Safer Buckinghamshire Partnership[1]

Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the manslaughter of Adult J In April 2021

Independent Chair and Author of Report: Paula Harding

Associate of Standing Together Against Domestic Abuse

[1] Safer Buckinghamshire Partnership is the statutory Community Safety Partnership for Buckinghamshire

ACRONYMS

AHAG – Aylesbury Homeless Action Group

ARD – Adult Restorative Disposal

CCR - Co-ordinated Community Response to domestic abuse

DAIU – Domestic Abuse Investigation Unit

DASH – 'Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification and Assessment Checklist for Police Staff'.

DVPN – Domestic Violence Protection Notice

IMR – Individual Management Review

MASH - Multi Agency Safeguarding Hub.

ORB – One Recovery Bucks

PCSO – Police Community Support Officer

SCAS – South Central Ambulance Service NHS Foundation Trust

VAWG – Violence Against Women and Girls

GLOSSARY

Autism Spectrum Disorder: Autism is a lifelong neurodevelopmental condition, the core features of which are persistent difficulties in social interaction and communication and the presence of stereotypic (rigid and repetitive) behaviours, resistance to change or restricted interests. The way that autism is expressed in individual people differs at different stages of life, in response to interventions, and with the presence of coexisting conditions such as learning disabilities (also called 'intellectual disabilities'). Autistic people also commonly experience difficulty with cognitive and behavioural flexibility, altered sensory sensitivity, sensory processing difficulties and emotional regulation difficulties. The features of autism may range from mild to severe and may fluctuate over time or in response to changes in circumstances. Source: https://www.nice.org.uk/guidance/cg142/chapter/Introduction

Oxycodone: Oxycodone is an opioid painkiller used to treat severe pain, for example after an operation or a serious injury.

Olanzapine: Used in the treatment of psychosis: dose: 10 mg daily, adjusted according to response, usual dose 5–20 mg daily, doses greater than 10 mg daily only after reassessment, when one or more factors present that might result in slower metabolism (e.g. female gender, elderly, non-smoker) consider lower initial dose and more gradual dose increase; maximum 20 mg per day. Source British National Formulary (BNF) online

Espranor: also known as **Buprenorphine oral lyophilisate:** is a prescribed drug, containing opioid (narcotic) analgesic, used in adults and adolescent over 15 years of age, as part of a medical, social and psychological treatment programme for addiction.

Supervised consumption is an NHS service that is used in certain conditions to ensure that patients take their medication at regular intervals such as in substance dependence. The prescriber writes the supervised consumption instructions on the prescription. Supervision of consumption by an appropriate professional provides the best guarantee that a medicine is being taken as prescribed. The principal reason for using supervision is to ensure the safety of the patient and to minimise the risk of toxicity. Source: Drug misuse and dependence: UK guidelines on clinical management

Essential Shared Care Agreements (ESCAs) are written agreements between specialist services and general practitioners that allow care, specifically prescribing, to be shared between them. They are individual to a specific drug, detail who is responsible for what aspect of care and when early referral is required back to specialist services. They allow the seamless transfer of prescribing responsibility from the specialist service to general practice. Source: https://www.mpft.nhs.uk/services/pharmacy/essential-shared-care-agreements-escas

Acknowledgements

Members of the review panel offer their deepest sympathy to the family all who have been affected by the death of Adult J.

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse.

Preface

When the time is right the family would like to provide a personal statement in the future, about their loss and the profound impact of the homicide upon them.

1. INTRODUCTION

1.0 Background

1.0.1 This review concerns the circumstances leading to the death of 77-year-old Adult J who was killed by his son, Adult C, who was 36 years of age at the time. Adult C pleaded guilty to the manslaughter of his father. As he was found to have had diminished responsibility at the time of the killing, he was sentenced to a Hospital Order, with restrictions, under the Mental Health Act 1983.

1.1 Aims of the review

1.1.1 Domestic homicide reviews came into force on the 13th April 2011 having been established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a domestic homicide review should be 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 they were related or with whom they were or had been in an intimate personal relationship or (b) member of the same household as themselves; with a view to identifying the lessons to be learnt from the death.

1.1.2 The purpose of a domestic homicide review 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 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"* (Multi-Agency Statutory Guidance 2016, para 7)

1.1.3 As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of [the victim] … situating the review in the home, family and community of the victim and exploring everything with an open mind" (Multi-Agency Statutory Guidance 2016, paras 8 and 9).

1.2 Timescales

1.2.1 The homicide occurred in April 2021.[2] The decision to undertake a review was made by the Chair of Safer Buckinghamshire Partnership in consultation with local agencies on 19th May 2021 and the Home Office was notified of the decision on the same day.

1.2.2 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. In this case, the review commenced promptly with the first panel meeting being held in September 2021 when the decision was made to postpone the review until criminal proceedings had concluded in June 2022. The trial itself had been delayed whilst psychiatric assessments were undertaken and further delayed through national arrangements to contain the spread of the COVID-19 pandemic. As a result of changes in availability over this period, a new Independent Chair was commissioned from Standing Together Against Domestic Abuse, hereinafter 'Standing Together', and the reconvened panel went on to meet four further times over the next year. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed.

1.2.3 The panel considered and agreed the draft Overview Report in April 2023 and family members had the opportunity to provide their comments before the final draft Overview Report was endorsed by the Safer Buckinghamshire Partnership in September 2023 before being submitted to the Home Office Quality Assurance Panel for approval.

1.3 Confidentiality

1.3.1 This Overview Report has been anonymised in accordance with statutory guidance. In order to protect the identity of the homicide victim and his family, and after consultation with the family, the following pseudonyms have been used:

[2] Actual date redacted.

- Adult J: the victim of manslaughter
- Adult L: the wife of Adult J
- Adult C: the elder son of Adult J and Adult L and perpetrator of the manslaughter of his father

1.3.2 Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the family's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality and anonymity.

2. Terms of Reference

2.0 Methodology

2.0.1 The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (HM Government, 2016a).

2.0.2 14 local agencies were notified of the homicide and were asked to examine their records to establish if they had provided any services to the victim, his wife and his son and to secure records if there had been any involvement. 11 agencies were found to have had relevant contact.

2.0.3 Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel.

2.0.4 Thames Valley Police provided the findings from the criminal investigation and provided details of the family who were to be invited to engage with the review.

2.0.5 The terms of reference for the review were drawn up by the Independent Chair together with the panel and incorporated both key lines of enquiry and specific questions for individual agencies where necessary. It was identified that ten agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement.

2.0.6 All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with

recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

2.0.7 The Independent Chair authored the Overview Report after consultation with the victim's family and each draft was discussed and endorsed by the review panel before submission to the Safer Buckinghamshire Partnership.

2.1 Involvement of family and friends

2.1.1 Adult J's family were notified about the review in writing by the Independent Chair of the review and they were also provided with Home Office explanatory leaflets. As a result, they took the opportunity to meet with the Independent Chair and comment on the draft terms of reference and were updated as the review progressed, through their support workers from Advocacy After Fatal Domestic Abuse[3] and the Victim Support Homicide Service. The findings of the review were discussed with the family and the draft report shared prior to submission to the Home Office. The family were highly disillusioned by the shortcomings of agencies but were satisfied that the report was an accurate account of their circumstances. Their comments have been incorporated into the report.

2.1.2 As Adult C was subject to a Hospital Order, the Chair sought advice from his consultant concerning contact. The consultant considered that Adult C was not well enough to be consulted and that any contact would be destabilising for his mental health. The opportunity to make contact was left open throughout the period of the review, but medical advice was provided that his condition did not change sufficiently for engagement with him during this time.

2.2 Independent chair and author

2.2.1 The Independent Chair and author is Paula Harding, an Associate of Standing Together. She has over thirty years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years she was the local authority strategic and commissioning lead for domestic abuse and violence against women for a large metropolitan area and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed

[3] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office, *Conducting a Homicide Review,*[4] received specialist training from Standing Together and undertaken training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

2.2.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR).[5] The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 90 reviews across England and Wales from 2013 until present day.

2.2.3 Paula Harding has no connection with the area or any of the agencies involved in this case beyond undertaking a domestic homicide review in a neighbouring area which involved those agencies working regionally across the two areas.

2.3 Members of the review panel

2.3.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies, and all were independent of the case.

2.3.2 Wider matters of diversity and vulnerability were considered when agreeing panel membership. Aylesbury Women's Aid provided the local domestic abuse service and therefore brought independent expertise on domestic abuse and the 'victim's perspective' to the panel. One Recovery Bucks provided expertise on drugs and alcohol and Buckinghamshire Mind provided expertise on mental health, each of which were issues particularly pertinent to this review. Independent expertise on

[4] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning.

[5] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

mental health and autism was also provided by an Independent Reviewer, whose details are featured later in the report.

2.3.3 The review panel members were:

Name	Role/Organisation
Paula Harding	Independent Chair
John Enser	Independent Reviewer
April Benson	Chief Executive Officer, Aylesbury Women's Aid
Celina Wieremiejczyk	Residential Scheme Manager, Bromford Housing
Claire Walker	Operations Manager, Aylesbury Homeless Action Group
Faye Blunstone	VAWG Lead, Buckinghamshire Council
Gillian Attree	Designated Nurse Safeguarding Children and Looked After Children, Buckinghamshire Integrated Care Board
Jacqueline Osbourne	Adult Safeguarding Practitioner, South Central Ambulance Service
Jas Pejatta	Senior Operational Support Manager, National Probation Service - Buckinghamshire
Jenab Yousuf	Interim Head of Service – Early Resolution and Safeguarding, Buckinghamshire Council Adult Social Care
Julia Hall	Acting Head of Services, Buckinghamshire MIND
Julie Oliver	Homelessness & Advice Manager, Buckinghamshire Council
Karen Sobey Hudson	Head of Patient Safety and Litigation, Buckinghamshire Healthcare Trust
Kate Francis	Detective Inspector, Thames Valley Police
Mark Prescott	Clinical Lead, One Recovery Bucks
Ruth Hemsley	DHR Co-ordinator, Buckinghamshire Council
Victoria Harte	Patient Safety Services Manager, Oxford Health NHS Foundation Trust

2.4 Time period and key lines of enquiry

2.4.1 The panel agreed that the review should focus on the contact that agencies had with [Adult J] and son, [Adult C], during the period from 1st January 2017, when

Adult J planned to remarry his ex-wife, until the homicide in April 2021. Information about earlier times was included for contextual information only.

2.4.2 Agency responses to indicators or disclosures of domestic abuse towards Adult J 's wife, Adult L, during the same period were also to be considered.

2.4.3 The review should address both the 'generic issues' set out in the Statutory Guidance[6] and the following specific issues identified in this particular case:

- To provide a **pen picture**[7] of the homicide victim and to understand what knowledge each agency had about
    - the relationship between the homicide victim and his son, the perpetrator
    - the relationship between the homicide victim and his wife
- To consider whether indicators of domestic abuse, including economic abuse, were identified and responded to
- To consider **individual practice:** how effective were practitioners in identifying and responding to the needs, threat and risk for the homicide victim, his wife and the perpetrator?

  Reflective Questions. In responding, IMR authors are asked to consider:

    - What needs did your agency identify for each of the individuals and how did your agency respond?
    - How were decisions made and actions taken by agencies to reduce risk and prevent harm, considering, for example: indicators of risk; how risk was assessed and managed; attention to previous history; how were the individual's attitudes to risk perceived and understood, and how did this affect decisions made or actions taken; safety planning; escalation; managing risk on closure of cases
    - How did agencies respond to indicators of economic abuse?
    - If domestic abuse was not known, how might each agency have identified the existence of domestic abuse from other issues

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[6] Home Office (2016) *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.* Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf.

[7] A pen picture is a summary of the biography of an individual.

presented to them? Were there policies and procedures for direct or routine questioning and how well were they implemented in this case?

- How was the relationship between the homicide perpetrator's mental ill-health and substance use understood?
- What barriers to engagement did agencies face and how did they seek to overcome these barriers?
- How did agencies recognise and respond to issues of equality and diversity? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?
- Did resource issues impact upon the services offered?

- To consider **multi-agency practice:** how effective were agencies in working together to prevent harm and to meet individuals' needs?

  Reflective Questions. In responding IMR authors are asked to consider:

  - What opportunities were there to engage and refer over mental health and substance use issues?
  - How did agencies respond to opportunities to make safeguarding referrals?
  - How were roles and responsibilities understood and multi-agency protocols adhered to?
  - Was there a shared ownership and approach?
  - How effective was the co-ordination of services?
  - How effective was communication, information sharing and sharing records?
  - How effective was escalation between agencies?

- What **good practice** can be identified?
- **Improving services:**

  Reflective Questions. In responding IMR authors are asked to consider:

  - What lessons can be learnt to prevent harm in the future?
  - What recommendations are to be made for organisation and how will the changes be achieved?

- What system-wide, multi-agency recommendations do you consider need to be made?

2.4.4 In addition, the following agencies are asked to respond specifically in their IMR to the following additional questions:

- **Thames Valley Police** to additionally consider:
  - Whether every opportunity was taken to take criminal action against Adult C
  - How were counter-allegations of violence and abuse responded to, and what efforts were made to identify the primary perpetrator?
  - Whether the homicide perpetrator's previous history was taken fully into account
  - The rationale, within the terms of the restraining order taken out against the homicide perpetrator in 2020, to exclude him only from his mother's address and not his father's address
- **Adult Social Care** to additionally consider
  - the advice given to the homicide victim regarding Lasting Power of Attorney for his wife when her mental capacity deteriorated, and whether this advice was influenced by allegations made by family members regarding his domestic abuse of her.
- **Oxford Health NHS Foundation Trust** and **Adult Social Care** to additionally consider
  - How did professionals respond to the perpetrator's presentation in relation to assessing a drug related cause or as a deterioration in his mental health?
  - Key lines of enquiry from the Mental Health Homicide Review to accompany their IMR
- **Buckinghamshire Clinical Commissioning Group** and **One Recovery Bucks** to additionally consider:
  - The nature of prescribing managed between the GP and addiction services.
  - Whether the history of the perpetrator's substance use was known and if so, how that influenced the decision to prescribe, and thereafter review, the suitability of opiate-based medication for him?

- **All Health Agencies** to additionally consider
    - How did health agencies manage the perpetrator's non-medical use of prescription drugs, including his alleged attempts to gain duplicate prescription scripts from health agencies?

2.5 Individual agency reports

2.5.1 Individual agency reports and chronologies were provided by the following organisations:

- Aylesbury Homeless Action Group
- Bromford Housing
- Buckinghamshire Integrated Care Board (formerly Clinical Commissioning Group) regarding primary care
- Buckinghamshire Council Adult Social Care
- Buckinghamshire Council Housing Team
- Buckinghamshire Healthcare NHS Trust
- Oxford Health NHS Foundation Trust
- One Recovery Bucks provided by Midland Partnership NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- Thames Valley Police

2.6 Agencies without contact

2.6.1 The following agencies were contacted but confirmed that the individuals concerned were either not known to them, or that their involvement was not relevant to this review:

- Aylesbury Women's Aid
- Buckinghamshire Fire and Rescue Service
- Buckinghamshire MIND

2.7 Definitions and Terminology

2.7.1 The Review applies the statutory definition of domestic abuse as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

(d) economic abuse

(e) psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[8]

2.7.2 Economic abuse is defined as any behaviour that has a substantial adverse effect on a person's ability to acquire, use, or maintain money or other property or obtain goods or services (s.3: Domestic Abuse Act 2021).[9]

2.7.3 Within this definition, controlling behaviour is understood to be "a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour….Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." (HM Government, 2016a)

2.7.4 The review panel was mindful that the homicide occurred as a result of abuse from a grown-up son to his father and there were indicators of the same son's previous domestic abuse of his mother. Abuse within the family is understood as a particular form of domestic abuse, and in this report will be referred to as (Adult) Child-to-Parent-Abuse as described within the statutory guidance (Home Office, 2022).

2.7.5 Indicators of domestic abuse can be found, but are not limited to, the following:

- health indicators of abuse as evidenced within NICE Quality Standard;[10]

[8] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted.

[9] Ibid.

[10] NICE Quality Standard QS116 can be found at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse.

- economic indicators of domestic abuse as evidenced by Surviving Economic Abuse;[11]
- general indicators as evidenced by Thames Valley Police[12] and Women's Aid Federation England[13]

2.7.6 The review has used identity-first terminology referring to "autistic people" rather than "people with autism", in line with guidance provided by the Department of Health and Social Care (2019)

2.8 Parallel reviews[14]

2.8.1 As Adult C had been referred to the Crisis Resolution and Home Treatment Team of Oxford Health NHS Foundation Trust at the time of the homicide, NHS England determined that an independent investigation needed to be undertaken. Independent investigations are commissioned under the Serious Incident Framework (2015)[15], to ensure that mental healthcare-related homicides are investigated in such a way that effective learning can be identified, and changes implemented to minimise the risk of recurrence. In agreement with the Independent Chair, Safer Buckinghamshire Partnership and the bereaved family, NHS England commissioned an independent reviewer to support the Chair and panel and ensure that the aims of both reviews could be met in the one process. John Enser, an Independent Reviewer was commissioned to fulfil this task.

2.8.2 John Enser is a registered mental health and general nurse. He has 40 years' experience, initially in clinical practice, before moving into middle and senior management roles in both the NHS and Independent sector. For 10 years, he was an executive member of the Forensic Psychiatric Nurses Association (FPNA).

2.8.3 John Enser has designed and developed many new services including in-patient services, prison mental health and primary care, police and court liaison services and community services. Inevitably, this has involved working with multiple

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[11] https://survivingeconomicabuse.org/what-is-economic-abuse/.
[12] https://www.thamesvalley.police.uk/police-forces/thames-valley-police/areas/c/2020/domestic-abuse/signs-of-domestic-abuse/.
[13] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/recognising-domestic-abuse/.
[14] The coroner deferred to the outcome of the criminal trial and no further inquest was opened.
[15] At the time of writing, the Serious Incident Framework was being replaced by Patient Safety Incident Response Framework. For more information see https://www.england.nhs.uk/patient-safety/incident-response-framework/.

agencies and reviewing incidents when things have gone wrong as part of the governance and assurance framework.

2.8.4 Independently, and as a Director for Psychological Approaches[16], a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies, he has carried out reviews of other services which were experiencing difficulties and led on “deaths in custody" reviews. He was an Honorary Lecturer at Canterbury Christchurch University and has an MSc in Health Services Management.

2.9 Equality and diversity

2.9.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[17] for Adult J, his wife and son and considered the following as relevant characteristics to be considered within the review:

- The older ages of Adult J and Adult L
- Sex and gendered violence towards Adult L
- Disability in relation to Adult C’s autism and mental ill health
- Disability in relation to Adult L’s dementia

2.9.2 Moreover, issues of vulnerability concerning substance use, care and support needs, caring responsibilities and homelessness were also considered.

2.9.3 The Review applied an intersectional framework in order to understand the lived experiences of both victim and perpetrator. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual’s journey and experience with local services and within their community.

[16] Psychological Approaches focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. Their ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

[17] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

2.10 Dissemination

2.10.1 The following individuals and organisations will receive copies of this review:

- [Adult J]'s family
- Agencies directly affected by this review
- Safer Buckinghamshire Partnership and its agencies
- Buckinghamshire Local Domestic Abuse Partnership Board
- Buckinghamshire Safeguarding Adults Board
- Thames Valley Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales

2.10.2 Safer Buckinghamshire Partnership will be responsible for monitoring the recommendations from this review.

3. BACKGROUND INFORMATION

3.0 The homicide

3.0.1 The victim's son, Adult C, visited his father at home and killed him in a frenzied sustained attack during which he punched, kicked and stamped upon his father and hit him over the head with a heavy ornament. He then tried to prevent his father's friend from phoning for an ambulance and posed unconvincingly as a police officer to try to prevent the Ambulance Service from responding. Emergency Services were unable to resuscitate Adult J at the scene and Adult C was arrested and charged with his murder.

3.0.2 As the trial approached, Adult C pleaded guilty to manslaughter on the grounds of diminished responsibility. He received a number of psychiatric assessments that agreed that he was floridly psychotic[18] on the day of the assault.

3.0.3 In sentencing, the judge concluded that Adult C had been severely psychotic in the weeks leading up to the homicide although there had not been any violent incidents since he received treatment. His psychosis was seen to be exacerbated

[18] Floridly psychotic refers to a phase of acute symptoms such as severe delusions, hallucinations and disorganised thinking.

by, but not caused by, alcohol and drugs and that he probably used drugs to self-medicate.

3.0.4 Psychiatric assessments agreed that his mental disorder and delusional beliefs diminished his responsibility but did not extinguish it, but he had little insight into his behaviour. Moreover, whilst Adult C had visited his father with the purpose of confronting him, this was not seen as a pre-planned attack.

3.0.5 Adult C was sentenced to a Hospital Order, with Restrictions, under sections 37/41 of the Mental Health Act 1983 without limitation of time. In order to protect the surviving members of his family upon release, a restraining order was made prohibiting him from entering the area in which his family live or going within 500 metres of their home or place of work. The restraining order will stay in effect until/unless a further court order is made.

3.1 Adult J's background

3.1.1 Adult J had retired from his position as the owner of a kitchen-fitting firm. He was married to Adult L until they divorced in 2000 and had two sons, Adult C and a younger brother. Adult J had children from a previous marriage but had been estranged from them since they were very young. He went on to have one further marriage before remarrying Adult L.

3.1.2 Adult J had various convictions in his early life including theft offences, driving offences and an assault. Beyond these, he did not appear to have come into contact with agencies and so little is known by them about him. However, members of his close family described him as being very controlling in the family and that Adult L would not have remarried him if she had been of sound mind.

3.2 Adult L's background

3.2.1 Adult L also had little contact with agencies. After her divorce from Adult J, she too went on to remarry, and was widowed from her second husband in 2013 and was left with a large inheritance.

3.2.2 In 2015, she was assaulted by her son, Adult C, and this is considered later in this report.

3.2.3 Adult L started experiencing significant confusion and memory loss and it was at this time that she remarried Adult J.

3.3 Adult C's background

3.3.1 By contrast, much more was known about Adult C. As a child, his difficulties with social interactions were observed from an early age and his mother tried to get him assessed before he went to school. School reports noted that he was bullied at school. He was described as anti-social and often did not want to play with other children. Less was known about autism at the time and, when Adult C was aged 8, an educational psychologist considered that his difficulties were due to a lack of confidence.

3.3.2 During his teenage years, he began to abuse alcohol and illicit substances and it was during this period that he was admitted to an adolescent unit for approximately three months with unspecified, non-organic psychosis[19].

3.3.3 As an adult, his polysubstance use and problematic alcohol use continued, and he overdosed several times. He went on to become known to local mental health services from 2012 when he was first admitted to hospital following threats to kill himself. As time went on, mental health services became aware of his history of illicit substance misuse, opioid type dependence syndrome, non-organic psychosis, depression, self-harm and suicidal ideation. He was diagnosed with Asperger's Syndrome in 2015 and Autistic Spectrum Disorder in 2016.

3.3.4 Mental health services were made aware from the earliest admission that Adult C had been verbally abusive towards his mother and blamed his parents for his admission. Indeed, his stepfather told staff that Adult C normally took his frustrations out on his mother who was vulnerable. When Adult C attempted an overdose in 2014 whilst intoxicated, his mother told the Community Mental Health Team that she was frightened by his aggression and threats.

3.3.5 Adult C had five convictions between 2003 and 2021 for offences of possession of drugs, criminal damage, driving with excess alcohol, and assault. He also received two reprimands/cautions/warnings between 2009 and 2010 for burglary, theft, criminal damage and sending a letter conveying false information.

3.3.6 In 2015, Adult C was arrested for assaulting his mother. She had denied him access to his car and he became highly agitated and held a knife to her throat. He became highly agitated again the next day, was paranoid and smashing property and after the police were called, they witnessed him head-butt his

[19] Reports of this admission were not available to the panel.

mother and had to use CapTor[20] spray to subdue him.[21] Adult L told the police that his mental health was deteriorating and he was more violent, but she later withdrew her statement as she believed that her son needed help with his mental health and feared that the court system would not help him and that he relied upon her to organise his medication. He pleaded guilty to the assault, and it was noted in the pre-sentence report that both parents minimised the risk that their son posed to them.

