OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

The Victim

Born 1941

Eleanor Stobart MBA LLM

5 July 2015

Tamworth Borough Council,
Marmion House, Lichfield Street, Tamworth, Staffordshire. B79 7BZ

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1. INTRODUCTION

The key purpose for undertaking domestic homicide reviews (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This domestic homicide review was commissioned by Tamworth Community Safety Partnership following the death of a Tamworth resident. He died from injuries sustained during an assault by his son. His son subsequently pleaded guilty to manslaughter and he was sentenced to seven years' imprisonment. This report examines the contact and involvement that agencies had with both the father and his son between January 2008 and the time of the father's death in May 2014.[1]

The chair and author of this review is a freelance consultant. She is independent of, and has no connection with, any agency in Tamworth and Staffordshire. She specialises in safeguarding children and vulnerable adults with a particular focus on domestic abuse.

The review panel would like to express their condolences to the family following the father's death. The panel also wishes to thank all those who have contributed and assisted with this review.

1.1. Timescales

The Tamworth Community Safety Partnership Chair called a meeting of partner agencies on 27 June 2014 when the decision was taken that the circumstances of the case met the requirements to undertake a domestic homicide review. The Chair ratified the decision at that meeting and the Home Office was notified on 1 July 2014.

The police investigation and subsequent criminal proceedings delayed the completion of the review, which was therefore not completed within the six months recommended in statutory guidance. In addition, the complexity of the case and number of agencies and departments involved meant that the Panel required additional time to consider the learning from the case and subsequent recommendations.

The review was concluded on 13 July 2015.

[1] The panel recognised that domestic homicide reviews should look at all intervention opportunities, but in this case (apart from one family member) there was only the information from agencies available

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until the report was approved for publication by the Home Office Quality Assurance Group.

To protect the identity of the father, his son, and family members the following anonymised terms have been used throughout this review:

- Father – victim, aged 73
- Son – perpetrator, aged 21
- Daughter aged 24
- Son's girlfriend aged 23
- Son 1
- Son 2
- Stepdaughter
- Stepdaughter's husband
- Ex-wife (mother of all the children)
- Half-sister

Age at the time of the victim's death and living at the same one-bedroomed property

The father, his son and all other family members are all of white British origin.

1.3. Dissemination

The organisations contributing to the review (listed in 2.2) have received copies of this report for learning within their organisations.

2. THE REVIEW PROCESS

The review has been conducted in accordance with statutory guidance under s. 9 Domestic Violence, Crime and Victims Act (2004). Individual management reviews (IMRs) or information reports were sought from all agencies, organisations or departments that had any recent involvement with the father and his son. The agencies involved were asked to consider any relevant information before the period under review that might have had an impact on the case.

2.1. Purpose and terms of reference of the review

The aim of the review is to:

i. Establish what lessons can be learned from the father's death about the way in which local professionals and organisations work individually and collectively to safeguard victims

ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result

iii. Apply these lessons to service responses including changing policies and procedures as appropriate

iv. Prevent domestic homicide and to improve the way services respond to all victims of domestic abuse, and their children, through improved intra and inter-agency working. [2]

The key lines of enquiry addressed within the individual management reviews included:

- Was there anything about the father's presentation that indicated that he was distressed or suffering from abuse? If so, how did your agency respond and what support was the father offered?

- Did his son or any of the father's other carers show any signs that they might be violent, abusive, financially controlling or controlling in any other way? If so, how did your agency respond and what support/intervention was offered to the father, his carers or his son?

- Is it possible to identify any specific occasions when practitioners had the opportunity to intervene? And if they did intervene, were the services offered,

[2] Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts

accessible, appropriate, empowering, supportive and understanding to the father and any risk he faced?

- Were there any issues that impeded your agency's ability to work effectively with the father or his son? These might include issues such as capacity, resources, training, knowledge or understanding.

- If the service provided was not adequate, why was this – what lessons has your agency learned from undertaking this review? And how have these lessons been implemented?

2.2. Contributors to the review

In all, individual management reviews and chronologies were requested from:

- Staffordshire County Council Children's Social Care
- Heart of England NHS Foundation Trust
- Pathway Project Domestic Abuse Services
- Queens Hospital and Burton Hospital NHS Foundation Trust
- Radis Domiciliary Care
- South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
- Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Staffordshire County Council Specialist Adult Protection Investigation Team
- Staffordshire Police
- Staffordshire Youth Offending Service
- Tamworth Borough Council Housing Services
- West Midlands Ambulance Service NHS Foundation Trust

An information report and chronology was requested from:

- Lancashire Youth Offending Team

The individual management reviews, information reports and chronologies covered the period between January 2008 and the date of the victim's death in May 2014. In 2008 the father's health started to deteriorate and he became increasingly vulnerable.

2.3. Involvement of family and friends

Family members were also contacted so their views could be incorporated into the review. The chair and a panel member were able to meet with the son in prison and also meet with his half-sister at her home. There was no response from other members of the family to the letter sent to them offering them the opportunity to contribute or to the request sent via the police family liaison officer.

During the meeting with the perpetrator, he described his relationship with his father as bad. It appeared that as long as he could remember there was violence and they did not get on. His half-sister described both her father and mother as alcoholics. She explained that during her childhood (from the age of six) she frequently cared for her younger siblings, particularly her youngest half-brother (the perpetrator). She said that when he was seven years old, he phoned children's social care and asked them to take him away. By this time she, and her eldest half-brother, lived with their maternal grandmother and hence she was not able to be there to care for her youngest half-brother.

The perpetrator spoke positively about his time in care, especially entering residential schooling at the age of seven. He said after a while he ceased to return home at weekends, finding it easier to stay at school. He also spoke positively about his time in care in Lancashire. Despite, living in several different residential placements, he regretted leaving the care system at the age of 15. He thought it would have been better for him to have finished his schooling in Lancashire, get a job there and never to have returned to Tamworth. Interestingly, his half-sister reiterated this same point. His half-sister thought it was inappropriate that the stepdaughter was able to take the perpetrator out of care at the age of 15 so he could go to live with her. This stepdaughter is only four years older than the perpetrator. The half-sister also said that during the son's time in care he could only have supervised contact with his father. The placement with the stepdaughter broke down and the son moved in with his father. Unsurprisingly, their relationship had not improved. It has been difficult to clarify some of these details, as they were not described in the children's social care individual management review.

The son discussed the circumstances around his father and his sister coming to live with him and his girlfriend in February 2014. He knew the property was over-crowded but explained that by the time his father moved in, he had started using heroin and

his "head wasn't in a good place". With hindsight he recognised that they could have asked the council for help, but at the time he was not capable of doing so.

The main point that his half-sister asked to be addressed in this review was how her father could have been so ill and professionals lose sight of him when he was so vulnerable.

2.4. The review panel

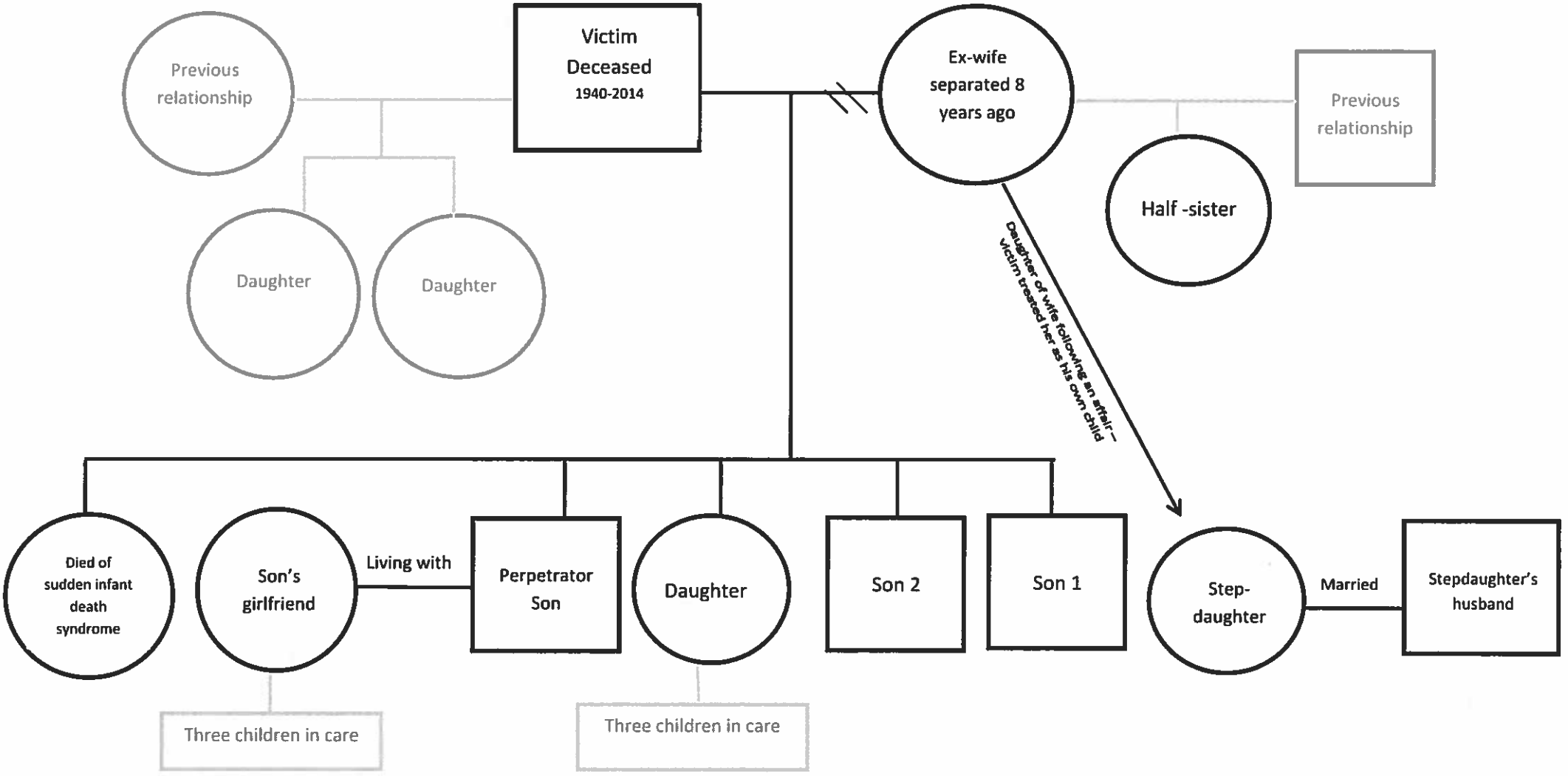
The review panel consisted of:

- Eleanor Stobart – Independent Chair and Overview Report Writer
- Pathway Domestic Abuse Services – Operations Director
- South East Staffordshire and Seisdon Peninsula CCG – Adult Safeguarding Lead Nurse
- Staffordshire and Stoke-on-Trent Partnership Trust – Head of Adult Safeguarding
- Staffordshire County Council – County Commissioner Adult and Children Safeguarding
- Staffordshire County Council – District Commissioning Lead for Tamworth
- Staffordshire County Council – Principal Community Safety Officer
- Staffordshire County Council Children's Social Care – Strategic Lead (Looked After Children)
- Staffordshire Police – Crime and Policy Review Manager
- Staffordshire Police – Investigator, Review, Policy and Development Team
- Staffordshire Youth Offending Service – Area Manager Youth Offending Team Lichfield
- Tamworth Borough Council – Head of Community Safety
- Tamworth Borough Council – Head of Landlord Services

2.5 Parallel reviews

There were no parallel reviews taking place.

3. THE FAMILY GENOGRAM



4. THE FACTS

Just before midday on a date in late May 2014, an ambulance was called to an address in Tamworth. On arrival, the ambulance staff found a 73-year-old man who was dead. There was evidence that he may have sustained a trauma. It was considered suspicious and Staffordshire Police was called.

During the police investigation, an allegation was made that the victim's son had assaulted him the previous day. The subsequent post mortem examination revealed bilateral rib fractures, which were alleged to have been as a result of the son kicking his father.

His son was arrested and charged with his father's murder. He pleaded guilty to manslaughter and he was sentenced to seven years' imprisonment.

5. BACKGROUND AND FAMILY HISTORY

Throughout this report the victim is referred to as "the father" and the perpetrator is referred to as his "son". The father's other sons are referred to as "son (1)" or "son (2)".

5.1 Father – the victim

The victim was born on 27 March 1941; he was the father of seven children (see genogram, page 10) and was a retired taxi driver. His two eldest children were from a previous relationship. The other four (plus the child who died of infant death syndrome) were all children from a relationship that he had with his wife. His wife also had a daughter from a previous relationship (referred to as the half-sister) and his wife also had a daughter as a result of an affair (referred to as the stepdaughter), who the victim brought up as his own child. All the family are white British.

Over the years, the father lived with a number of his children at different addresses. At the time of his death he lived with his son, his daughter and his son's girlfriend in a one-bedroomed ground floor flat. The father was 73, his son was 21, his daughter was 24 and his son's girlfriend was 23 years old.

Apparently, the father slept in the bedroom which had no door, just a curtain. His son and his son's girlfriend had a blow-up bed in the lounge and his daughter slept on the sofa in the lounge. There was also a Staffordshire bull terrier living at the property. The father and his daughter had moved in with his son and his son's girlfriend in February 2014. Police reported that there was no electricity and very little food at the property.

Although this review focussed on the period between January 2008 and May 2014, there was information outside the timeframe that was relevant. For example, over the

years there had been reports of domestic abuse at the family home. These incidents involved the father assaulting his wife and the children. Indeed an assault on the stepdaughter in 1988 resulted in her being placed on the child protection register for two years. Children's social care records described the parents as drinking alcohol to excess which contributed to their poor parenting.

The father first came to the attention of the police in August 1988 aged 47 when he received a 12-month conditional discharge for an assault with intent to resist arrest. Then between 1994 and 2002 there were a series of arrests and investigations (nine) which involved incidents of domestic abuse against his wife, and breaches of the peace. In addition, there were also two incidents of assault on non-family members.

A number of the incidents involved his son. For example, in September 2001, the father was arrested for common assault on his wife and it was also recorded that he struck his son with a slipper. Although he was charged with the assault on his wife, there was no investigation into the assault on his son. The following year the father was arrested for another assault on his son. The police records stated that his son aged nine was "play-fighting" with his sisters when his father entered the room and hit him with a hammer causing "minor bruising". On Christmas Eve 2002, the father was arrested for assaulting his wife.[3] It was alleged that he had kicked and punched her, split her lip and pulled out a clump of her hair. He was charged and he received a conditional discharge for 12 months.

The father and his wife separated in 2000 and the children remained in his care. After the separation, the father continued to live at the family home until around January 2013 when he moved in with his stepdaughter and her husband. However, in February 2014 the father and his daughter moved to the one-bedroomed property that his son shared with his girlfriend.

5.2. Son – the perpetrator

His son was born in January 1993. He was the youngest child. By the age of two he had been identified as having delayed speech. He started school at the age of five but had difficultly settling. He was excluded twice due to his disruptive behaviour and by the age of seven he started attending a residential school for children with behavioural, emotional and social difficulties. A family member said that, at the age of seven, the son called children's social care himself and asked to be removed.

When his parents separated in 2000, the children remained in their father's care. In March 2002 following an assault by his father, his son's name was added to the child protection register under the category of physical abuse. His father had difficulty managing his son's behaviour and that of his siblings. There were also reports that

[3] It was not clear why his wife was at the house, as according to records they separated in 2000

his son was violent towards his siblings. Thus in March 2002, aged nine he became a "looked after child" under s.20 Children Act 1989.[4] He was initially placed in foster care and later moved to a children's residential unit locally. He came into contact with the police during 2004 and 2005 whilst at local children's units in Staffordshire. On one occasion he assaulted a fellow resident but no further action was taken on advice from the Crown Prosecution Service. On eight occasions he was the alleged offender for inappropriate sexual behaviour and minor assaults on members of staff.

In October 2005 when he was 12 years old, he moved to a specialist residential school in Lancashire as a result of being charged with indecent assault on a female member of staff. In January 2006, he was sentenced to a 12-month supervision order for three assaults and a sexual assault. He remained in a residential placement in Lancashire and so his order was managed on a "care-taking" basis by Lancashire youth offending service.

He was assessed by Lancashire youth offending services as presenting low risk of serious harm to others. The rationale for this assessment was that he was complying with his supervision order as he had attended 22 out of 25 appointments with the youth offending service and he was settled in a stable placement which was meeting his needs. The case records indicated that he was receiving the appropriate level of supervision for this status. The supervision order was revoked in July 2006 (for "excellent progress"). Following the revocation of the order, Lancashire youth offending services had no further contact with him.

At 14 years old, he was moved to a "placement" in Blackpool because there had been several allegations of indecent assault made by young people at his previous placement. Later that year he was diagnosed with attention deficit hyperactivity disorder.

He had sporadic contact with his family whilst in care. Initially he went home at weekends but following his parents' separation, his father was unable to manage all three of the remaining children. Thus, the weekend contact with his father stopped and over time the contact with his mother became increasingly infrequent. It was not until 2008 that he (15 years) started having weekend contact with his step-sister. Then in May 2008 following one of these visits he refused to return to the residential placement in Blackpool. In August 2008 he informed children's social care that he wished to live with his step-sister on a permanent basis. He was 15 years old.

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[4] Under s.20 Children Act 1989, children and young people can be voluntarily accommodated with the consent of those with parental responsibility. Any person who has parental responsibility for a child may at any time remove the child from accommodation provided by or on behalf of the local authority. If the young person is 16 or 17 years old, they can leave the accommodation without parental consent. S.20 is based on co-operative working between the local authority, the young person and his or her parents because the court is not forcing the child or young person to be looked after – accessed online 5 December 2014 @ http://www.childrenslegalcentre.com/index.php?page=LocalAuthoritySupportforChildrenandFamilies_lookedafterchildren

By October 2008, he was no longer a "looked after" child so his case was transferred to the team responsible for supporting young people who had left care. His placement with his step-sister broke down as his behaviour was difficult to manage and he would not adhere to any boundaries. It appeared that he was offered housing but chose to live with his father. However, this arrangement did not work and by February 2009 he was living with his half-sister. This arrangement ended after six months because he allegedly threatened a young person via social media.

He made an application as a homeless young person to Tamworth Borough Council in June 2009. He was offered supported accommodation but decided to return to live with his father.

Children's social care reviewed his case in August 2009. The team manager for leaving care services concluded (despite three broken down placements) that as he was now living at home and had returned to the care of his family before his 16th birthday, he was no longer eligible for support as a "care leaver".[5] The individual management review stated that the "decision was based on the legal and statutory framework that underpins eligibility for services for young people who leave care." Apparently, he and his father "accepted this decision and confirmed that they did not want any further support" from Staffordshire children's social care. However, he contacted children's social care on 18 October 2010 (aged 17) because he was homeless. He was given advice. He had no further contact with children's social care after this.

[5] The Children Act 1989 (ss. 23A & 23B) states that a child is not to be treated as a relevant child where the child lived with a family member for a period of six months (unless that placement breaks down)

6. OUTLINE OF KEY EVENTS

During 2008 when the father was 67 years old, his health deteriorated. He was diagnosed with chronic obstructive pulmonary disease which left him short of breath. He also had another potential but unrelated medical condition for which he declined to be examined or referred.

