Salford Safeguarding Adults Board

Salford Community Safety Partnership

Overview Report: Domestic Homicide Review/ Safeguarding Adult Review into the Death of

Peter
date of death March 2018

Note: Peter is a pseudonym used for the purposes of this Report.

Final dated: June 2021

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CONTENTS

1.	Introduction		4
1.1	Preface		4
1.1.1		Context of the Review	4
1.1.2		Legal context	5
1.1.3		Timescale of the Review process	7
1.1.4		Confidentiality and consent	7
1.2	Specific terms of reference		8
1.2.1		The specific purpose of this DHR/ SAR	8
1.2.2		The time period under Review	9
1.2.3		Agencies involved	9
1.2.4		Publicity/ media issues	10
1.2.5		Other issues	10
1.3	Methodology		11
1.3.1		Initiating the DHR/ SAR	11
1.3.2		Involvement of family members, friends and others	12
1.3.3		Individual management reviews	12
1.3.4		Review Panel members and meetings	14
1.3.5		Independent Reviewer/ Author of the Overview Report	15
1.3.6		Parallel reviews/ investigations of practice	15
1.3.7		Equality and diversity	16
1.3.8		Dissemination of the final Report	16
2.	Background information (The Facts)		17
2.1	Summary		17
2.2	Members of the family and the household		18
2.3	Background information		18
2.4	Chronology		21
2.4.1		Narrative chronology	21
2.4.2		Abbreviated and edited chronology	24
3.	Analysis		29
3.1	Issues raised in the terms of references		29
		Theme 1: Domestic abuse, coercion and control	29
		Theme 2: Safeguarding issues	34
		Theme 3: Legal issues	40
		Theme 4: Risk and multi-agency working	44
		Theme 5: Good practice	48
3.2	Other relevant issues		50
4.	Conclusions		53
5.	Lessons to be learnt		55

6. Recommendations 56

6.1 Single agency recommendations from IMRs 56
6.2 Multi-agency recommendations 57

Appendix 1: Glossary 60

1. INTRODUCTION

1.1 Preface

1.1.1 Context of the Review

This report of a joint domestic homicide review (DHR) and safeguarding adult review (SAR) examines agency responses and support given to Peter, a resident of Salford, prior to his death in March 2018.

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.

By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer for vulnerable adults in Salford.

Peter was aged 55 when he died. He had been dependent on alcohol for some years. In the months leading up to his death, there were concerns about self-neglect and that he was being abused/ exploited by others who were taking money from him. He was found dead at his home address by an associate. Internal injuries consistent with assault were discovered at post-mortem examination, and subsequently a suspect was identified and charged with murder.

This review considers agencies' contact/ involvement with Peter and the Perpetrator during the 12 months leading up to 26th March 2018, plus any relevant information falling outside this time frame. The time frame was selected to cover the period following the Perpetrator's release from prison and establish the context prior to that date.

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and, most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The aim of SARs is to promote learning and improvement action in order to prevent future incidents involving death or serious harm.

The Panel and all those involved in this Review would like to acknowledge how distressing these events have been for the family and to send our sincere condolences. We would also like to thank all those who have contributed in any way to the review process for their time, patience, commitment and cooperation.

1.1.2 Legal context

Initially the Salford Safeguarding Adult Review (SAR) Panel agreed that a SAR should be conducted in relation to the case of Peter in April 2019.

At the first meeting of the SAR Peter Review Team, the Greater Manchester Police (GMP) representative brought new information that the perpetrator had been living at Peter's home prior to the murder and this raised the question of whether the case met the criteria for a DHR, since the criteria for a DHR include un-related members of the same household who are not in an intimate relationship with the victim.

The Review was conducted as a combined DHR/ SAR and the legal contexts of both are set out below.

Domestic Homicide Reviews

The Domestic Violence, Crime and Victims Act 2004[1] states that:

"domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

The purpose of a DHR is to:

a) *establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*

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

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

d) *prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure*

[1] See Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) *contribute to a better understanding of the nature of domestic violence and abuse; and*

f) *highlight good practice*

Definition of Household

Household is defined in the Domestic Violence, Crime and Victims Act 2004[2] s5 (4) and the criterion applicable to this case is:

(a) A person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it (page 3).

Safeguarding Adult Reviews

The Care Act 2014[3] states the following:

(1) An[4] SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

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[2] See http://www.legislation.gov.uk/ukpga/2004/28/pdfs/ukpga_20040028_en.pdf
[3] See http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[4] This is a direct quotation from the Care Act see 44. Safeguarding Adult Reviews at http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

(4) An[5] SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

1.1.3 Timescale of the Review process

This combined DHR/ SAR began on 9 July 2019 and was concluded on 3rd September 2020.

The Review timescale was extended in order that every effort could be made to address the complexity of combining a DHR and a SAR, and to involve family members, should they wish to be involved. It was then further extended due to the COVID-19 pandemic and associated restrictions.

1.1.4 Confidentiality and consent

The detailed findings of this review are confidential and only available to participating officers/ professionals and their line managers. For this reason, the names of victim and perpetrator have been anonymised. The Overview Report or Executive Summary will be published after sharing it with the family, if they so wish.

Consent was sought from family members for their involvement in the Review and they agreed to contribute.

After discussion with Panel members it was agreed not to approach the Perpetrator.

[5] See footnote 4 page 6.

1.2 Specific Terms of Reference

1.2.1 The specific purpose of this DHR/ SAR

The purpose of this DHR/ SAR is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse.

- Identify clearly what those lessons are, both within and between agencies; how those lessons will be acted on, within what timescales and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Assist in the prevention of future domestic homicides through improved intra and inter-agency working to domestic abuse victims and their children.

- Determine what agencies could have done differently that could have prevented harm or death and that might prevent similar harm in future.

In addition, the following areas were to be addressed in the Internal Management Reviews and the Overview Report:

1. The victim had no known contact with any specialist domestic abuse agencies or services. Could more have been done to inform local residents about services available to victims of domestic abuse?

2. Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator to the victim.

3. Whether there were any barriers experienced by the victim or family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should he have wanted to.

4. Whether there were any warning signs and whether opportunities for triggered or routine enquiry and therefore early identification of domestic abuse were missed.

5. Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or the alleged perpetrator that were missed.

6. Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim or perpetrator.

7. Consider the potential role of safeguarding processes and section 42.

8. Consider assessment and risk management/ responsiveness after Peter had raised concerns.

9. Consider the possible role of coercion and control.

10. Consider how well coordinated were the services that were working with Peter and how might services have been better coordinated.

11. Consider financial abuse and how services addressed potential risks.

12. How was the Mental Capacity Act relevant and applied in practice.

13. Identify any good practice.

14. Consider any other information that is found to be relevant.

15. Consider whether there was evidence that Peter was self-neglecting, the response by agencies and the impact of this.

1.2.2 The Time Period under Review

The time period under Review was agreed as the 12 months leading up to Peter's death in March 2018 plus any relevant information falling outside this time frame.

1.2.3 Agencies involved

- Adult Social Care – Salford Royal Foundation Trust (ASC)
- Cheshire and Greater Manchester Community Rehabilitation Company (provider of probation services) (CGM CRC)
- ForHousing (formerly City West Housing)
- Client Affairs – Salford City Council
- Greater Manchester Fire & Rescue Service
- Greater Manchester Mental Health NHS Foundation Trust Substance Misuse Services/ Achieve (GMMH-SM)
- Greater Manchester Mental Health NHS Foundation Trust Mental Health Services (GMMH-MH)
- Greater Manchester Police (GMP)
- NHS Salford Clinical Commissioning Group (CCG)/ Primary Care
- North West Ambulance Service (NWAS)
- Salford Royal Hospitals NHS Foundation Trust (SRFT)
- Community Safety Partnership (CSP)

1.2.4 Publicity/ Media issues

- Media and publicity meetings were to be held as necessary.[6]

- All requests for information were to be dealt with by Salford Council's Marketing and Communications Team.

- Any materials published and their contents were to take proper account of privacy/confidentiality considerations and be subject to advice.

1.2.5 Other issues

- Legal Issues – Individual agencies were free to seek legal advice in relation to their agency's IMR however this was not to hinder agreed timescales.

- Timescale - The Home Office was informed of the intention to conduct a DHR in this case. The guidance requires that the first review panel must be held within a month of this date and that the whole process should be completed within 6 months.

- Anonymisation of Family Names - For the purpose of the Overview Report, it was agreed that the victim would be referred to as Peter and the perpetrator as the Perpetrator.

- Anonymisation of Staff – Staff were anonymised in IMRs and the Overview Report.

[6] Media and publicity meetings were not deemed necessary during the Review process.

1.3 Methodology

1.3.1 Initiating the DHR/ SAR

The Salford Safeguarding Adult SAR Panel agreed that a SAR should be conducted in April 2019, and this was agreed by the Salford Safeguarding Adult Board (SSAB) Independent Chair in line with Salford SAR procedures. A review group was established made up of the Salford SAR panel and additional members from core agencies and those most involved with Peter's care. Expressions of interest were sought for the role of Independent Chair/ Author and an Independent Chair/ Author for the proposed SAR was commissioned in May 2019.

At the first Panel meeting in June 2019, it emerged that the Perpetrator had been living with Peter following the Perpetrator 's release from prison in December 2017 and was therefore a member of the same household as the victim so that the incident potentially met the criteria for a Domestic Homicide Review. This was referred to the Community Safety Partnership (CSP) for them to review under the DHR criteria.

The CSP agreed that the incident met the criteria for a DHR and notified the Home Office on 9 July 2019. The Home Office acknowledged receipt of this notification and an update needed to be sent to them within 6 months of the aforementioned date.

The terms of reference were amended to reflect the fact that the review was to be conducted as a joint DHR/ SAR. They were sent to the Home Office DHR Team, and circulated to Independent Management Review (IMR) authors within a week. Membership of the review panel was also reviewed: it was agreed that the Council's Strategic Lead for Domestic Abuse would focus on domestic abuse issues and that no additional alcohol misuse input was required in view of the broad representation on the Panel.

Following the first Panel meeting, Review Panel members were asked to take steps to ensure that their agency's IMR and chronology were completed within agreed timescales. They were also asked to read all the circulated management reports and chronologies prior to the next Panel meeting and consider what additional information may be required.

Advice on how to complete IMRs/ chronologies was issued to all IMR authors, and all relevant workers were to be interviewed as part of the IMRs. Timescales were required to be kept and organisations were required to commit adequate resources to ensure this happens. A date for return of Individual Management Reviews (IMRs) was agreed.

As part of the Review process a Practitioners event was held on 15 October 2019.

1.3.2 Involvement of family members, friends, and other relevant community members

It was agreed that family members and friends were to be given the opportunity to participate in the review, and that any interviews would be undertaken by the Independent Reviewer/ Author and a member of the Safeguarding team.

A letter was sent to Peter's brother in May 2019 (at the stage that the review was following the process of a SAR) to invite his contribution to the Review.

After the decision was made that the review would be a joint DHR/ SAR, family members were sent letters with a link to the Home Office website and a copy of the Domestic Homicide Review Information Leaflet for Family Members[7]. They were offered a range of different ways to be involved (including meeting with the Review Panel) and were given contact details for Victim Support and Advocacy after Fatal Domestic Abuse. Letters were hand-delivered to two of Peter's brothers by a representative of the Safeguarding Adults Board accompanied by a representative of Housing: they introduced themselves and explained what the letters were about. Family members responded positively to the approach but did not take contact further at that stage.