3.3.7 During 2015 he completed a course of treatment for his drug use, and it was recorded that he was drug free when discharged.

3.3.8 In January 2016, Adult J 's youngest son (name redacted) shared significant and detailed concerns with Adult C's care co-ordinator about his brother's persistent abuse of his mother which included examples of controlling behaviour, emotional blackmail and persistent demands for money for drugs and alcohol and to pay off drug dealers. The psychiatrist was updated, and safety planning was discussed with Adult L.

3.3.9 In July 2016, Adult C was assessed and diagnosed with Autism Spectrum Disorder. He was discharged from mental health services back to his GP as his mood had stabilised, but he was not keen to address his alcohol or substance use. The discharge went on to request that his support needs be assessed with input from the local authority autism lead. When offered, Adult L contacted the service to say that Adult C did not want the appointment.

3.3.10 By 2017, where this review begins to explore the circumstances of the family in more detail, Adult C was approaching his 32nd birthday and was well known to several services. In relation to his mental health, he had by then experienced two episodes of in-patient psychiatric care. The first for three months as an adolescent; the second with Oxford Health when he was formally detained under the Mental Health Act from August to November in 2012. Following this, he experienced extensive support from various adult mental health teams in the community. He was a recognised polysubstance user of prescribed and non-prescribed drugs and other substances including IV use; made extensive use of primary care; had several attendances and admissions to acute health services for various physical health conditions and was well known to police and the criminal justice system.

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[20] CapTor is a form of pepper spray used by Thames Valley Police used to disarm a violent subject.

[21] Information provided from the Pre-Sentence Report.

4. CHRONOLOGY

4.0.1 As Adult J and Adult L had little contact with agencies in their own right, much of the chronology of events which follows considers agency contacts with Adult C.

Overdose and Awareness of Drug & Alcohol Use

4.0.2 In April 2018, Adult C was admitted to the Intensive Care Unit of Stoke Mandeville Hospital following an accidental overdose of heroin and cocaine. Once stable, he was reluctant to stay in hospital and requested to go home. His discharge summary was sent to the GP and mentions previous drug abuse, self-harm and psychosis. Adult C told the GP in a review shortly afterwards that he smoked heroin most days and that his alcohol intake was excessive at approximately 84 units per week. The GP expressed concern about the use of alcohol and drugs and signposted him to One Recovery Bucks (ORB), which provides drug and alcohol support, treatment and recovery services, but noted that he did not seem motivated to engage.

First Signs of Adult L's Dementia

4.0.3 In October 2018, Adult L was accompanied to the GP Practice by her husband, Adult J, who advised that he had had concerns over her memory loss for the previous six months. The GP noted that Adult L appeared vacant and referred her to the memory clinic, coding symptoms of dementia on her record. However, the GP was advised, during a consultation attended by both Adult J and Adult L two months later, that she had declined the referral.

4.0.4 In November 2018 Adult C saw his GP and asked about oxycodone[22] on NHS prescription to treat his pain and it was noted that he was also accompanied by his father. In view of his history, the GP did not prescribe oxycodone but signposted him to ORB.

July 2019 – Prescribing Oxycodone

4.0.5 July 2019 represented the beginning of a phase of Adult C's prolonged engagement with services, making the first of 35 calls to the Ambulance Service on 999 or 111 over the next 19 months, many of which were requesting repeat prescriptions of controlled drugs on the grounds that he had overused his

[22] Oxycodone is an opiate medication used for the treatment of moderate to severe pain.

medication and run out. He also repeatedly called the Out of Hours GP for the same reason who initially prescribed a five-day supply of a slow-release opioid.

4.0.6 He approached his GP Practice two days later, speaking with the duty doctor by phone, seeking oxycodone again. He complained about back pain and how other painkillers, codeine and tramadol, did not help. The GP checked recent prescriptions with the pharmacy and Out of Hours GP and prescribed a two-week supply of oxycodone with a plan to follow up with his usual GP.

4.0.7 An appointment was made for Adult C to see his usual GP two weeks later, in which Adult C described how his back pain had been unbearable and how taking his girlfriend's prescribed oxycodone had been effective for the same pain and that this had been issued whilst he was in hospital. The GP discussed concerns over drug dependency, coding his records as opioid drug dependent. A further prescription was issued, and Adult C was advised that the oxycodone would be carefully monitored.

July 2019: Victim Remarries

4.0.8 In July 2019, Adult J and Adult L remarried, telling their family only days before. Their family were concerned that Adult L, being in the early stages of dementia, she did not have capacity to consent to the marriage.

4.0.9 In August 2019, Adult J attended the Emergency Department with injuries that he believed had happened during a fall whilst drinking, although he could not remember and thought that he had lost consciousness. He was treated and given advice on his head injury and was also advised, both by the hospital and by the GP in a subsequent visit, to reduce his alcohol intake. No direct enquiry on domestic abuse appeared to have taken place, nor referral to alcohol treatment services.

September 2019: Car Theft Reported to the Police

4.0.10 In September 2019, the police were called by Adult J who believed that Adult C had taken his mother's car without permission. However, Adult C returned the car whilst the call was in progress.

4.0.11 The matter was dealt with by the police by offering an appointment in ten days' time by which time, Adult J felt that the matter had been resolved. Although Adult J declined to complete a DASH[23] risk assessment, officers were able to establish that there had been no domestic abuse in the past year, although they heard that

[23] 'Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification and Assessment Checklist for Police Staff' known locally as a DOM5.

Adult C's violence had remained consistent since childhood, and he had many un-diagnosed mental health problems including addiction to Class A drugs. Although the car belonged to Adult L she was not spoken with, nor completion of the DASH risk assessment offered to her. There was no record of her dementia or inability to engage which may have influenced this decision.

November 2019: Safeguarding Concerns for Adult L

4.0.12 In November 2019, Adult J's youngest son and his wife contacted Buckinghamshire Adult Social Care with concerns over the financial abuse and controlling behaviour of his father towards his mother who had dementia. He had contacted Adult Social Care twice during earlier months but had not disclosed his mother's details and so no further action could be taken by the local authority. However, on this occasion he was able to provide background information which included that his father had been verbally abusive and controlling towards his mother when he was a child and that when she was of sound mind, she had not wanted anything more to do with him. His mother had inherited a large sum of money following her second husband's death, whilst Adult J had only a pension for income and now his mother appeared malnourished and the house unkempt. The family circumstances were further complicated by his brother Adult C having a heroin addiction and living with them and he had been violent in the past. With these details, a safeguarding enquiry was initiated, and social workers visited the home.

4.0.13 The first visit by a social worker was planned to take place when Adult J was out, but Adult C would not allow them into the home when they arrived. However, two social workers were able to see the couple together a week later and they observed that Adult L appeared well kept, was able to express her views and had mental capacity. She told the workers there was no need for any concerns and she was being well looked after by Adult J and there was nothing wrong. Following the visit, the social worker reflected on their "*gut feeling* …[that] *… there was something not quite right*" but they could not establish that anything untoward was happening.

4.0.14 At the same visit, advice was provided to Adult J about deputyship for finance and property in the event that Adult L were to lose her mental capacity to make these decisions. A letter was sent to Adult J but not to Adult L, closing their involvement. However, over the next few weeks, Adult J 's youngest son and daughter-in-law repeated their concerns and the GP also referred concerns over Adult J 's financial abuse which had been disclosed to them by Adult C. A further visit was organised with Adult J's youngest son in attendance. The home was found to be spotless and not as described, but the fridge and cupboards were

bare of food. Adult J was written to and asked about both the lack of available food and Adult L not having access to a phone. Adult J responded saying that Adult L did have a mobile phone and the lack of food was due to Adult C eating everything he could find and, as a result, he took Adult L out to eat but she also had snacks in her bedroom.

4.0.15 In the meantime, Adult C contacted the Out of Hours GP to advise them that his mother was being 'taken financial advantage of' by his father by spending her inheritance and neglecting her and that he 'was not sure if his mother's violent behaviour could be contained.' He was advised to contact the police if he felt that either himself or his father was in danger and an urgent referral was made to the emergency duty team at Adult Social Care. The Out of Hours GP put a code on her records for dementia and made a request for the patient's GP to review this. However, on subsequent visits with other presenting medical issues over coming months, the dementia did not appear to have been reviewed. In these visits, Adult J accompanied Adult L on each occasion.

4.0.16 As January 2020 progressed, Adult J 's youngest son contacted Adult Social Care again with continued concerns that Adult J was not giving Adult L sufficient food and that he had challenged his father regarding this. He and his wife advised the social worker that they were providing food to Adult L every day in the form of a packed lunch. The social worker asked the youngest son to gently talk to Adult L about having an assessment of her care needs. Shortly afterwards, Adult J texted the social worker to say:

"Please do not enter or attempt to enter our house without our prior consent. I'm sure you would not like me to enter yours in your absence."

4.0.17 In February 2020, Adult J 's youngest son contacted his mother's GP concerned about her worsening dementia. Thames Valley Police's Force Intelligence Hub also received information anonymously that Social Care were involved with the family as Adult C was being verbally abusive to his mother, who has dementia and needs constant care, and was threatening to kill her and withholding food. They were advised that he had been physically violent before, for which he had been arrested, and that Adult L was isolated and had no access to phone or help. The information did not prompt the police to investigate further as an adult protection referral or to contact Adult Social Care.

4.0.18 In March 2020, Adult J 's youngest son contacted the police about his concerns that his father was neglecting his mother and there was never food in the house. He said that he had reported this to Adult Social Care, and he was advised that this had been the best thing to do as they could implement a care package for her, and the case was closed.

4.0.19 On the following day, Adult J 's youngest son texted the social worker stating he had contacted the Police about his dad and brother not adhering to COVID-19 social distancing rules and putting Adult L at risk as she was being moved between Adult J 's home and her own. He said that Thames Valley Police had directed him back to Adult Social Care to resolve. The social worker contacted them advising they need to agree between themselves as a family how to do this but gave a reminder to continue bringing food to his mother every day as he was doing previously.

4.0.20 A few days later, an aggrieved local resident notified the police that Adult C had posted on the local Facebook page that COVID-19 was a hoax and included a swastika on the post. It was reported that he had also been distributing hand-written notes with the same information. The police visited the home address and Adult C admitted the offence and was issued with an Adult Restorative Disposal (ARD)[24]. The police identified Adult C's mental health concerns and spoke with his parents who advised officers that they thought that mental health services would not see him whilst he was using drugs. Therefore, details of drug support agencies were provided to Adult C and the counter-terrorism unit was notified of the swastika.

May 2020: Assault on Adult J

4.0.21 In May 2020 (12.05.20), Adult J called the Police to report that Adult C had barged in and punched him approximately six times when he raised his voice in frustration with his wife. Adult J had some cuts to his arm and alleged that Adult C had assaulted him some seven months before this incident. When completing the DASH risk assessment, Adult J expressed concern that the assault had come out of nowhere and he did not know what Adult C was going to do next. The incident was graded as medium risk and a separate domestic abuse non-recordable crime was created in respect of Adult J 's behaviour towards Adult L particularly as Adult C said in his statement that he was defending his mother and himself against Adult J.

4.0.22 Adult C was released with bail conditions[25] to prevent contact with his father or from attending his mother's address, where his father said he was living, and

[24] ARD - Restorative Disposal is a tool to enable the police to use their professional judgement to make decisions about how to deal more proportionately with lower level crime and anti-social behaviour and is primarily aimed at first time offenders where genuine remorse has been expressed, and where the victim has agreed that they do not want the police to take more formal action.

[25] The police had considered a Domestic Violence Protection Notice (DVPN) but as bail conditions had been imposed, this was not considered necessary

Adult C returned his key to his father's home address although he was not resident there at the time[26].

4.0.23 Adult J was offered victim safety planning with an Independent Domestic Violence Advisor (IDVA) but declined support. The investigation found that Adult J's injury to his arm was consistent with being pushed to the floor, as Adult C described, and no evidence of having been punched as Adult J described, it was considered that there was no corroborating evidence to support a 'realistic prospect of conviction'. No further action was taken against Adult C.

May 2020: Safeguarding Concerns for Adult L

4.0.24 During the police investigation into this assault, Adult J's youngest son raised concerns about how both his father and his brother treated his mother. In respect of his father's abuse, he said that he had contacted 111 numerous times. He shared his observations that:

- Adult J was physically and verbally abusive, manipulative and controlling of his mother
- Adult J had removed the landline and had his mother's mobile
- Following their hasty remarriage, Adult J had taken control of his mother's finances, changed her will to his own benefit and had moved in. He had spent £60,000 of his mother's money on a new car and had booked three holidays
- Adult J had not obtained any specialist help for his mother's dementia and made her go to bed as early as 3:30pm. He did not look after her appearance or personal hygiene

4.0.25 He advised that his mother was taken out for a meal once a day and if she did not eat, was given nothing further until the following day. He had also observed his brother Adult C's abuse of his mother which had involved physical and verbal abuse as well as selling her things to fund his drug use. However, despite his brother's abuse, the youngest son was concerned that Adult C being removed from the home would leave their father free to neglect their mother at will.

4.0.26 The police were told that the youngest son bought shopping and delivered lunches to his mother and had notified Adult Social Care who asked him to keep a food diary. The police completed an adult protection notification for Adult L to

[26] The family questioned why exclusion from Adult J 's address wasn't a stipulation of bail conditions but Adult J told the police that he was living with Adult L so this would not have been considered.

be considered at the MASH. However, no further investigation was undertaken into Adult J's domestic abuse of his wife.

4.0.27 An allocated social worker attempted to contact Adult L several times and the problems that they were having reaching her was raised with Adult J who stated he was purchasing a new phone for her. A 'Staying in Touch' call service was organised to monitor and assist Adult L to ensure her wellbeing throughout the COVID-19 pandemic, but this was cancelled within weeks as her case was already open to the service, with the assumption being that contact with the service would be already monitored by the allocated social worker.

May 2020: Homelessness

4.0.28 Meanwhile, Adult C had been homeless since his assault on his father and was receiving support from various agencies involved in the local multi-agency Rough Sleeper's Initiative. Aylesbury Homeless Action Group (AHAG) began working with him in May 2020 and contacted him regularly over the summer to discuss his housing options and help him to find accommodation through the local authority or through the private sector, with a view to supporting his move through rent deposits.

4.0.29 Adult C was mostly sofa surfing with friends during this time or staying in the van of one of his friends. He had continued to call the Ambulance Service seeking repeat prescriptions of oxycodone at intervals and his friend had written to the GP advising that Adult C was overusing and selling his opioid medication; becoming homeless; being financially exploited by his girlfriend; was depressed and had recently experienced bereavement of a close friend following a drug overdose. The GP considered an adult safeguarding referral, but none was made, but a referral was made to ORB.

August 2020 – Safeguarding Enquiry Ended

4.0.30 At the end of August 2020, Adult Social Care made an unannounced visit to explore the allegations of Adult J 's financial abuse and neglect. Adult L advised that there were no concerns with her husband who provides good care, and it was noted that her appearance was very good and her home very clean, with no indicators of neglect or fear. The social worker did not consider that there were any reasons to doubt her mental capacity and the safeguarding case was closed. Shortly afterwards, Adult J advised the GP that he was struggling to care for Adult L as she was refusing to bathe, and she was referred to the community care team.

September 2020 - Adult C's Mental Health Deteriorated

4.0.31 During September 2020, Adult C's drug seeking behaviour escalated and he approached the Ambulance Service nine times over the month seeking either oxycodone directly or complaining of pain. His mental health appeared to have deteriorated and, feeling suicidal, he approached the Whiteleaf Centre, which is a mental health facility in Aylesbury. A full assessment was undertaken.

4.0.32 As a result, he was referred to the Crisis Resolution and Home Treatment Team (CRHTT) who were able to reach him after a few days of trying and he reported being fine although very angry towards his father for not letting him back into his mother's house and for owing him money. The Team did not consider that Adult C met the threshold for their services, notified the GP and advised him to self-refer to substance misuse services (ORB). However, he declined drug and alcohol services, saying they were "useless," despite his previous experience having appeared positive.

4.0.33 The Mental Health Liaison worker for the Rough Sleeper Initiative (RSI) assessed Adult C and had significant concerns regarding his psychosis and delusions. The worker contacted the Crisis Resolution and Home Treatment Team and Aylesbury Homeless Action Group who in turn liaised with Buckinghamshire Council to find Adult C temporary accommodation. He was started on antipsychotic medication.

September 2020 - Temporary accommodation

4.0.34 Buckinghamshire Council arranged for Adult C to access temporary housing in Griffin Place, temporary accommodation provided by the housing association, Bromford Housing. The accommodation was in a shared flat in a block for single people whom the local authority considered that it had a duty to accommodate, known as 'priority need' (Housing Act,1996). On referral, Buckinghamshire Council provided Griffin Place with details of his vulnerabilities including:

- mental ill-health: paranoia, depression, anxiety, previous overdose
- Asperger's Syndrome
- alcohol and drug dependencies, although he said that he had not used drugs for a while
- history of violence, although he said that this was 5 years ago

4.0.35 Griffin Place were not made aware of his recent assault of his father. Nonetheless, he was assessed as being a high risk to others and, as the only accommodation available was in a shared flat, albeit where each person had their own room, he was to be moved into a self-contained flat as soon as one was available. Arrangements were put in place for staff not to work with him alone; to increase support when not seen in case his paranoia was increasing and to meet

any visitors in the meeting room. Support was to continue to be provided by the Rough Sleeper's Initiative, and Aylesbury Homeless Action group supported him with referrals to various supported housing, including Amicus and Bearbrook, but he was turned down for both as they were unable to meet his level of complex needs. The local authority proceeded to accept that they had a statutory duty to assist Adult C in resolving his homelessness and he was supported to bid for properties as they arose on Home Choice.

4.0.36 During his stay at Griffin Place, Adult C was in regular contact with staff and was observed to make friendships with other residents and was never aggressive or abusive toward staff or other residents. Staff were not aware of the family relations, and he had been reluctant to talk about them when asked. He was never seen in possession of drugs. However, Griffin Place and the various agencies involved in the Rough Sleeper's Initiative continued to be concerned for his safety, particularly when he informed them that he had a noose tied to a tree.

4.0.37 Towards the end of September, Adult C disclosed his significant use of illicit substances, taking double of his dose of oxycodone as well as smoking heroin. Shortly afterwards, he was visited by the Crisis Resolution and Home Treatment Team for a Mental Health Act assessment, and they found him to have fixed paranoid delusions about being pursued by the Essex Boys (gangsters); that the Government worked for Satan; and that he had a tracker implanted in his mouth. During the assessment it was noted that his poor eye contact and blunt direct responses may have been linked to his autism. The Crisis Resolution and Home Treatment Team contacted him daily for a period thereafter and discussed his reluctance to engage with drug and alcohol services and the risks of overdose on anti-psychotic medication. However, Griffin Place staff challenged the assessment being undertaken, observing him to be minimising his suicidal ideation as he was mistrustful of the NHS.

4.0.38 This period was marked by a difference in how housing agencies considered him to be at high risk whilst mental health services considered him to be of no risk to self or others. Indeed, housing services considered that Adult C's mental health deteriorated significantly over the coming months, with suspected substance misuse, paranoia and inconsistent engagement with their services. He had also told the housing officer that he was not taking his prescribed anti-psychotic medication, olanzapine, as it made him feel "drowsy and stupid" (recorded as his words). He continued to approach the Ambulance Service another nine times during October seeking repeat prescriptions. On the occasion that he turned down pain relief and was experiencing three-day chest pain, the crew undertook diagnostic tests and when he declined to go to hospital, they assessed his mental

capacity to make that decision using the Capacity Assessment Tool on the electronic patient records device.

4.0.39 Adult C also approached Stoke Mandeville Hospital with back pain. Their records noted that he was being prescribed oxycodone at two-day intervals due to overuse. He was given alternative pain relief medication, Naproxen, and the GP was notified of his discharge.

4.0.40 Adult C went on to minimise his drug and alcohol use and as the weeks progressed, he continued to deny experiencing suicidal thoughts and did not feel that he needed support from mental health services. Neither was he prepared to take his prescribed anti-psychotic medication. The Crisis Resolution and Home Treatment Team contacted the Rough Sleepers Initiative and were advised that Adult C had become a lot calmer, and his suicidality had reduced and that they were in agreement with his discharge from mental health services with the recognition that if he continued not to take his prescribed olanzapine, that he would be back in crisis.

4.0.41 Although he was discharged from mental health services, he continued to be supported by the mental health worker at the Rough Sleeper's Initiative who saw him regularly and observed him to be calmer and with his delusions less at the fore although he became worried about money and debts. Over coming months, the mental health worker supported Adult C to help him manage his reactions to disappointment and stress.

October 2020 – Adult J seeking Lasting Power of Attorney

4.0.42 Adult L was accompanied on a visit to her GP by Adult J asking about Lasting Power of Attorney but as Adult L was judged not to have mental capacity to sign the forms, the GP advised them to apply to the Court of Protection and details of the local dementia support group were given. There were no codes on the system to alert the GP to previous allegations of economic abuse.

November 2020 – Restricted Oxycodone Prescribing

4.0.43 During these months, Adult C was seeing the mental health worker at the Rough Sleeper's Initiative weekly, and, in early November, it was noted that he was taking his medication regularly and appeared calmer. However, it was also recorded that it would not take much to trigger him and guided others to be cautious around him due to his propensity to violence.

4.0.44 Due to problems with Adult C running out of his oxycodone, the GP agreed weekly prescriptions with a plan to wean down the dose of opioid medication. However, Adult C was persistently approaching the Out-of-Hours GP and the Ambulance Service (111) and running out of his medication through over-use.

There were also reports of him selling the oxycodone. He was advised that the Out-of-hours GP would not be prescribing any extra medication for him and to register with a new GP as he had moved area. The GP referred him to ORB. The referral was for support with his addiction to oxycodone, saying that they were struggling to reach a manageable way of providing his painkillers and providing a detailed history including his drug and alcohol use, opioid dependence, autism spectrum disorder, overdose, homelessness and estrangement from his parents.

4.0.45 At the end of November 2020, Adult C told the mental health worker that he was in an on/off relationship with a girlfriend who was exploiting him financially and emotionally and that he was stressed about money. However, a safeguarding referral concerning domestic abuse did not appear to be considered at this time. The Rough Sleepers Initiative, AHAG and the mental health worker had all been helping him with his finances and his search for accommodation.

December 2020 - Referral to Adult Social Care

4.0.46 In the meantime, following a home visit review by a healthcare assistant from the local GP Practice, Adult L was referred to Adult Social Care as she was refusing to attend the Memory Clinic and struggling with personal hygiene, whilst Adult J was struggling in his caring role. The matter was referred to their Early Help Team but not responded to until the GP referred again three months later.

December 2020 – Engagement with One Recovery Bucks (ORB)

4.0.47 Following the GP referral, Adult C appeared to engage well with ORB. Their Clinical Lead/Independent Non-Medical Prescriber undertook a comprehensive assessment which included using the recommended alcohol screening tool, which assessed him as lower risk of drinking without any dependence. Drug screening tested him positive for cocaine, methadone and morphine. As there was evidence of opiate misuse, Adult C was offered Naloxone, which reverses the life-threatening symptoms of an opiate overdose, and prescribed Espranor as an opiate substitute which can help with withdrawal. Espranor was to be subject to daily supervised consumption at a pharmacy to minimise the risk of toxicity. Adult C was also advised that he would need to engage with ORB's psychosocial support to achieve a realistic recovery plan. During the assessment Adult C said that he was worried about money, but he was expecting to "inherit money that will keep him for the rest of his life". He went on to engage well with ORB over the following five months and developed a positive therapeutic relationship with his keyworker.

4.0.48 Following the assessment, the GP was provided with the assessment and treatment plans and the GP asked ORB to take over prescribing of Adult C's

opioid medication. However, as there was no shared care agreement (ESCA) in place, his medical record, which included information regarding his mental health history, was not shared with ORB. Nonetheless, ORB was aware that Adult C was being prescribed medication for his mood, and asked the GP to refer him into the community mental health team before they would consent to the switch. However, as Oxford Health did not prescribe or manage his medication, and it was unclear why the GP was referring Adult C to them, the referral was not accepted. The GP was notified, and ORB commenced prescribing his opioid medication without wider knowledge of his mental health needs and treatment.