At this time he was a council tenant. Sometimes he lived at the "family home" alone, but there were times when his children returned. During the dates under review his daughter, his son, and his stepdaughter and her husband also lived there for brief periods.

In June 2008 the father fractured his left hip when he, "tripped over a carpet in the lounge and fell awkwardly". The following year in March, he fractured his right hip when he had "fallen from a chair the night before when he had been playing with his daughter". On both occasions the reasons were plausible and it was not until 2013 that family members alleged that his daughter had caused the injuries.

On 5 May 2009, police were called to the father's house by his daughter as the father was very drunk and "smashing the house up". His daughter informed the police that her children were present. The father refused to leave so he was arrested to prevent a breach of the peace.

In November 2010 the father had another fall when he slipped on water whilst making a cup of tea. There was no fracture but he was short of breath and remained in hospital for a couple of weeks. Following his discharge from hospital a care package was provided by Radis domiciliary care, which continued until December 2012.

The father contacted the police on 18 November 2011 because his son was "smashing the house up". Police arrived and found the father struggling for breath. He was under the influence of alcohol but his son was not. It was a fight about money. His son's money was paid into the father's account and his son thought there should be more there than there was. The father did not want to make a complaint and therefore the case was finalised as "resolved in accordance with the father's wishes".

On 4 December 2011, the father (70) was admitted to hospital for five days with chronic obstructive pulmonary disease and pneumonia. Staff recorded that when informed he was being discharged, his breathing pattern changed and became erratic.

On 2 January 2013 an adult protection referral was made to Staffordshire County Council following information received from his stepdaughter's husband about bruising on the father's arms (71). The information was considered at the multi-agency safeguarding hub and recorded as medium risk. The case was passed to the local adult social care team to investigate. Around this time, the father relinquished

his tenancy on the family home and moved in with his stepdaughter and her husband. As this was considered a safe and stable arrangement, the case was closed.

On 27 August 2013 Staffordshire County Council received a further adult protection referral concerning the father. His stepdaughter and her husband alleged that the father's daughter and another of his sons (2) had threatened him and demanded money. It was considered high risk and was investigated by the adult protection investigation team. However, the father did not want the issue investigated further and the case was closed.

Around Christmas 2013, the father left his stepdaughter's house and went to stay with his daughter at her property. The reason given was that his stepdaughter was pregnant "and did not want the stress". However, other members of the family described the father being sent to his daughter's for Christmas. Then a couple of days later all his possessions arrived in a taxi and he was told he could not return to his stepdaughter's. It appeared that his daughter was then evicted from her property and thus she and her father moved into the one-bedroomed flat that his son shared with his girlfriend.

On 10 March 2014, the father (72) had another fall "when getting out of bed". He hit his head on the wall or floor and had a 3 – 4 cm laceration above his left eye. He had sutures to his head and was again admitted to hospital. During this admission, he asked to go into residential care but he did not meet the criteria. He was discharged on 19 March 2014.

The father saw his GP on 19 May 2014. His GP recorded that he was very frail. The GP contacted adult social care regarding finding a nursing home that could meet the father's needs. A social care assessor tried calling the father via landline and mobile phone but was unable to make contact.

An ambulance was called to the flat that the father shared with his son, his son's girlfriend and his daughter in late May 2014. The paramedic confirmed that the father had died and was told that he had fallen in the hallway the day before and hit his head. As there was evidence of trauma, the paramedic requested that the police attend.

During the murder investigation, it became apparent that the father had inherited about £25,000. It appeared that this was a source of conflict between his children. From September 2012 and throughout 2013, the money was withdrawn from his bank account, often thousands of pounds at a time. By January 2014 there was £1,400 left in the account and at the time of his death the account was overdrawn. It appeared that his stepdaughter and her husband, his daughter and his son had all taken this as an opportunity to exploit him financially.

7. SUMMARY OF INFORMATION KNOWN TO AGENCIES

7.1. Staffordshire Police

All Staffordshire Police and national police databases were examined for this review. There were some incidents outside of the timeframe that were relevant and those have been included in this review. Equally there were numerous incidents involving family members that were not directly relevant, these have not been included. As already described in section 5.1, the father had a long history of involvement with the police dating back to 1988. However, the main focus of this review is on the period after January 2008.

An incident occurred in December 2008 when the son reported to the police that his father was "throwing things around" and causing damage. His son stated "we all live together". He also said that his father was "always violent". The police attended the incident and the father was detained. He was recorded as having "slurred" speech and had drunk four pints of lager. The risk assessment on the custody log stated that he had a "mending hip", used a walking frame, suffered breathing problems and had a dog bite that was bandaged. No vulnerability was identified.

In May 2009 the daughter called the police because her father was "smashing up the house" and her two children were present. Her father had returned home drunk having had five pints of Guinness and started eating the children's food. When his daughter asked him not to, he had "kicked off". Things had calmed down by the time the police arrived but the father was arrested to prevent a further breach of the peace. The risk assessment in custody noted that he was recovering from "broken hips" and he had been discharged from hospital three weeks before. He was released later that day and no further action was taken.

In January 2010, the father's ex-wife called the police to ask them to remove their daughter from the family home as she was "going ballistic" because she had no drugs. There was no evidence of further exploration about what these drugs were. The ex-wife also stated that their daughter had assaulted her and her father, and she was threatening her father with a stick. Police went to the house and found that the ex-wife was drunk. They established that she normally lived elsewhere. No one would pursue a complaint thus no further action was taken.

On 18 November 2011, the father contacted the police because his son was "smashing the house up". The father was 70 at the time and his son was 18 years old; they both lived at the family home. The call-taker heard lots of shouting in the background and the call was cut off. When the police arrived, the son had left the property and his father was described as "struggling for breath" and very shaken. Apparently the argument was over money as the son's wages were paid into the father's bank account, and his son thought he should have more money in it than was there. His son was not intoxicated but the father "was under the influence of

drink". His son agreed to stay with his "sister" that evening. The father was checked over by paramedics and was uninjured. There was no record of the father being considered as vulnerable or at risk, and he did not want to make any form of complaint.

In November 2012, the father's home was searched and nine cannabis plants were found in his son's bedroom. His son was arrested and later he received a fine for the offence. It was recorded that the father was unaware of his son's activities. His son stated during the interview that he smoked £40 worth of cannabis a week. The records also noted that the father was 72 years old and disabled. However, there was no record that indicated that the father was vulnerable or at risk.

On 6 August 2013 the son reported to the police that he had arranged for his benefits payment to be paid into his girlfriend's Post Office account but she had refused to let him access that money. He was informed that it was a civil matter.

A dispute was reported to the police on 15 August 2013 by the father's stepdaughter. The dispute concerned two of the father's other sons (1&2) and his daughter. The father lived with his stepdaughter and her husband at the time and their house was adapted to accommodate him. However, his daughter and sons (1&2) claimed that the stepdaughter and her husband were taking their father's money. Son (1) threatened to stab the stepdaughter's husband. Son (1) was arrested and interviewed but ultimately the case was filed due to lack of evidence.

Another incident occurred on 26 August 2013 when the stepdaughter's husband told the police that the father's mail was being taken by other members of the family. Police records stated that members of the father's family were trying to make him live with them instead of with his stepdaughter and her husband. The father stated that he was happy living with his stepdaughter and her husband. A detective sergeant in the multi-agency safeguarding hub reviewed the case and raised concerns about the father's vulnerability. The officer in charge of the case was asked to contact the adult protection investigation team and a referral was initiated.

A strategy discussion took place involving the police and the records stated that police were "satisfied with seeking the father's wishes around the safeguarding options available to him. He declined and his choice was respected". The stepdaughter's house was considered safe, as the father no longer had contact with his sons or daughter.

In September 2013, Staffordshire Police was informed by the ambulance service that the son's girlfriend had sustained head and facial injuries the previous evening. The paramedics described the girlfriend as having "taken a considerable beating". She later told the police that she had been at her flat drinking with her boyfriend (the son) and a female neighbour. Her boyfriend pushed her to the ground and the woman dragged her along the ground by her hair. Her boyfriend shouted at her that she was a "disgrace" before following her into the bedroom and punching her in the face. She fell onto the bed. He then punched her in the nose, which caused a "pop". She said

he then punched her several times to her head. They then spent the night in the same bed and in the morning her boyfriend apologised and showed her his swollen hand. She brushed her hair and it fell out. She later visited her sister who called an ambulance. Her nose was broken in three places, her eyes were swollen and bruised, she had bruising behind her ears, a large bald patch, cuts and bruises to her knees and grazes on both elbows. She discharged herself from hospital despite concerns that she might have a fractured skull. The police assessed her as at "standard risk" because she declined a risk assessment. Therefore, although a referral was made to the multi-agency safeguarding hub, no referral was made to MARAC. The local domestic abuse service (Pathway) raised the case with the chair of MARAC and her case was subsequently discussed at the next MARAC meeting.

By November 2013, the son's girlfriend had retracted the allegations as she did not want to support a prosecution. The case was reviewed by the Crown Prosecution Service who concluded that she "would be unreliable in court and would need to be summonsed to attend". It was decided that no further action should be taken. The son's bail (with conditions) was cancelled. The conditions had been not to approach or contact his girlfriend (directly or indirectly). He breached the conditions on 5 September 2013 and caused damage at his girlfriend's flat; however, she did not make a formal complaint.

On 10 December 2013 the father's ex-wife reported to the police that she had stayed with her son at his girlfriend's flat the previous night. As she left the property, her son was in a hurry to get her into the taxi. Later she discovered there was £80 missing from her purse. The officers investigating the case attempted to conduct voluntary interviews with her son and his girlfriend but neither presented for interview. The case was finally closed in February 2014 as the ex-wife said she did not want any further action taken.