Subsequently the family was contacted and a meeting arranged but it was cancelled on the day for reasons related to the coronavirus pandemic. Since restrictions were put in place in view of the COVID-19 pandemic, it was not possible to rearrange the meeting as planned, so the Independent Reviewer spoke with a member of the family by phone, and that person agreed that background information contributed by the family could be included in the Report.

The family was asked about choosing a pseudonym, however they decided to leave the decision to the Independent Reviewer who chose a name at random. Peter's brother (on behalf of the family) was provided with a copy of the final draft report, along with a covering letter welcoming and inviting further comments or feedback, and the letter included the Independent Reviewer's contact details with her offer to answer any queries and talk through the recommendations. The Independent Reviewer contacted Peter's brother to enquire about further comments and to ensure that family views were incorporated. Peter's brother confirmed that he had nothing further to add and that he was satisfied with the report.

1.3.3 Individual Management Reviews (IMRs)

Fifteen agencies were contacted and asked about contact with victim and/ or perpetrator. Twelve agencies reported contact, secured their files, and provided information to the Review. IMRs provided are detailed in Table 1.

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[7] See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/601398/Leaflet_for_Family_English.pdf

Table 1: Details of IMRs produced for the Review

Agency	Abbreviated as	IMR in respect of Peter	IMR in respect of Perp.	Author (by role)	Quality assured by
Cheshire and Greater Manchester Community Rehabilitation Company[8]	CGM CRC	-	√	Interchange Manager, Risk and Public Protection Operational lead	Community Director Risk and Public Protection Strategic lead
Greater Manchester Mental Health Incorporating information from Achieve	GMMH	√	√	Professional Lead for Social Care	Safeguarding Adult Lead – GMMH NHS FT
Greater Manchester Police	GMP	√	√	Detective Sergeant	Detective Inspector
North West Ambulance Service	NWAS	√	√	Safeguarding Practitioner	Head of Clinical Safety
Salford City Council Client Affairs	SCC Client Affairs	√	-	Senior Finance Officer	Finance Manager, Adult Social Care
Salford Clinical Commissioning Group	CCG	√	√	Named GP Safeguarding Adults	Specialist Nurse Safeguarding Adults
Salford Royal Hospitals Foundation Trust	SRFT	√	√	Assistant Director of Nursing – Safeguarding Adults	Associate Director of Corporate Nursing and Governance

All IMR authors were independent of direct involvement in the case.

Additional information was sought from:

Adult Social Care – single agency summary

[8] CGM CRC is a provider of probation services to adult offenders and operates under contract to the Ministry of Justice.

ForHousing (formerly City West) - summary information regarding Peter
Greater Manchester Fire & Rescue Service
Pharmacy
Housing Options Service (Homelessness)

1.3.4 Review Panel Members and Meetings

The Review Panel met on the following dates:

13 June 2019 (as a SAR Panel, then expanded once the review became a DHR)

24 September 2019

12 December 2019

25 February 2020

6 May 2020 (by Microsoft Teams)

23 June 2020 (by Microsoft Teams)

A Practitioners' Learning Event was held on 15 October 2019.

Table 2 lists Review Panel members including their role and the organisation they represented.

Review Panel members were all independent of involvement in the case.

Table 2: Review Panel Members

Name	Organisation	Job Title
Alison Troisi	GMP	DS Serious Case Review Unit
Carol Marsh	GMMH	Operational Manager Achieve
David Chambers	GMMH	Operational Manager
Emma Hinchliffe	GMMH	Service Manager
John Fenby	GMMH	Professional Lead for Social Care
Judd Skelton	Salford Council/CCG	Assistant Director Integrated commissioning
Laura Forsythe	CCG	Specialist Nurse
Elizabeth Walton	CCG	Designated Nurse Adult Safeguarding

Janine Mellor	Adult Social Care	Principal Manager
Rebecca Flynn	Salford CRC	Risk & Public Protection Operational Lead
Michelle Hulme	Salford Safeguarding Adults Board	Training and Development Officer
Rob Grigorjevs	ForHousing	Tenancy Support & Sustainment Manager
Roselyn Baker	Salford Council	Principal Policy Officer and Strategic Lead for Domestic Abuse
Stephanie Whitelaw	SRFT	Assistant Director of Nursing
Susan Mary Benbow	Older Mind Matters Ltd	Independent Reviewer / Author

1.3.5 Independent Reviewer/ Author of the Overview Report

Susan Mary Benbow was appointed to the role of Lead Independent Reviewer/ Author on behalf of Older Mind Matters Ltd. She is by professional background a psychiatrist and systemic therapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands and undertook consultant roles in Manchester and then Wolverhampton until 2009 when she retired early from her NHS roles and started to develop a portfolio career in independent practice.

She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past.

She has no connections or ties of a personal or professional nature with the family, with the Community Safety Partnership, or with any other agency participating in this review. She has an ongoing interest in reviews involving older adults and in 2018 published, with colleagues, an analysis of domestic homicide reviews in England involving adults over 60 years of age.

1.3.6 Parallel reviews/ investigations of practice

Any misconduct issues raised during this review were to be addressed to ascertain what action, if any, was required. The Review started after the criminal justice process had been concluded. The perpetrator was convicted of murder and given a sentence of Life, to serve a minimum of 15 years.

A Serious Incident Review had been carried out by Greater Manchester Mental Health and concluded before this Review commenced. This Report was shared with the Reviewer.

A Serious Further Offence Review had been conducted by Cheshire and Greater Manchester Community Rehabilitation Company and concluded before this Review commenced. This Report was shared with the Reviewer.

1.3.7 Equality and diversity

Peter was a man of white British ethnicity. The perpetrator is described as Irish.

Of the protected characteristics age, sex and disability are potentially relevant and have been considered where appropriate during the review process. Age is relevant in respect of the age of the victim (55). Disability is relevant in respect of the victim who had been diagnosed historically with schizophrenia (this diagnosis was later changed) and alcohol related brain damage/ dementia, and was regarded as physically frail with impaired mobility.

It is generally accepted that male victims of abuse in comparison with female victims often face additional barriers to reporting abuse / seeking help for a range of possible reasons, including the 'shame' of being abused as a man. A report by the ManKind Initiative in 2017[9] found that men as victims of partner abuse are over three times less likely than women to **not** tell anyone about the partner abuse they are suffering. Although Peter was not subjected to intimate partner abuse, similar barriers may well have been relevant to his situation.

1.3.8 Dissemination of the final Report

The final Report and/ or the Executive Summary will be disseminated to all involved agencies and also published. The Panel offered to share the Report with the family prior to publication and the Independent Reviewer shared the recommendations with a member of the family by telephone.

[9] See http://new.mankind.org.uk/wp-content/uploads/2015/05/30-Key-Facts-Male-Victims-February-2017-1.pdf

2. BACKGROUND INFORMATION (THE FACTS)

2.1 Summary

Peter was a single white British man, aged 55 when he died in 2018. He had been dependent on alcohol since early adulthood. He had six psychiatric admissions since 2006 thought to be related to alcohol misuse, the latest being in April 2017, and he had been given a historic diagnosis of schizophrenia. The diagnosis of schizophrenia was later revised, as the psychotic illnesses were thought to be secondary to alcohol use. In May 2010 neuropsychological assessment showed cognitive difficulties thought to be related to alcohol misuse which affected his ability to retain verbal information and to make some decisions. In April 2016 there was a safeguarding enquiry following allegations of possible financial abuse. Peter was assessed as lacking capacity to manage his finances and Salford Council became his appointee.

Following this he continued to drink heavily. Community Mental Health Team (CMHT) professionals were involved and professionals' meetings were held. In the months leading up to Peter's death there were concerns that he was being abused/ exploited by others who were taking money from him and taking advantage of him in other ways. There were also concerns about self-neglect. On his last contact with his care coordinator, Peter referred to a man staying at his flat that he did not want to be there (possible 'cuckooing'[10]), but refused to agree that the care coordinator could contact the Police. He agreed that the locks could be changed.

In March 2018 (three days after agreeing that the locks could be changed but before this was done) a 999 call to Police reported that Peter had been found dead at his home address. A Home Office Post Mortem was carried out and the conclusion of the examination was that Peter had died as a consequence of internal bleeding caused by severe internal abdominal injuries caused by blunt force trauma. Subsequently a suspect was identified and charged with murder. The suspect was the man staying at Peter's flat and referred to during the care coordinator's visit.

The Perpetrator was convicted of murder following a trial in October 2018 and sentenced to Life, to serve a minimum of 15 years.

It later emerged that the Perpetrator had been living at Peter's address for 2-3 months prior to the murder. At times practitioners visiting the address had been aware of other people being in the flat, with or without Peter being present, but it had not been clear what their status was.

[10] See https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines for more information about properties used for cuckooing and the link to vulnerable adults.

2.2 Members of the family and the household.

Table 3: Pseudonyms used for people in this Review

Name	Age at time of Peter's death	Relationship	Address
Peter	55	Victim	Salford
Matthew	n/a	Peter's brother	Salford
Daniel	n/a	Peter's brother and carer	Salford
The Perpetrator	45	Perpetrator	Same address as Peter - Salford

Practitioners are referred to in the Report by role.

2.3 Background information

The information below is taken from a statement made by one of his brothers and is included with his consent.

Peter was one of eight brothers and the second youngest. His parents met in their early 20s and stayed together until Peter's father died. They had their sons over a period of 10 years while living in a council house in the area. At that time Peter's father was a labourer and his mother a housewife. The boys' childhood is described as a happy one. The brothers all completed their education with no major problems. At school Peter was said to be popular and to have lots of friends. The brothers were brought up Catholics, attended church every Sunday and all completed their Holy Communions. They were brought up as a close-knit family and remained close as adults.

When he left school at the age of 13, Peter got a job in an appliance shop where he learned how to fix washing machines and various other appliances. He worked there for a few years and, whilst there, made two good friends with whom he remained friends until he died. After this job he did various labouring jobs, but engaged in no long-term periods of employment.

Peter is described as popular with the girls from an early age. After having a few short-term girlfriends, he met the woman who became mother to his two children in his early 20s. They were in a relationship for around 6 or 7 years, and broke up when their younger child was around 4 years of age. Peter then moved back to live with his mother, but had contact with his children for a couple of years after the breakup, taking them round to his mother's house at the weekend. About a year after the relationship ended, he started drinking and, as his drinking increased, he stopped contact with his children, and had not seen them for some years prior to his death.

Peter is described by family as gradually becoming an alcoholic and, alongside that, developing other medical issues, including a psychotic illness and dementia. His mother was a strong woman and she managed to keep him from drinking for around 10 years. She managed his money and ensured he took his medication at the right times as he was unable to do this himself. Eventually she had a stroke and needed care. She died in January 2014. At that time both Peter and another brother (Matthew) were living with her, and both were re-housed after her death.

Once he had control of his own finances, Peter started drinking again. One of his brothers (Daniel) asked the council to re-home him close by, so that he could care for Peter. Daniel became Peter's carer, managed his money, tried to supervise his medication, took him to appointments, clothes shopping, on a weekly shop, made sure he had food in, would get his tobacco, and left him spending money. It is reported that Peter would forget to buy food if it wasn't bought for him and it got to the point where he would forget what day it was. He would call at Daniel's house a couple of days a week, have his tea, and would always ask what day it was: he lost track of time and days. He would sometimes knock on Daniel's door in the early hours of the morning for money, not realising what time it was. Daniel bought him a few mobile phones which he would always end up selling to feed his drinking habit, so for the few years prior to his death he didn't have a mobile.

Around four years ago Peter was referred to a Community Mental Health Team (CMHT) by his doctor and was allocated a mental health worker. He would attend the CMHT base regularly to collect his money and meet the worker. Salford City Council took over management of Peter's finances and Daniel reports that he found this a great help, though he felt that Peter was given too much money per week for his alcohol.

