Safer Somerset Partnership

Report into the death of Alfred

Contents

- Overview Report
- Executive Summary
- Appendices – a. Action Plan and b. Home Office QA Feedback Letter

STATUTORY REVIEW - OVERVIEW REPORT

Safer Somerset Partnership

REPORT INTO THE DEATH OF Alfred

Report produced by Peter Stride – Foundry Risk Management Consultancy

Report Completed January 2024

Table of Contents

FORWARD **6**

1. INTRODUCTION **7**

2. TIMESCALES **8**

3. CONFIDENTIALITY **8**

4. TERMS OF REFERENCE **9**

5. METHODOLOGY **10**

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS, AND COMMUNITY **11**

7. CONTRIBUTORS TO THE REVIEW **13**

8 REVIEW PANEL MEMBERS **14**

9 AUTHOR OF THE OVERVIEW REPORT **15**

10 PARALLEL REVIEWS **15**

11 EQUALITY AND DIVERSITY **16**

12 DISSEMINATION **17**

13 BACKGROUND INFORMATION (THE FACTS) **18**

14 COMBINED NARRATIVE CHRONOLOGY **18**

14.2 MATTERS OCCURRING PRIOR TO THE REVIEW PERIOD. 19

14.3 JUNE 2020 19

14.4 MARCH 2021 19

14.5 APRIL 2021 21

14.6 THE DAY OF ALFRED'S DEATH 25

15. OVERVIEW **26**

15.1 Avon and Somerset Police *26*

15.2 Integrated Care Board on behalf of Primary Care *26*

15.3 Adult Social Care *27*

15.4 Somerset NHS Foundation Trust – Som FT *28*

16. ANALYSIS **29**

16.1 HINDSIGHT BIAS 29

16.2 Domestic Abuse 29
16.3 Family stressors and carer support 30
16.4 Responding to crisis 32
16.5 Links between Relationship Tensions and suicide 34
16.6 The Sharing of information 35
16.7 Management Oversight 37
16.8 Male Victims of Domestic Abuse 38
16.9 Making Safeguarding Personal 41
16.10 The Impact of the COVID 19 Pandemic on health and social care providers 44
17. CONCLUSIONS 46
18. LEARNING POINTS 46
19. RECOMMENDATIONS 47
Single Agency 47
Somerset NHS Foundation Trust 47
Adult Social Care 47
Recommendation from this review 47
APPENDIX 1 49
Terms of Reference 49
APPENDIX 2 54
Single Agency Recommendations Som FT. 54
APPENDIX 3 55
Single Agency Recommendations Adult Social Care. 55
APPENDIX 4 56
Glossary of Terms 56
APPENDIX 5 58
Excerpts of the SomFT Mission Vision and Values Statement. 58
APPENDIX 6 59

College of Policing - The supervisor's responsibilities during crime investigation: 59

APPENDIX 7 60

Interpretation of the Term 'Making Safeguarding Personal. 60

APPENDIX 8 61

Somerset NHS Foundation Trust – Carers Service 61

APPENDIX 9 62

APPENDIX 10 63

Review Authors sources of research 63

Forward

Safer Somerset Partnership (SSP) would like to express their condolences to all those affected by the sad loss of Alfred. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future. The Independent Chair of the review panel would like to thank all agencies who contributed to the process in an open and transparent manner. This review has demonstrated that more needs to be done to raise awareness change attitudes towards domestic abuse and that it is crucial to offer appropriate and timely help and advice to victims, their families, and friends, and professionals. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to prevent what happened to Alfred from happening to others.

Following Alfred's death there is emerging evidence of positive change at a local level, and we all must do our utmost to take immediate action both to protect the vulnerable and the chair would urge everyone to take note and act on the findings of this review. Together we must take risks, to the vulnerable in our community, seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

1. Introduction

1.1 This Statutory Review was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004.

1.2 This Statutory Review (hereafter 'the review') examines agency responses and support provided to Alfred, a resident in Somerset prior to the point of him taking his own life in April 2021.

1.3 In April 2021 police were called following the discovering of a body which had been found floating in the water. The following day the body was identified as being that of Alfred a local resident. A police investigation confirmed that there was no 3rd party involvement and nothing to suggest that there was anything accidental which had caused Alfred to drown. The conclusion was therefore drawn that Alfred had taken his own life.

1.4 The review will consider agency contact/involvement with Alfred and Joan for the three years prior to Alfred's death. The reason for this timeframe was to allow the review to consider any history or pattern of known domestic abuse, whilst trying to avoid considering policies, protocols, and practices, which are no longer in use and could be viewed as being outdated. That said the chair of the panel encouraged agencies to collate and report any matters outside of this timeframe which it considered relevant in assisting the review process. This time frame also ensures that opportunities for learning and the recognition of good practice was relevant to current methods, policies, and processes.

1.5 At the initial stages of the process the panel considered the use of the term Domestic Homicide Review, in particular its potential impact upon those left behind, particularly Joan. The inference of this term is that there has been a murder and therefore a crime committed. Logically to consider Alfred as a victim of a homicide suggests that there is a perpetrator. The police investigation, and inquest, concluded there was no homicide and instead Alfred decided to take his own life. Further as Joan has a history of mental illness, which is replicated in other members of her family, a published document which discusses her husband's death, titled Domestic Homicide Review could have a significant impact upon their emotional and psychological well-being. Similarly, the impact of a report titled Domestic Homicide Review could create a perception, in the wider community, that is inappropriate. Therefore, the chair and review panel have agreed that the title 'Statutory Review' is a more suitable form of words and will used throughout this report.

1.6 The key purpose of undertaking this review is to enable lessons to be learned, and for them to be understood as widely and as thoroughly as possible. Professionals need to be able to understand fully what happened and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

1.7 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.8 The review panel wishes to express its sympathy to the family and friends of Alfred for their loss and thanks them for the contribution in supporting this process.

2. Timescales

2.1 Safer Somerset Partnership initiated this review in May 2021 in accordance with the Multi-Agency Statutory guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the guidance).

2.2 Following review of the circumstances leading up to the death of Alfred two referrals were made to the Safer Somerset Partnership. The first came from the Avon and Somerset Police Major Statutory and Crime Review Team who concluded that as Alfred had taken his own life and in the context of violence and abuse it was appropriate for either a Domestic Homicide Review or Safeguarding Adult Review to be carried out.

2.3 The second referral was made by the Safeguarding Adult Service at Somerset County Council. Their rationale for referring the incident for a DHR was based upon the information provided to them by the police in that there had been recent incidents of domestic abuse prior to Alfred's death. Additionally Adult Services had received their own referrals describing incidents of domestic abuse within the couple's relationship.

2.4 The Safer Somerset Partnership chair considered the case based upon the information that they had received from local partner agencies and referred matters to the Somerset Safeguarding Adult Board (SSAB). The SSAB confirmed that the case did not meet the criteria for a Safeguarding Adult Review and a decision was taken that a DHR should be carried out in order that potential lessons could be learned, and good practice highlighted.

2.5 In July 2021 the Safer Somerset Partnership informed the Home Office of their intention to hold a Domestic Homicide Review. A letter of reply and agreement was received on the 4th of August 2021.

2.6 Peter Stride was commissioned as Independent Chair (hereafter 'the chair') for this review on 16th of September 2021. There has been a significant delay to the review being concluded for several reasons as stated below in 2.7. The completed report was agreed by the review panel in September 2023 and passed to the Safer Somerset Partnership on the 25th September 2023 and submitted by the SSP to the Home Office Quality Assurance Panel on 11th January 2024.

2.7 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:

- Enabling contact with family members
- Issues relating to the COVID pandemic.
- Extended periods of engagement between the chair and panel agencies during the preparation of the Overview Report.
- The chair suffered a family bereavement which caused him to take some time out between March and July 2023.

3. Confidentiality

3.1 The findings of each review are confidential and remain so until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel.

Information is publicly available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed, between panel member agencies during the first panel meeting and all information discussed was treated as confidential and not disclosed to third parties without the agreement of the responsible agency's representative.

3.3 All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the review panel set up a secure email system. The chair advised that confidential information must not be sent through any other email system unless they were protected by a password.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The specific date and location of the death has not been recorded in this report and pseudonyms were selected by the chair and agreed with Joan and are used in the report to protect the identity of the individuals involved.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Alfred	Deceased	69yrs	White, British
Joan	Wife	65yrs	White, British

4. Terms of Reference

4.1 Following discussions at initial panel meetings the chair circulated the Terms of Reference (ToR), along with the templates for completing IMR's, to the agencies that had contact with Alfred and Joan. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from Alfred's death and for actions to be taken in response of that learning.

4.2 The Review Panel consisted of agencies from Safer Somerset Partnership as the deceased was living in the area at the time of his death. Agencies were contacted as soon as possible after the review was established to inform them of the creation of the review and inform them of the need to secure records.

4.3 The Review Panel considered the Key Lines of Enquiry upon which the process should focus. Consideration was given to the content of the Combined Chronology and Individual Management Reviews before deciding upon these case specific issues

- Family stressors and carer support
- Responding to crisis

- Links between domestic abuse and suicide
- The sharing of information.
- Management Oversight
- Male victims of Domestic Abuse

4.4 At the first meeting the panel shared brief information, obtained from the initial 'trawl for information' which had been carried out at the start of the process. At this stage it was agreed that the review process should look back three years into the history of involvement between panel agencies, the deceased and his wife, for the reasons explained in paragraph 1.4.

5. Methodology

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with domestic violence and the report uses the definition provided by the Domestic Abuse Act 2021 i.e.

- The Behaviour of a person (A) towards another person (B) if.

  I. A and B are each aged 16 or over and are personally connected to each other and.

  II. The behaviour is abusive.

- Behaviour is abusive if it consists of any of the following -

  1. physical or sexual abuse.
  2. violent or threatening behaviour.
  3. controlling or coercive behaviour.
  4. economic abuse (see subsection (4)).
  5. psychological, emotional, or other abuse.

It doesn't matter whether the behaviour consists of a single incident or a course of conduct.

5.3 Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated);
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).

5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

5.4 It is further defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological physical sexual financial and emotional.

5.5 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to initially seek chronologies of events from each agency followed by Individual Management Reviews (IMRs) from all the organisations and agencies that had contact with Alfred and Joan.

5.6 A total of 14 agencies were contacted to check their involvement, 8 agencies confirmed that they had had no contact. 5 agencies submitted chronologies and 4 of those produced IMR's with additional briefing notes being provided by the South West Ambulance Service NHS Trust (SWAST). The local District Council 'Together Team'[1] had no direct engagement or links to Alfred and Joan but were involved in a brief, undocumented discussion about the value of referring Alfred and Joan to the services that they provided, as is recorded below (see paragraph 14.8.7**)**. A briefing note was supplied to this review which outlined the nature of this discussion.

5.7 Independence and Quality of IMRs: IMRs were written by authors independent of case management or delivery of the service concerned. The reports were comprehensive and enabled the panel to analyse the contact with Alfred and Joan and to produce learning for this review. Where necessary the chair held separate meetings with individual agencies, including panel members and report authors. Three IMR's made recommendations and produced action plans of proposed and ongoing activity.

5.8 The Chair completed two face-to-face interviews with the deceased's wife Joan.

5.9 Details of the research completed by Chair and sources of their analysis are contained in Appendix 9.

6. Involvement of Family, Friends, Work Colleagues, Neighbours, and Community

Details of how Joan was informed of the DHR.

6.1 Contact with Joan was initially via the local Community Mental Health Team (CMHT). The chair was conscious of Joan's potential vulnerability and therefore delayed direct

[1] https://www.sacpa.org.uk/vacancies/together-team-and-safeguarding-lead-sedgemoor-district-council-somerset/

contact until it was agreed that she would be able to appreciate the nature of the review and her potential role within it.

6.2 At first Joan informed the CMHT that she was unwilling to meet the chair or take part in the process, however in February 2022 the CMHT contacted the chair and informed him that Joan had changed her mind and was keen to have a meeting.

6.3 The chair met with Joan in March 2022, and she was supported by the Community Psychiatric Nurse (CPN) who had been working with her since Alfred had died. Joan was provided with details of the Home Office DHR leaflet, information of the advocacy services provided by AAFDA and the Terms of Reference.

6.4 There were no communication issues between Joan and the chair and interaction was carried out via face-to-face meetings and email exchange between chair and the CMHT nurse who was supporting Joan.

6.5 In considering the issue of contacting other family members and previous employers the chair realised how much Joan was still traumatised by the death of Alfred. It was quite clear that Joan was looking to move forward with her life and not seeking to revisit the past. The chair discussed the idea of contacting other family members, with the CPN and it was agreed any such contact would almost certainly be fed back to Joan and cause her significant distress and upset. Additionally, Joan had explained that her brothers had mental health issues and may be unwilling or be distressed by any approach from this review. The chair considered the balance of the review against the well-being of the family and took the decision not to reach out to either of Joan's brothers.

Summary of Interview with Joan

6.6 The chair met with Joan along with her CPN, from the CMHT, and discussed various things including how she had been affected by her husband's death, how she was coping, as well as the family history and her relationship other family members. During the meetings with the chair, Joan provided the following details.

6.7 She explained that her relationship with Alfred began in 1997 and they were married in 1998, she mentioned that prior to their meeting Alfred had been involved in an accident from which he had suffered 'brain and physical' injuries. As a result of which Alfred had struggled to walk.

6.8 Alfred and Joan were married for twenty-four years, and he had acted in a caring role during her periods of mental ill health. Following his car accident Alfred had been through a long rehabilitation process which left him with short term memory and coordination problems. Joan told the chair that for a period, she became a carer for Alfred[2].

---

[2] Details confirming whether this statement is accurate are not available to this review due to the passage of time and any relevant records having been destroyed.

6.9 The chair asked about their life together, and Joan explained that the couple had a very active social life, including many holidays around the country, going for walks, attending parties with friends and evenings at the pub taking part in regular quizzes. Alfred had several jobs including as a trolley warden at a local supermarket and as a driver for the local council. Joan explained that Alfred was a very happy man and that throughout their marriage they had always got on extremely well. She described Alfred as always being full of life and highly motivated.

6.10 Over the last several years Joan had spent all her time as a carer for Alfred, and for her brother and mother who lived several miles away. Joan had reported finding life challenging, particularly as Alfred's physical capabilities had begun to deteriorate and he had regularly fallen over.

6.11 At the conclusion of the interview the chair discussed the fact this review would result in a report being prepared and that it may be subsequently published. Joan was invited to take further part in the review and offered the opportunity to see a final draft and provide feedback. Joan's response was that she was very happy to have met the chair and provide the details described above, but that she did not wish to have any further involvement with the review process.

7. Contributors to the Review

7.1 The following agencies were contacted and confirmed engagement with Alfred and Joan.

Agency Name	Known to the agency	Chronology	IMR
Avon and Somerset Police	Yes	Yes	Yes
Adult Social Care	Yes	Yes	Yes
Clinical Commissioning Group	Yes	Yes	Yes
Sedgemoor District Council	Yes	Yes	No
Somerset NHS FT	Yes	Yes	Yes
Southwest Ambulance Service	Yes	Yes	No

7.2 During the initial scoping process several other agencies were contacted but confirmed they were not involved with either party.

- National Probation Service
- Community Rehabilitation Company

- Somerset and Avon Rape and Sexual Abuse Support
- Somerset Drug and Alcohol Service
- Somerset Integrated Domestic Abuse Service
- Victim Support Service
- Somerset Safeguarding Adults Board

8 Review Panel Members

8.1 The Review Panel was populated by the following agency representatives. As per the statutory guidance, the chair, and the review panel are named, including their respective roles and the agencies which they represent. Agencies who provided information to the review are also identified.

Name	Role/Job Title	Agency
Peter Stride	Review Chair	Independent
Su Parker	Detective Inspector	Avon and Somerset Police
Heather Sparks	Named Professional for Safeguarding Adults	Somerset NHS Foundation Trust
Louise White	Service Manager, Safeguarding Operations	Somerset Adult Social Care
Emma Read	Deputy Designated Nurse for Safeguarding Adults	NHS Somerset Integrated Care Board
Mark Brooks	Chair	Mankind Initiative
Lucy Harling	Paragon Manager	The You Trust
Suzanne Harris	Senior Commissioning Officer	Somerset County Council
Rob Semple	Community Safety and Resilience Manager	Sedgemoor District Council

8.2 Independence and expertise. Agency representatives were of appropriate level of expertise and were independent of this case.

8.3 The panel initially met on the 3rd of November 2021 and subsequently on 3rd of February 2022, the 5th of May 2022, 5th December 2022 and the 6th of March 2023. On-going reports were reviewed at the latter meetings with the panel members

providing feedback. In between panel meetings the chair held a number of meetings with individual panel members.

8.4 The chair of the review wishes to thank everyone who contributed their time, patience, and cooperation throughout this review.

