North Worcestershire

Community Safety Partnership

Executive Summary of the Domestic Homicide Review

Into the circumstances of the death of a man 'Steven'

June 2016

Independent Chair

Ivan Powell

June 2018

2. Review Process

This executive summary outlines the process undertaken by North Worcestershire Community Safety Partnership domestic homicide review panel in reviewing the alleged homicide of Steven who was a resident in their area.

3. Pseudonyms

3.1 The following pseudonyms have been in used in this review for the victim and alleged perpetrator to protect their identities. Additionally family members and a family friend who contributed to the review have also been identified bypseudonym in agreement with them. The people referred to in this report will be known as:

1. Victim – Steven a white male 43 years old at the time of his death
2. Alleged perpetrator – Jenny a white female 49 years old at the time ofthe incident
3. Victim's son – L
4. Victim's sister – N
5. Perpetrator's sister – C
6. Family friend - B

4. Criminal proceedings

4.1 In mid-June 2016 West Midlands Ambulance Service attended Steven and Jenny's home address where Steven was found deceased lying beneath a duvet on a mattress which was on the living room floor of the property.

4.2 Jenny, was arrested by West Mercia Police a few days later in June 2016 on suspicion of the murder of Steven. Jenny was charged with Steven's murder in December 2016 and remanded to prison.

4.3 In December whilst Jenny was in prison she was seen by a Registered Mental Health Nurse who recommended that she would benefit from a period of assessment on the mental health/learning disability wing of the prison.

4.4 Jenny was transferred to a specialist hospital in Northamptonshire for an assessment commissioned by NHS England. She was diagnosed as having a learning disability.

4.5 Jenny was subsequently found not fit to stand trial before the Crown Court in accordance with The Criminal Procedure (Insanity) Act 1964, as amended bythe Criminal Procedure (Insanity and Unfitness to Plead) 1991 and as amended byThe Domestic Violence, Crime and Victims Act 2004.

4.6 The Crown Prosecution Service decided that Jenny should stand before a finding of fact hearing in accordance with guidance[1]. As a consequence Jenny appeared before

[1] cps.gov.uk/legal-guidance/mentally-disordered-offenders

Birmingham Crown Court for the jury to decide whether or not she committed the actus reus[2] of murder, namely unlawful killing. The jury did not have to consider her mens rea[3].

4.7 The first trial concluded in mid-October 2017 as the jury were unable to reach a verdict.

4.8 The second trial concluded at the start of November 2017 when the jury's verdict was that Jenny had not committed the unlawful killing of Steven.

4.9 The process began with an initial meeting of the Community Safety Partnership in January 2017 when the decision to commission a domestic homicide review was agreed. All agencies that potentially had contact with Steven and Jenny prior to the point of death were contacted and asked to confirm whether they had involvement with them.

4.10 Eight of the nine agencies approached confirmed contact with the Steven and/or Jenny and were asked to secure their files.

5. Contributors to the review

5.1 The following agencies were asked to prepare chronologies of their involvement with either or both of Steven and Jenny, carry out Individual Management Reviews and produce reports:

- Change, Grow Live (CGL) - (substance misuse treatment provider)
- NHS Redditch and Bromsgrove and NHS South Worcestershire Clinical Commissioning Groups (CCG)
- Redditch Borough Council (RBC) Housing Services
- West Mercia Police
- West Mercia Women's Aid
- Worcester Hospitals Acute NHS Trust
- Worcestershire County Council Adult Social Care

5.2 During the review process the following agencies also contributed to the review by providing information on specific areas by direct contact with the Chair.

- Department of Work and Pensions (DWP)
- The Hostel, Worcester

[2] The physical element in the commission of a crime, in this case the act of unlawful killing.
[3] The mental element in the commission of a crime, a person's awareness that his or her conduct is criminal.

6. Review Panel Members

6.1 In accordance with the statutory guidance a DHR Review Panel was established to oversee the process of the review. Members of the panel and their professional roles were:

- Sue Coleman, Chief Executive Officer, West Mercia Women's Aid
- Sarah Cox, Quality and Safeguarding Services Manager, Worcestershire County Council
- Ellen Footman, Head of Safeguarding, NHS Redditch and Bromsgrove CCG and South Worcestershire CCG
- Martin Lakeman, Advanced Public Health Practitioner, Worcestershire County Council
- Julie Payton, Work Coach, DWP
- Vikki Reay, Detective Chief Inspector, West Mercia Police who on retirement was replaced by Simon Mason, Detective Inspector, Warwickshire Police
- Christina Rogers, Head of Safeguarding, Worcestershire Acute Hospitals NHS Trust
- Liz Tompkin, RBC, who was replaced by Judith Willis
- Steve Tonks, Detective Chief Inspector, West Mercia Police
- Charlie Twinn, Black Country Regional Quality Assurance Lead, Change, Grow, Live (CGL) (substance misuse treatment provider)

6.2 None of the panel members had direct involvement with the individuals involvedin this case, nor had line management responsibility for any of those involved.

6.3 The panel met on four occasions. An arrangement had been made for Steven's son L to meet with the panel in June 2017 however he was unable to attend at short notice for personal reasons. L and other family members have been updated throughout the review by the Chair. The AAFDA family advocate has beenfully engaged by the chair and she has helped shape the report on behalf of the family.

6.4 Mr Twinn provided expert advice to the panel on alcohol dependency syndrome.

6.5 The panel enlisted Mrs Caroline Kirkby, Transforming Care Lead Commissioner Worcestershire County Council as the specialist advisor to the panel on learning disabilities. Mrs Kirby had not previously had any contact or involvement with Jenny prior to the review commencing.

