breach action being taken and revocation and re-sentencing in favour of outcomes that ended the statutory responsibility of the Probation Trust.

5.66 Episode 1 the 16th April 2007 to the 7th September 2007.

Mr B continually failed to engage with the Court report process. Finally, the Magistrates' remanded him in custody and he was interviewed via video link from Lincoln Magistrates Court to HMP Lincoln. The final report indicated that both offences were committed at the home address of the victim Mrs A and she was also victim of the assault. Mr B was assessed as presenting a medium risk of serious harm to a known adult and both Mrs A and Mr C were named as being at risk. OASYS which is a nationally accredited assessment tool was used to assess risk and the medium rating was felt to be correct at that time.

5.67 The OASYS definition of medium risk is as follows:-
"there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances e.g. failure to take medication, loss of accommodation, relationship breakdown, drug of alcohol misuse".

Serious harm is defined as "a risk which is life threatening and / or traumatic and which recovery whether physical or psychological can be expected to be difficult or impossible.

5.68 There were comments in the pre-sentence report regarding how Mr B described his relationship with his mother and stepfather "he wishes to return to the property and reports that his mother and stepfather have asked him to return to live with them. He says they want him there and need him to assist them with their care". There was no evidence of any attempts to verify or cross reference the above information. The Probation Officer considered proposing an accredited program but ruled it out. At that time the Officer was of the opinion that the perpetrators violence was due to anger management issues rather than domestic abuse. Consideration was also given to imposing a Drug Rehabilitation Requirement, however, given his lack of motivation this was not felt to be appropriate and his drug and alcohol use would be a focus of the Community Sentence as appropriate. Ultimately the proposal was for a 12 month Community Order with supervision, an education training specified activity and a 12 month exclusion requirement excluding Mr B from Mrs A's address. The exclusion requirement had not been proposed by the author.

5.69 Mr B only attended Probation on one occasion. There were several telephone calls between Probation, Police and Adult Care and between the Probation Officer and Mrs A. The Probation Officer phoned the Police on several occasions in order to report abuse, continued violation of the exclusion requirement and in order to get the Police to execute the outstanding arrest warrants.

5.70 When Mr B was arrested on warrant having failed to attend Court for breach of the Order the Community Order and all its requirements were revoked in favour of a 6 month custodial sentence on the 6th September 2007. This ended statutory involvement with the case for this period. There is no evidence recorded of any information being exchanged between Adult Care or Police following this outcome.

Episode 2 13th October 2009 to the 9th December 2009

5.71 Mr B pleaded guilty to theft at Lincoln Magistrates Court and a pre-sentence report was Ordered based on a low seriousness assessment of the offence. Mr B

complied with the PSR on this occasion. The overarching thrust of the report is Mr B's substance misuse and its links to his significant history of acquisitive offences. He was assessed as a medium risk of serious harm to his parents and this was considered to be an accurate assessment. The Probation Officer also completed a Spousal Assault Risk Assessment (SARA) as part of the process, this highlighted Mr B's behaviour towards his mother and stepfather as domestic abuse and this was identified as being of critical importance.

5.72 A 12 month Community Order with supervision and unpaid work was made on the 6th November 2009. Mr B did not attend one appointment with Probation. Given the risks presented by Mr B in consultation with the Manager, the Probation Officer breached him immediately. She also made a referral to Adult Safeguarding regarding both Mrs A and Mr C. On the 9th December 2009 despite a proposal for the continuation of the Order coupled with a financial penalty the Magistrates revoked the Order and Mr B was re-sentenced to a 2 month electronically monitored curfew between the hours of 7pm and 7am. The curfew was to the address of the family home where Mr B indicated to the Court he was living alone. To make a Curfew Order in a case where there is domestic abuse would appear ill advised in that it could exacerbate the situation by preventing the perpetrator leaving the address as a means to avoiding abuse.

Lincolnshire County Council Adult Care [AC]

5.73 In constructing the chronology and analysing the Council's involvement all manual and electronic files were examined. Supervision files of staff involved with the case were looked at. Interviews were held with twenty two members of County Council staff including the Lincolnshire Assessment and Reablement Service (LARS).

5.74 To enable the Council to identify any learning at an early stage an interim desk top review was undertaken and an action plan developed with an implementation date of "by October 2013". An internal audit reviewing contacts, referrals and case management has also been undertaken to provide assurance as to whether practice failures are specific to this case or more common place and indicative of

systemic failings. Practice was assessed and evaluated against a wide range of policies.

5.75 Specialist risk assessment tools are used by safeguarding teams, however there is no risk assessment tool in use consistently in AC. This review highlighted a propensity to consider risks within needs assessment as environmental physical risks associated with disability, rather than risks associated with relationships with other people. Similarly risk assessment actively undertaken by LARS staff tended to focus on risk factors impacting on providing support safely rather than risks of harm to people who use services. Although staff were aware of multi Agency safeguarding procedures very few practitioners in assessment care management were aware of MARAC procedures.

5.76 Safeguarding concerns were not always raised by a formal alert to the safeguarding team which is the prescribed referral route. Concerns of a potentially safeguarding nature raised by LARS were escalated to the Assessment Team Key Worker with a presumption that responsibility should sit with them. The review found that the practice of initially running concerns passed safeguarding principal Practitioners without logging a referral meant that there was less clarity around actions if the alert did not progress to an investigation.

5.77 Following the disclosure on the 8th March 2007 by Mrs A that she was feeling low as Mr B had been arrested for assaulting her, there is no evidence that any discussion with a manager took place or whether a safeguarding investigation was appropriate. Safeguarding action was only initiated following a further incident in 2007. This is considered a practice failure. Following the safeguarding alert from Probation on the 24th May 2007 about Mr B's violence towards Mrs A AC professionals assessed that no further action was needed as they did not live at the same address, that Mrs A was going abroad imminently and Mrs A did not want any intervention from AC. This was appropriate in terms of ensuring Mrs A's immediate safety.

5.78 An Adult Protection Case Conference was held about Mr C on the 11th July 2007 amongst other actions referred to in the chronology a hazard was placed on Mr C's manual and electronic file about the risk of violence and only joint visiting to be undertaken. It is apparent at this point only Mr C was seen as the vulnerable adult and not Mrs A. Given that Mrs A had been the victim of incidents of abuse at the hands of Mr B the risks to Mrs A should have been more thoroughly considered. There was no hazard recorded on Mrs A's file and this was an omission.

5.79 December 2007 was the final direct involvement of AC for this episode of contact as the case was closed for active involvement. There were two outstanding actions from the Case Conference on the 11th July:-

- The second opinion on Mr C's capacity and whether he understood the implication for his care if he allowed Mr B to live with him;
- A follow up of the domestic abuse referral and outcome.

The Practice Manager responsible for co-ordinating actions from the Case Conference should have ensured that these actions were implemented. This was not done.

5.80 There did not appear to be any consideration or legal advice sought on whether additional powers under inherent jurisdiction could be considered. The purpose would have been to enforce Mr B's exclusion from the property or remove Mr C to a place of safety as part of the action planning. The views and wishes of Mrs A and Mr C appear to have been prevalent factors in the decision making at that time.

5.81 The involvement with Mrs A in March 2009 for equipment and adaption took place in ignorance of her previous contact. This was contributed to by the lack of hazard recording on Mrs A's file. Therefore, no consideration appears to have been given as to whether Mrs A's choice to temporarily reside at the family home would potentially put her at risk. It is not usual practice for assessors to routinely consider risk of harm for making temporary arrangements. However,

where an assessor is aware of a specific case history then it would be best practice to undertake a risk assessment and consider intervention to provide alternatives.

5.82 There are no discussions recorded or risk assessments undertaken with the case workers line manager about the risks at this point or with Mrs A despite the case history. The Occupational Therapist undertook a number of assessments during this period. On the 11th November 2009 when the vulnerable adult referral was received from Probation in relation to Mrs A it was decided to take no further action as the risk had been mitigated by Mrs A and Mr C moving. However, the fact that Mrs A and Mr C had decided to stop living with Mr B could have been an opportunity for further work with them to ensure longevity of this arrangement.

5.83 On the 23rd March 2010 Mrs A contacted Adult Care requesting a direct payment. An assessment was undertaken, it was focused on a presenting need and did not include full evaluation of Mrs A's family circumstances and risks associated with Mr B. Good practice is that significant relationships should be discussed as part of the assessment, this was not done.

5.84 In October 2010 when Mrs A moved back to the family home and the Social Worker became aware of potential risks the decision was taken to record a manual alert on Mrs A's paper file. There was no hazard attached to Mrs A's electronic record. This is a significant omission. The hazard focus is on staff and not the vulnerable adult. Safeguarding concerns discussed in supervision were not researched and therefore not fully known and this should have been done.

5.85 On the occasions Mrs A requested review meetings they were arranged. However, the process became elongated due to Mrs A's trip to South Africa in January 2011. The risk should have triggered a more urgent response and a full assessment of the risks of Mrs A moving back to the family home, this was not done and is a practice failure. When Mrs A went to South Africa the direct payment was suspended and the case closed on the 27th January 2011.

5.86 On the 17th November 2011 when she returned from South Africa Mrs A requested re-instatement of the direct payment. The direct payment was recommenced on the 13th December without any face to face re-assessment. Policy states if no face to face re-assessment, irrespective of history, a follow up home visit should be undertaken within two weeks of the decision. This was not done. The decision was made in ignorance of the significant case history and the lack of a hazard warning on the electronic file did not alert people to the concerns. Practitioners are reliant on the hazards or information gathered at contact to trigger further, non-routine investigation, of a fuller case history.

5.87 Mrs A, Mr B and Mr C's records were linked in the up-dated Swift / AIS record by virtue of the relationship section. The information however was not accessed as part of the decision making process to re-instate the direct payment and it should have been.

5.88 On the 23rd January 2012 Mrs A requested a stair lift be fitted to the communal stairway at her home. This became the focus of contact. The request could not be granted and it was recommended that Mrs A would be better to pursue a request to be re-housed to a more suitable property. The case was allocated to a Community Care Officer (CCO) in ignorance of the case history due to the lack of hazard on the electronic record. As the current CCO left the Council on the 22nd June 2012 Mrs A's case was re-allocated to CCO 2 on the 7th August.

5.89 On the 25th July 2012 CCO 3 became involved in the case whilst Mrs A was in hospital. "Recording with Care" requirements were not followed. CCO 3 obtained information about concerns in the case e.g. Mrs A's son being an alcoholic, IV user who turned carers away. Also, issues over her capacity and family not wanting her to return home. On the 1st August 2012 CCO 3 spoke to Mrs A's nephew Mr D who raised concerns about Mrs A returning home. The worker informed Mr D that if Mrs A was deemed to have capacity and she wished to return home there would be nothing Mr D could do to stop her. They met again on the 2nd August 2012 when Mrs A's nephew Mr D made various comments e.g. if Mr B didn't drink he was ok but if he did then things were likely to "kick off".

5.90 The worker did not probe for further information, if she had done so, it is likely that the risks to Mrs A's safety would have been clear. A more comprehensive risk assessment may then have been undertaken which in turn would have triggered a safeguarding alert / domestic abuse Multi Agency Risk Assessment Conference (MARAC). The worker was unaware of the requirement of MARAC or the check list to refer cases to MARAC. No specific practice guidance exists relating to domestic abuse in Adult Care and the worker had not attended any training on the subject. This episode of assessment was inadequate. There was a failure to fully understand the risks to Mrs A and as a consequence there is no consideration of additional powers that may have been available to the Council i.e. applying to the Court of Protection to intervene under inherent jurisdiction, being explored in this case.

5.91 On the 3rd August 2012 a second stage capacity assessment was undertaken by the OT. Mrs A was considered not to have capacity to make informed decisions about her discharge home. The CCO did not discuss the case with the principal practitioner at this stage as she failed to recognise the risks. When advice was sought on how to progress the case, concerns related to the home environment not Mrs A's safety or threat of harm. There was a misunderstanding on behalf of the principal practitioner as to who was managing the case. The hospital worker completed the assessment and discharge arrangement. This should not have happened it should have been referred to the principal practitioner for advice on the next steps.

5.92 The capacity assessment triggered a "Best Interest Meeting" on the 10th August 2012. The recording was insufficient and risk remained vague. Mrs A was discharged from hospital on the 14th August 2012. Despite the hospital CCO having concerns there was no handover or contact made with the Key Worker to express these. Whilst the current process was followed it is evident that the assessments and understanding of the potential risks on which to base best interest decisions was flawed. Had risk concerns been explored or information accessed it is reasonable to conclude that the discharge planning process would have been managed differently. As a result of the review AC will be reviewing skills, experience and capacity at the Lincoln County Hospital Team.

5.93 A LARS package was put in place from the 14th August 2012. This commenced in ignorance of the risks associated with the property or Mr B. All relevant information should be given to providers and their staff before service commences. This did not happen. Also, the assessment was not completed, records were incomplete, ten different support workers were allocated to provide services.

5.94 Concerns about the environment and Mr B's ability to care for Mrs A were raised and escalated to the LARS co-ordinator by the Home Support Workers (HSW). The LARS co-ordinator raised concerns on the 17th August 2012. It was clear Mr B was drinking and using drugs. The case should have been allocated to an experienced Social Worker not an Agency CCO. Concerns were also raised by the OT that Mrs A stated that she wanted to go into residential care. At interviews the LARS co-ordinator stated she generally escalated concerns to the Key Worker and not safeguarding. Expectation is it should be raised with both. The LARS co-ordinator did not undertake any visits or have direct contact with Mrs A or Mr B, the expectation was that she should have visited when there were concerns. Also, initially risk assessment normally completed by LARS at the start of the package of care was not undertaken as Mrs A was not feeling well and this was never followed up. It could have provided an opportunity to identify further concerns.

5.95 The CCO who visited the home did not explore the case history or the concerns raised by Mrs A's nephew. The assessment was based on the presenting circumstances. On the 22nd August 2012, the CCO sought advice from the Principal Practitioner who stated that the worker should speak to Mrs A and get her views without Mr B being present.

5.96 On the 23rd August 2012 Mrs A's nephew contacted the CCO at the hospital raising concerns about Mr B having drinking parties, not taking care of Mrs A, not ensuring that she was being fed properly and that Mrs A was asking to be admitted to permanent care away from Mr B. The message was passed to CCO the same day. It was expected that the worker would have contacted the nephew

as a matter of urgency given the nature of the concerns, this did not happen. The home visit was made five days later and this was a missed opportunity.

5.97 On the 28th August 2012, an Adult Social Work Assessment was completed. However, it was considered to be poor and did not explicitly state all the information gained or the risks known. It should have explained the issues including Mrs A wanting to go to residential care more fully. Mr B was not offered a Carers Assessment and it was expected by the Agency that this would have been considered. No attempt was made to contact other Agencies e.g. Health, Addaction, which would have been expected to provide a fuller and more holistic assessment.

5.98 At a home visit on the 1st October 2012 the issue of direct payment was discussed. The previous carer was present and raised concerns about Mr B taking drugs and drinking plus demanding money from Mrs A to buy beer. When shared with the Principal Practitioner she advised the worker to contact safeguarding. The worker did not share Mrs A's name with the Principal Practitioner had he done so she would have been able to share some of the case history as she had been the Key Worker for Mr C which may have in turn increased the level of concern.

5.99 When the CCO contacted safeguarding he was given the following advice "due to Mrs A having capacity and that Mrs A would not make a referral about her son herself there was little the Safeguarding Team could do". The Agency would have expected the Principal Practitioner Safeguarding to establish the facts more fully and review the case history. This was not done and is a key practice failure. Despite the response from safeguarding given the level of concern raised and that three other professionals had also raised concern (CCO's, OT and LARS Co-ordinator) the Agency would have expected a formal alert to be raised by the worker and a strategy meeting convened. This was not done and was a missed opportunity.

5.100 In relation to the direct payment, following discussion with the Principal Practitioner, it was agreed to suspend direct payment. There was no

consideration of whether suspending the payment might have posed additional risk. A letter was sent to Mrs A dated 8th October 2012 stating that the payment was suspended pending a financial check. The Principal Practitioner approved this action. This is contrary to guidance from the Department of Health.

5.101 When staff from LARS were interviewed they raised concerns that were not recorded in the running record and were not seen as being significant individually. Yet, if viewed collectively, they show escalating concerns of potential financial abuse. None of these were escalated to the LARS co-ordinator and they should have been.

5.102 The LARS co-ordinator felt once safeguarding issues had been reported to the appropriate Social Worker appropriate safeguarding alerts had been made and there was no necessity to take further action. The fact that another person, raising concern, may have added weight to the alert seems to have been overlooked. The Agency would expect the co-ordinator to have raised a safeguarding alert irrespective of the ignorance of the previous case history. The presenting circumstances were expressing sufficient issues and concerns to warrant a more formal risk assessment being undertaken and this was not done.

United Lincolnshire Hospital Trust (ULHT)

5.103 In preparation for the IMR the medical notes in relation to care and treatment provided by ULHT for Mrs A and Mr B were sourced and analysed. No staff were interviewed as the medical staff involved are rotational and have since moved. Also, understandably nursing and therapy staff are unable to recall these individual patients, however, the IMR author believes that not being able to interview staff has not impacted on the quality and effectiveness of the review. Mr B's last attendance at Lincoln County Hospital was on the 19th September 2006 when he suffered a heart attack. He discharged himself against advice on the 20th September 2006 without completing the proposed treatment plan. There has been no further contact.

5.104 There were three admissions to hospital for Mrs A during the scoping period all in relation to her chronic medical condition. The presentation was one of shortness of breath and chest pain. She was admitted to hospital on the 17th March 2009 and discharged on the 26th March 2009, some nine days later. She was again admitted on the 14th October 2010 and discharged on the 22nd October 2010 after a seven day stay. The last admission was on the 12th June 2012 and discharged on the 14th August 2012 some two months later. Sadly Mrs A was admitted to hospital on the 12th October 2012 following the assault by Mr B and died later the same day.