9 Author of the Overview Report

9.1 Peter Stride was appointed by the Safer Somerset Partnership as independent chair and author of this Domestic Homicide Review panel. Peter is a retired Metropolitan Police Officer and has over 30 years of detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. His experience includes specialist and generic investigative roles at New Scotland Yard and the boroughs of Westminster Brent and Harrow.

9.2 As Detective Chief Inspector he has been the vice chair of two Local Adult and Children's Safeguarding Boards and was responsible for the creation and implementation of various MASH and MACE panels as well as chairing MAPPA and MARAC meetings.

9.3 Since retirement Peter has established his own consultancy business, coaching and training in a range of risk management environments focusing upon child and adult safeguarding within the public sector.

9.4 Peter has completed Home Office approved Training and has attended subsequent training by Advocacy After Fatal Domestic Abuse.

9.5 Peter has no connection with the Safer Somerset Partnership.

10 Parallel Reviews

10.1 Inquest: The inquest into the death of Alfred was opened in April 2021 and following an adjournment was concluded on the 21st of June 2022. The inquest recorded the nature of Alfred's death as suicide.

10.2 Criminal Investigation: Following a police investigation it was confirmed that no other parties are sought for the death of Alfred.

10.3 Internal Police Disciplinary Investigation Process. As the police had attended a call to the couple's home (i.e. a domestic incident) two days before Alfred's death, the case was referred to Avon and Somerset Constabulary's Professional Standards Department (PSD). The PSD assessed the incident and were satisfied that there was no causal link between police attendance at the incident, and the discovery of his body. The matter was therefore not reported to the Independent Office for Police Conduct (IOPC) and the matter was closed.

11 Equality and Diversity

11.1 The review panel considered all the protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment,
- Marriage and Civil Partnership.
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation.

11.2 The panel reflected upon each of these characteristics in evaluating the quality of the various services provided to Alfred, and whether there were any barriers to him accessing these services. Additionally, the review has considered the wider perspective of whether agency service delivery was impacted by any of these characteristics.

11.3 There were a number of protected characteristics requiring consideration. The first is sex, Alfred was male and a recent report from the Centre for Social Justice states 'one third of domestic abuse victims are men'.[3] Equally it was recognised, during the IMR preparation process, that sex was a relevant characteristic due to the fact that more domestic abuse is initiated by men against women and that in the case of Adult Social Care (ASC) domestic abuse services were less widely available to all victims. The subject of male victims of domestic abuse are discussed more widely in Section 16.9.

11.4 Disability Approximately 30 years prior to his death had sustained a traumatic head injury which had left him with short-term memory loss and co-ordination problems. On considering the Equalities Act, it is incumbent on this review to consider the duty on public authorities to:

- remove or reduce disadvantages suffered by people because of a protected characteristic
- meet the needs of people with protected characteristics
- encourage people with protected characteristics to participate in public life and other activities[4]

[3] https://www.centreforsocialjustice.org.uk/newsroom/why-are-men-often-overlooked-as-victims-of-domestic-abuse (Accessed August 2022)

[4] Source: https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/ (Accessed August 2022)

Following an assessment at the Panacea Healthcare centre in February 2020 Alfred was found to have “mild memory and mild limb incoordination problems”[5]. Following the assessment, Alfred was described as being able to live a fully independent life.

11.5 The third protected characteristic requiring consideration, is that of age. There have been a number of reports describing the systematic invisibility of the elderly in relation to Domestic Abuse. [6] The chair also notes that the British Crime Survey in relation to Domestic abuse had until 2017 only included those aged 16 to 59, but now includes those aged 60 to 74.

11.6 These issues are discussed later in this report.

12 Dissemination

12.1 Once finalised by the Review panel the Executive Summary and Overview Report was presented to the following SSP panel members for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

12.2 The recommendations will be owned by Safer Somerset Partnership, who be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of both reports

Agency
All panel members
Safer Somerset Partnership
Somerset Safeguarding Adult Board
Somerset Domestic Abuse Board
Avon and Somerset Police & Crime Commissioner

12.4 The report will be published online at https://somersetdomesticabuse.org.uk/ (the local Somerset domestic abuse website).

---

[5] CCG IMR

[6] Source: https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf (Accessed August 2022))

13 Background Information (The Facts)

13.1 As mentioned previously Alfred and Joan lived in Somerset. They had been together for 24 years. Joan has two siblings, both brothers. The couple lived nearby to Joan's brother who she regularly visited and provided care and support for.

Events leading to the initiation of this review

13.2 3 days prior to Alfred's death Joan had called the police and alleged that she had been the victim of domestic abuse. Officers went to the address and spoke to the couple, and it was while they were there that both Alfred and Joan spoke to Mental Health services on the phone. It appeared, to the police officers, that Joan was in the midst of having a mental health crisis and Alfred may be suicidal. During the call Alfred was able to rationalise his suicidal thoughts and no longer wished to take his own life. The opinion of the police officers regarding Joan's state of mind is supported by the content of paragraph 14.5.10 which details a call which Joan made prior to contact with the police. This report followed a number of preceding reports of domestic abuse by Alfred and Joan, alongside a number of social care and mental health contacts.

13.3 Three days later Alfred left the address and the following morning his body was found floating in the docks.

13.4 Details of the inquest and police investigation are recorded in Section 10.

14 Combined Narrative Chronology

14.1 The following section summarises contact between Alfred and Joan with agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the primary source of information.

Organisation	Role	Pre-Face
Avon and Somerset Constabulary	Police	Police
Somerset NHS Foundation Trust	NHS Foundation Trust consisting of acute and community hospitals, community nursing and mental health services	SomFT
Somerset County Council Safeguarding Adult Team	Adult Social Care, Alfred & Joan	ASC
NHS Somerset Integrated Care Board	Representing Alfred's Primary Care GP	GP1

NHS Somerset Integrated Care Board	Representing Joan's Primary Care GP	GP2
Sedgemoor District Council, Together Team	Multi Agency Problem solving forum	TT
South Western Ambulance Service Trust (SWAST)	Ambulance Service	SWAST

14.2 Matters occurring prior to the review period.

14.2.1 SomFT **-** Between June and September 2004 SomFT records show that Alfred reported 5 incidents where he was assaulted by Joan. During a 3-week period in March and April 2005 Joan's brother contacted the SomFT on 3 occasions to raise concern that Joan would 'do harm' to Alfred.

14.3 June 2020

14.3.1 GP1 – On the **27th of June** Joan called the surgery as Alfred had fallen, in the bathroom, 3 days earlier. He had grazed his back and Joan informed the surgery that Alfred was in agony. A pathway assessment was completed, and Alfred was asked an extensive series of questions including details of

- His current physical well-being
- Whether his condition had deteriorated
- Whether the injuries had occurred as the result of an assault, suicide attempt or self-harm
- Whether he had been hit with any heavy or fast-moving objects

14.3.2 Alfred was advised to take pain relief, call back if things got worse or 999 if he needed urgent or emergency help.

14.4 March 2021

14.4.1 SomFT – On the **5th of March** Alfred contacted the mental health team stating that "he can't cope anymore; something needs to be done" He was concerned about a possible decline in Joan's mental health and asked whether she needed an inpatient admission. There were further calls from family members expressing concerns for Alfred's safety and he was in a desperate state. The agency IMR reflects the families concerns that "something bad might happen soon". The mental health team provided reassurance to Alfred, Joan, and the family.

14.4.2 Police – On the **5th of March** a 999 call was received, with a female heard screaming 'get off me' and a male heard in the background. The call was traced to Alfred & Joan's address. Joan had been upset about not being given a prescription and had started

throwing things on the floor and removing photos. Alfred tried to calm Joan down and tapped her on the head to stop her, at which point she called the police. Officers spoke to both parties (separately) and one officer escorted Alfred to collect Joan's prescription. A DASH[7] was completed in respect of Joan and rated as standard. Officers agreed with Alfred that he would contact his GP about accessing mental health support. There were no injuries and Joan didn't wish to make a complaint. The case was filed, with no criminal prosecution being pursued. The matter was referred to the local Lighthouse Safeguarding Unit (LSU) and considered by the Domestic Abuse Triage (DAT)[8] process where a decision was made that it didn't fall within the remit of Adult Social Care, no onward referrals were made. The LSU contacted Joan after the incident to offer victim support, but this was declined, as was the offer to refer to Domestic Abuse support services. She reported that she and Alfred were now friends again, that there had been no further incidents and that the issue with her medication had been sorted.

14.4.3 SomFT – On the **8th of March 2021** during a visit by the Som FT Home Treatment Team (HTT)[9] they discussed current stress related issues and a recent 'rocky patch'. Alfred described Joan as being argumentative and moody. There was concern, in the family, that Alfred may not have sufficient support.

14.4.4 SomFT – On the **12th of March** Alfred and Joan were visited, at home, by the Community Mental Health Team (CMHT) as part of ongoing support for Joan's mental ill health. Alfred was anxious that Joan should be admitted to hospital and the practitioner explained the reasons why this wasn't appropriate and reiterated the need for Joan to take her medication.

14.4.5 SomFT – On the **15th of March** there was a consultation, by the HTT, with Alfred and Joan for the purpose of an assessment of Joan's mental health.

14.4.6 SomFT – On the **21st of March** Alfred contacted the CMHT regarding concerns he had about her current mental health. Alfred was given reassurance and an offer to provide a subsequent follow up call.

14.4.7 Police – On the **23rd of March** there was a 999 call from Alfred to report that Joan had assaulted him whilst he was asleep. Joan admitted to slapping him because he was snoring, saying that he used to do the same to her when she snored. Alfred felt the behaviour changes were due to changes in her medication. He did not want to take

---

[7] https://www.dashriskchecklist.co.uk/

[8] It is worthy of note that DAT was trialled as a multi-agency discussion and decision process, that encountered issues with robust implementation and workforce capacity so ceased.

[9] https://www.somersetft.nhs.uk/home-treatment-team/

any action regarding the assault and the case was closed. Officers spoke to both parties (separately) and a DASH was completed with Alfred and graded as medium risk, noting that both parties are dependent on each other financially and emotionally and that Joan has mental health issues. Officers gave Alfred the contact number for the local CMHT[10] and advised him to call them in the morning about Joan 's mental health. The incident was reviewed at DAT and allocated for contact by a Victim and Witness Care Officer (VWCO), who reviewed the case and made a safeguarding referral to Adult Social Care.

14.4.8 SomFT – On the **24th of March** a call was made to Alfred, by the HTT, to discuss the events of the previous evening. He told the mental health worker that he had been woken, in the night to find Joan's hands around his neck and that there had been no warning prior to her assault. Alfred said he felt very unsettled, due to the extensive damage to items in the house. The practitioner spoke with Joan who reported having little recollection of the event. Alfred and Joan stated that she was calmer today and both were reminded of the safety plan and emergency telephone contact details that were available. The practitioner agreed to reassess their position and offered on-going support.

14.4.9 SomFT – On the **30th of March** the mental health team received a call from Alfred during which he told them he was 'fearful for his life' and that Joan's behaviour was becoming more labile (giggling one minute and packing to leave him the next). Staff spoke with Joan who stated that the medication had 'messed her up' and there were other family stressors that were also affecting her. Alfred was advised to call the police if he continued to fear for his safety. A second call was made to Alfred and Joan later in the day and further support was offered.

14.5 April 2021

14.5.1 Police and ASC - On the **1st of April** a 999 call was received from Alfred reporting that Joan had assaulted him that he didn't feel safe. He also disclosed that she had tried to strangle him the previous night. Joan was arrested, but later released without charge. A DASH was completed with Alfred and rated medium, noting the escalation of behaviour. Alfred told officers just wanted Joan to get the help she needed. A Domestic Violence Protection Notice[11] (DVPN) was considered and discussed but

---

https://choices.somerset.gov.uk/025/send/adult-community-mental-health-teams-bridgwater/

[11] DVPN Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) are vital tools which can be used to impose a range of conditions such as barring the suspect from attending the family home or having contact with the victim. These are used where a charge has not been possible but where the victim still requires protection from the suspect. Under section 24-33 of the Crime and Security Act, Police can issue a DVPN which lasts 48 hours, during which time the

refused on the basis that Alfred was the main carer for Joan who depended on him. Joan was seen by a Health Care Professional (HCP) from the Advice, Support, Custody & Courts Service (ASCC)[12] whilst in custody. The ASCC liaised with the HTT who reported that Joan was Alfred's main carer. They did not feel that a MH assessment or hospital admission for Joan would be helpful. Joan was taken home by officers who completed a BRAG[13] risk assessment, with details of the vulnerabilities of both Joan and Alfred and rated the risk as amber-red. DAT reviewed the incident and made a referral to Adult Social Care; however, the referral was not accepted for a S42 enquiry[14]. A review of the situation was emailed to LSU by the Adult Social Care Practitioner, suggesting that a S9[15] Care Act Needs Assessment would be more appropriate. It was acknowledged that Alfred had said he was not coping and that he asked for Joan to be admitted to hospital which was considered to be a 'Nearest Relative's request' under S13 of the MHA[16]. The VWCO assessed the situation noting that details had been provided to Alfred of the Domestic Advice Support helpline and the Men's Advice Line and Enquiries (MALE).

14.5.2 The email that was sent by the LSU but did not enter the safeguarding triage process until the **6th of April**, due to the bank holiday period. There is no record from the out of hours service as to the advice they gave during the call on the **1st of April** and there is very limited information regarding the incident. On the **6th of April** the safeguarding triage team made attempts to contact the police, regarding the call made earlier in the

---

notice will be progressed at a court hearing, which if successful changes the notice to an order, which can last for between 14 and 28 days.

[12] ASCC is specialist team providing assessment and advice for people in police custody or appearing in the criminal courts where there are concerns or issues around mental health. This service is provided by SomFT.

[13] BRAG Tool – A tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies. It should be used alongside other N.B. Assessment tools (such as the DASH), and its use is subject to continual compliance monitoring via the Qliksense App.

[14] https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

[15] Assessment of an adult's needs for care and support. 90. This section requires a local authority to carry out an assessment, which is referred to as a "needs assessment", where it appears that an adult may have needs for care and support.

[16] *It shall be the duty of a local social services authority, if so, required by the nearest relative of a patient residing in their area, to make arrangements … for an approved mental health professional to consider the patient's case with a view to making an application for his admission to hospital; and if in any such case that professional decides not to make an application he shall inform the nearest relative of his reasons in writing.*

day (the day of Joan's arrest) to gather further information, these efforts were unsuccessful. Due to the limited information provided and following background checks on the ASC internal records, there was no other information to inform the decision-making process. The referral was not accepted as meeting the Care Act criteria for a Section 42 enquiry.

On the same day (06/04/21) a second police report was received, relating to the incident on the 23rd of March. *This second report was not viewed until the following day (7th of April). On the 7th of April a third referral was received (see 14.9.8). The Safeguarding service triaged these reports jointly and it was decided that the most proportionate response was for Joan and Alfred to be offered a S9 Care Needs Assessment from the Mental Health Social Care team to look at what care and support needs they had and how these could be supported.*

14.5.3 SomFT – On the **1st of April** Alfred contacted the mental health team to inform them that he had being assaulted by Joan and as a consequence she had been arrested. The mental health team also spoke to Joan regarding her scheduled appointment.

14.5.4 SomFT – On the **2nd of April** HTT contact with both Joan and Alfred. Joan declined to be seen on her own. Alfred made the HTT aware that he felt like he needed a break from caring for Joan. A risk assessment at this visit identified Joan as no risk to self and low risk to others.

14.5.6 SomFT – On the **4th of April and 5th of April** there were calls to the CMHT from Alfred expressing concern for Joan's mental health, querying whether she required inpatient admission. Joan also spoken to on 5th April, at which time both Alfred and Joan appeared to be calmer, and no further action was taken other than the couple agreeing to visit the GP surgery to collect Joan's medication.

14.5.7 ASC – On the **7th of April** there was a second referral from the police regarding Joan's arrest, on the **1st**.

14.5.8 Police – On the **8th of April** a 999 call from Alfred reporting that Joan had gone into his room, pulled his bedclothes off and thrown his things around. He thought she hadn't been taking her medication. There was no report of an assault. The incident was classified, as a Safeguarding Adult Report and then closed. A BRAG was completed for Alfred and Joan and rated as Amber. The incident was brought to the attention of the local Neighbourhood Policing Team (NPT) who approached the chair of the local Together Team to see whether all appropriate support was being provided. The case was discussed at the subsequent Together Team meeting, and it was decided that all

appropriate agencies were already involved[17]. The LSU reviewed the incident but did not make a new referral to Adult Social Care as Joan was going to be offered a S9 assessment after the social care referral a few days earlier.

14.5.9 ASC – On the **12th of April** an email was received from the LSU confirming that following the safeguarding decision – on the **8th of April** -the case would be closed.