6.6 The Chair also consulted directly with and is grateful for the time and expertisegiven by Mr Keith Smith, Head of Consultancy, British Institute of Learning Disabilities, Professor Erica Bowen, Professor of Prevention of Violence and Abuse at Worcester University and Mrs Judith Vickress, Safelives.

6.7 The review benefitted from the provision of information to the Chair by the Chief Executive Officer of the Hostel, Worcester, Mr Jonathan Sutton concerning Simon's time as a resident at the hostel.

7. Author of Overview Report

7.1 The Independent Chair and Author, Mr Ivan Powell, was appointed in February 2017 to carry out this function. He is a former Senior Police Officer having retired in April 2014. He has completed the Home Office DHR training and attended the report authors training provided by Advocacy After Fatal Domestic Abuse (AAFDA).

7.2 He is an experienced chair and is currently the Independent Chair of two Local Safeguarding Adults Boards, (commencing September 2015 and June 2016 respectively), and the Independent Chair of a Local Safeguarding Children's Board, (commencing December 2016), none of which are in Worcestershire.

7.3 Prior to this review he had no involvement either directly or indirectly with the family and individuals involved.

8. Terms of Reference

8.1 The Victim:

8.2 Was the victim recognised or considered to be a victim of abuse?

8.3 Did the victim disclose to anyone and if so, was the response appropriate?

8.4 Was this information recorded and shared, where appropriate?

8.5 Were services sensitive to the protected characteristics within the Equality Act 2010 (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity) of the victim and their family?

8.6 When, and in what way, were the victim's wishes and feelings ascertained and considered?

8.7 Is it reasonable to assume that the wishes of the victim should have been known?

8.8 Was the victim informed of options/choices to make informed decisions?

8.9 Were they signposted to other agencies?

8.10 Was consideration of consideration of vulnerability or disability made by professionals in respect of the victim?

8.11 How accessible were the services for the victim and the perpetrator?

8.12 Was the victim or perpetrator subject to a Multi-Agency Risk Assessment conference (MARAC) or any other multi-agency fora?

8.13 Did the victim have any contact with a domestic abuse support organisation, charity or helpline?

8.14 Was the victim a social housing tenant? If so was there rent arrears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation. Does the Social Housing Landlord carry out routine screening for domestic abuse?

8.15 Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?

8.16 The Perpetrator:

8.17 Was the perpetrator recognised or considered to be a victim of abuse?

8.18 Did the perpetrator disclose to anyone and if so, was the response appropriate?

8.19 Was this information recorded and shared, where appropriate?

8.20 Was anything known about the perpetrator? For example, were they being managed under MAPPA, had they received a Learning Disability diagnosis, did they require services, did they have access to services?

8.21 Were services sensitive to the protected characteristics within the Equality Act 2010 (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity) of the perpetrator and their family?

8.22 Were services accessible for the perpetrator? And were they sign posted to services?

8.23 Was consideration of vulnerability or disability made by professionals in respect of the perpetrator?

8.24 Did the Perpetrator have contact with any domestic abuse organisation, charity or helpline?

8.25 Was the perpetrator a social housing tenant? If so was there rent arrears orfrequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? These could be indicators of a potential domestic abuse situation. Does the social Housing Landlord carry out routine screening for domestic abuse? Are there policies in place which support and allow staff to identify and report suspected domestic abuse? Have the processes in place been reviewed to ensure that they remain effective?

8.26 Practitioners:

8.27 Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse including coercive control and behaviour and aware of what to do if they had concerns about a victim or perpetrator?

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

8.29 Policy and Procedure:

8.30 Did the agency have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators (for example DASH) and were those assessments correctly used in the case of this victim/perpetrator?

8.31 Did the agency have policies and procedures in place for dealing with concerns about adult safeguarding and domestic abuse? And are these subject to review?

8.32 Were these assessments tools, procedures and policies professionally accepted as being effective?

8.33 Did the agency comply with adult safeguarding and domestic abuse protocols agreed with other agencies, including any information sharing protocols?

8.34 Assessments and Decision Making:

8.35 What were the key points or opportunities for assessment and decision making in this case?

8.36 Was there reason to doubt the mental capacity of the victim or the perpetratorand if so was this considered appropriately in order to inform key decisions?

8.37 Do assessments and decisions appear to have been reached in an informed and professional way?

8.38 Did they consider either the victims or perpetrators past criminal history or indicators of risk?

8.39 Did actions or Risk Management Plans (RMPs) fit with the assessment and the decisions made?

8.40 Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

8.41 Were Senior Managers or agencies and professionals involved at the appropriate points?

8.42 General:

8.43 Consider the methods and frequency utilised by staff with both the victim and perpetrator in light of their reluctance to engage.

8.44 Are there other questions that may be appropriate and could add to the content of the case? For example, were there any previous lessons learnt from past DHR's that should have raised practitioner's awareness:- housing, community organisations, neighbours , employers etc.

8.45. Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies,

assesses and manages the risks posed by perpetrators? Where could practice be improved in your organisation?

8.46 Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

8.47 The Terms of Reference will be a standing item on the agenda of every meeting in order that we can remain flexible in our approach to identify learning opportunities.