On Sunday 2 February 2014 the daughter contacted the police to report that she was concerned about her father. She had not seen him since the previous Friday afternoon when a taxi had taken him to Tamworth. She told police that he had no family problems and no financial problems. The police recorded the father as a missing person and identified that he was vulnerable due to his age and health, and assessed him as at "medium" risk of harm.

Police enquiries revealed that the father had booked into a local public house for three nights. The police found him at 21:10 sleeping in a room "after a few drinks". The police recorded that he "intended to take a few days away from home and stated that he will be returning in the morning". He told witnesses that he had been made homeless by his family and that he was going to Tamworth Borough Council in the morning to request emergency accommodation. He appeared in reasonably good spirits and told officers that he just wanted a break.

Police left the father at the public house "safe and well" and he stated he would return home on Monday 3 March 2014.

On 11 May 2014, the son attempted to steal a bottle of wine from a local store. When the storeowner challenged him, the son assaulted the storeowner. At the time the son was using his father's cash card in the machine and when confronted he ran from the shop but left the cash card behind. No action was taken as the son was later arrested on suspicion of murdering his father.

7.1.1. Staffordshire Police – analysis of involvement

Staffordshire Police had numerous contacts with those living at the son's girlfriend's flat at the time of the father's death. Despite this, the police were unaware that the father was living there. The police also had numerous contacts with the father's wider family. It was clear from police records that most of the family members had the propensity to be aggressive and violent at times. They often appeared to take money from one another and resolve situations with violence. When police intervened, family members declined to press charges.

The son's assault on his girlfriend demonstrated his tendency towards violence but again she would not support a prosecution and the Crown Prosecution Service did not wish to call her as a hostile witness. Equally, following the incident when the father was visibly shaken following an altercation with his son, the father refused to make any form of complaint.

Thus, it was difficult for police to identify any specific incident that would indicate that the father was not only vulnerable but also consistently and persistently being financially controlled and exploited. Furthermore, police were unaware of his history of "falls" and therefore did not consider that he might be the victim of his children's aggression and violence. Had information been shared in a multi-agency setting, the scale and extent of the financial abuse may have become more apparent, as might the extent of the violence within the family.

The last contact that the police had with the father was when he went missing from his daughter's address at the beginning of February 2014. He was found "safe and well" at a local pub where he had booked in for a few days. He told officers that he needed a break. There was no record that the officers explored why he needed a break and from what. This was an ideal opportunity to investigate further the father's living arrangements and alert partner agencies to his vulnerability. The opportunity was missed and shortly afterwards his daughter was made homeless and both she and her father moved into the one-bedroomed flat with the son and his girlfriend.

The review demonstrated that there had never been an "adult at risk location marker" on any address where the father lived. This marker would have alerted police that a vulnerable adult was living at a particular address. Such a marker should have been used when the adult safeguarding referral was made when the father was living with his stepdaughter and her husband. This never occurred and thus any such marker did not "follow" the father when he moved to other addresses.

7.2. Heart of England NHS Foundation Trust

On 2 June 2008, the father went to the emergency department at Good Hope Hospital, Sutton Coldfield, having "tripped over carpet in lounge" and fallen awkwardly. His daughter was informed of his admission and she expressed concern because he might get symptoms of alcohol withdrawal as he drank every night. He was admitted for surgery on his left fractured hip. Following the operation he was described as reluctant to mobilise and on one occasion he was verbally aggressive towards the physiotherapist, although he did apologise. He was discharged on 23 June 2008 to Sir Robert Peel Hospital, Tamworth. There were no complaints or safeguarding disclosures during the course of his admission.

The father went to the emergency department at Good Hope Hospital on 27 November 2008 following a dog bite to the back of his right leg. It was cleaned and he was given an appointment to attend the review clinic the next day.

On 18 March 2009 the father went to the emergency department with a history of pain in his right hip. He had fallen from a chair the night before when "he had been playing with his daughter". He was admitted for surgery to his fractured hip. Records stated that he lived with his daughter and his son lived nearby, and both of them would help him when he was discharged. He was discharged to Sir Robert Peel Hospital on 1 April 2009. Again, there were no complaints or safeguarding disclosures during the course of his admission.

The father failed to attend an outpatient appointment on 7 May 2009 but did attend one the following month. His fractured right hip was healing; there was nothing else noted.

On 13 June 2010, the father attended the emergency department at Good Hope Hospital with a swollen right knee. His knee was treated with antibiotics and analgesics. Although the medical staff said he could go home, he asked to stay overnight as he would not be able to get upstairs to his bed. He was moved to a different cubicle and it was noted that he became slightly aggressive. The records stated that he lived with his son. He remained in hospital until 18 June 2010. No complaints, disclosures or concerns were raised by the father during his admission.

On 13 November 2010 the father went to the emergency department at Good Hope Hospital with history of pain in his left hip. He had tripped and fallen the night before. He said he had slipped on water whilst making a cup of tea. There was no fracture but he was short of breath so he was admitted as an inpatient until 24 November 2010 when he was transferred to Sir Robert Peel Hospital. Again, there was no record of safeguarding concerns.

He was admitted to Good Hope Hospital via the emergency department on 4 December 2011. He had pneumonia and was discharged on 9 December 2011. It was noted in his records that when he was informed that he was going home, his breathing pattern changed and became erratic. It is unclear from his records whether anyone explored this further.

The father missed four consecutive outpatient appointments on 25 June 2012, 21 February 2013, 18 April 2013 and 5 September 2013. A letter was sent to his GP, which stated that he had failed to attend outpatients' appointments three times. A copy was also sent to the father.

On 11 March 2014 the father was admitted to Good Hope Hospital via the emergency department having fallen and hit his head. He said this had happened when he got out of bed in the dark, tripped over his slippers and banged his head and knee on the wall. His daughter telephoned for the ambulance. His records noted that he was living with his stepdaughter and her husband. The staff nurse on the ward recorded that he was aggressive and refused to have his observations recorded. He was prescribed medicine for alcohol withdrawal.

On 18 March 2014 the father was seen by the community liaison nurse and an agency social worker from the hospital discharge team. He told them that he wanted to go into residential care "to be looked after" but was informed that he did not meet the criteria. The community liaison nurse and social worker were aware that there had been safeguarding concerns in the past, and therefore specifically asked him if he was worried about returning home. The father said he had no concerns except for the flat being overcrowded and his son had to sleep on the floor. They then spoke to his son who said it was a two-bedroomed flat and there were no problems as he was not sleeping on the floor. He said he was looking forward to his father coming home as he had missed him. However, it was apparent from the records that his son had only visited once and this was to take his father's cash card to get money for food. The community liaison nurse and the social worker spoke to the father about this. They explained that it was not a good idea to give his son the "PIN" number but the father insisted his son would only take the amount of money he required. The community liaison nurse asked if he was sure about this as there had been concerns about financial abuse in the past.

Both members of staff gave the father a number of opportunities to voice any concerns but he was adamant that he wished to return to the flat and declined any services or support. They asked the occupational therapist to undertake a home visit to establish the exact living arrangements. It transpired it was a one-bedroomed flat that was sparsely furnished, with a number of the windows boarded up. Again, the father was adamant that he wanted to return there.

The father was given the contact details for Staffordshire Cares and the community teams and told to call them if he had any concerns.

7.2.1. Analysis of involvement by Good Hope Hospital

During the period under review, the father attended the emergency department on seven occasions and had six admissions as an inpatient. On no occasion did his presentation indicate that he was distressed or suffering from abuse. He made no disclosures to any of the staff in the emergency department or as an in-patient.

The review identified two possible opportunities for staff to intervene. The first was during his in-patient stay in December 2011 when his breathing became erratic when he was informed of his discharge. However, the reason was not explored. At the time this was viewed as part of his condition. On reflection the ward sister identified that perhaps staff should not simply attribute this to a patient's condition and should explore the issue further.

The second opportunity for staff to intervene was on 18 March 2014 the day before the father was discharged. A joint assessment was undertaken as the social worker had asked the community liaison nurse to undertake a dual visit on the ward as she was aware of previous safeguarding concerns. This was only known to adult social care as it had been recorded separately on their system. Health practitioners do not have access to this system. The concerns related to a member of the father's family and referred to physical and financial abuse. Police had been involved but no one was ever charged. The father told the social worker and community liaison nurse that he wanted to go into residential care. They asked him whether he was worried about returning home. He was given a number of opportunities to disclose information but remained adamant that he wished to return to the flat.

Staff had noted that the son described the property as two-bedroomed whereas his father said it was overcrowded, as there was only one bedroom. The result was that the occupational therapist undertook a home visit. However, when this revealed that there was indeed only one bedroom and some of the windows were boarded up, no further action was taken. This was in fact an ideal opportunity to make a further referral to adult safeguarding or to make enquires about sheltered housing. Simply because the father insisted on returning to the property, did not mean that it was an appropriate place for him to live, or that those living with him were suitable adults to care for him.

7.3. Burton Hospitals NHS Trust

Good Hope Hospital transferred the father to Sir Robert Peel Hospital on 23 June 2008 for rehabilitation following a fracture to his hip. His stepdaughter was involved in his discharge planning as she lived with him at the time. A referral was made to adult social care but the family declined a package of care on discharge. There was nothing noted in the records about any safeguarding concerns although during his

admission, the father asked for his bankcard from the ward safe so he could give it to his son to withdraw cash.

On 1 April 2009, the father was transferred to Sir Robert Peel Hospital from Good Hope Hospital following a fracture to his right hip. Good Hope Hospital commissioned the beds on Philip Ward and therefore the record of this admission was not held by Sir Robert Peel Hospital. Nevertheless, on enquiry these records were also not available from Good Hope Hospital and despite several attempts could not be located.