14.5.10 SomFT – On the **23rd of April** the mental health team received a call from Joan's brother who sounded angry, reporting that Joan was mentally ill and needed to be in hospital or someone was going to be seriously hurt. He told staff that Alfred had threatened suicide due to Joan's mental health issues. The practitioner called Alfred and Joan to assess the reported risk, Joan was upset that her brother had become involved. Alfred told the practitioner that he felt emotional and exhausted but had no intention of taking his own life. There was a conversation, with Alfred, about ways of remaining calm during emotional outbursts and challenging behaviour before the call ended.

14.5.11 Police – On the **23rd of April a** 999 call from Mindline (A local confidential telephone service for those requiring emotional support)[18] who reported having had a call from Joan and Alfred. Joan appeared to be having an episode of mental ill health, was accusing Alfred of domestic abuse and he was threatening to kill himself by jumping into the dock. Alfred subsequently disclosed that Joan had tried to strangle him but provided no further details. Call handler called an ambulance for Alfred and police officers were also dispatched. Alfred repeated to officers that he'd considered jumping in the docks and broke down in tears whilst the police officers were there. The ambulance service called Alfred whilst officers were there, and officers ensured that he took the call in a separate room away from Joan. He was overheard telling the ambulance service that Joan had attempted to strangle him 3 weeks ago. He wouldn't disclose further information to officers when asked. BWV [19] showed the officer speaking directly to the ambulance service to support their risk assessment and decision making. Joan and Alfred were signposted to the Mental Health HTT. A BRAG was completed and rated amber, and a DASH was completed for Alfred and also rated amber, noting the escalating behaviour due to mental health issues. Officers ensured Alfred had details of the MH team before leaving. The case was filed, and no further

---

[17] Details of the Purpose, Aims and Responsibilities have been provided to the chair and are contained in Appendix 9

[18] https://www.mindinsomerset.org.uk/our-services/adult-one-to-one-support/mindline/#:~:text=Mindline%20is%20a%20confidential%20listening,you%20know%2C%20is%20in%20distress

[19] Body Worn Video cameras worn by police officers.

action was taken. This incident was classified as a Domestic Incident and in line with Home Office Counting Rules, an additional record was raised for the allegation of strangulation.

14.5.12 SWAST – on the **23rd of April** an ambulance attended the home address of Alfred and Joan, along with the police. Alfred was having a mental health crisis and threatening suicide, and Joan was accusing him of 'domestic abuse'. A safeguarding referral was sent to ASC and the GP surgery.

14.5.13 GP1 – On the **23rd of April** the GP Practice received an ambulance safeguarding report regarding Alfred stating that he had been to the docks as he had been struggling with his wife's behaviour and wanted to end his life. He did not go through with his attempt as there were other members of the public present. Alfred had gone home and although he was feeling a bit better, he was concerned that when he was alone at night, he might feel like this again. He disclosed that his wife who suffered with acute mental illness and had recently changed her medication, as a result her behaviour had been more difficult for him to deal with. He also reported feeling depressed. He stated that his wife had put her hands around his throat and had harmed him in the past. It is noted that the ambulance crew report contained welfare concerns i.e., both were struggling to cope, feeling depressed and suicidal.

14.5.14 Police – On the **24th of April** the LSU reviewed the incident and made a new referral to Adult Social Care.

14.6 The day of Alfred's death

14.6.1 SomFT – The HTT received call from Joan stating she is worried about her husband who had left the property at midnight after they had a disagreement. Joan was offered reassurance and advised to call the Police if she remains concerned for Alfred's wellbeing.

14.6.2 ASC – A police report was received, regarding an incident of domestic abuse involving Alfred and Joan which occurred on 23rd of April. There were concerns that Joan was having a mental health crisis and Alfred had expressed thoughts of ending his own life. Alfred had shared with the police that being Joan's full-time carer was putting strain on their relationship as her condition worsened and this has made him have suicidal thoughts. This referral was assessed, by Somerset County Council contact centre, and having viewed the case notes and previous safeguarding pathway a decision (which outlined the need for a S9 assessment of need) was sent to the Mental Health Social Care Team. The SCC Mental Health Social Care case noted that this was to be discussed at the referrals meeting on the 27th of April

14.6.3 Police – There was report of a body being found in the docks nearby to the couple's home. This was subsequently identified as being likely to be Alfred, who had been

reported by Joan as missing that morning after going out the previous night. The investigation concluded there were no suspicious circumstances, and the case was filed, no further action.

15. Overview

This section summarises what information was known to each agency, and the professionals involved, about Alfred Joan and relevant family members, within the review period. The overview from each agency is drawn from the IMR documents, details provided from various panel meeting and single agency meetings between the chair and the panel representative.

15.1 Avon and Somerset Police

15.1.1 During the preparation of the IMR the independent author has researched and analysed internal documents including local and national policy databases as well as investigation logs, videos, intelligence records and other internal documents and consulted with subject matter experts.

15.1.2 Between April 2018 and April 2021, the police were involved in 6 specific incidents, including the day of Alfred's death. The involvement of the police during each of these incidents was not restricted to a single initial contact but included subsequent visits and calls as part of the on-going support being provided to both parties.

15.1.2 It should be noted that all these contacts occurred within a 7-week period prior to Alfred's death and that prior to this period there had been no documented police contact for many years.

15.1.4 Each of the previous five incidents were reported following actions by Joan and on one occasion resulted in her arrest. Each contact resulted in referrals to the LSU for further assessment and onward information sharing. On each occasion police involvement was as the result of a 999-phone call. Officers managed each situation and the risks presented 'live' however on several occasions subsequent follow-up support was not provided.

15.1.5 Engagement with other agencies were generally carried out via the LSU although it should be pointed out on several occasions officers took direct action to support Alfred and Joan by liaising directly with other professionals to manage the risks that were presented or perceived.

15.2 Integrated Care Board on behalf of Primary Care

15.2.1 Alfred and Joan were registered as patients at a local GP surgery. They had been patients there for many years, Alfred had been registered since October 1998. Within the review period they had 4 engagements with the couple. None of these involvements were interpreted as involving matters of domestic abuse.

15.2.2 In February 2020 Alfred was assessed at a local Rehabilitation Unit in Taunton and was found to have "mild memory and mild limb incoordination problems, however, was able to live a fully independent life".

15.2.3 Alfred had limited contact with the surgery. He had several musculoskeletal problems over the years including a closed reduction of a dislocation of his shoulder in 2005 and knee problems following a fall in around 2012, which resulted in some arthritis and subsequent knee pain.

15.2.4 Alfred's last 2 consultations at the surgery were in August 2018, again for knee pain which was treated with analgesia and physiotherapy.

15.2.5 The only medication that Alfred was prescribed was Paracetamol, the last prescription for this was on the 30th of December 2020 for 224 tablets[20]. He also attended for his first Coronavirus vaccination on 8th of February 2021.

15.2.6 At no point is there any GP record of Alfred having mental ill health issues and no attempt of self-harm.

15.3 Adult Social Care

15.3.1 Somerset County Council Adult Social Care has reviewed all contacts with Alfred and records checked for Joan. Research has been conducted using the Adult Social Care Recording Database called AIS and involved a desktop review of the database and information recorded on the Adult Social Care records. No interviews were conducted with those directly involved with either the deceased or Joan.

15.3.2 ASC had a total of 4 contacts relating to Alfred during the review period. They all occurred between the 1st of April 2021 and the day of Alfred's death. Similarly, ASC had 4 contacts with Joan, and these were between the 17th of March 2021 and the day of Alfred's death. There are no records for either party prior to these dates.

15.3.3 Each of the contacts regarding Alfred came via referrals from the police. Two related to the arrest of Joan in early April 2021, and a third regarding an incident to which officers were called on the 23rd of March 2021. These referrals were triaged by the safeguarding team and consideration given to dealing with these matters under Sec 42 of the Care Act. However, it was viewed that the most proportionate response was a section 9 assessment of needs. This assessment process was to be coordinated by the Mental Health Social Care Team. (MHSCT)

15.3.4 The final referral came the day before Alfred's death. This was assessed by the SCC contact centre[21] and details passed to the SCC Mental Health Social Care Team MHSCT who were already preparing to respond to the Section 9 Social Care assessment following the referral which had been made on 17th March 2021. The MHSCT case notes reflect that this incident was due to be discussed at their referrals meeting the following day.

---

[20] This volume of paracetamol was challenged, by the review, but reassurance was provided by the ICB Medicines Management professional, that this was proportionate for longer term conditions and within the scope of what can reasonably be prescribed by the GP

[21] https://www.somerset.gov.uk/social-care-and-health/

15.4 Somerset NHS Foundation Trust – Som FT

15.4.1 Som FT reviewed all contacts with Alfred and Joan. Research has been conducted of internal electronic patient record systems.

15.4.2 Alfred had no active referral, throughout the scope of this review, to any individual team or allocated health professional other than his GP.

15.4.3 Joan has suffered with mental ill health for a number of years for which she received support and treatment via the CMHS. During the period of review, thirty-five (35) contacts were made for Joan and Alfred either separately or together.

15.4.4 Between the period of February and April 2021 there were 13 contacts involving the Trusts Mental Health Home Treatment Team with Alfred, Joan, and Joan's brother.

15.4.5 In February 2021 Alfred contacted the CMHS and left messages regarding his concern over Joan's failing mental health. During this time support and visits were undertaken by the Home Treatment Team at their home.

15.4.6 In March 2021 the CMHS and HTT responded to telephone calls from Alfred, Joan, and family members regarding concerns about a possible decline in Joan's mental health. Concerns were expressed by Alfred and family members about the impact on Alfred of Joan's mental illness.

15.4.7 During Alfred's calls to the CMHS he expressed needing a break from his caring role and questioned whether Joan should be admitted to a psychiatric inpatient unit. He reported feeling unsafe at times as a result of her behaviours. Alfred was offered reassurance during these calls and was advised to contact the Police if he felt at immediate risk at any point. During these periods the HTT and CMHS maintained contact with Joan in line with her treatment plan.

15.4.8 Contact between Alfred, Joan and Joan's family continued in April 2021 (as recorded in 14.9.4 – 14.9.5). Joan continued to be supported by the CMHS/HTT during this time as per her care plan. Providing support for Joan, at home was the least restrictive option regarding her care and support needs as it enabled Joan to receive care and negate the need for detention under the Mental Health Act (1983), thus depriving her of her liberty. There was also regular contact with Joan's GP during this period.

15.4.9 Three days before Alfred's death Joan's brother contacted the Mental Health Team. He told the practitioner that Alfred was feeling suicidal due to Joan's mental health issues. The Mental Health Team contacted Alfred and Joan and she was annoyed that her brother had called the Mental Health Team. Alfred stated that he was emotional and exhausted but had no intention of taking his own life.

15.4.10 On the day of Alfred's death Joan contacted the Mental Health Team concerned that he had left the property following an argument. Joan was offered reassurance and advised to call the police if she felt it was necessary.

16. Analysis

The Terms of Reference identifies key lines of enquiry which include:

- Family stressors and carer support.
- Responding to crisis.
- Link between Domestic Abuse and suicide.
- The Sharing of information.
- Management Oversight.
- Male victims of Domestic Abuse.
- Making Safeguarding Personal (MSP).

The facts leading to the death of Alfred have been documented in the combined chronology and overview sections of this report. This section examines how and why events happened, what information was shared, the decisions that were made and what actions were taken, or not. In considering these points it is accepted that none are mutually exclusive, but that incidents and issues identified under each of these headings could be used as opportunities to improve as well as recognising good practice.

16.1 Hindsight Bias

16.1.1 *As the report author I have attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias' and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.*

16.2 Domestic Abuse

16.2.1 Alfred died as the result of drowning. The exact reason for Alfred taking this action is not known with any certainty.

16.2.2 Considering the definition of domestic abuse (See 5.1 above) the review has considered the details provided during the collation of the various Individual Management Reviews and chronologies, as well as the interviews with Joan. The incidents that were reported to the police give a clear indication of the issues between Joan and Alfred, and suggest that Joan's mental ill health was a factor in her behaviour towards Alfred. The chair's contact and meetings with Joan left him with the feeling that she may not have been aware of her behaviour and its consequences. The issue of Male Victims of Domestic Abuse are discussed later in this report.

16.2.3 Tragically it has not been possible to build a picture from Alfred's perspective. The review has had to rely on anecdotal reports collated by involved agencies. Based upon these accounts, Alfred appears to have faced regular challenges regarding Joan's mental ill health and he was clearly concerned and anxious that her condition was deteriorating and made several requests for support from a variety of agencies

including the Somerset NHS Foundation Trust, and the police. As it is noted in the chronology that Alfred made several requests for Joan to be admitted into hospital in order that her conditions could be treated and so that he could have some respite. The issues of Family stressors and Carer support and Responding to Crisis is discussed later in this report.

16.2.4 On more than one occasion both Alfred and Joan contacted agencies and disclosed feelings of suicide. This apparent cry for help was something which was raised, not just with agencies, but within the family as Joan's brother also called SomFT for help. These appeals for support give a clear indication of the problems Alfred and Joan were experiencing and were a clear indication of stressors within their relationship. Prior to Alfred's death the police received a referral from 'Mindline' and the subject was further discussed when Alfred visited his GP. Alfred and Joan were both provided with advice and avenues of support. The subjects of 'Links between relationship tension and suicide' and the 'Sharing of Information' are also discussed later in the report.

16.2.5 Engagement between the couple and panel agencies followed the couple expressing their concerns. Issues were dealt with by agencies providing advice to manage the immediate risks and on occasion referrals were made through internal processes including the Lighthouse Safeguarding Unit and Domestic Abuse Triage process. Details of the issues raised here are discussed in the section 'Responding to Crisis' and 'Making Safeguarding Personal'.

16.2.6 Analysis by the chair of the 7 weeks prior to the death of Alfred shows that there were 32 contacts with panel agencies. The lead responsibility for Joan's care needs sat with SomFT and consideration has been given as to whether support workers could they have done more It was discussed whether, if the SFT staff had spoken to their safeguarding service, could there have been a different response at an earlier opportunity. There is further discussion on Management Oversight below.

16.3 Family stressors and carer support

16.3.1 The review panel considered the stress related factors affecting Alfred, Joan, and other family members. The process of reviewing individual agency engagement quickly identified that there had been challenging periods throughout Alfred and Joan's marriage and that these had been documented for many years outside the scope of this review.

16.3.2 There are two apparent stressors were Joan's diagnosed acute mental health needs that impacted upon the lives of everyone and seems to have been the cause of some domestic incidents. Those making calls to various agencies (including the Police, SomFT and Community Mental Health Team) were clear that they believed Joan to need help and they expressed their belief as to the consequences of not receiving support. Along with the need for Joan to receive an enhanced level of support, Joan's brother also expressed their belief that Alfred needed a break. On each of these occasions support and advice was provided to deal with the immediate, perceived crisis. Following this support Alfred made further calls, outlining his fears and concerns, and giving a clear indication of the stress he felt he was under, and these provided opportunities for agencies to consider his situation and whether a multi-agency approach to supporting him could be used. There is further evidence here of

the opportunity to use a more personal approach to Alfred's safety and this is discussed further in Section 16.10

16.3.3 Following Joan's arrest there was an assessment by the ASCC Health Care Professional, who spoke with the Home Treatment Team. They reported that Joan was a carer for Alfred following his head injury many years ago, and that a mental health assessment and hospital admission would not be helpful. The details provided to this review suggest that the function of carer had transferred from Joan to Alfred. During the chair's interview with Joan, she commented that she was responsible for her brother, who lived upstairs. It does suggest that Joan's position would have benefitted from a review, and consideration as to whether she was able fulfill the function of carer.

16.3.4 According to NHS England "A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support".[22] Som FT have a carers service[23] aimed at supporting those in a carer's role. Upon application to become a carer an initial assessment takes place with the option for further sessions. The range of services available to carers is recorded in Appendix 8.

Learning Point 1: The issue here relates to the of the role of the carer and the need to recognise when their circumstances change and the level and nature of the support they need similarly alters. **Recommendation 1:** SSP to gain assurance that health agencies have robust systems in place to identify / record known carers, and have pathways in place to ensure timely referral for carers assessment and support with recognition that when circumstances change re-referrals and/or reassessment may be required.

16.3.5 What is apparent is that the relationship between Alfred and Joan was under great strain Alfred was clear about his need, and he was offered the opportunity to have a carer's assessment in February 2021, which he declined.

16.3.6 Following Joan's release from police custody the Som FT had several calls and face to face meetings with the couple. Alfred continued to voice his need to have a break and told the mental health team that he'd had enough. At the same time there was a call from Joan's brother raising concerns about Alfred's safety.