January 2021: Arrest

4.0.49 Early in January 2021, Adult C was arrested for failure to appear at court for a charge of possession earlier in 2020. He was held in custody until being conditionally discharged during which time he had missed his daily prescribed dose of Espranor and informed his key worker at ORB[27]. When reviewed by ORB, Adult C was found to be engaging in recovery sessions, was focussed and working well with his keyworker. Relapse prevention strategies were explored and, in case he needed to isolate through COVID-19, he nominated his brother to pick up his prescriptions.

4.0.50 Despite Adult C's self-assessment of his mood as being good, his keyworker from ORB encouraged him to seek help from Healthy Minds as he talked about how his mood and sleep had dipped, but he declined the referral.

4.0.51 Adult C contacted 111 again, displaying drug seeking behaviour and advised AHAG that the new medication was not helping with his pain and so he is having to buy his own pain relief and was drinking more, resulting in him going into rent (service charge) arrears at Griffin Place. ORB advised him to see his GP for medication for pain relief and to refrain from taking Xanax, which he explained he had taken on one occasion to help him sleep. There was no record of the risk assessment being updated to reflect his declared cessation of anti-psychotic medication and the consequent need to monitor his mood.

February – March 2021: Deterioration in Adult C's Mental Health

4.0.52 After a more settled period during which Adult C continued to engage well with ORB, registered with a new GP, attended physiotherapy, cleared his rent arrears and was being helped to bid for properties, his paranoia and drug seeking

[27] It is standard practice and in line with DoHSC guidance (Drug misuse and dependence: UK guidelines on clinical management) that opioid substitute prescribing can continue unless a patient / service user misses three consecutive days, when the prescription must be reviewed.

behaviours appeared to increase again alongside increasing alcohol use. He missed drug screening and again sought oxycodone from his new GP who refused it after consulting with ORB. Various agencies and Griffin House staff observed a deterioration in his mental health including increasing paranoia, delusions and walking around in a high-visibility jacket with a phone taped to it saying that he was recording people with it.

4.0.53 The Rough Sleeping Initiative mental health worker was notified and whilst recognising Adult C's increasingly chaotic behaviour and delusions, did not consider that the level of his behaviour required crisis intervention. Recognising how mistrustful Adult C was of mental health services, the worker was reluctant to involve crisis services unless his condition had deteriorated to the point of needing in-patient admission. It was noted that as Adult C refused to take anti-psychotic medication, he was never symptom free but that they needed to keep an eye on him. Indeed, by early March, the mental health worker was aware that Adult C was developing new delusional beliefs and was becoming increasingly unpredictable. He said that he was angry with his family as he had found out that his father was not his real father but actually the true father to Prince William.

4.0.54 In mid-March 2021, Adult C was taken by ambulance to Stoke Mandeville Hospital complaining of chronic leg pain and seeking oxycodone. However, the hospital, aware of his addiction, offered him an alternative medication which he declined. He told the hospital that the GP had stopped prescribing oxycodone due to his addiction problems and as a result he used heroin and alcohol as a substitute. Although he had come in a wheelchair, he walked out of the Emergency Department before his consultation was complete. He advised ORB, that his injury appeared to have prevented him from attending for drug screening again, although he admitted to the ORB keyworker that he had taken oxycodone sourced from elsewhere.

March 2021 - Adult L's Care Needs Increased

4.0.55 During this time, Adult J approached his GP with continued concerns over Adult L's lack of personal hygiene and refusing any input from the memory team, although he recognised that the local dementia support group was helpful. The GP contacted Adult Social Care again asking for a Care Act Assessment to be undertaken for Adult L and a month later, the day before the homicide, the allocated social worker tried to contact Adult L and Adult J leaving voicemail messages.

The Day of the Homicide

4.0.56 Griffin House reception were contacted by one of their residents at midnight concerned for Adult C's well-being and behaviour. Adult C did not respond to staff at that time, but he met with staff the next morning and was observed to be delusional and verbally aggressive to staff. This led to staff calling the Crisis Resolution and Home Treatment Team for assistance as soon as their meeting with him ended at 11:11am.

4.0.57 The Crisis Resolution and Home Treatment Team responded around 11:30am but Griffin House staff would not disclose information or give them Adult C's phone number unless they had confirmation of the identity of the caller, which had not been provided. After this communication misunderstanding, the Crisis Team rang back with confirmation of their identity half an hour later and, after confirming with their manager, agreed that Adult C could be referred directly to them rather than go through his GP.

4.0.58 As Adult C had left the accommodation, the support worker was advised to call and text Adult C of their plan to involve the Crisis Resolution and Home Treatment Team and for Adult C to contact them directly.

4.0.59 Meanwhile, Griffin House received a call from Aylesbury Homeless Action Group who were also concerned for Adult C, as he was having delusions about his key worker at ORB and had an appointment at ORB that morning. Griffin House staff phoned ORB to warn them of their concerns, but Adult C had already phoned ORB to cancel his appointment with the keyworker leaving a bizarre message, saying his "Sergeant has called him for an urgent assignment". The message was picked up at 13:40 and ten minutes later, Griffin Place also contacted them to say that the Crisis Team had been alerted to his apparent psychotic episode.

4.0.60 At 17:11, Adult J 's neighbour called 999 reporting Adult J to be covered in blood. Adult C, pretending to be a police officer at the scene, tried to cancel the ambulance but the Ambulance Service contacted the police who confirmed that there were no officers at the scene and both emergency services attended the scene of the fatal incident alongside the Helicopter Emergency Medical Service. Unfortunately, all attempts at resuscitation were unsuccessful.

5. OVERVIEW OF AGENCY INVOLVEMENT

5.0.1 This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

5.1 Criminal Justice Agencies

5.1.1 Thames Valley Police

5.1.2 Thames Valley Police reflected upon their responses to each of the reports that they received. On the first occasion, Adult L was not seen as the potential victim of economic abuse by having her car allegedly stolen by her son, but rather the DASH (DOM5) was undertaken for her husband who reported it.

5.1.3 On the second occasion of anonymous information being provided to the Force Intelligence Hub, this did not lead to an investigation. Neither was the matter recorded as Adult Protection; refer the safeguarding concern to the local authority or put safety measures in place for an elderly vulnerable person.

5.1.4 On the third occasion, the call taker did not undertake any background checks when the youngest son contacted with concerns over his father's neglect of his mother. By this time, Thames Valley Police had information concerning Adult L's undiagnosed dementia and potential abuse by another family member. By advising him to go back to Adult Social Care, officers were not required to attend the home and assess the situation, manage risk or make a referral to the local authority themselves. As a result, the Force has added the example of these circumstances as key learning points for future domestic abuse refresher training for Contact Management.

5.1.5 When Adult J reported his son's assault of him, officers correctly identified that an adult possibly suffering dementia was potentially at risk of domestic abuse and spoke to Adult L alone. However, when she did not disclose domestic abuse, said how helpful Adult J was and could not remember recent events, this was taken at face value. Although an adult protection referral to the local authority was rightly made, by this time Thames Valley Police were aware that Adult L had a named social worker and did not appear to have considered contacting them and using an intermediary, before deciding to take no further action in relation to the alleged domestic abuse. This would have enabled the police to gain an account of the lived experience of a vulnerable adult.

5.1.6 By way of recommendations, Thames Valley Police were asked to provide Safer Buckinghamshire Partnership evidence-based assurance that:

- Adult protection reports are recorded on Niche and tasked accordingly.
- Adult protection notifications are consistently submitted.
- Domestic abuse is being identified for vulnerable adults, either child to parent, or in relation to caring roles; investigated and appropriate safety measures put in place.

- There is consistency in completion of the DOM5 (DASH).
- Background checks are systematically being taken when reports of neglect or abuse are received by Contact Management and callers are not only signposted to Adult Social Care when indicators of neglect or abuse are present.

5.2 Health and Social Care Agencies

5.2.1 Buckinghamshire Council Adult Social Care

5.2.2 Adult Social Care were first alerted to concerns of possible abuse of Adult L in November 2019 and, whilst they undertook unannounced home visits, which was good practice, they reflected that the safeguarding enquiry was not robust and ended too quickly. Adult L had not been seen on her own despite the social worker feeling that "something was not quite right". Given that Adult L was identified as the cared for person and subject to eligibility under Care Act (2014), a greater level of effort and depth would have been expected in the section 42 safeguarding enquiry.

5.2.3 *Making Safeguarding Personal*[28] principles of empowerment, prevention and protection should have been the key components to ensuring a more detailed enquiry took place to understand whether Adult L was subject to control and coercion. As part of this, exploration into the impact of her disability and memory issues would have enabled greater understanding of her responses, and whether she was feeling under pressure or coercion. Whilst it was recognised that at the time Adult L had full mental capacity to understand the decisions she was making, there did not appear to have been sufficient exploration of the concerns being raised and whether the collective intelligence added up to a vulnerable woman experiencing abuse.

5.2.4 Throughout their involvement, it was considered that social workers demonstrated poor understanding and awareness of the signs and indicators of coercive and controlling behaviour. One indicator may have been the text message that Adult J sent to the social worker where he said:

[28] The Care Act (2014) defines safeguarding adults as protecting an adult's right to live in safety, free from abuse and neglect. *Making Safeguarding Personal* aims to make safeguarding person-centred and outcomes focused and moves away from process-driven approaches to safeguarding.

"Please do not enter or attempt to enter our house without our prior consent. I'm sure you would not like me to enter yours in your absence."

5.2.5 The service reflected that safeguarding concerns were not considered collectively and were dealt with in isolation to each other. Considering the level of similar themed concerns being identified, there was a lack of sufficient oversight of the issues to build a story of wider concerns. It would have been expected in these circumstances to convene a multi-agency strategy discussion and create the opportunity for other professions involved with the family to consider the risks and how these might have been mitigated.

5.2.6 Throughout the episodes of safeguarding enquiries being carried out, there was a lack of adherence to Making Safeguarding Personal and ensuring that Adult L was at the centre of the concerns and support identified. Instead, she appeared to be seen outside of this and the main contacts were with her husband. This was made all the more apparent when the decision letter closing their first involvement was sent to Adult J, about whom the allegations had been made, rather than to Adult L herself.

5.2.7 There appeared no exploration of the wider family dynamics and, in particular, the relationships between parents and sons. Having a broader understanding of the potential tensions and challenges for the family may have enabled a clear risk assessment to have taken place.

5.2.8 As a result, Adult Social Care have committed to providing:

- Additional Safeguarding training with a focus on domestic abuse, including economic abuse in the context of deputyship for finances, and dealing with coercive and controlling behaviour.
- Greater emphasis across the service of the principles of Making Safeguarding Personal.
- Domestic abuse training delivered in a multi-agency forum to improve and strengthen links.
- Ensure that practitioners enable safe disclosures of domestic abuse during section 42 enquiries, including seeing individuals alone; asking directly about domestic abuse; seen in different settings where possible; consideration given to the use of advocates.

5.3 Primary Care

5.3.1 The response from primary care was considered for the victim, and his wife who were registered at the same practice, and for Adult C, who registered at another practice when he was forced to move out of his mother's home after his assault on his father.

5.3.2 **GP Practice for Adult J**

5.3.3 Adult J was seen by his GP infrequently and mostly for routine health reasons. However, when he was seen after attending the Emergency Department having experienced injuries to his eye and knee, consideration did not appear to have been given to enquiring about domestic abuse. At this time, he could not remember how the injuries had taken place but suggested that they were due to a fall when inebriated. The National Institute for Health and Clinical Excellence (NICE) provides a list of evidence-based health markers that are indicators of abuse including falls and alcohol abuse (NICE Quality Standard on Domestic Violence and Abuse [QS 116], 2016). Appropriate and sensitive routine enquiry on domestic abuse should therefore be standard practice, where indicators of domestic abuse are present, irrespective of the sex of the patient (Royal College of General Practitioners, 2012).

5.3.4 Although he was given advice to reduce his alcohol intake, it was not recorded that advice or encouragement was given regarding alcohol treatment services.

5.3.5 The GP Practice was aware that Adult J cared for his wife who had dementia, but it does not appear that the benefits of a carer's assessment were discussed with him or a referral to the local authority for a carers' assessment discussed.

5.3.6 In respect of Adult J 's care, the following has been recommended:

- To develop practice responses so that sensitive and routine enquiry is undertaken into domestic abuse where indicators of domestic abuse are present, irrespective of the sex of the individual.
- To develop practice responses so that individuals presenting with problematic alcohol use are advised about, and encouraged to use, alcohol treatment services.
- To ensure that the value of a carer's assessment is routinely discussed with individuals caring for others and signposting to the local authority systematically undertaken.

5.3.7 **GP Practice for Adult L**

5.3.8 The GP Practice was first alerted to Adult L's problems with her memory in October 2018 and she was referred to the Memory Clinic. Her husband accompanied her to this appointment and to the next, in which the GP was

advised that she had declined the referral. After a year had passed, her husband went on to accompany her to GP appointments, and he reported increasing challenges in managing her care. Her sons also alerted the GP to her dementia. Despite her apparent increasing dementia, a mental capacity assessment did not appear to be considered until the matter of Lasting Power of Attorney was raised two years later. Neither was consideration given to the potential for domestic abuse, or the need to see persons on their own for at least part of the consultation.

5.3.9 However, the GPs did refer to Adult Social Care on at least four occasions and provided the couple with information on the local dementia group which proved helpful.

5.3.10 After the Out of Hours GP service was alerted, in December 2019, to allegations of Adult J's financial abuse of Adult L and her violent behaviour due to her undiagnosed dementia, the GP was asked to follow up the concerns about dementia, but this was not picked up in subsequent appointments. Thereafter, the connection between potential economic abuse and Lasting Power of Attorney was not considered.

5.3.11 In respect of Adult L's care, the following recommendations are made for the practice:

- To raise awareness with Practice staff that dementia symptoms can be a veil for domestic abuse.
- To develop practice responses so that mental capacity assessments are considered when services for memory loss are declined.
- To develop practice responses so that individuals are seen alone for at least part of the consultation when indicators of domestic abuse are present in order that any disclosures could be made or routine questioning on domestic abuse undertaken.
- To develop practice responses so that the potential for economic abuse is considered when applications for Lasting Power of Attorney are being made.
- To develop practice responses so that GPs are alerted in future consultations to allegations of domestic abuse through effective coding and recording of domestic abuse.

5.3.12 **Adult C's GP Practice**

5.3.13 The Practice were aware of Adult C's long-term mental health, heroin and alcohol misuse and self-harm issues as well as his periods of psychosis. They had been advised about his accidental heroin overdose in April 2018 and, when first

approached for opioid medication (oxycodone) in November 2018, the GP did not issue it. However, when Adult C refused all other pain medication on the basis that only opioid analgesia would work, this was taken at face value and a prescription provided. The Practice reflected that his heroin overdose and past substance and alcohol misuse could have been weighed up more in the decision to issue opioid medication in 2019. A referral to One Recovery Bucks could have been considered before prescribing as well as a referral to the specialist pain clinic for the long-term management of his condition.

5.3.14 Once the decision had been made, the Practice were notified of Adult C's attempts to obtain opioid medication from other health services, particularly the Ambulance Service, Out of Hours GP services and the hospital. Initially both the Out of Hours GP service and the GP were issuing small supplies of additional oxycodone whilst he was being advised on the correct dosage and the dangers of taking extra medication. It has been recognised that firm boundaries and a strict no issuing of extra medication rule or directive could have been enforced earlier.

5.3.15 Once commenced on opioid medication, his addiction was coded, and the medication was being reviewed and monitored. However, it does not appear that that the decision was questioned whether this was the most appropriate medication to be issued, especially in the context of illicit drug misuse and previous opioid addiction. Indeed, it was not until Adult C had approached Out of Hours six times in the previous month that his medication was reviewed indicating both that there appeared to be poor communication between Out of Hours and the GP Practice and that there appeared to be poor systems in place to alert either service to drug misuse. The review heard how the GP Practice and Out of Hours service could not see each other's records which are still on separate computer systems, but the Out of Hours service would send a typed report of their interaction with the patient to their GP in the next working day.

5.3.16 Indeed, it did not appear that Adult C's drug seeking behaviour was recognised for some time. As well as approaching several different health agencies, who notified the practice, Adult C also spoke to his GP about various different pains in different parts of his body, including his shoulders, back and Achilles tendon, in his apparent quest to seek opioid medication. A review of his notes and the notifications received from Out of Hours and the Ambulance Service, would have alerted the GP to the inconsistency in his presentations.

5.3.17 Prescriptions were initially set for 2-weekly given Adult C's background, but then issued monthly, without a rationale provided, despite him having admitted to misuse of oxycodone. Thereafter, having recognised Adult C's drug seeking

behaviours, the Practice tried to control his usage through reducing his prescribing periods to two-weekly, weekly, then every 2 days. Adult C was signposted to One Recovery Bucks early on, and then again when this prescription regime was found not to be working. It was considered that an earlier formal GP referral to One Recovery Bucks would have been beneficial. However, when the referral was made, the GP provided a particularly detailed, comprehensive and helpful background to his needs, which was seen as good practice.

5.3.18 When the GP was sent a detailed letter from the perpetrator's friend in July 2020 advising of Adult C's range of vulnerabilities and risks, the GP questioned whether an adult safeguarding referral was needed, and committed to discuss this with colleagues, but this did not appear to have been done and no referral was made. In the context of Adult C having Asperger's Syndrome and mental health issues, it was considered that these concerns from his friend should have prompted an adult safeguarding referral which was considered but not undertaken.

5.3.19 In respect of Adult C's care, it was recognised that the GP had worked hard to maintain their engagement with Adult C, even though they will have been faced with his demands and hostility at times in his very challenging drug seeking behaviour. However, the following recommendations have been made for primary care services, which includes the Out of Hours service:

- To develop GP awareness of drug seeking behaviours in order that they are alert to the risk of addictions for patients being prescribed opioid medication, considering referrals to One Recovery Bucks before prescribing where there is a history of drug use. If alternative pain relief is not issued, to develop practice responses so that decisions to prescribe opioid medication are reviewed and that firm boundaries are put in place from the start of the prescribing period.
- To review the systems in place that alert the GP Practice to Out of Hours, and vice versa, of each other prescribing and risk monitoring so that there is not over-prescribing, particularly of medication that can lead to addictions.
- To review the system within the Practice whereby repeated notifications from the Ambulance Service about drug seeking behaviours did not raise the need to alert a GP to review the patient
- To develop practice responses so that third party information received and alerting to safeguarding risks for a patient is acted upon and adult safeguarding referrals made when needed.

5.3.20 Whilst the recommendations listed were for the GP Practices involved, the Integrated Care Board was asked to consider which of the recommendations for the Practice have wider application to GP Practices in the area and ensure that the recommendations were extended across the area as needed. In particular, the need to develop the domestic abuse pathway was identified and the Integrated Care Partnership committed to develop the domestic abuse primary care pathway in order that sensitive and routine enquiry is systematically undertaken into domestic abuse, across Buckinghamshire GP Practices, where indicators of domestic abuse are present, irrespective of the sex of the individual. In order to develop the domestic abuse pathway, and meet the ambitions of *Making Every Contact Count*, Buckinghamshire Integrated Care Partnership will consider Domestic Abuse Statutory Guidance (2021)[29] which promotes the Whole-Health Model to domestic abuse incorporating:

- "Findings from the Pathfinder Project highlighted that health professionals feel better able to enquire about domestic abuse if their Integrated Care System and primary care networks supported the placement of Independent Domestic Violence Advisors (IDVAs) or other accredited domestic abuse peer advocacy programme. These specialised trauma-informed services might then be best placed to follow up with any disclosures of abuse; a greater understanding of local referral pathways; specialist recovery and peer advocacy services to which they can refer or signpost victims, survivors or perpetrators dependent upon their unique situation." (para 293) …
- "Implementing the IRIS (Identification and Referral to Improve Safety)[30] Programme. IRIS is an evidence-based intervention to improve the general practice response to domestic abuse through training, support to practice teams and having a DA specialist embedded in practices. It is nationally recognised as best practice and has informed NICE guidance" (para 306)

5.3.21 **Buckinghamshire Healthcare NHS Trust**

5.3.22 The Trust treated Adult C for Hepatitis C infection in 2015 and when he visited the Emergency Department of Stoke Mandeville Hospital for a variety of reasons, some of which concerned drug seeking behaviours. At other times, he was often accompanied by his mother. The Emergency Department also treated Adult J when he attended for head and knee injury following a suspected fall in 2019

[29] https://www.gov.uk/government/publications/domestic-abuse-act-2021

[30] https://irisi.org.uk

which occurred whilst intoxicated. Adult L also accompanied him on this occasion. The Trust was able to demonstrate how routine or selective enquiry had become much more embedded within the Emergency Department when indicators of domestic abuse were present for female patients, such as in response to a head injury. However, the Trust reflected that more was needed to be done to promote consideration of domestic abuse indicators for male patients and in the context of child-to-parent abuse, and this is considered further in the thematic section which follows.

5.3.23 Adult C's use of prescription and non-prescription drugs was well documented and when he presented requesting oxycodone, it was not given due to concerns around his addiction, although alternative pain medication was offered and declined.

5.3.24 When emergency healthcare intervention was sought, Adult C appeared at times to be unable to follow procedure and instructions and would leave the setting without assessment or would leave as soon as able and the Trust reflected that his neurodivergent diagnosis of autism spectrum disorder may have impacted upon his decision making and interactions at these times. The Trust reflected that consideration and practical steps to support Adult C may have helped him to access and accept the services that were offered. Since 2021, the Trust has introduced a Learning Disability Liaison Service, to support staff in-situ as needed. The Trust has also rolled out mandatory Learning Disability training for clinical and non-clinical staff, and attendance is robustly monitored.

5.3.25 Whilst discharge letters were sent to the GP each time, the Trust reflected that follow-up correspondence between the hospital and GP might have enabled a joined-up approach and a plan of action to assess Adult C's substance use, alcohol use and mental health, as well as to reinforce messaging about possible harm reduction interventions. The Trust further reflected on the multiple presentations and whether this could have led to a multi-agency discussion and whether a safeguarding adult alert should have been considered. Since this time, the Trust has strengthened its infrastructure and response to adult safeguarding through, for example: more capacity to support practitioners through its Corporate Safeguarding Team; duty support, mandatory training, reflective learning and appreciative inquiry opportunities; twice daily 'safety huddles' to allow for concerns to be discussed in real-time, and in-situ support being available from a safeguarding adult clinician. The impacts of these improvements are systematically monitored through the Trust's Safeguarding Committee and evidence was provided to the review concerning an increase in safeguarding referrals as well as an increase in advice and guidance being sought by staff.

5.3.26 Although Adult C often left an assessment prematurely, the Trust noted that there was no record of conversations with him about the impact of his substance misuse and mental health upon those around him. Since this time, the Trust has advocated a 'Think Family' approach and publicised the importance of the NHS initiative, 'Make Every Contact Count' which encourages an approach to identifying opportunities to have meaningful conversations about wider, relevant, health issues beyond those that have been presented.

5.3.27 It was not apparent that information was consistently shared with the mental health service, for example when Adult C presented to the Emergency Department in 2018, and this may have had an impact upon opportunities to support Adult C or his family. Since this time, the Emergency Department has been working much more closely with the mental health liaison service, which has since been provided by Oxford Health. The two agencies now have clear operating procedures with specified response times and responses are subject to cyclical monitoring and review.

5.3.28 **Oxford Health NHS Foundation Trust**

5.3.29 In Buckinghamshire, Oxford Health NHS Foundation Trust (Oxford Health) provides mental health and social care for people across the age spectrum and its services are delivered at community bases, hospitals, clinics, and at people's homes. Part of the Trust's services include a Crisis Resolution and Home Treatment Team. This is a multi-disciplinary team in psychiatric services specialising in the treatment of severely mentally ill patients in their home environment.