On 24 November 2010, Good Hope Hospital transferred the father to Sir Robert Peel Hospital following a fall. Records stated that he lived alone although his daughter was staying with him. His ex-wife was his next of kin and he told staff that she cleaned the house "every so often" and helped him with shopping and finances. He was referred to a social worker and accepted a package of care from Radis domiciliary care. No safeguarding concerns were raised during his admission or assessment.

Burton Hospitals NHS Trust records stated that on 1 September 2013 the son attended the emergency department at Queen's Hospital. Records stated that he had a fractured 5th metacarpal having punched a wall. He was to be followed up at the fracture clinic but did not attend.

7.3.1. Analysis of involvement by Burton Hospitals NHS Trust

There were no safeguarding concerns raised during any of the father's admissions to Sir Robert Peel Hospital. There was the issue of getting "panicky" during his admission in June 2008 but there is no record that this was explored further. Equally, there is no exploration of the reason for his son punching a wall in September 2013.

7.4. Staffordshire and Stoke-on-Trent Partnership NHS Trust[6]

The father was admitted to Sir Robert Peel Hospital from Good Hope Hospital in June 2008. He was assessed by the ward physiotherapist and occupational therapist following a surgical repair of a fractured left hip. His progress was slow and he sometimes required motivating to participate. He declined an assessment by the occupational therapist to review his ability to maintain his personal care and undertake kitchen activities. He informed them that he mainly went out for meals and that his daughter and stepdaughter would support him if required.

A referral was made to the adult social care discharge team by staff at Sir Robert Peel Hospital on 3 July 2008. The subsequent assessment described him as "self-caring". He said he lived with his stepdaughter, her husband, their children, and his son. The assessment identified that the father had some mobility difficulties but no

[6] Prior to 2011, Staffordshire and Stoke-on-Trent Partnership NHS Trust health staff were employed by the Primary Care Trusts and adult social care staff were employed by Staffordshire County Council

services were required as his family, primarily his stepdaughter, said that they could meet his needs. There was no suggestion that this injury might be the result of abuse or an assault. The outcome of the assessment was that no social care services were required and the case was closed on 29 July 2008. The father was discharged on 1 August 2008 and he continued with outpatient physiotherapy until 3 October 2008.

The father was visited by the district nurse in December 2008 following a dog bite to his left calf which had become infected. The district nurse recalled the house being "small, messy, dirty and chaotic". There was another man there who did not engage with her at all and she assumed it was the son.

In April 2009, another referral was made to the adult social care discharge team by staff at Sir Robert Peel Hospital. Again, no services were assessed as being necessary. On this occasion his daughter was described as living with him at his house.

In November 2010, the father was transferred to Sir Robert Peel Hospital from Good Hope Hospital for inpatient rehabilitation following a fracture to his right hip. He said he lived alone at his house, although he described his daughter living with him temporarily. It was clear from both the physiotherapy and occupational therapy records that he required a lot of persuasion to participate in his rehabilitation. Records showed that he frequently became annoyed at being interrupted by therapy staff. He was discharged home on 14 December 2010. There was no record of any interaction with the family during this admission.

In November 2010, the father was referred again to the adult social care team following a fall at his home. He described losing confidence since his mobility had declined and was fearful of falling and not being able to get help. The records stated that he could do most things for himself but he declined a "care line service" and meals on wheels. The records stated that he was living on his own. A care package was commenced in December 2010 with Radis domiciliary care. It consisted of a 30-minute morning call and an additional 30-minute midday call to assist with preparation of a hot meal and drink, to prepare a sandwich for the afternoon and to prompt him to take his medication. The care package was reviewed in October 2011. The care package appeared to be working well and the review implied that he was living alone.

His care package with Radis was again reviewed by the adult social care team at the beginning of January 2011. Nothing specific was highlighted although the father stated he felt isolated and wanted to "explore a day centre in the future". He also said that he would like an evening call from Radis "to provide him with company" but it was explained that this was not possible. The case was closed on 11 January 2011 and transferred to the adult care team.

The father was discharged from Good Hope Hospital on 9 December 2011 with an increased care package from Radis. He was also referred to the community matron team as he had difficulties managing his medication. The records detailed a number

of visits by staff and the house was described as "grubby, unkempt and sparse". However, there was never anything that indicated a safeguarding concern. In March 2012 the records noted that a "very lively young dog (son's dog) now lives with" the father. In July, it was noted that the father had put on some weight. When asked about this he said he had been eating more chocolate biscuits – although when his son left the room, the father told the member of staff that he was having a carvery or cooked meal most days at a local pub. "I don't want my son to know because he would want me to buy him food as well."

At the beginning of January 2013, the stepdaughter and her husband decided that the father should live with them at their house. The husband contacted Staffordshire County Council to say that he was not happy with the care provided by Radis as the father had bruises on his arms. The husband also discussed this with Radis. Radis made an adult protection referral because they suspected that his son might have been responsible for the bruising. Radis also informed Staffordshire County Council that the property had been raided by police because cannabis was being grown there.

The referral was assessed as "medium risk of harm" and therefore passed from the adult protection investigation team to the Tamworth adult social care team. It was recommended that a strategy discussion and investigation should take place before referring the case to the police if necessary. There is no record that a strategy discussion took place. However, a social worker visited the father, his stepdaughter and her husband on 3 January 2013.

The social worker ascertained that the father had mental capacity and no further assessment of this was required. She interviewed the father alone and in the presence of his stepdaughter and her husband. The father stated that he bruised easily and referred to a fall he had after consuming eight cans of beer. In reference to his black eye, he explained that his eye was not black, but he had a red swollen area around his eye the cause of which he could not explain. During the interview the father referred to an incident when he refused to give his son money. His son had hit him "lightly in the eye" – the father demonstrated the lightness of this by "hitting" the social worker's arm. He then stated that he wished to forget about the incident as it was a long time ago and his son was very remorseful. The father explained to the social worker that he felt safe living with his stepdaughter and her husband. Her husband was not working at the time and was prepared to support the father with his needs so the father felt he no longer required assistance from Radis. The father stated that he had no concerns about the care provided to him by Radis.

The social worker provided the father with housing advice as his stepdaughter was expecting her third (or fourth) [7]child. She also updated a referral to the occupational therapist, arranged a benefits check and offered a carer's assessment to the stepdaughter and her husband. The social worker established from Staffordshire

[7] It was unclear from records whether the victim's stepdaughter was expecting her third or fourth child as records varied between agencies.

County Council "debt recovery" that the father was in arrears totalling £3000 and debt recovery proceedings were being commenced.

The outcome of the investigation was that that the bruising had occurred when the father fell down the stairs "and therefore the allegations are not substantiated". The information from the meeting was recorded on strategy discussion documentation, although it was not entered onto the computer system until 25 April 2013.

A carer's assessment was offered to the stepdaughter and her husband, and they were given the documentation to consider. On 12 April 2013 they were contacted by the social worker (who apologised for the delay) but they declined a carer's assessment as they were "happy to continue" as they were. The only issue of concern was potential overcrowding because the stepdaughter was expecting a baby. They were advised to seek advice from housing. The case was then closed to the local adult care team on 25 April 2013.

On 30 January 2013, the community matron visited the house. Records stated that the stepdaughter was "newly pregnant" and had three other children. There were also two "status-type" dogs at the property. During the visit the community matron asked for the dogs to be removed. The father kicked one of them and it urinated. The community matron was upset by this and told the father that if she saw anything like that again she would call the RSPCA. The father told the community matron that he lived with his stepdaughter because there were "issues" between him and his son, and his son was continuing to live at the father's house. The community matron was unaware of any safeguarding concerns at this time.

Whilst the father lived with his stepdaughter and her husband his condition improved and he was discharged from the district nurse and community matron team on 28 August 2013.

On 14 March 2014, a referral was received by the adult social care team from Good Hope Hospital. The father had been admitted following a fall and he had a laceration above his left eye, which required suturing and a painful knee on which he could not bear weight. The notes recorded that the father lived with his son and his son's girlfriend in a council flat. The father said they would be moving soon and told the ward staff that he would need alternative accommodation. The hospital rehabilitation staff recorded that he could progress to live independently in sheltered accommodation.

On 18 March 2014, the father was seen by the community liaison nurse and an agency social worker from the hospital discharge team. He told them that he wanted to go into residential care "to be looked after" but was informed that he did not meet the criteria. The community liaison nurse and social worker were aware that there had been safeguarding concerns in the past, and therefore specifically asked him if he was worried about returning home. Further detail of this assessment can be found in section 7.2.

On 19 May 2014, a referral was received via Staffordshire Cares from the receptionist at the father's GP. The address given was his stepdaughter and her husband's. The duty social care assessor phoned the GP, as the GP's receptionist had been unclear about the details of the referral. The GP explained that the father was a very frail 73-year-old who had chronic obstructive pulmonary disease, he was homeless and sleeping on his son's floor and he wanted to go into a nursing home. The GP described the father as very untidy and unclean, and apart from his pension, he had no other income.

A social care assessor tried to phone the father's mobile number but the number was not recognised. She rang the GP surgery and was given a landline number but there was no reply so she left a message to call her back. The social worker assessor phoned the GP surgery again the following day and was given mobile numbers for the son and his girlfriend. Both of the numbers were unobtainable. She left a further message on the landline and asked the father to contact her if he would like an assessment. On 21 May 2014, a standard "no contact" letter was sent to the father at his son's girlfriend's flat.

7.4.1. Analysis of involvement by the Partnership NHS Trust

Although the father was seen by many staff from different disciplines, he never displayed any signs or disclosed any information that might have led them to consider him vulnerable. Nevertheless, there were two incidents that indicated safeguarding concerns.