16.3.7 The chair has raised the subject of professional curiosity and discussed with the panel, whether there is a learning opportunity and recommendation to be made on the subject. The review has been reassured that learning has been drawn from previous Domestic Homicide Reviews and that the SSAB has produced various briefing videos and training to uplift the knowledge of all those within the safeguarding community.

[22] https://www.england.nhs.uk/commissioning/comm-carers/carers/

[23] https://www.somersetft.nhs.uk/carers-service-and-triangle-of-care/

16.3.8 On the 1st of April the couple were visited by staff from HTT and Alfred told them that he didn't feel safe at home. The following day he called Som FT and told them that Joan wasn't well and that he was exhausted. Alfred was offered reassurance, but an assessment of risk appears not to have been carried out by Som FT. Whilst the Police engagement routinely included the completion of DASH and BRAG risk assessments, and referrals to the LSU the underlying issues were not deemed to be police issues.

16.3.9 The 'Safer Somerset Domestic Abuse Newsletter'[24] raises the issue of risk assessing and encourages staff to complete DASH Risk Indicator Checklists and Referrals. It seems reasonable that this review recommends that Safer Somerset Partnership analysis's the quantity and quality of risk assessments that are carried out when engaging with families where there is a history of domestic abuse.

16.3.10 The panel considered the subject of assessing risk and the need to consider various protected characteristics, relevant to this review, i.e., age, sex, and disability. The DASH checklist[25] remains the most common method with regards to domestic abuse and acts as an aide memoire and useful checklist for practitioners to use. However, it is important that the 9 protected characteristics as defined by the Equality Act 2010 are recognised as an additional factor whilst assessing risk. Therefore, there is a need for practitioners completing risk assessments to do so to a high standard and with appropriate vigour. This process should be supported by a suitable Quality Assurance process to ensure these levels are being reached.

Learning Point 2 – All agencies within this review should ensure that they have a Quality Assurance process that ensures that their Domestic Abuse risk assessment processes also acknowledge the 9 protected characteristics. **Recommendation 2** – SSP to ensure that the DA assessments they promote across the health and social care system include questions relating to the 9 protected characteristics.

16.4 Responding to crisis.

16.4.1 Following on from the previous section, the panel has considered the issue of how agencies responded to the crisis which was developing in the family home of Alfred and Joan. It has considered how frontline practitioners reacted to initial reports and what subsequent activity took place.

16.4.2 What is clear from the information provided to this review is that Alfred and Joan's brother perceived the couple's relationship was under significant strain and that they needed help. This is demonstrated by the frequency and veracity of the incidents. It is acknowledged by all the panel agencies that there were safeguarding concerns, and that immediate support was provided at the point of each contact.

---

[24] https://somersetcc.sharepoint.com/sites/SCCPublic/Community/Forms/AllItems.aspx?id=%2Fsites%2FSCCPublic%2FCommunity%2FDomestic%20%2EAbuse%20Newsletter%20Spring%20Edition%20April%202021%2Epdf&parent=%2Fsites%2FSCCPublic%2FCommunity&p=true&ga=1

[25] https://www.dashriskchecklist.co.uk/wp-content/uploads/2021/12/DASH-2009.pdf

16.4.3 It is important to be clear what adult safeguarding means. The NICE guidelines on domestic violence and abuse defines this as

- "Working with adults with care and support needs to keep them safe from abuse or neglect. It is an important part of what many public services do, and a key responsibility of local authorities. Safeguarding is aimed at people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect. In these cases, local services must work together to recognise, respond, and report abusive situations, those at risk and take steps to protect them".

16.4.4 There is further guidance regarding the symptoms and triggers of possible domestic abuse and violence in a relationship. These include:

1. symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
2. suicidal tendencies or self-harming

16.4.5 The panel was satisfied that frontline practitioners were caring and professional when dealing with calls and reports from Alfred and Joan. They were able to make immediate referrals to support teams and sought to reassure and calm situations presented to them.

16.4.6 Equally, it is important to reflect upon what opportunities there were to expand upon this initial engagement and consider a broader plan to manage the issues faced by the couple and their family. The chronology presents several examples of incidents that could have triggered additional referrals and the preparation and execution of longer-term safeguarding strategies. The Care Act is clear about how best to support people and prevent situations from escalating to the point where a safeguarding response is necessary.

16.4.7 The panel has considered the issue of the delay following four police referrals to Adult Social Care and planned meeting to discuss the allocation of Joan for section 9 assessment. The chair has considered whether a recommendation is needed to be made with regards to such delays and the need for ASC to review its policies and processes. However, this incident has been reviewed by the service manager of the responsible team. It appears that in the case of Alfred the issues arose due to individual performance and have been addressed by way of internal processes and training.

16.4.8 Additionally the service manager has reviewed, fully, the process from receiving a new referral to the allocation of this work in the team. In the situation of Alfred and Joan further dialogue had occurred between SCC and Som FT to gather more information to support the prioritisation of allocation. This information was omitted from the records but held within the team. The service manager has put in place processes to stop this from happening again.

16.4.9 At the end of March (see 14.8.9) Alfred called SomFT stating that he feared for his life. Staff spoke to Joan, and she raised concerns regarding other family stressors. Alfred was advised to call the police if he was at immediate risk of harm. Details of the SomFT Mission and Values statement are recorded in Appendix 5 and the review recognises that during each engagement mental health staff worked towards supporting Joan's

care and support plan. As mentioned previously, Alfred was offered a carers assessment but declined.

16.4.10 The chair raised the question as to whether more could be done to support staff dealing with similar cases and has been reassured that their training includes the understanding and benefits of assessing risk and the available options when presented with calls from people who fear for their life. Additionally mental health call handlers have access to immediate managerial support.

16.4.13 The panel has formed the view that Joan was more 'cared for than carer'. As Alfred had declined the offer of a Carers Assessment, his needs as a carer had been recognised, but these were not clearly understood. However, it has also been recognised that there is learning for SomFT in ensuring that this offer remained open, and that Alfred be reminded of this whenever appropriate. This learning should be embraced as part of Recommendation 1 above.

16.4.14 Following Joan's release, from police custody, it was decided that the most proportionate response was for Alfred and Joan to have an assessment of needs under Section 9 Care Needs Assessment. It was also noted that Alfred had made requests for Joan to be admitted to hospital for assessment and treatment. The Triage Safeguarding Team commented that this was a 'Nearest and Dearest request[26] (See footnote). Considering the previous requests and appeals, made by Alfred, this seems to be a reasonable recommendation however it is pertinent to remember that Joan also has rights in relation to Human Rights Act, Mental Capacity Act, and the Mental Health Act. Any offer of respite for Joan would need to have been agreed to by her.

16.4.15 At the point of final submission, of this report, to the Community Safety Partnership, it was noted that the final agency contact was with the ASC on the Friday, prior to Alberts death two days later. The question was raised as to whether the response to the call may have been different had it occurred in midweek.

16.4.16 This was referred with the ASC panel member who had reviewed service delivery during this review process. Their feedback confirmed that the actions taken by the contact centre were appropriate, with relevant referrals being made to the Mental Health Social Care Team (these were in support of previously referrals to the same agency). The Out of Hours service, is extremely limited and would not have been affected as the received information had already been supplied via the ambulance service and could have been escalated for crisis intervention, by them, had their risk assessment indicated the need.

16.4.17 Additionally the information supplied to the ASC would not have changed their response as Alfred and Joan were awaiting a social care assessment, as well as being supported with matters of mental Health and safeguarding. This is view supported by the review chair and panel.

16.5 Links between relationship tensions and suicide

[26] https://themaskedamhp.blogspot.com/2015/11/sec-134-right-of-nearest-relative-to.html

16.5.1 The review recognises the several factors which made life very difficult for Alfred, the reports he had made to the panel agencies and his apparent frustration at the perceived lack of support he was receiving.

16.5.2 This section has been raised as the review feels it is important that agencies are able to recognise when individuals and circumstances are in crisis to the point where someone decides to take their own life. It is difficult not to use hindsight bias and make assumptions when reviewing the circumstances of Alfred's death. This section is intended to draw attention to potential prompts or moments in time when incidents occurred, or comments were made, that could if noted in future could trigger a need to discuss suicidal ideation with individuals. Also, for practitioners to consider opportunities and options to support those in a similar position to Alfred.

16.5.3 Somerset Council has guidance for frontline workers and volunteers about suicide prevention[27]. The guidance was produced in 2020 and provides advice to those engaging with service users who report or demonstrate symptoms of suicidal ideation. Among the various signs are 'Expressing feelings of hopelessness', and while the interpretation of Alfred's comments is always subjective it is important to be cautious when considering calls such as those made by Alfred and Joan's brother and recorded in the chronology of this report. The guidance suggests that if practitioners recognise signs of this ideation, they should feel confident to ask questions of the service user and explore whether they plan to harm themselves. The review believes that this guidance is an extremely valuable source of information, when dealing with various circumstances presented by this review. It's content (along with other related material) has been shared with relevant staff and form part of a training input, in the future.

16.6 The Sharing of information

16.6.1 This subject has been raised previously and it is something which the review feels is crucial in the successful identification and reduction of domestic abuse and in keeping people safe. Practitioners who encounter victims, perpetrators and their families often need to assess whether and how to share personal information regarding their clients with other professionals. Lawful and proportionate information sharing can be vital to help victims, carry out risk assessments, and help bring perpetrators to justice.

16.6.2 The chair has considered the use MARAC, as a potential route of sharing information between cases like this. The MARAC process is designed to provide a multi-agency response to domestic abuse cases considered to be High Risk. There are 3 basic principles which are used to interpret when an incident or set of circumstances should lead to a MARAC referral i.e.:

1. Visible High Risk - 14+ yes answers to the DASH checklist
2. Potential escalation of the risk being apparent during a series of reports or engagements.
3. Professional Judgement.

[27] https://www.google.com/search?client=safari&rls=en&q=suicide+prevention+in+somerset&ie=UTF-8&oe=UTF-8

16.6.3 The review period demonstrates that there were 5 police reports in the two months prior to Alfred's death and there is an argument to suggest that this volume of engagement could, in theory, have been sufficient to trigger a referral into MARAC. However, as the panel identified, the reporting of domestic abuse needs to be contextualised against the other issues, within the couple's relationship i.e., Joan's apparent deteriorating mental health, rather than a criminal intent to cause injury or damage property. Police records indicate that this was the case and that they made regular and relevant referrals and shared information to primary and secondary health care agencies. Avon and Somerset police did not feel it necessary to make any referrals to MARAC.

16.6.4 The review has also looked into the pathways available for police officers to pass relevant notifications to GP practices in order to ensure that information is shared quickly and securely. Such notifications are now sent, via email, to Som FT [28] who access the NHS 'Spine' system and allows operators to identify the correct GP Practice and ensure that information is then promptly sent to the relevant doctor's surgery. This is currently limited to notifications of high and medium scored domestic abuse related incidents that involve children. Information sharing relating to incidents only involving adults are yet to be addressed but is planned to take place as the next steps.

16.6.5 In terms of Som FT and the MARAC process, the IMR author recognises that there were opportunities for DASH risk assessments to be completed and for the matter be brought to the MARAC for coordinated support and safety planning. This issue has been raised as a point of learning, by SomFT and the lessons learned form part of their Safeguarding Adult Level 3 training programme. There is also an e-learning module specifically about Domestic Abuse and the Elderly, in addition to a 30-minute webinar about DASH (Domestic Abuse Stalking/Harassment and Honour based Violence) risk assessment which is available to all Som FT staff.

16.6.6 The review understands that SSP is currently revising its multi-agency information sharing agreement.

Learning Point 3: It's important that all agencies provide training which cover competencies and specifications relevant to the gathering and sharing of information. Therefore, it would be beneficial to know how improvements have been recognised.

Recommendation 3: SSP to ensure that:

- There is training carried out, in relation to the sharing of information, by all agencies involved in this review.
- That all agencies have processes in place for domestic abuse referral and/or DA Policies.

[28] https://www.england.nhs.uk/wp-content/uploads/2022/06/42-nhs-somerset-icb-constitution-010722.pdf

16.6.7 Paragraph 15.3.3 references a discussion regarding various Care Act opportunities including Sec 42 Safeguarding Enquires and Sec 9 Needs Assessments. The panel pointed out that as the action taken was in relation to Joan, an opportunity was missed to consider the issues that Alfred faced. This could have been considered in the completion of a section 42 adult safeguarding enquiry and may have identified the issues or risks that Alfred was facing and the support that a multi-agency response.

Good Practice:

The ASC's IMR contains details of an Action Plan that has been created and is detailed in the Recommendation Section it contains activity to reduce the likelihood of these types of missed opportunities from happening in the future.

16.6.8 The final agency to consider is the GP Surgery. The IMR from the ICB records that Alfred had 4 contacts with the surgery, and didn't mention having relationship problems, or there being any occurrences of domestic abuse, However, the IMR author does comment that, had they received a DASH assessment from the SWAST following their attendance to him 3 days prior to Alfred's death, then an urgent practical escalation of support could have been provided if he was believed to be suicidal.

16.7 Management Oversight

16.7.1 Throughout this report it has been acknowledged that there were excellent levels of real time support provided to Alfred and Joan. In particular, the rapid response and attendance by police officers and also the engagement by SomFT staff. However, it has also been noted that longer term strategy planning could have been better and there were several chances for multi-agency working. In this section the report will reflect upon the role of management oversight and whether agencies should ensure their staffing groups have supervision relevant to their roles.

16.7.2 The police IMR has considered the support provided to officers who engaged with the couple and their report confirms that management supervision is standard practice in all police investigations. The College of Policing provides guidance to those supervising investigations like those created following calls from Alfred See Appendix 6.

16.7.3 In terms of performance, there were two incidents where BRAG risk assessments were not completed by the police following calls to the couple's home. These omissions were not identified by supervisor review.

16.7.4 Separate to this review Avon and Somerset Police have looked at their own performance with regards to the use of the BRAG risk assessment process and as a result produced a series of recommendations i.e.

- Clearly set out which forms officers are expected to complete and why to enable better safeguarding of victims.
- Additional training should be given to staff in relation to the BRAG which should include:

- Why, when, and how to use the BRAG tool, including consequences of not.
- How to access guidance to support use of the BRAG tool.
- Pathways for onward referrals for vulnerable individuals and understanding who is responsible for what (including when officers should make referrals directly).

This review supports this position and makes no further commentary.

16.7.5 During Joan's period in police custody decisions were made regarding with regards the type of assessments that would best support the couple. Whilst the ASC safeguarding triage worker acknowledged Alfred's request that Joan should be admitted to hospital, and recognised that this could be achieved through a "Nearest Relative" application, they didn't communicate this to Alfred.

16.7.6 This is an important issue and one that requires careful consideration. This review has found no record of any supervision of the ASC frontline workers, and this is something that the review felt needed further investigation. Subsequent scrutiny of Adult Social Care processes in this area has confirmed that the supervision of ASC workforce is not recorded on individual records for people. Within the SCC Safeguarding triage team there is a registered professional who holds the decision-making responsibility. They provide supervisory support to unqualified triage practitioners who are carrying out the 'fact finding' work with regards to Sec 42 (1) of the Care Act. The information is presented to the registered professional, a decision is made, and the rationale is recorded. This is management oversight. All social care staff in the adult safeguarding service receive 1:1 supervision on a monthly basis and have sensor practitioners available on an ad hoc basis throughout the working day.

16.7.7 Som FT had multiple engagements with the couple and an equal number of reports were created. Joan received support from CMHS and HTT throughout the scope of this report. There are various pieces of commentary within the SomFT IMR that suggest there were multiple references regarding the issues faced by Alfred which could have prompted opportunities for discussions with senior colleagues. These include multiple references to opportunities for discussions with senior colleagues regarding the issues faced by Alfred.

16.7.8 For the purposes of clarity, discussions between colleagues and methods of supervision are distinct activities. All Mental Health staff have supervision (minimum 6 weekly) with their line managers and some MH teams have safeguarding supervision quarterly. In SomFT staff supervision isn't recorded in patient records.

16.8 Male Victims of Domestic Abuse

16.8.1 Sadly, it has not been possible to explore this with Alfred and it is not appropriate to make any assumption from his engagements with agencies or reports from family members.

16.8.2 The Office of National Statistics (ONS) report[29] that for the year ending 31st March 2019, 786,000 men were reportedly the victim of domestic abuse compared to 1,600,000 women. In 75% of domestic abuse -related crime recorded by the police (for the same period) the victims were women. Therefore, the assumption has been drawn that 1 in 3 victims were men.