Peter is described by family as a quiet man with a big heart who would do anything for anyone, but this left him open to manipulation by people he considered friends. These so-called friends would go to his flat when he got his money and sit and drink beer with him and, when he didn't have money, they would buy him alcohol. He could never remember who he had borrowed from, so he was an easy target to extract money from.

Peter's family say that he led a simple life and liked nothing more than sit in his flat with a cider and listen to Smooth FM radio: they say that everyone in the community knew him to be a harmless human being. Sometimes he would let people stay at his place if they were struggling for somewhere to stay, including his friend who became the perpetrator of his murder. The family had known this man (the Perpetrator) for many years, as he used to live near Peter's mother's house with his girlfriend.

Peter in the service context

This information is taken from a telephone conversation with Peter's care coordinator and is included with his consent.

Peter was a man with a long history of alcohol dependence together with withdrawal hallucinations and seizures. He also had a long history of self-harm, almost all in the context of alcohol intoxication or withdrawal. A deterioration in his memory had been noted and following investigations he was said to have brain atrophy/ dementia. His mobility was poor, and this was thought to be the result of a fall in the flat. At times Peter took pride in himself and liked to be clean and to wear sportswear. He had little in the way of interests, apart perhaps from football. Sometimes he reflected with sadness on his past life.

Peter's flat was cold and had few belongings in it. He slept on a sofa and latterly the door to the flat was hanging off, leaving him at the mercy of anyone passing by.

The care coordinator knew Peter for the last couple of years of his life and regarded Peter's main problem as alcohol addiction. His brother, Daniel, was his main carer, did food shopping for him and gave him money but Peter often asked for more cash. Later Salford City Council took on appointeeship and bills were paid directly: this seemed to work reasonably well. The care coordinator was aware that Peter would have people with him when he was seen, and that they did not always have his best interests at heart, but, when Peter was asked about it, he would give different accounts. If he had a detox and returned to his flat, the concern was that he would continue to be accessed by the same circle of people and would relapse back into his former lifestyle. Nevertheless, a referral was made for sheltered accommodation but this did not progress.

It seems now that the Perpetrator had been staying with Peter for 2-3 months and that Peter had no control over his comings and goings.

2.4 Chronology

2.4.1 Narrative chronology

Context

Peter died as the result of an assault at the age of 55. He had been known to local alcohol services since 2000 and to a local CMHT from 2005. He had a historic diagnosis of schizophrenia (but psychotic symptoms were increasingly thought to be secondary to alcohol misuse) and a diagnosis of brain atrophy/ dementia, again thought to be related to alcohol misuse: this latter condition affected his ability to retain verbal information and to make some decisions. He was regarded as frail for his age with impaired mobility that was believed to have followed a fracture incurred in a fall. Salford City Council acted as his appointee from 2016, as he had been assessed as lacking the capacity to make decisions about his finances.

Whilst his mother was alive Peter lived with her and it appears that she managed his finances and therefore his drinking. After she died in January 2014, Peter was rehoused in a flat and drank more heavily. By the time the detailed chronology (see below for an abbreviated and edited chronology) starts in March 2017 he was regarded as addicted to alcohol and was living in a flat with poor self-care, few belongings and attending a local Emergency Department frequently in relation to alcohol use and incidents of self-harm. The flat was noted not to be heated, yet the property had gas central heating and a boiler had been installed in 2012. There had been ongoing issues with no access to the property to check the boiler which on one occasion resulted a warrant to gain access. In addition, sometimes the question of whether Peter had ingested other substances was raised. He collected his "spends" from the CMHT base weekly.

March 2017-December 2017

By April 2017 the flat was noted to be dirty, untidy and "odorous". On 16 April Peter presented at an Emergency Department after cutting both wrists with a razor blade. He was agitated, voicing suicidal ideas, and complaining of auditory hallucinations, and was admitted as a voluntary patient to a psychiatric unit from which he was discharged on 26 April. At an assessment by the Mental Health Liaison Team in May 2017 a pattern was noted: he would use alcohol for 3-4 days after obtaining his money, then withdraw from alcohol before feeling low in mood and hopeless, often culminating in suicidal behaviour. He disclosed to his care coordinator and the Mental Health Liaison Team that his house had been burgled three times since the start of the year and while he was in hospital.

A professionals' meeting took place on 8 June 2017, and agreed the following: six months support from the Achieve Salford High Impact Substance Misuse Team (HISMT) (previously known as Alcohol Assertive Outreach Team, employed by SRFT, and sub-contracted by GMMH Achieve

Treatment and Recovery Service) and referral for sheltered accommodation. On 25 August the senior nurse from the HISMT liaised with the consultant from the in-patient drug and alcohol unit and agreed that a referral for a detoxification admission would be made once Peter was in new accommodation.

A further professionals meeting took place on 1 September 2017 and it was noted that Peter appeared to have a group of people around him on the day he collected his money and that he was unable to assert himself against people using his flat. A move to new accommodation was regarded as the best way to address these concerns and the HISMT took the lead on this, but Peter needed to obtain formal identification in order to complete the application process for sheltered accommodation. Information from the Housing Options Service[11] is that the application was never made active as Peter failed to provide the necessary documents – identification, proof of address, etc. At the meeting it was also agreed to request community visits to the flat from the police in order to deter unwanted visitors: this request was made by the care coordinator on the same day and the plan was for community support officers to 'doorstep' Peter.

At a home visit on 22 December 2017, Peter reported poor dietary / fluid intake and struggling to walk relatively short distances. He was low in mood and reported frustrations with people coming to his house asking for money, food and cigarettes. The front door was described as covered with foot prints. Following this visit, it was planned to arrange a review with the consultant psychiatrist and the senior nurse from the HISMT.

January to March 2018

Peter was visited 5 times by his care coordinator between January 2018 and his death at his home address in the early hours one day in late March 2018. Until the end of February 2018, the plan was for him to be seen weekly at home by the HISMT, however this was dependent on him being there and letting them in. He was also seen weekly at the CMHT and pharmacy when he picked up his money and medication respectively (from March 2018 he collected his medication from the pharmacy daily).

At home visits on 5 January 2018 and 11 January 2018 the care coordinator noted the flat to be very untidy and dirty. A sign saying 'free cash withdrawals and note machine' was seen in the flat: it is unclear whether this was a joke or whether it referred to people taking advantage of Peter. Concerns that Peter had begun using substances were also raised (as he had reportedly disclosed this at the pharmacy), but he denied using substances when asked by the care coordinator. There were continuing concerns in relation to financial abuse. At the first visit, despite collecting £150 two days earlier, Peter had no money. At the second visit, Peter's relations with an associate were

[11] The Housing Options Service manages Salford Home Search, a web-based housing register. People are encouraged to self-register which means that for many people registered there is no face to face contact, as they are also encouraged to search and bid for properties on-line.

discussed: she had been at his flat at 9am for the past four money collection days and Peter reported that she was only interested in him for money, cigarettes and alcohol. When he gave her money for his shopping, he said that she would just take the money. Peter said he did not know how to stop this and felt low in mood as a result. It was agreed that a referral should be made for supported accommodation. (The GP had recently sent a letter to the care coordinator asking that supported accommodation be considered.)

After this, the care coordinator did not see Peter on a home visit until 12 March 2018: there was no answer on 31 January (although people were thought to be in the flat), on 12 February and 26 February. The GMMH IMR notes that there will have been brief weekly contacts at the CMHT when Peter collected his money, but the system is that clients sign for their money when they collect it in a book held in reception: nothing is recorded on Paris, the electronic patient record and case management system. On 7 February the care coordinator and the senior nurse from the HISMT met, and the latter noted that it was often difficult to talk to Peter at home as there were associates there. He reported that the HISMT would be closing Peter's case at the end of the month because of poor engagement. The plan was for the care coordinator to refer Peter for supported accommodation. On 12 March poor self-care was observed and Peter had no money, no food, and had needed to borrow tobacco from his brother. Despite this, Peter reported he had stopped buying alcohol for others and felt less harassed. Accommodation options were discussed and Peter said that he would take supported accommodation if offered.

Late March 2018, Peter was seen again by the care coordinator at a routine home visit. He was intoxicated and reported that a man had been staying at his flat for the past two months, that this man (later identified as the Perpetrator) kept the only front door key around his neck, was coming and going as he pleased, and was sleeping in the only bedroom. This man appeared to be taking Peter's money each week, buying alcohol for them both and taking any remaining money. Peter had no money or food despite picking up his money two days earlier. Peter was clear he did not want this man at his flat but said he felt unable to challenge him as he was physically intimidating. Peter declined getting the police involved, but agreed that the care coordinator could request that the locks be changed. The care coordinator planned to visit again in a week and to discuss the situation with the CMHT safeguarding lead.

Three days later, a 999 call to Police reported that Peter had been found dead at his home address. Internal injuries consistent with assault were discovered at post-mortem examination and subsequently a suspect was identified and charged with murder. The suspect was the man referred to during the care coordinator's visit. He had been released from prison 3 months before the murder and had been known to Peter in the past. This man was later convicted of Peter's murder.

2.4.2 Abbreviated and edited chronology

Unshaded events refer to the victim

Shaded events refer to the perpetrator

Date	Source	Detail
6/6/2016	Client Affairs	Received confirmation appointeeship had been granted.
7/6/2016	NWAS	Peter taken to Emergency Department intoxicated, abusive and violent – NWAS flagged his home address.
26/10/2016	GP[12] GMMH-MH	Letter received regarding financial concerns.
9/11/2016	GP[13] SRFT	Seen in Emergency Department – stating he was going to die and requested detoxification.
1/2/2017	GMMH-MH SRFT	Taken to Emergency Department – found intoxicated in the street and had taken crack cocaine. Seen by Mental Health Liaison Team (MHLT). Aggressive. Self-discharged.
3/2/2017	GMMH-MH	Seen by MHLT. Took tablets while intoxicated – frustrated with constant cycle of alcohol abuse. Self discharged.
10/2/2017	GMMH-MH	Home visit by care co-ordinator and a doctor from the Mental Health service. Poor self-care. No heating in use.
17/2/2017	GMMH-MH	Seen by MHLT. Alcohol related seizure. Had been assessed as having capacity to refuse support.
4/3/2017	GMMH-MH	Seen in Emergency Department, then EAU. Seen by MHLT. Collapse - ? had taken cocaine and heroin. Later denied taking drugs.
5/3/2017	GMMH-MH	Agreed to engage with alcohol services.
6/4/2017	GMMH-MH SRFT	Went to Hospital by ambulance. Seen by MHLT. Suicidal thoughts, voices.
10/4/2017	GMMH-MH	Home visit by care coordinator. Withdrawing. Continuing self-neglect. Flat more dirty, untidy, “odorous”.
15/4/2017	GMP SRFT	Cut wrists with blade, police called, then ambulance. Seen in Emergency Department.
16/4/2017	GMMH-MH	Seen by MHLT. Diagnosis (historic) of schizophrenia. Low mood. In patient admission, expressing suicidal intent. Arranging a professionals’ meeting.
26/4/2017	GMMH-MH	Seen by MHLT. Discharge date.
5/5/2017	GMMH-MH SRFT	Attended Emergency Department – took overdose when intoxicated.

[12] Information included in chronology from GP records – attributed to GMMH-MH.
[13] Information included in chronology from GP records – attributed to SRFT.

8/5/2017	GMMH-MH SRFT	MHLT seen and expressed wish to remain abstinent.
13/5/2017	NWAS GMP GMMH-MH SRFT	Told by-passers that he had taken overdose and ambulance called. Reference to burgled 3 times this year, self-neglect, not eating. Police officer described him as a “frail alcoholic”. Taken to Emergency Department and seen by MHLT.
14/5/2017	GMMH-MH SRFT	Seen again by MHLT in Emergency Department and discharged.
16/5/2017	GMMH-MH GMMH-SM SRFT	Professionals’ meeting. Attended by Care Coordinator, Dual diagnosis practitioner, and Substance Misuse Practitioner. Reviewed the history of Peter's interventions. In-patient admission from 11 April until 26 April 2017, partly because of increased risk of self-harm and partly for alcohol detox. Since discharge, 2 weekends admitted to general wards at SRFT: he had presented with suicidal thoughts and intoxication. Flat had been burgled 3 times this year: he is clearly a vulnerable adult. Accommodation identified as a major factor in the maintaining factors that keep Peter using alcohol. He also identified unwanted visitors using his flat to drink. Spoke to Peter about options: needs to show he is motivated. Support with housing from Great Places. He is at the CMHT base weekly to collect cash.
21/5/2017	SRFT	Seen in Emergency Department - intoxicated.
22/5/2017	SRFT	Seen in Emergency Department - collapsed, suicidal.
23/5/2017	GP[14]	Emergency Department letter – “unwell adult”.
26/5/2017	SRFT	Seen in Emergency Department – mental illness, intoxicated and confused.
28/5/2017	SRFT	Seen in Emergency Department – collapsed adult.
31/5/2017	GMMH-MH	Care coordinator noted Peter refused to attend CPA, encouraged by an associate not to attend.
6/6/2017	SRFT GMP GMMH-MH	Police involved following threats of suicide. Seen by MHLT in Emergency Department – mental illness.
8/6/2017	GMMH-MH GMMH-SM SRFT	Professionals’ meeting. Historic diagnosis of paranoid schizophrenia. “Vulnerable adult at risk of exploitation in the community” – self-neglect, cognitive deficits.

[14] Information included in chronology from GP records – attributed to SRFT.

9/7/2017	GMP	Detained at local supermarket taking 2 bottles of wine – banned.
29/7/2017	SRFT	Attended Emergency Department – drunk.
2/8/2017 to 4/8/2017	GMMH-MH SRFT	Care coordinator note. At CMHT base breathing laboured, fell and had 2 seizures. Taken to Hospital. Admission. Letter to GP – unwell adult. Seen by MHLT on 4/8.
8/8/2017	SRFT	Attended Emergency Department – drunk.
1/9/2017	GMMH-MH AAOT	Professionals' meeting. Noted a number of people around Peter especially on when he collects his cash from the CMHT base. These people not acting in a supporting role; they are drinking Peter's alcohol and probably eating his food. Move would help manage the group exploiting him.
9/10/2017	GMMH-MH	Care coordinator noted seen at CMHT base. Money split for collection twice weekly.
10/11/2017	SRFT	Attended Emergency Department following overdose.
1/12/2017	GMMH-SM	Perpetrator released from prison 4/12/2017 under supervision and on licence until 5/5/2019. Detoxified in prison.
4/12/2017	GMP	Perpetrator released from Custody - no release address recorded on the Police National Computer.
18/12/2017	GMMH-SM	Perpetrator failed to attend appointment.
19/12/2017	GP	History of heroin misuse last night. Well presented.
22/12/2017	GMMH-MH	Home visit by care coordinator. People asking him for money, food and cigarettes.
5/1/2018	GMMH-MH	Home visit by care coordinator - front door on the catch so anyone could gain entry. Peter's self-care was poor. Care co-ordinator suggested he had a shower, made himself a meal and drank plenty of water. Peter agreed he would do so. Peter's flat was untidy and the carpet was dirty. Someone had put a swing sign in his flat that read 'free cash withdrawals and note machine'. Peter denied any substance use, denied any thoughts to harm himself, not compliant with medications - could not remember what he had taken and when. Of the £150 collected from CMHT base two days ago, Peter had no money left. Peter did have food in his kitchen. Kitchen particularly badly kempt- flies, dirty plates of food, unwashed plates, grubby cupboard doors and flooring.
8/1/2018	GP	Telephone consultation with Pharmacy – ongoing concerns that Peter is using all his medication in 3 days. Agreed to change him to daily prescriptions during the week and 3 days at weekends.

10/1/2018	GMMH-SM CRC	Sofa surfing. Long history of opiate use, injecting and smoking cocaine. No fixed abode.
11/1/2018	GMMH-MH	Care coordinator home visit. Peter presented with poor self-care, very dry skin patches on his face that were peeling in places. Bare feet (dirty) and long toenails, suspected he had lost some weight recently. Continues to drink to dependent levels. Discussed Peter's exploitation at the hands of a female associate, who is basically only interested in him for money, cigarettes or alcohol. She had been at his flat at 09.00 for the past few Wednesdays and had accompanied him to the CMHT base to collect his £150 cash. Peter then gives her the cash to get his shopping but she just pockets the money leaving Peter with nothing. Peter understands that this is wrong but had no idea how to prevent this exploitation. Peter's flat was reasonably tidy and he had vacuumed the carpet - kitchen remained very dirty, and in need of a deep clean. Little food available. Discussed that the main issue/hurdle is that he needs a change of accommodation. Care coordinator had agreed to refer him to supported accommodation. Peter agreed that a move would help him feel less vulnerable and may help reduce his drinking because his motivation may improve with a change of environment.
13/1/2018	NWAS	Ambulance called – refused to go to hospital. Documented to have capacity.
17/1/2018	CRC	Speed balling 3 times/ day. Some lager and cannabis. Complaining of paranoia.
23/1/2018	GMMH-MH	Management plan put in place.
31/1/2018	GMMH-MH	Home visit by care coordinator. Did not answer. Man shouted that Peter had gone out. Had collected money that day.
7/2/2018	GMMH-MH	Care coordinator met Senior Nurse Practitioner – being financially exploited – plans to get him away from those abusing him.
12/2/2018	GMMH-MH	Home visit by care coordinator. No reply.
26/2/2018	GMMH-MH	Home visit by care coordinator. No reply.
28/2/2018	GMMH-MH CRC	3 way meeting. Delay in referral to MO:DEL team, first mentioned 17/1/2018. (Note the MO:DEL team offers liaison and criminal justice diversion services.)
12/3/2018	GMMH	Home visit by care coordinator. Presented with poor self-care. He said that he had stopped buying alcohol for other people and so he was less harassed. Peter said that he would accept supported accommodation if offered.

Later in March 2018	GMMH	Home visit by care coordinator. Told care coordinator that a man staying at the flat for 2 months and had taken front door key. Said he did not want this man in flat and he was “physically intimidating’. Impression that this man taking money. Peter did not want Police told but was okay for the care coordinator to discuss with ForHousing (regarding changing the locks). Plan to discuss with safeguarding lead.
3 days later	NWAS	Found in cardiac arrest by “friend” (Perpetrator) in early hours.

3. ANALYSIS

Themes identified during the Practitioners event are set out in a separate document and related to the following areas:

- Safeguarding and multi-agency working
- Vulnerability and risk
- Offender checks and balance
- Housing
- Money management
- Resources for practitioners in challenging situations

The analysis addresses the key lines of enquiry from the terms of reference in section 3.1 and other relevant issues in section 3.2.

3.1 Issues raised in the Terms of Reference

The terms of reference for the DHR/ SAR included 15 key lines of enquiry. The numbers 3.1.1 to 3.1.15 refer to the points in the terms of reference (see 1.2.3) but the key lines of enquiry are grouped below under themes.

Theme 1: domestic abuse, coercion and control

3.1.1 The victim had no known contact with any specialist domestic abuse agencies or services. Could more have been done to inform local residents about services available to victims of domestic abuse?

3.1.2 Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator to the victim.

3.1.3 Whether there were any barriers experienced by the victim or family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should he have wanted to.

3.1.4 Whether there were any warning signs and whether opportunities for triggered or routine enquiry and therefore early identification of domestic abuse were missed.

3.1.5 Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or the alleged perpetrator that were missed.

3.1.9 Consider the possible role of coercion and control.

These six key lines of enquiry (3.1.1, 3.1.2, 3.1.3, 3.1.4. 3.1.5 and 3.1.9) are addressed together below.

Understandings of domestic abuse: Peter was not regarded as at risk of "domestic abuse" in part because there are different understandings of what constitutes domestic abuse, in part because different terms are used to describe it [15]. Thus, although the perpetrator was living in the same household as the victim, not all agencies would regard this as a situation of potential domestic abuse although they would be likely to understand it as fitting into coercion and control and/or exploitation. Practitioners' understandings of domestic abuse are relevant as they will influence responses to domestic abuse.

The Home Office guidance on domestic violence and abuse[16] defines domestic abuse as follows:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional.* (page 2)

The GMP IMR helpfully includes the definition of domestic abuse used by GMP:

> *any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.*

The relevant definition for this DHR is the one in the Domestic Violence Crime and Victims Act s9(3) 2004[17], which includes the following within the definition of domestic homicides:

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 was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself.

Thus, this case is regarded as a domestic homicide because the perpetrator was a member of the same household as the victim, Peter. Nevertheless, the

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[15] See What's in a name? Family violence involving older adults. Benbow SM, Bhattacharyya S & Kingston P. The Journal of Adult Protection (2018) **20** (5/6): 187-192 https://doi.org/10.1108/JAP-08-2018-0016
[16] See Home Office. (2018). Guidance domestic violence and abuse. Retrieved from https://www.gov.uk/guidance/domestic-violence-and-abuse - domestic-violence-and-abuse-new-definition
[17] http://www.legislation.gov.uk/ukpga/2004/28/section/9

issue of differing terminology/ understandings of domestic abuse[18] means that, to many practitioners, abusive behaviour between the perpetrator and Peter would not have been regarded as falling within their understanding of domestic abuse, although it would potentially have been (and was) recognised as abusive, coercive and/ or exploitative.

From the written records and discussions during this review we know that Peter was regarded, by practitioners in contact with him, as vulnerable and at risk of exploitation by those he regarded as 'friends' and who latterly included the perpetrator. Does safeguarding training address how vulnerable people might be exploited by those they describe as, and regard as, 'friends'?

Warning signs included the following:

Prior to the detailed timeline:

10 Nov 2016	Daniel visited the CMHT and conveyed concerns to the care coordinator, including worries about Peter's continuing alcohol misuse, and about people using Peter's flat to take alcohol and drugs and sometimes taking Peter's cash and belongings.
23 Nov 2016	Similar concerns were raised at an assessment Peter had with GMMH-SM. At this appointment, Daniel reported that people always called when Peter had money and, because he left the door open, they would usually just walk in. He noted that, since the CMHT had managed Peter's finances, he would generally have no food in the house. Peter shared that he did not feel safe at his flat and wanted to move.

Despite these safeguarding issues in the latter part of 2016, there is no record of an adult safeguarding referral being made.

During the detailed timeline of this review there were other occasions when concerns were noted:

13 May 2017	Reference to being burgled three times this year.
8 June 2017	At professionals' meeting: "Vulnerable adult at risk of exploitation in the community". It is unclear to what extent ongoing safeguarding issues (e.g. unwanted visitors at his flat) were discussed at this point and whether consideration was given to making a safeguarding referral.