The first was the adult protection referral in January 2013 that was allocated to Tamworth adult social care team. The ensuing investigation was limited and there was no strategy discussion or multi-agency approach. This meant the police were not involved thus there was no further exploration of the wider family. In addition, there was no consideration that Radis staff may have caused the bruising as was initially suggested by the stepdaughter and her husband. In fact, the investigation appeared to focus on the father's mental capacity and once this was established no wider investigation of present or past events took place, despite the father disclosing that both his son and daughter had physically assaulted him in the past. The outcome of the investigation was that the allegation was "unsubstantiated".

The other opportunity arose in March 2014 when the community liaison nurse and social worker met with the father to discuss his discharge from hospital. Both were aware that there had been safeguarding concerns in the past so when the father explained that he wanted residential care, they asked him whether he was worried about returning home. There were a number of opportunities to disclose information, but he was adamant that he wished to return to the flat.

They asked the occupational therapist to do a home visit to establish the number of bedrooms as the father and his son had given staff conflicting information. The occupational therapist reported that it was a sparsely furnished, one-bedroomed flat

with some of the windows boarded up. This was an ideal opportunity to make a further adult protection referral, which would have highlighted who was living at the flat. It would also have given other agencies the opportunity to share their information about the family.

Ultimately, apart from the two incidents described above, there was no evidence from the records or interviews with members of staff that the father might be vulnerable or at risk of harm. In fact, the records gave the impression of "a man very much in control of his management and future".

The father's GP made a referral for him to be assessed for a nursing home. This was just over a week before his death. Following the referral, a social care assessor tried to contact him by phone. When she failed, the father was simply sent a letter asking him to make contact if he wanted an assessment. This was an inadequate response considering he was an adult at risk of abuse and harm. The GP had described the father as frail, very untidy and unclean, homeless and sleeping on his son's floor. Thus, it would have been more appropriate if the social care assessor had visited him rather than sending a letter.

7.5. Adult Protection Investigation Team

Adult social care services are provided by the Staffordshire and Stoke-on-Trent NHS Partnership Trust. The Trust also undertakes safeguarding investigations of low and medium risk cases on behalf of the local authority. High risk or complex cases are normally investigated by the adult protection investigation team, whose members of staff are employed by Staffordshire County Council. The same information and recording systems are used by both organisations.

At the beginning of January 2013, the stepdaughter and her husband decided that the father should live with them at their house. The husband contacted the Staffordshire County Council to say that he was not happy with the care provided by Radis as the father had bruises on his arms. The husband also discussed this with Radis. Radis made an adult protection referral because they suspected that his son might have been responsible for the bruising. Radis also informed Staffordshire County Council that the property had been raided by police because cannabis was being grown there.

The referral was assessed as "medium risk of harm" and therefore passed from the adult protection investigation team to the local adult care team (see section 7.4).

A second adult protection referral was made on 27 August 2013. The referral was made by the stepdaughter's husband. He stated that demands for money and threats had been made against the father by the father's daughter. Threats had also been made to his stepdaughter and her husband by another of the father's sons (1). There was also an allegation that the daughter had broken her father's hips in the past.

The referral was considered high risk and therefore the investigation was carried out by the adult protection investigation team. The father was visited as part of the investigation. He stated that his daughter had borrowed several hundred pounds from him but had not repaid it. He said he did not want to pursue the debt and did not want it investigating further. Although his daughter had tried to pressure him into living at her address, the father said he had no intention of leaving his stepdaughter and her husband's house. The father appeared to confirm that his daughter had broken his hips in the past but no details about how this had happened were set out in the records. The father said he just wanted a police officer to visit his daughter and tell her not to visit him.

The conclusion of referral was that the financial abuse by his daughter was "unsubstantiated" on the basis that he did not wish further action to be taken. The report stated that his daughter was spoken to by police officers on 31 August 2013 and the case was verbally closed. It was not finally signed off until 30 January 2014.

7.5.1. Analysis of involvement of the Adult Protection Investigation Team

The allegation that Radis members of staff caused the bruising to the father's arms was never investigated. Ultimately, no interviews were carried out with any of the Radis members of staff. This would have given the staff the opportunity not only to refute the allegations but they may also have been able to shed light on their observations of family members and the injuries that the father sustained.

The investigation around the referral on 27 August 2013 commenced with a strategy discussion but then adopted a narrow focus which led to an outcome of "not substantiated". The interview with the father identified that his daughter had been lent money that she had not repaid. It also confirmed that his daughter had pressurised him to go to live with her. Thus, it is hard to understand why the investigation concluded that the allegations were not substantiated. Furthermore, the risk of harm to the father was judged as low which appeared to ignore the wider threats that had been disclosed and also the disclosure relating to the alleged assaults by his daughter in the past. There was no evidence beyond the disclosure that his daughter was responsible for the injuries but the interview did not appear to seek clarification about how she was alleged to have caused this, or exactly when. The police contribution to the strategy discussion and the statements from the stepdaughter and her husband had clearly shown that the family dynamics were volatile.

Had the level of risk been judged as higher, an investigation review meeting would have been indicated. This would have provided a multi-agency forum to consider the allegations, the evidence and continuing risk. This may have addressed issues such as what might happen if the father ceased to live with his stepdaughter and her husband and how the risk to the father might change. Instead, it was left to them to contact adult social care if they required further assistance.

The records showed that the father did not appear to be overly concerned by the threats from his son and daughter. The only disclosures that he made were about events in the past. Whether this was evidence of intimidation is not clear from the records, and it was not the impression of the workers who came into contact with him.

This review highlighted some issues around documentation, particularly around providing appropriate prompts to staff members and about recording decisions and actions. This case will now be one of a number that will inform the review of local procedures and documentation in preparation for the implementation of the Care Act 2014.

It was concerning that both adult protection investigations ended with the allegations being considered as "not substantiated". A more appropriate conclusion would have been that the investigation was "inconclusive".

7.6. Radis

Radis provided domiciliary care to the father between December 2010 and December 2012. Initially Radis provided two-half hour calls per day, one call in the morning and the other at lunchtime. In agreement with the father, the lunchtime visit was cancelled in January 2012 as the son visited most days and was happy to help his father prepare a meal. A care plan was completed for the father at the beginning of his care package and it was revised in July 2012.

Approximately, 30 members of staff delivered domiciliary care to the father over the two-year period. A few of them remembered him and when interviewed gave an insight into his life.

> *"At one time I think his daughter and a child lived with him but she moved out….. …… He was quite an abrasive chap and could be abrupt but he was alright with me. There was a chap living upstairs, I think it might have been his son but I never saw him".*

Another member of staff stated that there were a "couple of occasions" when the father "would not let him in". The staff member recalled that there had been people upstairs playing music but he never met them and did not know who they were. He said that the father was not "a very pleasant chap" and could be abrupt.

It was clear from the records that risk assessments were undertaken. The risk assessment undertaken in 2010 did not identify any risks. Although an updated risk assessment noted "clutter" and a dog that had to be kept in a separate room whilst members of staff were in the property.

Radis confirmed that all members of staff receive safeguarding vulnerable adults training during their induction. This is via e-learning and in a classroom setting. All

staff members have annual training updates. This training requires staff members to inform the office of any safeguarding concerns although it is not recorded in the client's diary log "in order not to alert any potential abuser to the report". It was not clear from the individual management review how other members of staff would be alerted to any potential safeguarding concerns.

Interestingly, records from other agencies established that Radis sent an adult protection referral to adult social care in January 2013. However, Radis has no record of this referral. The original concerns were raised by the stepdaughter and her husband about the bruises on the father's arm when he went to live with them. The implication was that the Radis carers might be responsible. This does not appear to have been investigated as the referral to adult social care implied that his son must be responsible.

7.6.1. Analysis of involvement by Radis

The Radis individual management review provided some information about the father's care. However, there appeared to be over-reliance on organisational memory i.e. what the staff remembered of the father rather than a detailed account in his records. This was demonstrated by the fact that although Radis made an adult safeguarding referral, they had no record of making this referral. Radis assured the panel that there is a procedure in place to ensure that when referrals are made using the relevant online forms, a copy is also filed in the safeguarding file and another is saved to a safeguarding folder on the Company's main server. Radis is currently establishing the details of the referral and investigating why in this instance it was not documented appropriately.

According to the chronology, during the two years that Radis provided daily visits to the father, 123 appointments were cancelled. These included, 41 appointments cancelled by the service user, 44 appointments that were aborted and 38 appointments cancelled due to "holiday". It appeared that the father would telephone, send a letter or tell his morning carer to cancel his lunchtime appointment – usually because he was going out to lunch with a friend to the local pub. Equally, the "aborted" appointments occurred when social care reviewed his package and cancelled the lunchtime calls. At the time, no manager was available to update the system and thus the calls were labelled as "aborted".

7.7. General Practitioners

During the period under review, the father was registered with two GP surgeries. From January 2008 to February 2014, he was a patient at Crown Medical Practice. Then from February 2014 until his death, he was then registered with Wilnecote Surgery.

He had chronic obstructive pulmonary disease [8] for which he had regular reviews during 2008. He was also seen on three occasions for another health condition for which he declined further investigation.

During October 2008, his chronic obstructive pulmonary disease deteriorated and an ambulance was called because he was breathless. The father refused to go to hospital but agreed to be treated by his GP. In November 2008, he was seen following a dog bite to his right leg and a district nurse was arranged to provide dressings to the wound.

In September 2010 he was seen by his GP following a fall. The GP described his mobility as "poor". However, records showed that during 2011 and 2012 the father had fewer contacts than previous years with his GP. In fact, he was only seen once during 2012.