16.8.3 In terms of male suicide, a summary report was published by the All-Party Parliamentary Group on Issues Affecting Men and Boys in September 2022[30] where evidence was taken from national and international experts on this area. The lead author was a panel member (Mark Brooks). Currently, just under 5,000 men take their own lives across the UK each year, 13 per day – 75% of all suicides. The report concluded that male suicide was primarily due to the impact of a range of external issues (often called 'stressors') on men that they felt they could not resolve, even though they had tried. These stressors mainly range from relationship breakdown (in a wide sense), employment, workplace culture, bereavement, and financial problems. Cross-cutting issues such as isolation add further risk. It is not possible to ascertain from Alfred the direct cause of his suicide, however the report may illuminate the broad background to some of Alfred's thought processes at the time.

16.8.4 The chair wishes to acknowledge the detail with which IMR authors have explored this subject and the way in which they have recognised areas for improvement. What is clear is that Alfred did not consider himself to be a victim of domestic abuse when reporting matters to the various agencies, and instead was more concerned in getting support to manage the issues presented by Joan. In reviewing the IMR's there is clear acknowledgment that more could have been done to support Alfred.

Learning Point 4: The review feels that there is an opportunity to enhance the support provided in this area and that men should be given greater encouragement to come forward when they feel they are the victims of domestic abuse and/or coercive control. **Recommendation 4:** SCC Public Health to review its activities and provide agency training aimed at better recognising male victims of domestic abuse. In addition, more support to be provided to encourage male victims of domestic abuse to come forward. Support services and advice lines should be advertised more widely.

16.8.5 It is possible that Alfred chose not to raise any of his issues due to feelings of loyalty towards Joan, particularly as they were an older couple who had been married for

---

[29] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

[30] https://equi-law.uk/inquiry-no-3-male-suicide/

many years. Equally he may have normalised any issues, particularly as they appear to have been going on for several years prior to his review period.

16.8.6 It appears that when considering Care Act assessments, Alfred's position as a victim wasn't the focus, instead it was upon the needs of Joan. Regarding the assessment process, in early April 2021 the IMR from ASC commented that "they have not, in this instance viewed him as a victim needing support from safeguarding" and that following 2 reports within 7 days of Alfred being the victim of assault, he should have been viewed as a male experiencing domestic abuse who appeared to have support needs and is likely unable to protect himself. Due to availability of the SomFT worker there was no direct contact between SomFT and ASC at the time of the triage decision, instead email communication was exchanged and the assessment was a desk top review of records available at the time. These records included details from SomFT to which ASC has access. Engagement with the CMHT and/or Alfred would have benefitted this risk assessment process and enhanced support going forward.

16.8.7 Considering the situation that Alfred faced, Adult Social Care acknowledge that he was eligible for a safeguarding enquiry to further understand what he was experiencing. It is reasonable to draw the conclusion that the behaviour of Joan was due to her mental health issues, rather than being premeditated acts of violence or aggression. However, this should not have detracted from the fact that Alfred needed help. The ASC author comments that part of the qualifying criteria included the carer fatigue that was something Alfred was clearly suffering from. It appears that frontline practitioners believed that if they could address Joan's needs of then this would reduce Alfred's need for support.

16.8.8 On the day of his death the SCC call centre received a referral from the police following the report of Alfred's suicidal behaviour and ideation. In assessing the situation, call centre staff have understood the previous triage decision to mean that Alfred had been referred for a Needs Assessment, and therefore referred this report to the Mental Health Social Care Team, who were due to meet the following day. It is the view of the IMR author that this new information should have been reviewed by the SCC Adult Safeguarding triage team. Had this been done then practitioners may have considered a more urgent safeguarding response, particularly considering the behaviour and emotions that Alfred displayed.

16.8.9 In order to address the issues raised here Adult Social Care have produced a series of recommendations (as mentioned in 16.7.6) The review supports these proposals.

16.8.10 There were no reports to ASC regarding domestic abuse, until the middle of March 2021. This, however, does not mean that we should assume March 2021 was the first-time such incidents occurred. Despite receiving 4 reports prior to Alfred's death, he was never spoken to directly, and this review has drawn the conclusion that, based upon these referrals, Alfred 'qualified' for an assessment under Sec 42 of the Care Act 2014. It could have provided him with sufficient reassurance that agencies were listening and there was available support to reduce any feelings of isolation.

16.8.11 From reviewing the records in this case it appears that an assumption was being made that Alfred's vulnerability was as a result of Joan's declining mental health and the ASC workers have judged that, by addressing Joan's condition, Alfred's vulnerability would be reduced. Whilst it is acknowledged that the police recognised Alfred as a

victim, the question to be asked is how they would manage a situation in which their referrals were not receiving a suitable response.

16.8.12 The review panel discussed the need for a recommendation to address the issues that have arisen here. However, reassurance has been provided to confirm that SSP has reviewed it 'what to do if it's not safeguarding' guidance and a relaunch is planned for Autumn 2023.

16.8.13 In terms of support from Som FT, the agency acknowledges that they were able to offer immediate responses when receiving report of Joan's condition however there seems to have been a lack of appreciation of wider issues within Joan and Alfred's relationship. This led to missed opportunities to offer Alfred support through the various assessments mentioned earlier and discussions at Multi-Disciplinary Meetings (MDT's) safeguarding supervision sessions.

16.8.14 The Safelives study of 2016 ''Safe Later Lives: Older people and domestic abuse'' (www.safelives.org.uk) , identify six key findings in this area; specifically:

1. Systemic invisibility
2. Long-term abuse and dependency issues
3. General attitudes about abuse may make it hard to identify
4. Increased risk of adult family abuse
5. Services not effectively targeted at older victims, and do not always meet their needs.
6. Need for greater coordination between services.

16.8.15 For Alfred and Joan, the key findings 1,2,3,5 and 6 may apply. As mentioned earlier Alfred did not seem to identify himself as a victim or make any such disclosures, he remained 'systemically invisible'. There appears to have been no coordinated discharge planning following Joan's episodes of inpatient care when there were many opportunities to explore, with Alfred, the nature of their relationship, his concerns, and the completion of a DASH risk assessment with appropriate referral for support and safety planning.

16.8.16 These factors have been identified by the Safer Somerset Partnership and their partners. In response to this, Som FT now include a specific section on Adult Abuse/Domestic Abuse in their Safeguarding Adult Level 3 training (as detailed in 16.7.6) and have an e-learning module specifically about Domestic Abuse and the Elderly, in addition to a 30-minute webinar about DASH (Domestic Abuse Stalking/Harassment and Honour based Violence) risk assessment which is available to all Som FT staff.

16.9 Making Safeguarding Personal

16.9.1 When considering this subject, it is important to consider how Making Safeguarding Personal (MSP) is defined. The interpretation of the term 'Making Safeguarding Personal' by the Somerset Safeguarding Adult Board and Local Government Association are documented in Appendix 7.

16.9.2 The Local Government Association defines MSP as:

"a sector-led initiative which aims to develop outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances". [31]

16.9.3 It is clear to this review that Alfred was never recognised as a victim of domestic abuse, and he never identified himself as being in that position.

16.9.4 The example of the assessment issues following Joan's arrest was a chance to contact Alfred directly, discuss his welfare and obtain a greater understanding of the challenges he faced. It is logical to suggest that this would have gone a long way to supporting the MSP principles within local and national policies.

16.9.5 Throughout this reporting period and as the chronology reflects, Alfred, Joan and the family made many calls particularly concerning Joan's mental health. On more than one occasion they told front line practitioners that Alfred was unable to cope. Other areas of this report reflect the gravity of these pleas for help and the details provided in many of the IMRs reflect the fact that that Alfred's position was not prioritised.

16.9.6 Following the referral from Mindline, 3 day's prior to Alfred's death Somerset Direct interpreted the previous triage decision to mean that Alfred had been referred for an assessment of need, we know that this was not the case.

16.9.7 Research by Safelives on Older People and Domestic Abuse recognises that often victims can often have emotions of guilt and loyalty as well as feelings of 'obligation'. which result in them feeling that they cannot leave a situation due to partner dependency. This was something which Alfred spoke to police officers about during discussion about the use of a Domestic Abuse Prevention Order, following Joan's arrest.

16.9.8 The presence of mental health as a perceived primary issue within a relationship can also cause professionals to miss other factors. Whilst this was not a missed opportunity by the police, the situation detailed in 16.10.4 suggests that the assessment failed to appreciate Alfred's position. Despite receiving 4 referrals, for Alfred as being vulnerable and struggling to cope in his carer's role, he wasn't contacted by staff from ASC and therefore, it seems likely that he was never aware of the support available to him, which is at the centre of the MSP principles.

16.9.9 The ASC correctly recognise that, had a Sec 42 Care Act enquiry been carried out, then this may have gone a considerable way to supporting Alfred with his needs as a carer, to manage and support the emotional impact of the situation he faced. There is

---

[31] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

a piece of commentary, in the ASC IMR which is particularly relevant regarding the potential use of the Sec 42 process.

- *It could have afforded him with enough assurances that agencies were listening, and support was available, rather than risking him feeling isolated and alone, having to take matters into his own hands.*

16.9.10 The issue of MSP is further acknowledged by Som FT. They recognise that the lack of awareness or appreciation of the individual and collective responsibility to consider, acknowledge, and respond to the possibility, and declared expressions from Alfred and others, that there were safeguarding issues in the relationship. They also acknowledge the repeated missed opportunities to offer Alfred additional support through concerted reiteration of the opportunity to have a Carer's Assessment. In addition, SomFT didn't recognise, respond, or report concerns about the issues within Alfred and Joan's relationship. SomFT did not refer either party to SCC for consideration of safeguarding needs.

16.9.11 It appears that there could have been more engagement through Multi-Disciplinary Meetings where Alfred's vulnerability discussed and responded to.

16.9.12 There were several occasions, particularly in the twelve months, prior to Alfred's death when practitioners could have created the opportunity to explore with him the frequency, nature, and severity of the incidents he had already disclosed and to refer these incidents to SCC for consideration under section 42 of the Care Act. Practitioners could also have taken the opportunity to complete and submit a DASH risk assessment, based on professional judgement, and request that the case be discussed in MARAC for consideration of coordinated support and safety planning. Alfred's case wasn't discussed with the SomFT's Safeguarding Team or at safeguarding supervision sessions.

16.9.13 SomFT also acknowledged the Safelives study in 2016 and recognised the key factors which related to Alfred and Joan. Alfred remained 'systemically invisible' by virtue of not being referred for his own anecdotally reported health needs, nor in consideration of his needs as the primary carer for Joan. The entrenched nature of Joan's mental ill health appears to have rendered Alfred invisible to practitioners.

16.9.14 Further issues regarding engagement with Alfred and the recognition of missed opportunities by SomFT are recorded elsewhere in this report, as are the remedial training activities which have already been put in place.

16.9.15 In 2020 the Association of Directors of Adult Social Services and the Local Government Association developed a national MSP outcomes framework[32]. The

---

[32] https://www.local.gov.uk/making-safeguarding-personal-outcomes-framework

purpose of the framework is to provide a means of promoting and measuring practice that supports an outcomes focus, and person led approach to safeguarding. The review believes that these principles should form part of a recommendation to ensure that this focus is reflected in the working methods across SSP.

Learning Point 5 What this section of analysis reveals is that there is a need for further exploration of how the Making Safeguarding Personal guidance is implemented by frontline practitioners and how these staff are supported and managed in ensuring that every opportunity to protect the vulnerable is identified and explored.

Recommendation 5 SSP to ensure that all agencies with safeguarding responsibilities have.

- An Outcomes Framework in place,
- A process for measuring its success, in terms of volume of engagement.

Each agency should provide a report discussing both evidence of good practice and areas for development.

16.10 The Impact of the COVID 19 Pandemic on health and social care providers

The panel discussed the issues of the pandemic and whether there was a direct impact on the treatment provided, or offered to either Alfred, in insolation, or along with Joan. It is worth considering the national picture.

The state of health and care systems prior to beginning of the Pandemic.

16.10.1 As was highlighted by the British Medical Association

"Health and care systems across the UK were operating in environments of scarcity long before COVID-19 and were poorly prepared to weather the storm of the pandemic. Critical underlying issues were brutally exposed with too few staff, too few beds, and buildings that were unsuitable for effective infection control".

16.10.2 Health services across the UK entered the pandemic with a significant backlog of care. Waiting times for diagnostics and elective care were increasing, while access to emergency care was worsening. Across the health services, targets were being missed with growing frequency.

The First Wave: February – September 2020

16.10.3 During the first wave existing chronic workforce shortages were exacerbated by rising staff absences due to infection and self-isolation, and a sharp reduction in international recruitment. This shortage of staff necessitated redeploying staff to high-need services to help maintain a base level of service provision across critical and emergency care.

16.10.4 Other measures included asking retired and non-practicing doctors to return, enabling medical students to join the health services early and establishing volunteer programmes for the public.

16.10.5 The model of care delivery, within primary care, changed considerably. To mitigate infection risk, general practice shifted to remote consulting where feasible, which further exposed the limitations of IT infrastructure within the UK health services. However, in-person consultations continued to take place where necessary. The lack of capacity in secondary care meant GPs also saw increased demand as a result of cancellations elsewhere. They were also responsible for many patients whose health issues had been exacerbated by lockdowns, and who had nowhere else to go for care.

The Second Wave: September 2020 – April 2021

16.10.6 During the second wave of the pandemic UK health services attempted to deliver COVID and non-COVID care concurrently, which was an immensely challenging task given the context of rapidly rising COVID-19 case numbers, the emergence of the Alpha variant, the usual winter pressures, and the impact of ongoing IPC measures on capacity.

16.10.7 Record numbers of patients were admitted to hospitals, the number of ambulances held outside hospitals or diverted elsewhere was rapidly worsening, and A&E waits skyrocketed. Increasing staff absences further reduced capacity, which impacted on patient care and pushed services into dangerously unsafe levels of staffing.

16.10.8 Like in the first wave, waiting lists drastically increased. There was also growing awareness of the 'hidden backlog' of unmet need - patients who required care but had either not yet presented or who had referrals cancelled due to reprioritisation or lack of capacity.

16.10.9 In terms of the local picture the Somerset Intelligence, in partnership with Somerset County Council produced a 'COVID 19 Frist Wave Overview Report'[33] which confirmed that:

- Throughout the first wave of the pandemic, and in common with many parts of the South West, Somerset had comparatively low rates of new COVID-19 infection. In part this reflects the characteristics of Somerset in terms of low population density and relative affluence. Other factors, including ongoing commitment by residents of Somerset for social distancing and hand hygiene

[33] http://www.somersetintelligence.org.uk/covid-19-somerset-overview.html

measures, and effective infection prevention and control in health and care settings, will have contributed.

16.10.10 Avon and Somerset Police continued to deploy officers to all appropriate calls.

16.10.11 SomFT continued routine engagements with their patients via telephone and other related guidelines were followed.

16.10.12 Whilst the pandemic itself caused a great of stress and strain on both primary and secondary health care providers, this review can find no direct links that impact this review.

17. Conclusions

17.1 The interview with Joan said Alfred was a caring, loving husband. He was a loyal and popular friend who was well thought of by those around him. His death was a tragedy and has deeply affected those close to him.

17.2 It has been a challenge for the review panel to understand the emotional and psychological impact that these incidents and challenges had upon Alfred however, the impact upon men, of domestic abuse, is a subject which needs urgent review, analysis, and wider acknowledgement. Whilst recognising that domestic abuse against any person is unacceptable and abhorrent, we recognise it’s impact and potential to cause those involved to take the ultimate sacrifice.

17.3 It is not the role of these statutory reviews to apportion blame or find fault. The content of the report simply reflects the findings of panel agencies and seeks to identify opportunities for learning and the recognition of good practice.

17.4 Information provided by the agencies involved in this review would appear to demonstrate that there are several themes that need to be considered because of Alfred’s death. The report acknowledges that several of the earlier incidents outlined above would now be dealt with differently and we thank agencies for providing accounts of how systems have changed due to self-evaluation and improvement.

17.5 There are various themes within the review, each of these have been explored, during this process and the various learning points and recommendations are intended to support families facing similar difficulties and challenges. In approaching these learning points and recommendations the Review Panel has sought to try and understand what happened and recognise the issues in the life of Alfred that might help to explain why he reached the decision to take his own life. The Review Panel would like to extend their deepest sympathy to all those affected by Alfred’s death.

18. Learning Points

Learning Point 1: The issue here relates to the role of the carer and the need to recognise when their circumstances change and the level and nature of the support, they need similarly alters.

Learning Point 2 – All agencies within this review should ensure that they have a Quality Assurance process that ensures that their Domestic Abuse risk assessment processes also acknowledge the 9 protected characteristics.

Learning Point 3: It's important that all agencies provide training which cover competencies and specifications relevant to the gathering and sharing of information. Therefore, it would be beneficial to know how improvements have been recognised.

Learning Point 4: The review feels that there is an opportunity to enhance the support provided in this area and that men should be given greater encouragement to come forward when they feel they are the victims of domestic abuse and/or coercive control.