9. Chronology

9.1 The alcohol treatment provider for the parameters of the review in Worcestershire was Change Grow Live (CGL) who operated under the local project name of 'Pathways to Recovery'. CGL transparently reported some gaps in their service in the few months prior to the date parameters of the review. Given Steven's alcohol dependency they were included as they are considered to be relevant to the review process and related learning.

9.2 No definitive date can be established for the start of Steven and Jenny's relationship. In February 2015 Jenny was visited at home by a local police officer (LPO 1) and the Anti-social behaviour (ASB) Coordinator as a consequence of emerging reports of anti-social behaviour. Steven was at the flat and the officers established he was living there. Jenny explained that she had met Steven by the church in the town centre and that she didn't know anything about him.

9.3 The officers explained to Jenny that they considered her to be very vulnerable and had serious concerns regarding her welfare. They also explained that her neighbours had reported being fearful about what was happening at her flat.

9.4 Jenny specifically asked if Steven could still come to the flat. She was told that he could but that if there were further problems the Police could consider a Domestic Violence Protection Order (DVPO) against Steven to ban him from visiting.

9.5 Jenny was also told that her tenancy could be at risk.

9.6 Following this visit the Housing Locality Leader allocated a Home Support Worker to Jenny.

9.7 The ASB Coordinator formally informed housing benefits colleagues that Steven was living with Jenny at the address, which had implications for the administration of housing benefit payments reported on later, but had the immediate impact of causing Jenny's housing benefit payments to be suspended. She was formally informed of this by the borough council by letter in April 2015 and of the need for her to declare Steven as being resident at the address.

9.8 In April 2015 neighbours called Police to Jenny's flat reporting an argument. Police did not respond for four hours by which time the house was in darkness and the officers could not get a response from inside. The Police IMR was unable to establish why there was such a delay in the Police response.

9.9 The following day officers from the Safer Neighbourhood Team (SNT) re-visited Jenny and Steven and completed a Domestic Abuse Stalking and Harassment (DASH) risk assessment, although it was not clear to whom the assessment related. All of the questions on the assessment were answered in the negative.

9.10 LPO 1 re-opened a pre-existing risk management plan in respect of Jenny, which had been in place between early 2013 during a previous relationship. LPO 1 recorded that she considered Jenny to be vulnerable, the relationship bore the same risk traits as her previous one, that Steven was homeless and she considered he may be taking advantage of Jenny's situation. She recorded that the flat was very untidy when it had previously been well kept.

9.11 By mid-May Jenny had accrued three weeks of arrears at her flat.

9.12 In mid-May 2015 LPO 1 and the ASB Coordinator attended Jenny's home with her sister C. Jenny was not present despite being asked to be in attendance. C had a key and the flat was found to be messy. C outlined her concerns about her sister's relationship with Steven. C said that she was not able to pay her sister's rent and explained that it was becoming increasingly difficult to see Jenny and that Jennydid not want to engage with support agencies any more.

9.13 In late May 2015 Jenny had not actioned the requirements from the housing benefit department and her housing benefit was cancelled.

9.14 In June 2015 a Police referral was received by adult social care which outlined that Jenny was a vulnerable adult and the circumstances of her relationship with Steven. Adult social care responded to the police explaining that as there were no apparent eligible social care requirements for Jenny they would be taking no further action.

9.15 Also in June 2015 a County Council Safeguarding Team duty social worker concluded there were no adult protection concerns within a borough council housing department referral.

9.16 In July 2015 Police were notified by a neighbour of arguing and shouting at Steven and Jenny's flat.

9.17 Police attended within ten minutes by which time the address was silent. The officers spoke with Jenny and Steven. The officers recorded that Jenny was a vulnerable adult with learning difficulties and that Steven was drunk. He was removed by Police and taken to a local address.

9.18 A DASH assessment was completed with Jenny during which she said she was upset at the way he treated her but was also upset that he may not come back to the flat, as she wanted to continue the relationship. The officer recorded that the victim was a vulnerable adult who wanted to resume the abusive relationship and that neighbours and friends had expressed concern. The officer concluded the level of risk to Jenny to be medium.

9.19 The officer secured a witness statement from one neighbour to whom Jenny had disclosed, that evening, that she had been assaulted by, and was afraid of Steven who was subsequently arrested.

9.20 The officer pursued a victimless prosecution but a charge was not authorised bythe Crown Prosecution Service.

9.21 The officer then pursued a Domestic Violence Protection Notice (DVPN) which was authorised by a Police Superintendent and served on Steven in July 2017.

9.22 The investigation was passed on to officers to pursue a Domestic Violence Protection Order (DVPO). Court records indicate that police did not attend court and the case was dismissed. The review was unable to establish why this happened.

9.23 In July 2015, following the police referral regarding the incident adult social care raised a safeguarding concern with their triage team.

9.24 The adult safeguarding team confirmed with the Police Harm Assessment Unit (HAU) that Jenny had not engaged in the police investigation and had indicated that she wished to remain in a relationship with Steven. The adult safeguarding team closed the section 42 enquiry recording Jenny had not been highlighted as having any concerns regarding her capacity, had declined any support to the incident, and did not wish to pursue charges towards her partner insisting that she wished for him to return to the home environment.

9.25 In August 2015 the ASB Co-ordinator and Home Support Worker told Jenny and Steven that as they were now living as a couple they would need to re-arrange their Employment Support Allowance (ESA) jointly as well as their housing benefit. Jenny told the officers that she now had her own bank account. Steven agreed that they would visit the Town Hall to see what they had to do.