At the beginning of 2013, the father moved in with his stepdaughter and her husband. He visited his GP because of shortness of breath and he was referred for an assessment for long-term oxygen therapy in February. Records showed that he had lost weight in May 2013 and he missed an appointment at the respiratory department. The GP requested another appointment.

He missed a GP appointment in February 2014 and was sent a warning letter. However, by this time he had moved to the flat his son shared with his girlfriend and he re-registered with another GP. Records showed that he had lost more weight during 2013. Then in March, he was seen following another fall and admitted to hospital.

The last contact that he had with his GP was on 19 May 2014. He was described as a "very frail gentleman, well orientated, but has severe chronic obstructive pulmonary disease". The GP then recorded that he would contact social services regarding finding a nursing home for the father that could meet his needs.

The son registered with a GP in July 2013 but had very little contact with the surgery. In October 2013, he told his GP that he was not sleeping well due to the death of his mother. He was given a prescription for valium (diazepam). [9] His final visit was on

[8] Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing. Typical symptoms of COPD include increasing breathlessness, a persistent cough and frequent chest infections

[9] Police records showed that his mother (the victim's ex-wife) was alive as she contacted them after this date

the day after his father died when he stated that his father had died in his sleep and he wanted tablets to "calm him down".

7.7.1. Analysis of involvement by General Practitioners

Despite being aware that the father had fractured both his hips within nine months, it is not clear from his GP records whether his home environment was ever discussed or assessed. Nor is there any evidence that a review would have been arranged if his housing circumstances changed.

The GP records did not identify a professional who was responsible for the father's care in the community. Therefore, it appeared that a "handover" of his care from one professional to another was not always timely, clear or explicit. Thus when he lost 12.5kg in weight (over a period of time), it was not consistently and clearly documented, and available to all health professionals. In addition, although the GP would have been aware that the father was a "vulnerable adult",[10] the GP appeared unaware of the safeguarding concerns raised about him in the past.

Indeed, in 2014, the father missed an appointment at the surgery and a warning letter was sent to him. This is standard practice when a patient has missed three appointments over a 12-month period. However, it is concerning that the father was sent this letter as the GP should have recognised that he was in poor health and may have had difficulty attending appointments.

The father's final consultation with his GP on 19 May 2014 identified that he needed to be referred to social services. However, the conversation with the social worker was not recorded in the GP notes so it is unclear what was discussed. Furthermore, there did not appear to be a coordinated response to this referral and thus it is unclear whether a referral to the housing department was ever considered.

7.8. Ambulance service

West Midlands Ambulance Service is only able to search their records by addresses and not by a patient's name. Therefore, if a patient is assessed at an address other than their home or in a public place, the contact with that patient would not show up on the search.

On 13 June 2010, the father was taken by ambulance to Good Hope Hospital with a swollen, painful knee. Then on 16 June, a solo paramedic responded to an incident

[10] The government defines a vulnerable adult as anyone aged 18 or over "who is or may be in need of community services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". See – www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multiagency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf - accessed online 6 December 2014

where his daughter had cut her thumb whilst washing up. She had dropped the knife on the floor and both she and her brother (the son) had reached for it at the same time. Her brother had grabbed the handle whilst she had grabbed the blade. This resulted in a laceration to her thumb. She was advised to go to minor injuries but she declined, as she would not be able to get home afterwards.

An ambulance was called to the father's home in November 2010 as he had fallen six hours before and later he found he was unable to get out of bed or walk. It was noted that he lived alone. He was taken to hospital for treatment.

On 18 November 2011, the father was treated for an asthma attack. The records stated that the attack was brought on by a "domestic". The police were at the property and the father was treated at the scene by ambulance staff. There was no record of any other injury or who was involved in the dispute.

An ambulance went to the father's home on 4 December 2011 following contact with the GP "out of hours" service. The father had difficulty breathing and was transported to hospital. He was described as "self-caring" and lived with his son.

On 10 March 2014, a call was received from a woman who described the victim as her father-in-law. When they arrived at the son's girlfriend's flat, ambulance staff found the father had a 3 – 4 cm laceration to his head above his left eye. He also had swelling and bruising to his right knee. He told the crew that he had fallen to the floor whilst getting out of bed.

On a day in late May 2014 two 999 calls were received from the son's girlfriend's flat. The first caller did not identify herself but she passed the phone to a woman who stated she was the son's girlfriend. The original caller is heard to shout at someone in the background. It later became apparent that the son was attempting to resuscitate his father during the calls. A second call was made simultaneously with the first but by a woman who identified the patient as her "dad" – this call began a few moments after the first. In the background, a distressed male can be heard. The second caller is apparently unaware of the first call being made at the same time.

On arrival at the address, the solo responder confirmed that the father had passed away. The records noted that he had last been seen around 20:00 the previous evening and was subsequently found unresponsive the following day. It is also noted that he had a history of falls. The paramedic noted that there was a graze/skin tear to the deceased's right forearm. She noted that he had fallen in the hallway the previous afternoon and hit his head. As there was evidence of trauma, she requested the police attend.

7.8.1. Analysis of involvement by the ambulance service

Each incident attended by the paramedics was dealt with appropriately and no pattern of abuse emerged. In hindsight, the incident involving the daughter and son in June 2010, when the daughter cut her thumb on the knife, was suspicious but still plausible. Equally, the incident when the father had an exacerbation of his asthma

following a domestic assault was dealt with appropriately, although normally a referral would be made to the police. However, as the police were present on that occasion no referral was made. Practice has changed since this incident and now a referral would be made even if the police had attended the incident.

The paramedics did attend an incident at the girlfriend's flat on 10 March 2014. They were unaware of any safeguarding concerns for the father's welfare; otherwise they would have been in a position to inform other agencies of where he was living and with whom.

7.9. Tamworth Borough Council Housing Services

The son's girlfriend's flat was a ground floor council-owned one bedroomed flat. She held the tenancy there from 6 June 2011. Initially it was a joint tenancy with her previous boyfriend but from 1 August 2011 she was the sole tenant.

Throughout her tenancy she had issues with rent arrears. She informed housing services that her boyfriend (the son) lived at the property between 11 February 2013 and 20 May 2013 (although he continued to live there until May 2014). It was around the time that he moved in that neighbours started complaining about anti-social behaviour. The anti-social behaviour included allegations around intimidation, noise, arguments, dog fouling, drug use and possible fraud.[11] The complaints continued until May 2014. Tamworth Borough Council housing services had no opportunity to pursue formal court possession for anti-social behaviour because either the neighbours would not provide witness statements or their allegations were not substantiated. The housing services attempted to fit noise recording equipment on several occasions. When they finally succeeded, the result proved inconclusive, as the complainants were responsible for some of the noise.

On 9 January 2014 following further complaints of anti-social behaviour, the tenancy sustainment officer made a visit to the flat and recorded that there was "no evidence of other people living" at the property. However, on 5 March 2014 housing services visited a neighbour who said they thought members of the son's family had moved in. A similar allegation was made by a different neighbour on 27 March, this time the neighbour stated that it was the son, his father and his sister that were all living at the flat with the son's girlfriend. The records stated that the girlfriend would not confirm whether anyone else was living at the address. Therefore, the housing department made a routine referral to the local benefits department to ascertain whether anyone else at the flat was receiving benefits. The resulting investigation showed no trace of other occupants and thus the case was not pursued.

The tenancy sustainment officer attempted a number of times to gain access to the flat. For example on 28 January 2014 the officer made an appointment to meet with

[11] It appeared from records that the allegations around fraud concerned the son and his girlfriend having parcels delivered to nearby residents but with the girlfriend's name on the parcels

the girlfriend at the property but "could not gain access" and on 10 February 2014 there was a joint visit with a police community support officer but again they failed to gain access. During March 2014, there were reports of broken windows and a leak in the bathroom. Contractors were able to enter the flat to make the necessary repairs. The tenancy sustainment officer attempted another visit by appointment to see the girlfriend on 7 May 2014 and again was unable to gain access.

During the course of this review, it became apparent that Western Power had disconnected the electricity at the flat on 28 April 2014. The flat remained without electricity until the time of the father's death. Npower (the supplier) had requested that Western Power disconnect the electricity supply following "repeated meter interference" during April 2014. However, contrary to the normal procedures neither Western Power nor Npower informed Tamworth Borough Council about the disconnection until 31 May 2014 (after the father's death). Furthermore, the son's girlfriend did not let Tamworth Borough Council know that she had no electricity.

7.9.1. Analysis of involvement by Housing Services

Clearly, there were issues around the property throughout the girlfriend's tenancy. Neighbours informed Tamworth Borough Council about anti-social behaviour at the property as well as drug use and noise. Police received regular complaints about the smell of cannabis emanating from the flat. However, housing services were confronted with allegations and counter allegations none of which they could substantiate. Even the installation of noise recording equipment failed to provide conclusive evidence.

Despite two different neighbours alleging that others were living at the property, Tamworth Borough Council was unable to gain access or use other methods to confirm or refute the allegations. Tampering with the electricity supply was clearly a breach of the girlfriend's tenancy. Had Western Power or Npower informed the housing department or police of this, it would have led to an investigation and the housing department may have had an opportunity to gain access to the flat. In turn, a visit may have established that the property was overcrowded and the father was potentially vulnerable.

8. EMERGING THEMES, LESSONS LEARNED AND RECOMMENDATIONS

8.1. The effect of domestic abuse on children in the household

It was clear from the individual management reviews that the son witnessed domestic abuse from an early age. Children respond differently to domestic abuse depending on a number of factors including their age, gender, race, stage of development and resilience. However, research[12] describes a range of behaviour in younger children who experience domestic abuse including bed-wetting, poorly developed verbal skills, difficulties at school and increased difficultly forming relationships with peers.