Learning Point 5 What this section of analysis reveals is that there is a need for further exploration of how the Making Safeguarding Personal guidance is implemented by frontline practitioners and how these staff are supported and managed in ensuring that every opportunity to protect the vulnerable is identified and explored.

19. Recommendations

Single Agency

Somerset NHS Foundation Trust

Following the conclusion of the review SomFT have preprepared an action plan which is considered a proportionate response to ensure the recommendations and learning are captured and undertaken. See Appendix 2.

Adult Social Care

Following the conclusion of the ASC IMR the following action plan is considered a proportionate response to ensure the recommendations and learning are captured and undertaken. See Appendix 3.

Recommendation from this review.

Recommendation 1: SSP to gain assurance that health agencies have robust systems in place to identify / record known carers, and have pathways in place to ensure timely referral for carers assessment and support with recognition that when circumstances change re-referrals and/or reassessment may be required.

Recommendation 2 – SSP to take steps to ensure that professionals completing DA assessments across the health and social care system understand importance of the 9 protected characteristics in relation to domestic abuse victims and barriers to disclosure

Recommendation 3: SSP to ensure that.

- There is training carried out, in relation to the sharing of information, throughout the Partnership.
- That all agencies have processes in place for domestic abuse referral and/or DA Policies.

Recommendation 4: SCC Public Health to review its activities and provide training aimed at encouraging male victims of domestic abuse to come forward. Support services and advice lines should be advertised more widely.

Recommendation 5 SSP to ensure that all agencies with safeguarding responsibilities have.

- An Outcomes Framework in place,
- A process for measuring its success.

Each agency should provide a report discussing both evidence of good practice and areas for development.

Appendix 1

Terms of Reference

Terms of Reference

Domestic Homicide Review (case 038)

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the Somerset County Council has commissioned this review, following notification of the death of Alfred.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Review Panel

1.3 The resources required for completing this review will be secured by the independent chair commissioned by Somerset County Council on behalf of the Safer Somerset Partnership.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of …

2.2 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.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
    - the actions of all the involved agencies.
    - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken.

- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by June 2022 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair. Additionally, the coronial proceedings may impact on timescales, although the statutory guidance is clear a DHR should be commenced and concluded as soon as possible – and the Review Panel should be mindful of paragraphs 90 to 96 of the Home Office guidance.

4 Scope of the review

4.1 To review events up to this domestic abuse related death of Mr Morris. This is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies for 3 years preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. In particular what were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4.8 Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar homicides occurring in future.

5 Key Lines of Enquiry

5.1 The following themes have been prepared by the chair and discussed with the panel. Their purpose is to focus the review upon areas of learning and opportunities to improve service. They have been reviewed and discussed at various stages of this review.

- Family stressors and carer support
- Responding to crisis
- Links between and domestic abuse and suicide
- The sharing of information.
- Management Oversight
- Male victims of Domestic Abuse

6 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6))*
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that reviews incorporate suggested the outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses

- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the SSP

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

Name	Agency
Peter Stride	Independent Chair
Heather Sparks	Somerset NHSFT
Emma Read	Somerset CCG
Louise White	SCC Adult Social Care
DI Su Parker	Avon and Somerset Police
Suzanne Harris	Safer Somerset Partnership
Lucy Harling	The You Trust (representing SIDAS)
Rob Semple	Sedgemoor DC
Mark Brooks	Mankind Initiative
TBC	SW Ambulance Service NHSFT

The above was confirmed at the first Review Panel Meeting held 3rd November 2021

7.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

8 Liaison with Media

8.1 Somerset County Council will handle any media interest in this case.

8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.3 Confidentiality

All panel members are bound by the agreed confidentiality agreement

Appendix 2

Single Agency Recommendations Som FT.

Action	Activity
1. Domestic abuse routine enquiry within mental health contacts	Awareness raising regarding DA routine enquiry (DARE) for clients/carers presenting with suicidal ideation.
2. Consideration of carers assessments for carers of relatives with mental ill health	Memo to MH team managers and via MH teams' supervision, to remind them of a carers right to assessment under the Care Act 2014. Plus information to be disseminated via Staff news article for wider Trust information
3. Mental health teams to be aware of out of hours escalation regarding domestic abuse concerns	Re-circulation of safeguarding adult and domestic abuse pathways
4. Mental health teams to have domestic abuse information available to pass on to clients / carers.	Recirculate web details for Somerset Survivors and other DA support services

Appendix 3

Single Agency Recommendations Adult Social Care.

Action Plan
1. SCC to review the guidance regarding MSP
2. SCC to review internal decision-making guidance,
3. SCC to incorporate learning from review into training and CPD opportunities for staff
4. SCC to review the domestic abuse training available to ASC to ensure it meets the needs of the organisation.

Appendix 4

Glossary of Terms

Glossary of Terms	
Domestic Homicide Review	DHR
Adult Social Care	ASC
Safer Somerset Partnership	SSP
Individual Management Reviews	IMR
Clinical Commissioning Group	CCG
Somerset NHS Foundation Trust	Somerset NHS FT
South West Ambulance Service Trust	SWAST
Multi Agency Safeguarding Hub	MASH
Multi Agency Child Exploitation Hub	MACE
Multi-Agency Public Protection Arrangements	MAPPA
Multi-Agency Risk Assessment Conference	MARAC
Professional Standards Department	PSD
Independent Office for Police Conduct	IOPC
Safeguarding Adult Board	SAB
Home Treatment Team	HTT
Lighthouse Safeguarding Unit	LSU
Domestic Abuse Triage	DAT
Community Mental Health Team	CMHT
Mental Health Social Care Team	MHSCT
Domestic Abuse Stalking & Harassment	DASH
Victim and Witness Care Officer	VWCO
Blue, Red, Amber, Green	BRAG
Domestic Violence Protection Notice	DVPN
Advice, Support, Custody & Courts Service	ASCC
Somerset County Council	SCC

General Practitioner	GP
Police Community Support Officer	PCSO
Neighbourhood Policing Team	NPT
Body Worn Video Camera	BWV
Adult Social Care Recording Database	AIS

Appendix 5

Excerpts of the SomFT Mission Vision and Values Statement.

- Provide safe, effective, high quality, person-centred care in the most appropriate setting.
- Deliver care closer to home in neighbourhood areas with an emphasis on self-management and prevention.
- Give equal priority to physical and mental health, and value all people alike.
- Improve outcomes for people with complex conditions through personalised, co-ordinated care.

Additionally, the corporate objectives include:

- Promoting a culture of learning to transform and innovate services, including through digital working to improve safety, outcomes, and efficiency.
- Delivering the benefits of integrated care in our merged organisation and work with primary care, social care, public health, and voluntary sector partners to deliver integrated, high-quality services.
- Working with partners to deliver the Fit for My Future strategy, prioritising prevention and neighbourhood working, to maintain a sustainable county health economy.
- Delivering levels of performance that are in line with our plans and national standards.

Appendix 6

College of Policing - The supervisor's responsibilities during crime investigation:

- regularly review and confirm the risk assessment.
- manage the investigation
- ensure appropriate tasks are set, completed, and recorded
- ensure continuity of investigation and contact with person reporting the missing person through effective handover
- own the investigation plan
- ensure appropriate resourcing and supervision levels
- consider the need for a multi-agency response and involve partner organisations[34]

---

[34] https://www.college.police.uk/app/major-investigation-and-public-protection/missing-persons/missing-persons-quick-reference-guides/supervisors-and-first-line-managers

APPENDIX 7

Interpretation of the Term 'Making Safeguarding Personal.

Somerset Safeguarding Adult Board

- A response which will be as individual as the person or situation.
- Person-led.
- Outcome Focused.
- Enhancement of involvement.
- Choice and Control.
- Improving quality of life.
- Engaging people in conversations about their safety.
- Improving wellbeing and safety
- Providing a proportionate response.[35]

The Local Government association defines MSP as:

"a sector-led initiative which aims to develop outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances". [36]

---

[35] https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/2016/02/Powerpoint-Presentation-10-Feb-2016.pdf

[36] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

Appendix 8

Somerset NHS Foundation Trust – Carers Service

- Carers’ assessments
- Emotional support
- Practical advice
- Carers’ employment support
- Carers’ support groups
- Carers’ website
- Carers’ newsletter
- Carers’ information
- Carers’ participation group
- Information and advice about carers’ breaks
- Carers’ events.

Appendix 9

TOGETHER TEAM –

MULTI AGENCY CASE WORK MEETINGS

PURPOSE

Act as a coordinating hub to provide a local case management framework for multi-agency sharing of casework, community intelligence and relevant information, in relation to tackling issues synonymous with social and economic deprivation and crime and disorder. Deliver the operational community safety and health and wellbeing function to local communities, by utilising the resources available across Somerset to find effective solutions to local challenges. Work with partners relative to the local area to create a more resilient and empowered community.

AIMS AND RESPONSIBILITIES

- Share information, intelligence, and knowledge in order to identify issues relating to social and economic deprivation, to improve wellbeing and to tackle crime and disorder within the community.
- Identify high demand from particular households and individuals, and where possible/necessary, work in collaboration to assist in seeking solutions or providing support.
- Proactively seek opportunities to intervene at the earliest point to avoid a service demand.
- Escalate concerns/failures/requirements/unmet need/potential gaps in services/unsolved problems.
- Coordinate Interventions for individuals with multiple and complex needs.
- Share good practice where appropriate and necessary with the Sedgemoor Tactical Group

In terms of 038 the subjects were raised by PCSO Supervisor James Brunt outside of a TT meeting who notified the chair of a domestic incident and was asking if this would be an appropriate case to raise at the TT. After discussion it was decided that all appropriate agencies were already involved and partners that attended the TT would not have added value or been able to offer support.

Appendix 10

Review Authors sources of research

https://www.sacpa.org.uk/vacancies/together-team-and-safeguarding-lead-sedgemoor-district-council-somerset/

https://www.centreforsocialjustice.org.uk/newsroom/why-are-men-often-overlooked-as-victims-of-domestic-abuse

https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

https://www.somersetft.nhs.uk/home-treatment-team/

https://choices.somerset.gov.uk/025/send/adult-community-mental-health-teams-bridgwater/

https://www.dashriskchecklist.co.uk/

https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

https://www.mindinsomerset.org.uk/our-services/adult-one-to-one-support/mindline/#:~:text=Mindline%20is%20a%20confidential%20listening,you%20know%2C%20is%20in%20distress.

https://www.somerset.gov.uk/social-care-and-health/
https://www.england.nhs.uk/commissioning/comm-carers/carers/

https://www.somersetft.nhs.uk/carers-service-and-triangle-of-care/

https://somersetcc.sharepoint.com/sites/SCCPublic/Community/Forms/AllItems.aspx?id=%2Fsites%2FSCCPublic%2FCommunity%2FDomestic%20%2EAbuse%20Newsletter%20Spring%20Edition%20April%202021%2Epdf&parent=%2Fsites%2FSCCPublic%2FCommunity&p=true&ga=1

https://www.dashriskchecklist.co.uk/wp-content/uploads/2021/12/DASH-2009.pdf

https://www.england.nhs.uk/commissioning/comm-carers/carers/

https://www.somersetft.nhs.uk/carers-service-and-triangle-of-care/

https://themaskedamhp.blogspot.com/2015/11/sec-134-right-of-nearest-relative-to.html

https://www.google.com/search?client=safari&rls=en&q=suicide+prevention+in+somerset&ie=UTF-8&oe=UTF-8

https://www.england.nhs.uk/wp-content/uploads/2022/06/42-nhs-somerset-icb-constitution-010722.pdf

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

https://equi-law.uk/inquiry-no-3-male-suicide/

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

http://www.somersetintelligence.org.uk/covid-19-somerset-overview.html

https://mensadviceline.org.uk/

https://www.mankind.org.uk/

https://www.itv.com/thismorning/articles/domestic-violence-men-helplines

https://www.refuge.org.uk/get-help-now/help-for-men/

STATUTORY REVIEW – EXECUTIVE SUMMARY

Safer Somerset Partnership

REPORT INTO THE DEATH OF Alfred

Report produced by Peter Stride – Foundry Risk Management Consultancy

Report Completed January 2024

Table of Contents

1. **Review Process** 3
2. **Contributors to the Review** 3
3. **Review Panel Members** 4
4. **Author of Overview Report** 4
5. **Terms of Reference** 4
6. **Summary Chronology** 5
7. **Conclusions and Key issues Arising out of the Review** 7
8. **Lessons to be Learned ……………………..…………………………………………...15**
9. **Good Practice……………………………………………………………………………….. 16**
10. **Recommendations** 16

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Safer Somerset Partnership (SSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Alfred who lived with his wife Joan. Both were residents local to Somerset.

1.2 The following pseudonyms have been in used in this review to protect their identities.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Alfred	Deceased	69	White British
Joan	Wife	65	White British

1.3 The inquest into the death of Alfred concluded in June 2022. The inquest determined that Alfred died as a result of suicide.

1.4 The Safer Somerset Partnership reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The chair ratified the decision, and the Home Office was notified on 4th of August 2021

1.5 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was extended for several reasons:

- Enabling contact with family members
- Issues relating to the COVID pandemic.
- Extended periods of engagement between the chair and panel agencies during the preparation and finalisation of the Overview Report.
- The chair suffered a family bereavement which caused him to take some time out between March and July 2023.

1.6 Agencies that potentially had contact with Alfred and Joan prior to the point of death were contacted and asked to confirm whether they were involved with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Alfred and Joan.

2.2 The following agencies who had contact and their contributions are shown below.

Agency	Nature of the contribution
Clinical Commissioning Group	IMR and Chronology
Somerset NHS Foundation Trust	IMR and Chronology
Somerset County Council Safeguarding Adult Team	IMR and Chronology

Avon and Somerset Constabulary	IMR and Chronology
South Western Ambulance Service (SWAS)	Chronology & additional briefing notes
Sedgemoor District Council, Together Team	IMR and Chronology

2.3 IMRs were completed by authors who were independent of any prior involvement with Alfred and Joan.

2.4 The authors and panel members assisted the panel further, with a number of one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	Job Title	Agency
Peter Stride	Review Chair	Independent
Su Parker	Detective Inspector	Avon and Somerset Police
Heather Sparks	Named Professional for Safeguarding Adults	Somerset NHS Foundation Trust
Louise White	Service Manager, Safeguarding Operations	Somerset Adult Social Care
Emma Read	Deputy Designated Nurse for Safeguarding Adults	Somerset Integrated Care Board
Mark Brooks	Chair	Mankind Initiative
Lucy Harling	Paragon Manager	The You Trust
Suzanne Harris	Senior Commissioning Officer	Somerset County Council
Rob Semple	Community Safety and Resilience Manager	Sedgemoor District Council

3.2 The review panel met on 5 occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Peter Stride. Peter has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 30 years-service with the Metropolitan Police Service retiring at the rank of Detective Chief Inspector. During his service he gained experience leading the

response to Domestic Abuse, Public Protection and Safeguarding. (See Appendix A for Statement of Independence)

4.2 Peter has no connection with the Safer Somerset Partnership, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Somerset's statutory agencies and Non-Government Organisations worked together in their dealings with Alfred and Joan.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

5.3 Case specific key lines of enquiry included the following:

- Family stressors and carer support
- Responding to crisis
- Links between and domestic abuse and suicide
- The sharing of information.
- Management Oversight
- Male victims of Domestic Abuse

6. SUMMARY CHRONOLOGY

Family Perspective (Joan)

6.1 Joan explained that her relationship with Alfred began in 1997 and they were married in 1998, she mentioned that prior to their meeting Alfred had been involved in an accident from which he had suffered 'brain and physical' injuries. As a result of which Alfred had struggled to walk.

6.2 Joan explained she had been married to Alfred for twenty-four years, and he had acted in a caring role during her periods of mental ill health. Following his car accident Alfred had been through a long rehabilitation process which left him with short term memory and coordination problems. Joan told the chair that for a period, she became a carer for Alfred.

6.3 Joan explained that the couple had a very active social life, including many holidays around the country, going for walks, attending parties with friends and evenings at the pub taking part in regular quizzes. Alfred had several jobs including as a trolley warden at a local supermarket and as a driver for the local council. Joan explained that Alfred was a very happy man and that throughout their marriage they had always got on extremely well. She described Alfred as always being full of life and highly motivated.

6.4 Over the last several years Joan had spent all her time as a carer for Alfred, and for her brother and her mother who lived several miles away. Joan had reported she found life challenging, particularly as Alfred's physical capabilities had begun to deteriorate and he had regularly fallen over.

Avon and Somerset Police

6.5 Between April 2018 and April 2021, the police were involved in 6 specific incidents, including the day of Alfred's death. The involvement of the police during each of these incidents was not restricted to a single initial contact but included subsequent visits and calls as part of the on-going support being provided to both parties.