[18] See What's in a name? Family violence involving older adults. Benbow, Bhattacharyya & Kingston. The Journal of Adult Protection (2018) **20** (5/6): 187-192, https://doi.org/10.1108/JAP-08-2018-0016

1 Sept 2017	Professionals' meeting noted a group of people around Peter when he collected his money. Despite increasing safeguarding concerns, there is no evidence that other housing options (e.g. supported accommodation, residential respite) that may have been more readily available got discussed at this meeting.
22 Dec 2017	Told care coordinator that people were asking him for money, food and cigarettes. There was still no adult safeguarding referral despite all the indicators. Alternative accommodation options could have been considered that may have been quickly available including urgent residential respite placement.
11 Jan 2018	Peter told the care coordinator about an associate who was only interested in him for money, cigarettes and alcohol, and who would take the money and not get his shopping.
2 Feb 2018	Care coordinator met the Senior Nurse Practitioner and noted concerns about financial exploitation.
March 2018	Peter told care coordinator about a person staying at the flat for two months who had taken front door key and was "physically intimidating'.

Understanding of coercion and control: There is documented evidence that Peter was the victim of burglaries and exploitation, including financial exploitation, often involving people who he perceived to be "friends" but who others felt did not have his best interests at heart.

The Home Office definition of coercive behaviour, taken from Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework[19] (2015), is as follows:

Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another.

The document this definition is taken from refers to intimate or family relationships, but evidence suggests that Peter's "friends" were exploiting him and taking advantage of him in ways that fit with the concept of coercive behaviour.

[19] See Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

Another way of understanding how Peter's "friends" may potentially have influenced him is by exerting undue influence, which is defined in a legal dictionary[20] as follows:

Virtually any act of persuasion that over-comes the free will and judgment of another, including exhortations, importunings, insinuations, flattery, trickery, and deception, may amount to undue influence.

The Home Office document Criminal Exploitation of children and vulnerable adults: County Lines guidance (2018) defines child criminal exploitation as follows:

an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual.

But the document goes on to say that it:

can affect any vulnerable adult over the age of 18 years

and

*is typified by some form of power imbalance in favour of those perpetrating the exploitation. Whilst **age** may be the most obvious, this power imbalance can also be due to a range of other factors including gender, **cognitive ability**, physical strength, status, and access to economic or other resources.*

Although age in the phrase quoted above (with bold added) refers to young people being exploited by adults older than them, in respect of frail older adults the power imbalance may be in favour of younger adults who exploit more vulnerable older people. Peter could have been regarded as exploited by his 'friends' financially and psychologically. Cognitive ability is also relevant since it had been established that Peter had cognitive impairments secondary to longstanding alcohol misuse. The document referred to above focuses on children in relation to county lines, but the concept of exploitation describes the situation Peter was in. The difficulty is that (as the Home Office documents state) the activity may appear to be consensual: with respect to Peter, how far was exploitation by others considered and explored and what responses to it could have been considered? (See section below on safeguarding.)

Barriers to Peter disclosing the extent of abuse/ exploitation he was experiencing: There were a number of potential barriers that may have influenced Peter in not disclosing the extent of the abuse/ exploitation that he was experiencing, including fear of his "friends", reluctance to lose the social contact of his "friends", perhaps feeling trapped in his context/ the local area, reluctance/ "shame" as a man to reveal the extent of the abuse/ exploitation.

[20] See https://legal-dictionary.thefreedictionary.com/undue+influence

Nevertheless, practitioners documented signs of the abuse/ exploitation and there were missed opportunities to intervene. Perhaps barriers to practitioners responding to the abuse/ exploitation are also relevant here, the likely main one being that what was happening to Peter was regarded as consensual and Peter's presumed autonomy was privileged over his safety. An example of a missed opportunity was a potential move: there was discussion about the potential benefits of Peter moving to more appropriate accommodation - acting on this stalled when Peter could not produce identification (ID). Another example is that when he had a mobile phone Peter would sell it for money: this meant that he could not contact services in an emergency. Had his situation been recognised as abusive/ exploitative other options could have been considered eg a panic alarm, assisting him with obtaining ID documents instead of leaving the onus on him. A safeguarding process would have provided the framework for a broader community safety approach to his care.

The **conclusions** arising from these six key lines of enquiry are:

- That Peter's situation does not fit with many practitioners understanding of domestic abuse and is more readily understood as involving coercion and control and exploitation of a vulnerable person.
- That practitioners working with Peter were aware of aspects of his exploitation by so-called friends but regarded it as consensual. (See also Theme 3 legal issues where use of the Mental Capacity Act 2005 is addressed).
- Peter was regarded as living a 'risky lifestyle'. This raises the question of how far his vulnerability was seen as resulting from 'lifestyle choices'. (See also the section on use of the Mental Capacity Act.)
- There were missed opportunities to initiate a safeguarding process (see below).
- A safeguarding process could have introduced a broader community safety perspective (see Theme 2)

Theme 2: Safeguarding issues

Three key lines of enquiry (3.1.7, 3.1.11, and 3.1.15) are addressed below under the theme of safeguarding issues.

3.1.7 Consider the potential role of safeguarding processes and section 42.

There were a number of missed opportunities to invoke safeguarding processes, including the following:

10 April 2017	Home visit by care coordinator – self-neglect, inability to cope in the community, frequent attendances at Emergency Department. No evidence that a safeguarding referral was considered at this point despite continuing self-neglect and inability to cope. If the situation at this

	point was thought to be below the threshold for a safeguarding referral, local self-neglect policy and procedures could have guided practice.
13 May 2017	Mental Health Liaison Team saw Peter after he attended the Emergency Department following an overdose. A safeguarding referral was considered but not thought to be required – perhaps because a professionals' meeting was due to take place shortly.
16 May 2017	Ongoing vulnerabilities and had been burgled 3 times. Safeguarding referral not initiated and the burglaries were not reported to the Police, so a Police welfare call was not logged.
31 May 2017	An associate was encouraging Peter not to attend his CPA review. This could have been taken as a safeguarding concern.
8 June 2017	Professionals' meeting. Not clear whether a safeguarding referral was considered despite unwanted visitors to flat, self-neglect and ongoing concerns about financial exploitation.
3 August 2017	Concerns with respect to female friend who had her own key to his flat and was believed to be financially exploiting Peter. No evidence that a safeguarding referral was considered.
1 Sept 2017	Professionals' meeting. Group of people known to be financially exploiting Peter - he was regarded as unable to resist. He could not control who had access to his flat. There were people around when he collected his money who were believed to be drinking his alcohol and possibly eating his food. Mounting safeguarding concerns at this point.
22 Dec 2017	Home visit by care coordinator. Peter said he had had enough of people continually knocking on his door persistently until he opened it; people asking him for money, food and cigarettes; finds it very difficult not to open the door. His front door was noted to be painted white and covered in foot prints from people kicking it. Noted that he was not eating and drinking properly and that his medications were at a 'friend's' house. No evidence that safeguarding referral considered.
11 Jan 2018	Home visit by care coordinator. Documented self-neglect and neglect of kitchen; exploitation at the hands of female associate documented. Further safeguarding concerns

	but s.42 procedures still not triggered and no urgent measures discussed. There could have been consideration of how the appointeeship framework could have been used differently to ensure Peter ran out of money less and had food/ other essential items.
31 Jan 2018	Unannounced home visit by care coordinator. Peter did not answer the door. An unknown man came to the window and shouted down that Peter had "gone out". Peter would have collected his money from the CMHT base that day.
23 March 2018	Home visit by care coordinator. Told care coordinator that a man had been staying at his flat for the past two months. He had taken Peter's only front door key and was wearing it on string round his neck. He had been sleeping at Peter's flat in the bedroom, coming and going as he pleased. Peter said he didn't want this man in the flat, but that he did not know how to challenge the man, who was physically intimidating. Impression was that this man had taken all Peter' s money every week, bought alcohol for both of them and pocketed the rest. Peter had no money or food in the flat two days after the weekly money collection. Care coordinator asked Peter if he wanted the Police involved but he said no.

From the practitioners' event, information in the IMRs and a telephone interview with the care coordinator it appears that the perception of practitioners was that safeguarding would not add to the efforts that were already being made, and that the professionals' meetings already brought people together in a way that was similar to how a safeguarding process would operate. The recurring rationale (evident from the GMMH IMR) appeared to be that adult safeguarding procedures were not going to add to what was already being done. It may also have been thought that this was Peter's lifestyle. There were numerous points from 2016 onwards where safeguarding referrals could and should have been raised but were not.

However, as pointed out at the practitioners' event, involving other agencies (Housing and GMP being two important ones) a safeguarding referral might have brought in new ideas and offered alternative ways of intervening eg referring to the Tenancy Support and Sustainment service operated by ForHousing. It is, of course, impossible in retrospect to know what difference, if any, this might have made. Alcohol Change UK has highlighted a need for national guidance in relation to safeguarding thresholds in people who self-neglect due to alcohol misuse.

An additional point is that SRFT has a frequent attenders process and this could (and arguably should) have been invoked in response to Peter's frequent attendances at the Emergency Department.

3.1.11 Consider financial abuse and how services addressed potential risks.

Peter's mother is described by family as having kept him from drinking for around 10 years. She managed his money and ensured he took his medication. She died following a stroke in early 2014. After this, one of his brothers (Daniel) became Peter's carer, managed his money, supervised his medication, took him to appointments and shopping, tried to make sure that he had food and tobacco, and left him spending money.

In March 2016 an application was made for Salford City Council to take over appointeeship on Peter's behalf. This followed a mental health admission in early summer 2015 when an adult safeguarding referral was raised due to concerns that one of his brothers, who was the formal appointee for his finances, was not releasing appropriate amounts of money to Peter. Peter was assessed as lacking capacity to manage his finances. Formal appointeeship was transferred to Salford City Council in June 2016, and after that arrangements were made for Peter to collect money from the CMHT base. These events fall outside the detailed timeline of this Review but are important context. The Panel understands that no improper conduct was established on behalf of Peter's brother.

In November 2016 Daniel visited the CMHT and conveyed concerns to the care coordinator. He expressed worries about Peter's continuing alcohol misuse, and said that people were using Peter's flat to consume alcohol and drugs and were sometimes taking Peter's cash and belongings. Daniel raised similar concerns at an assessment Peter had with Achieve that same month. He reported that people always called when Peter had money and, because he left the door open, they would usually just walk in. He commented that since the CMHT had managed Peter's finances, he would generally have no food in the house and that Peter had said he would rather Daniel managed his finances. It seems likely that Peter's mother may have managed his drinking by limiting his access to money to buy alcohol and that his brother may have endeavoured to do so too, but that this attempt to manage Peter's access to funds may have appeared unduly restrictive to Peter and possibly to others.

The system of collecting money from the CMHT weekly did not solve the problem of financial exploitation by so-called friends. Practitioners involved in Peter's care were alerted to this prior to the timeline of this Review and there are regular references to it in the detailed chronology e.g. at the professionals' meetings. Indeed, the proposal to seek alternative accommodation was related to a perceived need to support Peter in getting away from the people who were exploiting him. The financial exploitation, ongoing coercion and control, unwanted visitors at the flat and self-neglect were all interrelated and could have led to a safeguarding referral.

From checking records, it has been confirmed that twice weekly money collections had appeared to commence in mid-July 2017 but were patchy until the end of August 2017, then reverted to weekly in September 2017. There was then a period of more consistent twice weekly pick-ups from the start of October 2017 (following a decision

that month to change to regular twice weekly pick-ups) until mid-November 2017, when collections reverted back to weekly until mid-December 2017. Pick-ups were patchy until mid-January 2018 and then were consistent twice weekly pick-ups (apart from one week) until Peter's death. Amounts varied slightly but it was all recorded in a book and signed for. The inconsistency at times may have related to Peter struggling to adhere to the twice weekly arrangement, perhaps due to owing money or being pressured to give others money / buy alcohol for them etc. Twice weekly money collection and other alternatives could have been considered earlier as there was evidence of financial exploitation over a lengthy period.