5.3.30 Whilst neither Adult J nor Adult L had been provided with services directly by Oxford Health, Adult C had received services on and off since 2012 when he was admitted as an inpatient following an overdose. The Trust had good knowledge of his history and the risks he posed to himself and to others over the years. During his earliest admission, they were informed by his stepfather about how Adult C was a risk to his mother: taking his frustrations out on her and being verbally abusive. During 2014, his mother told staff that she was becoming very frightened of his aggression and his threats. During 2015, they were aware of his assault of his mother and, during 2016, they were notified by his sibling of Adult C's coercive control, economic and physical abuse of his mother, having put a knife to her throat. However, it was recognised that both the exploitation of a person's money as well as the physical assaults on family members need to be considered within the context of domestic abuse and this needs to influence the continued safeguarding of the family as well as the individual. Indeed, the Trust was aware of Adult C's various domestic abuse towards his family, specifically:

his assault on his father that had been dealt with by the police; his continued threats towards his father; his sense of entitlement to his mother's money in 2020; and that he was quick to trigger, within the context of a propensity for violence and domestic abuse towards his mother. They would have benefited from considering how this information, from both the late and recent past, impacted upon their risk assessments and assessments of risk to others and part of this was due to how information was being recorded and retrieved.

5.3.31 The Trust provided the panel with a detailed explanation of how their approach to safeguarding had manifestly altered since 2015. Their strengthened infrastructure and responses included multi-disciplinary structures with integrated social workers, Moreover, in terms of identifying the history of violence and abuse within the family, the Trust was further able to demonstrate how their risk assessments addressed both risk to others and risk from others and how their processes required these to be reviewed at each subsequent assessment, with check points being in place within the organisation to ensure this was done.

5.3.32 Examining the periods of Adult C's care from the Crisis and Home Treatment Team, the Trust reflected that there were multiple different staff involved. They recognised that providing a crisis 24/7 service presents a challenge to the continuity of care and barriers to building a therapeutic relationship with the individual, particularly where the individual has an autism spectrum disorder. The Trust has committed to review how the Crisis Resolution and Home Treatment Team can improve the continuity of staff.

5.3.33 However, the mental health worker embedded in the Rough Sleeper's Initiative grew to know Adult C well and had regular contact with him over the six months before the homicide. The review heard how the embedded mental health practitioner was managed by the Trust and received supervision sessions every 4-6 weeks. The mental health worker also had contact with the Crisis Resolution and Home Treatment Team regarding Adult C at numerous times. Nonetheless, and particularly in the latter period when Adult C was displaying increasing paranoia, the worker appeared to be working in isolation from the Trust and this is considered further within the thematic section below.

5.3.34 It was not clear how much of the information about Adult C's family dynamics, and the risks to others identified from Adult C's deteriorating condition, which were held by the Trust, was considered by the mental health worker. This factor may have been exacerbated by how records were kept. For example, the mental health practitioner's records of involvement were held with the Rough Sleeper's Initiative, which Oxford Health, beyond this embedded worker, did not have

access to. The Trust has therefore committed to review how information is recorded and shared across Oxford Health and the Rough Sleeper Initiative.

5.3.35 Clinicians considered that Adult C's symptoms of mental ill-health and psychosis were predominantly drug induced and found him resistant to accessing support from drug and alcohol services, despite it being known in his records that he had previously had good engagement with ORB. It was reflected that there had been no proactive contact with ORB made by Oxford Health, nor consideration of how Adult C may be supported under the dual diagnosis pathway, which is considered in the thematic section which follows.

5.3.36 Although Trust staff recommended a re-assessment of Adult C's social support needs in 2016 by the local authority's autism lead, it was not evident how they had understood his mental health and alcohol and substance use within the context of his autism spectrum disorder. These matters are also considered further in the thematic section of the report.

5.3.37 **One Recovery Bucks - Midland Partnership NHS Foundation Trust**

5.3.38 One Recovery Bucks (ORB) provides drug and alcohol support, treatment and recovery services as part of a holistic Inclusion service commissioned by Buckinghamshire Council. They provide a range of interventions which includes prescribing.

5.3.39 ORB was able to engage positively with Adult C throughout their involvement with him which commenced in November 2020 and there was evidence of a non-judgmental and holistic approach. Harm minimisation and management of risk were consistent themes in his keyworker sessions, and he was actively involved in the formulation of his care and recovery plan. Evidence based assessment tools were utilised during the assessment process and documentation was of a good standard.

5.3.40 Adult C was directly asked if he required adjustments in his care and treatment due to his diagnosis of autism spectrum disorder, but he declined. However, ORB staff were aware of potential barriers that he may face, and care was taken to check his clinical records to ensure that he was not being disadvantaged by his ASD. Thereafter they maintained a consistency of approach with one named keyworker and regular fortnightly contact.

5.3.41 ORB was able to identify good practice in much of their service response to Adult C, as indicated by his continued engagement with the service. Good practice was also evidenced in the initial, comprehensive assessment; treatment plans; psychosocial interventions; harm minimisation, routine self-monitoring of mood and communications with pharmacy. In this way, it could be seen that they

invested in the care of Adult C as an individual and that this care was reciprocated by his openness with them. However, they also identified a number of care delivery problems.

5.3.42 The Risk Assessment was not fully completed. Adult C 's risks associated with his Autism, suicidal ideation, drug and alcohol use were discussed and he was assessed as medium risk. Whilst other aspects of risk information were being considered informally, there were several areas of risk that were not formally assessed, including his risk of violence and aggression to others. On the occasion that Adult C was assaulted by a fellow resident, he advised his keyworker that he would retaliate if he was assaulted again, but the housing provider was not advised of this threat. ORB was not aware of any other violent episodes in his history and knew little about the circumstances that led to him leaving the family home.

5.3.43 Referrals were offered to other services, such as Healthy Minds, but it did not appear that ORB had notified Adult C's named community mental health nurse from Oxford Health of their involvement. Neither did they request supporting information from them or consider a dual diagnosis approach. Although they had requested Adult C's clinical records from the doctor which would include an outline of his mental health treatment, this was not provided and ORB did not follow this up. In this way they did not have up to date knowledge of his mental health treatment. Thereafter, when Adult C advised the ORB keyworker that he had stopped taking his anti-psychotic medication in January 2021, it did not appear that they notified key agencies including the GP, Oxford Health and the housing provider and this was not picked up in supervision. Neither did they update their risk assessment or monitor ongoing symptoms through asking specific questions relating to symptoms of psychosis.

5.3.44 The organisation has made recommendations for each of these potential shortcomings and updated the panel on its move to a quadrant model of working with dual diagnosis which will be considered later in the report.

5.3.45 **South Central Ambulance Service NHS Foundation Trust**

5.3.46 The Ambulance Service had no contact with Adult J or Adult L before the homicide but their first contact with Adult C was in July 2019 and he thereafter made 35 calls to 999 or 111 over a 19-month period. Most of these calls concerned him requesting a prescription of a controlled drug and, on several occasions, it was recorded that he had taken more than the prescribed amount of his medication, hence running out of his previous prescriptions. On one

occasion, it was recorded that he was 'displaying drug seeking behaviour.' His records did not identify domestic abuse and his behaviour was never violent to staff or others during these calls for service.

5.3.47 The Ambulance Service reflected that, although Adult C's calls were high, they did not meet the threshold for him to be considered a frequent caller. South Central Ambulance Service's local Frequent Caller Policy, which has a lower threshold than national recommendations[31], requires them to review and refer for care and assessment patients who present:

- Ten or more times to 999 in any twelve-month period
- Twenty or more times to 111 in any twelve-month period

5.3.48 However, it was considered that Adult C's repeated requests for prescriptions for a controlled drug and his drug-seeking behaviour could have prompted a safeguarding referral and the Service has made recommendations to that effect for the future. The review heard how a recent Care Quality Commission inspection had identified the need to strengthen safeguarding responses and for greater resilience in the Safeguarding Team. Since this time, the Service has been increasing the capacity of the Safeguarding Team and is working to an improvement plan to promote good quality safeguarding processes and referrals, and links across the Service, as required by the Care Quality Commission. In order to address the needs of callers with repeated drug seeking behaviour, such as Adult C, the Safeguarding Team are working with the Demand Practitioner Team to agree ways in which safeguarding can and should be dealt with in cases such as this.

5.4 Housing Services

5.4.1 Buckinghamshire Council Housing Service

5.4.2 The Housing Service was first contacted by Adult C in May 2020 after his bail conditions required him to leave his mother's home. He explained that he had used reasonable force to prevent his father from bullying his mother and outlined

[31] An adult is defined as a 'Frequent Caller' to 999 as determined by the Frequent Caller Ambulance National Network (Frecann) / Association of Ambulance Chief Executives (AACE):

- 5 or more emergency incidents in a month.
- 12 or more emergency incidents in a quarter.

his needs in relation to Asperger's Syndrome, depression, anxiety and paranoid psychosis for which he explained he had to take medication.

5.4.3 After this initial presentation, he indicated that he could find his own permanent accommodation but was referred again in September 2020 when his mental health deteriorated, and his sofa surfing opportunities were exhausted. The Council arranged his temporary accommodation at Griffin Place and, whilst providing much detail about his needs to the accommodation provider, did not advise them of the assault against his father that had rendered him homeless, mainly because they accepted his description of having been defending his mother. Buckinghamshire Council Housing Service have therefore committed to ensure that details of violence are always provided to temporary accommodation providers in order for them to be able to undertake effective risk assessment and management.

5.4.4 Recognising Adult C's multiple and complex needs, the Housing Service levered in multi-agency support from the Rough Sleeper's Initiative, to support him whilst he was in this temporary accommodation. Nevertheless, the Housing Service considered moving Adult C when his mental health deteriorated further, but as housing officers did not consider that he had care and support needs, the only other accommodation that was available to Housing Services was low-supported accommodation out of the area and away from the support he was already receiving. They therefore decided to keep him somewhere that he could be observed for his own safety.

5.4.5 It was evident that the Housing Service worked hard to lever in additional support for Adult C, including liaising with mental health services to keep his case open but they were unclear how to escalate concerns when his mental health deteriorated, and no referrals were made to Adult Social Care for either safeguarding or care and support. Since this time the Service has introduced dedicated complex case housing officers and introduced 'complex case' safeguarding meetings' through which, issues can be escalated between housing and adult social care services. The local multi-agency approach to managing homeless people is considered further in the thematic section below.

5.4.6 **Bromford Housing**

5.4.7 Bromford Housing is one of the largest housing associations in the UK and provided temporary accommodation to Adult C at Griffin Place for seven months before the homicide.

5.4.8 Although they were not aware that Adult C had assaulted his father and that this was the reason for him becoming homeless, they nonetheless assessed him as

high risk. At this time, they were accepting all levels of risk, as part of the national 'Everyone In' initiative to accommodate rough sleepers during the COVID-19 pandemic.[32] However, they put steps in place to manage his risk to others: advising their own staff to avoid lone working with him; requiring that any visitors would have to meet him in the meeting room and moving him out of a shared flat and into his own as soon as one became available.

5.4.9 It was evident that staff at Griffin Place referred to mental health services when Adult C was presenting as distressed, expressing suicidal thoughts or displaying unusual behaviour. They also challenged a decision when they considered that he needed more help than the mental health service were prepared to offer, which was seen as good practice.

5.4.10 In terms of the matter of the short delay in sharing contact information with the mental health team whilst confirmation of identity was sought, this issue was picked up immediately after the homicide and a protocol was put in place to ensure that information could be responsibly shared without delay.

5.4.11 **Aylesbury Homeless Action Group**

5.4.12 Aylesbury Homeless Action Group (AHAG) is a local charity providing advice and support on housing options to those who are homeless or at risk of homelessness. Support staff work as part of the Rough Sleeper's Initiative and supported Adult C from May 2020, when he was excluded from the family home due to assaulting his father. He was supported by two support workers in succession during this time and therefore benefitted from continuity of service in trying to find suitable long-term housing for him.

5.4.13 This period was influenced by COVID-19 lockdowns where they mostly provided telephone advice. Whilst the support worker liaised closely with the mental health nurse in the Rough Sleeper Initiative each time that Adult C's mental health was of concern, the charity reflected that there were limitations to the service in not being able to have face to face contact. Nonetheless, the service was seen to be proactive in trying to maintain contact with Adult C, reflective and responsive to his needs. They acted on concerns promptly, particularly in securing a mental health assessment and with placing him in temporary accommodation, and consistently encouraged him to engage with his GP and with mental health services.

[32] The Government's 'Everyone In' initiative during 2020/21 required all local authorities to take urgent action to house rough sleepers, and those at risk of rough sleeping, in order to protect people's health and reduce wider transmission of Covid-19.

5.4.14 Apart from Adult C's initial disclosure that the reason he had become homeless was because bail conditions arising from his assault of his father, no other records showed any indicators of domestic abuse towards his mother or father.

5.4.15 Their contribution to the multi-agency approach will be considered further in the thematic section which follows.

6. THEMATIC ANALYSIS

6.0.1 This section considers the overarching themes arising from the review.

6.1 Indicators of Domestic Abuse Within the Family

6.1.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). This review examined abuse that was present within the whole family, not least because Adult C had described how his anger towards his father was caused by his father's abuse of his mother. Nonetheless, it did not appear to have been clear to any agency what was happening within the household.

- Adult J was a victim of an alleged assault from his son before being killed by him, but he also abused Adult L.
- Adult C was the perpetrator of the homicide of his father and abuser of his mother but was also an autistic person with significant mental health needs and in need of care and support himself.
- Adult L was the victim of domestic abuse from both her husband and her eldest son and was a perpetrator to neither.

6.1.2 Whilst no one agency had the complete picture, there were indicators of domestic abuse which were visible to some agencies at the time.

6.2 Domestic Abuse within an Intimate Relationship

Forced and 'predatory' marriage

6.2.1 Family accounts established that Adult J had a history of coercive control towards Adult L, and that Adult L had earlier divorced him as a result. However, they remarried after Adult L's second husband died and when early signs of dementia

were becoming apparent. Indeed, the marriage took place eight months after a GP appointment first signalled Adult L's dementia.

6.2.2 Their family did not consider that Adult L would have remarried Adult J if she had had full mental capacity to make that decision. They recounted that their mother had previously said to them, "Please do not let that man get anywhere near me."[33] Although no agency was involved with the couple at the time, and having dementia does not mean that a person automatically lacks capacity to consent to a marriage, it is possible that the marriage was forced.[34]

> *"Where a person lacks the capacity to consent to marriage, an offence is also capable of being committed by any conduct carried out with the purpose of causing the victim to marry, whether or not it amounts to violence, threats or any other form of coercion."* (HM Government,2022:4)

6.2.3 A campaign has recently been set up by the relatives of Joan Blass, who had been the victim of a 'predatory marriage,' in order to strengthen the laws around the economic abuse which is involved.[35] 'Predatory marriages' are a type of forced marriage and involve fraudsters marrying vulnerable and often elderly individuals and who are then able to access their new spouse's savings and inherit their entire estate. After Adult J's re-marriage to Adult L, their family considered that he changed her will to his benefit and thereafter, Adult L's family described how she was subject to economic abuse, ill-treatment, neglect and coercive control by her husband.

Economic Abuse

6.2.4 Adult L had inherited a large sum of money from a former husband, whereas Adult J, before the remarriage had only a pension for income. After their remarriage, he was reported to control his wife's finances and used her money to support his more lavish lifestyle including the purchase of a £60,000 luxury car and multiple holidays.

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[33] Cited in Thames Valley Police IMR.

[34] Note however the judgement in Sheffield City Council v E [2004] EWHC 2808 (Fam) [2005] 1 FLR 965 h "As we have seen, the question has always been formulated in a general and non-specific form: Is there capacity to understand the nature of the contract of marriage?' and in relation to her marriage the only question for the court is whether E has capacity to marry. The court is not concerned – has no jurisdiction – to consider whether it is in E's best interests to marry or to marry S. The court is concerned with her capacity to marry, not with the wisdom of her marriage in general or her marriage to S in particular." (Pike, 2016:2)

[35] For further information on the case of Joan Blass see https://www.theguardian.com/society/2021/sep/15/daphne-franks-the-woman-who-lost-her-much-loved-mother-to-a-predatory-marriage.

6.2.5 Adult J later made enquiries of the GP into Lasting Power of Attorney, which could have alerted the GP to potential for ongoing abuse, had there been alerts on their system concerning the prior allegations made.

6.2.6 Lasting Power of Attorney was also discussed with Adult J by social workers after safeguarding enquiries had been initiated by the allegations from the younger son. He had detailed how his father was abusing his mother and how he was economically abusing her, and we have seen how Adult Social Care have committed to strengthening their understanding of domestic abuse, including economic abuse.

> **Learning Point: Economic Abuse and Lasting Power of Attorney**
>
> All practitioners need to be alert to how Lasting Power of Attorney can be used by domestic abusers to gain further control over their victims, particularly in respect of economic abuse. *Surviving Economic Abuse* has found that economic abuse rarely happens in isolation and 95% of domestic abuse involves economic abuse.[36]

6.2.7 Adult J's economic abuse of his wife also extended to taking away the landline phone, restricting her access to her mobile phone and restricting her access to food.

Ill-treatment and Neglect

6.2.8 The family reported to social workers that Adult J did not look after Adult L's personal appearance or hygiene and denied her help for her dementia, making her go to bed as early as 3:30pm. They described Adult J's neglect of her extending to depriving her of food, giving her only one meal a day. Adult J explained to social workers, who investigated the allegations, that the food cupboards were bare as Adult C would eat everything, and Adult L had access to her own snacks.

[36] https://survivingeconomicabuse.org/what-is-economic-abuse/.

Isolation

6.2.9 Adult J appeared to control all of Adult L's contact with professionals and was ever present in their contact with her. He also controlled her access to the telephone, removing the landline and restricting Adult L's mobile, whilst giving excuses to social workers as to why they were having trouble contacting her.

6.2.10 Adult J took Adult L to the GP in respect of her memory loss, but later advised that Adult L had declined the referral to the memory clinic. Whilst it is not uncommon for those experiencing the early signs of dementia to be fearful of the assessment and decline the service, as Adult L was not seen alone, it was not known whether this was her choice.

6.2.11 A social worker originally planned to see Adult L on her own, whilst Adult J was out, in order to explore the allegations of abuse that had been made. Having been thwarted on their first attempt, thereafter Adult J was always present when they saw Adult L. Moreover, he menacingly warned social workers not to come into the house without his prior consent and they had a 'gut feeling' that something was not right in the household.

Learning Point: Seeing people on their own for at least part of the assessment

Although practitioners will want an individual with dementia to be supported by their carer, from both a domestic abuse perspective and a Making Safeguarding Personal perspective, the individual may not be able to disclose abuse with the other person present. Individuals should always be seen on their own, wherever possible, for at least part of the consultation or assessment.

6.3 Elder Abuse or Domestic Abuse?

6.3.1 In each of these examples of abuse, professional's focus appeared to be more on the care that a vulnerable person was receiving rather than the domestic abuse and coercive control that she was experiencing.

6.3.2 Adult L's younger son worked hard to try to get support and protection for his mother. He raised safeguarding concerns with the local authority, either directly, or indirectly through his approaches to the GP, in December 2019, and through the Police, in May 2020. We have seen that on each of these occasions, Adult Safeguarding missed opportunities to convene multi-agency strategy discussions as, soon afterwards, the decision to move to enquiry was made. Had they done so, this would have enabled a more holistic understanding of the concerns raised

and multi-agency involvement in safety planning for and with Adult L, with an independent advocate as necessary.

6.3.3 At the same time, the police did not investigate fully themselves when the allegations of domestic abuse were raised with them in February, March and May 2020, referring to the MASH on the last occasion.

Learning Point: Making Safeguarding Personal

Safeguarding is everyone's responsibility. Practitioners need to use professional curiosity and relationship-based practice to ensure that someone is not pushing them away because they are influenced, coerced or controlled by someone else. They need to check their own intuition about the circumstances in which a concern has been raised about the possibility of abuse or neglect (LGA & ADASS, 2019:3).

6.3.4 In part, agency responses may have been influenced by the distinctive fields of elder abuse and domestic abuse, each having built their evidence base, language and pathways to support and protection separately. Research has shown that these distinctive definitions may have created a gulf between those working in domestic abuse and those working in elder abuse (Bows, 2018:5). As Adult L was an older woman in need of care and support, the default position was to consider elder abuse and her care and support needs. However, the introduction of coercive control as a criminal offence in 2015, can equip each sphere with greater power and insight, and much of this understanding was lacking in agency's response to the abuse that Adult L was experiencing. This was despite the fact that family members had provided significant detail about the coercive control that their mother was experiencing from her father.

Learning Point: Elder Abuse, Domestic Abuse and Coercive Control

Although significant detail about domestic abuse and coercive control had been provided to agencies, attention was only given to the quality of the care that this older woman with dementia was receiving from her husband. Consideration was not given to investigating the coercive control as a crime or as coercive control within the section 42 enquiry which was undertaken as an individual agency rather than multi-agency response.

6.3.5 It was not always apparent that practitioners understood the powers that were available to consider Adult L's capacity to make decisions whilst experiencing coercive control.

Learning Point: Coercive Control and Mental Capacity

The Court of Protection is a useful resource to draw upon where there are questions about a person's capacity to make a decision related to key issues over their everyday life. Where someone's capacity is in question, and they are experiencing coercion which may impair their decision-making abilities, the High Court can exercise its inherent jurisdiction to make an order in respect of that person.

6.3.6 The review heard how multi-agency understanding of coercive control, and of the many forms of domestic abuse, had been promoted with practitioners across Buckinghamshire, through Buckinghamshire Domestic Abuse Partnership multi-agency training and support and through the Buckinghamshire Domestic Abuse Champions Network. This will[37] shortly include awareness of domestic abuse amongst adults with care and support needs and amongst older populations.

Recommendation 1: Coercive Control and Adults with Care and Support Needs

Safer Buckinghamshire Partnership to seek evidence-based assurance from key partner agencies[38] that practitioners understand how older adults and/or those with care and support needs may experience coercive control and that the law is being fully utilised to safeguard them.[39]

6.4 Domestic Abuse from (Adult) Child to Parent

6.4.1 From Adult C, Adult L also experienced domestic abuse. During his assault of her in 2015, the police's domestic abuse risk assessment recorded an escalation in Adult C's abuse towards her which ranged from verbal aggression to physical assault. This included him head-butting her and holding a carving knife to her neck. She also recounted how he had previously put a wire around her neck and made threats of suicide.

6.4.2 His brother described how Adult C's domestic abuse of his mother began in 2010. In 2016, he provided Oxford Health with a chronology of this abuse:

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[37] To be delivered in June 2023.

[38] Key partner agencies listed below.

[39] Where evidence base could include the number of referrals to Hourglass, the national domestic abuse charity supporting older people experiencing domestic abuse, which is promoted in the area. See https://wearehourglass.org/domestic-abuse.

"2010 – Took ½ ounce of his so-called friend's cocaine then my mum was forced to pay the £600 within 48 hours after Adult C got volatile and pushed her over
2011 – Went to Centre Parks with girlfriend and family and called my mum demanding she pick him up as the parents were picking on him when the truth was he did drugs in the toilet and it was all around his nose in public view.
2012 – Went to Kent did drugs called myself and my mum saying that people were watching him and then drove back with a kitchen knife to stab my mum. She locked herself in her house scared and Adult C was later found by the police at the side of the road and was …. sectioned.
2012 – Went to appointment in Milton Keynes with my partner, new-born baby and my mum. Because the appointment didn't go how he wanted he started to shout abuse and threats to beat my mum up while she was driving.
2013 to Present – Continuously lies about going out with friends to get money for drugs and has to have alcohol every day from the moment he wakes up. He goes to my mum's and says he is depressed when he is on a come down from drugs and as soon as he has been given money, he will be very happy and leave.
2014 – Mum left money for Adult C in envelopes for each day while she was on a cruise for myself and my partner to hand out to him. He had roughly £20 - £30 for each day and some days he had £40, he demanded that we gave him all of it because he owed drug dealers money and needed to pay his debt
2015 – Made my mum meet drug dealers to pay his debt
2015 – Numerous visits to my mum's house where he was verbally abusing her to give him money
2015 – Head butted my mum in the face and put a knife to her throat while he was completely drunk and under the influence of drugs, he stole a very expensive bottle of Champagne which he still thinks is hilarious. Police arrested him and he went to court and was given a £400 fine to which my mum paid.
2015 – Sent text messages to my mum saying this was his last Christmas
2016 – My partner has been asked to control his money as it is too much stress for my mum, every day he asks for money for alcohol and drugs and when told no, he will go to my mum's house and say he is depressed because he has no money and nothing to do. We then receive calls from my mum to say Adult C has been invited out by friends and needs money,

my partner gives it to him and he laughs that he is going to do drugs."
(Notes from Oxford Health records)

6.4.3 Thereafter, the family reported to the police that Adult C had threatened to kill his mother and was himself withholding food from her. They advised the police that he had been arrested for assaulting her before, but the police neither followed up this complaint, nor alerted Adult Safeguarding.