6.6 It should be noted that all these contacts occurred within a 7-week period prior to Alfred's death and that prior to this period there had been no documented police contact for many years.

6.7 Each of the five incidents were reported following actions by Joan and on one occasion resulted in her arrest. Each contact resulted in referrals to the LSU for further assessment and onward information sharing. On each occasion police involvement was as the result of a 999-phone call. Officers managed each situation and the risks presented 'live' however on several occasions subsequent follow-up support was not provided.

6.8 Engagement with other agencies were generally carried out via the LSU although it should be pointed out on several occasions' officers took direct action to support Alfred and Joan as well as to manage the risks that were presented or perceived.

Health Agencies GP and Somerset NHS Foundation Trust

6.9 Alfred and Joan were registered, as patients at a local GP surgery. They had been patients there for many years, Alfred had been registered since October 1998. Within the review period they had 4 engagements with the couple. None of these involvements were interpreted as involving matters of domestic abuse. Alfred had no active referral, throughout the scope of this review, to any individual team or allocated health professional other than his GP.

6.10 In February 2020 Alfred was assessed at a Rehabilitation Unit locally in Somerset and was found to have “mild memory and mild limb incoordination problems, however, was able to live a fully independent life”.

6.11 Alfred had limited contact with the surgery. He had several musculoskeletal problems over the years including a closed reduction of a dislocation of his shoulder in 2005 and knee problems following a fall in around 2012, which resulted in some arthritis and subsequent knee pain.

6.12 Alfred’s last 2 consultations at the surgery were in August 2018, again for knee pain which was treated with analgesia and physiotherapy.

6.13 The only medication that Alfred was prescribed was Paracetamol, the last prescription for this was on the 30th of December 2020 for 224 tablets[37]. He also attended for his first Coronavirus vaccination on 8th of February 2021. At no point is there any GP record of Alfred having mental health issues and no attempt of self-harm.

6.14 Joan has suffered with mental ill health for a number of years for which she received support and treatment via the CMHS. During the period of review, thirty-five (35) contacts were made for Joan and Alfred either separately or together.

6.15 Between the period of February and April 2021 there were 13 contacts involving the Trusts Mental Health Home Treatment Team with Alfred, Joan, and Joan’s brother.

6.16 In February 2021 Alfred contacted the CMHS and left messages regarding his concern over Joan’s failing mental health. During this time support and visits were undertaken by the Home Treatment Team who then visited the couple at home.

6.17 In March 2021 the CMHS and HTT responded to telephone calls from Alfred, Joan, and family members regarding concerns about a possible decline in Joan’s mental health. Concerns were expressed by Alfred and family members about the impact on Alfred of Joan’s mental illness.

6.18 During Alfred’s calls to the CMHS he expressed needing a break from his caring role and questioned whether Joan should be admitted to a psychiatric inpatient unit. He reports to feeling unsafe at times as a result of her behaviours. Alfred was offered reassurance during these calls and advised to contact the Police if he felt at immediate risk at any point. During these periods the HTT and CMHS maintained contact with Joan in line with her treatment plan.

6.19 Contact between Alfred, Joan and Joan’s family continued in April 2021. Joan continued to be supported by the CMHS/HTT during this time as per her care plan. Providing support for Joan, at home was the least restrictive option regarding her care and support needs as it enabled Joan to receive care and negate the need for

[37] This volume of paracetamol was challenged, by the review, but reassurance was provided by the CCG Medicines Management professional, that this was proportionate for longer term conditions and within the scope of what can reasonably be prescribed by the GP

detention under the Mental Health Act (1983) and thus deprive her of her liberty. There was also regular contact with Joan's GP during this period.

6.20 Three days before Alfred's death Joan's brother contacted the Mental Health Team. He told the practitioner that Alfred was feeling suicidal due to Joan's mental health issues. The Mental Health Team contacted Alfred and Joan and she was annoyed that her brother had called the Mental Health Team. Alfred stated that he was emotional and exhausted but had no intention of taking his own life.

6.21 On the day of Alfred's death Joan contacted the Mental Health Team concerned that he had left the property following an argument. Joan was offered reassurance and advised to call the police if she felt it was necessary.

Adult Social Care

6.22 Somerset County Council Adult Social Care has reviewed all contacts with Alfred and records checked for Joan. ASC had a total of 4 contacts relating to Alfred during the review period. They all occurred between the 1st of April 2021 and the day of Alfred's death. Similarly, ASC had 4 contacts with Joan, and these were between the 17th of March 2021 and the day of Alfred's death. There are no records for either party prior to these dates.

6.23 Each of the contacts regarding Alfred came via referral from the police. Two related to the arrest of Joan in early April 2021, and a third regarding an incident to which officers were called on the 23rd of March 2021. These referrals were triaged by the safeguarding team and consideration given to dealing with these matters under Sec 42 of the Care Act. However, this was declined in favour of using the processes under Sec 9 of the same act to focus upon Joan's needs for care and support. This assessment process was to be coordinated by the Mental Health Social Care Team.

6.24 The final referral came the day before Alfred's death. This was assessed by the SCC contact centre[38] and details passed to the SCC Mental Health Social Care Team (MHSCT) who were already preparing to respond to the Section 9 Social Care assessment following the referral which had been made on 17th March 2021. The MHSCT case notes reflect that this incident was due to be discussed at their referrals meeting the following day.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically it has not been possible to build a picture from Alfred's perspective. The review has had to rely on anecdotal reports collated by involved agencies. Based upon these accounts, Alfred appears to have faced regular challenges regarding Joan's mental ill health and he was clearly concerned and anxious that her condition was deteriorating and made several requests for support from a variety of agencies including the Somerset NHS Foundation Trust, and the police. As it is noted in the

[38] https://www.somerset.gov.uk/social-care-and-health/

chronology that Alfred made several requests for Joan to be admitted into hospital in order that her conditions could be treated and so that he could have some respite.

7.2 On more than one occasion both Alfred and Joan contacted agencies and disclosed feelings of suicide. This apparent cry for help was something which was raised, not just with agencies, but within the family as Joan's brother also called SomFT for help. These appeals for support give a clear indication of the problems Alfred and Joan were experiencing and were a clear indication of stressors within their relationship. Prior to Alfred's death the police received a referral from 'Mindline' and the subject was further discussed when Alfred visited his GP. Alfred and Joan were both provided with advice and avenues of support.

7.3 Engagement between the couple and panel agencies regarding their concerns and issues were dealt with by advice to manage the immediate risks and on occasion referrals were made through internal processes including the Lighthouse Safeguarding Unit and Domestic Abuse Triage process.

7.4 Whilst the review has highlighted learning opportunities, it is not suggested that the tragic events were foreseeable.

Family stressors and carer support

7.5 The review panel considered the stress related factors affecting Alfred, Joan, and other family members. The process of reviewing individual agency engagement quickly identified that there had been challenging periods throughout Alfred and Joan's marriage and that these had been documented for many years outside the scope of this review.

7.6 There are two apparent stressors were Joan's diagnosed acute mental health issues that impacted upon the lives of everyone and seems to have been the cause of any domestic incidents. Those making calls to various agencies (including the Police, SomFT and Community Mental Health Team) were clear that they believed Joan to need help and they expressed their belief as to the consequences of not receiving support. Along with the need for Joan to receive an enhanced level of support, Joan's brother also expressed their belief that Alfred needed a break. On each of these occasions support and advice was provided to deal with the immediate, perceived, crisis. Following this support Alfred made further calls, outlining his fears and concerns, and giving a clear indication of the stress he felt he was under and provided opportunities for agencies to consider his situation and whether a multi-agency approach to supporting him could be used.

7.7 Following Joan's arrest there were assessments by Health Care Professionals and the ASCC, who spoke with the Home Treatment Team. They reported that Joan was a carer and that a mental health assessment and hospital admission would not be helpful. The details provided to this review suggest that the function of carer had transferred from Joan to Alfred. During the chairs interview with Joan, she commented that she was responsible for her brother, who lived upstairs. It does suggest that Joan's position would have benefitted from a review, and consideration as to whether she was able carryout the function of carer.

7.8 What is apparent is that the relationship between Alfred and Joan was under great strain Alfred was vocal and clear about his need, and he was offered the opportunity to have a carer's assessment in February 2021, which he declined.

7.9 Following Joan's release from custody the Som FT had several calls and face to face meetings with the couple. Alfred continued to voice his need to have a break and told the mental health team that he'd had enough. At the same time there was a call from Joan's brother raising concerns about Alfred's safety.

7.10 The chair has raised the subject of professional curiosity and discussed with the panel, whether there is a learning opportunity and recommendation to be made on the subject. The review has been reassured that learning has been drawn from previous Domestic Homicide Reviews and that the SSAB has produced various briefing videos and training to uplift the knowledge of all those within the safeguarding community.

7.11 Several days later the couple were visited by staff from HTT and Alfred told them that he didn't feel safe at home. The following day he called Som FT and told them that Joan wasn't well and that he was exhausted. Alfred was offered reassurance, but assessment of risk appears not to have been carried out. Police engagement routinely included the completion of DASH and BRAG risk assessments, and matters being raised to the LSU.

7.12 The 'Safer Somerset Domestic Abuse Newsletter'[39] raises the issue of risk assessing and encourages staff to complete DASH Risk Indicator Checklists and Referrals. It seems reasonable that this review recommends that Safer Somerset Partnership analysis's the quantity and quality of risk assessments that are carried out when engaging with families where there is a history of domestic abuse.

7.13 The panel considered the subject of assessing risk and the need to consider various protected characteristics, relevant to this review, i.e., age, sex, and disability. The DASH checklist[40] remains the most common method with regards to domestic abuse and acts as an aide memoire and useful checklist for practitioners to use. However, it is important that the 9 protected characteristic as defined by the Equality Act 2010 are recognised as an additional factor whilst assessing risk Therefore, there is a need for practitioners completing risk assessments to a high standard and with appropriate vigour. This process should be supported by a suitable Quality Assurance process to ensure high standards of completion.

Responding to crisis

7.14 The panel has considered the issue of how agencies responded to the crisis which was developing in the family home of Alfred and Joan. It has considered how frontline practitioners reacted to initial reports and what subsequent activity took place.

7.15 What is clear, from the information provided to this review is that Alfred and Joan's brothers perceived the couple's relationship was under significant strain and that they needed help, this is demonstrated by the frequency and veracity of the incidents. It is

---

39 https://somersetcc.sharepoint.com/sites/SCCPublic/Community/Forms/AllItems.aspx?id=%2Fsites%2FSCCPublic%2FCommunity%2FDomestic%20%2EAbuse%20Newsletter%20Spring%20Edition%20April%202021%2Epdf&parent=%2Fsites%2FSCCPublic%2FCommunity&p=true&ga=1

40 https://www.dashriskchecklist.co.uk/wp-content/uploads/2021/12/DASH-2009.pdf

acknowledged, by all the panel agencies, that there were safeguarding concerns, and that immediate support was provided at the point of each contact.

7.16 The panel was satisfied that frontline practitioners were caring and professional when dealing with calls and reports from Alfred and Joan. They were able to make immediate referrals to support teams and sought to reassure and calm situations presented to them.

7.17 Equally it is important to reflect upon what opportunities there were to expand upon this initial engagement and consider a broader, plan to manage the issues faced by the couple and their family. The chronology presents several examples of incidents that could have triggered additional referrals and the preparation and execution of longer-term safeguarding strategies. The Care Act is clear about how best to support people and prevent situations from escalating to the point where a safeguarding response is necessary. *All practitioners should be working with people to reduce such risks and limit the need for them to need a safeguarding response. This duty is the responsibility of all agencies.*

7.18 The panel has considered the issue of the delay following four police referrals to Adult Social Care and planned meeting to discuss the allocation of Joan for section 9 assessment. The chair has considered whether a recommendation is needed to be made with regards to such delays and the need for ASC to review its policies and processes. However, this incident has been reviewed by the service manager, of the responsible team. It appears that in the case of Alfred the issues arose due to individual performance and have been addressed by way of internal processes and training.

7.19 Additionally the service manager has reviewed fully the process from receiving a new referral to the allocation of this work in the team. In the situation of Alfred and Joan further dialogue had occurred between SCC and SFT to gather more information to support the prioritisation of allocation. This information was omitted from the records but held within the team. The service manager has put in place mitigations from this happening again.

7.20 At the end of March Alfred called SomFT stating that he feared for his life. Staff spoke to Joan, and she raised concerns regarding other family stressors. Alfred was advised to call the police if he was at immediate risk of harm.

7.21 The chair raised the question as to whether more could be done to support staff dealing with similar cases and has been reassured that their training includes the understanding and benefits of assessing risk and the available options when presented with calls from people who fear for their life. Additionally mental health call handlers have access to immediate managerial support.

7.22 The panel has formed the view that Joan was more ‘cared for than carer’. As Alfred had declined the offer of a Carers Assessment, his needs as a carer had been recognised, however it has also been recognised that there is learning for SomFT in ensuring that this offer remained open, and that Alfred be reminded of this whenever appropriate.

7.23 Following Joan’s release, it was decided that the most proportionate response was for Alfred and Joan to have an assessment of needs under Section 9 of the same act. It was also noted that Alfred had made requests for Joan to be admitted to hospital for assessment and treatment. The Triage Safeguarding Team commented that this was

a 'Nearest and Dearest request[41] (See footnote). Considering the previous requests and appeals, made by Alfred, this seems to be a reasonable recommendation however it is pertinent to remember that Joan also has rights in relation to Human Rights Act, Mental Capacity Act, and the Mental Health Act. Any offer of respite for Joan would need to have been agreed to by her.

Links between relationship tensions and suicide

7.24 This section has been raised as the review feels it is important that agencies are able to recognise when individuals and circumstances are in crisis and have descended to the point where someone decides to take their own life. It is difficult not to use hindsight bias and make assumptions when reviewing the circumstances of Alfred's death and this section is intended to draw attention to potential prompts or moments in time when incidents occurred, or comments were made, that could trigger a need to discuss suicidal ideation with individuals and for practitioners to consider opportunities and options to support those in a similar position to Alfred.

7.25 Somerset County Council has guidance for frontline workers and volunteers about suicide prevention[42]. The guidance was produced in 2020 and provides advice to those engaging with service users who report or demonstrate symptoms of suicidal ideation. Among the various signs are 'Expressing feelings of hopelessness', and while the interpretation of Alfred's comments is always subjective it is important to be cautious when considering calls such as those made by Alfred and Joan's brother and recorded in the chronology of this report. The guidance suggests that if practitioners recognise signs of this ideation, they should feel confident to ask questions of the service user and explore whether they plan to harm themselves. The review believes that this guidance is an extremely valuable source of information, when dealing with various circumstances presented by this review. and that its content (along with other related material) has been shared with relevant staff and form part of a training input, in the future.

The sharing of information

7.26 Practitioners who encounter victims, perpetrators and their families, often need to assess whether and how to share personal information, regarding their clients, with other professionals. Lawful and proportionate information sharing can be vital to help victims, carry out risk assessments, and help bring perpetrators to justice.

7.27 The chair has considered the use of MARAC, as a potential route of sharing information between cases like this. The MARAC process is designed to provide a multi-agency response to domestic abuse cases considered to be High Risk. There are 3 basic principles which are used to interpret when an incident or set of circumstances should lead to a MARAC referral i.e.: Visible High Risk - 14+ yes answers to the DASH checklist, Potential escalation of the risk being apparent during a series of reports or engagements and Professional Judgement.

[41] https://themaskedamhp.blogspot.com/2015/11/sec-134-right-of-nearest-relative-to.html

[42] https://www.google.com/search?client=safari&rls=en&q=suicide+prevention+in+somerset&ie=UTF-8&oe=UTF-8

7.28 The review period demonstrates that there were 5 police reports in the two months prior to Alfred's death and there is an argument to suggest that this volume of engagement could, in theory, have been sufficient to trigger a referral into MARAC. However, as the panel identified, the reporting of domestic abuse needs to be contextualised against the other issues, within the couple's relationship i.e., Joan's apparent deteriorating mental health, rather a criminal intent to cause injury or damage property. Police records indicate that this was the case and that they made regular and relevant referrals and shared information to primary and secondary health care agencies. Avon and Somerset police then did not feel it necessary to make any referrals to MARAC.

7.29 The review has also looked into the pathways available for police officers to pass relevant reports to GP practices in order to ensure that information, is shared quickly and securely. Such notifications now are sent, via email, to the Integrated Care Board (ICB) [43] who access the NHS 'Spine' system and allows operators to identify the correct GP Practice and ensure that information is then promptly sent to the relevant doctor's surgery.