This financial abuse/ exploitation occurred within a broader context of economic abuse, in that Peter's economic resources were being exploited, including his property, housing and food. The practitioners involved with Peter only recognised the extent of this abuse shortly before his death, although indicators of the abuse had been noted over a longer period. The two likely possible reasons for this are that Peter's situation was regarded as a lifestyle choice and that his care was organised from a health perspective without a broader view of his vulnerabilities. The missed opportunities to initiate a safeguarding process were also missed opportunities to include broader perspectives on what was happening to Peter.

3.1.15 Consider whether there was evidence that Peter was self-neglecting, the response by agencies and the impact of this.

There are documented concerns about Peter neglecting himself dating back prior to the detailed timeline of this review:

21Sept to 28 Oct 2015	Hospital admission noted concerns in relation to self-neglect.
June 2016	Increased concerns in relation to self-neglect.
2 Aug 2016	GP phoned the CMHT with concerns following a home visit. She said the door had been open, that there was no food in the house and Peter was using a milk bottle to urinate in.

And concerns were documented regularly throughout the timeline, including the following:

10 April 2017	Care coordinator home visit: Peter's flat noticeably more untidy and dirty, with half eaten meals on plates not washed up in the kitchen making the flat odorous. He appeared to be sleeping on the sofa.
13 May 2017	Mental health liaison team risk assessment: Self-neglect-moderate.
8 June 2017	Professionals' meeting: at risk of self-neglect. There is no evidence from the notes or via interviews undertaken for the IMR that the self-neglect policy was considered.

22 Dec 2017	Care coordinator home visit: Peter's self-care was not good. He had flaky skin patches on his face.
5 Jan 2018	Care coordinator home visit: Peter's self-care was poor… flat was untidy and the carpet was dirty.
11 Jan 2018	Care coordinator home visit: Peter presented with poor self-care. He had very dry skin patches on his face that were peeling in places. Bare feet (dirty) and long toenails.
26 Feb 2018	Seen by Gastro at SRFT – concerns re alcoholism/ self-neglect and vulnerabilities.
7 Feb 2018	Care coordinator discussion with Senior Nurse Practitioner: Peter continued to be at risk of self-neglect and both had observed this getting more evident recently… his kitchen remained very dirty, and in need of a deep clean. He had little food available.

Visits to Peter's address documented evidence of neglect of self-care/ hygiene, dietary intake, and his home environment. The Care Act (2014) recognises self- neglect as a form of neglect. A person is defined as self-neglecting (Page 2 of Braye, Orr and Preston-Shoot, 2015)[21] when they present with one or more of the following:

- *Lack of self-care, including hygiene, nutrition, hydration and health*
- *Lack of care of one's environment, including squalor and hoarding*
- *A refusal of services which would mitigate the risk of harm*

Peter arguably met all three of these criteria and alcohol is recognised as linked with self-neglect.

Alcohol Change UK's Report notes that:

People with complex needs who are self-neglecting may require flexible, outreach-driven services in order to address their alcohol problems. Alcohol Change UK, page 15

The **conclusions** from these three key lines of enquiry related to safeguarding are:

- That there were missed opportunities to initiate safeguarding processes

[21] See https://www.scie.org.uk/files/self-neglect/policy-practice/self-neglect_general_briefing.pdf

- The acute Trust frequent attenders' process could have led to a safeguarding response
- The financial/ economic exploitation could have led to a safeguarding response
- The documented self-neglect could have led to a safeguarding response
- The rationale throughout amongst those working with Peter appeared to be that practitioners' meetings were being held and that safeguarding "would not add anything"
- The absence of information sharing meant that primary care involvement was lacking
- That safeguarding offers a multi-agency structure that may open up possibilities that otherwise might not be considered

Theme 3: Legal issues

Two key lines of enquiry (3.1.6 and 3.1.12) relating to legal issues are addressed below.

3.1.6 Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim or perpetrator.

Age is a protected characteristic under the Equality Act[22]. Peter was 55 when he died. Older prisoners are often defined as those aged over the age of 50[23], due to the accelerated ageing associated with being in prison, but there are other circumstances where people might be regarded as subject to accelerated ageing, and one of these is long term alcohol misuse/ addiction. Alcohol may accelerate conditions that are usually regarded as related to ageing[24] including cognitive impairment and some physical health conditions. This was likely to be the case with Peter who was sometimes described as frail with impaired mobility and had been diagnosed with cognitive impairment/ dementia.

Disability is also a protected characteristic under the Equality Act and is relevant to Peter. The Equality Act 2010 (Disability) Regulations 2010[25] state that:

addiction to alcohol, nicotine or any other substance is to be treated as not amounting to an impairment for the purposes of the Act.

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22 See https://www.equalityhumanrights.com/en/equality-act/protected-characteristics
23 See https://www.ageuk.org.uk/globalassets/age-uk/documents/policy-positions/care-and-support/ppp_older_prisoners_en_wa.pdf
24 See https://drinkwiseagewell.org.uk/professionals/ageing-alcohol/
25 See http://www.legislation.gov.uk/uksi/2010/2128/made

However, alcohol addiction may result in physical or mental impairments that amount to a disability, since disability covers physical or mental impairments which adversely affect a person's ability to carry out their normal activities of daily living: Peter's cognitive and physical impairments constituted disabilities.

In this case both of these protected characteristics are particularly relevant in relation to housing/ accommodation options. Some housing/ accommodation options are designed for 'older' adults, yet in some circumstances it might be appropriate to consider them for 'younger' people who have conditions which accelerate ageing. Was the range of options considered for Peter in terms of a move limited by his age and what difference would it have made if options usually focused on older adults had been considered?

With respect to the perpetrator, substance misuse and substance misuse related mental health issues should be mentioned here as relevant issues. Both were acknowledged and addressed by the services involved with the perpetrator after he left prison.

One further aspect is the stigma associated with substance misuse and alcohol misuse and the possible perception amongst some practitioners, families and members of the public that alcohol misuse and substance misuse are 'lifestyle choices'. Alcohol Change UK[26] summarises this succinctly as follows:

All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinkers.

This Review found no evidence of stigmatising practices on behalf of practitioners involved, rather that they showed commitment to working with people in complex and difficult circumstances, although it appears that choices Peter made may have been understood by those working with him as lifestyle choices and as a result his mental capacity to make some decisions was not called into question (see 3.1.12) and risky circumstances were tolerated by the practitioners working with him instead of triggering safeguarding referrals.

3.1.12 How was the Mental Capacity Act relevant and applied in practice.

The Mental Capacity Act (2005) Code of Practice[27] refers to the two-stage assessment of capacity, namely:

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[26] See https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

[27] See Mental Capacity Act 2005 Code of Practice at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)

If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? (page 41, Code of Practice)

It sets out four questions to consider when assessing mental capacity:

Does the person have a general understanding of what decision they need to make and why they need to make it?
Does the person have a general understanding of the likely consequences of making, or not making, this decision?
Is the person able to understand, retain, use and weigh up the information relevant to this decision?
Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful? (page 41, Code of Practice)

The starting assumption is that an adult has mental capacity, unless there are reasons to suspect otherwise.

The GMMH IMR notes that there was little reference made to mental capacity in Peter's case records and it appears that services assumed that Peter had capacity to make the relevant decisions, e.g. to reside at his home address following discharge from the Emergency Department. It appears that services such as the Mental Health Liaison Team did not doubt Peter's mental capacity to make relevant decisions and therefore did not refer to mental capacity issues in the records. It is likely that he presented as more capacitous when more sober. If they assumed mental capacity, this would explain why there was no formal mental capacity assessment in relation to discharge decisions or admissions to wards. However, there are reasons to suspect that Peter's mental capacity may have fluctuated when more intoxicated or when suffering severe withdrawal symptoms, and it is likely his decision-making capacity in relation to key areas was compromised when intoxicated or when experiencing significant withdrawal symptoms (and a deterioration in mental state). It would have been helpful and appropriate to assess his mental capacity with respect to key areas and key decisions, e.g. care, treatment and residence, when intoxicated or experiencing withdrawal symptoms.

In addition, in May 2010 neuropsychological assessment had demonstrated cognitive difficulties, thought to be related to alcohol misuse, which affected Peter's ability to retain verbal information and to make some decisions. He had continued to drink following that assessment so his cognitive difficulties in 2017-2018 are likely to have been more, rather than less, pronounced, and his ability to execute decisions may have been more, rather than less, compromised. It is not clear from the records whether this area was considered by involved professionals at the CMHT as no records refer to this.

The SRFT IMR similarly notes no evidence that a mental capacity assessment was undertaken in the records, despite admissions with altered consciousness, alcohol withdrawal and fitting. Peter's mental capacity must have fluctuated and Mental Capacity Act assessments would have been expected to be undertaken in relation to some of the decisions he was required to make.

It is, however, difficult to say whether more attention to, and formal assessment of, capacity would have made any difference to the approach taken, particularly if Peter's mental capacity was thought to fluctuate and he was deemed able to make decisions on a relatively frequent basis. Alternatively, if Peter had been assessed as lacking the mental capacity to make particular decisions in relation to important areas, such as care, on a frequent basis when he may have been regarded as more vulnerable, this may well have had an impact on the approach taken by services.

The Mental Capacity Act 2005 Code of Practice provides statutory guidance for practitioners in applying the Mental Capacity Act in practice. It does not specifically address mental capacity in the context of alcohol misuse, although it acknowledges that mental capacity may fluctuate. Thus, an individual might have the mental capacity to make certain decisions at one point in time and lack that mental capacity at another. This is highly relevant to people with alcohol problems, who may experience ongoing fluctuations in their mental capacity to make decisions, and it complicates the use of the Mental Capacity Act in some situations involving alcohol misuse. Guidance is that a decision might be deferred if the person might have capacity to make that decision at a later time:

Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right?[28] (p.29)

However, in some circumstances a person's mental capacity to make a decision might fluctuate over a lengthy period of time, as the Alcohol Change UK report[29] points out:

(waiting to assess capacity) *is challenging if an individual continually moves in and out of capacity due to intoxication, or spends the majority of their waking hours intoxicated with some moments of lucidity. It is this dynamic that limits the application of the Act to people with alcohol problems* (p.23)

and the same report recommends for the future that:

The Mental Capacity Act 2005 Code of Practice should be amended to include specific guidance for working with individuals with alcohol misuse or dependence, especially when they are likely to have complex needs. (p. 25)

[28] See Mental Capacity Act 2005 Code of Practice at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

[29] See https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

Peter had complex needs that would be likely to have constituted an indication for a formal assessment of mental capacity at a number of points when he was in contact with services.

The **conclusions** arising from these two key lines of enquiry relating to legal issues are:

- That Peter's circumstances might have excluded him from some housing options as he would have been deemed to be adequately housed
- That a safeguarding protection plan (had one been in place) might have opened up other housing options
- No evidence of stigmatising practices on behalf of practitioners was found - they showed commitment to working with people in complex and difficult circumstances.
- However, it is possible that risk was tolerated by practitioners as it may have been seen as a "lifestyle choice" and that this was a factor in the failure to consider safeguarding.
- That Peter had complex needs that would be likely to have indicated a need for formal mental capacity assessment on a number of occasions.

Theme 4: Risk and multi-agency working

Two key lines of enquiry (3.1.8 and 3.1.10) are addressed below under the theme risk and multi-agency working.

3.1.8 Consider assessment and risk management/ responsiveness after Peter had raised concerns.

Peter told the care coordinator about the Perpetrator for the first time in March 2018, three days before he died.