6.4.4 At the time of writing, domestic abuse research is beginning to capture the nature of, and distinction between, (adult) child-to-parent abuse and interpersonal abuse as well as the distinctions between Interpersonal Homicide from Adult Family Homicide (Benbow et.al., 2019; Bows, 2019; Chantler et al, 2020; Home Office, 2016, 2021, 2022; Montique, 2020; Sharp-Jeffs & Kelly, 2016).

6.4.5 The review noted that when agencies were earlier involved over Adult C's abuse of his mother in 2015, it was evident that she was caring for her son and did not want him to be prosecuted but wanted him to receive help as she was worried for his mental health. She considered that his abusive behaviour was due to his not taking his medication and fuelled by alcohol misuse. It was evident that Adult L had devoted much time to seeking a diagnosis for him from an early age. By the time he was in his early 30s, a psychiatrist questioned whether Adult L was creating over-dependency and that Adult C may be experiencing a disordered attachment. It was this concern that motivated the need to finally undertake an assessment and diagnosis for autism spectrum disorder in 2016.

6.4.6 It is not uncommon for parents of abusing children, grown-up or otherwise, to experience barriers in defining their experiences as domestic abuse and not access protective services for themselves as a result (Benbow, 2018; Bows 2018). In seeking help they are exposed to judgements of poor parenting. Indeed, in 2016, Adult C's psychiatrist questioned the extent to which Adult L had promoted Adult C's problems through her attachment style rather than recognising, either, that Adult C's autism may have made him reliant upon his family to help him communicate with professionals.

6.4.7 Mothers will often feel guilt or shame that they are failing in their caring role. Culturally, mothers still bear the primary responsibility for rearing children, and this will be all the more so for older mothers, for whom such cultural assumptions were less likely to have been questioned. For Adult L, barriers to help will have become all the more accentuated when her dementia later took hold.

Learning Point: (Adult) Child-to-Parent Abuse

Parents of abusing grown-up children will face additional barriers to receiving support and protection. They:

- Are less likely to identify their experiences as domestic abuse
- Are more likely to have lived with abuse for prolonged periods without receiving help and minimise the abuse
- Are less likely to identify or accept support from police or specialist services
- May face isolation and may fear disrupting family dynamics
- Are more likely to have caring responsibilities
- May have additional vulnerabilities as a result of their own age and ill-health

Recommendation 2: (Adult) Child-to-Parent Abuse

(i) As parents experiencing child-to-parent abuse are less likely to identify their experiences as domestic abuse and less likely to seek support and protection from the abuse, Safer Buckinghamshire Partnership to raise awareness with the public and with partner agencies, about the nature of child-to-parent abuse and the help that is available

(ii) Safer Buckinghamshire Partnership to seek assurance from police, social care, health and specialist domestic abuse and substance misuse agencies that increasing numbers of parents experiencing child-to-parent abuse are being identified, supported and protected and that they are adopting a multi- agency collaborative approach to the issue

6.4.8 It was also evident that economic abuse featured heavily within Adult C's abuse of his mother: demanding money for drugs and alcohol and even requiring her to go and pay off a drugs debt. Adult L therefore experienced economic abuse from both her husband and her son.

Adult C's alleged abuse of his father

6.4.9 Prior to his homicide, Adult J appeared to experience abuse from Adult C in the form of an assault which was reported to the police. Adult C's defence was that he was defending his mother. Indeed, Adult C's brother cautioned the police against Adult C being removed from the home as their father would be freely able to neglect and abuse their mother.

6.4.10 The review requested a check of the decision not to charge Adult C in relation to this assault. A Justice Gateway Officer from Thames Valley Police reviewed the file and supported the decision that was made, saying:

> *"The suspect states he was defending his mother and himself, I am of the view that if his account is to be believed then it appears reasonable in the circumstances to push the victim, the fact he fell and had a small injury appears within the realms of reasonableness, it is not excessive. I am of the view that it is one person's word against the other. Whilst there is an injury, which is documented, and an image taken, it appears this occurred whilst been pushed to the floor. There is no corroborating evidence of punches to support a Realistic Prospect of Conviction."*

6.4.11 In this way, the domestic homicide review found no evidence that Adult C had been abusive towards Adult J prior to the homicide, but rather that Adult L had been the recipient of abuse by both her husband and her elder son at different times.

Killing a parent

6.4.12 Although the apparent absence of prior abuse from the perpetrator towards his father, made this homicide atypical, there were characteristics of the homicide which were more common. Research now indicates that the combination of mental health and substance/alcohol misuse is one of the five most common pre-cursors of an adult killing a parent (Bracewell et al, 2021). In this research which examined the characteristics of perpetrators of adult family homicide in all of the published domestic homicide reviews in England and Wales (n=66)[40]: 91% were men; 79% had mental health difficulties; 62% experienced alcohol misuse; 61% experienced substance misuse; 70% had housing needs. These published domestic homicide reviews consistently called for greater understanding of domestic abuse involving family members and the risks involved as well as greater co-ordination of services to both perpetrator and victim (Bracewell et al, 2021).

6.5 Multiple and Complex Needs

6.5.1 Although Adult C's psychosis at the time of the homicide was a significant factor in his fatal assault of his father, the combination of mental illness, alcohol and substance use also posed additional risks to his mother when he was abusing

[40] Between 2016 and 2019

her. From her younger son's chronology, we can see that much of Adult C's abuse towards his mother involved coercion and threats of violence to gain money to fund his drug use. He was also physically abusive, particularly when under the influence of alcohol. However, the role his autism played in his alcohol and drug use was not made clear to agencies.

Autism Spectrum Disorder

6.5.2 Although Adult C was only diagnosed with autism spectrum disorder (ASD) in 2016, his mother had suspected the diagnosis when her son was still a toddler. Various records from his early years pointed to him being shy, with low self-esteem, and finding it difficult to relate to others. Therefore, developing what may be considered as "ordinary" meaningful relationships, would have been challenging and may have led to him being very reliant on close family who, in turn, may have been more accommodating of unusual behaviour. Families often develop methods to assist with deficits in areas such as communication and poor social skills.

6.5.3 His mother invested in a private educational assessment for Adult C whilst he was at school, but far less was known about ASD at that time. For youngsters diagnosed with ASD in more recent times, we might anticipate responses to include, as part of their early year's education, social skills training which could provide practice opportunities to help improve their interaction with others. We might also anticipate reasonable adjustments through early years to include the use of electronic devices or picture cards to help them better express their thoughts and needs.

6.5.4 We have seen that the records from the assessment undertaken in 2016 demonstrated that Adult C's difficulties in social interaction were not identified as autism. Again, less was known about autism at this time. Indeed, since this time, there has been a proliferation of research, information, training and support assessment tools to aid practitioners in their response to autistic people, particularly in how they can make reasonable adjustments in their communication and sensory assessments. The review, therefore, went on to consider, how Adult C's ASD may have affected him and how agencies made reasonable adjustments to his treatment and care.

6.5.5 The compounding impact of Adult C's ASD on his condition, will have complicated his treatment and care. One Recovery Bucks discussed the possibility of adjustments with Adult C, but he declined offers made and they found no evidence that he was disadvantaged in their service due to his diagnosis.

6.5.6 Oxford Health staff responded to Adult C's diagnosis of autism spectrum disorder in 2016 by recommending an assessment of his social support needs by the local authority's autism lead. Thereafter, they reflected that it was not evident how they had understood his mental health, alcohol and substance use within the context of his autism spectrum disorder. Likewise, Buckinghamshire Healthcare NHS Trust reflected that they did not appear to have considered Adult C's neurodivergence when observed that Adult C appeared to be unable to follow procedure and instructions and would often leave the hospital prematurely. Some individuals with ASD can be very sensitive to loud noise, or particular and sometimes very specific smells, light, or temperature. Understanding these sensory issues with the individual, and adjusting the environment to make it more comfortable, can help reduce stress and greatly assist to improve concentration. Whilst it is not known whether these factors influenced Adult C's premature departure from health settings, for example, it is these types of considerations that we would expect of agencies making reasonable adjustments to their workplace to accommodate the needs of individuals.

Learning Point: "My Health Passport"[41]

The National Autistic Society has introduced guidance and supporting documents such as "My Health Passport", which individuals can complete, if necessary, with assistance. This can help to assist health care professionals and others to access quick information to aid their understanding how to easily interact or understand the needs of the individual.

6.5.7 For people with ASD, structure, daily routines and schedules help immensely. Sudden and unexpected changes are often difficult. It was evident that when Adult C's accommodation situation was more settled, although challenges and crises did still occur, they were fewer. However, following his assault of his father and being prevented from living at his mother's address, he led a transient lifestyle: moving from place to place; sofa surfing and living in a friend's van for four months. This was clearly an extremely difficult time for Adult C and a point of heightened risk, as demonstrated in his increase abuse of all substances and a marked deterioration in his mental state.

6.5.8 Research has indicated that autistic people are no more likely to be violent than the rest of the population and may even be less likely to be violent (King and

[41] Available at https://www.autism.org.uk/advice-and-guidance/topics/physical-health/my-health-passport.

Murphy, 2014). However, ASD has been a theme of several safeguarding adult reviews locally. Buckinghamshire health and social care agencies described how they were delivering the Oliver McGowan Mandatory Training on Learning Disability and Autism[42] in line with the Core Capabilities Framework for Supporting Autistic People (Department of Health & Social Care, 2019).

Autism, Mental Health, Alcohol and Drugs

6.5.9 The review considered the extent to which Adult C may have sought to cope with his autism by using alcohol and drugs. Despite common stereotypes of autistic people being rule-driven, rigid and socially avoidant, it is not uncommon for autistic people to resort to alcohol and drugs as a way of relieving social anxiety or as a means of self-medication to help them cope with, for example, sensory dysregulation (Weir, 2021).

6.5.10 Adult C first used illicit substances at the age of 16 years. Although he did not discuss how alcohol and drugs may have been helping him to cope with his autism, if indeed they were, he did consider that he experienced psychosis through stimulant use. He went on to use opiates more frequently and in increasing quantity until becoming opioid dependent in his early 30s.

6.5.11 We have seen that Oxford Health considered that Adult C's symptoms of mental ill-heath and psychosis were predominantly drug induced. Despite this, they were not proactive in referring him to ORB despite knowing that he had had a positive experience with them previously, and they considered that he was resistant to treatment for his drug and alcohol use. Neither was ORB pro-active in referring Adult C to Oxford Health, although they were aware that he was in regular contact with the mental health practitioner at the Rough Sleeper's Initiative and might reasonably have considered that Adult C was connected into mental health services through this route.

6.5.12 It is important to note that the symptoms of substance use disorder may mask the symptoms of mental health disorder, and vice versa. For Adult C, this will have been further complicated by his ASD. In this situation, it would have been essential that a comprehensive evaluation from a multi-professional team determined the appropriate treatment plan. This may have included, in addition

[42] The Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose.

to his medication regime, behaviour therapy such as Cognitive Behavioural Therapy[43] and possibly peer support such as Alcoholics Anonymous or Narcotics Anonymous.

6.5.13 In the intervening time, the panel heard how a revised joint working pathway had been developed locally in order to address the thresholds for services between substance use and mental ill-health and the co-ordination of care thereafter. The pathway, which has been recently launched, contains a joint working protocol based around the quadrant model of dual diagnosis; introduces a quarterly quadrant based Complex Needs Panel and is seeking to share medical records. As well as the complex needs panel, the pathway will promote smaller, regular meetings between ORB and Oxford Health to pick up areas of concern regularly and in real-time. The different models of care between the two services were recognised. Substance misuse services work with self-efficacy and motivation with the individual leading the treatment, whereas mental health services also are able to use the Mental Health Act at times of crisis to enforce treatment.

6.5.14 Within the individual recommendations for each service, One Recovery Bucks and Oxford Health NHS Foundation Trust will provide assurance to Safer Buckinghamshire Partnership on the outcomes of the revised joint working pathway and clarity over the pathways for people with complex needs.

Engagement

6.5.15 The challenge of engagement with both services was recognised, although Adult C went on to engage well with ORB during the months before the homicide. Review panel members described the value of assertive methods of engagement. Indeed, the Integrated Care Board recognised the shortcomings of merely signposting individuals to drug and alcohol service and relying on their motivation, recognising the need to support individuals between their services.

Recommendation 3: Primary Care Pathway to Substance Misuse Service
Buckinghamshire Integrated Care Board to consider the pathway between GP Practices and One Recovery Bucks in order that there is a more seamless route between the two services than merely signposting patients.

[43] CBT is recognised as effective in helping individuals with ASD manage anxiety, depression or other mental health conditions, as well as improve social skills and emotional regulation. However, input from a suitably qualified person with experience of working with individuals with ASD is important to ensure that the treatment is tailored to the individual's unique needs.

6.6 Homelessness and Multiple and Complex Needs

6.6.1 The Local Authority Housing Service was the lead agency for the multi-agency Rough Sleeper's Initiative, funded by the Department of Levelling Up, Housing and Communities. The initiative was established to offer extra assistance to those who are rough sleeping or at risk of rough sleeping and who do not meet the 'priority need' thresholds under the homelessness legislation and involved statutory and third sector housing services, mental health and drug and alcohol services.[44]

Managing risk

6.6.2 Utilising government funding, Buckinghamshire Council commissioned a role for a mental health practitioner from Oxford Health to be embedded in the multi-agency team. The role was ostensibly to support those who have been assessed as not having a 'priority need' for accommodation, but nonetheless had some mental health concerns. However, in this case, the mental health worker provided ongoing support to Adult C, despite his 'priority need' status, as housing officers were struggling to support him whilst he was in temporary accommodation. Indeed, the Housing Service reflected that none of the housing services were sufficiently skilled to manage Adult C's multiple and complex needs, particularly when his mental health deteriorated.

6.6.3 We have seen that there were differences in the final period between how Adult C's risk was viewed by the housing agencies that were supporting him and by the mental health practitioner in the Rough Sleeper's Initiative. Housing workers considered that Adult C's mental health had deteriorated to the point that he needed a Mental Health Act assessment, but the mental health practitioner, recognising how fearful Adult C was of medical staff, was reluctant to make that referral until there was some confidence that Adult C had reached the threshold for detention. However, the mental health practitioner could be seen to have been working in isolation from his clinical colleagues by not discussing Adult C's deteriorating behaviour with them. For other agencies involved, there appeared to be an assumption made that the mental health practitioner would be connected to clinical colleagues in the Trust.

6.6.4 Indeed, it was reflected that the mental health practitioner role would benefit from having direct access to a consultant psychiatrist at times of a patient crisis or

[44] Buckinghamshire Rough Sleepers Initiative includes local authority Housing Service, Connections Support, Aylesbury Homeless Action Group, Wycombe Homeless Connection, Oasis, One Recovery Bucks, Oxford Health NHS Foundation Trust and MIND.

complexity. The Trust therefore considered that a review was needed of the structure of how the mental health practitioner in the Rough Sleeper's initiative is connected into the Trust and how the role is supported. For the housing agencies who were expressing their concerns, their routes of escalation were not apparent and the Memorandum of Understanding between the two agencies has since been revised.

Recommendation 4: Mental health crises in temporary accommodation

Buckinghamshire Council Housing Services and Oxford Health NHS Foundation Trust to provide assurance to Safer Buckinghamshire Partnership concerning how the revised Memorandum of Understanding:

(a) has ensured that the mental health needs of homeless people within temporary accommodation are identified, supported and where necessary, disputes escalated to resolution.

(b) that the embedded mental health worker is effectively supervised and supported in real time when individuals present themselves with acute mental health issues

(c) that the embedded worker has clear guidance on where information should be recorded across both systems.

Availability of supported accommodation

6.6.5 We have also seen that since this time, Buckinghamshire Council has introduced two new roles for complex case housing officers and co-ordinates the multi-agency Complex Case Panel[45], in order to support individuals with multiple and complex needs, but whose needs fall below the threshold for statutory care and support. This investment in support and co-ordination was seen as good practice and consistent with the evidence from programmes aimed at reducing homelessness for individuals with multiple needs (MHCLG, 2020).

6.6.6 It was noted that accommodation in the area for those with medium or high support needs was highly limited. Buckinghamshire Council's Homelessness and

[45] This is separate to the quadrant complex case meeting within the dual diagnosis pathway referred to earlier.

Rough Sleeping Strategy 2022-2025[46] has already identified the need to review accommodation options, including whether additional provision is needed, for those with high and multiple needs and Buckinghamshire has recently received £2.7million funding to help fund emergency beds with housing support and drug and alcohol outreach services attached.[47]

6.7 Domestic Abuse Training

6.7.1 Having a clear and robust domestic abuse policy in place, which is regularly reviewed, can provide an organisation with the support and guidance to best respond to domestic abuse. It is also important that this policy is accompanied by regular and stand-alone domestic abuse training which is mandatory. Information provided for this review, as demonstrated in Appendix 1, shows inconsistencies across agencies in having a policy and/or domestic abuse training. In addition, much training that is delivered is through wider safeguarding training and may be insufficient to address domestic abuse sufficiently.

Recommendation 5: Domestic Abuse Training and Policies

All Safer Buckinghamshire Partnership agencies and those involved in this review, to ensure that domestic abuse policies are up to date, or, for those without one, to ensure a policy is developed. The policy must be accompanied by regular and mandatory training on domestic abuse.

[46] Available at https://buckinghamshire-gov-uk.s3.amazonaws.com/documents/Homelessness_and_Rough_Sleeping_Strategy_2022_to_2025_print_version.pdf.

[47] https://www.buckinghamshirelive.com/news/buckinghamshire-news/buckinghamshire-council-given-27million-help-7732236.

7. CONCLUDING REMARKS

7.0.1 This review has considered, firstly, how agencies understood and responded to the numerous reports of domestic abuse raised by the younger son of the family. He was clearly working hard to secure support and protection for his mother who was experiencing domestic abuse from both her husband and her other son. Secondly, the review considered how agencies identified and responded to the elder son's multiple and complex needs and how they understood and responded to the risk that he posed to himself and others.

7.0.2 There was no doubt that practitioners on the front line of services to the family, had to navigate a highly complex terrain of, on the one hand, domestic abuse, coercive control, elder abuse and care and support needs, and on the other hand, autism, mental health, substance misuse and multiple presentations of drug seeking behaviour.

7.0.3 In order to respond effectively, practitioners needed to *Think Family:* to be professionally curious, thorough and diligent in their enquiries and to consider how behaviours may impact upon others in the household. In order to be able to interpret what they found, practitioners needed to understand coercive control in the context of a victim who has care and support needs. Practitioners also needed effective pathways for safeguarding, homelessness and for dual diagnosis. Despite some evidence of good practice, the review found shortcomings in each of these areas leading to missed opportunities to identify and manage the risks that ultimately manifested for all of the individuals concerned.

8. RECOMMENDATIONS

8.1 Overview & System Recommendations

Recommendation 1: Coercive Control and Adults with Care and Support Needs

8.1.1 Safer Buckinghamshire Partnership to seek evidence-based assurance from key partner agencies that practitioners understand how older adults and/or those with care and support needs may experience coercive control and that the law is being fully utilised to safeguard them. Key agencies in this regard are:

- Aylesbury Homeless Action Group
- Aylesbury Women's Aid
- Bromford Housing
- Buckinghamshire Integrated Care Board
- Buckinghamshire Council Adult Social Care
- Buckinghamshire Council Housing Team
- Buckinghamshire Healthcare NHS Trust
- Buckinghamshire MIND
- Oxford Health NHS Foundation Trust
- One Recovery Bucks provided by Midland Partnership NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- Thames Valley Police

Recommendation 2: (Adult) Child-to-Parent Abuse

8.1.2 As parents experiencing child-to-parent abuse are less likely to identify their experiences as domestic abuse and less likely to seek support and protection from the abuse, Safer Buckinghamshire Partnership to raise awareness with the public and with partner agencies, about the nature of child-to-parent abuse and the help that is available

8.1.3 Safer Buckinghamshire Partnership to seek assurance from police, social care, health and specialist domestic abuse and substance misuse agencies that increasing numbers of parents experiencing child-to-parent abuse are being

identified, supported and protected and that they are adopting a multi- agency collaborative approach to the issue

Recommendation 3: Primary Care Pathway to Substance Misuse Service

8.1.4 Buckinghamshire Integrated Care Board to consider the pathway between GP Practices and One Recovery Bucks in order that there is a more seamless route between the two services than merely signposting patients.

Recommendation 4: Mental health crises in temporary accommodation

8.1.5 Buckinghamshire Council Housing Services and Oxford Health NHS Foundation Trust to provide assurance to Safer Buckinghamshire Partnership concerning how the revised Memorandum of Understanding:

a) has ensured that the mental health needs of homeless people within temporary accommodation are identified, supported and where necessary, disputes escalated to resolution

b) that the embedded mental health worker is effectively supervised and supported in real time when individuals present themselves with acute mental health issues

c) that the embedded worker has clear guidance on where information should be recorded across both systems

Recommendation 5: Domestic Abuse Training and Policies

8.1.6 All Safer Buckinghamshire Partnership agencies, and those involved in this review, to ensure that domestic abuse policies are up to date, or, for those without one, to ensure a policy is developed. The policy must be accompanied by regular and mandatory training on domestic abuse.

Recommendation 6: Accountability

8.1.7 Safer Buckinghamshire Partnership to share an update with the bereaved family in 12 months' time, concerning what has changed as a result of the domestic homicide review and subsequent action plans.