5.105 When Mrs A was admitted on the 12th June 2012 she confirmed she lived at her home address with her son. However, when she moved to Medical Emergency Admissions Unit (MEAU) she nominated her nephew as next of kin. It is suggested that staff could have exercised professional curiosity at this stage to further explore the next of kin status. It is unusual for an individual to live with a close relative and yet have a more distant one genetically and geographically as next of kin / first contact. Such a discussion would have given staff first hand clarification and could have alerted them to potential concerns and complications.

5.106 Whilst the student nurse appropriately recorded on the 2nd July 2012 that Mrs A wished for a residential placement on discharge as her and her son "do not get along anymore". There was no evidence that this was either explored further or relayed to nursing staff as a prompt to further explore the statement made. Had this been done it may have resulted in Mrs A sharing further information. A disclosure of DA would have warranted completion of a DASH Assessment potentially resulting in a MARAC referral. This could have increased protective factors, access to services and a multi Agency awareness of risk and in turn have altered interventions and final outcome. Even if the DASH had not indicated a MARAC referral staff would have had a greater awareness of the risks relating to decisions made in Mrs A's best interest when she was deemed to lack capacity regarding discharge planning.

5.107 The comments made by nephew Mr D “there are complex issues regarding next of kin” and nursing staff’s documentation “son is an intravenous drug user and alcoholic and often refuses carers entry”. These statements were not recorded as having been explored further. Clarification or dismissal could have been sought from Mrs A and would have given staff clearer insight into the risks.

5.108 Mrs A made several comments to both medical and nursing staff regarding Mr B’s feelings that he wanted her to come home because he needed her. Although medical staff document a cautionary warning to Mrs A to “think carefully and consider herself”, there is no evidence of escalation to senior medical / nursing staff or to the "discharge team" for specialist support and advise regarding what could potentially have been an increasingly complex discharge scenario.

5.109 Comments made by Mrs A on the 25th July 2012 about her son borrowing money and not repaying it and she wished for it to stop was not explored by staff. It was referred to Social Care to Manage. The IMR author felt that whilst being mindful of hindsight that medical and nursing staff could have sought input from specialist safeguarding colleagues who would have given appropriate advice regarding robust Multi-Agency discharge planning.

5.110 On discharge the information shared with Mrs A’s GP focused on medical discharge rather than a holistic review. This was a missed opportunity to alert primary care colleagues and LCHS to the social scenarios relating to the assessment of need.

5.111 On the post discharge home visit the OT contacted the GP due to concerns and he agreed he would make a home visit that day which he did. The OT also referred to the Social Worker requesting urgent assessment. The OT followed this request up and was told the assessment had been completed and a re-assessment would take place on the 30th August 2012. The appropriate process of onward referral was followed. In general, there was limited professional curiosity and exploration of meaning behind comments, which is central to plans developing and delivering holistic and robust care.

5.112 No evidence of, or suspicion of physical abuse was presented to the clinical staff. Potential risks were around unsuitable property and Mr B's chaotic lifestyle and his ability to care for his mother. The home circumstances of a second floor maisonette with no lift facilities and being confined to one room because of poor mobility made Mrs A extremely reliant on her son. She was dependent on him for all aspects of her care food, drink, medication, personal care and social interaction. Discharge planning did not fully consider any risks relating to Mr B's chaotic lifestyle, potential financial abuse nor Mrs A's increased vulnerability due to isolation.

Victim Support

5.113 In preparing the IMR each communication and note has been researched and checked against service delivery, policies and procedures. The policy was updated in November 2012 to bring Victim Support in line with CAADA recommendations. The CAADA DASH risk indicator check list was not completed by Victim Support staff until September 2011. No staff were interviewed during the preparation of this review. Victim Support had five contacts with Mrs A between 2008 and October 2012.

5.114 On the 25th July 2008 the referral to Victim Support identified the crime as criminal damage caused by a temporary lodger who had asked for money. It did not identify domestic abuse. The victim was contacted but declined support but requested information on help available for someone struggling with addiction. Information was given and case closed.

5.115 The referral of the 26th August 2008 for common assault and criminal damage identified domestic abuse as a factor. Different spellings of the surname meant that systems did not identify that this was a repeat victimisation. In line with procedure, permission to contact the victim Mrs A and the safest method to contact her was established. The Victim Contact Officer contacted the victim by telephone and conducted a needs assessment. The victim declined support and the case was closed. There was no evidence that domestic abuse help information was provided for the victim's future use if needed.

5.116 There was a referral for a domestic "non-crime" incident on the 11th November 2010. Again there were different name spellings in the address and the system did not automatically identify a repeat victim. Procedures for DA were followed and the victim contacted. She declined support and the case was closed. Again there is no evidence that information of DA services were provided to the victim for future reference.

5.117 A referral was received on the 15th October 2012 the referral was for grievous bodily harm with intent and domestic abuse was identified. Again the lack of punctuation meant that the system did not identify links to previous referrals. There was missing information that meant that the case was closed as there was no available contact methodology. The victim Mrs A had sadly died on the 12th October 2012.

6. Analysis of Agency involvement relating to terms of reference

6.1 Were Practitioners sensitive to the needs of the victim and the alleged perpetrator, knowledgeable about potential indicators of DV and aware of what to do if they had concerns about the victim or perpetrator?

6.1.1 There were sixty four incidents of domestic abuse identified by the reviewing Police Officers. 58 occurred between October 2006 and October 2008. Less than 50% of total incidents were recognised and recorded as domestic abuse. The reasons for this would appear to be despite the Police having comprehensive policies and guidance staff did not appear to be knowledgeable about the definitions and potential indicators of domestic abuse at that time. As they did not recognise abuse, they did not comply with the relevant Force policy. Many of the incidents were dealt with quickly and positively without being recognised as DA. Out of sixty four incidents only twenty three had a P548 completed and only eighteen were given the final classification code and only thirty the qualifier code. All 3 processes are key to the Police in identifying domestic abuse.

6.1.2 There is evidence of a lack of input by supervising staff within the Police to ensure that domestic abuse incidents were recognised, recorded and dealt with

effectively in line with Policy. Police were sensitive to the needs of the victim in that the urgency of the need was recognised when calls were made and the graded response policy was applied. Fifty nine of sixty four incidents were graded either urgent or priority. On average Officers responded to calls for assistance within 6.9 minutes. Not only was Mrs A responded to urgently there is also evidence that Police Officers and staff were sensitive to the needs of Mr B and responded to his calls for assistance equally urgently.

6.1.3 The critical register was used constructively to identify that Mr B was violent and Mrs A vulnerable and should there be a call urgent response is required.

6.1.4 There is evidence that Police Officers and staff failed to recognise indicators of DA on several occasions. They dealt with presenting behaviour and did not recognise the abusive nature of the situation or the accumulative picture of systematic abuse. Recognition should have resulted in information sharing with other Agencies with a view to protecting Mrs A via a full assessment and risk action plan.

6.1.5 The Police became aware that Mrs A's carer 2 was believed to be a criminal associate of Mr B who he met in prison. The Police would not have considered it to be part of their role to assess carer 2's suitability as a carer. However, this information should have been shared with Adult Care for further assessment.

6.1.6 There are a number of incidents that did not appear to have been investigated at all or were not investigated thoroughly and therefore were a missed opportunity to identify abuse, share information and work together with other Agencies to develop a plan to protect the victim.

6.1.7 There were times when following the reporting of a crime the victim withdrew her complaint and the case was ultimately discontinued. There is evidence of concerns from the Domestic Abuse Officer (DAO) and the CPS lawyer for the welfare of Mrs A and the efforts they made to try and achieve a satisfactory outcome, despite her wishes, via a hearsay application. The application was refused by Lincoln Magistrates' Court when no evidence was offered. It is

recognised that DA victims often wish to retract complaints due to the complex relationship with the perpetrator and the effect of the coercive control element of the abuse. Force policy current and previous provides advice and guidance for dealing with cases where the victim refuses to make a complaint or withdraws support for a prosecution. "Officers should focus efforts from the outset on gathering alternative evidence in order to charge and build a prosecution case that does not rely entirely on victim's statement".

6.1.8 There are also examples of inadequate un-coordinated and poorly managed investigations which were not given the attention or priority required by the force in DA cases. Despite the CPS lawyer chasing matters up with Police on at least three occasions for further information and details of injuries. Mr B was never charged with some offences committed e.g. on the 12th January and on the 3rd July 2007 the crime was finalised and recorded as undetected following Mrs A's withdrawal.

6.1.9 The primary aim of Addaction staff was to engage Mr B in treatment services to deal with his substance misuse. He did not comply with the process and missed many appointments. Had he complied personal issues and financial matters would have been included in a holistic treatment / care package. Nevertheless staff did have information that in 2006 he "trashed his mother's house and used her money to buy drugs". His behaviour was not challenged or explored further to gather information. It was known Police and Courts were involved and it was assumed they were dealing with matters. Liaison with the Police and a referral to Adult Care could have been considered at this point and may have added information available to ensure a Multi-Agency approach to the abuse.

6.1.10 A further note of concern in 2006 by Addaction was in regarding to Mr B's risk to himself and others. There is a note on file to say "a referral to psychiatric services is deemed suitable and will be sought". There is no record of any such referral being made and was a missed opportunity to involve other services in the full assessment and risk management plan. It is recognised non-compliers with treatment processes present a higher risk of harm than drug users who are complying.

6.1.11 When there was telephone contact with Mrs A by Addaction and she was seeking advice about keeping Mr B away from the home appropriate advice was given. With hindsight had this been followed up with a call to the Police and Adult Care it may have provided a further alert to those Agencies to take action and better meet the needs of both Mrs A and Mr B. It is recognised that there has been much development in terms of recognising and dealing with domestic abuse over the last 7 years and Addaction managers are confident staff are now knowledgeable about indicators of abuse and what to do.

6.1.12 City Council Housing Practitioners main contact with the family was in relation to noise nuisance, anti-social behaviour and repairs as a result of damage at the house caused by Mr B. Staff were aware of the potential indicators of and arrangements for the safeguarding of vulnerable adults but did not recognise that this case constituted domestic abuse. Therefore no referrals were made under safeguarding. They were sensitive to need in terms of attempting to involve the GP when Mrs A wanted to move back to the family home and were sensitive in terms of some of the impact of Mr B's drug and alcohol use on his parents. Housing provided information to Mrs A about OASIS Drugs Support Agency which she utilised.

6.1.13 Prior to 2010 EMAS staff training and knowledge was limited in relation to DA and the referral on process lacked rigour. A dedicated safeguarding team was established in 2010 and safeguarding training is now delivered annually. As a result knowledge about DA and what to do has improved.

6.1.14 EMAS now have procedures in place to ensure support is provided to patients and also others on the scene e.g. safeguarding and support with drugs and alcohol use. These procedures were not in place at the time of intervention with Mrs A.

6.1.15 Although a warning flag was placed on the family address in October 2010 by EMAS relating to Mr B being "a heroin addict who liked to hold people hostage" there is no record of the risks posed to Mrs A by Mr B having been assessed. It was not recognised as an indicator to explore DA and there was no evidence staff

had any DA concerns. However, crews were not made aware of the flag, which had they been, may have increased their professional curiosity. The lack of communication to front line staff about the flag meant it was of no benefit to patients or professionals and was therefore ineffective.

6.1.16 When ambulance staff did suspect domestic abuse at the 12th October 2012 call they did what was expected in terms of acting in Mrs A's best interest, conveying her to hospital, keeping Mr B informed and informing Police and the hospital of their suspicions. A referral was not made to AC, however as Mrs A subsequently died from her injuries the same day, this was not considered to be significant.

6.1.17 Practitioners from LCHS had no awareness, knowledge or suspicions of any domestic abuse. The fact that the abuse was instigated by a son onto his elderly mother does not meet with the most common expectations of domestic abuse. Such behaviour requires practitioners to think more widely and to be more investigative and have a greater knowledge and understanding of those they provide services to.

6.1.18 The Probation Trust Officers did recognise this case constituted domestic abuse and involved the Police and Adult Care. One Practitioner progressed to a referral based on her concerns. Both supervising Probation staff involved in 2007 and 2009 knew what to do and they moved swiftly. Despite their actions, procedures to adequately protect the victim were not invoked. In 2009 a referral to MARAC could have been considered.

6.1.19 In general Adult Care was sensitive to presenting needs of Mrs A, Mr B and Mr C at different times. However, episodes of contact following the safeguarding alert regarding Mr C in 2009 did not focus on a long term plan in relation to safeguarding or domestic abuse. There was failure to undertake full risk assessment at different times e.g. when Mrs A moved back to the family home in 2010 and when direct payments were re-instated in 2011. When Mrs A was discharged from hospital in August 2012 the assessment and support activity took place in ignorance of the information gathered in previous years. It was

clear practitioners were not aware of the case history and did not research family circumstances. Consequently decisions were flawed as they were not based on full information, these are significant practice failures.

6.1.20 There was a lack of information sharing between Agencies e.g. when AC explored drug and alcohol problems with Mr B. There was no liaison with Addaction and vice versa which would have enhanced the case history. Agencies failed to work together and adopt a Multi-Agency approach to assessment and risk management.

6.1.21 Despite Mr B being identified as the carer from June 2012 his needs were not assessed in relation to this role. There is no evidence in the records that Mr B was offered or declined a carer's assessment.

6.1.22 Whilst DV was not recognised several staff OT's, LARS workers and the nephew identified deterioration in the family home with no food, electricity, unkempt and unclean. These issues were seen in isolation and were not put together and seen as an accumulation of deterioration and concerns which indicated the neglect of Mrs A's needs by her son Mr B. Mr D, nephew, specifically shared his concerns about the care of his Aunt but this was not explored sufficiently and is a significant practice failure. Potential safeguarding risks and domestic abuse indicators were present and were not explored e.g. kicking off when under the influence of drugs and alcohol. The carer suggested as being somebody Mr B met whilst he was in prison. Specific concerns about finances were not appropriately escalated. The culture in LARS was for the co-ordinator to discuss concerns with the case manager rather than escalate to the safeguarding team.

6.1.23 Many staff interviewed in AC were unaware of the requirement under MARAC. A DASH risk assessment was not undertaken. A key opportunity to keep Mrs A safe was in hospital. However, the AC needs assessment was not of sufficient quality or depth to identify the potential risks to Mrs A. Whilst in hospital there was a lack of professional curiosity by hospital staff in relation to information given that was unusual e.g. next of kin and a failure to explore comments made

by Mrs A regarding her relationship with her son. Inconsistencies in information given to AC staff was not challenged in relation to the home circumstances reported by her nephew for her discharge.

6.1.24 Hospital discharge planning lacked robust Multi-Agency input and planning and was based on presenting health needs rather than a full holistic review. Due to the lack of exploration of the underlying issues in this case, Primary Care staff in the community were not alerted to the complexity of the situation which may in turn have increased the possibility for protective factors, access to services and Multi-Agency awareness of the potential risk.

6.1.25 Interviews with Practitioners from LPFT identified some inconsistencies around knowledge of the definition of domestic abuse. They would have recognised domestic abuse if it had been between two people within an intimate relationship but may not have recognised the abuse between family members under the same definition. Staff interpreted the familial domestic abuse as an adult safeguarding issue. At the time of Mr C's involvement with the Trust, Practitioners felt that the correct Agencies of the Police and Adult Care were involved in investigating.

6.2 Was it reasonable to expect Practitioners given their level of training and knowledge to fulfil these expectations?

6.2.1 As knowledge and understanding regarding domestic abuse has developed over the years, so has Agency training, approach and resulting expectation of Practitioners. Initial and ongoing training modules are delivered to Practitioners in most Agencies. Routine Orders were used to keep Police Officers and staff informed and up-to-date about domestic abuse issues. In most Agencies where training, policy and procedures is adequate it was reasonable to expect Practitioners to fulfil roles and expectations. In 2011 Police staff were informed via a routine Order about a number of common errors and omissions that had been identified in completing the form P548. This reflects the findings contained in the Police IMR some 2 years later and are subject to a recommendation. It identifies the necessity to monitor that expectations are embedded into practice.

6.2.2 Whilst it was reasonable to expect police staff to fulfil force expectations, this review has highlighted many examples where Officers and staff did not seem knowledgeable about force policy and procedure. The reviewing Officers considered the force need to ensure that the importance of policy and procedure relating to domestic abuse is re-enforced and measures are introduced to ensure policies are understood and complied with.

6.2.3 Several Agencies identified they were not confident that the level of training for DA in place in 2006 was sufficient. For some Agencies 2010 saw development in adult safeguarding training which became mandatory for staff. In various Agencies there are specialist or specific staff with more training than other staff to refer to for advice. For the Ambulance Service safeguarding has become embedded into practice and is recognised as an essential part of the paramedic's role. Specific training for domestic abuse is currently being delivered in EMAS. The City Council found staff had limited knowledge of potential indicators of domestic abuse which reflected their lack of specific training.

6.2.4 Whilst having to keep up-to-date with professional practice, there is no mandatory training for GP's. In the absence of physical injury or verbal indication no indicators of abuse were recognised by the general practice.

6.2.5 Whilst in normal circumstances AC should have been able to spot potential indicators of abuse, it was not reasonable for newly appointed and inexperienced or agency staff to manage a case of this complexity. The depth and quality of assessment was not sufficient for the circumstances of the case with a lack of questioning of information provided or recognition of any pattern of behaviour being presented. It is crucial that the right staff are asked to undertake the right job.

6.2.6 At the time ULHT had no specific internal policies and procedures relating to domestic abuse and direct questions to all patient groups was neither standard or expected. A clear policy and procedure would raise awareness of this crucial area of work with specific training on domestic abuse rather than it being incorporated into other training programmes. Whilst it is difficult to make

assessments when there is limited information and lack of engagement often it is this type of case where risk is greatest and assertive practice is required.

6.3 Did the Practitioners seek and were given appropriate levels of supervision advice and guidance during the decision making process?

6.3.1 In the main Practitioners did not identify domestic abuse concerns that they believed required support via supervision or managerial advice and guidance. Domestic abuse went unnoticed in the main and undisclosed in most instances of intervention. Even where there is a safeguarding prompt and it is a crucial element of supervision this case went unrecognised and unreported.

6.3.2 There were exceptions to this, where the ambulance service placed a marker flag relating to "risks to staff" there is no evidence that the flag used was appropriately risk assessed by the team leader. Nor was advice sought about the implications of the risk to Mrs A, a vulnerable adult living with Mr B. This was not acceptable and there is now a standard operating procedure in place to be utilised when applying risk markers. There is also concern that a safeguarding referral should have been made but wasn't in relation to a full time carer i.e. Mr B, being potentially under the influence of drugs and alcohol. The process for raising flags and considering the implications for the family of living with someone who presents a risk to staff should have triggered concerns for Mrs A and a fuller assessment of her needs and risks.

6.3.3 The role of the supervising Sergeant of the Police Domestic Abuse Officer (DAO) was felt by the DAO and reviewing Officers to be too wide. The availability of advice and supervision would be enhanced if there was a dedicated Sergeant for domestic abuse who would have an increased opportunity to know the cases and follow up any concerns.

6.3.4 It is recognised that line managers have a responsibility to be pro-active in terms of the management of domestic abuse cases and ensure that there is adequate support and challenge to assist Practitioners to be more questioning, pro-active and to have the confidence to intervene and involve other Agencies as necessary.

6.3.5 Access to clinical supervision in relation to Community Health Practice needs to be strengthened. GP's are independent and do not receive clinical supervision at all unless they seek it themselves. In child safeguarding Doctors are employed to specifically provide advice, support and training. There is nothing comparable for domestic abuse. However, all Doctors are required to act within the limits of their competence and seek advice where appropriate. Whilst in Hospital there was no escalation of concerns to involve senior decision makers even though the discharge plan lacked robustness.

6.3.6 Where in Adult Care staff did seek advice from principal Practitioners they did not clearly explain all concerns or share all of the information which meant advice was flawed. However, given the complexity of the case and lack of experience of staff principal practitioners should have probed deeper to assist staff to arrive at a defensible decision.

6.3.7 Where domestic abuse was recognised by the Probation Trust Officers, they discussed actions with line managers but were sufficiently empowered by their role to make decisions and act accordingly.

6.4 Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

6.4.1 In general there was limited evidence of management accountability for decision making, as senior Officers were not involved in the management of this case. For most Agencies, as there was no recognition of DA there was no expectation of escalating issues to senior managers or other organisations. Also, many of the practitioners involved were capable of working autonomously, undertaking assessments and making decisions. Where senior managers were involved it was due to routine involvement at relevant points or via the supervision process e.g. EMAS sought support of line management and the Police in an appropriate and timely manner following the incident that caused Mrs A's death. One Agency recorded that the review had identified an apparent lack of involvement and leadership by senior Officers whose role it was to take a strategic lead for

Policing the area in which Mrs A and Mr B lived. Also, in accordance with Police force policy and procedure the senior manager should have ensured that a Multi-Agency approach was taken and all relevant information shared.

6.4.2 There was evidence of some involvement and information sharing between organisations e.g. Police, Probation and Social Care. However, it is one of the short comings of the management of the case that Agencies worked in silos and did not involve others to arrive at a Multi-Agency approach.

6.4.3 In Adult Care it was felt that there was poor communication between professionals. Principal Practitioners rely on staff to raise issues as they occur. However, it was discovered that in this case the managers were not given all the facts therefore decisions made were flawed and advice given and actions taken on occasions were inappropriate and not in line with policy e.g. suspending direct payment.

6.4.4 In 2007 assumptions were made by the CPN visiting Mr C that the right people involved in the safeguarding vulnerable adult process meant that the right decisions were being made in the case. However, there was evidence of poor information sharing and the CPN that was involved was not consulted or involved in any Multi-Agency decision making. The Practitioner felt unable to make a professional challenge feeling that the power of action was out of their sphere or influence. In 2008 LPFT appointed a strategic lead for safeguarding. Safeguarding adults and escalation of concern to support professional challenge are well embedded in the trust.

6.5 Did the Agency have policies and procedures for DASH risk assessment and risk management for DV, victims or perpetrators and were those assessments correctly used in the case of this victim and her perpetrator? Did the Agency have policies and procedures in place for dealing with concerns about domestic violence?

6.5.1 Lincolnshire Police introduced the DASH risk assessment when they introduced a new domestic abuse policy in 2010, prior to that they used the P548 format.

The review identified the quality of the Police assessments varied and some were poor assessing the risk as medium when reviewing Officers felt with hindsight it should have been high. A recent force audit in 2013 shows the problem of incompleteness and inaccuracies in DASH assessments and this issue is subject to a recommendation.

6.5.2 The repeat victimisation policy was not used to assist in the development of any risk management plans in this case. It should have been. The recognised good practice of the repeat location / victim for domestic related crime bulletins sent to the Detective Chief Inspectors to raise their concern is limited in circulation. The reviewing Officers considered these should go to senior management teams so that they can take a strategic lead in targeting input.

6.5.3 ULHT did not have a specific risk assessment and risk management policy and procedure for DA which is subject to recommendation from this review. The City Council Housing role is one of awareness of indicators and referring on to statutory Agencies for assessment; they are addressing areas for improvement in policy by participating in the Lincolnshire Domestic Abuse Strategic Management Board and have adopted the domestic abuse charter which sets out ten standards, the City Council is working to ensure compliance with these.

6.5.4 The ambulance service do not complete DASH but have a dynamic risk assessment and have introduced a specific domestic abuse policy in 2012 and are currently training staff in line with this policy. AC does not have a specific DA procedure for dealing with concerns. Multi Agency Adult Safeguarding Procedures would be used, with the Safeguarding Team following the Multi Agency MARAC operating protocol. It is a recommendation of this review that LCC AC develop and implement a specific DA policy for their staff to understand what is required for their particular practice.

6.5.5 All other Agencies have policies and procedures in place that cover domestic abuse. However, there were various comments about lack of awareness of MARAC which is subject to recommendation. Also, it was questioned how well policies and procedures are understood and are imbedded in practice. Of course

abuse has to be recognised before policies are utilised and for many Agencies it was not recognised in this case.

6.5.6 LPFT has a specific adult screening tool which requires staff to ask the user if they have experienced sexual or emotional abuse at any time in their life. This is considered to be good practice. However, no staff had asked these questions specifically in this case although did ask Mrs A directly whether she felt at risk from Mr B which she denied. There is now evidence that the screening tool is embedded into practice across both LPFT's Mental Health and Drug and Alcohol Services, staff ask the question at every assessment.

6.5.7 The Chief Executive of the National Charity Standing Together Against Domestic Violence visited Lincolnshire in 2012 to carry out a report on behalf of the Home Office on Lincolnshire Domestic Abuse Services and Partnership Working. This Co-ordinated Community Response To Domestic Violence In Lincolnshire report identified that the processes were operating effectively. There were many positive comments about how Agencies were approaching DA e.g. it was recorded that LPFT provided the best example of activity for such a Health Agency in the report writers experience. The report also identified some areas for improvement to assist Lincolnshire to develop services. It was noted that DA partnerships understood where there were gaps in their work and consideration was being given to how to fill the gaps e.g. Despite the evidence that LPFT has robust embedded policies and procedures around assessment and management of domestic abuse for victims, a gap in process relating to perpetrators has been identified. LPFT has recognised that if there is a disclosure or awareness of service users being perpetrators of DA the Trust nor the multi agency policy has an agreed process that can be accessed when it is not safe to contact the victim to risk assess. This is subject to a recommendation.

6.6 Were these assessment tools procedures and policies professionally accepted as being effective? And, was the victim subject to MARAC?

6.6.1 Where assessment tools, procedures and policies exist they are professionally accepted as being effective. Most reflect national guidance and recommended

good practice and are tools used across the Multi-Agency Domestic Abuse Process in Lincolnshire.

6.6.2 EMAS are working with the regional MARAC co-ordinator to consider introducing an ambulance specific CAADA risk assessment. Currently they share information but do not refer to MARAC.

6.6.3 Although the procedures and policies were sound they were not always implemented effectively and the victim was never referred to MARAC. Many Practitioners failed to recognise abuse. In AC not all key workers were aware of procedures for MARAC. An outcome of the review will be a recommendation for a domestic abuse procedure note to go out to AC staff to ensure that they comply with joint protocols and information sharing.

6.7 Is there evidence that historical information was analysed to provide a holistic assessment of risk?

6.7.1 There is evidence within the records and from interviews to say that assessments of risk were completed from the information available to staff at the time. Whilst some Agencies had historical information there was evidence it was not analysed, in every case, to provide a holistic assessment. The Police review noted that there were examples of real concerns for Mrs A in records, however incidents were dealt with in isolation and therefore no attempts were made to seek a Multi-Agency solution or to refer to MARAC or the Adult Protection Committee.

6.7.2 The City Council and AC identified that the full case history was not routinely explored and this issue is subject to recommendation. AC relies on the hazard warning process or information gathered at contact. The absence of a hazard on Mrs A's electronic file played a significant part in how the case was managed and defined how staff viewed the case resulting in inadequate risk assessments.

6.7.3 It became apparent during the reviews that LPFT had a record that Mr B was a known risk to Mr C a previous user. However, this was not apparent to staff at

the time. Electronic records across different people are not linked due to the Data Protection Act. No access to records of deceased persons in these circumstances would be considered appropriate.

6.7.4 Records of different Trust Services are not accessible (so the information held in mental health history was not obvious to LDAS), unless specifically requested which they had no evident need to request as the singular Mental Health Assessment was not highlighted by Mr B during his assessments some years later.

6.7.5 There was nothing in the GP records that was considered could have informed risk. However, the fragmented nature of the NHS, means patients records are held in numerous places. A single electronic patient record would be a solution to this issue but is not currently planned by the DOH.

6.7.6 Victim support systems did not allow identification of repeat victims if there was even a slight difference in spelling of names or addresses etc. The new CMS system will make that much easier for victim support.

6.7.7 The Probation Trust effectively analysed past records and historical information on risks to the victim, together with inter Agency communication (including Police information that did not proceed to conviction) to complete a full risk assessment and referral to Adult Care about concerns.

6.7.8 Despite not having awareness in this case LPFT frequently works with service users whereby there is awareness or disclosure of them being perpetrators of domestic abuse. The Trust does not currently have a standard response in the form of policy or procedure to deal with these scenarios and they are currently dealt with on a case by case basis with advice from the Trusts Safeguarding and Mental Capacity Team as and when they arise. Nor, does the Multi-Agency arrangements currently have an identified and agreed process that the Trust can access when it is not safe to contact the victim to risk assess. This is subject of recommendation.

6.8 Did the Agency comply with domestic violence protocols agreed with other Agencies including any information sharing protocols?

6.8.1 Police are a key partner in terms of Multi-Agency domestic abuse protocols and have an information sharing agreement. There was some inter Agency communication but this review has highlighted a lack of information sharing and missed opportunities for Multi-Agency working e.g. no referral to MARAC or MAPPA or information shared under Lincolnshire Adult Protection Committees Multi-Agency Protection of Vulnerable Adults policy.

6.8.2 Several Agencies confirmed that as DA was not recognised for reasons outlined elsewhere in the report, there was no consideration of using domestic abuse protocols. Episodes were seen in isolation. Information was sometimes embedded in records e.g. LCHS information was linked to the dressing of Mr B's legs and therefore it was not easily visible. This has resulted in a recommendation for a "chronology of significant events" within the adult electronic health record.

6.8.3 Housing was alerted by Police that Mr B had history of drug abuse and violence towards the Police. An alert flag was used to advise staff they should not visit alone. However, there was no consideration of the impact of the violence on Mrs A or Mr C. This issue was replicated in other Agencies.

6.8.4 If comments made by Mrs A whilst in Hospital had been explored further, it may have led to concerns being raised and the use of protocols to share information to provide a Multi-Agency safeguarding plan to protect Mrs A.

6.9 Was inter and intra Agency communication efficient and effective?

6.9.1 Generally Agencies worked individually without any significant or effective inter Agency communication. Where communication did take place it worked efficiently and effectively e.g. between Probation, AC and Police in relation to concerns being shared that led to a speedy arrest of Mr B. Also between ambulance crew and the Police and hospital on the 12th October 2012.

6.9.2 However the lack of inter Agency working and information sharing was seen as a key failure in this case. There is evidence that Practitioners failed to share intelligence gathered during their involvement with other professionals e.g. Adult Care to Health and Addaction, Police to Adult Care. Inquiries with other Agencies may have identified potential risks associated with Mrs A or at the very least that there was a previous case history that needed to be taken into consideration.

6.9.3 The review also identified issues in relation to intra Agency working that had the effect of causing a breakdown in essential communication. E.g. there was a misunderstanding about process in the Police about the PPU message group. The force control room understood that once the qualifier code for domestic abuse was applied to the incident log the system automatically placed the incident on the PPU message group. Further enquiries revealed this was not the case and the incident had to be manually added to the PPU message group. There was evidence of incidents about which the DAO had not been notified. The problem was brought to the attention of the head of PPU immediately as a result of the review and remedial action has been taken.

6.9.4 The internal communication about hazard warning flags was problematic for the ambulance service and Adult Care. AC did not mark Mrs A's electronic file thereby failing to alert staff that there had been risk concerns. The ambulance service failed to pass onto ambulance crews visiting the address the concerns about Mr B's behaviour. This meant that the opportunity to make a full and holistic assessment was undermined.

6.9.5 The issue of professional curiosity is a theme throughout the review e.g. had some agencies exercised greater professional curiosity about Mr B, a chaotic drug user acting as carer for his mother this may have resulted in further investigation and inter Agency communication in relation to the appropriateness of Mr B as a carer.

6.10 What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

6.10.1 There were numerous opportunities for many of the twelve different Agencies involved with this family to undertake assessments and make decisions. Each Agency has identified these in their IMR's. Rather than list them all, what is important is to capture the learning identified from the process and what needs to change. Due to Mrs A's and Mr B's lack of engagement Agencies such as Addaction and Victim Support consider that they did not have the opportunity to undertake a full assessment although Addaction acknowledge they could have referred onto others.

6.10.2 Some of the assessments were well informed and professional e.g. the Probation Service in 2007 and 2009 where timely assessments were made in the light of information and inter Agency exchanges were made using an accredited assessment tool. The assessment in the community by the CPN on the 1st October 2012 was thorough but despite probing questions Mrs A did not disclose any abuse.

6.10.3 Other Agencies on occasions missed the opportunity to gather and share information and refer matters to partner Agencies for full assessment and possible Multi-Agency decision making e.g. the Police did not refer to MAPPA or MARAC despite a high risk assessment (and others that should have been high risk according to the reviewing Officers but were recorded as medium). Given the number and history of domestic abuse incidents this was a missed opportunity.

6.10.4 Most assessments and decisions could have been better informed and more professional if there had been greater information sharing and gathering, more probing questions, use of case history and exploration of the risks.

6.10.5 Mrs A could have been identified as a vulnerable adult and referred to the Adult Protection Process and Mr B could have been assessed as to his suitability to be his mother's carer but neither was.

6.10.6 Mrs A and Mr C were both the subject of mental capacity assessments at different stages. Mr C in 2007 and Mrs A in 2012. Certainly in the case of Mrs A she met the criteria to have the capacity questioned. There are a number of reasons why people may question a person's capacity to make a decision:-

- The persons behaviour or circumstances caused doubt as to whether they have the capacity to make a decision, somebody else says they are concerned about the persons capacity, or
- The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works and, it has already been shown they lack capacity to make other decisions in their life.

Following assessment it was considered Mrs A had fluctuating capacity and did not fully understand the risks of returning home from Hospital in relation to her physical needs. However, following a Best Interest Meeting involving her nephew it was agreed she would return home. Lincolnshire Safeguarding Adults Board introduced new multi agency policy and procedure in August 2013, alongside SCIE within this mental capacity is clearly defined and considered in relation to all cases of adults at risk.

Due to national concern about capacity issues, A Lords Select Committee was appointed to consider the issue of assessing capacity. The Committee reported in February 2014 that vulnerable adults are being failed, as key professionals are not aware of the Mental Capacity Act (MCA). The Committee recommends that an independent body is given general oversight to drive forward the changes in practice. It is clear this issue will continue to receive attention to improve practice across the country.

6.10.7 There was no specific risk of harm management planning by individual Agencies or jointly which was a Multi-Agency failure due to not clearly recognising the risks.

6.11 Did actions or risk management plans fit with the assessments and decisions made? Were appropriate services offered or provided or relevant enquiries made in the light of the assessments given what was known or what should have been known at the time?

6.11.1 Due to lack of engagement by both Mrs A and Mr B some Agencies were unable to make assessments and therefore develop action plans and risk management plans in response and contact ended without significant intervention. Other Agencies considered that due to a lack of identification of any abuse and assessments that failed to articulate risk, actions and services provided at the time were in line with what could be expected. On reflection some assessments were inadequate and therefore services offered were limited. Agencies generally did not formulate a risk management plan.

6.11.2 Whilst the Probation Trust did formulate a risk management plan which seemed appropriate and included liaising with others there was no mention of consideration of a referral to MARAC, which could have been explored further. The LPFT concluded that there was no further risks apparent despite active attempts to clarify and therefore on that basis decisions were reasonable and justifiable.

6.11.3 The CPN used Addenbrooks Cognitive Examination Revised (ACE/R). The score indicated further assessment. This was considered the correct course of action and further appointments were arranged. However, Mrs A died before they took place. Mrs A told the CPN that she was happy with everything, had lived at the address a long time and felt safe. She had good neighbours who kept an eye on her. She liked her carers and felt well supported by her family. The CPN specifically checked out the relationship with her son and she was positive about this.

6.11.4 The ambulance service recognised that whilst there were many incidences of appropriate clinical assessment and responses there were times when there was the opportunity to refer to others e.g. AC, which did not happen. Whilst with hindsight this was not good practice, at the time it would have been considered

acceptable. Alternatively on two occasions concerns did not lead to appropriate actions e.g. when the risk flag was placed on the property the concern was not translated to Mrs A as a vulnerable adult. Similarly on the 17th August 2012 the crew did not identify the unsuitability of Mr B as a drug user to be the main carer for a vulnerable adult.

6.11.5 The Police recorded that there was an absence of any formalised risk management planning. However, there was considerable action taken in line with recommendations made in the guidance provided by ACPO DASH risk management e.g. refusing Police bail. Mrs A, was said to be very articulate. Whilst she was not prepared to go to Court and give evidence against her son she wanted to help him and his drug addiction. The Police however did not refer on to any drug Agencies or liaise with those drug Agencies that were involved.

6.11.6 The Lincolnshire Adult Protection Committee Multi-Agency Protection of Vulnerable Adult policy states "all staff in all Agencies have a duty to report any concerns or evidence that they have of alleged abuse of a vulnerable adult". It is considered Police should have made a referral independently to Adult Care on the evidence available to them alone. It is often only by having all relevant information that a full picture can be seen and the full extent of abuse recognised. One piece of information is no more important than the next, it is how they all fit together to inform the risk assessment that counts.

6.11.7 LPFT considered that LDAS's risk management plan fitted with assessments and decisions made in relation to Mr B. There was nothing identified in risk to others or risks from others. Mr B indicated that Mrs A was one of "the motivating factors for him trying to stop using heroin and to stop using drugs". However, given the level of drug use Mr B acting as a carer for Mrs A, would inevitably be problematical. Potentially if practitioners had made further enquiries they may have gone on to query the appropriateness of Mr B being a suitable registered carer. Further investigation may have led to consultation with other Agencies, to potential referrals, carers' assessments or support for one or both parties. This in turn may have led to a different outcome.

6.12 When and in what way were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options, choices to make informed decisions? Was the victim sign posted to other Agencies?

6.12.1 There is significant evidence that Mrs A's wishes and feelings were ascertained and considered by a range of Agencies.

6.12.2 On many occasions Mrs A's views were obtained and respected by Police; although not always willingly. This related largely to her changing her mind e.g. about wanting Mr B to be prosecuted and kept away from her home then clearly requesting he return to live there as she wanted him to be her carer. There were many examples of this behaviour. At other times Mrs A's wishes were ascertained and did lead to a successful prosecution.

6.12.3 It is difficult to know whether the withdrawals of complaints were down to coercion from Mr B. Also, if Mrs A had been given choices and options for advice and ongoing support from domestic abuse Agencies, perhaps she would have been able to sustain her resolve to keep Mr B away. It is not unusual for victims of DA to retract their complaints in the light of coercion but also to believe that they were the one responsible for the incident and not the perpetrator e.g. "I need to get him help for his drug use".

6.12.4 The wishes of Mrs A were ascertained throughout contact with ambulance services and AC. However the potential risks were not discussed with her or the options available to mitigate those risks e.g. alternative living and caring arrangement.

6.12.5 Although Mrs A was starting to consider alternative care arrangements e.g. residential care. This followed discussions about whether her increasing care needs could be met at home and was not in the context of removal to a place of safety. As it was not considered that Mrs A was being influenced by pressure from people posing risks to her inherent jurisdiction was not considered. LPFT completed standardised assessments including a Manchester Care Assessment 65

(MANCAS65) an older adult risk profiling tool. A conversational approach was used to facilitate the "user's voice". Mrs A spoke positively about her neighbours and the environment in which she lived "she felt she got support from carers and her son when she wished to mobilise from bed". She was signposted on for further assessment e.g. CT Scan. No external referrals were identified and no concerns raised.

6.12.6 ULHT record that there were questions about Mrs A's capacity to understand and make informed decisions. Following assessment it was reported that she had fluctuating capacity and did not recognise the risks of returning home in terms of her care and her inability to live independently. Her wishes changed several times and she fluctuated between wanting to return home and wanting to live elsewhere. She did identify that she "no longer gets on with her son" which was a factor that went unexplored. A best interest meeting was held on the 10th July 2012 and after expressing concerns about the risks presented by Mr B as a carer her nephew asserted that he wanted Mrs A to go home and he would ensure that she got the appropriate care. This was the outcome of the meeting.

6.12.7 Some signposting did go on e.g. Addaction gave appropriate advice about how to stop her son returning to her flat. However, no Agency appears to have clearly informed Mrs A of the options and choices that were available to her in terms of DA or alternative care. She was not actively signposted to other Agencies other than by housing to OASIS Drug User Service. No effective safeguarding or protective input was forthcoming despite AC discussions with the safeguarding team Practitioner whose advice was in any event considered inappropriate. It is recognised that victims of DA can rarely be the drivers for the protection they require, which is an element of the cycle of psychological and emotional abuse. Domestic abuse victims often do not consider themselves as victims.

6.13 How accessible were the services for the victim and alleged perpetrator?

6.13.1 It was known that latterly Mrs A was not only housebound but largely bedbound and could not mobilise herself without assistance. She had broken her leg during

a trip to South Africa in 2011 but it is unclear what impact this had on her mobility. She also had significant heart and related breathing difficulties.

6.13.2 Services were accessible 24 hours a day 7 days a week in the case of Police, Addaction, ambulance, ULHT via telephone and other means. It would appear for a time, the telephone was disconnected for non-payment. This would have seriously affected Mrs A's ability to contact Agencies. It is unknown if she had a mobile phone. She had a Lifeline alarm fitted in August 2012 before her discharge from hospital which enabled calls for assistance if necessary e.g. in the case of a fall or other concerns by the user.

6.13.3 LPFT initially arranged for an appointment with Community Mental Health at the office base. When Mrs A did not turn up they quickly contacted her and arranged a home visit. Police and ambulance have both provided evidence of priority response times in terms of Mrs A accessing their services when she called.

6.13.4 No specific issues about accessing GP services were identified. Although housebound Mrs A did not request home visits. The GP responded to a request from the Occupational Therapist and home visited as required. Due to Mr B's failure to attend the GP's surgery to have the medical problem with his legs dressed, home visits by District Nurses was arranged to ensure he got the care he needed.

6.13.5 Mr B's access to services was marked by his failure to engage. Despite LDAS persistently trying to engage him in treatment he was discharged three times due to lack of contact as per commissioning guidelines. Mr B was transferred from LDAS to Addaction on the 29th March 2012 this was potentially a time of risk for Mr B due to further risk of disengagement. However transfer was via a carefully planned transition route from one service to another. The premises remained the same and steps were taken to ensure information sharing procedures were followed.

6.13.6 Despite all the services involved with this family, and given that some Agencies were aware of domestic abuse, there is no evidence that specific domestic abuse services were offered or made available to either Mrs A or Mr B. The possible effective outcomes had they been, will never be known.

6.14 What was known about the alleged perpetrator? Had MAPPA been considered?

6.14.1 It was known by many Agencies that Mr B was misusing substances to a significant degree. Many attempts had been made to engage him in treatment. However, due to his lack of compliance no meaningful assessments or interventions took place by drug Agencies. His health was poor and he suffered abscesses and ulcers on his legs at the sites where he injected drugs. The GP knew that he was dependent on drugs and alcohol and was hepatitis B and C positive. Despite infected wounds he continued to inject heroin and amphetamine. Also he had attempted to obtain his mother's controlled drugs by deception. The GP practice did not report this to the NHS Lincolnshire Accountable Officer for Controlled Drugs. Had this been reported it is likely the issue would have been discussed with the Police Controlled Drugs Liaison Officer. This in turn may have provided a trigger for greater assessment of this family.

6.14.2 Mr B was well known to Lincolnshire Police having twenty seven convictions for a total of fifty five offences. His first conviction being on the 17th August 1988 when 14 years old for criminal damage and dishonesty. The last offence before the conviction for murder of his mother in October 2012 was on the 20th December 2011 for an offence of handling stolen goods. He had been convicted of a range of offences often acquisitive but also some for violence e.g. the affray and endangering an aircraft in 1998. There was a flag on the property indicating he was a risk to Police. Ambulance, Adult Care and Housing all had alert flags providing a warning about Mr B. Those Agencies that are not involved in criminal justice did not consider they had sufficient information about risks to others to refer Mr B to MAPPA. MAPPA was known about and was well established in Lincolnshire throughout the review period.

6.14.3 The reviewing Police Officers, with the benefit of hindsight, consider Mr B could have been referred to MAPPA as being eligible under category 2 and 3. Category 2 is where an offender is sentenced to a period of 12 months and over imprisonment for a violent offence. Category 3 is where the risk posed by the individual presents a high likelihood of causing serious harm to the public. All those referred to MAPPA are considered for active Multi-Agency Management.

6.14.4 Evidence nationally would suggest the Probation Trust is the main referrer to MAPPA, although it is open to other Agencies to refer. At no point during Probation contact with Mr B was he considered, for referral to MAPPA, for either level 2 or 3 registration. Even with hindsight this is considered appropriate practice at that time given the absence of presenting risks of serious harm. Mr B was assessed as a medium risk of serious harm. Serious harm is defined as "a risk which is life threatening and / or traumatic and from which recovery whether physical or psychological can be expected to be difficult or impossible. Whilst Mr B's violence was known about no Agency at that time (2007 to 2009) actively considered it met the serious harm threshold, which would make Mr B one of the critical few in Lincolnshire to be managed via the Multi-Agency route provided by MAPPA. At that time that would appear reasonable.

6.14.5 The Police Domestic Abuse Officer, the CPS lawyer and Mrs B's nephew's wife in 2007 did consider risk was increasing and it is recorded as such. This was, evidentially, at the high point of the abuse. However, the killing actually happened some 5 years later at a time when the Courts, the Police and Probation had less or no involvement. No Agency identified that risk was increasing in 2012 and that the outcome would be serious harm. With hindsight the reasons for this may have been less reported physical assaults due to the fact that Mrs A was more isolated, bed bound, suffering ill health and possible dementia. This increased the likely impact of the risks Mr B posed to Mrs A.

6.15 Had the victim disclosed to anyone and if so was the response appropriate?

6.15.1 The victim disclosed to Police Officers, Police staff, relatives, private carers and to Probation Officers on a number of occasions particularly between October 2006 and October 2008. There is also information to Addaction that Mr B had caused damage to her flat. The ambulance crew attending on the 7th March 2007 were aware that Mrs A had been assaulted by her son. She had been hit in the face causing bruising and swelling to the left eye.

6.15.2 Mrs A did indicate to Adult Care and hospital staff in 2012 that she wished to be away from Mr B and was considering alternative care arrangements. Why this was the case could have been explored more fully. She did not disclose anything specific to the other Agencies.

6.15.3 Referrals to other Agencies were made in 2007 and 2009 but were not made at other times. This was largely as Agencies latterly did not recognise domestic abuse and Mrs A was not specific about being at risk.

6.15.4 Responses from Agencies even where Mrs A disclosed abuse in 2006 / 2008 and later when she was assaulted in 2010 did not include information about or referral onto a Domestic Abuse Support Agency or to MARAC or as a vulnerable adult in need of protection to the adult protection arrangements. To do so may have elicited a Multi-Agency response and positively affected outcomes.

6.16 Was the information recorded and shared where appropriate?

6.16.1 All Agencies had recorded information where appropriate. However, the quality and standard of the information recorded varied considerably. One Agency referred to poor record keeping and others that recording and communication with other Agencies had been handled "supremely well" on occasions. Improvements in recording is subject to recommendations by some Agencies. There is clear evidence that information was not, in the main, shared sufficiently

either internally e.g. with specialist safeguarding teams or externally with other Agencies.

6.16.2 The Police found that some relevant records had been destroyed in 2007 during a "back record conversion" from paper to electronic records and only a summary was available. However, the command and control incident logs were still intact.

6.16.3 LCHS also found that not all information was recorded in the patient electronic file and therefore was not available to all Practitioners.

6.16.4 Numerous opportunities were missed by several Agencies to review the recorded history of the case and to share with others. This led to a lack of formal Multi-Agency assessment, planning and intervention.

6.17 Were procedures sensitive to the ethnic cultural linguistic and religious identity of the victim, the alleged perpetrator and their families?

6.17.1 Both Mrs A and Mr B were born in South Africa and had roots in that culture. Mrs A continued to visit South Africa until her death in 2012 having spent 11 months there in 2011. Mr C was Polish. The Police recorded that there was, on occasions, difficulty in understanding Mr C due to language differences however there is no evidence to suggest this had any impact on services offered or received.

6.17.2 Most Agencies had ethnicity and cultural background recorded as part of the assessment process in line with policy and procedure. The GP's surgery did not have ethnic status recorded which did not meet Agency expectation.

6.17.3 Mrs A's and Mr B's lifestyle choices were recognised as unconventional and the home support workers adapted services to take account of their late eating and bedtimes. Both Mrs A and Mr B identified themselves as Roman Catholics, Mrs A stipulating that she was an active Roman Catholic.

6.17.4 Latterly Mrs A was housebound and virtually bedridden, however, an appointment was made for her to visit Community Mental Health at their work base. When she did not attend alternative arrangements to better meet her needs were made, other than this there was no evidence of any unfavourable access to services due to issues of diversity.

6.18 Was consideration for vulnerability and disability necessary? Was the victim a "vulnerable adult" in line with the official definition of a vulnerable adult?

6.18.1 With the benefit of hindsight Mrs A was considered to be a vulnerable adult in line with the official definition by most Agencies who had knowledge of her circumstances. The definition of a vulnerable adult from the 1997 consultation "who decides" issued by the Lord Chancellors Department "is any person aged 18 years and over who is or may be in need of community care services by reason of, disability, age or illness and who is or may be unable to take care or unable to protect him or herself against significant harm or exploitation".

6.18.2 Mrs A was disabled by ill health involving heart and respiratory disease. She was said to be housebound and bedridden, she was dependent upon her son Mr B for her care and her support. However at the time Agencies failed to recognise Mrs A was vulnerable in terms of being unable to protect herself and she was not seen as a person at risk of harm or in need of safeguarding. Most felt she had capacity to understand and make reasonable decisions.

6.18.3 Police considered their lack of referral of Mrs A to Lincolnshire Adult Protection Committee in line with policy meant it was an opportunity missed to consider a Multi-Agency approach and develop a protection plan.

6.18.4 Following assessment by Adult Care the City Council made adaption's to Mrs A's house to assist her with her difficulties surrounding her lack of mobility.

6.18.5 Mr C could have been considered to be a vulnerable adult by way of age, physical health problems and the fact that he was in receipt of community care.

However, the right Agencies were already involved and were aware of his vulnerability i.e. Police and Adult Care.

6.19 Have there been any other similar cases in recent years and are there any lessons that could have been learnt?

6.19.1 Most Agencies considered from their experience and view point that there had not been any other similar cases in recent years. The Police, Adult Care, EMAS and LPFT did identify cases where there had been investigations, learning and actions plans.

6.19.2 The Police identified a similar case where a woman died of stab wounds in 2010. The investigation found some Officers failed to complete risk assessments and Control Room staff wrongly coded a number of incidents as anti-social behaviour rather than DA. This combination of factors led to specialist DAO's being unaware of a pattern of increasing harassment and of an opportunity to identify an escalation of risk to the victim was missed.

6.19.3 Many of the issues identified by the IPCC investigation are the same as or certainly reflect the issues identified during the course of this IMR e.g. supervisory responsibility regarding DA incident management, the completion of the P548 risk assessment and completion of the incident qualifier. It is apparent that the force continues to try and bring about improvements in practice but further work is still required. There was only one incident in the case of Mrs A and Mr B that took place after the review into the similar case. Therefore, it is not considered that lessons learnt could have impacted on the management of this case.

6.19.4 EMAS have been involved with a case from another region that recognised the need to consider the role of the carer and whether the carer had been assessed as appropriate. This re-enforces the ongoing work with EMAS in raising awareness around the role of the carer.

6.19.5 AC identified there has been some complex and serious case reviews which identified similar lessons as in this review. Action plans were developed and implemented as a result, however similar issues have remained and have been identified during this review. This indicates that improvements are needed to strengthen organisational learning and management oversight, to ensure practice meets the standard. The recommendations relevant to this case are related to risk assessment, clarity of role in key meetings, the quality and requirement of recording , quality audits of practice, ensuring staff are appropriately skilled and competent, improving information sharing and management accountability for practice.

6.19.6 LPFT recorded that there was a similar case in April 2011 where a man under the care of the Trust presented at Swansea Police Station stating that he had stabbed his mother in Lincoln. There were three recommendations surrounding:-

a) risk assessment
b) carers assessment
c) quality of documentation.

All areas of improvement have been completed and signed off. Whilst these issues are areas for improvement in this review, they are not specifically so for LPFT.

6.20 What effective practice can be passed to other organisations?

6.20.1 In terms of the Police the repeat location / victim for domestic related violent crime bulletin which identifies locations of victims who had been the subject of two or more incidents of domestic abuse in a twelve month period is effective. The bulletin that brings locations and victims to the attention of the neighbourhood policing teams and senior officers is considered by the author to be good practice. It has the potential to increase awareness and maintain focus in order to protect and encourage the sharing of information. Also, the practice of attaching information about domestic abuse to the payslip of all staff in order to disseminate the message would seem to be a positive practice.

6.20.2 The way the ambulance crew dealt with the final incident on the 12th October 2012 in identifying quickly the likelihood of DA and the fast response given in alerting others was a good example of effective practice.

6.20.3 The City Council Housing Department made efforts to contact Mrs A's GP when they had concerns regarding Mrs A's moving back to the family home. It was considered that in a practical way the family home would not meet her needs as well as her adapted property. Although there was no recorded response from the GP the practice was good.

6.20.4 LPFT has a safeguarding screening tool which is supported by the expectation that every service user is asked whether they have experienced abuse of a physical, sexual or emotional nature. The purpose is to ensure early awareness of the risks the service user may face which in turn should create earlier opportunity for intervention to protect where necessary.

6.20.5 Probation highlighted significant attempts to share information and communicate with staff in other Agencies, sometimes within minutes of becoming aware of problems. This was also considered good practice.

6.21 To what degree could the homicide have been accurately predicted and prevented?

6.21.1 There are differing views identified in response to this question depending on the information that was available to the Agency.

6.21.2 As far as the Police are concerned if the homicide had taken place at any point between October 2006 and 2009 the homicide could have been predicted. During this time sixty three of the sixty four reported DA incidents involving Mrs A and Mr B took place. The reviewing officers therefore concluded that the homicide could have been predicted to a high degree and was therefore possibly preventable at this time.

6.21.3 However since 2009 there has only been one other recorded incident of DA on the 10th November 2010. The risk was seen as standard but the reviewing officer felt it could have been graded higher. Also, the incident of the 17th August 2012 when it was alleged that Mrs A fell out of bed and Police were required to force the door for the ambulance crew was not considered as DA. Given the history the incident should have received much closer scrutiny.

6.21.4 Adult Care considered that an assault against Mrs A by Mr B when under the influence of drink and drugs was predictable given that it had happened before. However Mrs A's increasing vulnerability due to her deterioration in health made it likely that the consequences of any assault would be more serious.

6.21.5 Similarly Probation had assessed Mr B's risk of serious harm as medium. The risk was seen as hitting, punching, kicking his mother including in the face and head, damaging of her property and verbal assault. There was no evidence of high risk of serious harm which would have included risk of death or serious injury. The risk was last assessed in 2009, 3 years before her death. There may have been a different assessment if it had taken place in 2012. However, this will remain an unknown.

6.21.6 Other Agencies generally considered from their perspective the homicide could not have been predicted or prevented given what was understood about Mrs A's and Mr B's relationship. Mrs A had denied any risk issues from her son when asked directly by a Community Mental Health Practitioner. Several Agencies were unaware of any history of abuse, and did not identify any of the triggers of domestic abuse being present. Some Agencies viewed the relationship as mutually supportive.

6.21.7 The review highlights the facts that Agencies work individually and in silos, they were not integrated and did not work together to arrive at a shared risk assessment and risk management plan. The assessment, management and possible outcome may have been different in terms of prediction and prevention, had information been shared, the full history of the case considered and staff's

awareness heightened leading to a Multi-Agency response and integrated approach.

7 Lessons learned

7.1 Despite all Agencies but two involved with this family having comprehensive domestic abuse policies and procedures, the understanding and implementation of procedures varies amongst practitioners. Practice fell short of the standard, on occasions and more work is required to ensure professionals are aware of the DA policy, understand their role within the process and that the Agency expectation of action becomes embedded into practice.

7.2 There was a lack of recognition and identification of domestic abuse by many Agencies. The failure at times to correctly identify and code the incidents by the Police meant that the magnitude and regularity of abuse was not clear. There was some confusion as to the process relating to the communication of DA incidents to the Police PPU for the attention of the DAO. This was brought to the notice of the head of PPU for immediate attention to rectify and action has been taken.

7.3 Police force policy advocates firm and positive action when dealing with DA incidents and encourages Officers to arrest offenders and pursue prosecution. However, the practice in this case was variable with occasions when the Prosecution was discontinued before it got to Court or abandoned when no evidence was offered. The outcome was often influenced by Mrs A's withdrawal of complaints. Force policies are clear that prosecution should be continued even without the support of the victim wherever possible.

7.4 There was evidence of incidents where Police investigations were not given the level of priority and care required to bring about a positive conclusion e.g. allegations of theft and assaults that were not pursued. A more robust approach may have resulted in more arrests and convictions providing a clear picture of abuse and giving a message to Mrs A that she was supported and to Mr B that his

behaviour was unacceptable and would not be tolerated. It may also have prompted referral for a Multi-Agency approach e.g. MARAC.

7.5 Leadership is crucial to having successful DA services and outcomes. A strategic approach with clear priorities and ensuring practice adheres to policy is fundamental and has been identified for improvement by some Agencies.

7.6 Supervision and the role of principal Practitioners and Line Managers in identifying and responding to a domestic abuse is important to provide the objective professional challenge, support and quality assurance required and must be strengthened. Where there are safeguarding specialist teams staff must be encouraged to make referrals rather than ask for informal advice which may not involve sharing all the information and concerns that are available. This undermines a robust safeguarding response as the full facts are not being assessed.

7.7 There was evidence that there was significant historical information available on this family that was not researched, analysed and taken into account during the risk assessment process e.g. history of domestic abuse and vulnerability. Incidents were dealt with in isolation and opportunities to communicate with and involve other Agencies and seek a Multi-Agency solution were missed e.g. following reported abuse in 2008 / 2009. It is important in reaching a full analysis and assessment of risk and need that all information is gathered, considered and taken into account in arriving at a defensible decision. Not all decisions were defensible in this case.

7.8 There was a failure of Practitioners to see the accumulative picture and significant events were buried in day to day recording. Events were seen in isolation of each other.

7.9 There was a lack of professional curiosity on occasions where staff heard concerns e.g. Mrs A not wanting to return to live with her son but further probing questions were not asked to clarify the situation, possibly uncover abuse and inform assessments. The presenting issues were willingly accepted by

Practitioners rather than exploration of the underlying issues to arrive at an in-depth assessment. The presenting issues became the focus of action taken and decisions made e.g. cleaning the home and removing beer cans rather than the impact of the drinking on the care of Mrs A.

7.10 Risk assessments were inconsistent in terms of quality across the range of twelve Agencies involved. Risk levels attributed to them were also inconsistent. Most assessments failed to articulate the risks often focusing on environmental issues e.g. moving the bed downstairs rather than fully exploring the risks provided by the relationship. Whilst most of the Police involvement took place between 2006 and 2009, audits of practice undertaken in 2013 indicate many of the same errors, omissions and inaccuracies identified still exist.

7.11 There was a lack of any formalised risk management planning despite some Agencies being aware of domestic abuse. There were no referrals to MARAC in 2008 / 2009 when Police and Probation identified concerns.

7.12 MAPPA was not considered, although it is unlikely given that his risk was seen as medium of serious harm that he would have been considered as suitable for MAPPA.

7.13 Mrs A and Mr C were at different times recognised as vulnerable adults and met the definition. However, they were not identified as requiring referral onto the Lincolnshire Adult Protection Committee for a safeguarding assessment and protection management plan. This was a missed opportunity for a co-ordinated strategy and for professionals to consider together and challenge each other in relation to this case. Whilst presenting issues were the subject of concerns discussed with Mrs A the potential risk for her living with Mr B were not discussed in detail with her, nor were options available to her to mitigate the risks explored with her e.g. contact with Domestic Abuse Agencies.

7.14 At times Mrs A's capacity to make informed decisions was questioned e.g. when she was in hospital in June to August 2012. Assessments identified fluctuating capacity possibly linked to an acute medical condition. Whilst she appeared

unaware of the risks of returning home, in terms of her ability to live independently with support, there was no formal action taken to provide a safety net. This case has highlighted the complexities in the practice of assessing capacity.

7.15 It must be remembered by all practitioners that risk assessment is not a one off process but needs continuous re-evaluation with every significant event. Dynamic factors such as increased financial difficulties, changing relationships and ill health need to be taken into account on an ongoing basis. It is these factors that can increase the risk of harm.

7.16 Despite awareness of the fact Mr B was a chaotic intravenous drug user and alcohol abuser Mr B's suitability as carer for Mrs A was not questioned. An assessment was not offered or undertaken. Greater professional curiosity and assessment may have uncovered his lack of suitability and the risks he presented to Mrs A and enabled him to identify pressures for himself involved in the role of carer. In turn this may have enabled appropriate interventions to provide support.

7.17 The quality of recording across Agencies was variable in terms of accuracy and relevance. There was evidence of poor recording that requires improvement. There was a particular issue in health regarding the storing and sharing of information between teams, but on different electronic recording systems. Patient records are held in numerous places. A single electronic record would be the solution to this issue but is not currently being planned by the Department of Health. As a result, practitioners will have to make the effort required to access all systems to gather the information available to arrive at a holistic assessment. Some Agencies identified information detail had been lost when records were transferred from paper to electronic systems.

7.18 Agencies used a variety of flagging systems to warn staff about risks and concerns in this family. The Police used the critical register to good effect. However, generally the process of flagging hazards was insufficient and largely ineffective. Where there was a flag it was not always shared with frontline staff to assist their

intervention. Where the flags were recorded within the system was somewhat ad hoc e.g. there was a warning about Mr B on Mrs A's AC paper file but it did not appear on the electronic file. The absence of the electronic hazard played a significant part in how the case was managed in the Agency and in how staff viewed the case.

7.19 The emphasis of the hazard flag was to alert staff to the risks presented by Mr B e.g. his potential for violence and that staff should not visit alone. Staff safety is extremely important however there did not appear to be any lateral thinking about the implications of this and the risks for Mrs A and Mr C as vulnerable elderly dependent parents. AC withdrew services at one point due to the risks for staff. However, there was still the option to keep a professional watching brief which was not done and was an omission.

7.20 Whilst Agencies have undertaken domestic abuse training for staff there is a need to constantly review and improve the training available particularly around triggers for identification, assessment and referral to domestic abuse procedures. Particular attention needs to be given to how the learning arising from serious case reviews and DHR's is disseminated and incorporated into processes and changes in individual practice.

7.21 The NHS recognised the effectiveness of child safeguarding procedures i.e. having designated named Doctors and Public Health Professionals to advise and assist. It was suggested that this system could be replicated for DA, however, the implication for cost and staffing would need to be considered and allowed for.

7.22 AC noted that their case allocation process needs to be reviewed to ensure Practitioners with the appropriate level of experience and competence are allocated appropriate cases. The process of self allocation at the hospital must be reviewed. It is recognised that the right people doing the right job is critical to the right outcomes. Cover arrangements when staff leave jobs or are off work sick, need to be reviewed to ensure there is appropriate handover and understanding of the risks involved with complex cases.

7.23 The direct payments process by AC to individual service users should only be suspended following preliminary discussions and when a risk assessment has been undertaken to consider the full implications for the individual's welfare of such action.

8 Conclusion

8.1 The mother / son relationship between Mrs A and Mr B had recorded difficulties for many years and since Mr B's childhood. As early as 1988 Mrs A had sought assistance from Social Services to manage her son, asking that Mr B be taken into care of the Local Authority as she was unable to control him.

8.2 Despite the problematic relationship it was recorded in a psychiatric report on Mr B in 2004 that whilst he did not share a good relationship with his step-father he had an excellent relationship with his mother. It was also noted that the psychiatric assessment was one of a personality disorder with impulsive and dissocial traits.

8.3 Throughout the period of the review, it is noted that even when Mrs A was the victim of Mr B's instrumental domestic violence she continued, in the main, to prioritise Mr B's needs to have help with his drug addiction over and above her own need for safeguarding and protection. It would appear other than the immediate time following an incident of abuse she did not see herself as a victim. In the main it would appear Mrs A saw the violence as a feature of her relationship with her son, which she possibly felt she had managed over the years and could continue to manage. This in turn may have given professionals involved a false assurance which they relied upon rather than considering the underlying issues and concerns.

8.4 Mr B had a longstanding and significant drug and alcohol problem which in the main dominated his life. It would appear that many of the triggers, motivators and influences for the abuse of his mother and step-father prior to his death in 2010 were linked to demanding money to fund his drug and alcohol use. When it was

not forthcoming from his mother records have shown he would punch and slap her around the head, pull her hair and kick her.

8.5 Mr B had a long history of both acquisitive and violent offending behaviour for which he had received many sentences of the Court including imprisonment and Community Supervision. In general Mr B was a non-complier with attempts to assist him to take responsibility for his behaviour and make the changes necessary to move forward without relying on drugs and alcohol.

8.6 Both Mrs A, Mr B and Mr C suffered poor health. Mr B had abscesses and ulcers on the sites where he intravenously injected. Mrs A had respiratory and heart disease and Mr C dementia and physical difficulties. Mrs A and Mr C became more dependent on Mr B to provide care for them in their own home. They were seemingly reluctant to have outside intervention other than carers that were known to them. The two carers referred to in the review were both of Polish extraction and it is suggested that they were acquaintances of Mr B who he met in Prison. The increasing lack of mobility experienced by Mrs A and Mr C meant they were increasingly vulnerable and could not easily escape Mr B's abusive outbursts.

8.7 From the information available there was clearly recorded domestic abuse on a very regular basis between 2006 and 2009 with sixty three of the sixty four DA incidents taking place at this time. The reporting of DA significantly declined after 2009 until Mrs A's murder in October 2012. Whether the actual incident of abuse declined or it was only the reporting of it that reduced is unknown. Several Agencies were aware of abuse at the time it was taking place. Despite some limited information sharing and the imposition of Court Orders to address Mr B's offending behaviour there was no significant Multi-Agency response in terms of joint risk assessment or risk management planning.

8.8 Mr B's non-compliance rendered any individual Agency e.g. Probation and Drug Agencies involvement ineffective. There was only a limited attempt to seek inter agency communication. There was a failure to put Mrs A and Mr C's needs at the centre of intervention and to ensure all that could be done was done.

8.9 Mrs A became increasingly vulnerable following her husband's death due to a lack of mobility and poor health. She was unable to take steps to protect herself and as she became bedbound her position as a likely victim became more dangerous.

8.10 With hindsight there was a clear pattern of abusive behaviour exercised by Mr B to exert power and control over his parents particularly his mother. It has been one of the unanswered questions of the review as to why reporting suddenly declined in 2009 when it is unlikely the abuse stopped. With the benefit of hindsight this may have been due to the fact that Mrs A moved from the family home for a period to another address, Mr B was subject to bail conditions to reside in East Grinstead and between January to November 2011 Mrs A was out of the Country visiting South Africa. At other times during the review period carers 1 and 2 resided with Mrs A and their presence may have offered some protection. Certainly on occasions they reported abuse and attempted to protect Mrs A and Mr C.

8.11 On discharge from hospital on the 14th August 2012, Mrs A had a Lifeline alarm fitted. At that time her phone had been disconnected, lack of access to a phone may have been significant in the reduction of reporting of abuse.

8.12 Latterly and after Mr C's death no Agency, despite the significant history of abuse appeared to recognise the possible risks of harm facing Mrs A from her son. As a result they did not institute the various policies and procedures relating to DA or vulnerability that may have led to actions to protect.

8.13 When asked directly about her safety Mrs A either did not recognise or did not raise issues of abuse or concern. Her short term memory was identified as failing and her capacity to make informed decisions fluctuated. Dementia was to be the subject of further assessment which may also have played a part in failure to identify concerns. Latterly her vulnerability was without doubt increasing as was her need for safeguarding. Mrs A's nephew's wife who had given her support and played a significant part in reporting abuse had apparently moved away in 2009. This may have played a significant part in increasing Mrs A's isolation and lack of support in reporting abuse. Her nephew, whilst declaring clear concerns about Mr

B's ability to care for his Aunt, was inconsistent in his resolve to ensure Mrs A's best interests were met. His assurances, linked with Mrs A's variable and unrecognised disclosures provided sufficient lack of clarity for staff not to identify concerns and share them with other Agencies.

8.14 Despite carers visiting twice a day the conditions within the home deteriorated. Finances were an obvious concern even though the nephew was said to be in control of Mrs A's finances.

8.15 Given that obtaining money for drugs and alcohol had been a trigger for violence from Mr B to Mrs A in the past, it is possible that the decision of AC to stop the direct payment without full discussion and assessment may have heightened tensions. There remain unanswered questions about how the direct payment may have been used during 2012 as whilst in hospital Mrs A did not appear to be aware that she was in receipt of it.

8.16 There are times when it is recorded that Mr B identified to others that his mother and step-father needed assistance in terms of their care. It is unclear how much of a pressure and subsequent stress this placed upon him and his relationships with them and what, if any, impact it had upon his abusive behaviour towards them.

8.17 The lessons learnt identify short comings and some failings in practice in this case. Had Mrs A's death occurred between 2006 and 2009 when DA appeared prolific this review may have concluded it was both predictable and preventable. However, the more recent lack of reporting of abuse by Mrs A and others, the lack of recognition of concerns by Practitioners and the lack of rigorous risk assessment and risk management meant Mrs A's death was not predictable. However, had her requests not to return home but to live in residential care been assessed and progressed together with full exploration of the risks presented by Mr B being her Carer, it is likely her tragic death may have been prevented.

9. Changes already made by Agencies

9.1 All Agencies involved in this review undertook individual management reviews. Where the findings, that required action, critically impacted on practice, changes were made straightaway and did not await the final outcome of the DHR. Each Agency identified recommendations and an action plan that included the action to be taken, who in the Agency was responsible and by what time scale. The action plan is an appendix to this report and its progress will be monitored through to completion by the Lincolnshire Community Safety Partnership.

9.2 Changes made by Addaction

9.2.1 Since these events Addaction have appointed a dual diagnosis Practitioner, to improve the pathways for clients into Mental Health Services. This Practitioner will also act as a point of contact for other project workers to provide information and advice. Addaction have also liaised with Public Health Commissioners to assist in formalising such pathways in an effort to make it easier for this client group to access Mental Health Services. Communication channels have been established between local Mental Health services and Addaction Lincolnshire with a view to improving pathways and processes.

9.2.2 Following the implementation of the Think Family Agenda in 2010 all members of staff were trained and family meetings were instigated to improve holistic service provision.

9.2.3 Communication channels have been established with the LSCB for both adults and children with the aim of Addaction Lincolnshire becoming a member of local Safeguarding groups to improve partnership working and communication.

9.2.4 A Memorandum of Understanding(M O U) devised between Addaction Lincolnshire and Oasis the parent and carer family support group for those with substance misuse issues. This will improve communication and partnership working. Operational/referral paperwork to be devised to further secure the MOU and enhance joint working.

9.2.5 Increased partnership working through development of a partnership log as mandatory within each client file. Three way partnership meetings are now common practice. The sharing of key documents, i.e. recovery plans, care plans, sentence plans is now encouraged as standard in order to improve client experience, reduce repetition and increase chances of engagement in services.

9.2.6 Risk assessment paperwork reviewed and updated to ensure appropriate identification of risk in a timely manner and its wider impact on treatment planning.

9.2.7 Recovery planning paperwork reviewed and updated to ensure appropriate identification of goals and target setting. Paperwork promotes review and progression of treatment.

9.2.8 Initial assessment currently under review to consider all aspects of assessment particularly, from this DHR, domestic abuse in its various forms, incorporating financial abuse.

9.2.9 Audit processes embedded to ensure that required changes are maintained and sustained and to highlight areas for improvement. Peer audits and locality audits undertaken monthly with feedback to managers to action.

9.2.10 Training needs analysis undertaken to determine demand for Domestic Abuse training. Mandatory approach taken to ensure all staff have basic competencies and confidence in addressing disclosure of Domestic Abuse. Training being undertaken as and when training available through Lincolnshire County Council Domestic Abuse Team.

9.2.11 Dedicated Domestic Abuse Policy now devised and in operation nationally. Published November 2013.

9.2.12 Safeguarding Children Policy Issue 1 published – 23/1/12
Safeguarding Adults Policy Issue 1 published – 1/4/12

Mandatory e-learning modules for the above introduced June 2012 and July 2013.

9.2.13 Following the implementation of the Think Family Agenda in 2010 all members of staff were trained and family meetings were instigated to improve holistic service provision.

9.3 Changes made by Adult Care

9.3.1 An interim desk top review was carried out by Audit Lincolnshire with early recommendations delivered in February 2013. A Head of Service was assigned as lead officer to work with a team of managers to deliver and track an action plan stemming from the initial recommendations, merging the plan to address the fuller recommendations of the IMR. Adult Care's Quality Assurance Team has provided additional oversight and challenge to the work of that delivery group.

9.3.2 Risk and Mental Capacity – a professional lead has been appointed to contribute to the review of practice, training, guidance and recording tools in relation to assessing and managing risk, mental capacity and best interests in all assessments. Revised recording tools and guidance have been issued, recording systems changed and a programme of training for all assessment practitioners will be complete by 31st March 2014.

9.3.3 Quality Assurance of Adult Care Practice – A set of Quality Practice standards and an audit process was implemented in October 2013. The standards for practice reflect the key learning from the IMR and are supporting the heightened emphasis on practice quality in information gathering, decision making and recording.

9.3.4 Complex case management – a framework for defining complex cases has been introduced, with a protocol defining minimum standards for case management and the skill and experience required of practitioners to manage complex cases.

9.3.5 Safeguarding Policies and Procedures – A new Multi-Agency framework developed in partnership with the Social Care Institute of Excellence was adopted in Lincolnshire in August 2013. Adult Care has appointed a manager to further develop Adult Care's internal procedures and protocols for managing safeguarding concerns within this framework.

9.3.6 Domestic Abuse – The County Domestic Abuse Manager has reviewed the new Adults Multi Agency Policy and Procedure document to ensure that it sufficiently covers the agreed multi- agency domestic abuse protocols. It has been directed that all MARAC meetings will be attended by a Safeguarding Principal Practitioner and all MARAC cases are cross checked against Adult Care case records.

9.4 Changes made by EMAS

9.4.1 The importance of assessing the role of the carer has been delivered to staff as part of the Think Family Safeguarding Education. Safeguarding has become embedded within EMAS and this is evident through the level of activity and referral rates as well as audit analysis.

9.4.2 Since the original flag was placed on the property practice has improved and during 2012 the risk markers were reviewed by the security team and a new standard operating procedure is now in place.

9.4.3 EMAS are awaiting the results of a DA project within a South East Coast Ambulance Service in relation to an ambulance specific trigger tool that can be utilised as an alternative to the CAADA DASH which is not feasible for use by the service. The pilot is due to finish in January 2014 and EMAS will receive evaluation and feedback via the National Ambulance Safeguarding Group with the aim for the tool to be accepted and evolved nationally.

9.5 Changes made by City of Lincoln Council Housing

9.5.1 City Council Housing has already taken action to strengthen its response to reports of anti-social behaviour. Procedures and guidelines in dealing with repeat reports of anti-social behaviour have been amended. An integrated public protection and anti-social behaviour team has been created and The Anti-Social Behaviour Risk Assessment Conference (ASBRAC) has been developed to bring Agencies together as appropriate.

9.5.2 The ASBRAC arrangements have been reviewed and an action plan agreed including an ongoing annual review of the arrangements the next review being scheduled for June 2014.

9.5.3 Housing now participates in the Lincolnshire Domestic Abuse Strategic Management Board and have adopted the DA charter and is working towards achieving the ten standards laid out within the charter. The Council has established an internal steering group to drive forward compliance against all elements of the Charter and is making progress towards compliance.

9.5.4 Staff have been briefed on how to sign post families impacted by drug and alcohol to other agencies to access appropriate support and specialist advice. Further training is scheduled by the Tenancy Services Manager for April 2014 and will be refreshed annually.

9.6 Changes made by LCHS

9.6.1 A referral form has been developed to capture all relevant information from a referrer and is an integral part of the electronic records this will include all risks identified in relation to the patient.

9.6.2 A process has been developed where individual cases are reviewed within team meetings and lessons learnt are shared within the team and the wider community services.

9.6.3 Record keeping audits are carried out within all teams/services within LCHS. These are carried out on a quarterly basis and linked with appraisal system.

9.7 Changes made by LPFT

9.7.1 Since 2008 there have been significant changes to LPFT's safeguarding adult at risk and domestic abuse processes. In 2008 LPFT appointed a strategic lead for safeguarding. In 2009/10 domestic abuse procedures were developed in line with multi-agency processes and implemented across the organisation. The Trust has developed a safeguarding and mental capacity team with increased capacity in both 2012 and 2013 due to the increased demand from front line services for safeguarding advice, support, escalation of concerns and training. LPFT has devised safeguarding screening tools which guide staff through processes and actions required to safeguard against several issues related to child protection, adults at risk and domestic abuse.

9.7.2 Staff within LPFT are asked about safeguarding issues at every managerial supervision session (at least every 6 weeks).

9.7.3 In 2013 the Trust developed a single policy and procedure document for all safeguarding processes including MAPP, adults at risk and domestic abuse. This is readily available to all staff and the safeguarding and mental capacity team have introduced a system to make it easier for staff to request and gain timely safeguarding advice.

9.7.4 All staff involved in this review are compliant with their mandatory safeguarding adult and children (includes domestic abuse) training.

9.7.5 As a result of this review it became evident that some staff were not adequately aware of the changes in domestic abuse definition which includes family relationships such as mother and son. The Trust has been out to all teams within the older adult teams and made embedding the Governments 2013 definition a priority of the Trust in the 2013-14 safeguarding and mental capacity work programme.

9.7.6 It also became apparent that some older adult staff were reticent to ask their patient group about abuse and neglect and that they were not utilising the safeguarding screening tools as required. Face to face coaching has been provided to the Older Adults Teams to demonstrate the tool, raise awareness and to increase its use and effectiveness in highlighting and preventing or reducing the impact of abuse.

9.7.7 Over the past year there has been a significant increase in referrals to MARAC by LPFT staff.

9.7.8 LPFT has introduced safeguarding and mental capacity champions in to every team. This means that they receive additional specialist training and supervision relating to safeguarding and mental capacity to assist them to embed safeguarding across the whole organisation.

9.8 Changes made by NHS Lincolnshire Primary Care Trust [LPCT]

9.8.1 NHS Lincolnshire Primary Care Trust was abolished alongside all other Primary Care Trusts across England on 1st April 2013. Their functions were distributed amongst a number of agencies including Clinical Commissioning Groups (CCG), of which there are four in Lincolnshire:
South West Lincolnshire CCG
South Lincolnshire CCG
West Lincolnshire CCG
Lincolnshire East CCG
Within Lincolnshire each CCG has a lead responsibility for the substantial contracts for acute services, community and mental services as well as the commissioning responsibilities for local service provision to meet the needs of each CCG population.

9.8.2 General Practitioners are not directly employed by the NHS. Rather they provide services to their local NHS commissioning organisation, under the terms of a national contract where there is very limited local discretion to vary. NHS England manages the contracts of all general practices in England. Failure to

meet the terms of the contract may result in disciplinary action taken by their local Area Team (Leicestershire and Lincolnshire Area Team) and may also result in the relevant practitioner being referred to the General Medical Council.

9.9 Changes made by Lincolnshire Police

9.9.1 Statistics for 2012 / 2013 show that Officers are now confidently referring high risk domestic abuse cases to MARAC and there is evidence that it is embedded in practice.

9.9.2 Work has been completed with the Force Control Room and Crime Management Bureau with regards to putting the right qualifier code on incidents and crimes.

9.9.3 A Safeguarding Matters Bulletin is now produced regularly, including significant findings from DHRs, SCRs and ongoing briefing issues for all officers and staff (force wide).

9.9.4 A Stop Abuse Notification system was launched in January 2014 – it allows ANY officer / member of staff to report a concern for children or adults that the PPU CRU will then manage and coordinate information with Adult or Children's Services (Safeguarding).

9.9.5 Quarterly meetings are now being held with Senior Management Teams (SMT) of each District by DA Coordinator, SCR Author/PPU Auditor and DIs PPU.

9.9.6 Dip Sample Audits are completed by SCR Author/PPU Auditor and sent to dedicated SPOCs on each District (West / East) and SMT members.

9.9.7 Briefings to all Sergeants have been completed on West District by PPU. East District dates are to be confirmed and completed in 2014. Importance of supervision of cases and risk management is a key message delivered.

9.9.8 Head of PPU provided an input on the Inspectors course in October 2013. Training inputs remain ongoing across the force.

9.9.9 The initial recommendations have been circulated widely across the force within bulletins, routine orders, and to SMTs via email.

9.9.10 A Lessons Learned page on the force Intranet has been created and updated regularly with national and local reports. The initial recommendations of this DHR are available within this system.

9.9.11 A DA Review process commenced in 2013 and is due to deliver in March 2014. This is looking particularly at how to:-

- Identify and map the DA process from initial call to disposal
- Review each stage of the process identifying inefficiencies and best practice to make improvements
- Specifically identify which working practices are most successful and disseminate these
- Conduct an analysis of the distribution of caseloads for Domestic Abuse Officers

9.9.12 A new post of a Detective Sergeant created who manages and supervises specifically the Domestic Abuse Officers within the Public Protection Unit.

9.9.13 An Information Sharing Agreement with Adult Safeguarding was signed off in November 2013 and the process simplified over secure email between PPU CRU and Safeguarding Adults in Lincolnshire.

9.9.14 An Information Sharing Agreement is in place across the Domestic Abuse Partnership and is being reviewed at time of writing.

9.9.15 An Information Sharing Agreement is in place with Children's Services. It was reviewed in August 2013.

9.9.16 In October 2013 the new DA specialist services for standard and medium risk victims were re-commissioned and launched. A services information leaflet for officers to carry in their pocket note books was revised and all officers therefore are able to carry such information. The next IMU Audit of DA incidents has been discussed and will include checking whether officers passed such information on to those involved in incidents and the information will be sent to SMTs for action. There is a field on the P548 DASH proforma for them to state if information was provided or not.

9.9.17 Domestic abuse is discussed at each District (East / West) Senior Management Team meetings. Both have DA as high risk on the performance framework.

9.9.18 DASH training course remains mandatory for all officers and remains a half day classroom based course.

9.9.19 HMIC has also inspected every force and visited Lincolnshire in October 2013. The report was published in 2014. The Executive Summary identified that DA is a priority for The Police and Crime Commissioner and for The Chief Constable. It is recorded that Officers have a good understanding of their important role in dealing with perpetrators, safeguarding victims and in exercising professional judgement appropriately. Overall the view was that Lincolnshire Police is generally effective at tackling DA ,however there are some areas that require further improvement. An action plan will be created under the Assistant Chief Constable Crime and Ops. HMIC will also produce a thematic report for policing Domestic Abuse which should contain key recommendations going forward.

9.10 Changes made by LPT

9.10.1 LPT fully participates in the MARAC process with designated staff attending meetings contributing to decision making and giving feedback to Offender Managers. A revised Accredited Programme for DA perpetrators has been implemented.

9.10.2 LPT is testing an integrated quality assurance model which makes an assessment of the overall holistic approach to case management. The first benchmarking exercise has been completed and has indicated a high level of understanding of domestic abuse and partnership working. Further work is required, however, before firm conclusions can be drawn.

9.10.3 LPT is working towards achieving the ten standards laid out in the DA Charter.

9.11 Changes made by ULHT

9.11.1 Prior to commencement of this DHR the safeguarding team reviewed and amended training provision to extend it to include a specific session on domestic abuse and violence as opposed to incorporating it into other training this commences in April 2014.

9.11.2 The continuing challenge of raising awareness of internal processes for support, advice and guidance in relation to safeguarding and DA is a central part of the safeguarding teams remit and responsibility. The learning from the IMR has been incorporated into this.

9.12 **Changes made by Victim Support Lincolnshire**

9.12.1 Since Victim Support's involvement in this case, they have developed domestic abuse policies and training in line with CAADA guidance and referrals are made to MARAC as appropriate.

9.12.2 The new CMS system rolled out in 2013 incorporates a repeat victimisation identification process and will also identify near misses of data and no exact matches. In time monitoring should show an improvement in relation to practice in this area.

10 Recommendations

10.1 Multi Agency Recommendations

All agencies involved in this review to:

10.1.1 Provide guidance to staff to ensure assessments are based upon full information and that historic records are accessed and utilised.

10.1.2 Develop improved inter agency information sharing and multi agency working together, in relation to DA, in order to arrive at a shared and robust risk management plan.

10.1.3 Review the use of the MARAC referral process to ensure all agencies are clear about the procedure and their role in referring to MARAC.

10.1.4 Provide evidence of a quality assurance process in relation to the effective management of DA cases.

10.1.5 Provide evidence of a DA training plan including learning arising from this DHR.

10.2 Lincolnshire Community Safety Partnership

10.2.1 Lincolnshire Community Safety Partnership to develop an overall policy for the prevention and management of domestic abuse that describes expectations of all agencies and partnerships including all public protection arrangements.

10.2.2 Lincolnshire Community Safety Partnership to ensure there is multi agency DA training available to enable practice staff to understand other agencies DA processes and the importance of each agency's contribution to a positive outcome.

10.2.3 Lincolnshire Community Safety Partnership to review public protection arrangements to ensure domestic abuse is recognised and understood across arrangements for vulnerable adults and safeguarding.

10.3 Lincolnshire Addaction

10.3.1 Addaction to carry out a review of domestic abuse safeguarding referral processes to ensure staff are both aware and confident in those processes and procedures, incorporating DASH and MARAC.

10.3.2 Addaction to formally establish staff confidences and competences relative to identification and recognition of domestic abuse and the appropriate response to such incidents.

10.3.3 Addaction to ensure continued staff attendance on domestic abuse training provided by the County Domestic Abuse Team and / or Addactions Learning and Development Team.

10.3.4 Develop a dedicated organisational domestic abuse policy (had previously been part of the safeguarding policy).

10.3.5 Further develop improved partnership working and joint working with Mental Health Services across Lincolnshire.

10.3.6 Further develop improved partnership working with LSCB and LSAB for both adults and children.

10.3.7 Revise current assessment paperwork to incorporate information regarding family circumstances in order to assist recovery and ascertain wider risks. Incorporate financial abuse in assessment as a form of assessment.

10.3.8 Revise current assessment paperwork to further incorporate assessment of Domestic Abuse (including financial) ensuring appropriate support for those disclosing and keyworkers where necessary.

10.4 Lincolnshire Adult Care [AC]

10.4.1 Adult Care should put in place effective measures to ensure that assessment and case management activity promotes holistic assessments of the person's needs, strengths and outcomes which puts the person at the centre of the intervention and supports them to live safely in their environment.

10.4.2 Risks must be recorded and evaluated in all assessments of need and risk management plans are to be put in place where significant risks are identified.

10.4.3 All staff involved in assessments should understand the Mental Capacity Act and be able to apply its principals in practice.

10.4.4 All staff should have an awareness of domestic abuse and be able to respond to such concerns effectively where they are identified.

10.4.5 Adult Care should ensure that effective measures are in place to determine the nature and complexity of cases and ensure that cases are allocated to staff with the appropriate experience and skills to manage them.

10.4.6 Information gathering and sharing should be improved by:-

- The important components of a case history should be available to the allocating officer at the point of allocation.
- Case file hazard warning should be clear and unambiguous
- Allocating officers should obtain all relevant information for cases where concerns have been identified.

10.4.7 Quality assurance should be improved and managers must be able to produce evidence that cases are being effectively managed and service standards are being complied with.

10.4.8 Adult Care should ensure that measures are in place to improve and assure the consistency and quality of case recording. Also ensure that electronic recording

consistently evidences that the key components of case history and hazards are shown in the record.

10.4.9 Competencies, training and management accountability to be improved by clear practice standards and evidence of compliance with those standards to be monitored. Also Adult Care should have a clear training plan which maintains the level of competency required of its staff.

10.4.10 All staff involved in Adult Care should have an understanding of the Multi-Agency MARAC operating protocol and understand what it means for their own practice.

10.4.11 Develop and implement a specific DA policy and protocol to enable staff to be clear about what is expected of them.

10.5 Lincolnshire Community Health Service [LCHS]

10.5.1 A referral form template and referral pathway into LCHS Adult Community Nursing Services to be developed and be available for use and the process audited. The referral form must highlight the need to record a description of any risk that the patient presents and a description of the existing or suggested controls to mitigate the risk. The referral form to be scanned and attached to the patient's electronic record.

10.5.2 A chronology of significant events is to be added to the clinical tree on adult electronic health records. Staff working with adults are to receive training on the use and importance of recording a chronology of significant events.