9.26 In late August 2015 Jenny's neighbour called Police to report a disturbance. Police concluded that a domestic incident had not occurred but that it was part of ongoing neighbour complaints about the anti-social behaviour displayed by Jenny and Steven and casual visitors to the address, but they did complete a DASH risk assessment with Jenny who declined to answer any questions. The risk was deemed to be medium.

9.27 In September 2015 the then Head of Housing, RBC chaired a 'Vulnerable Adults' meeting in respect of Jenny, the purpose being to try and resolve issues relating to individuals in a multi-agency arena. It was not constituted to address 'adult safeguarding' as defined by the Care Act 2015 and did not accord with Care Act guidance. The agreed action was to refer to the triage team and Social Services were to check information held. Adult social care were not at the meeting and were unable to find reference to the action.

9.28 The case was removed from the Group at the next meeting in October 2015 as it was felt as Home Support and Council Locality Officers were meeting with Jenny regularly this was sufficient at the time.

9.29 Welfare visits to Jenny continued and in September 2015, because of the concerns of the visiting officers of potential financial abuse being indicated by the number of requests for food parcels and reports of her being seen street begging, atelephone call was made by borough council staff to the Adult Social Care Safeguarding Team. This was not recorded on the adult social care system and so it cannot be confirmed it occurred and if so what the resultant outcome was.

9.30 In September 2015 the ASB Coordinator and Home Support Worker Jenny told the officers that her sister had stopped her having a bank account and she now had no money. The officers helped Jenny understand a letter from DWP regarding her ESA claim. Jenny was reluctant for the officers to help complete the enclosed claimform so they encouraged Jenny to go to the Citizens Advice Bureau (CAB) for help and advised her to take Steven with her so that he could include his details. Jenny agreed to do so and also to see a Housing Benefit Worker as her housing benefit had stopped.

9.31 Between the end of September 2015 and December 2015 the ASB Coordinator and Home Support Worker visited Jenny and Steven frequently at home with significant focus on her welfare and attempts to resolve their financial position.

9.32 In mid-December 2015 the ASB Coordinator and LPOs 1 and 3 visited Jenny and Steven at home following further reports from neighbours of shouting and swearing and reports of Jenny begging in the street. During this conversation Steven agreed to be referred to the alcohol treatment service and LPO 1 subsequently made a telephone referral to the alcohol treatment provider.

9.33 In December 2015 a patrolling PCSO attended a report of a Jenny and Steven arguing and becoming rowdy in the town centre. Both were drunk and were escorted by the officer out of the town centre precinct. The PCSO made an entry on the risk management but a domestic incident report was not created.

9.34 In early January 2016 LPOs 1 and 3 visited Jenny and Steven at home to discuss reports from residents of shouting and screaming from the flat over the Christmas period. Both Jenny and Steven were spoken to but denied that any arguments had taken place. They immediately said the neighbours 'had it in for them'.

9.35 Jenny was spoken to on her own but maintained there was no issue. LPO 1 was concerned that Jenny may be reluctant to make disclosures and so arranged for the Safer Neighbourhood Team to pay late night attention to the property. Checks were subsequently made of the property but no further disturbances noted.

9.36 Between mid-January 2016 and mid-February 2016 Housing Workers visited Jenny and Steven on a number of occasions to facilitate their house move, which occurred on 23rd February 2016. Jenny and Steven were given a significant amount of

coordinating support by Housing Workers, and a new washing machine was purchased through the Essential Living Fund. The Benefits Officer also changed over housing benefits and council tax payments.

9.37 In March 2016 LPO 2 and the ASB Coordinator visited Jenny at home to speak with her about reports of her begging in the town centre and explained that they were concerned because of the significant level of her benefit payments per month.

9.38 Jenny was spoken to alone and asked about her money. She stated that Steven looked after her money and that they just bought food. She was asked directly whether Steven was abusing her in any way; she replied no. She was asked directly if Steven was controlling her; again she replied no. She was asked if she was happy and said that she was. She maintained that Steven had not done anything to her. No referral was made as a result of this but it was included on the Police risk management plan.

9.39 LPO 2 asked a female PCSO 1 to talk to Jenny, qualifying the request saying that Jenny may be more comfortable talking to a female.

9.40 Despite several visits by PCSO 1 Jenny did not make any further disclosures. PCSO 1 did note that more often than not, both Jenny and Steven were out of the property and when located in the town area Steven was intoxicated.

9.41 In March 2016 Police attended Jenny and Steven's home following a '999' call from neighbours about shouting and screaming. Steven initially told the attending Police officer that he had been assaulted by Jenny who had struck him on the hip causing bruising, but later said he did not know how he had sustained the bruising. A DASH assessment was conducted with Steven and the risk graded as standard. Steven did not wish to pursue a complaint.

9.42 The case was discussed at the multi-agency 'Every Victim of Domestic Abuse' (EVODA) meeting in March 2016, EVODA being at that time held every Monday to Friday morning to discuss all reported domestic abuse incidents which had occurred the previous evening or over a weekend. The decision from this multi-agency meeting was that there would be no further action.

9.43 In March 2016 the ASB Coordinator and Home Support Worker told Jenny that they may have to withdraw their home support to her as she was not engaging with them. Jenny told the officers that she no longer needed support as she had Steven.

9.44 The borough council officers remained so concerned about Jenny's ability to manage her finances, and of the reports of Jenny begging in the streets, that they made contact with the Local Policing Team to organise a joint home visit.