8.2 Individual Agency Recommendations

Buckinghamshire Council Adult Social Care

- Reinforce and refresh Safeguarding training for all staff with a focus on domestic abuse and dealing with coercive and controlling behaviour and including economic abuse in the context of deputyship for finances,
- Greater emphasis across the service of the principles of Making Safeguarding Personal (MSP)
- Greater emphasis across the service of the principles of Making Safeguarding Personal and ensuring that practitioners enable safe disclosures of domestic abuse during section 42 enquiries, including seeing individuals alone; asking directly about domestic abuse; seen in different settings where possible; consideration given to the use of advocates

Buckinghamshire Council Housing Services

- Details of an applicant's known history of violence are systematically provided to temporary accommodation providers before referred and placed with them

Buckinghamshire Integrated Care Board

- To develop the domestic abuse primary care pathway in order that sensitive and routine enquiry is systematically undertaken into domestic abuse, across Buckinghamshire GP Practices, where indicators of domestic abuse are present, irrespective of the sex of the individual.
  In order to develop the domestic abuse pathway, and meet the ambitions of *Making Every Contact Count*, the Partnership to consider Domestic Abuse Statutory Guidance (2021)[48] which promotes the Whole-Health Model to domestic abuse incorporating:
  - *"Findings from the Pathfinder Project highlighted that health professionals feel better able to enquire about domestic abuse if their Integrated Care System and primary care networks supported the placement of Independent Domestic Violence Advisors (IDVAs) or other accredited domestic abuse peer advocacy programme. These specialised trauma-informed services might then be best placed to follow up with any disclosures of abuse; a greater understanding of local referral pathways; specialist recovery and peer advocacy services to which they can refer or*

[48] https://www.gov.uk/government/publications/domestic-abuse-act-2021

signpost victims, survivors or perpetrators dependent upon their unique situation." (para 293)

- *"Implementing the IRIS (Identification and Referral to Improve Safety)[49] Programme. IRIS is an evidence-based intervention to improve the general practice response to domestic abuse through training, support to practice teams and having a DA specialist embedded in practices. It is nationally recognised as best practice and has informed NICE guidance" (para 306)*

GP Practice 1

- To develop practice responses so that sensitive and routine enquiry is undertaken into domestic abuse where indicators of domestic abuse are present, irrespective of the sex of the individual
- To develop practice responses so that individuals presenting with problematic alcohol use are advised about, and encouraged to use, alcohol treatment services
- To develop practice responses so that the value of a carer's assessment is routinely discussed with individuals caring for others, and referrals to the local authority made where accepted

GP Practice 2

- To raise awareness with Practice staff that dementia symptoms can be a veil for domestic abuse
- To develop practice responses so that mental capacity assessments are considered when services for memory loss are declined
- To develop practice responses so that individuals are seen alone for at least part of the consultation when indicators of domestic abuse are present in order that any disclosures could be made or routine questioning on domestic abuse undertaken
- To develop practice responses so that the potential for economic abuse is considered when applications for Lasting Power of Attorney are being made
- To develop practice responses so that GPs are alerted in future consultations to allegations of domestic abuse through effective coding and recording of domestic abuse

[49] https://irisi.org.uk

GP Practice 3

- To develop GP awareness of drug seeking behaviours and ensure that they are alert to the risk of addictions for patients being prescribed opioid medication, considering referrals to One Recovery Bucks before prescribing where there is a history of drug use. If alternative pain relief is not issued, to ensure that decisions to prescribe opioid medication are reviewed and that firm boundaries are put in place from the start of the prescribing period.
- To review the systems in place that alert the GP Practice to Out of Hours, and vice versa, of each other prescribing and risk monitoring to ensure that there is not over-prescribing, particularly of medication that can lead to addictions.
- To review the system within the Practice whereby repeated notifications from the Ambulance Service about drug seeking behaviours did not raise the need to alert a GP to review the patient
- To develop practice responses so that third party information received and alerting to safeguarding risks for a patient is acted upon and adult safeguarding referrals made when needed.

One Recovery Bucks (Midlands Partnership NHS Foundation Trust)

- That all areas of the Risk Assessment are completed; where elements are not completed a rationale for this should be documented within the Risk Assessment.
- That where a service user / patient is known to be open to mental health services / other services; that, with the service user's consent that organisation is informed off the service user's engagement with ORB either by writing or in an email format and that the ORB requests a summary including diagnosis and treatment from the named relevant mental health service. ORB Clinical Summaries should be shared with named mental health services as standard practice
- that the risk assessment is an accurate reflection of case note entries when describing risk. Where a service user/patient verbalises a threat, ORB staff should discuss the need to react in a socially acceptable and legal manner, educate them of the potential consequences of any threatening or

aggressive behaviour and inform any associated agencies of the potential risk. Risk assessment should be updated to accurately reflect risk

- Keyworker to confirm any medication changes with the prescriber and to record these within the service user/ patients case notes and care plan. Keyworker and other ORB staff who have contact with the service user / patient to observe and monitor for any changes in mental health and to ask the service user / patient to describe any mental health symptoms at appointments. Any significant changes to be shared with prescriber / mental health service. Consent to share information with health services should be sought at the point of initial assessment.
- that bloods should ideally be taken prior to commencing Espranor and if not possible then taken a soon as possible after prescribing is initiated.
- Service users/patients should be reminded of the need to attend appointments and to fully participate in their recovery programme. Full compliance with the ORB Did Not Attend procedures.

Oxford Health NHS Foundation Trust

- Improve how actions from Section 42 or other safeguarding reviews involving Oxford Health are recorded and monitored centrally.
- Improve joint working with One Recovery Bucks
- Improve how Rough Sleeper Initiative embedded MH practitioner role is managed.
- Review how Oxford Health contributed to the multi-agency approach, communicated, shared information escalated issues.

South Central Ambulance Service NHS Foundation Trust

- Include the importance of considering safeguarding for people who make frequent calls requesting controlled drugs and who display drug-seeking behaviours within the new training package.
- Learning from the review will be shared with staff to inform future practice

Thames Valley Police

- To provide Safer Buckinghamshire Partnership evidence- based assurance that:
    - Adult protection reports are recorded on Niche and tasked accordingly

- Adult protection notifications are consistently submitted
- Domestic abuse is being identified for vulnerable adults, either child to parent, or in relation to caring, investigated and appropriate safety measures put in place
- Consistency in completion of the DOM5 (DASH)
- Background checks are systematically being taken when reports of neglect or abuse are received by Contact Management and callers are not only signposted to Adult Social Care when indicators of neglect or abuse are present.

BIBLIOGRAPHY

ADAAS (2011) Carers and safeguarding adults working together to improve outcomes, https://www.adass.org.uk/adassmedia/stories/Policy%20Networks/Carers/Carers%20and%20safeguarding%20document%20June%202011.pdf.

Benbow, S. M., Bhattacharyya, S. and Kingston, P. (2019) Older adults and violence: An analysis of domestic homicide reviews in England involving adults over 60 years of age. *Ageing & Society*, 39(6): 1097–121.

Bows, H. (2019) Domestic homicide of older people (2010–15): a comparative analysis of intimate-partner homicide and parricide cases in the UK, *The British Journal of Social Work*, 49(5): 1234–53. doi: 10.1093/bjsw/bcy108

Bracewell, K. and Jones, C. Haines-Delmont, A. Craig, E. Duxbury, J. Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide, *Journal of Gender-Based Violence*, vol XX, no XX, 1–16,
DOI: 10.1332/239868021X16316184865237

Chantler, K., Robbins, R., Baker,V. and Stanley, N. (2020) Learning from domestic homicide reviews in England and Wales, *Health & Social Care in the Community*, 28(2): 485–93.

Department of Health and Social Care (2019) *Core Capabilities Framework for Supporting Autistic People.* Health Education England. Available at https://www.skillsforhealth.org.uk/wp-content/uploads/2020/11/Autism-Capabilities-Framework-Oct-2019.pdf

Collins, J., Horton, K., Gale-St. Ives, E. *et al.* A Systematic Review of Autistic People and the Criminal Justice System: An Update of King and Murphy (2014). *J Autism Dev Disord* (2022). https://doi.org/10.1007/s10803-022-05590-3

Home Office (2016) Domestic homicide reviews: key findings from analysis of domestic homicide reviews,https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide- Review-Analysis-161206.pdf.

HM Government (2022) Multi-agency statutory guidance for dealing with forced marriage. Available at https://www.gov.uk/government/publications/the-right-to-choose-government-guidance-on-forced-marriage/multi-agency-statutory-guidance-for-dealing-with-forced-marriage-and-multi-agency-practice-guidelines-handling-cases-of-forced-marriage-accessible#iv-specific-issues-to-be-considered-by-agencies-working-with-or-providing-services-to-children-and-young-people-facing-forced-marriage

Home Office (2021) Domestic Abuse Statutory Guidance. Available online at https://www.gov.uk/government/publications/domestic-abuse-act-2021

Ministry of Housing, (MHCLG) (2020) Evaluation of the Housing First Pilots: Interim Process Evaluation Report Final. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/946110/Housing_First_first_interim_process_report.pdf
King, C. & Murphy, G., 2014. A Systematic Review of People with Autism Spectrum Disorder and the Criminal Justice System. Journal of Autism and Developmental Disorders, pp. 2717-2733.
LGA & ADASS (2019) *Myths and realities about Making Safeguarding Personal.* Local Government Association. London
Montique, B. (2020) Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process,London:StandingTogether,https://www.standingtogether.
Mouridsen, S. E., Rich, B., Isager, T., & Nedergaard, N. J. (2014). Autism and homicide offending: A total population study. Journal of Autism and Developmental Disorders, 44(10), 2526-2532.
National Institute for Health and Care Excellence (NICE) (2016) *The evidence statements. Domestic violence and abuse - how services can respond effectively.* Available online at:https://www.nice.org.uk/guidance/ph50/evidence/evidence-statements-pdf-431661277
National Institute for Health and Care Excellence (NICE) (2016) *Quality Standard* [QS116]. Available online at: https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-3-Referral-to-specialist-support-services-for-people-experiencing-domestic-violence-or-abuse.
Office for National Statistics (ONS) (2021) *Homicide in England and Wales: year ending March 2020.* https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2020#the-relationship-between-victims-and-suspects.
Pathfinder Consortium (2020) *Pathfinder Toolkit: Enhancing the response to domestic abuse across health settings.* Standing Together Against Domestic Violence. Available online at https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef35f557271034cdc0b261f/1593007968965/Pathfinder+Toolkit_Final.pdf.
Pike,L. (2016) *Supporting People with Social Care Needs Who are Experiencing Coercive Control*
Research in Practice. Available online at https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Guidance_sheet_two_Mental_capacity_and_coercion.pdf
Potter, R (2021) Key findings from analysis of domestic homicide reviews. Available online at https://www.gov.uk/government/publications/key-findings-from-analysis-of-

domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#fn:21.
Public Health England, NHS England & Health Education England (2016). *Making Every Contact Count (MECC): Consensus statement.* Available online at https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf.
Rodway, C., Flynn, S., While, D., Rahman,M., Kapur, N., Appleby, L., and Shaw, J. (2014). Patients with mental illness as victims of homicide: a national consecutive case series. Lancet Psychiatry, 1, 129-134.
Sharp-Jeffs, N. and Kelly L. (2018) *Domestic Homicide Review Case Analysis. Report for Standing Together.* London Metropolitan University and Standing Together Against Domestic Violence. London
Standing Together (2019) *Adult Family Violence Briefing.* Available online at
Weir, E., Allison, C.,Baron-Cohen,S. (2021) *Understanding the substance use of autistic adolescents and adults: a mixed-methods approach.* Available online at https://doi.org/10.1016/S2215-0366(21)00160-7

Appendix 1: Domestic Abuse Training by Agency

Agency	Domestic Abuse Policies, Strategies and Training
Aylesbury Homeless Action Group	**Domestic Abuse Policy** No specific policy on domestic abuse but it is covered within the Safeguarding Procedure (May 2022) **Domestic Abuse Training** Support workers are able to access basic domestic violence training through Aylesbury Women's Aid. The training is not mandatory.
Bromford Housing Group	**Domestic Abuse Policy** Dedicated domestic abuse policy last reviewed in October 2021 There is information for staff about domestic abuse on the intranet. **Domestic Abuse Training** Safeguarding and policies – e-learning – mandatory Introduction to risk management – e-learning – mandatory Localities getting job ready – Domestic abuse module – e- learning –mandatory Safeguarding level 1 – classroom training – mandatory Safeguarding level 2 – classroom training – mandatory Domestic abuse – buzz session – online – additional
Buckinghamshire Council Adult Social Care	**Domestic Abuse Policy** Domestic abuse is included within Buckinghamshire Council Safeguarding Policy (2021) There is information for staff about domestic abuse on the intranet. **Domestic Abuse Strategy** The council has a Domestic Abuse Strategy and an action plan. **Domestic Abuse Training**

	Domestic Abuse Level 1: Understanding Domestic Abuse & Violence - Mandatory Domestic Abuse Level 2: Domestic Abuse & Sexual Violence – Mandatory Safeguarding Training Level 1/2/3 – Level 1 Mandatory, level 2/3 mandatory depending on role.
Buckinghamshire Council Housing Service	**Domestic Abuse Policy** Domestic abuse is included within Buckinghamshire Council Safeguarding Policy (2021) **Domestic Abuse Strategy** The council has a Domestic Abuse Strategy and an action plan. **Domestic Abuse Training** Understanding Domestic Abuse & Violence – provided by Women's Aid DASH risk assessment Safeguarding and policies – e-learning – mandatory Introduction to risk management – e-learning – mandatory Homelessness Code of Guidance-mandatory
GP Practices	**Domestic Abuse Policy:** policy online (2021-24) **Domestic Abuse Training** Domestic abuse is covered in Practice safeguarding learning network training that is offered to GPs yearly. Also domestic abuse training is part of level 3 safeguarding training that all GPs complete on a regular basis as per RCGP recommendations. https://www.rcgp.org.uk/clinical-and-research/safeguarding.aspx
Buckinghamshire Healthcare NHS Trust	**Domestic Violence and Abuse Policy (30.06.2022)** **Domestic Abuse Training**

	Internal safeguarding training is provided by BHT safeguarding team in accordance with the intercollegiate document; Adult Safeguarding: Roles and Competences for Health Care Staff (RCN 20/08/2018). All safeguarding training provided makes reference to domestic violence and abuse (DVA) and includes recognition and indicators of abuse. The safeguarding team also delivers specific stand- alone DVA training for practitioners employed by Buckinghamshire Healthcare NHS trust. • Level 1/2 core training for clinical staff • Level 3 for Safeguarding service clinical staff • Training should be completed once, and refresher training every 3 years. • All patient facing clinical staff undertake level three training. This is monitored through the monthly Safeguarding Committee and Mandatory & Statutory Training Committee and is also reported quarterly to Quality and Clinical Governance Committee which is a sub board committee.

One Recovery Bucks (Midland Partnership NHS Foundation Trust)	**Domestic Abuse Policy** MPFT has a Domestic Abuse standard operating procedure (SOP) and Procedure for Staff Working Within Midlands Partnership NHS Foundation Trust (MPFT) (2020) **Domestic Abuse Training** Training is delivered in line with the Training Needs Assessment and is not mandatory. The Trust offers an online Domestic Abuse Awareness course Based on the Department of Health (DOH): responding to domestic abuse a resource for health professionals (2017) which aims to support the continuing improvement in the health service to respond to Domestic abuse. This Awareness e-Learning covers responding to disclosure with sensitivity in a way that ensures safety and being able to direct people to specialist services. • For practitioners to recognise the signs of domestic abuse. • Ask selective questions when concerned that a service user is experiencing domestic abuse. • Respond to disclosure with sensitivity. • Staff understand the MARAC and that staff can complete a domestic abuse risk assessment and referral for this conference. • Appropriate record keeping.

	• Consider the safety of others, following a domestic abuse disclosure, to include children and adults with care and support needs. • Can carry out some safety planning with the victim. All ORB staff are provided with monthly safeguarding supervision with their Specialist Safeguarding Lead. All staff have monthly line management supervision and monthly clinical supervision (group).The ORB Specialist Safeguarding Lead has completed the following list of training and attends the Domestic Abuse related meetings as described below: • Honour Based Violence. • Female Genital Mutilation (FGM). • DHR Learning event male victims of domestic abuse. • 2 day domestic violence training. • 2 day domestic violence champion training. • Exploring adolescent to parent abuse. • Modern day slavery and exploitation. • Understanding perpetrators of domestic violence. • Female perpetrators of domestic violence. • Domestic violence champion network meetings. • Serious case review practitioner event. • Weekly MARAC meetings up until 2020. • Monthly MATAC meetings. • Monthly safeguarding group supervision with safeguarding lead at Inclusion which includes training and learning from serious case reviews (SCRs).
South Central Ambulance Service	**Domestic Abuse Policy** Domestic abuse is specifically referenced in both the Safeguarding Adults and Safeguarding Children's policies. SCAS has a Management of Domestic Abuse Policy and Procedure (2022) **Domestic Abuse Training** Domestic abuse is covered in both the online e-learning safeguarding packages (levels one and two) and level three face-to-face/virtual safeguarding training as per intercollegiate guidance. These are all mandatory.
Thames Valley Police	**Domestic Abuse Policy**

	Within TVP Operational Guidance is available for all officers and staff dealing with domestic abuse. Operational Guidance is reviewed and updated on an ongoing basis as procedures and legislation change. Domestic Abuse Operational Guidance was last updated in May 2022. **Foundation Training** In Foundation Training, recruits receive a detailed mandatory input in relation to domestic abuse in two parts. Part 1 looks at domestic abuse as a subject and explores it in some detail. It also introduces the DOM5 (also known as DASH)[50] and risk assessment. Part 2 looks at a domestic abuse investigation and allows the officers to work through an investigation using their knowledge from Part 1. Both sessions look at levels of risk and officers are tasked with defining the level of risk in scenarios. **DA Matters Training.** **Target audience:** Constable to Inspector on shift and Neighbourhood (Not Police Community Support Officers (PCSOs)), Contact Management, and DAIU teams. Delivery began in January 2020 and forty sessions ran around the Force until an enforced pause due to Covid. Around 80% of officers were captured, plus a slice of the other groups, custody being the exception, as they couldn't be abstracted to attend. Training resumed in June 2020, targeting Foundation students. In January 2021, training resumed to a bigger, wider audience. PCSOs and CID were included. These ran through to December 2021. 152 sessions ran and 85% of the target audience were captured. DA Matters training was delivered by two people, one giving a police perspective, the other the perspective of someone who works with or supports victims. The second role was usually a caseworker or volunteer from outside agencies. **Module learning outcomes – DA Matters** • Define what is meant by the term 'domestic abuse.' • Explain the role of the first responder and DA Matters Champion in the DA Matters change programme.

[50] DOM5/DASH – risk assessment tool. **DASH -** The full title of this form is 'Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification and Assessment Checklist for Police Staff'.

	• Explain what is meant by the term “coercive control” and how to discover evidence of coercive control using appropriate questions and communication techniques. • Describe the effect of multiple controlling behaviours on victims, other vulnerable persons, and children impacted by the perpetrator’s behaviour • Identify why victims can find it difficult to leave an abusive relationship and how hard perpetrators work to resist their victim leaving an abusive relationship. • Identify the stages of change a victim experiences when in, and preparing to leave, an abusive relationship and how this impacts on them as responders. • Describe what intervention responders can provide to a victim at each stage of an abusive relationship. • Specify the link between coercive control and stalking and harassment. • Explain best practice when recording and reporting the responses to domestic abuse incidents including recognition of crimes(s) which should be recorded, maximising evidential opportunities, and minimising victim blaming. • Describe the tactics perpetrators may use to manipulate first responders. • Describe the importance of securing evidence at the scene of a domestic abuse incident. • Identify the need and potential options to safeguard victims and children.
Oxford Health NHS Foundation Trust	**Domestic Abuse Policy** CP101: Oxford Health NHS Foundation Trust policy and guidelines for staff in the management of domestic abuse **Domestic Abuse Training** 2 levels of training available: • Level 1/2 core training for clinical staff • Level 3 for Safeguarding service clinical staff, Health Visitors, Family Nurses, Designated MARAC Officers, Domestic Abuse Champions, Social Workers. Training should be completed once, and refresher training every 3 years.

Appendix 2: Action Plans

BUCKINGHAMSHIRE DHR ADULT J ACTION PLANS

This is a live document which will be monitored and updated when required.

Table of Contents

Overview Recommendations

Recommendation 1: Coercive Control and Adults with Care and Support Needs
Safer Buckinghamshire Partnership to seek evidence-based assurance from key partner agencies that practitioners understand how older adults and/or those with care and support needs may experience coercive control and that the law is being fully utilised to safeguard them.
Key agencies in this regard are:

- Aylesbury Homeless Action Group
- Aylesbury Women's Aid
- Bromford Housing
- Buckinghamshire Integrated Care Board
- Buckinghamshire Council Adult Social Care
- Buckinghamshire Council Housing Team
- Buckinghamshire Healthcare NHS Trust
- Buckinghamshire MIND
- Oxford Health NHS Foundation Trust
- One Recovery Buckinghamshire provided by Midland Partnership NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- Thames Valley Police
- Bucks and MK Probation Delivery Unit

Desired outcome from the recommendation: Older adults and those with care and support needs are protected from coercive control

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Listed key partner agencies negotiate with the CSP how they will evidence how those with	Local	Key agencies	Methodology for evidencing effective identification and support to older adults and those with care and support needs agreed with	July 2023	30/4/24 Evidence and assurance received from all agencies bar one.

	care and support needs are protected from coercive control					Bucks Mind are working on a new training pathway for staff which will be launched in September.
1.2	Partner agencies provide evidence of how those with care and support needs are identified in their services and protected from coercive control	Local	Key agencies	Outcome focussed evidence provided. Monitoring and chasing ongoing.	December 2023	

Recommendation 2: (Adult) Child-to-Parent Abuse

As parents experiencing child-to-parent abuse are less likely to identify their experiences as domestic abuse and less likely to seek support and protection from the abuse, Safer Buckinghamshire Partnership to continue to raise awareness with the public and with partner agencies, about the nature of child-to-parent abuse and the help that is available.

Safer Buckinghamshire Partnership to seek assurance from key agencies (listed above) that increasing numbers of parents experiencing child-to-parent abuse are being identified, supported and protected and that they are adopting a multi- agency collaborative approach to the issue

Desired outcome from the recommendation: Parents experiencing child-to-parent abuse are identified and provided with support and protection at the earliest opportunity

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
2.1	To raise awareness with the public about the nature of child-to-parent abuse and the help that is available.	Local	*Safer Bucks Partnership*	Support Services promoted on Bucks DA Partnership website. CAPVA (child to parent abuse) training being rolled out to multi agency professional across Bucks from Sept 23-March 24. Previous training ran from December 2022-March 2023. On the advice of a support agency a mapping exercise carried out of current support services available. Awareness raising campaign to start after professionals have been trained and are able to identify child	Dec 24	Training on CAPVA has been rolled out for professionals since December 2022. Professionals now have a clearer understanding of how to identify and support families experiencing CAPVA. June 24 Safer Bucks Partnership is now reviewing the capacity of specialist agencies to support extra CAPVA referrals and planning next steps.

				to adult abuse. A directory of support services available is now available on the Respect website.		
2.2	To continue to raise awareness with practitioners about the nature of child-to-parent abuse and safe responses.	Local	Safer Bucks Partnership	Multi-agency training has been rolled out to professionals across Bucks on child to-parent abuse since December 2022 up until March 24.	March 24	Professionals now have a clearer understanding of how to identify and support families experiencing CAPVA.
2.3	Listed key partner agencies negotiate with the CSP how they will evidence how victims of child-parent abuse are identified and responded to.	Local	Key agencies	Methodology for evidencing effective identification and support of parents experiencing child-to-parent abuse.	July 2023	Evidence from all agencies bar one which is being continually monitored. The agency is introducing new training pathways to include CAPVA for all staff.
2.4	Partner agencies provide evidence of how victims of child-parent abuse are identified and responded to.	Local	Key agencies	Outcome focussed evidence provided. Monitoring and chasing continually	December 2023	
Recommendation 3: Primary Care Pathway to Substance Misuse Service Buckinghamshire Integrated Care Board to consider the pathway between GP Practices and One Recovery Bucks in order that there is a more seamless route between the two services than merely signposting patients.						
Desired outcome from the recommendation: Primary care patients are empowered and able to access substance misuse treatment						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3	Arrange for One Recovery Bucks to talk to safeguarding leads so that they have an understanding about their service and referral process.	Local	ICB Safeguarding staff	One Recovery Bucks presented to Primary care Safeguarding Leads as Part of PLSN Training. Also training recorded to reach wider audience. Information shared and contact details provided and shared of referral into the service.	Oct 23	October 23 Safeguarding leads are now able to refer directly into the service. April 24 GP surgeries now liaise closely with One Recovery Bucks about patients.

Recommendation 4: Mental health crises in temporary accommodation

Buckinghamshire Council Housing Services and Oxford Health NHS Foundation Trust to provide assurance to Safer Buckinghamshire Partnership concerning how the revised Memorandum of Understanding:

- has ensured that the mental health needs of homeless people within temporary accommodation are identified, supported and where necessary, disputes escalated to resolution
- that the embedded mental health worker is effectively supervised and supported in real time when individuals present themselves with acute mental health issues
- that the embedded worker has clear guidance on where information should be recorded across both systems

Desired outcome from the recommendation: The mental health needs of homeless people within temporary accommodation are identified and supported and able to access secondary mental health care swiftly at times of crisis

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
	Joint MoU developed between agencies to embed mental health practitioner role as part of the Rougher Sleeper Initiative	Local	Service Manager, Oxford Health	Complete review and implement changes.	28/04/ 2023	Action completed. New jointly written memorandum of understanding between Buckinghamshire Council and OHFT in relation to Rough Sleeper Initiative (RSI). The mental health practitioner in the RSI has a supervisor and line manager to escalate any concerns. Review completed and information sharing requirements included in new memorandum of understanding.