Routine home visit to monitor mental state. Peter allowed (the care coordinator) access to his flat. … he told (the care coordinator) that a man called (name) had been staying at his flat for the past two months. (This man) … had apparently taken Peter' s only front door key wearing this on string round his neck.. (and) had been sleeping at Peter's flat in the bedroom, coming, and going as he pleased. (The care coordinator) asked Peter if he wanted (this man) at the flat and Peter said "no". Peter said he did not know how to challenge (this man), as he was physically intimidating… (The care coordinator's) impression from what Peter was saying was that (this man) had taken all Peter' s money every week when collected at (the CMHT base), bought alcohol for the both of them and then pocketed the rest. Peter had no money or food in the flat and this was only Friday (two days after the weekly … collection of (money)). (The care coordinator) asked Peter if he wanted

(him) to go to the Police- Peter did not want (him) to do that … (and) asked Peter if (he) should speak with City West and he was okay with that plan… (Will) discuss changing the locks.
Plan- … to see Peter next week and discuss with Safeguarding lead.

There was an established history of Peter being subject to coercion and control (see 3.1.9 above): he was known to be a vulnerable adult and to be subject to financial exploitation. At this last visit there were indications for an adult safeguarding referral, plus evidence suggesting that Peter was under duress and that a crime may have been committed. Yet he was regarded by practitioners in contact with him as able to make choices and decisions for himself and it appears that this may have been the reason that the care coordinator privileged Peter's request not to contact the Police over his own concerns (which led him to plan discussion with the Safeguarding Lead.) The indicators of risk were picked up, but the situation was not judged to be urgent and did not lead to urgent action to attempt to mitigate that risk. Possible reasons why the situation was not thought to be urgent may include:

- Peter was regarded as having capacity to make decisions for himself
- The context was that of a long-standing 'risky lifestyle' in an area where his lifestyle did not stand out
- In working over a long period with ongoing risks, practitioners themselves may develop a 'tolerance' for risks
- There was no sudden change in Peter's circumstances to alert practitioners to a change in level of risk – although this new individual intimidating Peter and taking his front door key was new, it may have seemed less concerning given the long-term context
- The full extent of the coercion and control may not have been understood
- The care coordinator had no knowledge of the perpetrator's history and circumstances
- Assessment of risk in relation to a vulnerable person with complex needs is not straight forward – Alcohol Change UK's 2019 report includes a recommendation that *national guidance should be developed on how to assess alcohol-related risk* (recommendation 7, page 17).

We know that risk is dynamic: it fluctuates over time. It is regarded as best practice[30] that:

Risk management must always be based on awareness of the capacity for the service user's risk level to change over time and a recognition that each service user requires a consistent and individualised approach. p 28.

[30] From Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services: see https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

In drawing together this report we have the benefit of hindsight, and, with hindsight, comes the knowledge of the perpetrator's circumstances – knowledge that was not available to Peter's care coordinator at the time of the visit. Also, at an earlier home visit, on 12 March 2018, Peter told the care coordinator that he had stopped buying alcohol for other people and so he was less harassed. This may have appeared to decrease the risk to Peter, but, with hindsight, we might question whether this, paradoxically, increased the level of risk.

It is possible that urgent action to put a protection plan in place could have been taken following the last visit and Peter's disclosures about the man who became the perpetrator, but, within the context of longstanding exploitation, it appears that the disclosures did not stand out as in need of urgent action, raising the question of how to recognise an increase in risk should similar circumstances occur in the future and what is an appropriate threshold for initiating urgent action? No safeguarding referral was raised on the day and there was no plan to look at urgent respite – two courses of action that would have been possible had the situation been recognised as urgent.

Initiating safeguarding processes at various points prior to the last visit might have mitigated some of the risk to Peter. Extrapolating from domestic abuse, is it possible that making a decision that an intimidating and exploitative person in one's household is not wanted also paradoxically increases risk?

If the disclosures by Peter at the last visit had been recognised as requiring an urgent response, what action would have been likely to follow? Would it have been possible to put a protection place in place immediately? It is possible for a housing provider to get an ex parte injunction to exclude the someone from a property. This can be done the same day but would be dependent on Peter being willing to make a statement to the housing provider and would have to demonstrate that the individual concerned presented a significant risk of harm - had he threatened Peter for example? Why did Peter feel intimidated by him?

3.1.10 Consider how well coordinated were the services that were working with Peter and how might services have been better coordinated.

The practitioners who worked with Peter believed that by holding professionals' meetings they were coordinating services. Whilst key people were involved in these meetings, a formal safeguarding process would have involved other professionals (eg Police, Housing) who would have brought in different ideas and possibilities, and it is likely that this would have improved service coordination.

As events unfolded, there were several specific difficulties in coordinating the services. Firstly, notes made by the HISMT are not on the same system as the GMMH Mental Health notes so GMMH staff do not have access to HISMT information.

Secondly there was a missed opportunity to get information when Peter collected his money. He picked up money from the CMHT base after appointeeship was transferred to Salford City Council. Once granted appointeeship to manage a service user's funds, a weekly allowance for the individual is established in collaboration with the person's social worker. The Panel was informed that the system then is that clients sign for their money when they collect it and this is recorded in a book held in reception. They may not see their care coordinator when they collect their money. Nothing is recorded on Paris, the electronic patient record and case management system. We understand that any concerns noted at money collections would have been passed on to the care coordinator, but it is unclear what the threshold would be for this to happen, and it is possible that Peter attending with others did not trigger concerns. There was informal knowledge that Peter went to collect his money with others who were thought not to have his best interests at heart but a system of recording more information when a service user collects their money, eg noting who is with them, might have flagged up what was happening.

A third difficulty relates to housing. There were periods when housing was seen as an issue and it has been difficult to understand what did or did not happen in relation to exploring and pursuing alternative housing options. In addition, there appears to have been a lack of clarity among practitioners about the difference between sheltered and supported housing.

At the professionals' meeting on 8 June 2017 there is reference to a move to warden-controlled housing. On 1 September 2017 it is said that Peter had been referred to Great Places for support to bid for a ground floor flat but that he needed ID in order to progress this and subsequent attempts to take Peter to obtain ID failed. (Peter was referred to Great Places Housing Group, working in partnership with GMMH Achieve Salford, as he was struggling to attend any of his appointments with his then housing provider. HISMT report Great Places had very little contact with him. Great Places met with the team at Peter's home address to look at the possibility of sheltered accommodation.) The Panel has been unable to trace any formal application for supported accommodation or for sheltered accommodation, and ForHousing (formerly CityWest) has confirmed that they were unaware of Peter's situation. Checking out tenure and involving social landlords is useful in these situations and may open up alternative options. Involving Housing would have been an option that might potentially have improved coordination of services, as there is support and help available that was not considered in this case.

A fourth difficulty is Peter's fluctuating agreement to become involved with services. At times Peter agreed to engage with alcohol treatment services but then subsequently he might not engage, and there are references in the chronology to him 'lacking motivation to engage' with alcohol treatment services. However, this is within a context that was probably characterised by fluctuating capacity to make decisions. Lack of engagement is highlighted in the Alcohol Change UK report and one of their recommendations is:

*Local authorities should ensure that vulnerable adults with alcohol problems are actively supported to engage with services and should support services to adapt so that they can better serve these adults. In particular, there should be support for multi- agency systems that can coordinate assertive outreach and **view the task of generating positive engagement as an important action in its own right**.* Page 11.

The bold has been added to emphasise that the task of generating positive engagement might be seen as an important action in its own right. How might this be taken on by services? There is a link here with capacity (see 3.1.12).

The **conclusions** arising from these two key lines of enquiry are:

- It is possible that when someone stops buying alcohol for people exploiting them (that they have formerly bought alcohol for) this increases their risk
- It is possible that in working long-term with chronic ongoing risks practitioners develop a 'tolerance' of those risks – the advantage of multiagency working is that it gives practitioners access to other perspectives on what is happening
- There are ways in which multi-agency working could be better coordinated and communication improved
- Initiating safeguarding processes offered one possible way of attempting to mitigate some of the risks to Peter but it is impossible to know what difference it might have made.
- Practitioners are not always aware of what tools and powers other agencies such as Housing can utilise to protect their tenants.
- Practitioners appeared to lack clarity regarding housing options

Theme 5: Good practice

3.1.13 Identify any good practice

Comprehensive record keeping
There was evidence of comprehensive entries made by various staff from the Mental Health Liaison Team and of that team applying their knowledge of Peter's case to decision making. The attention to detail in the recorded assessments is acknowledged here as good practice.

Flexible person-centred approach to care
There was evidence of flexibility in approach in relation to the plan to negotiate an admission to the in-patient alcohol detoxification centre once new accommodation was secured for Peter. Services had previously focused on the requirement for Peter to demonstrate motivation for change by attending appointments with Achieve before initiating a referral for in-patient

detoxification, but this approach had never worked due to Peter's lifestyle and home context.

This fits with the Alcohol Change UK recommendation that services *view the task of generating positive engagements as an important action in its own right,* and is included here as an example of good practice.

Early introduction of mandatory training including child and adult safeguarding
Between May and August 2019, Cheshire and Greater Manchester Community Rehabilitation Company has completed a range of mandatory training events, which have been attended by over 90% of eligible staff. During these events the importance of home visits has been addressed and guidance has been issued to staff as to when and how to complete these. The training also addresses professional curiosity and an investigative approach to case management. The introduction of this training prior to the commencement of this Review constitutes an example of good practice.

Approaching family members about the Review
Letters were hand-delivered to two of Peter's brothers by a representative of the Safeguarding Adults Board accompanied by Housing, who introduced themselves and explained what the letters were about. This was going above and beyond what might be expected and is an example of good practice.

The **conclusions** from these good practice points are:

- That there are examples of good practice within various organisations involved in this Review.

3.2 Other relevant issues

3.2.1 Checks and balances in relation to the Perpetrator

There were missed opportunities in relation to the Perpetrator. During the time he was managed by CGM CRC, he was assessed as presenting a medium risk of serious harm. His needs were identified as accommodation, substance misuse, finances, lifestyle and associates, and cognitive functioning. At the time of sentence, he had a lengthy offending history consisting of 22 convictions for 80 offences dating back to 1987. He mainly committed driving and theft related offences, including a number of burglaries, and, on several occasions, offences linked to the use and possession of drugs. In 2004 he was convicted of serious violent offences including Grievous Bodily Harm (GBH) and Possession of a Firearm and served a five-year custodial sentence for these offences. There are no recorded convictions for abusive behaviour within a domestic context on the Perpetrator's record.

The Perpetrator was released from custody on licence on 4 December 2017 but had no fixed address. Under the terms of his licence the Perpetrator was required to remain offence free, reside at an address approved by his case manager and attend appointments with her, including an appointment on the day of his release at which time he was offered support with his housing needs. He was advised to present as homeless to the Local Authority and an appointment was made with a local housing agency with a view to securing accommodation in the longer term. Making a homeless application and registering with Salford Home Search are two separate processes. The Perpetrator did not make a homelessness application nor did he register with Salford Home Search.

On 15 December 2017 the Perpetrator advised his case manager that he was residing with a 'friend' in the Eccles area, but he refused to disclose the identity of the 'friend' with whom he was staying, although details of an address were obtained. Under the terms of the Perpetrator's licence, it was necessary for the case manager to approve this address, which was not Peter's address. The case manager did not complete a visit to the property: instead she sought intelligence from the Intelligence Officer employed by CGM CRC and, in the absence of any information that would suggest otherwise, the case manager approved the Perpetrator's residence at the given address in the short term. The CGM CRC IMR notes that the case manager did not carry out a home visit at this point despite identifying a need for one.

3.2.2 Relevant information from other sources

In 2019 Alcohol Change UK published a document called Learning from tragedies an analysis of alcohol-related Safeguarding Adult Reviews

published in 2017[31]. (This document has been referred to earlier in this Report.) The document sets out an analysis of 11 SARs in England and Wales published in 2017 where alcohol was identified as a significant factor. It found that most of the adults involved had multiple complex needs including those related to mental health, physical health, self-neglect, exploitation by others, and living conditions. In six of the 11 SARs the vulnerable adult was being exploited and abused by others. Four involved men who were unemployed, living alone and disconnected from their families. The cause of death in three cases was murder or injury from physical abuse. The report also highlights the close relationship between alcohol misuse and self-neglect.

The recommendations state that:

'free choice' is an unhelpful paradigm (page 2)

and one of the practitioner perceptions identified is that behaviours may be regarded by practitioners as a lifestyle choice. This is noted to prevent deeper analysis of the situation and to preclude attempts to intervene. Was Peter's self-neglect a 'choice' or an indication of his vulnerability and exploitation by others? The document argues this perception (ie that people are choosing this lifestyle) that can lead to under-reporting of safeguarding concerns. The recommendation in full (number 3, page 2) states the following:

All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinker.

Other recommendations include:

Number 5: *The commissioning of alcohol services should be carried out in a way that minimises levels of staff turnover and recognises the importance of continuity in supporting people with complex needs.*

Number 9: *National guidance should be produced on applying the Mental Capacity Act (2005) to people with fluctuating capacity due to alcohol misuse.*

The question of how to assess (and work with) someone with fluctuating capacity was raised at the practitioners' event.

Recommendation 7 of the Alcohol Change UK document deals with risk and states:

National guidance should be developed on how to assess alcohol-related risk, including how to address potential under-reporting of alcohol use.

[31] See https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

Conclusions from these other relevant issues are:

- That there were missed opportunities in relation to the Perpetrators' support and supervision after his release from custody.
- That Peter's case involves parallels with other SARs where alcohol was identified as a significant factor and that there may be additional learning from bringing cases together to draw out common themes.

4. CONCLUSIONS

4.1 The Review has not identified any opportunities to predict Peter's death and the only opportunity to prevent it would have been if Peter had moved from his address following the disclosure to the care coordinator in March 2018 or if an injunction had been obtained to exclude the Perpetrator (but this could have increased the risk). If a Power of Arrest had been attached to the Injunction, Police should attend and arrest immediately for breach of injunction.

However, given the fact that the care coordinator had no knowledge of the Perpetrator and no reason to assign urgency to the situation, it is unlikely that Peter's death could have been prevented.

4.2 Earlier interventions via safeguarding or possible change in accommodation could have mitigated some of the ongoing risk but it is impossible to know what difference this might have made.

4.3 Peter's situation did not fit with many practitioners' understanding of domestic abuse.

4.4 There was evidence that Peter was being exploited financially by so-called friends. Practitioners working with Peter were aware of aspects of his exploitation by so-called friends but regarded it as consensual. The financial exploitation could have led to a safeguarding response.

4.5 There was evidence that Peter was subject to coercion and control by so-called friends and, towards the end of his life, by the Perpetrator. The coercion and control could have led to a safeguarding response.

4.6 There was evidence of self-neglect over a long period prior to the homicide. The documented self-neglect could have led to a safeguarding response.

4.7 Peter's frequent attendances at the Emergency Department could have led to a safeguarding response in line with the acute Trust frequent attenders' process.

4.8 There were missed opportunities to trigger safeguarding processes.

4.9 Safeguarding offers a multi-agency structure that may open up possibilities that otherwise might not be considered. It is possible that, in working long-term with chronic ongoing risks, practitioners develop a 'tolerance' of those risks. The advantage of multiagency working is that it gives practitioners access to other perspectives on what is happening.

4.10 Practitioners are not always aware of what tools and powers other agencies such as Housing can utilise. This is another advantage of the multi-agency structure of a safeguarding response.

4.11 Peter’s circumstances may have excluded him from some housing options.

4.12 Practitioners appeared to lack clarity regarding housing options.

4.13 No evidence was found to suggest stigmatising practices on behalf of practitioners - they showed commitment to working with people in complex and difficult circumstances. However, it is possible that risk was tolerated by practitioners and may have been seen as a "lifestyle choice": this may have been a factor in the failure to initiate safeguarding processes.

4.14 Peter’s complex needs would suggest that a formal mental capacity assessment would have been appropriate on a number of occasions.

4.15 That there were missed opportunities to intervene in relation to the Perpetrators’ support and supervision after his release from custody.

4.16 Peter’s case involves parallels with other SARs where alcohol was identified as a significant factor and there may be additional learning from bringing cases together to draw out common themes

5. LESSONS TO BE LEARNT

5.1 Concerning domestic abuse

Practitioners’ understanding of domestic abuse may not include situations where people are members of the same household but neither intimate partners nor family members.

People living a ‘risky lifestyle’ and being exploited by so-called friends might be regarded by practitioners as making choices.

5.2 Concerning safeguarding

Safeguarding processes might not be initiated in some complex circumstances, particularly those involving alcohol or substance misuse and including, perhaps, situations that are regarded as ‘consensual’ or resulting from ‘lifestyle choices’.

In complex and often longstanding circumstances, safeguarding should be initiated when appropriate since it brings in a multi-agency structure that supports practitioners and opens up other perspectives and possibilities for intervention.

The involvement of Housing may allow access to their powers to make timely interventions.

5.3 Concerning legal issues

Formal mental capacity assessments may be indicated and appropriate in people with fluctuating capacity related to alcohol/ substance misuse.

Relatively young age might limit consideration of housing options normally focused on older adults, despite the fact that they may be appropriate in situations of accelerated ageing.

5.4 Concerning risk and multi-agency working

Ways of better coordinating multi-agency working and communication exchange were identified during the Review.

When working long-term with people in risky settings and with ongoing established risk practitioners are at risk of developing ‘tolerance’ of those risks and need access to a forum where they can draw on other perspectives and expertise – this might be available using safeguarding processes when that is appropriate.

6. RECOMMENDATIONS

These are set out below under single agency and multi-agency recommendations:

6.1. Single Agency Recommendations

This includes those that were identified in agency IMRs and those identified by the panel during the review process.

There were no single agency recommendations in respect of the following agencies:

GMP
NWAS
Salford City Council Client Affairs
Salford CCG

6.1.1 <u>GMMH</u>

Single agency recommendations from IMR

(1) Initial learning from the joint DHR/SAR is shared in an agreed format from this case and will be disseminated to all CMHTs, Early Intervention, Home Based Treatment, Liaison, in-patient wards.

(2) The key learning points identified in this document to be disseminated in the form of interim guidance to all qualified staff at GMMH

Note: These recommendations are in addition to those from the Serious Incident which have already been implemented.

A**dditional single agency recommendations arising from the Review**

(3) That GMMH explores how information may be better shared between GMMH Mental Health Services and the HISMT.

(4) That GMMH investigates how relevant information could be entered on Paris when clients attend to collect money. This might include who they are accompanied by.

6.1.2 SRFT

Single agency recommendations from IMR

(5) The frequent attenders' process should be reviewed and promoted within the Trust to highlight the referral process to the community based Multi-Disciplinary Group.

(6) Frequent attenders with substance misuse and mental health problems should have a safeguarding referral where appropriate.

(7) There is a need for regular mental capacity assessments when patients present with fluctuating capacity

(8) A schedule of regular replenishment of domestic abuse signposting posters needs to be developed to ensure patients and relatives have access to contact numbers.

6.1.3 CGM CRC

A Serious Further Offence Review was conducted by Cheshire and Greater Manchester Community Rehabilitation Company and made three recommendations which were signed off in October 2018 before this Review commenced and are therefore not included here.

6.2 Multi-agency recommendations

This section includes recommendations identified during the review process

The Community Safety Partnership and the Safeguarding Adults Board to seek assurance from all relevant agencies that they have regard to the multi-agency recommendations listed below:

Practice recommendations

(1) Adult safeguarding referrals should always be made when there is a concern a person may be at risk of harm from abuse or neglect. This promotes wider multi-agency involvement and information exchange between partner agencies, and may open up options that further inform decision-making and practice.

(2) Agencies to review no reply policies and ensure that they are fit for purpose and include escalation routes. This aims to address the importance of regular and timely care coordination visits in accordance with the presenting needs of service users.

(3) To investigate with housing providers what housing options are available in these circumstances and what the process is to apply.

(4) To investigate how practitioners working long-term with people with ongoing established risk might have access to a forum where they might draw on other perspectives and expertise if clients do not meet the threshold for a Section 42 enquiry.

(5) Practitioners to be reminded to ask about the tenure of service users and to involve social landlords where possible: if it is a social landlord there are a range of people, services and expertise that can add value in terms of solving issues and taking remedial action.

(6) Salford Safeguarding Adult Board to formulate a Seven Minute Briefing (or similar) to concentrate the key learning points into an accessible format. This should be disseminated to all qualified staff at each partner agency.

Safeguarding recommendations

(7) Staff involved with adult safeguarding enquiries should:
  a. Understand when abuse and / or neglect may result in the need to consider urgent interventions such as a change of accommodation,
  b. Be able to identify potential options in the context of relevant legal frameworks,
  c. Understand the importance of promptly formulating and implementing an appropriate interim protection plan once an adult safeguarding referral has been raised.

(8) SSAB website to be updated to include more information about different services, tools, and raising awareness of legal powers partners may have when dealing with different situations.

Training recommendations

(9) The delivery of a be-spoke training package to key staff across partner agencies aiming to address the agreed learning points from this case in relation to: the operation of adult safeguarding procedures, risk assessment / management and mental capacity issues with specific reference to those people presenting with alcohol addiction and/or subject to exploitation and/or coercion and control, and including when Police should be consulted in relation to a crime.

(10) Training/awareness raising on how to access/navigate the system for applying for housing and on what housing options are available.

(11) The key learning points from this case to be incorporated into existing training packages at each partner agency.

(12) Mental Capacity Act training to include how excessive alcohol use and withdrawal from alcohol may impact upon mental capacity; the likelihood of fluctuating capacity in relation to key decisions such as care, treatment, residence etc in these situations; and how coercion and control might influence decision-making.

Policy recommendations

(13) Salford Safeguarding Adult Board to ensure local adult safeguarding policy, procedures and guidance incorporate the key learning points so staff can be fully supported in their practice.

(14) Ensure that staff are fully aware of the different ways that formal appointeeship can be implemented in order to protect a person's finances. This may include consideration of a commissioned package of care to ensure essential items are bought.

Appendix 1: Glossary

ASC	Adult Social Care
CCG	Clinical Commissioning Group
CGM CRC	Cheshire and Greater Manchester Community Rehabilitation Company (provider of probation services)
CMHT	Community Mental Health Team
CPA	Care programme Approach
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DI	Detective Inspector
DS	Detective Sergeant
EAU	Emergency Assessment Unit
GDPR	General Data Protection Regulation
GMMH-MH	Greater Manchester Mental Health NHS Foundation Trust Mental Health Services
GMMH-SM	Greater Manchester Mental Health NHS Foundation Trust Substance Misuse Services/ Achieve
GMP	Greater Manchester Police
GP	General Practitioner
HISMT	Achieve Salford High Impact Substance Misuse Team
ID	Identification (formal means of)
IMR	Independent Management Review
MHLT	Mental Health Liaison Team
MO:DEL	Manchester Offenders: Diversion Engagement and Liaison Team
NWAS	North West Ambulance Service
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
SCC	Salford City Council
SRFT	Salford Royal Hospitals NHS Foundation Trust