10.5.3 A process of group / team case discussion from which practitioners can share the lessons learnt from case reviews and be supported is to be developed and formalised within community nurse teams.

10.5.4 To develop a formal 12 month schedule of random record keeping reviews for community district nursing staff to identify risk assessment record keeping skills.

10.6 Lincoln City Council Housing

10.6.1 Housing Tenancy Management staff should be provided with advice and training to raise awareness of the impact of drug and alcohol abuse on families and in particular older members of the household. Details should be provided on how to sign post those families to other Agencies to consider appropriate levels of support and advice.

10.6.2 In dealing with repeat reports of anti-social behaviour Housing Tenancy Management staff should amend procedures and guidelines to include analysis and identification of potential high risk cases of domestic abuse. The whole life history of the tenancy should be considered and cross referenced to other electronic records including housing repair records, housing benefit records and related housing and homelessness applications.

10.6.3 The effectiveness and Agency participation in the Anti-social Behaviour Risk Assessment Conference (ASBRAC) arrangements should be reviewed periodically.

10.6.4 Following adoption of the Multi-Agency Domestic Abuse Charter 2013 / 2016 the City Council should ensure compliance with the ten standards set out in the Charter.

10.6.5 In investigating cases of Benefit Fraud, staff should be provided with advice and training to raise awareness and identify potential cases of financial abuse in the household.

10.7 Lincolnshire Partnership NHS Foundation Trust [LPFT]

10.7.1 To ensure that the 2013 / 2014 Safeguarding Work Plan pays particular focus to embedding the domestic abuse risk assessment across all areas of the Trust.

10.7.2 The Trust to develop a clear protocol through the Domestic Abuse Operational Management Board to ensure that when abuse is identified via a perpetrator, Agencies are able to access the victim through a standard process.

10.7.3 The Trust to review all the clinical systems that it currently uses in relation to how information is stored and shared between teams within the same organisation operating on different electronic record keeping systems. This is with a view to ensuring a more holistic assessment of risk can be achieved as standard.

10.8 Lincolnshire Police

10.8.1 All officers and staff should be reminded of the importance of assessing the full circumstances and nature of every incident and considering whether those circumstances fit the definition of domestic abuse as described by force policy. If the incident is one of domestic abuse then attending officers must complete a P548 and the FCR should give the incident the Final Classification Code P07 and Qualifier P06 and put the incident on the PPU Message Group prior to closing the incident.

10.8.2 The force needs to ensure that officers who attend domestic abuse incidents investigate all allegations of offences thoroughly and record the result of the investigation accurately on the incident log or within the crime report.

10.8.3 The force needs to ensure that all officers and staff involved in the investigation of offences involving domestic abuse give the case the appropriate level of priority and care, all aspects are investigated thoroughly and every effort is made to bring about a positive and satisfactory conclusion for the victim.

10.8.4 The importance of policy and procedures relating to domestic abuse is reinforced to ensure that all officers and staff are knowledgeable, comply with policy and are able to fulfil the force's expectations of them.

10.8.5 Sergeants and supervisors should be reminded that they have a responsibility to ensure that all domestic abuse incidents are dealt with positively, effectively and in accordance with force policy. Also that all allegations and offences are investigated thoroughly and information is shared with other Agencies in accordance with information sharing agreements and protocols.

10.8.6 Senior officers should be reminded of their responsibility to ensure that force policies and procedures relating to issues such as domestic abuse, dangerous offenders and vulnerable adults (now adults at risk) are implemented and adhered to by police officers and staff under their command.

10.8.7 All officers and staff should be reminded of the importance of completing P548 ACPO DASH risk assessments fully and accurately and in accordance with force policy. The force must ensure that P548's continue to be audited and quality assured and any shortcomings addressed through appropriate supervision and management.

10.8.8 The force needs to ensure that all officers and staff who attend domestic abuse incidents or are involved with domestic abuse matters do not deal with incidents in isolation. All historical information must be considered and taken account of to provide a holistic assessment of risk and every opportunity to manage and minimise that risk by a Multi-Agency approach is taken.

10.8.9 The force must ensure that all officers and staff are aware of the importance of sharing information with other agencies to enable a Multi-Agency approach to be taken to deal with domestic abuse and remind all officers and staff of their responsibility to refer appropriate cases to MAPPA, the Safeguarding Adults Board and MARAC.

10.9 Lincolnshire Probation Trust [LPT]

10.9.1 The domestic abuse and adult safeguarding strategies to be aligned in order to identify the cross over between the two areas of risk.

10.9.2 Ongoing training should be provided to staff in relation to domestic abuse with familial domestic abuse being considered as opposed to collective notions of traditional domestic violence. Sentencers and legal representatives could be invited to join the training to ensure a common understanding.

10.10 United Lincolnshire Hospital Trust [ULHT]

10.10.1 ULHT to develop, implement and embed into working practice a policy / practice guidance for domestic abuse for ULHT staff.

10.11 **Victim Support Lincolnshire**

10.11.1 Victim Support to monitor the effectiveness of the new CMS system in relation to identifying repeat victims and near misses.

10.12. **NHS Lincolnshire Primary Care Trust [LPCT]**

10.12.1 GPs should be held to account to report cases of attempting to obtain controlled drugs by deception to the accountable officer for controlled drugs. This will be done via NHS England Leicestershire and Lincolnshire area team the CCGs who have a role both to inform and hold GPs to account.

Marion Wright

Glossary of Terms

A & E	Accident and Emergency
ACPO	Association of Chief Police Officers
AC	Adult Care
ASBRAC	Anti-social Behaviour Risk Assessment Conference
CAADA	Co-ordinated Action Against Domestic Abuse
CCG	Clinical Commissioning Groups
CCO	Community Care Officer
CHD	Coronary Heart Disease
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
DAO	Domestic Abuse Officer Police
DASH	Domestic Abuse Stalking and Honour Based Violence
DIP	Drug Intervention Programme
DHR	Domestic Homicide Review
ECP	Emergency Care Practitioner
EMAS	East Midlands Ambulance Service
EOC	Emergency Operation Centre
FCR	Police Force Control Room
F & L	Housing Finance and Leaseholder Team
GP	General Practitioner
HB	Directorate of Resources Revenue & Benefit Team
HSGO	Housing Options Team
IDAP	Integrated Domestic Abuse Programme
IMR	Individual Management Reviews
LCSH	Lincolnshire Community Health Service
LDAS	Lincolnshire Drugs and Alcohol Service
LPFT	Lincolnshire Partnership NHS Foundation Trust
LPT	Lincolnshire Probation Trust
Lincare	Community Alarm Control Centre
LSAB	Lincolnshire Safeguarding Adults Board
LSCB	Lincolnshire Safeguarding Childrens Board
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference

MCA	Mental Capacity Act
MEAU	Medical Emergency Omissions Unit
NHS	National Health Service
OASyS	Offender Assessment System
PCT	Primary Care Trust
PPU	Public Protection Unit Police
SCIE	Social Care Institute for Excellence
TEN	Tenancy Services Team / Officers
ULHT	United Lincolnshire Hospital Trust

Appendix 1

Chronology of Significant Events

1995 – 1999

A.1 Records indicate Mr B is diagnosed as having drug dependency and alcohol dependency syndrome. His behaviour is problematic and there are complaints of neighbour nuisance at the home he shared with his mother following the separation of Mrs A and Mr C in 1991.

A.2 In April 1996 Mr B was arrested for firearms offences having made threats to shoot someone and having shown a handgun. He was convicted and made the subject of a Community Service Order.

A.3 During this period Mrs A suffered 2 heart attacks and had a major heart operation aged 54.

A.4 In 1998, Mr B was convicted of endangering the safety of an air craft, affray and criminal damage. This involved fighting and being abusive on a flight to Cape Town, South Africa. There was £9,000 worth of damage. He was sentenced to 18 months imprisonment.

A.5 In 1999 Mrs A's nephew, his wife and son came to live with her from South Africa allegedly as her carers.

A.6 On 4th August 2003, there is the first crime report of many concerning common assaults against Mrs A, Mr B having asked Mrs A for money and when she refused he pulled her hair and poured a glass of water over her.

A.7 On 10th November 2003 Mr B made threats to kill his family to a worker at the drugs action team. This was reported to the Police and a visit made but the family were openly unconcerned indicating he made threats regularly.

2006 / 2007

A.8 On 1st October 2006 the Police were called to the family home due to windows and doors being smashed. Mr B was charged with criminal damage and Section 18 wounding of a Police Officer. Having tested positive for hepatitis B and C Mr B who had cut his wrist badly during the incident lunged at Police Officers in a deliberate effort to transfer blood. The Officer was smeared with blood on his face and clothes. Batons and CS gas was used to restrain him.

A.9 As a result of this incident a critical marker was placed on the address by Police. It identified Mr B as being unpredictable, a known drug user and violent. Mr B would, at times, throw furniture, the television and other household items.

A.10 On 29th November 2006 following a 999 call by Mrs A the Police attended the home. Mrs A, stated she was ill in bed, Mr B had repeatedly asked for money, when she refused he became violent she felt 2 blows to the top of her head and one to her cheek. This assault did not result in a criminal conviction.

A.11 There were several Police call outs during December and over the Christmas.

A.12 On 12th January 2007 Mrs A rang the Police saying Mr B was causing problems and he had locked her in and taken her prescribed drugs and left the home and she could not let the Police in. (For Mrs A and Mr C to be locked in is a common feature of the abusive episodes that are reported). The Police Officer found the suspect Mr B and returned him to the home address having given him strong words of advice. The Police were called back 40 minutes later by Mrs E, Mrs A's nephew's wife, she had received a hysterical telephone call from Mrs A. The crime report stated Mr B had repeatedly punched Mrs A to her head and pulled her hair, there were bruises to both eyes and clumps of hair missing.

A.13 Following this incident Mrs E made a statement to the Police saying she feared for the victim's safety as Mr B had assaulted Mr A several times but these occasions were unreported. She added in her view "if Mr B was not taken into custody soon he was going to kill his mother".

A.14 During the time period of the review October 2006 to October 2012 there were 105 separate incidents involving Mrs A and or Mr B. Each of the incidents has been analysed by the Police reviewing officers and 64 incidents had been identified to fit both the current and previous definition of domestic abuse. 63 of the incidents took place between 2006 – 2008. Not every incident will be included in the overview report but are referred to in the full chronology.

A.15 Most of the reporting was directly due to telephone calls to the Police from Mrs A. However, her nephew's wife called the Police on several occasions to report alleged domestic incidences following calls to her from Mrs A.

A.16 During the period 2006 – 2007 Addaction Drug Service made a series of unsuccessful attempts to engage Mr B in treatment services to address his chaotic substance abuse. Mr B was unwilling and lacked any motivation to enter into treatment and make the changes necessary to stop using amphetamines, heroin and alcohol. On occasions he demanded his mother's prescribed drugs for his own use and when she refused he would become aggressive until she succumbed. He also attempted to sell his own prescribed drugs. This appears to have been unreported.

A.17 On the 23rd January 2007 Mrs A rang the Police, but hung up as she could not talk. Later it is reported that Mrs A and Mr C had fled from the house to a neighbours as Mr B was "kicking off". The Police attended within 4 minutes, however, the incident log was updated to the effect that the suspect had left the premises and no offences had been committed.

A.18 Neighbours made several complaints to Housing of neighbour nuisance and were involved in reporting to the Police when situations became critical and Mr C and Mrs A retreated next door.

A.19 On the 7th March 2007 Mrs E telephoned Police. She said that Mrs A had contacted her in a distressed state. Mr B had assaulted his mother whilst drunk, he asked Mrs A for money to buy drugs, on being refused Mr B hit Mrs A once in the face causing injury to the left eye before taking £15. Mrs A was not

prepared to be a witness, however, she acknowledged she did not want her son at the address but felt she could not stop him. The ambulance service attended on this occasion although Mrs A refused treatment and refused to go to hospital. The ambulance was called and also attended on the 5th December 2006 when Mrs A was in a distressed state due to her son's aggression.

A.20 When seen by a Social Worker from AC on the 12th March 2007 Mrs A shared information about the assault, however, she declined home care and day care.

A.21 On the 16th April 2007 Mr B pleaded guilty to criminal damage and common assault on his mother relating to the incident of the 7th March 2007. The Court ordered a pre-sentence report to be prepared by Lincolnshire Probation Trust (LPT). Records show Mr B repeatedly failed to engage with the report process, leading to two submissions of "nil" reports. Eventually Mr B was remanded in custody to HMP Lincoln. The outcome was a 12 month Community Order with supervision, a specified Education and Employment Activity and a 12 month Exclusion requirement excluding Mr B from the home address of Mrs A.

A.22 Despite attempts to engage Mr B he only attended Lincoln Probation Office on one occasion. There was ample evidence of numerous telephone calls between the Probation Office, Lincolnshire Police and Adult Safeguarding and with Mrs A.

A.23 On the 6th September 2007 Mr B was arrested on warrant having failed to attend Court for his second breach of the Community Order. At Court, the Community Order and all its requirements were revoked in favour of a 6 month custodial sentence.

A.24 When Probation became involved, preparing the Court report, in April 2007 they contacted AC and made clear their concerns for Mrs A's safety due to Mr B's abusive behaviour. At this time a capacity assessment in relation to Mr C was undertaken by Health Services and confirmed Mr C did have capacity to make decisions.

A.25 On the 17th May 2007 Mrs B travelled to her native South Africa. She was away some weeks returning in June 2007. No further action was taken in response to the safeguarding alert for Mrs A on the grounds that she was allegedly not residing at the same address as her son, she was going abroad and she did not want the intervention.

A.26 Mr B returned to live at the home address after his release from remand in custody on the 12th June 2007. The support worker raised an urgent safeguarding alert following an incident where Mr B threatened Mr C with a knife after pressurising him for money. Mr C was frightened for his safety. Whilst Mrs A had been away Mr C had asked the carer for assistance to obtain cash from a cash point each day.

A.27 Mr C went into respite care until Mr B was arrested and remanded into custody. He returned from care on the 15th June 2007, his stepson was released from Prison on the 5th July 2007.

A.28 An Adult Protection Case Conference was held on the 11th July 2007 concerning Mr C, to risk assess the situation. The outcome was that the risk was too high to reinstate the care package at his home following the knife incident, Mr B's likelihood to return to the home, and his unpredictability. Day care was offered and a place found but Mr C refused to go. It was reported that the family wished to provide the care required rather than recruit others to help. A hazard was placed on Mr C's manual and electronic file by Adult Care about the risk of violence and identified that only joint visits should be undertaken to the address.

A.29 The risk was considered to Mr C who was seen as the vulnerable adult and not Mrs A. There was no hazard warning placed on Mrs A's electronic files. Adult Care's case notes show that Mrs A and Mr C did not wish to enforce the exclusion requirements obtained via the Magistrates Court Community Order and wished Mr B to return home. Mrs A is quoted as saying "it was all a misunderstanding" and "that although she and her son fight like cats and dogs her son loved her husband and would not harm him." The final involvement for Adult Care at that time was in December 2007 and showed that Mr B had

returned to the home to help with Mr C's care and the case was closed to active involvement for both safeguarding and the provision of services.

A.30 Mrs A took out an Occupation Order via a Civil Injunction at Lincoln County Court on the 12th November 2007 for 2 years until the 12th November 2009 in an attempt to keep her son away from the home. The suspect Mr B was ordered to leave the address within 4 hours of being served the Order and not to return or go within 200 metres of the address. The record also showed there were powers of arrest linked to the Order.

2008 – 2009

A.31 On the 7th January 2008 there was a neighbour nuisance complaint. Also on that day there was a breach of the Civil Court Occupation Order reported by Mrs A. Mr B had visited the address asking for money. On the 10th January 2008 Mr B was back at his mother's home and in breach of the Occupation Order. He was arrested and appeared in Court the following day, the 11th January 2008. He was sent to Prison and released on the 3rd March 2008. He was seen by Addaction whilst in custody and given an appointment for after his release.

A.32 On the 2nd July 2008 Mrs A reported to the Police that Mr B had taken money from her and her husband Mr C. He had taken Mr C to the bank on the 30th June 2008 and the 1st July 2008 and taken the money from him and also had taken money from beside Mrs A's bed. Mr B was charged with theft and convicted on the 3rd July and received a 1 day detention in the Court and Ordered to pay compensation of the £20 to Mrs A.

A.33 On the 20th August 2008 the victim reported that Mr B had assaulted her. He had grabbed her hair and pulled her about. He had wanted money for drugs but when this was not forthcoming he had threatened to "smash her up" and then he had left. There was another call 50 minutes later reporting that Mr B was outside trying to get in. When he could not gain access he had hit the glass panel in the door with a hose reel causing the glass to smash. A previous assault was also disclosed at this time. Mr B was charged with assault x 2 and criminal damage.

He was arrested on the 1st September 2008 and remanded in custody until the 6th October 2008 when he was given conditional bail. The case was eventually dismissed on the 8th January 2009 due to no evidence being offered. On the 29th September 2008 Mrs A made a statement withdrawing the complaints.

A.34 The Police felt they should proceed with the case in spite of the retraction of Mrs A's statement. Mr B was considered very unstable and presented a risk to Mrs A and her husband. The Crown Prosecution Service (CPS) agreed and attempted to gather information for a hearsay application. This application was refused by the Court and the case was dismissed, no evidence offered. In total there were 15 incidents of domestic abuse involving Mrs A and Mr B between April and the end of August 2008.

A.35 Victim Support made contact with the victim Mrs A following automatic referral from the Police on the 25th July 2008 and the 27th August 2008. However, the victim Mrs A declined support and there was no further contact.

A.36 When Mr B appeared in Court on the 6th October 2008 he was bailed, his bail conditions included residence at a Hostel in East Grinstead and not to enter the road on which his parents lived. These conditions were in place until the 8th January 2009. Despite this he breached the conditions and was found at his parents on the 6th December 2008.