9.45 In April 2016 the ASB Coordinator and LPO 2 visited Jenny at home to discuss her begging. She told the officers that she was going to stop begging and was worried about being arrested. She also said she was using her benefits to buy clothes and food. The officer's checked the flat with Jenny's permission. It was noted that there

was very little food in the fridge and freezer. Jenny told the officers that herbenefit money was paid into Steven's Post Office account and that he gave her money to buy food and clothes and to pay for their bills.

9.46 The officers talked to Jenny about her welfare however she said that there was not a problem with her and Steven and that he cooked her meals. Jenny became agitated saying that she wanted to leave the flat.

9.47 LPO 2 said he would make an adult safeguarding referral on return to the Police station due to concerns of financial abuse from Steven. The police could not confirm submission of this referral, nor adult social care receipt of it.

9.48 In April 2016 Police attended the address following a '999' call from neighbourswho reported that Steven and Jenny were arguing. Police found all was calm inside and Jenny and Steven were cooking dinner. They denied arguing saying they had both been drinking and had the TV on loud. Police completed a DASH assessment with Jenny, graded as standard. It was recorded that both parties denied arguing. Previous emotional domestics were noted on the incident record. Jenny's declined to consent to being referred to domestic abuse agencies. The matter was discussed at EVODA in April 2016, the decision being no further action to be taken.

9.49 In April 2016 the Housing Locality Team Leader decided that no further Home Support Workers visits were to take place as Jenny had declined to engage with the support offered.

9.50 In June 2016 a further joint visit was conducted by LPO 2, PCSO 1 and the ASB Coordinator to discuss anti-social behaviour reports from neighbours and further reports of Jenny begging in the town centre. When the officers arrived at the rear of the flat they could hear shouting and arguing inside the flat. Initially both Jenny and Steven denied that they had been arguing.

9.51 They were told by the Police that they would be the subjects of the Police risk management plan. Steven asked if it was because the Police thought he was hitting Jenny. He was told that it was in respect of reported anti-social behaviour however the Police did outline the possibility of pursuing a DVPO against him.

9.52 It was agreed that the Police would make a referral to the alcohol treatment provider for Steven and to Social Services for Jenny and LPO 2 emphasised the importance of them engaging with support.

9.53 In June 2016 LPO 2 spoke with a Consultant Social Worker. He explained he had recently made a referral in respect of Jenny and outlined his ongoing concerns regarding Jenny's vulnerability and in particular that Steven was financially abusing her as he had control over their joint benefits and he was alcohol dependent. The Social Worker asked the LPO if he wanted to report the suspected abuse as safeguarding but he said he would just like his concerns passed through and asked if a Social Worker could call him back as soon as possible.

9.54 In the early hours of the 13th June 2016 Steven's death was reported by Jenny.

9.55 In mid-July 2016 a letter from Worcestershire Health and Care Trust was received by Jenny's GP which informed the GP that Jenny had been assessed as lacking capacity for managing her finances.

10. Key issues arising from the review

10.1 Steven's referral into alcohol treatment services was met with some shortcomings of response by the treatment provider. When Steven did not attend appointments CGL should have both made attempts to contact Steven to re-arrange and informed Steven's GP of his non-attendance.

10.2 In August 2016 CGL introduced a new 'Engagement and Re-engagement Policy' which will ensure that the reported shortcomings in their response will be avoided in future.

10.3 Steven was supported well by his GP practice. He was seen frequently at thepractice and GP's as well as treating Steven's alcohol dependence syndrome also repeatedly encouraged him to engage with the treatment service. When he moved to another area he was encouraged by the GP to register with a local practice.

10.4 Steven was known to the Borough Council housing services prior to moving in with Jenny. He was given support by the Council in the form of food parcels on numerous occasions. The Council also offered to help Steven secure a place in hostels which he declined.

10.5 Jenny was housed by the Borough Council in 2012. Steven moved in with Jenny and was recorded by the Council as living with her in February 2015.

10.6 Between February 2015 and the date of his death Steven and Jenny were visited frequently by a combination of the anti-social behaviour officer and housing support worker from the Borough Council and members of local policing teams.

10.7 Both agencies regarding Steven as vulnerable because of his alcohol dependency and repeatedly tried to encourage him to engage with treatment services.

10.8 Both agencies regarded Jenny as being vulnerable submitting numerous referrals to adult social care regarding their concerns that she was seen begging in the streets, was the subject of controlling behaviour and suspected to be the victim of financial abuse.

10.9 Both agencies also had concerns about Jenny's ability to live independently and raised doubts concerning her understanding and recognition of the risks she faced.

10.10 Officers from the Borough Council and the Police were to be commended for the significant commitment and effort displayed in working both individually and together to try and engage Steven and Jenny.

10.11 Better outcomes could have been secured but the officers from both organisations had not been appropriately trained by their organisations in the Mental Capacity Act 2005 and The Care Act 2014 and the related guidance on adult safeguarding procedures and Making Safeguarding Personal[4].

10.12 The College of Policing have yet to produce national Approved Professional Practice (APP) for the police service on adult safeguarding. APP is the usual precursor for a local police force to implement local procedures and deliver training on the subject matter concerned.

10.13 The Borough Council did not have a policy and procedure nor related training for its frontline staff on domestic abuse.

10.14 The Police had not adequately trained their staff in the section 76 Serious Crime Act 2015 offence of 'coercive and controlling behaviour'.