Children and young people who grow up in households where domestic abuse is a feature are often disruptive, find it hard to concentrate in school, and they may be aggressive towards teachers and other pupils. Older children may develop mental health problems such as depression or self-harming, or start to use drugs and alcohol. Some children, particularly boys, may model the abusive behaviour.

Many of these issues played a part in the son's life and perhaps we should not be surprised that he was aggressive when he returned to live with his family. In hindsight, more should have been done to assess the appropriateness of his return. A recent study[13] shows the importance of undertaking evidence-informed risk assessment and supporting children and families throughout the reunification process. Had this practice framework been available and utilised when the son left local authority care, the outcome may have been different.

8.2. Understanding domestic abuse involving vulnerable adults

There was a long history of violence and domestic abuse within the family, and for many years the father was the perpetrator of this violence and viewed as head of the family. Nevertheless, as his health deteriorated, circumstances changed and his position became more tenuous. It is clear that during the period under review, the

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[12] See for example, www.womensaid.org.uk/domestic-violence-survivors-handbook.asp; www.refuge.org.uk/get-help-now/what-is-domestic-violence/effects-of-domestic-violence-on-children/ and
Guy, J (2014) Early Intervention in Domestic Violence and Abuse, Early Intervention Foundation, London @ www.eif.org.uk/wp-content/uploads/2014/03/Early-Intervention-in-Domestic-Violence-and-Abuse-Full-Report.pdf, chapter 3 – accessed online 8 April 2015

[13] Hyde-Dryden, G et al., (2015)Taking Care: Practice Framework for Reunification, Evaluation Report, Loughborough University @ www.nspcc.org.uk/globalassets/documents/research-reports/taking-care-practice-framework-reunification-evaluation-report.pdf.pdf - accessed online 9 April 2015

father met the definition of a vulnerable adult. However, although agencies recognised that he fulfilled this statutory definition, practitioners did not recognise his potential vulnerability, especially as his son became more influential within the family.

Practitioners failed to make appropriate referrals to specialist domestic abuse services or to the appropriate partner agencies. Instead, their focus seemed to be on whether the father had mental capacity and thus was entitled to make "poor decisions", rather than viewing him as a victim of domestic abuse. The result was that when he declined to make complaints or have incidents investigated further (rather than using their professional expertise to question events) this was accepted by health, police and adult social care. There did not appear to be any appreciation of the type of coercive and controlling behaviour exhibited by perpetrators that might prevent the victim from being able to articulate what was happening to him.

The majority of victims experiencing domestic abuse have mental capacity and this in no way protects them. Therefore, it is important not to assume that mental capacity might protect a vulnerable adult. Understandably, professionals should consider their views, but professionals must also be equipped with the knowledge to provide meaningful solutions. These might include the use of inherent jurisdiction, legal remedies such as non-molestation and non-harassment orders as well as making referrals to local domestic abuse services or to the MARAC. Input from local domestic abuse services can assist professionals to understand the wide-ranging impact of domestic abuse on all individuals including vulnerable adults.

This case demonstrates that practitioners continue to view domestic violence and abuse as an issue affecting partners in an intimate relationship, and thus sometimes overlook violence and abuse that may occur between children and their parents or other family members.

i. Recommendation One

Staffordshire County Council should invite a domestic violence specialist worker to all meetings concerning adults at risk of neglect and abuse where domestic abuse is identified

ii. Recommendation Two

Staffordshire County Council and Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board should ensure that adult safeguarding awareness training includes domestic abuse to (amongst other things):

a. Equip staff to recognise that the definition of domestic abuse also encompasses those adults who are abused by their children and/or other family members

b. Ensure staff are able to assess the risk to victims of domestic abuse

c. Enable staff to know how and when to refer victims of domestic abuse to specialist domestic abuse services or appropriate partner agencies

iii. Recommendation Three

Staffordshire County Council and Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board should ensure that training on the Mental Capacity Act, adult safeguarding awareness training and training on legislation all emphasise the reasons for not over relying on mental capacity.

Such training should focus on interventions and preventative measures such as the role of inherent jurisdiction, risk assessment, MARAC referrals, and the criminal sanctions and civil remedies available (such as non-molestation orders and injunctions)

8.3. Communication and information sharing

Communication and information sharing are common themes in domestic homicide reviews, and this one is no exception. The lack of communication had a direct impact on the amount of information about the father that was known to individual agencies.

Although the father was a vulnerable adult and two adult protection referrals had been made, this information was not known to other agencies. Had police, health, housing and his GP been aware of his vulnerability, there would have been opportunities to share information and understand the risk that he was facing.

Although adult social care was aware of the father's vulnerability and previous safeguarding concerns, there was no integrated system to enable health practitioners to be aware of the situation. Thus, when the father saw his GP about a week before his death, his GP was unaware of any safeguarding concerns.

In addition to these issues around communication and information sharing, it became apparent during the course of this review that West Midlands Ambulance Service is only able to search their records by addresses and not by a patient's name. Therefore, if a patient is assessed at an address other than their home or in a public place, the contact with that patient would not show up on the search. The panel raised concerns that victims of domestic abuse may sustain injuries at locations other than their own homes and the pattern of these incidents may go unnoticed.

iv. Recommendation Four

Where there are integrated teams, Staffordshire and Stoke on Trent Partnership NHS Trust should consider introducing an integrated case recording system that can be accessed by all health and social care staff within the Partnership

v. Recommendation Five

Staffordshire County Council together with the Adult Safeguarding Board should ensure that all statutory adult safeguarding enquiries involve multi-agency strategy discussions. This should include discussion about the suitability of potential carers from within the household or family

vi. Recommendation Six

West Midlands Ambulance Service should consider developing a system that will enable searches to be made by patients' names as well as by addresses.

9. CONCLUSION

The father's family was large, chaotic and the majority of the individuals were known to a significant number of services and agencies. A long history of violence and domestic abuse spanned the generations. The father's children witnessed domestic abuse from an early age and perhaps unsurprisingly his daughter experienced domestic abuse in her adult life, whilst his son became a perpetrator of domestic abuse. Furthermore, other issues spanned the generations such as substance misuse. From records, it appeared that both the father and his ex-wife drank heavily, while it was documented that his son and daughter used drugs and alcohol. In addition to domestic abuse, violence, and drug and alcohol use, there were other issues that brought many members of the family to the attention of agencies including child protection concerns, anti-social behaviour and shoplifting.

The fact that the father had inherited about £25,000.00 did not become known until after his death but throughout the period under review it appeared that family members took money from one another if the opportunity arose. When family members fell out, they often moved accommodation and this mixed with a chaotic lifestyle made it difficult for agencies to know where individuals were living and with whom. This inhibited agencies' ability to monitor where the father was living which manifested as a problem as he became more vulnerable.

Although the father did at times disclose historical financial and physical abuse, when questioned he often retracted the allegations or declined to take the issue further. Equally, when he did disclose, practitioners failed to recognise his vulnerability and make the appropriate referrals. Therefore, the help he was offered

from professionals was reactive rather than preventative. While there were a couple of opportunities to potentially intervene to remove the father from the exploitative situation in which he found himself, there was nothing to indicate that his son might murder him. Thus, the panel concluded that this domestic homicide was neither predictable nor preventable.

10. SINGLE AGENCY RECOMMENDATIONS

STAFFORDSHIRE POLICE

i. Where adults at risk are reported missing, the risk assessment and response should be consistent irrespective of their residential circumstances

ii. When investigating an allegation of financial abuse of an adult at risk by a perpetrator in a position of trust, the investigating officer must give access to tangible advice and support

HEART OF ENGLAND NHS TRUST

i. Support the implementation of independent domestic abuse advisors in the Emergency Department

ii. Respiratory team W10 Good Hope Hospital to review assessment of chronic obstructive pulmonary disease and causes of breathlessness

iii. Ensure all staff in the emergency department and acute assessment areas use the domestic abuse flow chart and policy

iv. When a patient is assessed as being at risk of neglect or abuse following a case conference, their electronic records should be "flagged" to raise awareness of these safeguarding concerns

v. Ensure staff in the emergency department and acute assessment areas use the alcohol screening tool and make appropriate referrals to the drug and alcohol team

BURTON HOSPITALS NHS TRUST

i. To ensure that routine enquiry concerning domestic abuse is embedded in practice for maternity cases

ii. To ensure awareness and understanding of safeguarding vulnerable adults is embedded in the organisation

ADULT PROTECTION INVESTIGATION TEAM

i. All safeguarding cases should be recorded clearly and this information should be available to the relevant staff

ii. Risk assessments to be revised to ensure that practitioners consider family history, background and context

iii. The Safeguarding Adults Board should introduce an escalation procedure to resolve inter-agency disputes and difficulties

iv. All safeguarding plans should be clearly marked and contain contingency plans in case the situation changes

RADIS DOMICILIARY CARE

i. Staff to be aware of signs of domestic abuse

ii. Staff supervisions to refer to domestic abuse

iii. Awareness of signs of abuse including domestic abuse to be an agenda item for all staff meetings

GENERAL PRACTITIONERS

i. Undertake a local review to consider whether it would be appropriate to have a named care coordinator for patients in the community

ii. Practice nurses undertake a biopsychosocial assessment that has core assessment questions that include asking about the home environment and any carers/family that they reside with

iii. Develop an adult at risk booklet

STAFFORDSHIRE CHILDREN'S SOCIAL CARE

i. Assessments of risk in relation to domestic violence should identify any potential risk to all household members, not just the victim, and share information with relevant others where appropriate

STAFFORDSHIRE YOUTH OFFENDING SERVICE

i. Staffordshire Youth Offending Service Managers to ensure reflective supervision discussions take place with Case Managers