A.37 On the 29th January 2009 a neighbour rang the Police and reported a disturbance at the family home. On the 30th January 2009 Mr B appeared in Court for breach of the Occupation Order. He was sentenced to 6 months custody and was finally released from this on the 28th April 2009.

A.38 Having closed the case of Mr C on the 8th January 2008 Adult Care were next involved in March 2009 when equipment to aid Mrs A's day to day living was requested. This referral related to a separate address in Lincoln where Mrs A had the tenancy in her name. Work was carried out at the address and there was a similar involvement in July and August 2009.

A.39 On the 20th June 2009 the Police were called to an incident leading to Mr B being arrested and charged with assault of Mrs A, Mr C and carer two. The carer had intervened when Mr B was screaming in the faces of Mrs A and Mr C and trying to force feed them, during the early hours of the morning. The door was damaged when Mr B returned later and found himself locked out. He was charged with both assault and criminal damage and breach of the Occupation Order. The case was discontinued on the 24th July 2009 when both the carer and Mrs A and Mr C withdrew complaints. The breach of the Occupation Order was withdrawn on the 29th June 2009 after it is believed the victim asked for the Order to be cancelled via her Solicitor.

A.40 The Probation Trust was requested to prepare a pre-sentence report on Mr B for burglary. This was undertaken and on the 6th November 2009 he appeared before Lincolnshire Magistrates' Court and was made the subject of a Community Supervision Order with unpaid work of 60 hours and compensation of £150.

A.41 On the 11th November 2009 there was a vulnerable adult referral concerning Mrs A and Mr C from Probation to Adult Care due to the history of abuse by Mr B and informing Adult Care that he appeared to be living at the home address and was believed to present a risk to his parents. However, at this time Mr C was spending time with his wife at the alternative address therefore Adult Care considered that as Mrs A and Mr C had moved and left the son at the family home the issue had resolved itself. It is noted by Adult Care that when safeguarding measures have been put in place Mrs A and Mr C allow the son back into the property making them vulnerable. They had declined services previously. There is a hazard alert on Adult Care records to say that staff shouldn't go to the address alone and a male should be present.

A.42 Mr B failed to keep appointments with Probation, he was returned to Court and on the 9th December 2009 despite a proposal for a financial penalty the Community Order with supervision was revoked and instead he was made the subject of a 2 month Curfew Order to be at home between 7pm and 7am.

2010 – 2011

A.43 On the 23rd March 2010 Mrs A called Adult Care to say that she was struggling to manage with her lack of mobility and requested a direct payment to assist with paying a carer. On the 20th April 2010 Adult Care undertake a home visit. Mrs A indicated that Mr C spends most days with her but his main carer is their son and his needs are to be considered separately. On the 9th June 2010 Adult Care make a home visit to Mrs A to confirm that a direct payment had been agreed and carer 2 was identified and was present at the visit.

A.44 On the 7th July 2010 reports were made to the Police that Mr B was knocking at neighbours houses asking for food. Later Mr B telephoned the Police to report a 6ft snake under the chair. Police called to find there was no snake.

A.45 On the 10th July 2010 Mr C was admitted to Lincoln County Hospital via A & E at 1.16am having been found at the foot of the stairs at his home. His wife was woken by the noise. Paramedics attended and he was taken to the hospital where it was revealed he had fractures. He subsequently died at 21.15 hours that day. Accidental death was recorded.

A.46 On the 15th July 2010 Mr B requested the right to buy the house. On the 10th August 2010 during a home visit to the property by Housing Officers, Mr B asked if his mother could move in as she lived on her own. On the 18th August 2010 Housing wrote to Mrs A's GP regarding advice about Mrs A's request to move in with son given the physical complications of a first floor maisonette. On the 23rd October 2010 Mrs A telephoned Housing to ask that her nephew deal with her affairs. On learning that Mrs A had already moved back to the family home Housing agree to a joint tenancy from the 1st November 2010.

A.47 Mr B was seen by Lincoln Drugs and Alcohol Service (LDAS) following a self referral for drug treatment. He was seen again on the 4th November 2010 and admitted to using between £60 to £80 of heroin each day. He identified he cared for his mother. On the 11th November 2010 it is reported by the Chemist that Mr B was not collecting his drugs and it was also reported that he was not engaging

with treatment. On occasions the dispensing Chemist witnessed Mr B trying to sell his drugs to others.

A.48 On the 10th November 2010 Police are called by Mrs A to say that her son is downstairs causing damage. She is bedridden and cannot do anything. The Police visit and all was safe and well and there was no sign of the son. On the 11th November 2010 Victim Support contacted Mrs A and offered support. Mrs A declined support and the case is closed. This is the last report of an offence by Mrs A concerning Mr B.

A.49 13th January 2011 GP notes refer to Mrs A going to Cape Town for 3 months on the 15th January 2011. Later a home visit was made by Adult Care who talked to carer 2 who advised them that Mrs A had gone to South Africa for 3 months. Direct payment was suspended to be restarted on her return. The carer advised the person from Adult Care of the terrible living arrangements due to Mrs A's son's use of drugs and alcohol. On the 19th January 2011 an email was sent suspending direct payments and noting on the file the risk presented by Mrs A's son and that workers should not visit alone.

A.50 Between the 18th January 2011 and the 8th April 2011 there were several incidents of ambulances and Police being called to the address and of Mr B trying to get prescription drugs on behalf of his mother who was away. There were clearly tensions between Mr B and carer 2 who was living at the property whilst Mrs A was away. It was recorded by the Police that Mr B was trying to get carer 2 removed and had been for some time.

A.51 The 15th November 2011 Mrs A rings Adult Care to request a review of her care, as her direct payments were suspended whilst she was away. She had broken her leg whilst in South Africa. She informed AC that her nephew is dealing with her finances. Her son is currently dealing with her care. It would appear that she was out of the Country for some 10 months. On 9th December 2011 Adult Care agreed to reinstate direct payment.

2012

A.52 From the 14th January 2012 until the 12th October 2012 Mr B was receiving treatment via home visits from the District Nurses for his leg ulcers and linked difficulties. He also received a prescription for drugs and was offered regular appointments with LDAS and Addaction to discuss his usage and how to manage it. Due to his non-compliance he was eventually discharged from treatment. During this time it was noted that his mother was housebound and was confined to her bed upstairs.

A.53 On the 12th June 2012 Mrs A was admitted to Lincoln Central Hospital for shortness of breath, she said she was happy at home and had a carer on call. Between the 14th June 2012 and the 18th July 2012 Mrs A is seen in hospital by a range of different professionals including Nurses, Doctors, Occupational Therapists and an Adult Care Key Worker. The information she provides to various professionals varies. On occasions she says that she wants to be with her son and his friends who visit daily. At times she says she wishes to continue with her private care arrangements and requires a ground floor flat and at other times as she no longer gets along with her son she would like a residential placement. She is referred for a Lifeline Connect Smoke Alarm, emergency caller and monoxide detector. It is recorded that her nephew has Power of Attorney and that her son is a recovering drug addict.

A.54 On the 18th July 2012 a Staff Nurse rings Adult Care to speak to the key Worker as Mrs A is considered medically fit for discharge. Mrs A at this point is saying that she does not want to return to her flat. Adult Care record that Mrs A has fluctuating capacity due to not comprehending the dangers of returning home. Mrs A states son and carer take care of her personal care and feeding, however, she is looking at a long term residential care as she realises that she may not manage for much longer at home. A best interest meeting is held with the nephew and he gives reassurances that Mrs A would receive regular care at home and they would be looking at a long term residential placement for her. Mr B provides some of her care needs but he struggles with his own problems.

A.55 Discharge options are discussed with the nephew of Mrs A by a Doctor and Nurse he informs them of the complex issues relating to Mrs A's son who is an alcoholic and intravenous drug user and has, at times, refused entry to carers. On the 23rd July 2012 Adult Care assess Mrs A via the NHS continuing health care needs check list form which was completed. It was noted that she required two staff to move her and needs prompting for meals and medication. It is noted that the "patient lives with son who is an IV drug user, this is no longer appropriate due to change in needs". On the 25th July 2012 the Doctor records that there is no doubt of Mrs A's capacity and that she wished to return home as her son will not be happy if she doesn't. She mentions that she is tired of the son returning home late at night and borrowing money and not returning it. The Doctor records that Social Services should investigate the home circumstances. Adult Care called her nephew he identified concerns regarding her going home, around her son drinking and "kicking off" and her not getting the care that she needs. Also there were concerns regarding her mental state. The Adult Care Community Care Officer advised that if she is deemed to have capacity, it would be her choice to go home and nothing could be done to stop her.

A.56 On the 2nd August 2012 Mrs A's nephew raised concerns about Mrs A returning home. Mrs A was assessed as having fluctuating capacity and as not having the capacity to make informed decisions about returning home. The home environment was considered a risk given the inconsistent care provided by her son and his friends who have access to the property 24 hours a day. On the 3rd August 2012 a meeting took place with Mrs A's nephew and Adult Care. He said his cousin wasn't as bad as he had first made out and that he does have issues but did care for his mum. However he again voiced concerns about Mr B. He suggested that carers could come in to look after Mrs A, however, the Adult Care Community Care Officer (CCO) explained this could not be done as she received a direct payment. He said he would make sure Mrs A got appropriate care. On the 6th August 2012 the CCO spoke to a Senior Colleague where it was decided that if Mrs A wanted to go home then she should be allowed to do so with support.

A.57 The Occupational Therapist (OT) outlined concerns via telephone to the CCO about people coming and going and inconsistent care. When the OT saw Mrs A later that day Mrs A said that she didn't want her son feeding her at 2am in the morning when he returned home and she said sometimes she hadn't been given a meal as her son had gone out and forgotten to feed her. She was asked about going into short term care and Mrs A thought that this would be a good idea. The CCO called Mrs A's nephew to inform him of the conversation regarding the short term care. However, he wanted Mrs A to go home for a few weeks so that they could decide on a long term care plan in terms of residential care. When concerns were expressed he said that he would guarantee she had the right care. However the OT was still concerned and asked for a best interest meeting.

A.58 The Lifeline was fitted and the bed moved downstairs for Mrs A's return home. When the Lifeline was fitted it was found that the telephone had been disconnected due to non-payment of bill. The Social Worker discussed a temporary placement to which Mrs A agrees. On the 7th August 2012 Mr B telephoned the hospital, he confirmed he wanted his mum home and he would be home all day every day. The nephew states Mrs A should return home and not to go into residential care.

A.59 On the 10th August 2012 a best interest meeting was held and it was deemed in Mrs A's interest to return home and discharge planning was to be processed. Assurances were given by her nephew that she would receive regular care and they will be looking at a long term residential placement. Prompts were required to ensure Mrs A had eaten and drunk enough fluids and for her to take her medication. On the 14th August 2012 Mrs A was discharged to her home address with home support workers going in twice a day am and pm.

A.60 On the 16th August 2012 when home support workers tried to visit to provide care they could not gain entry in the evening as Mr B had left the keys in the door and they had been stolen.

A.61 On the 17th August 2012 at 4.28am the ambulance were called via Mrs A pressing her Lincare alarm she had fallen out of bed and was unable to get up.

When the ambulance arrived she refused to go to hospital. She had bruises and abrasions on wrists. When the ambulance crew visited access to the property had to be gained by the Police forcing the door as the keys were lost. Carers report that the home was untidy and unclean with lots of empty alcohol cans. Mrs A appeared confused repeatedly requesting "Chinese people need to leave fed up with them coming in and out of the property". Mr B was said to be unkempt with tired red eyes popping out. Concerns were expressed by carers regarding son's ability to cope. Request Social Worker be allocated as soon as possible to review home environment and ongoing support.

A.62 On 17th August 2012 the OT visited the home for a follow on discharge visit. The OT was concerned about how Mrs A was coping at home and Mrs A indicated that she wanted to go into care. Mrs A told the OT that she had fallen out of bed and was on the floor a long time. Mrs A informed that the son had helped her back into bed. It was recorded that the OT had spoken to the GP and suggested a referral to safeguarding. Also recorded was that an urgent community assessment was required. Mrs A is refusing assistance from carers and son is struggling with the care and not coping although he says he is. On the 19th August 2012 home support workers record son not able to cope with Mrs A adequately, there is no food in the cupboard and no necessities, no hot water or bathing things. Mr B was at home but had not responded to Mrs A's calls in the night or the morning. On the 20th August 2012 support workers suggest an earlier evening visit as concerned the previous night the house was in darkness and it is noticed that the son starts drinking early.

A.63 On the 21st August 2012 the home support worker states that Mrs A is in a terrible state today referring to needing washing etc. The Adult Care CCO home visit, son is present. The house is in poor state with lots of beer cans and damage to the front door. The community nurse arrived to check Mrs A's bloods, she had not had her medication. On the 22nd August 2012 the OT rings the CCO to share concerns. The CCO says that he will assess again on the 28th August 2012. The CCO contacts the principal practitioner informing her that two different professionals have heard Mrs A saying that she wants to go into care. Principal practitioner advised the CCO to speak to Mrs A to get her views without the son

being present and to check if the son had made the changes to the home that had been requested.

A.64 The nephew called the CCO at the hospital on the 23rd August 2012 to say that Mr B is having drug parties in the home whilst Mrs A is in the lounge and is not making sure she is being fed properly. Mr B is preventing carer's access. Mrs A is also being asked to be admitted to permanent care away from her son. The CCO in the community advised the hospital CCO that he is aware of the issues and is reviewing again on the 28th August. Mr B is present at the assessment visit on the 28th August. Mrs A denies that she has said that she wanted to go into care, however, when her son was out of the room she indicated that she was interested in going into "The Cottage". When her son re-entered the room she changed her mind saying she was happy to be at home with her son. Both Mrs A and Mr B identified they would like time away from each other but Mr B said that there was no-one else to care for his mum.

A.65 Over the next few days concerns are recorded by the Home Support Workers about Mrs A. It was recorded that there was no food in the house and the house needed to be cleaned and clothes and bedding washed. Despite the request for food to be bought there was still no food in the house. Mrs A told the home worker that the son cannot cook so they order food in. Mrs A says that she is always hungry as she can't eat what the son orders.

A.66 On 5th September 2012, Addaction send a letter to Mr B as he hasn't collected his prescription since the 16th August. He was discharged from services on 14th September due to no contact.

A.67 When District Nurses visited on the 17th September 2012 to dress Mr B's legs it was recorded that he appeared to be drinking heavily and on drugs and he was getting verbally abusive. Mother also trying to advise him on his behaviour.

A.68 The Home visit was cancelled on 11th September 2012 by the CCO and rearranged for the 28th September 2012. Mrs A enquired about funding to employ a carer. Would like to employ carer 2 as previously employed.

Outstanding electricity bill of £503, son agreed to deal with this. An annual letter for review of direct payment is sent to Mrs A as the telephone is no longer in use.

A.69 On the 30th September 2012 Mrs A tells the Home Support Worker (HSW) she is considering other care, she thinks she wants to go into respite care so that she can have time to think about what she wants long term. It is to be noted that her son was outside at this time.

A.70 The CCO from Adult Care visits Mrs A on the 1st October 2012 confirmed nephew dealing with the electricity bill, said she gets confused with medication and would like direct payment as before. Carer 2 was present and outside of the home carer 2 informed the CCO that Mr B is taking speed and is demanding money from Mrs A to buy beer. The CCO called the safeguarding team to explain the situation. He was advised by safeguarding as Mrs A has capacity she would have to make a referral herself regarding Mr B and his behaviour.

A.71 Lincolnshire Partnership Foundation Trust Older Adult Community Health Team visits on the 1st October 2012 to make initial assessment. Mr B and nephew are present but did not participate. Paperwork completed suggests that Mrs A does not meet the criteria for continuing health care. Discussion will take place at the team meeting on the 3rd October 2012. An out patient appointment is made for Mrs A to see a psychiatrist following referral from GP.

A.72 It is confirmed that the direct payment is in place and the CCO is of the opinion the direct payment should be suspended and an audit undertaken as soon as possible. Mrs A informs the Home Support Worker that she needs to go into respite care and may need to consider a different home due to her health. Mrs A is concerned about money and food for herself and her son. Later when the Home Support Worker visited there was no electricity. On the same day Mr B self referred to Addaction stating he was using five bags of heroin daily both smoking and intravenously and wanted a methadone script.

A.73 It was agreed with Mrs A that the new care provider should start on the 11th October 2012. On the 5th October 2012 the CCO from Adult Care discussed direct payments with nephew. He confirmed he was aware that Mrs A received the direct payment. The CCO asked why the nephew thought that she thinks she is not receiving it. The nephew's response was that she must know as she is the only one that could reinstate it. The CCO informed the nephew that he was thinking of suspending the direct payment and having an audit carried out. Agreed to meet the nephew on the 15th October 2012. Concerns regarding the direct payment were discussed by the CCO with the principle practitioner who agreed to have it suspended. The payment was £703.80 every four weeks. On the 8th October 2012 the direct payments team confirmed that the direct payment had been suspended from the 11th November 2012. This was confirmed in a letter to Mrs A.

A.74 Older Adult Community Mental Health Team visit to say that tests have been requested and an outpatients appointment was made for the 14th November 2012 to see Mrs A again.

A.75 On the 11th October 2012 when Home Support Workers visited at 8pm it is recorded that Mr B came in whilst they were there and Mrs A and Mr B had words about the bank card. The son was adamant he gave it back. All seemed quiet when the workers left. Earlier that day when District Nurses visited to redress legs Mr B freely admitted that he had been using drugs and drinking earlier that day and had not been taking prescribed medication. He had removed his bandages from his legs.

A.76 On the 12th October 2012 at 5.22am an emergency call was received from Mrs A's lifeline in regards to a 72 year old woman who had fallen and banged her head and was vomiting. Son was present when lifeline called but he would not talk on the phone. The patient was vomiting when the crew arrived, ambulance staff who attended believed that due to her injuries and the comments she made about Mr B that she was a victim of an assault. Mrs A was described as being in a bad way with lots of bruising and a black eye. She was transferred to hospital where she died later the same day.