10.15 Whilst it was a reasonable assumption on the part of the County Council Adult Social Care staff that other agencies had policy and procedures and had appropriately trained staff on the Mental Capacity Act and Care Act, including Adult Safeguarding and Making Safeguarding Personal, the reviewed identified that this was not in fact the case. On that basis Adult Social Care could have taken a system leadership role prompting other agency staff appropriately.

10.16 Jenny grew up with her mother and lived with her until 2011 when she moved to Worcestershire where she was supported by her sister. In particular Jenny was supported by both her mother and sister with her finances. As a consequence it remained questionable as to whether Jenny could live independently with regard to her finances. Between February 2015 and November 2015 Jenny and Steven were working through arrangements regarding their joint finances.

10.17 Jenny did not have a bank account of her own and as a consequence all of her benefits were paid into Steven's account. The outcome was inevitable in that Steven due to his compulsion spent significant amounts of Jenny's money on alcohol resulting in his financial abuse of her.

10.18 The review was unable to resolve whether or not there are potential gaps in process with DWP. Jenny having been classified as being in 'the support group' had no requirement to personally meet with a member of DWP regarding her benefit payments. Whilst there are safeguards in place regarding appointee ship, which include an interview by DWP with a new appointee, records in respect of Steven and Jenny which could have provided clarity had been weeded. Given that Jenny could not read nor write, coupled with the questions of her capacity to make decisions regarding her finances, it remained a concern that there may have been gaps in the process which led to Steven having sole control of their welfare benefits.

[4] Making Safeguarding Personal Guide April 2015 Local Government Association and Association Directors of Adult Social Services

11. Conclusions

11.1 Steven was acknowledged by many agencies as being vulnerable because of his social circumstances, his alcohol dependency and his related physical and mental illnesses. He lived variously between friends' houses, hostel accommodation and later in his life was homeless, again reinforcing his vulnerability.

11.2 Individuals described by many agencies as a 'vulnerable adult' often fall beneath the threshold for longer term engagement and support of statutory services, and in the case of an adult, any support is predicated on the issue of having the consent and engagement of the person (accepting the circumstances where a lack of mental capacity may be a factor). In Steven's case he was never referred to adult social care for a formal Care and Support Assessment and were such an assessment have been conducted the likely outcome cannot be predicted.

11.3 On this aspect the CGL panel member in his capacity as an expert on alcohol addiction suggested that any of the agencies could have referred Steven to adult social care for a Care and Support Assessment.

11.4 Statutory guidance[5] states that:

A Local Authority must undertake an Assessment for any adult who appears to have any level of needs for care and support, regardless of whether or not the Local Authority thinks the individual has eligible needs.

11.5 The guidance states that an adult's needs meet the eligibility criteria if:

(a) The adult's needs arise from or are related to a physical or mental impairment or illness

(b) as a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes, and

(c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being.

11.6 The panel member identified that Steven suffered from alcohol addiction, a mental health problem. As a result was unable to achieve two or more of the specified outcomes, in his specific case;

to maintain a habitable home environment, engage in work or training and maintain family relationships and;

there was clearly a significant impact on Steven's well-being.

11.7 The panel member acknowledged some of the challenges this would pose but outlined that most often referrals for a Care and Support Assessment on the outlined rationale would not result in an Assessment of Need or in the provision of support or

[5] Chapter 6 Assessment and Eligibility Care and Support Guidance issued under the Care Act 2014

care. Currently if an individual is engaged in alcohol treatment the service provider will advocate in relation to housing and finances.

11.8 It is acknowledged that for either access to treatment services or assessment for care and support an individual would have to be willing to engage and in Steven's case most often he did not engage with alcohol treatment services, but a joint approach with adult social care may have been a more attractive proposition.

11.9 The panel member for adult social care identified that the overall assessment would determine the level of impact on an individual's well-being, thus determining eligibility. It cannot be assumed that Steven's 'alcohol addiction' and his related 'mental health problem' would automatically lead to him being unable to achieve one or more of the specified outcomes.

11.10 It was apparent that GP services and the Hostel did provide good levels of support to Steven. It was also evident that members of the Police and the Borough Council Housing Services also tried hard to secure Steven's engagement with alcohol treatment services but were unable to get him to do so.

11.11 Jenny was acknowledged as being vulnerable by all of the agencies involved.

11.12 In 2012 a capacity assessment was conducted by a member of the County Council Adult Social Care with Jenny when she was deemed to understand the risks involved in continuing her relationship with a previous partner.

11.13 No formal capacity assessment was conducted with Jenny concerning her understanding of the risks within her relationship with Steven. The review has revealed information which would indicate that within this relationship she was not recognising the risks of his behaviour on her welfare.

11.14 There was a lack of clarity on Jenny's status of having either a learning difficulty ora learning disability. The diagnosis of learning disability remains a matter of professional discussion in Worcestershire.

11.15 It was apparent that there was also a lack of awareness of learning disability/learning difficulty and of the need to personalise and adapt procedural approaches when providing services to an individual with Jenny's needs.

11.16 This is of particular relevance given the statement that Jenny is describedas 'refusing to engage with services'.

11.17 The Police and the Borough Council had not adequately trained their staff on the Mental Capacity Act 2005 with particular regard to Capacity Assessments, Best Interest Decision Making and Advocacy.

11.18 The time period of the review included 1st April 2015, the date on which the Care Act 2014 was enacted and 29th December 2015 the date on which 'coercion and control' became a criminal offence under the Serious Crime Act 2015. It was established that not all agencies had appropriately trained their staff in thisregard.

11.19 Adult Social Care Services help people to live as independently as possible for as long as possible, and any action with an adult can only be instigated with their consent (accepting where mental capacity may be an issue alternative approaches may be appropriate). Where protection activity is necessary it must be in a way in which the individual affected is empowered to take action themselves and that the least intrusive response for the risk presented is taken.

11.20 The Police and Borough Council staff did not understand the role and remit of adult social care, and the process of Adult Safeguarding. This resulted in referrals to adult social care from the police and borough council which were not and could not be acted upon. This 'inactivity' in turn manifested itself as frustration from police and borough council staff who were in anticipation of action by adult social care when in fact this was not going to be the case.

11.21 Conversely there were possible opportunities for adult social care staff to recognise these gaps in knowledge amongst other agencies and to both take and prompt activity accordingly.

12. Lessons to be learned

12.1 The term 'vulnerable adult' is used variously by differing agencies and with no degree of consistency. It must therefore be considered to be unhelpful to continue to use the term 'vulnerable adult' within multi-agency communications. It is certainly unhelpful and without purpose for agencies to refer a 'vulnerable adult' into services when there is no consent for such a referral and/or no referral pathway exists for the matter referred.

12.2 Jenny not supporting police investigative processes into alleged domestic abuse offences were interpreted by adult social care professionals as a proxy for her lack of engagement with the adult safeguarding system.

12.3 There was a lack of knowledge of and clarity on the inter-dependency and inter-connectivity between domestic abuse offences and processes, the Mental Capacity Act, the Care Act (Adult Safeguarding) and Making Safeguarding Personal. There was also a lack of awareness of the West Midlands Regional Adult Safeguarding Procedures amongst some agencies, notably the Police and the Borough Council.

12.4 The Care Act 2014 defines domestic abuse as one of the categories of abuse for adult safeguarding. LGA and ADASS have produced guidance[6] for frontline adult social care professionals which did not appear to be embedded into current working practice. There needs to be local clarity in process and procedures regarding domestic abuse within the context of adult safeguarding settings which should include a protocol between adult social care and West Mercia Women's Aid.

12.5 There was a lack of understanding and clarity of referral pathways for a range of matters available to the multi-agency partnership, including whether a referral

[6] Adult safeguarding and domestic abuse A guide to support practitioners and managers

pathway exists at all. This indicates that whilst there was significant contact between agencies there was some lacking in the degree of actual communication.

12.6 Improved communication between the agencies would have led to shared understanding of Jenny's needs and how they were being met, and indeed what to do when those arrangements were becoming unsustainable, between professionals working to support her.

12.7 The impact of Jenny's needs was an area of consideration for the review, the panel benefiting from specialist advice as outlined in paragraphs 6.6 and 6.7 page 5 of this executive summary.

12.8 Mrs Kirby outlined to the panel that in her experience was very common for parents of children with a learning disability to be over protective and as a consequence they are not empowered to develop life skills for themselves.

12.9 Mr Smith advised that people with moderate learning disabilities are likely to present as being much more able than they actually are. It would take particular skill and experience to both recognise this and draw out the relevant aspects of a conversation.

12.10 Mr. Smith and Mrs Kirby were asked specifically about the likely impact of asking Jenny and both domestic and financial abuse and the use of DASH with her.

12.11 Mr Smith advised that officers engaging in such conversations were likely to have formed the view that given her answers that she understood the questions posed. He explained that Jenny would be giving answers based on her life experiences and in a manner she felt pleased the person posing them as opposed to being the actual answer.

12.12 In considering the same points Mrs. Kirby advised that Jenny would be keen to please and likely to answer simply yes or no. She also advised that when Jenny was talking to people she perceived to be in a position of authority she would be likely to try and quickly 'get them off her back'. Jenny would also be likely to feel scared about what the consequences might be when answering questions and this would impact negatively on the degree of her engagement with agencies.

12.13 Mrs. Kirby also advised that given Jenny's life experiences she would be likely to actively seek out control given her previous dependence on her mother and sister.

12.14 This does not seek to detract from Steven's actions to have been coercive and controlling, more to show that Jenny had a higher degree of vulnerability to this type of behaviour.

12.15 Mrs. Kirby and Mr. Smith agreed with the Chair's contention that it was probable that Jenny did not understand what in fact she was being asked to engage with, or as a minimum that services were not being explained to her in a way which she understood.

12.16 Professor Erica Bowen, a Professor of Prevention of Violence and Abuse at Worcester University, was spoken to by the Chair to examine the level of understanding currently on the incidence of domestic abuse where learning disability is present.

12.17 She too confirmed that Jenny would be likely to respond with 'no' responses tothe direct questions on the DASH Risk Assessment, and would answer in ways she believed would avoid people (Steven) getting into trouble.

12.18 Professor Bowen explained that there was a lack of international research on the subject, and with no work on perpetrators with learning disability at all.

12.19 Professor Bowen also identified that there remains some stigmatisation of people with learning disabilities and that there is a lack of appreciation that people with learning disability want relationships, including physical relationships. She identified that there is no systematic education programme on healthy relationships forpeople with learning disability.

12.20 It is accepted that these elements are possibly beyond the parameters of this DHR however it was felt by the Chair to be of fundamental importance for this matter to be raised as a matter of significant importance for those agencies who provide domestic abuse services.

12.21 The Chair also engaged with Mrs Judith Vickress of Safelives. She explained that Safelives have observed often that police are not always using the DASH risk assessment as a tool to inform their professional judgment as intended but more as a 'tick box exercise'.

12.22 Taking into the whole circumstances of the relationship between Steven and Jenny a Multi-agency risk assessment conference (MARAC) referral should have been made. Had this happened it is likely that this would have been the catalyst for a bettermulti agency response. MARAC would have looked to reduce the risk to Jenny by creating an action plan that worked to manage the behaviour of Steven and in doing so it is highly likely that this would have led to the identification of the support he may have needed.

12.23 Referral to the MARAC process would result in a referral to the Independent Domestic Violence Advisor (IDVA) service whose role is to engage victims into support and coordinate the multi-agency response. There was a notable absence in this case of any domestic abuse specialism which may have made a considerable difference to support her response to the domestic abuse Jenny experienced.

12.24 The publication of the College of Policing national review into the police service use of DASH is awaited however the Chair made enquiry regarding this case with the national review team to discuss early findings.

12.25 The College of Policing are in the process of piloting a DASH model which has a reduced focus on a 'yes/no' process in favour of more involved discussion and

enquiry with victims. It was felt unhelpful by the College of Policing to support a recommendation to seek a DASH related specifically to victims with needs such as Jenny's. This was on the basis that had there been better understanding of and compliance with the legislation and procedures previously outlined then engagement with Jenny could and should have been secured.

12.26 As has been reported although a DVPN was issued against Steven, it was neither enforced nor was the Order pursued. The review found that there was a lackof collective multi-agency understanding of the DVPN/O process and the proactive partnership opportunity the DVPN/O process presents.

13. Recommendations

The following are overarching recommendations made on behalf of North Worcestershire Community Safety Partnership:-

The College of Policing

- DHR author to write to the National Police Lead for Adult Safeguarding DCC Pilling, Greater Manchester Police to highlight the need to produce Approved Professional Practice on Adult Safeguarding.

Department of Work and Pensions (DWP)

- DHR author to write to the Local Government Association (LGA) who are currently working with DWP for the LGA to seek assurance that governance arrangements exist within the Department to ensure effective policies and procedures are in place in respect of adult safeguarding, domestic abuse and compliance with the Mental Capacity Act 2005.

Worcestershire Forum against Domestic Abuse

- The chair of the Worcestershire DHR sub group on behalf of the North Worcestershire Community Safety Partnership to write to the Worcestershire Office of Data Analytics project who is working on the development of shared systems and/or data. To share the themes and learning from this review to inform the future of data capture and sharing arrangements.

Worcestershire Public Health

- On behalf of the North and South Worcestershire Community Safety Partnerships to develop scope and commission domestic abuse training which seeks to bring together both Children and Adult social care and wider partners, making the links to safeguarding.

West Mercia Women's Aid and Worcestershire Adult Social Care

- To develop a joint working protocol around clients with complex needs that are suffering domestic abuse.

In addition the IMR authors identified the following 16 single agency recommendations.

Worcestershire Acute Hospitals NHS Trust

Recommendation 1

Worcester Acute Hospitals NHS Trust to review the number of previous Accident and Emergency Department attendances upon admission of a person and to consider any potential safeguarding concerns.

Recommendation 2

Worcester Acute Hospitals NHS Trust to ensure compliance with NICE public health guideline on 'Domestic Violence and Abuse: how services can respond effectively' (PH50); recommendation 6 (Ensure trained staff ask people about domestic violence and abuse).

NHS Redditch and Bromsgrove and NHS South Worcestershire Clinical Commissioning Groups (CCG)

Recommendation 1

GPs and Clinical Practice Staff in Worcestershire to complete Safeguarding Adults Level 3 Training which includes Domestic Abuse (DA) training and PREVENT.

Recommendation 2

CCG to audit Safeguarding Adult Level 3 training as part of the CCG Programme of Audit for GP Practices.

Recommendation 3

CCG to communicate current Domestic Abuse Guidance to all Worcestershire GP Practices.

Redditch Borough Council

Recommendation 1

Redditch Borough Council to produce policy and procedures regarding domestic abuse, which should include risk assessment and riskmanagement.

Recommendation 2

Redditch Borough Council to provide training in domestic abuse for all home visiting staff relevant to their role.

Recommendation 3

Redditch Borough Council to promote awareness amongst its staff of the adult safeguarding process and escalation procedures.

West Mercia Police

Recommendation 1

West Mercia police to provide assurance to partners around notifications of Domestic Violence Protection Orders and to ensure there is a revised programme of training in their application.

Recommendation 2

West Mercia Police to ensure that when RMPs are in place for combined issues domestic abuse policy and procedure is always pursued.

Recommendation 3

West Mercia Police should equip officers and staff with the required knowledge and understanding of behaviours and legislation in relation to coercive and controlling behaviour.

Recommendation 4

West Mercia Police to produce a local policy and procedure on Adult Safeguarding given the current absence of Approved Professional Practice.

Recommendation 5

West Mercia Police to raise staff and officer's awareness of the Care Act with particular regard to adult safeguarding and review their process of 'vulnerable adult' referrals.

Recommendation 6

West Mercia Police to review the process of referrals to partner agencies following response to incidents involving vulnerable adults.

Worcestershire Adult Social Care

Recommendation 1

Worcestershire Adult Social Care and Worcestershire Health and Care NHS Trust to ensure that an assessment by the most appropriate team should take place to determine whether a person has eligible needs.

Recommendation 2

Worcestershire Social Care to amend the guidance on the risk assessment of people who do not engage with services to include lack of engagement with professionals and disseminate to staff.