Recommendation 5: Domestic Abuse Training and Policies

All Safer Buckinghamshire Partnership agencies, and those involved in this review, to ensure that domestic abuse policies are up to date, or, for those without one, to ensure a policy is developed. The policy must be accompanied by regular and mandatory training on domestic abuse.

Desired outcome from the recommendation: Practitioners in all key agencies are trained, supported and guided to provide safe and effective services to victims and perpetrators of domestic abuse						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
5.1	Safer Bucks Partnership to write to agencies asking whether they have a stand alone DA policy and regular DA training	Local	Safer Buckinghamshire Partnership	All agencies written to and offered assistance with creating a DA policy if they do not have one. Responses received from most agencies.	March 24	One agency is currently writing a new DA policy to be launched in September 2024. All other agencies have a DA policy and training in place to support staff.

Recommendation 6: Accountability Safer Buckinghamshire Partnership to share an update with the bereaved family in 12 months' time, concerning what has changed as a result of the domestic homicide review and subsequent action plans.						
Desired outcome from the recommendation: For the bereaved family to have confidence that agencies have improved their services, in the way they have said, and will be better able to prevent harm in the future						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
	Safer Buckinghamshire Partnership to share an update with the bereaved family in 12 months' time, concerning what has changed as a result of the domestic homicide review and subsequent action plans.	Local	Safer Bucks Partnership	All outstanding actions have been monitored regularly and updates to progress recorded. Agencies have changed many practices and processes to improve their services. All agencies will be asked to provide a short summary of their improvements in plain English.	December 2024	June 2024 All agencies have been asked to provide a short summary in Plain English of improvements/changes made that can be shared with the family.
	Safer Bucks Partnership to ensure that action plans are	Local	Safer Bucks Partnership	Action plans being continually monitored and updated.	December 2024	All actions either complete or ongoing training being carried out.

	monitored and updated regularly.					

Individual Agency Recommendations

Buckinghamshire Council Adult Social Care

Individual Agency Recommendation 1: Reinforce and refresh Safeguarding training for all staff with a focus on domestic abuse and dealing with coercive and controlling behaviour.						
Desired outcome from the recommendation: Staff to recognise signs of coercive and controlling behaviour.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	New dates to be advertised for DOMESTIC ABUSE LEVEL 1 & 2: UNDERSTANDING DOMESTIC ABUSE & SEXUAL VIOLENCE	Local	*Workforce Team*	28/29 Nov 22 Making Connections (Provider) delivered a Domestic Abuse Level 1 2 days training which was attended by 10 professionals to include Social Workers, ASYE (Newly Qualified Social Workers and Occupational Therapist (OTs). 23/24 Jan 2023 Level 2 Training was delivered over 2 days and attended by 12 staff members across Adult Social Care and the Home Independence Team. The course will be mandatory and will be rolled out every 3	April 2023	Both levels of training have been completed. Course is also being offered to new staff joining the organisation. Feedback obtained from staff who attended the training was that 1. More awareness was raised for staff in this area. 2. Staff are now able to help service users experiencing abuse and be able to signpost and create safety plans. 3. As a result of this training, staff have been inspired to take up the Domestic Violence Championship. The champions are in the process of acquiring in-depth

				years. Managers will keep a record of training log for all their staff. More training opportunities will be offered to all staff September 2023.	Sept 2023	knowledge and understanding in this area to become subject experts and go to person to help and support colleagues. Sept 23 Staff are now able to attend the multi-agency training provided by the Safer Bucks Partnership which covers all areas of DA.
1.2	Ensure the Safeguarding Policy covers DA – Economic abuse and Coercive and Controlling behaviour fully.	Local	QSP (Quality Standards & Performance) /BSAB (Bucks Safeguarding Adults Board	BSAB are currently updating and reviewing our Safeguarding Policy and guidance. The policy will also include types of abuse and Domestic abuse and coercive and controlling behaviour. Once the task is completed by end of June this year, the updated Policy will be shared to all staff and will be easily accessible via the Knowledge Hub. Emphasis to read and familiarise with the updated policy will be communicated during Managers and Team Meetings. The updated Policy will also be used to develop the	30 June 2023	6 weekly audits, reflective practice sessions and supervision will evidence that practitioners can identify indicators of coercive control and economic abuse. Unable to measure at the moment as the Policy is yet to be updated.

				safeguarding training – for the trainer to understand what our policy and guidance is. A request is in progress for BSAB policy subgroup to include a section on Domestic Abuse in the current BSAB policy.		
1.3	Economic Abuse and Coercive Control training included in training programme on offer.	Local	*Workforce Team/QSP*	Our Workforce and QSP team are looking into providing this training in the future. However, some aspects of it, such as Coercive Control was covered during the Domestic Abuse level 1 and 2. Our Workforce team is also working on incorporating the Economic abuse training to all staff to raise more awareness.	September 2023	This training is now provided via our internal training offer.
1.4	Invite staff to Safeguarding Training in line with when they need to refresh, or it has been identified at supervision a refresh is required.	Local	*Workforce Team*	A total of 8 sessions of Level 2 Safeguarding was offered between May 2022 and February 2023; a total of 80 staff members attended. Our Training programme for 23/24 also lists this training as ongoing, being mandatory to all staff and refresher training for existing	April 2023	Ongoing discussion are being held between Managers and staff during team meetings and one to one supervision. Feedback received from staff following the training for the period mentioned: - 1. Staff shared their learning with the team and ensured

				staff. Our Workforce Team will continue to provide regular update regarding occupancy of training.		everyone is keeping the person at the centre of any safeguarding. 2. Staff are able to incorporate making safeguarding personal when carrying out enquiries. 3. Staff are being more inquisitive when carrying out section 42's

Recommendation 2: Greater emphasis across the service of the principles of Making Safeguarding Personal (MSP)						
Desired outcome from the recommendation: Embed MSP principle and how to apply when undertaking s42 enquiries.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Formal training for making safeguarding personal. Arranging bespoke safeguarding reflective sessions.	Local	*QSP*	The MSP principle was covered during the safeguarding training above. The concept is being discussed during the safeguarding reflective huddles and during one-to-one supervision. Service user and professional workshop to listen to their views and how to make safeguarding personal. Had an external	April 2023	May 2023 1. Staff are now able to apply the skills and knowledge they have learnt to identify any risks or potential risks when carrying out safeguarding enquiries. 2. We have developed an Action Plan because of the feedback received during the Service user/professional

				person to facilitate the workshop. QSP lead will be meeting/calling random sample of service user to gain their experiences during safeguarding enquiry – to make to more strength based and person centred. Safeguarding reflective sessions being held with the QSP Practice Lead with the teams.		workshop to better improve the service user experience. A number of revisions have also been made to the client recording system to include the principles of MSP to enable staff to have these principles at the forefront of their practice. Prior to the cessation of all enquiries requires management oversight which is evidenced in client recording system. Routine monthly practice audits are also demonstrating that managers are having more oversight with the changes to system.
2.2	MSP to be discussed during safeguarding supervision and management oversight to be clearly visible	Local	Ops/QSP	Management oversight is incorporated in all safeguarding activities and an enquiry can only be closed following Manager's approval.	Sep 2022	Manager's input in all safeguarding enquiries is evidenced by their records on our system. This has improved our practice which

						is being evidenced during random case audits.
2.3	Staff to have clear guidance on MSP	Local	QSP/BSAB	Review Safeguarding policy. Commence an MSP improvement project.	April 2023	As part of the MSP improvement project a Safeguarding practice Handbook is currently being developed with a focus on Making Safeguarding Personal. Safeguarding Training is promoted and remains ongoing. All information relating to safeguarding training and compliance is on the knowledge hub. Heads of Service and managers are expected to attend level 3/4 training therefore the training team are booking relevant people. Safeguarding Training is promoted and remains ongoing. All information relating to safeguarding training and compliance is on the knowledge hub. Heads of Service and managers are expected to attend level 3/4 training therefore the training

						team are booking relevant people. In August 2023 work began with diverse communities to develop and improve safeguarding awareness.

Recommendation 3: Training to be delivered in a multi-agency forum to improve and strengthen links.						
Desired outcome from the recommendation To recognise each agency's role in safeguarding and the importance of joint working to achieve greater outcomes.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	Deliver training on the lessons learned from the domestic homicide review. Collate evaluation feedback from the training.	Local	*QSP/Workforce*	Hold a lessons learned training event for SAR/DHRs. Holding webinars to staff for specific topic such as Domestic Abuse. Include the DHR lessons learned training as part of the training plan for 2023/24.	**Jan-Dec 2024**	The lesson learnt from this case with be shared in the Managers in Action group, this group consists of managers across all the operational teams, to ensure the case is shared and discussion had about lesson learnt and actions for managers to then share learning with all teams. Staff now offered ongoing training in a multi-agency forum.
3.2	Multi-agency training BSAB 1-day course: 'Everyone's Responsibility'	Local	BSAB	Produce a summary report of the number of staff that have been trained during the next 12 months.	**April 2023**	**Update Jan 2024** Summary of staff trained has been provided**.** The workforce team are currently engaging with BSAB safeguarding board unit to enable better sharing of the

						multi-agency training and uptake of this offer**.**

Recommendation 4: Ensure that practitioners enable safe disclosures of domestic abuse during section 42 enquiries, including seeing individuals alone; asking directly about domestic abuse; seen in different settings where possible; consideration given to the use of advocates						
Desired outcome from the recommendation Victims are able to make safe disclosure about any domestic abuse or risks that they may be facing						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
4.1	Offer Staff training to raise more awareness and build staff confidence in dealing with disclosures of domestic abuse.	Local	*Workforce*	This concept has been covered during the Domestic Abuse training which was offered to staff in November 2022 & January 2023. Managers will maintain a training log to ensure all staff attend the Domestic abuse training. More training will be offered to all staff throughout the year 23 -24.	**June2023-June 2024**	Feedback from staff who attended the training: - 1. Staff area able to create a safer environment for clients to share their experience/disclosures. The training offer illustrated above has strengthened awareness and will continue to support staff confidence and knowledge in this area.

Individual Agency Recommendations for
Buckinghamshire Council Housing

Recommendation 1: Details of an applicant's violence are systematically provided to temporary accommodation providers before referred and placed with them						
Desired outcome from the recommendation Temporary accommodation providers are able to undertake full and robust risk assessment and management and keep all residents safe						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Further training for the team on disclosure of risk to our temporary accommodation providers and amendments to our procedure for staff . Senior Sign off needed for all temporary accommodation placements	local	*workforce*	Team Leaders to provide further training on risk disclosure in team meetings. Amendment made to Homeless Procedure Guide. All requests for temporary accommodation to be signed off by senior to ensure all risks passed on.	**7 July 23**	Ongoing to be completed by 7 July 23-completed. Completed small amendment to ensure all relevant information is passed on. Completed, Seniors check all cases before placements are made.

Individual Agency Recommendations for Buckinghamshire Integrated Care Partnership

Individual Agency Recommendation 1: To develop the domestic abuse primary care pathway in order that sensitive and routine enquiry is systematically undertaken into domestic abuse, across Buckinghamshire GP Practices, where indicators of domestic abuse are present, irrespective of the sex of the individual. In order to develop the domestic abuse pathway, and meet the ambitions of *Making Every Contact Count*, the Partnership to consider Domestic Abuse Statutory Guidance (2021)[51] which promotes the Whole-Health Model to domestic abuse incorporating:

"Findings from the Pathfinder Project highlighted that health professionals feel better able to enquire about domestic abuse if their Integrated Care System and primary care networks supported the placement of Independent Domestic Violence Advisors (IDVAs) or other accredited domestic abuse peer advocacy programme. These specialised trauma-informed services might then be best placed to follow up with any disclosures of abuse; a greater understanding of local referral pathways; specialist recovery and peer advocacy services to which they can refer or signpost victims, survivors or perpetrators dependent upon their unique situation." (para 293)…

"Implementing the IRIS (Identification and Referral to Improve Safety)[52] Programme. IRIS is an evidence-based intervention to improve the general practice response to domestic abuse through training, support to practice teams and having a DA specialist embedded in practices. It is nationally recognised as best practice and has informed NICE guidance" (para 306)

Desired outcome from the recommendation *Victims of domestic abuse are identified at the earliest opportunity when they approach primary care and are able to access specialist domestic abuse services, safety and support.*

Ref	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
	Training to be provided to GP practices on DA and referrals	Local	ICB Safeguarding	November 23 Training completed and well attended on referrals and contacts within safer Lives and contact	***Nov 23***	Regular Training Programmes delivered by safeguarding leads. To raise prospect of delivering IRIS Project in line with other areas within BOB DA Forum

[51] https://www.gov.uk/government/publications/domestic-abuse-act-2021

[52] https://irisi.org.uk

				details shared across Buckinghamshire.		raised that they send out survey of questions following DHRs and this will be considered around understanding recommendations and how this is embedded.

Individual Recommendations for GP Practice 1

Individual Agency Recommendation 1: To develop practice responses so that sensitive and routine enquiry is undertaken into domestic abuse where indicators of domestic abuse are present, irrespective of the sex of the individual						
Desired outcome from the recommendation *Victims of domestic abuse are identified at the earliest opportunity*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Training at GP training sessions and extra training as evening session to be delivered.	Local	*ICB Safeguarding*	To improve earlier detection of DA all recommendations have been discussed at training with 50 Primary Care leads. Training also delivered in evening sessions to make it more accessible.	November 2023	November 2023 To improve earlier detection of DA all recommendations have been discussed at training with 50 Primary Care leads. Training also delivered in evening sessions to make it more accessible.

Individual Agency Recommendation 2: To develop practice responses so that individuals presenting with problematic alcohol use are advised about, and encouraged to use, alcohol treatment services						
Desired outcome from the recommendation *Individuals with problematic alcohol use know their options and are assisted in engaging with alcohol treatment services*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Training to be delivered by One Recovery Bucks regarding referral and pathways	Local	*Named GP safeguarding/ICB safeguarding*	Training delivered by One Recovery Bucks regarding referral and pathways to help understand delivery and support of One Recovery Bucks and referral pathway. This was delivered to 50 practices.	Nov 23	November 2023 GPs and One Recovery Bucks now liaise closely with each other about patients.

Individual Agency Recommendation 3: To develop practice responses so that the value of a carer's assessment is routinely discussed with individuals caring for others and referrals to the local authority made where accepted

Desired outcome from the recommendation: *The needs of carers are identified and addressed*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	Raise awareness of the value of carers assessment with GPs and Practice staff	Local	*ICB Safeguarding Adults Team*	This was raised as part of the training at the GP training sessions and implemented by Named GP who can share practice with others. Reference to Intercollegiate document.		Completed with ongoing support available. This was raised as part of the training at the GP Training sessions. Implemented by Named GP who can share practice with others Reference to Intercollegiate document. Initial action completed with Ongoing support.
3.2	Introduce system of automatic texting details of local authority carers' assessment service to patients with caring responsibilities	Local		System developed and operational		Completed- The needs of carers are identified and addressed.

Individual Recommendations for GP Practice 2

Individual Agency Recommendation 1: To raise awareness with GPs and Practice staff that dementia symptoms can be a veil for domestic abuse.						
Desired outcome from the recommendation: *GPs and Practice staff are aware that dementia symptoms can be a veil for domestic abuse and identify domestic abuse at the earliest opportunity*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Deliver training to raise awareness as part of the GP safeguarding training.	Local	*ICB Safeguarding Leads*	Delivered as part of the GP safeguarding training. Training delivered Nov 2023	Nov 23	50 practices are now aware and are more able to identify abuse at the earliest opportunity**.**

Individual Agency Recommendation 2: To develop practice responses so that mental capacity assessments are considered when services for memory loss are declined						
Desired outcome from the recommendation: *It is understood by GPs and Practice staff that patients with symptoms of dementia may not have capacity to make decisions to decline treatment, or may be subject to coercive control*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Training to be delivered and discussed at GP training sessions and also covered during training this year. Highlight the MCA Template that is available and importance of completion.	Local	*ICB Safeguarding Leads*	Previously discussed at GP training and covered during training this year. Highlighted MCA Template that is available and importance of completion. DA Board raised awareness of older persons abuse and Predatory Marriage at a conference in November 23 which was attended by some practices and social prescribers.		GPs and practice staff are now more aware that patients with symptoms of dementia may not have capacity to make decisions to decline treatment or may be subject to coercive control.

Individual Agency Recommendation 3: To develop practice responses so that individuals are seen alone for at least part of the consultation when indicators of domestic abuse are present in order that any disclosures						
Desired outcome from the recommendation: *Victims of domestic abuse are able to safely disclose their abuse*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	Training to be delivered to practice staff on the importance of seeing individuals alone when indicators of DA are present.	Local	Named GP/ICB safeguarding leads.	Training delivered to 50 primary care leads and discussions had around how to record disclosures.	Nov 23	Nov 23 Practice staff are now aware of the importance of seeing individuals alone when indicators of DA are present which should enable safe disclosures.

Individual Agency Recommendation 4: To develop practice responses so that the potential for economic abuse is considered when applications for Lasting Power of Attorney are being made						
Desired outcome from the recommendation: *That economic abuse is identified and victims of domestic abuse protected*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
4.1	DA training should be part of safeguarding training and it should highlight economic abuse.		Named GP/ICB safeguarding leads	Ongoing support with DA Training Training delivered as part of GP training and also extra session delivered In November Nov 2023	Nov 23	November 2023 More clarification needed

Individual Agency Recommendation 5: To develop practice responses so that GPs are alerted in future consultations to allegations of domestic abuse through effective coding and recording of domestic abuse						
Desired outcome from the recommendation: *Victims of domestic abuse are identified in future consultations*						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
5.1	Discussions around coding and recording of domestic abuse in patient's records to be held with GP practices to develop practice.	Local	Named GP/ICB safeguarding leads	Coding and documentation discussed through training sessions. Discussions held from the training sessions to ensure accurate recording of DA disclosed. GP MARAC Letter Template has been revised through BOB ICB to ensure DA information is shared through MARAC Process.	**Nov 23**	GPs and practice staff are now more aware how to code and record disclosures of DA and how to refer to MARAC.

Individual Recommendations for GP Practice 3

Individual Agency Recommendation 1: To develop GP awareness of drug seeking behaviours and ensure that they are alert to the risk of addictions for patients being prescribed opioid medication, considering referrals to One Recovery Bucks before prescribing where there is a history of drug use. If alternative pain relief is not issued, to ensure that decisions to prescribe opioid medication are reviewed and that firm boundaries are put in place from the start of the prescribing period.						
Desired outcome from the recommendation: *There is safe prescribing for patients at risk of opioid addictions and they have access to specialist drug treatment service*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	**Training sessions with ORB (One Recovery Bucks) to be held to raise awareness of drug seeking behaviours and how to work with ORB.**	Local	*Primary care*	Training delivered by One Recovery Bucks regarding referral and pathways to help understand delivery and support of One Recovery Bucks and referral pathway. This was delivered to 50 practices.	Nov 23	Medications such as opioids are not now prescribed Out of hours. GP and One Recovery Bucks liaise closely on individual patients during office hours. This has been happening for the last 12 months 2022-23.

Individual Agency Recommendation 2: To review the systems in place that alert the GP Practice to Out of Hours, and vice versa, of each other prescribing and risk monitoring to ensure that there is not over-prescribing, particularly of medication that can lead to addictions.						
Desired outcome from the recommendation: *Safe prescribing for patients at risk of addiction whether they seek help during office or out of hours*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	The practice of prescribing opioids out of hours to be stopped.	Local	*Primary care*	Medications such as opioids are not now prescribed Out of hours. GP and One Recovery Bucks liaise closely on individual patients during office hours. This has	Nov 23	Medications such as opioids are not now prescribed out of hours. GP and One Recovery Bucks liaise closely on individual patients during office hours.

				been happening for the last 12 months 2022-23.		This has been happening for the last 12 months 2022-23.

Individual Agency Recommendation 3: To review the system within the Practice whereby repeated notifications from the Ambulance Service about drug seeking behaviours did not raise the need to alert a GP to review the patient.						
Desired outcome from the recommendation: *Repeated concerns for patients are identified through the notifications received in the Practice*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	**GP practice's systems to be reviewed and improved so that when drug seeking behaviour is reported by the ambulance service this is flagged and patient is reviewed.**	local	Named GP Safeguarding and ICB Safeguarding Leads	Informed and discussed with the practice - and they now would review patients that the ambulance service report are repeatedly for asking for opioid medication. Across the Bucks area - every practice has their own protocols - we have discussed at GP training the importance of GP practices responding to ambulance concerns re opioid seeking behaviour. We have discussed at GP Training the importance of GP practices responding to ambulance concerns re opioid seeking behaviour.50 practices attended training.	Nov 23	Informed and discussed with the practice - and they now would review patients that the ambulance service report are repeatedly asking for opioid medication.

Individual Agency Recommendation 4: To develop practice responses so that third party information received and alerting to safeguarding risks for a patient is acted upon and adult safeguarding referrals made when needed.						
Desired outcome from the recommendation: *That adult safeguarding concerns are identified from third party information and actions taken to protect vulnerable patients*						
Ref	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
4.1	All practices to review their processes so that third party information is acted on and safeguarding referrals made.	local	Named GP Safeguarding and ICB Safeguarding Leads	Safeguarding adult concerns are identified from third party information. This was discussed at GP training, and we have asked all practices to review their processes so that third party information is acted upon and referrals made. Discussed with the practice concerned and they have acted on this recommendation.	Nov 23	Discussed with the practice concerned and they have acted on this recommendation.

Individual Agency Recommendations for
One Recovery Bucks (Midlands Partnership NHS Foundation Trust)

Recommendation 1
It is recommended that all areas of the Risk Assessment are completed; where elements are not completed a rationale for this should be documented within the Risk Assessment.

Desired outcome from the recommendation
That all areas of the risk assessment are completed. Where elements are not completed the rationale for this should be documented within the Risk Assessment.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Care delivery problem to be shared with the ORB Team within the Team Meeting Setting	Local	*Service Manager and Clinical Lead*	Serious Incident Reporting including good practice and Care Delivery Problems added to the regular ORB Team Meeting Agenda	30/8/22	8/22 - All team meetings and clinical supervision sessions include this on agenda (this action was already standard in these forums)
1.2	Management of Clinical Risk Policy to be reviewed and discussed in the context of the care delivery with the ORB Team	Local	*Service Manager and Clinical Lead*	Care Delivery Problem discussed with the ORB Team in context with the Trust's Management of Clinical Risk Policy	30/8/22	8/22 - Risk assessment and management discussed in all case management. Annual MPFT case notes audit monitors this.
1.3	Risk Assessments to be reviewed as part of the supervision process.	Local	*Service Manager and Clinical Lead*	The review of Risk Assessments to be added to the supervisory process	30/9/22	8/22 - 10% of caseload is reviewed in supervision including risk assessment/management plans
1.4	Where / if it identified that Risk Assessments are not being fully completed or a rationale for the non-completion is absent. For	Local	*Service Manager and Clinical Lead*	Individual staff receive in-house support and training as required to become competent / confident in completing Risk Assessments and	30/10/22	10/22 – Mandatory NHS training is in place for all staff on clinical risk management.

	this to be explored with the supervisor and the individual member of staff to and an individual action plan formulated to address this need.		*Named supervisors*	documenting rationale for areas not completed. Competence is confirmed within the supervisory process. Individual staff receive in-house support and training as required to become competent / confident in completing Risk Assessments and this is recorded within their supervision process notes.		In-house risk management training provided to all staff, including through formal and informal supervision routes.

Recommendation 2:
It is recommended that where a service user / patient is known to be open to mental health services / other services; that, with the service user's consent that organisation is informed off the service user's engagement with ORB either by writing or in an email format and that the ORB requests a summary including diagnosis and treatment from the named relevant mental health service. ORB Clinical Summaries should are shared with named mental health services as standard practice.