7.30 In terms of Som FT and the MARAC process, the IMR author recognises that there were opportunities for DASH risk assessments to be completed and for the matter be brought to the MARAC for coordinated support and safety planning. This issue has been raised as a point of learning, by SomFT and the lessons learned form part of their Safeguarding Adult Level 3 training programme. There is also an e-learning module specifically about Domestic Abuse and the Elderly, in addition to a 30-minute webinar about DASH (Domestic Abuse Stalking/Harassment and Honour based Violence) risk assessment which is available to all Som FT staff.

Management oversight

7.31 It is acknowledged that there were excellent levels of fast time support provided, to Alfred and Joan. In particular the rapid response and attendance by police officers and also the engagement by SomFT staff. However, it has also been noted that longer term strategy planning could have been better and there were several chances for multi-agency working. In this section the report will reflect upon the role of management oversight and whether agencies should ensure their staffing groups have supervision relevant to their roles.

7.32 The police IMR has considered the support provided to officers who engaged with the couple and their report confirms that management supervision is standard practice, in all police investigations.

7.33 In terms of performance there were two incidents where BRAG risk assessments, were not completed by the police, following calls to the couple's home and these omissions was not identified when supervisors were assessing the reports made by the attending officers. Separate to this review Avon and Somerset have looked at their own performance with regards to the use of the BRAG risk assessment process and as a result produced a series of recommendations i.e.

[43] https://www.england.nhs.uk/wp-content/uploads/2022/06/42-nhs-somerset-icb-constitution-010722.pdf

- Clearly set out which forms officers are expected to complete and why to enable better safeguarding of victims.
- Additional training should be given to staff in relation to the BRAG which should include:
    - Why, when, and how to use the BRAG tool, including consequences of not.
    - How to access guidance to support use of the BRAG tool.
    - Pathways for onward referrals for vulnerable individuals and understanding who is responsible for what (including when officers should make referrals directly).

This review supports this position and makes no further commentary.

7.34 During Joan's period in police custody decisions were made with regards the type of assessments that would best support the couple. Whilst the ASC safeguarding triage worker acknowledged Alfred's request that Joan should be admitted into hospital, they recognised that this could be achieved through a "Nearest Relative" application, however this was never communicated to Alfred.

7.35 This is an important issue and one that required careful consideration. This review has found no record of any supervision of the frontline workers, and this is something that the review felt needed further investigation. Subsequent scrutiny of Adult Social Care processes in this area has confirmed that the supervision of ASC workforce is not recorded on individual records for people. Within the SCC Safeguarding triage team there is a registered professional who holds the decision-making responsibility. This is oversight to support the unqualified triage practitioners who are carrying out the 'fact finding' work with regards to Sec 42 (1) of the Care Act. The information is presented to the registered professional, a decision is made, and the rationale is recorded. This is management oversight. All social care staff in the adult safeguarding service receive 1:1 supervision on a monthly basis.

7.36 Som FT had multiple engagements with the couple and an equal number of reports were created. Joan received support from CMHS and HTT throughout the scope of this report. There are various pieces of commentary, within the SomFT IMR, that suggest supervision and support for staff is something that could be improved. These include multiple references to opportunities for discussions with senior colleagues regarding the issues faced by Alfred.

7.37 Equally the records that have been reviewed demonstrate that there were opportunities to consider Alfred's situation and provide him with support. This would include support for the frontline practitioners who were regularly engaging with the couple, including management oversight of the case. As part of the review process the issue of supervision and practitioner support has been looked into and SomFT have been able to provide reassurance that the Trusts supervision review on policy includes Community Mental Health Service staff having regular line management supervision at least once every six weeks.

Male victims of Domestic Abuse

7.38 The Office of National Statistics (ONS) report[44] that for the year ending 31st March 2019, 786,000 men were reportedly the victim of domestic abuse compared to 1,600,000 women. In 75% of domestic abuse related crime recorded by the police (for the period) the victims were women. Therefore, the assumption has been drawn that 1 in 3 victims were men.

7.39 In terms of male suicide, a summary report was published by the All-Party Parliamentary Group on Issues Affecting Men and Boys in September 2022[45] where evidence was taken from national and international experts on this area. The lead author was a panel member (Mark Brooks). Currently, just under 5,000 men take their own lives across the UK each year, 13 per day – 75% of all suicides. The report concluded that male suicide was primarily due to the impact of a range of external issues (often called 'stressors') on men that they felt they could not resolve, even though they had tried. These stressors mainly range from relationship breakdown (in a wide sense), employment, workplace culture, bereavement, and financial problems. Cross-cutting issues such as isolation add further risk. It is hard to ultimately ascertain from Alfred, for obvious reasons, the direct cause of his suicide, however the report may illuminate the broad background to some of Alfred's thought processes at the time.

7.40 The chair wishes to acknowledge the detail with which IMR authors have explored this subject and the way in which they have recognised areas for improvement. What is clear is that Alfred did not consider himself to be a victim of domestic abuse when reporting matters to the various agencies, and instead was more concerned in getting support to manage the issues presented by Joan. In reviewing the IMR's there is clear acknowledgment that more could have been done to support Alfred.

7.41 It is possible that Alfred chose not to raise any of his issues due to feelings of loyalty towards Joan particularly as they were an older couple who had been married for many years. Equally he may have normalised any issues, particularly as they appear to have been going on for several years prior to his review period. For obvious reasons these are not subjects that could be explored with Alfred.

7.42 Considering the situation that Alfred faced Adult Social Care acknowledge that he was eligible for a safeguarding enquiry to further understand what he was experiencing. It is reasonable to draw the conclusion that the behaviour of Joan was due to her mental health issues, rather than being premeditated acts of violence or aggression. However, this should not have detracted from the fact that Alfred needed help. The ASC author comments that part of the qualifying criteria included the carer fatigue that was something Alfred was clearly suffering from. It appears that frontline practitioners believed that if they could address Joan's needs of then this would reduce Alfred's need for support.

7.43 On the day of his death the SCC call centre received a referral from the police following the report of Alfred's suicidal behaviour and ideation. In assessing the situation call centre staff have understood the previous triage decision to mean that

---

44 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

45 https://equi-law.uk/inquiry-no-3-male-suicide/

Alfred had been referred for a Needs Assessment, and therefore referred this report to the Mental Health Social Care Team, who were due to meet the following day. It is the view of the IMR author that this new information should have been viewed, by the SCC Adult Safeguarding triage team. Had this been done then practitioners may have considered a more urgent safeguarding response, particularly considering the behaviour and emotions that Alfred displayed.

7.44 There were no reports to ASC, regarding domestic abuse, until the middle of March 2021. This, however, does not mean that we should assume March 2021 was the first-time such incidents occurred. Despite receiving multiple reports prior to Alfred's death, he was never spoken to directly, and this review has drawn the conclusion that, based upon these referrals Alfred 'qualified' for an assessment under Sec 42 of the Care Act 2014. It could have provided him with sufficient reassurance that agencies were listening and there was available support to reduce any feelings of isolation.

7.45 From reviewing the records in this case it appears that an assumption was being made that Alfred's vulnerability was as a result of Joan's declining mental health and the ASC workers have judged that, by addressing Joan's condition, Alfred's vulnerability would be reduced. Whilst it is acknowledged that the police recognised Alfred as a victim the question to be asked is how they would manage a situation in which their referrals were not receiving a suitable response.

7.46 In terms of support from Som FT, the agency acknowledges that they were able to offer immediate responses when receiving report of Joan's condition however there seems to have been a lack of appreciation of wider issues within Joan and Alfred's relationship. This led to missed opportunities to offer Alfred support through the various assessments mentioned earlier and discussions at Multi-Disciplinary Meetings (MDT's) safeguarding supervision sessions.

Making safeguarding personal

7.47 When considering this subject, it is important to consider how Making Safeguarding Personal (MSP) is defined.

7.48 <u>The Local Government association defines MSP as:</u>

"a sector-led initiative which aims to develop outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances".

7.49 It is clear to this review that Alfred was never recognised as a victim of domestic abuse, and he never identified himself as being in that position. The example of the assessment issues following Joan's arrest was a chance to contact Alfred directly, discuss his welfare and obtain a greater understanding of the challenges he faced. It logical to suggest that this would have gone a long way to supporting the MSP principles within local and national policies.

7.50 Throughout this reporting period, and as the chronology of this report reflect, Alfred Joan and the family made many calls particularly concerning Joan's mental health. On more than one occasion they told front line practitioners that Alfred was unable to cope. Other areas of this report reflect the gravity of these pleas for help and the details

provided in many of the IMR's reflect the fact that that Alfred's position was not prioritised.

7.51 Following the referral from Mindline, on the day of Alfred's death Somerset Direct interpreted the previous triage decision to mean that Alfred had been referred for an assessment of need, we know that this was not the case.

7.52 It appears that there could have been more engagement through Multi-Disciplinary Meetings where Alfred's vulnerability discussed and responded to.

7.53 There were several occasions, particularly in the twelve months, prior to Alfred's death when practitioners could have created the opportunity to explore with him the frequency, nature, and severity of the incidents he had already disclosed and to refer these incidents to SCC for consideration under section 42 of the Care Act. Practitioners could also have taken the opportunity to complete and submit a DASH risk assessment, based on professional judgement, and request that the case be discussed in MARAC for consideration of coordinated support and safety planning. Alfred's case wasn't with the SomFT's Safeguarding Team or discussed at safeguarding supervision sessions.

7.54 SomFT also acknowledged the SafeLives study in 2016 and recognised the key factors which related to Alfred and Joan. Alfred remained 'systemically invisible' by virtue of not being referred for his own anecdotally reported health needs, nor in consideration of his needs as the primary carer for Joan. The entrenched nature of Joan's mental ill health appears to have rendered Alfred invisible to practitioners.

7.55 Further issues regarding engagement with Alfred and the recognition of missed opportunities by SomFT are recorded elsewhere in this report, (See 16.9.20 and 16.9.21) as are the remedial training activities which have already been put in place.

The impact of the COVID 19 pandemic on healthcare providers

7.56 Whilst the pandemic itself caused a great of stress and strain on both primary and secondary health care providers, this review can find no direct links that impact this review.

8. LESSONS LEARNED

The review identified a number of learning points that build upon agency IMRs. These have then been considered against a background of agency and policy developments that mitigate the need for a number of recommendations that may have otherwise arisen.

Learning Point 1: The issue here relates to the role of the carer and the need to recognise when their circumstances change and the level and nature of the support, they need similarly alters.
Learning Point 2 – All agencies within this review should ensure that they have a Quality Assurance process that ensures that their Domestic Abuse risk assessment processes also acknowledge the 9 protected characteristics.

Learning Point 3: It's important that all agencies provide training which cover competencies and specifications relevant to the gathering and sharing of information. Therefore, it would be beneficial to know how improvements have been recognised.

Learning Point 4: The review feels that there is an opportunity to enhance the support provided in this area and that men should be given greater encouragement to come forward when they feel they are the victims of domestic abuse and/or coercive control.

Learning Point 5 What this section of analysis reveals is that there is a need for further exploration of how the Making Safeguarding Personal guidance is implemented by frontline practitioners and how these staff are supported and managed in ensuring that every opportunity to protect the vulnerable is identified and explored.

9 GOOD PRACTICE

9.1 Somerset NHS Foundation Trust

- The Som FT's IMR contains details of an Action Plan that has been created and is detailed in the Recommendation Section it contains activity to reduce the likelihood of these types of missed opportunities from happening in the future.

9.2 Adult Social Care

- The ASC's IMR contains details of an Action Plan that has been created and is detailed in the Recommendation Section it contains activity to reduce the likelihood of these types of missed opportunities from happening in the future.

10. RECOMMENDATIONS

10.1 Local IMR Recommendations

10.1.1 All agencies

All agencies within this review should ensure that they have a Quality Assurance process that ensures that their Domestic Abuse risk assessment processes also acknowledge the 9 protected characteristics.

10.1.2 Somerset Council (formerly Somerset County Council)

What this section of analysis reveals is that there is a need for further exploration of how the Making Safeguarding Personal guidance is implemented by frontline practitioners and how these staff are supported and managed in ensuring that every opportunity to protect the vulnerable is identified and explored.

10.1.3 It's important that training is converted into positive action. Therefore, it would be beneficial to know how improvements have been recognised.

The review feels that there is an opportunity to enhance the support provided in this area and that men should be offered greater encouragement to come forward when they feel they are the victims of domestic abuse and/or coercive control.

10.1.4 Somerset NHS Foundation Trust

It's important that training is converted into positive action. Therefore, it would be beneficial to know how improvements have been recognised.

10.2 Overview Report Recommendations

The following recommendations have been agreed by the panel.

Recommendation 1: SSP to gain assurance that health agencies have robust systems in place to identify / record known carers, and have pathways in place to ensure timely referral for carers assessment and support with recognition that when circumstances change re-referrals and/or reassessment may be required..

Recommendation 2 – SSP to ensure that the DA assessments they promote across the health and social care system include questions relating to the 9 protected characteristics.

Recommendation 3: SSP to ensure that: There is training carried out, in relation to the sharing of information, by all agencies involved in this review. And that all agencies have processes in place for domestic abuse referral and/or DA Policies.

Recommendation 4: SCC Public Health to review its activities and provide agency training aimed at better recognising male victims of domestic abuse. In addition, more support to be provided to encourage male victims of domestic abuse to come forward. Support services and advice lines should be advertised more widely.

Recommendation 5: SSP to ensure that all agencies with safeguarding responsibilities have.

- An Outcomes Framework in place,
- A process for measuring its success, in terms of volume of engagement.

Each agency should provide a report discussing both evidence of good practice and areas for development.

Appendix A – Action Plan

DHR 038 Action Plan					
Recommendation	Action Required	By Whom	Date for Completion	RAG Rating	Updates
SSP to gain assurance that health agencies have robust systems in place to identify / record known carers, and have pathways in place to ensure timely referral for carers assessment and support with recognition that when circumstances change re-referrals and/or reassessment may be required.	SSP to liaise with NHS Somerset ICB to conduct audit of Somerset health system, to determine policies and systems in place	Safer Somerset Partnership and NHS Somerset ICB	31.3.24		
SSP to take steps to ensure that professionals completing DA assessments across the health and social care system understand importance of the 9 protected characteristics in relation to domestic abuse victims and barriers to disclosure		Safer Somerset Partnership	31.3.24		
SSP to ensure that. • There is training carried out, in relation to the sharing of information, throughout the Partnership .	SSP to task Somerset Domestic Abuse Board to review specialist domestic abuse training content regarding information sharing	Safer Somerset Partnership	31.3.24		

• That all agencies have processes in place for domestic abuse referral and/or DA Policies.	Somerset Domestic Abuse Board to include in self-assessment	Somerset Domestic Abuse Board			
Somerset Public Health to review its activities and provide training aimed at encouraging male victims of domestic abuse to come forward. Support services and advice lines should be advertised more widely.	Public Health domestic abuse training lead to review content of existing training programme	Somerset Council Public Health	31.12.23		
SSP to ensure that all agencies with safeguarding responsibilities have. • An Outcomes Framework in place, • A process for measuring its success. Each agency should provide a report discussing both evidence of good practice and areas for development.	Safer Somerset Partnership to request that agencies complete audit and provide report	Safer Somerset Partnership	31.3.24		

Appendix B – Home Office QA Feedback Letter

Interpersonal Abuse Unit
Marsham Street

London
SW1P 4DF

Tel: 020 7035 4848 2

www.homeoffice.gov.uk

Suzanne Harris
Senior Commissioning Officer, Interpersonal Violence
Somerset Council
1 Saint John's Road
Yeovil
BA21 4NH

24th June 2024

Dear Suzanne,

Thank you for submitting the Domestic Homicide Review (DHR) report (Alfred) for the Safer Somerset Partnership to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd May 2024. I apologise for the delay in responding to you.

The QA Panel felt that this was a good, well-structured report that is easy to follow. The report contains a good exploration of protected characteristics and the analysis, set out in themes, is also helpful. The inclusion of representation from Mankind on the panel was also positive and good to see.

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

Areas for final development:

- The Action Plan needs to be updated with outcomes and dates of completion.

- The report feels slightly overfocussed on Joan and her mental health. As there was no tribute or engagement with friends, family, or work colleagues of Alfred, there is little sense of who he was as a person as it stands.

- There was no public health/mental health/suicide prevention representative on the panel, to provide the lens of domestic abuse, self-harm, mental health, and links to suicidality. The CSP may wish to consider this for any future DHRs undertaken.

- Disability (related to the perpetrator's mental illness) and marriage should be identified as relevant protected characteristics in the Equality and Diversity section.

- Information provided in the report makes it relatively easy to determine the date of death, which should be amended where possible.

- The Executive Summary title page is missing the CSP name.

- The decision not to contact family members (who were involved in reporting their concerns for the victim's welfare) should be clarified, as it appears to have been made based on information primarily from the perpetrator of the abuse. These relatives will be able to identify themselves when the report is published and may question why they were not able to contribute to the process.

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