Desired outcome from the recommendation
To routinely seek consent to share information and to document this in the relevant part of ILLY.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
2.1	Care delivery problem to be shared with the ORB Team within the Team Meeting Setting	Local	*Service Manager and Clinical Lead*	Serious Incident Reporting including good practice and Care Delivery Problems added to the regular ORB Team Meeting Agenda	30/8/22	9/22 – Information sharing agreement signed by both MPFT and Oxford Health. 3/23 – New joint working protocol launched (MPFT and Oxford Health) to improve and develop collaborative and partnership working 4/23 – Quadrant meeting will

						commence where complex cases can be discussed. 11/23 – Quadrant meetings taking place monthly and any barriers/issues/positive practice/complex cases/learning discussed at these.
2.2	Consent to share information is completed with the service user / patient at initial. Assessment and is clearly recorded within the ORB's ILLY records system. Where a service user / patient refuses to provide consent this is to be clearly documented. Within the case notes	Local	*Service Manager and Clinical Lead*	Care Delivery Problem discussed with the ORB Team in context with the issue of consent	30/8/22	8/22 – this was already in place as standard practice
2.3	The ORB informs those other services as being identified as working with the service user / patient of the ORB's involvement and provides them with a summary of their contact. The ORB formally requests a summary including diagnosis and treatment/ interventions from the named organisation.	Local	*Service Manager and Clinical Lead*	The review of consent and any outstanding actions to be added to the supervisory process. Where any outstanding actions are identified, these are to be addressed prior to the next supervision appointment.	30/10/22	9/22 – information sharing agreement in place now to support the safe and timely sharing of information 3/23 – staff from ORB and Oxford Health aware of new protocol and information sharing agreement via launch events of new protocol.

2.4	All information received by the ORB is uploaded into the Service user's ILLY electronic notes.	Local	*Lead Service Manager and Clinical Lead*	This will be reviewed within the supervision process.	30/10/22	10/22 – there was already an information governance policy in place, this has been reviewed in individual and team supervisions/meetings

Recommendation 3:
It is recommended that the risk assessment is an accurate reflection of case note entries when describing risk. Where a service user / patient verbalises a threat , ORB staff should discuss the need to react in a socially acceptable and legal manner , educate them of the potential consequences of any threatening or aggressive behaviour and inform any associated agencies of the potential risk. Risk assessment should be updated to accurately reflect risk

Desired outcome from the recommendation
To mitigate against risk. To inform relevant agencies of potential risk.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
3.1	Care delivery problem to be shared with the ORB Team within the Team Meeting Setting		*Lead Service Manager and Clinical Lead*	Serious Incident Reporting including good practice and Care Delivery Problems added to the regular ORB Team Meeting Agenda Care Delivery Problem discussed with the ORB Team in context with Risk Assessment	30/08/22	8/22 – risk management policy and training already in place to address this issue. This has been reviewed and discussed in individual and team supervisions/meetings
3.2	Risk assessments to accurately reflect case note entries when describing risk.	Local	*Lead Service Manager and Clinical Lead*	ORB staff to be informed to the requirement for Risk assessments to accurately reflect case note entries. Six monthly audits to continue to monitor case notes for accuracy – specifically cross referencing risk assessments with care plans and case notes and communication to other agencies.	30/9/22	8/22 – risk management policy and training already in place to address this issue. This has been reviewed and discussed in individual and team supervisions/meetings. 11/23 – 10% of caseload is reviewed at monthly individual supervision which audits risk assessment, care-plan, MDT work and case notes. This picks up any issues more effectively than having 2 standalone audits each year.

						11/23 – an annual case notes audit takes place (this was existing practice).
3.3	ORB staff to be training with verbal de-escalation techniques	Local	*Lead Service Manager and Clinical Lead*	ORB staff to ensure that any mandatory de-escalation technique training is attended. Non-attendance to be reviewed in routine supervisor and / or annual appraisal – whichever occurs first and a plan to become compliant agreed.	30/9/22	10/22 – all staff have attended Managing conflict and challenging behaviour training (face to face) This is also regularly discussed in clinical (group) supervision and in daily team briefings
3.4	Where an incident of potential risk occurs, ORB staff to inform all relevant agencies of the potential risk using the timeliest manner of communication.	Local	*Lead Service Manager and Clinical Lead*	Six monthly audits to continue to monitor case notes for accuracy – specifically cross-referencing risk assessments with care plans and case notes and communication to other agencies. Whilst this process in ongoing: in the event of an incident of increased risk taking place; ORB staff to seek advice from *Lead Service Manager and Clinical Lead to ensure all relevant actions have been undertaken.*	Ongoing	01/23 – risk to/from an individual or group is discussed in all multi-agency forums as appropriate Case notes audit regularly monitors how risk information is shared Monthly risk management meeting in place reviews all incidents and how relevant information had been shared Risk management policy in place (Trust wide) which is used in combination with the Trust Information Governance policy to appropriately share in a

						timely fashion relevant information. 11/23 – 10% of caseload is reviewed at monthly individual supervision which audits risk assessment, care-plan, MDT work and case notes. This picks up any issues more effectively than having 2 standalone audits each year.
3.5	Confirmation that that information has been shared should be retained within the service user/ patients case records.	Local	*Lead Service Manager and Clinical Lead*	Six monthly audits to continue to monitor case notes for accuracy – specifically cross referencing risk assessments with care plans and case notes and communication to other agencies.	Ongoing	01/23 – this is already standard practice as per Risk and IG policies, and monitored via audit and supervision.

Recommendation 4:

Care Delivery Problem: Lack of communication with supporting agencies: Cessation of Olanzapine was not confirmed following Adult C's disclosure that he had stopped taking this antipsychotic medication. Adult C's care plan did state that he should inform staff of any change in his mental health condition however there was no evidence that Adult C was asked any specific questions relating to why medication was stopped or if his mental health was deteriorating following the self-reported cessation of Olanzapine. Recommendation: Keyworker to confirm any medication changes with the prescriber and to record these within the service user/ patients case notes and care plan. Keyworker and other ORB staff who have contact with the service user / patient to observe and monitor for any changes in mental health and to ask the service user / patient to describe any mental health symptoms at appointments. Any significant changes to be shared with prescriber / mental health service. Consent to share information with health services should be sought at the point of initial assessment.

Desired outcome from the recommendation

Summary Care Records are accessed as standard practice to ensure ORB staff have an up to date record of GP prescriptions / interventions.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
4.1	Historically The ORB had an issue with getting up to date GP summaries from GP Surgeries; however, they now have a standard operating Procedure (SOP) in place to support prescribers accessing summary care records with the service user / patient's consent which means that the ORB can access the information directly themselves. This is available for review by prescribers prior to each clinical review appointment.	Local	*Lead Service Manager and Clinical Lead*	ORB now have a standard operating Procedure (SOP) in place to support prescribers accessing summary care records with the service user / patient's consent which means that the ORB can access the information directly themselves. This is available for review by prescribers prior to each clinical review appointment.	N/A	Completed 2022 ORB staff can access Summary Care records directly. 11/22 – Information sharing agreement signed by both OH and MPFT 11/23 - ORB staff access Summary Care records directly. This remains standard practice.

Recommendation 5:
It is therefore recommended that bloods should ideally be taken prior to commencing Espranor and if not possible then taken a soon as possible after prescribing is initiated.

Desired outcome from the recommendation
Summary Care Records are accessed as standard practice to ensure ORB staff have an up-to-date record of GP prescriptions / interventions.
That baseline LFTs, U&Es and BBV status (particularly Hepatitis C) are available prior to initiating an Espranor prescription and if this is not possible to be taken as soon as possible after prescribing is initiated.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
5.1	Care delivery problem to be shared with the ORB Team within the Team Meeting Setting	Local	*Lead Service Manager and Clinical Lead*	Care delivery shared with the ORB Team.	30/08/ 222	Discussed regularly (monthly) in clinical and line management supervisions (06/12/22)

				Serious Incident Reporting including good practice and Care Delivery Problems added to the regular ORB Team Meeting Agenda		Already standard practice (06/12/22) 9/22 – ORB have worked with ICB and Buckinghamshire Healthcare to obtain access to ICE (system to view and request tests). 11/23 – the practice of reviewing/requesting bloods is standard at ORB.
5.2	Pre-prescribing checklist already includes the requirement for bloods to be taken. Prior to commencement of Espranor wherever possible. This was not however expected during the pandemic if there was no history of poor renal and hepatic function.	Local	*Lead Service Manager and Clinical Lead*	To continue to adhere to Espranor SOP	Ongoing	Already standard practice (06/12/22) All prescribed patients have at least a 6 monthly medical review. Repeat/new blood tests would be considered within that appointment. (06/12/22)
5.3	Where bloods are not taken prior to Espranor prescribing, then an appointment should be made with the service user / patient and the relevant agency to have bloods taken.	Local	*Lead Service Manager and Clinical Lead*	All service users entering treatment for Espranor have bloods taken within one month of commencing treatment. If a service user / patient refuses, then a clinical review / discussion will take place and this will be documented in the case notes and risk assessment	30/9/22	This direction was dropped during the pandemic. All patient with history of any hepatic/renal function problem would have blood tests, the prescribed would risk assess whether to commence prescribing (06/12/22)
5.4	Blood results to be reviewed by an appropriately qualified member of the ORB Team within one week of receipt.	Local	*Lead Service Manager and Clinical Lead*	Incoming blood results to be shared with Non-Medical Prescribers / Medics at the earliest opportunity by ORB staff (Monday – Friday)	30/9/22	Blood results, once reviewed may impact a prescribing decision. These are always reviewed prior to prescribing (06/12/22) 9/22 – ORB have worked with IADULT C and

						Buckinghamshire Healthcare to obtain access to ICE (system to view and request tests) Audit of blood results every 6 months for patients on Espranor (06/12/22)

Recommendation 6: Service users / patients should be reminded of the need to attend appointments and to fully participate in their recovery programme. Full compliance with the ORB 'Did Not Attend 'SOP.						
Desired outcome from the recommendation						
REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
6.1	Care delivery problem to be shared with the ORB Team within the Team Meeting Setting	Local	*Lead Service Manager and Clinical Lead*	Care delivery shared with the ORB Team. Serious Incident Reporting including good practice and Care Delivery to be included as standard practice with ORB Team Meetings	30/08/222	Discussed regularly (monthly) in clinical and line management supervisions (06/12/22) Already standard practice (06/12/22)
6.2	All ORB clinical staff to have a working knowledge and be aware of how to access the DNA SOP for reference	Local	*Lead Service Manager and Clinical Lead*	A review of the DNA SOP to be provided within the ORB Team Meeting: Staff to be signposted to the SOP within this meeting.	Ongoing	Regularly discussed in all supervision routes/meetings (06/12/22) All staff have access to Trust systems and SOPS (06/12/22) 11/23 - The DNA/Engagement SOP is being reviewed by the Inclusion (National) quality group
6.3	Supervision to be utilised to review ORB staff compliance with the DNA SOP	Local	*Lead Service Manager and Clinical Lead*	Routine supervision to be used to review individual staff compliance with the DNA SOP. Where it is identified that additional training or	30/9/22	Case management reviews by line managers identify those not engaging with service. Supervision is then used to

				support is required this should be arranged by the Supervisor		support staff develop engagement plans or use of DNA SOP (06/12/22) Supervision occurs monthly for all staff (line management) with separate monthly clinical group supervision and individual safeguarding supervision, also monthly (06/12/22)
6.4	ORB staff to demonstrate confidence and competence in complying with the ORB DNA SOP	Local	*Lead Service Manager and Clinical Lead*	One to one support to be provided and to continue until the individual demonstrates a competence for DNA SOP compliance within their everyday practice.	30/9/22	If a staff member is not able to meet the competence expected they would be supervised using a support plan with milestones attached to achieve competence (06/12/22) All staff must have 100% completion of mandatory training (06/12/22)

Individual Agency Recommendations for
Oxford Health NHS Foundation Trust

Individual Agency Recommendation 1: Improve how actions from Section 42 or other safeguarding reviews involving Oxford Health are recorded and monitored centrally.						
Desired outcome from the recommendation Improved process and system of recording and monitoring actions.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Implement process of recording actions from S42 enquiries, SAR or CSPR on the Ulysses system so can be monitored, and ability to audit.	Local	*Deputy Head of Safeguarding*	Develop process of recording actions from safeguarding reviews being added to Ulysses. Audit compliance and completion of actions.	31/07/ 2023	Actions completed. We have a central Trust mechanism in place for overseeing learning and actions from SAR and CSPR. The actions are entered onto Ulysses and monitored for completion and evidence of closure. Safeguarding concerns/ enquiries related to adult mental health are delegated to OHFT from Buckinghamshire Council via the LAS (Local Authority service user record system). Since the new structure was introduced at the end of 2022 the Buckinghamshire Early Resolution and Safeguarding Team review all safeguarding

						concerns and decide on eligibility for a Section 42. Action is then delegated to the assistant team manager (senior social care professional) within the relevant adult mental health team. The assistant team managers keep an oversight of the Section 42 enquiries in their team with escalation to the Head of Social Care as required. There is a daily safeguarding tracker for OHFT sent to the Buckinghamshire Early Resolution and Safeguarding Team and the Service Director which details all current safeguarding contacts and Section 42 enquiries. There is also a weekly safeguarding supervision group to discuss cases and any concerns – this is open to social care and health professionals.

Recommendation 2:

Improve joint working with One Recovery Bucks.						
Desired outcome from the recommendation Improved communication routes between both organisations, ultimately improved patient experience.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Development and embedding joint working protocol	Local	Bucks Adult Directorate Service Manager	Joint Working Protocol, written and approved Protocol implemented and reviewed.	31/07/ 2023	Actions completed. The Joint Working Protocol was approved and signed off in November 2022 (protocol provided). Subsequently there were two launch events in March 2023 involving clinicians from both Buckinghamshire Mental Health and One Recovery Bucks. Actions completed. Monitoring of the joint protocol is via the new Quadrant meetings. The first Quadrant meeting took place in April 2023 (May notes provided) and is an established monthly meeting, including two Operational Leads (one from each organisation), and the team managers across organisations from the teams

						that will use the protocol practically. The agenda is mainly focussed upon relationship issues between organisations that impact on access to either service, so is difficult to quantify. However, we know that Buckinghamshire is an outlier in England and Wales with a low number of referrals into Substance Use services coming from professionals, with a tendency towards recommending self-referral. A key aim is to increase professional referrals from Bucks Mental Health to ORB by 50% in the first year. The Quadrant Meeting also looks at barriers to joint working for existing service users and learning from incidents that impact upon both organisations.

Recommendation 3: Improve how Rough Sleeper Initiative embedded MH practitioner role is managed.
Desired outcome from the recommendation

Improve the processes of joint working, escalation routes and supervision so supported within this role.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	Review the structure of how the Rough Sleeper Initiative MH Practitioner is supported and routes for escalation.	Local	Service Manager Oxford Health	Complete review and implement changes.	28/04/ 2023	Actions completed. Review completed with the outcome of a new jointly written memorandum of understanding between Buckinghamshire Council and OHFT in relation to RSI. The MOU includes information sharing requirements. The MH Practitioner in the RSI has a supervisor and line manager to escalate any concerns.
3.2	Review how information is recorded and shared across Oxford Health and RSI.	Local	Service Manager, Oxford Health	Complete review, identify and agree where information should be recorded, implement change and monitor.	28/04/ 2023	Review completed and information sharing requirements included in new jointly written memorandum of understanding between Buckinghamshire Council and OHFT in relation to RSI. Detail in MOU is available on request.

Recommendation 4:
Review how Oxford Health contributed to the multi-agency approach, communicated, shared information and escalated issues.

Desired outcome from the recommendation
Identify any gaps and plan implement improvement.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
4.1	Review existing forums of multi-agency response.	Local	Clinical Director, Associate Director of Nursing, Oxford Health	Map the existing forums	30/06/2023	Mapping of existing multi-agency forums completed. Each community mental health team has a weekly MDT meeting to discuss their caseload and any cases of concern. The next step would be to organise a professionals meeting and include all agencies in that. This is done on case by case basis and includes multiple agencies. Routine multi-agency forums include:- ❖ Complex case level 2 risk panel – This is a forum to discuss complex patients where all agencies involved in patient care are invited – hosted by Oxford health. ❖ Buckinghamshire Complex case panel hosted by the Safeguarding Adult Board – as

						required a forum to bring together agencies to meet a patients needs that have not been resolved through usual mechanisms. ❖ Partnerships in Practice meetings – These are monthly meetings where partner organisations including police, probation, Oxford health, ORB and social care meet up to discuss any complex patients as well as liaison issues. ❖ Case Resolution Meeting monthly involving adult social care, housing and bucks council commissioning to resolve complex cases and domestic abuse issues could be part of these discussions to determine priority for re-housing. ❖ Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists

						from the statutory and voluntary sectors. OHFT Bucks directorate have designated officers. Multi-agency public protection arrangements (MAPPA) is another mechanism to get together all agencies involved if there is risk of violence of sexual offence.
4.2	Review any gaps and how improved	Local	Clinical Director, Associate Director of Nursing, Oxford Health	Review completed and associated action plan.	30/06/ 2023	There are already several existing meetings and mechanisms as mentioned above, which provide opportunity of multi-agency or interorganisational working to raise safeguarding concerns related to domestic violence. No gaps have been identified in the structure and forums available for discussion. A flowchart for clinicians has been developed to help guide people to the most appropriate support and forum. The flowchart is currently in draft and being consulted on, it will be appended to the Trust's Adult Safeguarding Policy. Flow chart now added.

Individual Agency Recommendations for
South Central Ambulance Service NHS Foundation Trust

Recommendation 1: Include the importance of considering safeguarding for people who make frequent calls **requesting** controlled drugs and who display drug-seeking behaviours within the new training package.

Desired outcome from the recommendation:
Safeguarding needs of people who are considered to be displaying drug-seeking behaviour and repeatedly call the service requesting controlled drugs will be raised with the local authority,
Information will be shared with primary care
Any individuals who are frequent callers for repeat medication as in this case but who do not meet the current thresholds will have information shared with the GP.
Frequent callers to the service will have a patient management plan.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	New Level 3 Safeguarding children's and adults covering 7 hours of training developed by the current Safeguarding team.	Local	Head of Safeguarding	Added to training package. Delivery to all staff started 26/5/23 Bespoke Level 3 Safeguarding training that covers the requirements of the intercollegiate document created.	31/08/22 31/03/23	New level 3 Safeguarding training has been rolled out to staff from the 26/5/23 and is delivered by the Safeguarding practitioners. Training covers the importance of referring people who present with drug seeking behaviour to the GP or Local Authority Safeguarding if they have additional care and support needs. Complex care team who work with the complex patients who repeatedly call

						the service now work in partnership with the SCAS Safeguarding team.

Recommendation 2: Learning from the review will be shared with staff to inform future practice.						
Desired outcome from the recommendation: Staff to use this case as learning and development to improve future care of patients and safeguarding.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Feedback to staff involved via email	Local	Head of Safeguarding	Create a list of staff members involved. Send email to each staff member. Unable to confirm if this action was completed as new Safeguarding team in post. The DHR will be shared with all SCAS staff via a COMMS brief when the DHR is published.	When DHR published	

Individual Agency Recommendations for
Thames Valley Police

Recommendation 1: To provide Safer Buckinghamshire Partnership evidence-based assurance that:

Adult protection reports are recorded on Niche and tasked accordingly.

Adult protection notifications are consistently submitted.

Domestic abuse is being identified for vulnerable adults, either child to parent, or in relation to caring roles; investigated and appropriate safety measures put in place.

There is consistency in completion of the DOM5 (DASH).

Background checks are systematically being taken when reports of neglect or abuse are received by Contact Management and callers are not only signposted to Adult Social Care when indicators of neglect or abuse are present.

Desired outcome from the recommendation: Domestic abuse is being identified for vulnerable adults, either child to parent, or in relation to caring roles; investigated and appropriate safety measures put in place including enlisting the support of other agencies.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	Adult protection reports are to be recorded on Niche and tasked accordingly.	Local	Head of MASH	Head of MASH has confirmed that daily monitoring of AP tasks is completed and there are performance mechanisms to monitor the volume. Robotics also assist with the AP	January 24	Jan 24 Information is shared in a timely manner.

				internal queue where those tasks are held by sorting them into risk gradings (A.B, C). This allows staff reviewing the queues to quickly determine which tasks need to be prioritised. Demand is also reviewed daily at the Risk Daily Management meeting so that resources can be flexed across the MASH. This ensures information is shared in a timely manner.		
	Adult protection notifications are to be consistently submitted.	local	Head of MASH	In relation to working with Buckinghamshire County Council and Adult protection we participate in a Monthly Meeting with Sarah Beeks the Head of Service for Adults & Health Directorate. At this meeting we discuss a report compiled by Bucks Council covering data in relation to the AP notifications sent by TVP. The meeting has been set up due to the volume of AP submissions by TVP and the South-Central Ambulance Service (SCAS). Both the		AP submissions are reviewed, as there is reoccurring theme from Bucks Council that TVP submit far too many AP occurrences.

				quantity and quality of TVP AP submissions are reviewed, as there is reoccurring theme from Bucks Council that TVP submit far too many AP occurrences.		
	New risk assessment training to be devised and written and rolled out to frontline officers, to be included in the DA specialist course and new training for front line officers.	local	DCI- Domestic Abuse Investigation Unit	These themes will be re-enforced in a new risk assessment training that is be devised and written that will be rolled out to frontline officers, to be included in the DA specialist course and new training for front line officers.	July 24	Risk assessment training started as part of team days in Nov 2023 – April 2024. DA specialist and new frontline course is in the process of being written for delivery later in the year.
	DOM 5 training to be rolled out within the new risk assessment training.	Local	DCI - Domestic Abuse Investigation Unit	As above completion of the DOM 5 will be included in these training packages.	July 24	DA specialist and new frontline course is in the process of being written for delivery later in the year.
	To ensure background checks are systematically being taken when reports of neglect or abuse are received by Contact Management and callers are not only signposted to Adult Social Care when indicators of neglect or abuse are present.	Local	Contact Management Team	Confirmation that this is not internal practice and to be in a position to understand what the process is if a call is made.	Jan 24	03/01/24 – As long as sufficient details of the person are provided then a DOM 5 would be completed and therefore there would be no signpost to adult social care as Police would action.

Appendix 3

Interpersonal Abuse Unit

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Ruth Hemsley

Community Safety Coordinator

Adults and Health Directorate

Buckinghamshire Council

County Hall, Walton Street

Aylesbury, Bucks

HP20 1UA

29th May 2024

Dear Ruth,

Thank you for submitting the Domestic Homicide Review (DHR) report (Adult J) for Buckinghamshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24th April 2024. I apologise for the delay in responding to you.

The QA Panel noted that the report was sensitive and well written, with good use of current and emerging research into domestic abuse. There was strong expertise on the panel from a local domestic abuse service, a mental health organisation and a substance misuse service. It was also positive to see that domestic abuse policies and training had been considered as part of the review.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

• The completion date of the report needs adding to the front page.

• Although the report states that pseudonyms were used and chosen by the family, they were identified by letters (Adult J, Adult L and Adult C), this somewhat depersonalises the victim and others and is at times confusing to read.

• The author stated that the family will provide a tribute prior to publication. It

would have been helpful to have this included as part of the draft pre-published DHR as it provides a sense of the lived experience of the victim and keeps them central to the DHR.

• The individual action plans need completing consistently, with more detail, for example GP recommendations and recommendations for Thames Valley Police.

• At 2.2.2 it would be helpful to know which metropolitan area the Chair was the Strategic and Commissioning lead for.

• Though the analysis on economic abuse at 6.2.4-6.2.6 is on the abuse Adult J perpetrated against Adult L (though this could also include him taking away the landline phone/restricting her access to her mobile phone and food), the review does not explicitly recognise the economic abuse Adult C perpetrated against Adult L when exploring the abuse from an adult child to parent at 6.4. There are examples listed in Adult L's son's description at 6.4.2, but this could be drawn out further. The recommendations could also be strengthened further to ensure the training recommended is more specifically on economic abuse. For example, the information provided by the GP in the action plan says that economic abuse is 'highlighted' in the domestic abuse training, but this does not appear to be in-depth enough to cover the issue of Lasting

Power of Attorney, which is what the recommendation raises.

• Additional expertise on the panel could have included specialists on older vulnerable victims and autism.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and

other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel