Adult A

Domestic Homicide Review

Final version for publication

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1. Introduction

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the Domestic Violence Crime and Victims Act 2004 which came into force on the 13th April 2011.

1.2. Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004. Section 4 of the act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

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

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

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

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3. Hayley Frame, Independent Safeguarding Consultant, was appointed as the independent author. Gwen Doswell, Head of Service, Leicester City Council, was asked to chair the DHR panels. Neither Hayley nor Gwen had any prior knowledge or involvement with the case and the independent author, Hayley, was satisfied that the chair, Gwen, had no conflicts of interest.

Persons Covered by the Review

1.4. The principal focus of the Review is the victim Adult A. The other involved adults are the perpetrator, Adult C and his girlfriend Adult B. Adult B is the ██████ [family member] of Adult A. Adult C was found guilty of manslaughter and preventing the course of justice. Adult B was found guilty of preventing the course of justice and preventing the lawful and decent burial of a dead body.

Review Period

1.5. The scoping period is from January 2013 until February 2015, (capturing the period when Adult B commenced living with Adult A, Adult C became involved with Adult B and up to the period of Adult A's death).

1.6. A summary of agency involvement from 2004 until the beginning of the scoping period was also requested in order to capture any relevant background information.

Terms of reference:

1.7. The full terms of reference for the Review can be found at Appendix A.

1.8. The following areas were addressed in the Individual Management Reviews and has shaped the analysis of this Overview Report:

a. To review whether practitioners involved with Adult A and Adult B & Adult C were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator(s).

b. To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including:
   - whether the risk management plans were reasonable response to these assessments,
   - Whether risk assessments and management plans of Adult C took account of his early history, including convictions for sexual assaults on minors and assessments of risk made during this period,
   - whether there were any warning indicators of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals.
   - Whether any of the adults concerned were assessed to be vulnerable adults and whether they would now meet the criteria for an adult at risk as per the Care Act 2014

c. To identify whether services that were involved with Adult A were aware of the circumstances of Adult B's & Adult C's presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship(s).

d. Did agencies involved make routine enquiries about domestic violence when working with these adults and if so were any opportunities missed?

e. To establish whether agencies responded to alcohol dependence and offer appropriate services and support to Adult A and Adult B.

f. At each point of contact with emergency health services for assaults, self-harm and injuries –were enquiries made about domestic violence and procedures followed?

g. To establish whether the mental health needs of adults subject to this review were supported and managed appropriately by local agencies.

h. To establish if any agency or professionals considered that any concerns were not taken seriously or acted upon by others.

i. To establish if there were any barriers experienced Adult A, Adult B or family / friends that prevented them from accessing help; including how their wishes and feelings were ascertained and considered.

j. To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.

k. To establish whether local Domestic Abuse procedures were properly followed; to include whether the case was, or should have been, considered for MARAC.

l. To identify whether child sexual abuse allegations, leading to the risk of sexual exploitation, were appropriately managed by local agencies and the transition to adult services.

m. To establish whether adult safeguarding concerns (Adult A, Adult B, Adult C) were recognised by agencies and whether multi-agency safeguarding procedures were followed.

n. To consider whether there were any missed opportunities for a multiagency response to consider the multiple issues of Adult A and Adult B

o. To consider how issues of diversity and equality were considered in assessing and providing services to Adult A, Adult C and Adult B (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership).

p. To establish whether safeguarding children procedures were properly followed in respect of Adult B's allegations of historical abuse made against Adult A.

q. To establish how effectively local agencies and professionals worked together.

r. To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.

s. Identify any areas of good practice

Contributors

1.9. Agencies participating in this Review and commissioned to prepare Individual Management Reviews are:

- Leicestershire Police
- Leicester City Council – Children's Social Care

- Leicester City Council – Adult Social Care
- GP practices
- East Midlands Ambulance Service
- University Hospitals Leicester NHS Trust
- National Probation Service

1.10. Agencies with more limited involvement were asked to prepare summary reports:

- Leicestershire Partnership NHS Trust
- Leicester City Council – Housing
- Leicester City Council – Antisocial behaviour unit
- Leicester City Council – Education Welfare Service
- Leicester City Council – Youth Offending Service
- SAFE
- New Futures
- East Midlands Homes

DHR Panel members

1.11. DHR Panel members consisted of senior representatives from the following agencies:

- Leicestershire Police
- Leicester City Council – Children's Social Care
- Leicester City Council – Adult Social Care
- Leicester City Council – Community Safety
- Leicester City CCG
- East Midlands Ambulance Service
- University Hospitals Leicester NHS Trust
- National Probation Service

1.12. Having received feedback from the Home Office Quality Assurance Panel that it may be helpful if the report explored risk factors in the context of violent resistance, domestic violence specialist representation was engaged by the Adult Review and Learning Group (ARLG) to help further consider the dynamics of this abuse (Appendix D).

2. **The Facts**

2.1. Adult A resided at a flat in Leicester. He lived there with his [redacted] [family member] Adult B. Adult B had commenced a relationship with Adult C, a few weeks prior to Adult A's death and Adult C regularly stayed at the address during that time.

2.2. On 21st February 2015, Leicestershire Police formed concerns for the wellbeing of Adult A whose whereabouts were unknown. Later that day, as the situation developed and despite Adult A remaining missing, both Adult B and Adult C were arrested on suspicion of Adult A's murder.

2.3. On 23rd February 2015, Adult A's body was found a few hundred yards from his home. He had received multiple injuries.

2.4. On 24th February 2015, both Adult B and Adult C were charged with the murder of Adult A and preventing his lawful burial. Both were remanded in custody.

2.5. On 22nd September 2015 at Leicester Crown Court, Adult C was convicted of manslaughter and received life imprisonment, Adult B was convicted of perverting the course of justice and preventing the lawful and decent burial of a dead body. She was sentenced to three years imprisonment.

2.6. The HM Coroner recorded a verdict of unlawful killing on 29th September 2015.

3. Summary of individual agency contact/involvement prior to the scoping period with Adult A and Adult B.

Leicester City Council Children, Young People and Families Directorate

3.1. Adult B was subject to a statement of special educational needs yet attended mainstream school. From 2004 until December 2012, Children's Social Care received 10 contact/referrals in relation to Adult B. The first contact was when Adult B, aged 12, came into the office to see a duty social worker and received advice and information. There was evidence of information sharing from CAFCASS in relation to historical allegations of sexual abuse. Targeted Services in relation to Youth Offending also had involvement with Adult B and there were concerns about the parenting she was receiving.

3.2. An important event outside of the scoping period was a referral from the police to Children's Social Care in relation to Adult B in August 2010 when she was alleging sexual abuse by Adult A, both current and historical. In line with procedures this was followed up as a single agency investigation as Adult B was an adult. The working practice was that the police would seek to ascertain during their enquiries whether an alleged perpetrator has any contact with children and refer these children to children's social care. In addition, children's social care would check whether the alleged perpetrator is living with children. In this case, Adult A was not living with children and therefore no further action was taken by Children's Social Care.

Leicester City Council Adult Social Care

3.3. Prior to the dates within scope of this review Adult A had been closed to Adult Social Care (ASC) since March 2011. Prior to the dates within scope of this review ASC had no contact with Adult B.

East Midlands Ambulance Service

3.4. EMAS attended Adult B and Adult A 33 times outside of the scoping period and 22 of these attendances were for medical reasons. One attendance to Adult B related to an episode of domestic violence.

University Hospitals of Leicester NHS Trust

3.5. Adult A attended University Hospitals of Leicester NHS Trust on 40 occasions during the review period. On 39 of the 40 occasions he attended the Emergency Department. Of those, he did not require treatment, or he did not wait to be seen, on 10 occasions. Throughout 2004 – 2010 his attendances were not excessive, numbering 12 in total (average 1.5 attendances per year). However, in 2011 there was a sharp increase in the contact between Adult A and the Emergency Department, equalling 11 attendances in the calendar year. Of those he did not to wait to be seen on 4 occasions. It is difficult to know why this increase occurred in 2011, although 3 of

those attendances were related to the same injury. In 2012 his attendances had dropped to 4.

3.6. It is apparent that throughout Adult A's attendances that excess alcohol featured on numerous occasions with Adult A disclosing that he relied on alcohol to cope with the death of his daughter in the 1970s and the breakdown of his marriage in 1980. There were several attendances due to physical problems, mostly chest or abdominal pain; likely to have been exacerbated by excess alcohol intake. Adult A had a long history of gastric ulceration due to excess alcohol. On 7 occasions Adult A presented with minor injuries following episodes of self-harm, or expressing suicidal thoughts, although rarely was intent to commit suicide evident within the records. Low mood due to the death of his daughter appears to be a key factor in Adult A's self-harming behaviours. In 2007, Adult A claimed to feel suicidal and also claimed that his sister and ████ [Adult B] were accusing him of sexually abusing them. He stated that they were asking him for money to perform sexual acts on him. Adult A was described as being aggressive and hostile towards staff. He was heavily under the influence of alcohol at the time.

3.7. On two occasions Adult A presented with minor injuries as a result of physical altercations between himself and other unknown assailants. On another occasion, in 2011, Adult A attended with a minor head and hand injury after being allegedly hit by a bottle during a fight with his ████ [Adult B].

3.8. On each attendance, the records indicate that Adult A received appropriate and timely physical care and treatment. Where necessary Adult A was admitted to a ward for further investigations, treatment and follow up prior to discharge.

3.9. During the period 2004 – 2015, Adult B attended the Emergency Department on 32 occasions. Of those, she did not require treatment, or she did not wait to be seen, on 12 occasions. Throughout 2004 – 2010 she attended 8 times, averaging 1 attendance per year.

3.10. As in the case of Adult A, it is clear that alcohol was a key factor in Adult B's contact with UHL. She attended the Emergency Department having been drinking excess alcohol in 2006, when she was 15 years old. Standard practice at that time would have been to ensure that she was not allowed to leave unless accompanied by an appropriate adult and to refer to the school nurse and liaison health visitor for information (regarding her risky behaviours) and follow up if appropriate. As the relevant paper records from 2006 are destroyed it is difficult to determine what actions were taken at the time.

3.11. In 2011 there was an increase in the contact between Adult B and the Emergency Department equalling 9 attendances in the year. Adult B did not to wait to be seen on the first 2 occasions. Then, in July 2011, Adult B presented with genito-urinary symptoms and disclosed that she had a planned meeting with Police regarding sexual abuse by her ████ [Adult A]. The Emergency Department Doctor advised Adult B's GP of this in the discharge letter, and requested the GP to review and consider 'sexually transmitted infection' and 'vulnerable person' status. There is no evidence that a safeguarding adults or children referral was generated at the time.

3.12. In 2012, Adult B attended the Emergency Department on 3 occasions. In April she complained of spot bleeding in early pregnancy, and in May she attended after consuming excess alcohol, which generated a safeguarding children referral by Emergency Department staff due to concerns about the unborn child.

3.13. Adult B did not attend the Emergency Department again until April 2013. Following that there was another spike in attendances with 8 presentations, although she only waited to be seen on 6 occasions. Alcohol excess again featured in Adult B's attendances and the records indicate that Adult B was becoming more aggressive in her behaviours and was involved in more physical altercations with others / friends. Adult B was also increasingly uncooperative, aggressive and abusive towards staff in the Emergency Department.

Leicestershire Partnership Trust (LPT)

3.14. Adult A had various contacts with LPT through the Crisis Resolution and Home Treatment Team (CRHTT) and Deliberate Self-harm service. On 27th May 2006, Adult A was assessed by an on-call Senior House officer in Psychiatry for deliberate self - harm issues. Adult A denied any suicidal ideation and refused any offer of help for his drinking or otherwise. On 20th June 2007, a further referral was made for Adult A, from the Emergency Department, to the Leicestershire Partnership NHS Trust Liaison Psychiatry for deliberate self-harm issues. Adult A was seen by the deliberate Self-harm team and he reported that he had taken an overdose of morphine and had drunk excess alcohol. There was no psychotic or depressive signs evident and a personality disorder was noted. Adult A was then discharged with no further follow up.

3.15. On 19th May 2010, Adult A was referred by the Emergency Department to the on-call Deliberate Self Harm team. The team attended and found Adult A to be intoxicated and no evidence of mental health problems were found. They could not continue with the assessment until the patient was sober, however, Adult A left hospital prior to being seen by the Deliberate Self Harm team despite having agreed to be seen.

3.16. Adult A was again referred on 5th March 2012 by the Emergency Department however the process was that if the Deliberate Self Harm team attended to see a patient referred to them, and the patient was not medically ready, they would not continue their involvement until the patient was deemed medically fit. The initial referral would be closed and a new referral required when the patient was medically fit. In this instance, it would appear that the second referral was not made.

Leicestershire Police

3.17. Adult A had numerous convictions dating back to 1962 which include theft, criminal damage, arson, public order and racially motivated offences. Police officers responded to a large number of incidents at his home address with Adult A being both a victim and offender. In addition there are four vulnerable person reports which all related to Adult A self-harming.

3.18. Adult B has a number of convictions dating from 2004 which include wasting police time, racial harassment, public order, shoplifting, criminal damage, burglary, handling stolen goods and theft. The Police National Computer also shows that she has warning markers for depression, suicide and panic attacks and a heart condition. Outside of the scoping period, police officers have responded to a large number of domestic incidents between Adult B, her brother and her mother. Police reports show that Adult B may have been involved in prostitution since July 2010.

3.19. A significant event outside of the scoping period was on Wednesday 6th June 2007. Adult B's mother, took Adult B and a friend, who was a minor, to Adult A's address and whilst at the address the friend called the police stating that Adult A had indecently assaulted her by digital penetration. All three females provided statements and Adult B also alleged that she too had been sexually assaulted by Adult A by way of inappropriate touching over clothing in the groin and hip areas. Adult A was arrested and denied the offences. Forensic samples were taken from Adult A. The friend later retracted her accusation that digital penetration had occurred. The investigation did not identify any further corroborating evidence or witnesses and due to the conflicting victim and witness accounts a decision was made by the Crown Prosecution Service to take no further action.

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3.20. On Saturday 31st July 2010, the police were notified that Adult B had attended hospital with breathing difficulties; and whilst there she disclosed to staff that over the past three years she had been sexually abused on a number of occasions by Adult A. Although Adult B refused to engage with the police or make a formal statement, the Child Abuse Investigation Unit (CAIU) conducted an investigation during which Adult A was interviewed; he denied that any of the events (touching over clothing in the genital area) had occurred and the case was filed without further action.

3.21. On Wednesday 9th March 2011, police officers attended Adult A's address to assist the ambulance service with Adult B, who was at the address with her mother, and had visible injuries. Adult A was arrested on suspicion of assault but was released without charge as Adult B and her mother refused to give statements or make a complaint. A domestic abuse incident form was completed and a risk assessment identified a standard risk.

3.22. On Friday 8th April 2011 police officers attended the home address of Adult A; he had sustained significant injuries and Adult B was arrested on suspicion of assault. The attending officer completed a risk assessment and identified a high risk. Adult A declined to make a complaint and Adult B was advised to speak to a housing officer upon her release.

3.23. On Friday 27th May 2011, police officers attended the home address of Adult A after a report that he had assaulted Adult B. Upon arrival it was established that Adult A had left prior to the officer's arrival. Adult B refused to make a statement of complaint but disclosed that she had also assaulted Adult A during the incident.

National Probation Service

3.24. The NPS contributions to this process are made on the basis of access to legacy records from Leicestershire and Rutland Probation Trust (LRPT). The NPS was not formed as an organisation until June 2014.

3.25. Adult B was subject to a 12 months' Community Order imposed on 1st September 2011 due to Racially Aggravated Harassment and Section 4 Public Order. The pre-sentence report and order supervision were undertaken by LRPT.

3.26. In 2011, Adult B informed the Offender Manager completing the pre-sentencing report that was being prepared that at the time of the index offence she had been drinking with her ████ [Adult A] with whom she was residing. She also disclosed that her ████ [Adult A] had tried to touch her and used sexual language towards her, and that prior to this, her ████ [Adult A] had sexually abused her. The ████'s [Adult A's] name was not recorded. By the time of the report interview Adult B had moved out of her ████'s [Adult A's] address and was living with her mother. Adult B stated that she had reported the issues to the police but was not ready to gain support to deal with the abuse. Adult B was referred for counselling during the course of her order but declined the service. In relation to the alleged abuse by Adult A, the Offender Manager supervising the order took Adult B's word that she had reported the matter to the police.

4. Summary of individual agency contact/involvement with Adult C

Although there is significant agency involvement with the three individuals involved in this DHR, there was no information to link them together. Adult C essentially led a separate life and was not known to Adult B or Adult A until a matter of weeks prior to Adult A's death.

Given the fact that there was no agency information to link Adult C, Adult B and Adult A, and that the relationship between Adult C and Adult B had only begun a matter of weeks prior to Adult A's death, this summary of individual agency contact/involvement is in respect of Adult C only and includes involvement both before and during the scoping period.

Education

4.1. As a child, Adult C was made subject of a statement of special educational needs. It indicated that he had special educational needs due to difficulties in the following areas: general physical skills; hand eye coordination; self-help skills; language skills (both understanding and expression); social skills, difficulties with concentration; cognitive skills; literacy and numeracy difficulties. Adult C attended a school for pupils with physical and learning difficulties.

Leicester City Council Adult Social Care

4.2. Adult Social Care (ASC) had involvement with Adult C during and prior to the dates within scope of this review. Adult C was supported by ASC with his finances and had ongoing case management by a Social Worker in the Adult Mental Health Team throughout the period of January 2013 and February 2015.

4.3. In September 2014, Adult C was placed in residential care at Island Place. He had been living in the community prior to this but had lost his tenancy and there were concerns regarding his vulnerability and exploitation by the 'friends' he made.

Leicestershire Partnership Trust (LPT)

4.4. Adult C received care and support from the Leicestershire Partnership Trust Adult Community Mental Health Teams (CMHT) and the Specialist Psychological Therapy Services.

4.5. Adult C's first contact with LPT was in 2001 when he was referred by his GP for an assessment of Asperger's Syndrome. Adult C had been suffering from cerebral palsy since birth and had a diagnosis of learning disabilities during his secondary school years. By then, he had already had various educational psychology assessments and had been educationally statemented. His diagnosis of Asperger's Syndrome was made in October 2001.

4.6. Although Adult C received ongoing outpatient psychiatric care from the Community Mental Health Team between March 2005 and March 2012, he did not have a primary

psychiatric diagnosis of a severe mental disorder. The working diagnosis at the time he was seen in the psychiatric outpatient department was Asperger's Syndrome.

4.7. Between July 2005 and August 2011, Adult C was open to the Specialist Psychological Therapy Service for two reasons: firstly, to help manage some of the Asperger's Syndrome associated behaviours using Cognitive Behavioural Therapy and self-help groups' sessions and secondly, for the management of his secondary diagnosis of Post-traumatic stress syndrome which Adult C identified as caused by an alleged sexual abuse at a young age. Adult C was also concerned about the effect of his anger and the difficulties managing this upon his relationships. When Adult C disclosed his concerns about the impact of his anger on his personal relationships in a therapy session, he was not in a relationship; so no immediate risk to others was identified. The purpose of the therapy was to mitigate against the impact of his anger against future partners.

University Hospitals of Leicester NHS Trust

4.8. During the period 2004 – 2015 Adult C attended the Emergency Department on 17 occasions. Of those, he did not require treatment, or he was redirected to a more suitable service, on 4 occasions. Up until 2011, Adult C only attended with minor illnesses / injuries / sprains and no concerns were apparent in the medical records. He was treated appropriately on each occasion and discharged within a few hours.

4.9. In 2009, Adult C was seen at hospital because of an overdose with alcoholic intoxication, for which he was admitted. On 10th July 2009 he was admitted to hospital in Nottingham following an alleged assault where he had been beaten over his head and scalp.

4.10. On 19th July 2011, Adult C was conveyed by ambulance having been found crawling along a street intoxicated. It is recorded on the notes that Adult C was at that time residing in a 'care home' for people with mental health difficulties. Adult C could not recall events, had lost his glasses and was struggling to see. Hospital staff contacted the care home prior to discharge and were informed that Adult C was 'free to leave the home' at any time, and he was 'due to move out soon'. Consequently, no further action was taken and he was therefore discharged from hospital with head injury instructions.

4.11. On 12th September 2013, Adult C attended the Emergency Department, conveyed by ambulance. Adult C presented with suicidal thoughts, and had called the Police himself to report that he needed 'sectioning'. He was seen by the deliberate self harm team (see 4.12 above).

Leicestershire Police

4.12. Adult C has convictions for attempted buggery and gross indecency in 2001. The Police National Computer shows that he has warning markers for self-harming, anxiety, depression, deafness, cerebral palsy, post-traumatic stress syndrome, Asperger syndrome and for being suicidal. There are nine vulnerable person reports for Adult C which include three reports of him being a missing person, two calls for

assistance, a report from his mother over concerns of exploitation and one for harassment.

4.13. In October 2009, Adult C reported to the police that he had been assaulted by his then girlfriend and her friends; the case was investigated during which Adult C re-established his association with the perpetrators and despite all the appropriate referrals being made to support him he ultimately retracted his complaint.

4.14. On 3rd September 2013, the police were informed that Adult C had been assaulted by two males in the street and that it was part of a running feud between neighbours who had attacked Adult C with a bottle. The attending police officers conveyed Adult C, and two witnesses (who he lived with) to the Police Station in order to obtain statements. The officers were aware that all three requiring an appropriate adult due to their learning disabilities and mental health. Whilst a statement was being taken from one witness, Adult C left the police station with the other witness. The officers tried to contact them via their mobile phones and visited their address but there was no reply. The investigation was not supported by Adult C and he failed to attend an arranged appointment. The crime was filed as undetected.

4.15. On 12th September 2013, Adult C reported to the police that he had been threatened with violence by his male housemate. As a result of concerns regarding his mental health, Adult C was taken by ambulance to hospital that evening. Police officers attended the hospital to find Adult C had not been assaulted but that he was in a distressed state, he said that he was having difficulties with his 'carers' and that he wanted to admit himself voluntarily for an assessment of his mental health. Adult C was seen by the deliberate self-harm team. At that time he reported that he was drinking about 8 – 9 cans of lager every 2-days.

4.16. On 14th September 2013, the police officer established that Adult C was safe at a hostel but that he wanted to retrieve his property from the address he had shared with his two housemates; which was facilitated. An adult at risk referral was made to the police in house adult at risk team who viewed the circumstances and concluded that as Adult C was already in receipt of the appropriate care from other agencies further referrals were not required.

4.17. On Sunday 3rd November 2013 a member of staff from a hostel where Adult C was being housed reported that she had received a call from Adult C stating he had been sexually assaulted. Police officers arrived shortly after midnight and ascertained that Adult C had not been assaulted but had agreed to consensual sex earlier in the day with his girlfriend's brother. Later that day Adult C had given his bank card to him and asked him to go to the cash machine to withdraw money but he did not return. Adult C was taken back to his hostel; where both officers and the hostel staff expressed doubts over the validity of the allegations or whether an offence had actually been committed. An adult at risk referral was made however Adult C's social worker had already been informed of events.

4.18. On 7th May 2014, EMAS reported that they had been called to an assault where a male was bleeding from a head injury; the attacker was not believed to be at the

scene. Police officers arrived and established that Adult C was the victim, he did not have a head wound but he did have a cut to his hand which required stitches. At the time Adult C was unable to recall any details of the incident and when he was seen later he decided that he did not want any further police action.

4.19. On 31st July 2014, Adult C was accused, along with 2 others, of beating a female over a period of days whilst at a shared address and that Adult C had recorded some of the assaults on his mobile phone. A decision was taken by the CPS that no further action would be taken in respect of these allegations.

4.20. On 6th August 2014, a member of staff from Adult C's support housing reported him missing; information was received that he had taken his clothes and television with him. Adult C was located with two associates and a vulnerable person report was completed. There was a concern that he was being exploited by the two associates but when questioned he did not support this and stated that he was "sofa-surfing" of his own free will.

4.21. However Adult C later reported to the police on 25th September 2014 that he had been assaulted by the two associates over a period of weeks. Adult C was safe at a hostel at the time of the report so an appointment was made to visit him. Adult C gave conflicting accounts to the investigating officer and CCTV opportunities were explored which did not match the events he described. Enquiries were completed however no evidence was found to support the allegation and the crime remained undetected. An adult at risk referral was made, Adult C's social workers were made aware of the allegation and he was given safety advice.

GP

4.22. Adult C registered with a new GP on 13th October 2014. Adult C asked for Sertraline which he was being prescribed for depression and anxiety. The prescription was issued and he was asked to book an appointment prior to his next request for medication. However a medication review was subsequently completed based on patient records rather than face to face contact.

Housing

4.23. Adult C was provided with supported accommodation in 2012 and 10 hours of care per week. This ceased due to Adult C failing to engage and he went on to lose his tenancy as he was failing to engage with the support that was a prerequisite of the tenancy. In addition, Adult C had allowed two associates to move in with him, leading to concerns regarding antisocial behaviour.

4.24. Adult C was rehoused in further supported accommodation but was served with a notice of abandonment of his property of 7th September 2014. On 22nd September 2014, he informed housing options that he was staying with friends who were abusing him. Temporary accommodation was sought.

4.25. Adult C then moved to Island Place, a residential care home on 22nd September 2014. This was intended to be a temporary placement pending exploration of other housing options.

There was no evidence of any association between Adult A and Adult C in the agency case records for Adult C apart from a very brief mention in the adult social care case records on 19th February 2015, where Adult C advised that he would be staying with his girlfriend (Adult B) at the weekends. This was *after* the recorded date of death for Adult A.

5. **Summary of key events within the scoping period**

NB: This section relates to Adult B and Adult A as Adult C was not known to them until a few weeks before Adult A's death. Information in respect of Adult C has been summarised in the sections above.

Author comments are in bold

5.1. On 9th March 2013, police attended Adult A's home address after he called to report that he felt suicidal and had heard rumours that people were calling him a paedophile. The attending officers saw cuts to Adult A's arms and he was conveyed to hospital. Adult A was seen by the Deliberate Self Harm team who noted that the patient's difficulties were secondary to alcohol dependency and social stressors and that he has no mental health needs. Adult A was also seen by the Acute Assessment and Recovery Service in relation to alcohol misuse to Adult A declined their input. Adult A was discharged as his mood was described as stable and he was willing to reduce his drinking.

Adult A was seen by the appropriate services as a result of his self-harm and alcohol misuse.

5.2. Adult A was seen again in the Emergency Department, in the company of Adult B, on 21st March 2013. Adult A was intoxicated and had self-harmed causing a laceration to his forearm. Adult A disclosed earlier to the police that he had self-harmed as a result of being accused by the ex-partner of Adult B that he had sexually touched Adult B and her daughter. Both Adult A and Adult B were described as aggressive and soon left the hospital.

5.3. Adult A returned to the Emergency Department on 24th March 2013, to have the wound on his arm examined. An Adult Mental Health Proforma was completed by an Emergency Department Doctor and Adult A was not deemed to be a current risk to self. Adult A denied suicidal ideation and reported to the Doctor that he was drunk at time of the self-harming incident. The Doctor was unable to suture the wound due to the age of the wound, so it was cleaned and dressed. Adult A was adamant that he did not want to see Deliberate Self Harm team and was discharged.

5.4. On 2nd April 2013, Adult B was seen in an area used for street prostitution by New Futures Outreach Workers. Adult B was provided with condoms and advice in respect of alcohol use and the dangers of this when working in prostitution. This was due to Adult B appearing intoxicated.

5.5. On 5th April 2013, and ambulance was called to Adult B who had a hand injury. Adult B reported that she had punched a door the day before. Whilst she was on the ambulance, Adult A became abusive and "squared up to staff". The ambulance crew noted that Adult A would not allow Adult B to travel on her own or to answer her own questions. The crew also noted that she taken alcohol. On arrival at the Emergency Department, Adult B refused to enter a cubicle and left without seeing a doctor.

This incident could have prompted a safeguarding referral being made by EMAS in respect of Adult B.

5.6. Adult B was seen again by New Futures Outreach Workers on 18th April 2013 in an area used for street prostitution. Adult B appeared intoxicated and advice was given regarding the dangers of this.

5.7. The following day, Adult B attended the Urgent Care Centre after having been allegedly assaulted the previous Monday by an unknown assailant. Adult B was difficult to assess due to the level of intoxication but she was seen to have bruising to the kidney region so was sent to the Emergency Department. Once there, Adult B did not wait to be seen by a doctor.

There is no evidence of liaison with the police or consideration of a safeguarding referral being made in respect of Adult B.

5.8. On 22nd April 2013, at 01.03 hours, Adult B attended the Emergency Department complaining of blood in her urine after being kicked previously in the back. Adult B was accompanied by Adult A. Adult A became loud and was asked to leave by the security staff and became racially abusive. Adult A was subsequently arrested. Adult B did not wait for assessment and left the hospital. As a result of this admission, Adult B's GP tried to contact Adult B and an appointment was arranged at the surgery. Adult B failed to attend this appointment.

The proactive attempt of the GP to see Adult B as a result of her attendance at the Emergency Department is an example of good practice.

5.9. Adult A admitted the offences and was charged. He subsequently appeared in court and was fined.

5.10. Later that day on 22nd April 2013, an ambulance was called to Adult A for pain in his wrists. Adult A reported that he had an altercation with the police the previous night and was handcuffed, since then he has suffered from pain in his wrists.

5.11. The police were contacted on 15th June 2013 by Adult B's mother who reported her concerns for Adult B's wellbeing; there was then a further call reporting a disturbance in the street involving both Adult B and her mother. Adult B's mother was concerned that Adult A and Adult B were engaged in sexual activity and that Adult B was working as a prostitute, with Adult A acting as her 'pimp'. Adult B denied the allegations of sexual activity with Adult A but admitted that he was accompanying her to work on the streets and that he was looking after her money. She told officers that Adult A had allegedly tried in the past to "come on to her" but she did not let him; it was the officer's observations that Adult B did not seem concerned by this. Adult B declined to make any statements. Attempts to speak to Adult A were unsuccessful as he was not at home. A vulnerable adult's form was completed in respect of Adult B and referral made to New Futures (prostitution outreach) and Open Hands (a Christian charity) but Adult B failed to engage with them.

The referrals made to support Adult B are examples of good practice.

5.12. On 13th July 2013, Adult B's mother contacted the police as she had information that Adult A had assaulted Adult B. This was later denied by Adult B despite having a large bruise on her arm. The police referred Adult B to Adult Social Care following her having disclosed that she was working as a sex worker. Also on that day a report of antisocial behaviour was made. After this, regular reports continued to be made concerning Adult A, Adult B and various unknown others including reports of drinking and fighting.

5.13. As a result of the referral made by the police, Adult Social Care made contact with New Futures. Adult Social Care were unsuccessful in contacting Adult B.

5.14. On the 26th July 2013 the GP for Adult B received a call from Adult Social Care. The social worker reported to her that they were investigating claims made by a third party that Adult B is being assaulted by her ████ [Adult A] whom she was currently living with and that she was also involved with prostitution. The social worker had requested if there was anything in the GP records that would collaborate this information and if there was any underlying health problems. The GP reported the Adult B had not been seen in the GP surgery for some time but had presented to the Urgent Care Centre smelling of alcohol and with alleged physical abuse.

5.15. An ambulance was called to Adult B on 28th July 2013 after she was seen fitting. Her aunt was with her and she also appeared intoxicated. Adult B was wearing clothes that the crew considered inappropriate in that she was wearing leggings, and underwear with a bathrobe and jacket over. Adult B was observed to have bruising to her upper and lower body. The aunt stated that Adult B lived with her ████ [Adult A] who was a registered sex offender and had been allegedly abusing Adult B since she was 12 years of age. She also alleged that Adult A supplied Adult B with alcohol and other substances and then abuses her. The crew approached Adult B about this and she denied it. She refused to be transported without her ████ [Adult A]. She also informed the crew she might be pregnant. The crew completed a safeguarding referral. On arrival at the Emergency Department, Adult B was seen to have bruising to her head, caused during falling. Adult B was treated for alcohol withdrawal and admitted to the Admissions Unit.

The safeguarding referral made by EMAS is an example of good practice.

5.16. The following day Adult B was discharged as she wanted to go home. Advice was given regarding her alcohol use. There are no records of any discussions regarding alleged abuse.

5.17. As a result of information provided by the police and ambulance crew, Adult Social Care decided to open a safeguarding alert in respect of Adult B. Attempts were made to contact the admissions unit but by the time contact was made, Adult B had already been discharged.

5.18. Continued attempts were made to contact Adult B, including two home visits, letters and telephone calls. Despite this no contact was made. It was decided that Adult B's

case would be transferred to a locality team for ongoing social work involvement under the Vulnerable Adults Risk Management Policy.

The potential risks to Adult B were recognised by Adult Social Care and the transfer for ongoing social work involvement was a positive step.

5.19. On 4th August 2013, a neighbour of Adult A reported to the police that there had been a forced entry to her property. She reported that the noise from and frequent visitors to Adult A's flat were having an adverse effect on her and her son. Allegations were made of drug use and prostitution. The City Council Anti-social behaviour unit were notified.

5.20. On 21st August 2013, Adult A attended the Emergency Department reporting that he had been assaulted the previous day and had rib pain. He told staff that he was pushed over by a female friend. No abnormalities were noted and he was discharged.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.21. An ambulance was called to Adult A on 1st September 2013 who reported that he had been assaulted by a large lady who jumped on his chest. Adult A declined being conveyed to hospital.

Again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.22. On 3rd September 2013 a meeting was held between a police officer and a Housing Officer from Foundation Housing to discuss Adult B living at Adult A's flat. It was agreed that the best outcome was to disrupt the arrangement by issuing a warning letter to Adult A as the tenant and to invite them both to a meeting on 9th September 2013 to discuss the matter. The City Council Antisocial Behaviour Unit was also invited to attend but did not do so as it was felt that the matter did not meet the thresholds of serious and protracted antisocial behaviour. Adult A and Adult B did not attend the meeting but were located on the street near to Adult A's address. They were handed Anti-Social Behaviour Warning letters from the police officer and informed that Foundation Housing would be escalating proceedings to evict Adult A unless the situation changed. Adult B agreed with the police officer that she would move out of the address.

This attempt to disrupt the living circumstances of Adult A and Adult B is an example of creative methods to address the issues of concern.

5.23. On 6th September 2013, Adult A attended the Emergency Department complaining of right sided chest pain as a result of a further alleged assault during which he sustained blows to his chest and face. A facial x-ray identified a fracture of left zygomatic arch (cheekbone). Whilst in hospital, Adult A was reviewed by the alcohol liaison nurse but Adult A did not engage and refused community help or support. Adult A denied being alcohol dependent but admitted to excessive drinking of approximately 40 units per week.

Yet again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.24. On 7th September 2013, an ambulance was called to Adult B. On arrival of the crew, Adult B was lying on the bed hyperventilating, semi dressed and exposing her breast. The crew noticed a lot of circular bruising to her arms, hands and legs. They asked if Adult B was clumsy and Adult A replied yes. Adult B continued to expose herself in the presence of the male crew member and Adult A, even though she had been asked by the female crew member to cover up. The crew on scene completed a safeguarding referral in relation to this attendance. The crew also made contact with Adult B's GP who also made a safeguarding referral. He also expressed in the referral letter previous information received from the social worker suggesting possible abuse physical abuse from her ████ [Adult A].

The safeguarding referrals made are examples of good practice.

5.25. On arrival at hospital, doctors also notice faded bruising but Adult B denied that she was being abused. She stated that the bruising was due to her having been in a fight with a girl. Adult B's mother reported that she had concerns about Adult B living with her ████ [Adult A] because of his alcoholism; and she confirmed that Adult B's daughter lived with her. Both Adult B and her her mother disclosed that Adult A would not allow Adult B to leave the flat, was controlling and gave her alcohol. Adult B's mother alleged that Adult A was having sex with Adult B and was coercing her into prostitution. Adult B did not confirm either allegation. Adult B was seen by the alcohol liaison nurse and admitted to drinking to excess. Adult B described the living arrangements with her ████ [Adult A] as suitable but said 'we argue all the time'. She denied any physical or sexual abuse by Adult A when asked. An alcohol detox programme commenced.

5.26. On 12th September 2013, Adult B was seen on the ward by a social worker. Detoxification was progressing well and discharge options were discussed. Adult B agreed to stay with her mother's friend in the short term. Adult B denied experiencing domestic abuse. The social worker recorded that Adult B had capacity to make decisions around discharge and support, and provided her with contact details of various support agencies including women's aid. After review by the alcohol liaison nurse Adult B was discharged, with arrangements made for community follow up support.

5.27. On 4th October 2013, the social worker made telephone contact with the friend Adult B was going to reside with after discharge from hospital. The friend stated that Adult B never arrived and went back to reside with Adult A. She was reported to be drunk with 2 hours of discharge. The case was subsequently closed by Adult Social Care.

Given the potential risk that a return to live with Adult A may have posed to both individuals, plus the associated alcohol abuse, it would have been good practice for Adult Social Care to have made contact with Adult B and Adult A and establish their safety.

5.28. On 17th October 2013, Adult A was arrested for an assault upon a female, having punched and spat at her. He later pleaded guilty and was given a community order and a fine.

5.29. On 28th November 2013, an ambulance was called to Adult A following an assault. Adult A was aggressive and abusive to the crew. A further ambulance was called the next day when Adult A reported that the pain from the attack was increasing. Adult A would not agree to being conveyed to hospital.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.30. Adult A saw his GP on 3rd December 2013 and mentioned that he had been assaulted and kicked in the ribs. He was prescribed ibuprofen.

Again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.31. An ambulance attended to Adult B on 12th December 2013 due to excessive alcohol consumption. Again she was seen to be exposing herself despite being asked by the crew not to do so. Adult B was conveyed to hospital and admitted to the admissions ward. Adult B reported that her alcohol consumption had increased over the past 6 months since splitting with her boyfriend. She was noted to have alcohol hepatitis, kidney injury, sepsis and her condition deteriorated whilst in hospital. Adult B required intensive care due to Type 2 respiratory failure before recovering prior to discharge on 22nd December 2013.

5.32. Whilst in hospital, the ward nurse contacted Adult Social Care and was advised that they had closed the case. The nurse recorded that the call handler was 'unhelpful and did not provide further assistance', so the nurse then found the social worker's direct number in an old set of notes and contacted him directly. The social worker advised that he had been unable to help Adult B as she had refused all previous offers of help and support.

The case had been closed to Adult Social Care without contact having been made with Adult B following her last discharge from hospital. It would have been pertinent to consider whether the case should have been reopened given her current circumstances.

5.33. On 19th January 2014, Adult B was admitted to hospital following excessive alcohol intake. She was treated for chest and kidney infection and alcohol withdrawal. Whilst in hospital Adult B was diagnosed with acute hepatitis and pyelonephritis. She was discharged on 27th January 2014 as medically fit.

5.34. On Tuesday 6th February 2014 a Post Office worker reported that Adult A was in the Post Office, Leicester and very upset as he believed money had been stolen from his account. Police officers attended and Adult A was taken back to his home address and completed a statement with the officers. A Police National Computer enquiry, undertaken by the officers whilst still at the address, identified that Adult A was wanted

on warrant for failing to attend a court summons the previous day; and so he was arrested. Whilst on his way to the police station, Adult A told officers that he had been diagnosed with cancer and had only three months left to live. He made comments that he no longer wished to live as he was in a lot of pain. Once at the police station, Adult A was seen by a doctor due to the comments he had made and he was considered fit to detain. An adult at risk referral was made for Adult A as he was without money, was very upset by the incident and had made comments of a suicidal nature. The Police in house Adult at Risk Team contacted Adult Social Care and were told that they had previously offered Adult A services in 2011 which he had declined, and so a re-referral was made. As a result of this referral, Adult Social Care left a message to ask for the out of hours GP to visit Adult A and made an unsuccessful attempt to contact Adult A by phone. The GP subsequently spoke with the police as it was felt that it was unsafe to visit due to a history of violence and racism. The GP was reassured by the police that they would visit, which they did do and confirmed that Adult A was safe and well.

This was an appropriate response to Adult A.

5.35. On 7th February 2014, Adult A was sentenced at court to a 12 months Community Order for Assault by Beating and Racially Aggravated Harassment. In terms of the theft incident reported on 6th February 2014, Adult A had initially accused Adult B of the theft but on 10th February 2014 he contacted police to say that it was actually someone else and as there was no CCTV evidence or witnesses, the crime was filed as undetected.

5.36. On the 10th February 2014, Adult B had a consultation with a health professional from Inclusion Health Centre where an alcohol screening test was performed which identified Adult B as having problems with alcohol. Adult B also reported suffered with depression due to not being able to see her one year old daughter who was in the care of her mother. Adult B also reported she had be physically and sexually assaulted by her ████ [Adult A] and this had been also caused her to feel low. Adult B said she was drinking heavily and had done so since she was 20 years of age. She reported she dislocated her thumb as she was assaulted about a week ago on the street. Adult B was then also seen by a nurse on the same day at Inclusion Health Centre and she gave further information to the nurse and stated that she had now started drinking 2 bottles of wine a day. She said she was staying with friends but could not continue to do so, she was in touch with the outreach team who were arranging dormitory accommodation for her. Adult B was treated for a urine infection. She was also introduced to a CPN and was made aware of how to access services for support, including alcohol supports services.

There is no evidence of consideration of a safeguarding referral or of liaison with the police given the allegations of physical and sexual abuse.

5.37. On 16th February 2014, Adult B attended the Urgent Care Centre and was then sent to the Emergency Department following an alleged assault that occurred 2 weeks previously, where she was pinned to the ground injuring her right wrist. Adult B was examined and no injury was noted. Adult B reported that she was thrown out of a car but did not disclose who by. She was noted to smell of alcohol.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.38. On 28th February 2014, Adult Social Care made unsuccessful attempts to contact Adult A, including a home visit. This was a result of the police referral on 6th February 2014. Adult Social Care spoke to agencies, including his GP who confirmed that he did not have terminal cancer. The case was subsequently closed.

5.39. On the 27th May 2014, Adult B had a further alcohol screening test at the GP surgery. Adult B reported that she had been drinking ¾ of a litre of Vodka a day. She was feeling unwell at the time. The GP advised her to consider a referral to the alcohol team which she said she would think about. The GP also arranged blood tests but Adult B failed to attend.

5.40. Adult A was invited to meet with the housing provider on 28th May 2014 to discuss reported antisocial behaviour. Adult A failed to attend, so the property was visited by a housing officer and 2 police officers. Adult A was adamant that Adult B was not living at property, despite her being present. A formal warning letter was sent to Adult A regarding antisocial behaviour and visitors to the property.

5.41. On 30th May 2014, Adult A was conveyed by ambulance to hospital after having fallen due to being intoxicated. He had hit his head as he fell, after having drank 1.5 litres of vodka. Relevant investigations were carried out and Adult A was discharged. Adult A was admitted again on 3rd June 2014, with sudden onset left sided chest pain. He had been drinking to excess all day, no medical problems were detected and he was again discharged.

5.42. A housing officer visited Adult A on 9th June 2014. Adult A stated that Adult B had moved out, despite evidence of women's clothing and make-up being in the flat.

5.43. On 18th July 2014, Adult A was referred to the specialist antisocial behaviour team, however the complainant requested no action be taken against Adult A until they had moved due to a fear of repercussions. The complainant subsequently moved to alternative accommodation and the case was closed.

5.44. On 24th September 2014, Adult A was admitted to hospital with abdominal pain secondary to pancreatitis. He was advised by doctors that his condition was caused by excess alcohol and was advised to reduce to safer drinking levels. Adult A was seen by the alcohol liaison nurse but did not engage and declined offers of support. Adult A was discharged on 27th September 2014.

Attempts were made to support Adult A with his alcohol misuse.

5.45. On 25th December 2014, Adult A reported a number of incidents to the police ranging from someone pointing a gun at his head two weeks earlier to being attacked in the street and stabbed in the stomach. The call handler considered Adult A to be intoxicated and doubted the truth of his reports however having established he was

safe, a scheduled response was agreed and police officers attended the following day. The officers questioned Adult A about the allegations he had made, he said that he had encountered two males in the street on 25th December 2014 who had proceeded to cut him in his stomach area. Adult A was vague about the event and gave conflicting information. The officers viewed the injuries and the clothing he had been wearing at the time and the officers believed the injuries had been self-inflicted. An adult at risk referral was made to the police in house adult at risk team owing to the belief that Adult A had self-harmed. Adult A's GP surgery were also informed of the incident and the GP made telephone contact with Adult A on 2nd January 2015. Adult A denied excessive alcohol intake and any self-harm/suicide ideas.

The referral made by the police plus the contact with the GP are evidence of good practice.

5.46. Adult B contacted the police on 25th January 2015 to report having being raped by a male she had agreed to have sex with for money. She told the police officers that she had spent the previous night in Leicester city centre drinking with a friend and, after being dropped off at home by a male at 2:00am, she had gone back out to look for clients. Adult A had reportedly accompanied her to 'watch over her'. Adult B left alone with the suspect after agreeing a price for sex and was taken to an unknown address. Adult B stated it was at this address that she was raped.

5.47. Adult B completed a video recorded interview several weeks after the incident. She admitted to having met the suspect on two previous occasions at Adult A's address; and on both occasions she had sex with him for money. She also stated that she had arranged to meet him through a mutual friend. Whilst a scene was never identified a CCTV trawl was completed. As the investigation progressed, Adult B's account of the event changed from when she first disclosed the rape. Adult B's clothing was seized however she refused to provide forensic samples. The police made contact with New Futures and Adult B's GP following the investigation.

The police contact with support services and the GP is examples of good practice.

5.48. A referral was made to Adult Social Care by the on call GP on 29th January 2015 in respect of Adult B. Concerns were expressed regarding the rape allegation, psychological problems and whether Adult A was her 'pimp'. A safeguarding alert was opened and the case was allocated to the same worker who had attempted to make contact with Adult B in 2013. Despite further attempts being made, the worker was again unable to make contact with Adult B.

5.49. An ambulance attended to Adult A on 3rd February 2015, and it was recorded that Adult A was intoxicated and admitted to having drank a bottle of vodka that day.

5.50. On 4th February 2015, Adult B made an application for housing.

5.51. On the 12th February 2015, Adult B's GP received a phone call from a paramedic who was with Adult B. He said that he knew Adult B well and that she was intoxicated, abusive and threatening self-harm. The paramedic reported that she had been like this for many years and wanted to know what the next step of action should be. The GP

advised that Adult B should be taken to a place of safety, the Emergency Department, however if she preferred to be seen at the GP surgery then he would be happy to see her.

When a patient is threatening self harm and experiencing mental health difficulties the referral routes available to GPs can take several weeks to process. The view of Leicestershire Partnership Trust is that this scenario would constitute a medical emergency and so the patient should be taken to the Emergency Department where they can be seen and assessed by the Deliberate Self Harm team. The challenge with this arrangement is that Emergency Departments are not equipped or resourced to manage the demands of intoxicated patients who are expressing thoughts of self harm.

5.52. The Adult Social Care worker spoke with Adult B on the telephone on 16th February 2015. Adult B stated that she had been raped on a couple of occasions with the last time being in January. She said she had given a DNA test and was waiting for the police to make an arrest. Adult B had a male in the background as she was talking and made reference to the poor housing conditions that Adult A was living in. Adult B also complained about the contact occurring between her daughter and her father, whilst she had no access. The Adult Social Care Worker arranged to see Adult B the next day, but this resulted in no access. The social worker then spoke with the GP, the police and Children's Social Care. The case was then closed.

Again a lack of engagement by Adult B prompted the case to be closed.

5.53. On 19th February 2015, Adult C spoke with his social worker and informed her that although he would be staying at his residential care home placement from Monday to Friday, he would be spending weekends with his girlfriend Adult B. He stated that she might be pregnant.

This is the only agency record of the relationship between Adult C and Adult B. In mid-January 2015, Adult C was in a relationship with someone else and as such the relationship with Adult B was very recent.

5.54. On 23rd February 2015. Information was received by the police to indicate that Adult A had been murdered. Adult B and Adult C were arrested.

6. **Family Perspectives**

6.1. The family of Adult A were contacted at the outset of the DHR process to ascertain whether they would wish to contribute to the review. No response was received.

6.2. The DHR panel decided that there would be merit in pursuing the contribution of Adult B and Adult C to the review. Adult B chose not to meet with the Independent Author.

6.3. Adult C agreed to speak with the Independent Author, which occurred via video link in the presence of his Offender Manager. Adult C spoke of the difficulties that he has experienced as a result of Asperger's syndrome and named friendships and relationships as being a particular area where he struggled, and did not know how to respond. Adult C felt that he had never received the support that he needed in order to manage his Asperger's syndrome but struggled to identify what support he felt that he needed. Adult C spoke of services withdrawing when he was perceived as doing well, when he felt that he needed ongoing support. Adult C gave the example of social work visits reducing to monthly when he would have preferred to have seen the social worker more frequently. Adult C spoke positively of his time at Island Place care home, reporting good relationships with staff. It is evident that Adult C has learning difficulties and, as described in the agency reports, is vulnerable to exploitation. This has also continued since he has been in prison.

6.4. Adult C stated that he had met Adult B via a friend and that they had been together for 3-4 weeks at the time of Adult A's death. He stated that he would often stay at Adult A's flat and that initially he got on well with Adult A. He described how Adult A and Adult B would sometimes argue but that he never saw any violence between them but stated that they both drank heavily. Adult C stated that he disliked Adult B working as a prostitute but would sometimes accompany her instead of Adult A. He stated that Adult B had told him that Adult A would often walk into the bathroom when she was taking a bath. At first Adult C did not believe Adult B.

6.5. Adult C gave his account of the day that Adult A died. Adult B and Adult A had argued that day and he saw them face up to one another. That day he and Adult B had been drinking and Adult B decided to take a bath, whilst Adult C sat in the bathroom with her. Adult A walked into the bathroom which led Adult C to believe that Adult B was telling the truth and Adult C followed Adult A into the bedroom and was strangling Adult A on the bed, asking him if he was a 'nonce'. Adult C then stated that Adult B [redacted] and he cut Adult A's throat.

7. **Relevant Summary of analysis from IMRs when considering the Terms of Reference**

Leicester City Council Children, Young People and Families Directorate (pre scope)

7.1. The social worker's risk assessment completed on 2013 was in relation to Adult B's parenting capacity and he assessed that she was vulnerable and that her lifestyle, decision making and parenting capacity was affected by her alcohol misuse. He encouraged her to engage with alcohol services and was aware that she was not engaging with these services. He was concerned about her relationship with Adult A and felt that it was an unhealthy relationship in that it affected her use of alcohol and was a barrier to change.

7.2. With regard to Adult B's allegations of sexual abuse by Adult A, the social worker involved in completing the core assessment did not conclude that she had been sexually abused by Adult A, even on the balance of probabilities. He considered Adult B's allegations in the context of someone who had made various allegations of sexual abuse against different people over time and then changed her accounts. He was aware that there were suspicions that Adult B was a sex worker and he believed that she had been sexually abused in the past and was probably being exploited if she was sex working. During his involvement he gave Adult B opportunities to discuss her history of alleged sexual abuse but she did not want to engage with him. He did not give her any information about services that may have been available to her for support and advice.

7.3. The risk assessment in relation to Adult A was that he was not a safe person to care for a child given his alcohol dependency. The social worker noted that he was vulnerable but did not assess his vulnerability to warrant referral to adult social care as he was presenting as managing in his accommodation with self-caring skills.

7.4. Given the known vulnerabilities of Adult B and Adult A and their inter-dependency and misuse of alcohol, it would have been advantageous for them to have been referred to adult social care. The children's social worker seemed to have made decisions about the referral pathway based on his knowledge of the eligibility criteria. It is understandable that he would not want to raise expectations about what services may be forthcoming from adult social care however he should have taken account of adult social care's responsibilities to assess the level of vulnerability. These decisions meant that adult social care did not have opportunity to provide services to Adult B and Adult A.

7.5. The multi- agency procedures in relation to safeguarding children give clear guidance and protocols for agencies to have a Think Family approach and how to refer adults to adult social care and promote engagement with partner agencies who work with adults. The context is to promote joint assessment and working in families who are caring for a child.

Leicester City Council Adult Social Care

7.6. At the point of referral by the police in February 2014 it does not appear from the case records that Adult Social Care (ASC) were made aware of any concerns regarding

domestic violence within Adult A's life. As a result of this, it would not have been deemed necessary for practitioners to act on domestic violence issues. ASC practitioners did not meet with Adult A and thus there would be no opportunity for them to have identified any indicators for domestic abuse.

7.7. At the point ASC received a referral regarding Adult B the concerns raised by the Police mentioned Domestic Violence from Adult B's [Adult A] toward her. Practitioners were unable to contact Adult B and showed a good insight into the risks that Adult B could be in by ensuring that the case remained open and was not closed due to non-contact. The practitioners initiated the LCC VARM policy[1] to ensure that the risks were to be considered despite being unable to contact Adult B.

7.8. The hospital ward confirmed that Adult B had the mental capacity to make decisions and was able to manage her own care needs. A decision could have been made at this point to provide information over the phone and close the case. However, the practitioners showed a good awareness of risks regarding domestic violence by visiting Adult B on the ward. During the initial contact with Adult B on the ward, the social worker showed good awareness of domestic violence by providing Adult B with alternative options for housing and support from specialist domestic violence agencies. Although Adult B denied that there was any domestic violence between herself and her [Adult A], the social worker continued to offer the information and encourage Adult B to obtain support.

7.9. During ASC involvement with Adult C there were no referrals directly relating to domestic violence and there was no link between Adult C and either Adult B or Adult A.

7.10. Throughout the case records for Adult C, there is a pattern evident of Police incidents and concerns raised regarding Adult C's vulnerability in relation to making unwise decisions regarding friendships and being easily led. There is also evidence that Adult C places himself in risky situations and has been assaulted as a result. There are records that indicate when Adult C is in the company of some people he is more likely to commit an offence or increase intake of drugs and alcohol. There appears to be no analysis of risk as a result of these incidents.

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[1] A significant development has been introduced in Leicester called Vulnerable Adult Risk Management (VARM). This is a framework to facilitate effective working with adults who are at risk due to self-neglect, where that risk may lead to significant harm or death and the risks are not effectively managed via other processes or interventions. Self-neglect is determined to be any of the following:

- the inability to care for one's self and/or one's environment
- a refusal of essential services
- a failure to protect one's self from abuse by a third party (where "normal" adult safeguarding processes are not applicable or sufficient).

The VARM guidance sets out a co-ordinated, multi-agency response designed to protect adults deemed most at risk and ensure that any significant issues raised are appropriately addressed. A key aspect of the response is the identification of the agency best placed to engage and the development of holistic support plan via a Support Planning meeting. Having established the Support Plan, the adult at risks' resistance to engagement is be tested by the introduction of the Support Plan by the person or the agency most likely to succeed. If the plan is still rejected, the Support Planning meeting should reconvene to discuss and review the plan. The case should not be closed simply because the adult at risk is refusing to accept the plan.

7.11. There is reference throughout Adult C's records of him being in a relationship with numerous people. There does not appear to be any work from the practitioner to identify further who these people are in order to identify potential risks to either Adult C or his new partner. It is therefore not evident that Adult C's history regarding assault against children was taken into account or risk assessed. There does not appear to be any risk assessments in place regarding Adult C's apparent vulnerability when he is in destructive friendships and the changes in his behaviour at these times.

7.12. There was not a formal Mental Capacity Assessment for Adult C completed by ASC. Due to the repeated concerns regarding his friendships and the apparent risks, combined with Adult C's Asperger's Diagnosis, it would have been good practice to complete a Mental Capacity Assessment although it appeared the practitioners assumed capacity as stated in the MCA.

7.13. Adult C had been assessed by ASC as a vulnerable adult prior to the Care Act 2014. Since the introduction of The Care Act it is felt that Adult C would have met the criteria for an adult at risk as he had needs for care and support.

7.14. There was no evidence in the records that there were any barriers to Adult A or Adult B that prevented either accessing services. In the records it is clear that practitioners tried to engage with both Adult B and Adult A and they refused to engage with ASC.

Leicestershire Police

7.15. During the scoping period, police officers knowledge and understanding of domestic abuse is evident in the fact that completed domestic abuse, stalking and harassment (DASH) risk assessment forms were submitted following all the domestic incidents attended which contained sufficient information for the risk assessment to be made and adult at risk referrals made where necessary. Police officers decision making was proportionate and appropriate for the incidents they were faced with and the correct referral procedures were followed.

7.16. Leicestershire Police Procedure for Managing Adults at Risk gives guidance to officers when dealing with the victim or the perpetrator. Adult C, Adult B and Adult A were all at more than one point in the scoping period deemed by the police to be adults at risk due to their situation or circumstance.

7.17. When an officer attends an incident involving an adult at risk (where no crime has been committed), a vulnerable adult report is created. Where the victim of a crime is deemed to be vulnerable they are identified by a Q code on the modus operandi page of the crime report. All these incidents are automatically placed into a queue for the Adult at Risk Team Sergeants to risk assess and make decisions about referrals to other agencies, as appropriate.

7.18. Adults at risk are categorised by four tiers of risk based on outcomes:

- Tier 1: resolved through police involvement. Initial recording only (temporarily vulnerable because of their situation or circumstances)
- Tier 2: comprehensive recording on police systems and consideration of multi-agency information sharing and support

- Tier 3: Multi Agency Safeguarding (people who are unable to protect themselves and who are being abused or who are at risk of abuse)
- Tier 4: Critical where if action is not taken there will be grave consequences for the individual and the agencies

7.19. Police officers who attended incidents concerning Adult C, Adult B and Adult A did not raise concerns that they lacked the mental capacity to make decisions regarding their safety.

7.20. Whilst investigating reports that Adult B and Adult A were in a sexual relationship the police officer completed a vulnerable adult referral and attempts were made to disrupt the living arrangements between them which involved a meeting with the housing association. The police officer reported that Adult A would be issued with a warning that would state that Adult B could not stay at the address any longer.

University Hospitals of Leicester NHS Trust

7.21. There is no evidence of any indicators of domestic abuse within the health records relating to Adult C. His attendances were in relation to minor illnesses / injuries and there was nothing to suggest these were as a result of domestic abuse, either as a victim or a perpetrator.

7.22. In relation to Adult A and Adult B, it does appear that there were indicators of domestic abuse on several occasions. There is no evidence that staff completed the domestic abuse risk assessment which was in use at that time or considered a MARAC referral.

7.23. However, the practitioners involved in this review felt that emergency department staff would not consider domestic abuse in these circumstances because they would not identify a victim / perpetrator scenario. The practitioners also felt that staff, and the public in general, still think of domestic abuse in relation to husband and wife / boyfriend and girlfriend relationships. There remains amongst most staff an image of 'wives' being beaten' when they think of domestic abuse and this does not resonate easily across other family relationships.

7.24. There is no evidence that emergency department staff made routine enquiries about domestic violence when working with Adult A, Adult B or Adult C. Practitioners involved feel that it would be unrealistic to expect staff to routinely ask about domestic abuse due to the number of people they attend to each day. However, where there are potential indicators of domestic abuse then staff ought to be considering it and asking the question.

7.25. On the rare occasions that Adult B and Adult A were admitted to a ward from the emergency department, it is clear that they had mental capacity and were able to consent to /decline treatment.

7.26. Emergency department staff routinely complete a mental capacity assessment as part of their mental health proforma. This is completed whenever patients present with mental health disturbances, self-harming behaviours or suicidal thoughts/intent. On the occasions where Adult A and Adult B were reviewed and assessed by mental health services they were deemed to have no mental health problems and did not require treatment, it is also recorded that they had mental capacity to be discharged. In

relation to Adult C, he was assessed by MH services in September 2013 and deemed safe to be discharged with outpatient psychiatric follow up in view of his low mood. There is no evidence that Adult C lacked capacity to leave hospital.

7.27. The Trust hosts a Frequent Attender Nurse on a part time basis, within the Emergency Department. Part of this role is to consider whether or not an individual might benefit from referrals to other agencies in order to improve outcomes and reduce reliance on the Emergency department, where relevant. However, the Frequent Attender Nurse would only consider becoming involved once the person has attended and been assessed within the emergency department on more than 10 occasions within a rolling 12 month period. Therefore, in this case none of the individuals met the threshold.

7.28. Although staff complete mandatory safeguarding adults and children training, there is no specific standardised training provision for domestic abuse and violence across the Trust. There is also no commissioned resource for dealing with domestic abuse within UHL. The adult safeguarding team provide some support / advice to staff where concerns are raised but they are not dedicated specialists in this field. An Independent Domestic Violence Advisor (IDVA) is based on a part time basis within the Emergency Department and it is hoped that this provision will improve the service available for victims of domestic abuse. Since October 2015, the IDVA has worked with 192 cases, 52 of which were considered at MARAC.

East Midlands Ambulance Service

7.29. The IMR found that EMAS attended Adult A for various medical reasons and on review of the Patient report forms Adult A did not appear to have care and support needs. Additionally it was felt that Adult A appeared to have the ability to protect himself. Adult A was sometimes verbally aggressive and threatening towards EMAS staff, he was often reluctant to follow medical advice and on some occasions was seen as a perpetrator of abuse against Adult B. On review of the patient report forms (PRFs) there is no evidence of Domestic Abuse with Adult A as the victim.

7.30. EMAS attended Adult B for various medical reasons and on review of the PRF's Adult B did not appear to have care and support needs. On review of the patient report forms Adult B has been able to seek help when required and it was felt that appeared able to protect herself from abuse. Adult B was often verbally aggressive and threatening towards EMAS staff on attendance to her.

7.31. There was a missed opportunity to engage with Adult B about domestic violence at the attendance on the 5th April 2013. EMAS attended Adult B for a hand injury from punching a door. Whilst on scene Adult A became abusive to staff, not allowing Adult B to speak for herself and insisting on travelling to hospital with her, this behaviour should have given staff cause for concern. No referral was completed for Adult B however based on the injuries Adult B had and the behaviour of Adult A a referral should have been considered.

7.32. On the attendance on the 28th July 2013, EMAS raised a safeguarding referral due to historic allegation and concerns that the alleged perpetrator, Adult A, was still abusing Adult B however Adult B denied all the allegations. This referral was shared with

children social care to ensure they were aware of the historic allegation and also to ensure that Adult B's child was protected.

7.33. On the attendance on the 7th September 2013, EMAS staff did share concerns about domestic violence and abuse following an incident where Adult B had different bruises in different stages of healing and always referred to Adult A to answer questions.

7.34. EMAS missed an opportunity on the 3rd September 2013 and the 12th September 2013 to raise safeguarding referrals for Adult C following an assault. The PRF provides information that he has care and support needs due to his ongoing medical problems and he had been unable to protect himself from abuse as EMAS attended him twice following assaults. Adult C was also known to be under the community mental health team.

National Probation Service

7.35. When the Probation Service was working with Adult A, the only person that he disclosed to be living with him, albeit on a temporary basis, was Adult B. Adult C's name was not mentioned in any of the documents pertaining to Adult A's or Adult B's case. There was no evidence in the probation records of Adult A or Adult B being a perpetrator of domestic abuse.

7.36. During the period February 2014 to January 2015 Adult A was offered 25 appointments. He attended 20 of these. Four were made acceptable absences due to hospital admissions. Adult A was offered advice about referrals to adult social care and to the Macmillan nurse service. He did not return any of the paperwork needed for a referral to take place. Adult A was also given the paperwork for a referral to NACRO/SHARP for accommodation support. He did not consider his alcohol consumption to be problematic and in 2014 informed the offender manager that his alcohol consumption was dictated by his income and that he limited his drinking to two days per week. As a consequence of this he did not meet the threshold for an Alcohol Treatment Requirement. It was noted that Adult A appeared satisfied and content with his drinking and had no motivation or desire to alter his ways.

7.37. In 2011, Adult B alleged that she had been sexually abused by her ████ [Adult A]. She told the probation officer that whilst she had reported this to the police "she did not yet feel ready to gain support for the abuse experienced". She described the abuse in terms of him using sexual language and attempting to touch her. Professional curiosity could have led to the identity of the ████ [Adult A] being disclosed, which would have triggered a referral to Children's Social Care and further information gathering from the police. Adult B also disclosed that at the age of 7 years she was raped by the friend of a cousin. Professional curiosity may have led to this person being named and the appropriate follow up action taken.

GP practices

7.38. Although Adult A attended his GP surgery, and was asked general questions on wellbeing, he was not asked directly about domestic abuse. The GP practice has discussed whether potentially vulnerable adults should be asked screening questions about threat or history of violence as this can be hidden and not disclosed by the

patient. The GP practice has also recognised the need to be aware of patients attending Emergency Departments on a regular basis as Adult A had a history of attending with injuries following assault, self-harm and suicidal ideation which indicated social, physical and mental health concerns that required addressing. It was also recognised that referral for alcohol treatment services would have been appropriate for Adult A and the practice will now screen all new patients for excessive alcohol use and ensure relevant follow up.

7.39. Adult B was seen mainly in the Urgent Care Centres by different doctors and nurses. She attended several times with injuries which she claimed were from assault by strangers, although there is no documentation of possible domestic abuse causing her injuries. There is evidence of GP's making safeguarding referrals in respect of Adult B which is positive practice.

7.40. Adult B rarely attended the GP practice and failed to attend pre-arranged appointments. How to engage patients who are hard to engage is a priority action for the surgery, including developing an alert system when a patient has not attended 3 consecutive appointments.

7.41. Adult C registered with a new GP surgery during the scoping period. He was issued with prescriptions for sertraline (an antidepressant) without a face to face medication review being undertaken. The practice policy is that all new patients on repeat medication are reviewed face to face or on the telephone to determine the ongoing need for the medication and to inform future management. In the case of Adult C, this did not happen. Face to face assessments of newly registered patients are now encouraged, in particular for patients on repeat medications, although capacity issues within the practice have a negative impact upon this.

8. Lessons learned from IMRs when considering the Terms of Reference

8.1. Children's social care have to ensure that they follow the guidance in relation to non-recent allegations and consider the therapeutic needs of the alleged adult victim and the potential vulnerabilities of the alleged perpetrator. They need to ensure that their information sharing practices with adult social care are effective and promote best practice.

8.2. Children's social care must ensure that practitioners in the children's workforce ensure that they take account of the vulnerabilities of adults, not just how they impacts on an adult's parenting capacity and risk to children but also whether that vulnerability means that they need assessment/ services in their own right.

8.3. Where there are concerns about finances or developing unsafe relationships and a diagnosis of Mental Health issues, a Mental Capacity Assessment should be carried out, this was not apparent in the work completed with Adult C as a formal capacity assessment was not completed.

8.4. Repeat concerns raised regarding physical abuse should be recorded together and considered as a time line in order to identify patterns and analyse the risks together, ensuring that apparently isolated or infrequent incidents are viewed in their wider context.

8.5. When considering support to any victim of domestic abuse, where agreed and risk assessed, considerations should be given to support of the perpetrator to help reduce the risks involved.

8.6. Emergency Department staff did not consider the possibility of domestic abuse between Adult B and Adult A. Staff also have knowledge gaps in the field of adult safeguarding. There is ample evidence that staff working within emergency department make IDVA/ MARAC referrals for people who are experiencing domestic abuse as part of an intimate relationship and this demonstrates their general knowledge and awareness. However, they acknowledge that their appreciation of domestic abuse in extended family relationships is less robust, especially when alcohol abuse is a factor. Using the learning from this case review will support staff to understand domestic abuse in the context of wider family members.

8.7. There is learning for EMAS within this review in relation to the attendance on the 5th April 2013 to Adult B. The learning is in relation to professional curiosity around mechanism of injury and the way individuals respond on scene. There is also learning identified in relation to the attendance to Adult C. Both of these attendance no referral were raised, the common theme is that Adult C was assaulted in a public place and police were called. EMAS need to highlight to staff that abuse can occur within a public place and that even if police are involved they should still raise a referral to social care.

8.8. The National Probation Service Fast Delivery Report that was prepared for Court on 5th February 2014 in respect of Adult A's offences of Assault by Beating and Racially Aggravated Harassment was requested only 2 days earlier. As neither the offences nor Adult A's known history indicated safeguarding or domestic abuse concerns then under current practice checks would not be made with police or safeguarding services. Had the request been made and the information provided, the allegations of sexual abuse reported by Adult B would have come to light and the case would have been managed in a different way by the probation service in that a qualified probation officer would have been allocated to Adult A. Because this action was not taken, the potential risk that Adult A posed was not identified and acted upon.

9. **Overview analysis**

9.1. This review has established that there was no professional knowledge of the connection between Adult A, Adult B and Adult C prior to the domestic homicide. There were no indicators or evidence of Adult A being at risk of harm from Adult C.

9.2. It is clear however that all three individuals had histories of concern, involving alcohol misuse, domestic abuse and mental ill health.

9.3. A number of themes/areas of learning have arisen from the review of this case. These can be summarised in the following headings:

- The correlation between domestic abuse, violence and aggression and alcohol misuse
- Care pathways for mental health and alcohol misuse and engaging the hard to engage
- Recognition of and response to safeguarding concerns
- Responding to historical abuse allegations
- The role of the GP

9.4. Any findings made are highlighted within each theme.

The correlation between domestic abuse, violence and aggression and alcohol misuse

9.5. The review has considered that Adult A was not perceived by agencies as a victim of domestic abuse. Despite numerous alleged assaults, there was overall a failure to recognise indicators of domestic abuse and a lack of professional curiosity with regard to the nature of the assaults. Adult A's lack of engagement with and hostility towards agencies, coupled with his frequent intoxication, led to assumptions being made about his presentation. It has been acknowledged that it is a challenge for professionals to view an aggressor as a victim.

9.6. The review has highlighted that there was an absence of routine enquiries regarding domestic abuse. This was evident in the cases of the GPs and the Emergency Department. The review has also highlighted a lack of awareness of interfamilial domestic abuse which would appear to have been evident between Adult B and Adult A.

9.7. The dynamics of the abuse between Adult A and Adult B were clearly complex, and deep rooted.

Finding: All agency training in respect of domestic abuse must include abuse outside of intimate partner relationships.

9.8. In October 2014, the charity Alcohol Concern wrote a research paper entitled 'domestic abuse and treatment resistant drinkers: a project to learn lessons from domestic homicide reviews'. The research highlighted that in 75% of the cases viewed alcohol played a significant contributory role in the domestic homicides. The majority of these alcohol related homicides involved high risk treatment resistant drinkers. The Blue Light project is Alcohol Concerns' national initiative to develop alternative care pathways for treatment resistant drinkers who place a burden on public services. The project has developed tools for understanding why clients may not engage, risk

assessment tools, harm reduction techniques, and relevant management frameworks. There is merit in embedding these tools within local device delivery in Leicester.

Care pathways for mental health and alcohol misuse

9.9. Concerns regarding self-harm and suicidal ideation whilst intoxicated is a key feature within this case. All three individuals presented in this way on several occasions and their engagement with follow up services was limited.

9.10. The review has established that there is an assumption that until someone's substance misuse is managed and they are deemed stable, that an assessment of their mental health will not be accurate in terms of diagnosis. There is a need to be able to separate intoxication from mental health as it is recognised that alcohol is a depressant and that once sober, a person may behave entirely differently. However in the case of problematic, intractable drinkers, the difficulties may have become entrenched and therefore require a joint, dual diagnosis, approach.

9.11. When a patient is threatening self harm and experiencing mental health difficulties the referral routes available to GPs can take several weeks to process. In order to refer to the crisis team, the GP would have to see the patient first. The team will then respond within 4 or 24 hours depending upon the clinical need. The crisis team are unable to assess people who are so intoxicated that they cannot be safely assessed. The view of Leicestershire Partnership Trust is that this scenario, or indeed if the patient needed to be seen sooner, would constitute a medical emergency and so the patient should be taken to the Emergency Department where they can be seen and assessed by the Deliberate Self Harm team. The DSH team can then refer for home treatment with the crisis team, ask for a mental health act assessment or arrange informal admission. In reality, the DSH team are equally unable to assess a patient who is intoxicated, leaving the management of that individual with the Emergency Department staff.

9.12. The challenge with this arrangement is that Emergency Departments are not equipped or resourced to manage the demands of intoxicated patients who are expressing thoughts of self harm. Often patients may leave prior to receiving medical input (missing a crucial window of opportunity to engage the patient) and until that time they can present management issues within the department.

9.13. This review has established that the three individuals involved proved difficult to engage and that in the case of Adult B and Adult A in particular, support services were unable to engage with them effectively.

Finding: The review has considered that there is a requirement for a specific care pathway for the management of acutely intoxicated people. The review has also considered that the provision for adults in acute mental health crisis needs to be reviewed.

Recognition of and response to safeguarding concerns

9.14. The review has established that there were a number of missed opportunities to make safeguarding referrals in respect of the adults involved in this case. Adult A was not perceived as a victim of abuse and assumption were made about him given his difficult presentation. Adult B's allegations of sexual abuse, her alcohol misuse and ongoing mental health concerns were not responded to robustly. Adult C was perceived as a vulnerable individual yet there was a lack of risk assessment with regard to what this meant in terms of the risks to himself and to the risk he posed others. It is evident that awareness raising in respect of adult safeguarding continues to be essential.

9.15. The review has established that poor compliance by some agencies with adult safeguarding training has been a concern to the LSAB. Assurance has been provided that agencies have a clear framework for adult safeguarding and regular training. Safeguarding training figures are monitored by the LSAB safeguarding effectiveness group. A significant development is that the Director for Adult Services has ensured that adult safeguarding training is now mandatory within adult social care.

Finding: agencies must ensure that adult safeguarding is a key priority within their strategic and operational service planning and ensure that their staff are equipped to make safeguarding referrals.

Responding to historical abuse allegations

9.16. The history of this case indicates that Adult B disclosed and denied on numerous occasions and to many different agencies that she had allegedly been sexually abused by Adult A. These disclosures were seen as a life event rather than a potential crime that required investigation. There was a lack of consideration of any ongoing risks potentially posed by Adult A.

9.17. The local adult safeguarding procedures do not contain any reference to how to manage historical abuse allegations. This is a significant shortcoming. Importantly, no national or statutory guidance is available to guide professionals in dealing with such matters. The local safeguarding children board (LSCB) procedures contain a short chapter entitled historical abuse allegations. This chapter stresses the importance of a high quality organisational response as there is a significant likelihood that a person who abused a child in the past will have continued and may still be doing so, and that criminal prosecutions can still take place despite the allegations being historic in nature. The chapter describes how the disclosure must be recorded, a chronology should be completed and it must be explained to the adult disclosing historical abuse that the information will need to be shared with the police. The chapter lacks any further detailed guidance regarding how such cases should then be managed. There is reference to strategy meetings being held but this appears to refer to alleged perpetrators who are still working with or caring for children.

Finding: Robust procedural interagency guidance must be in place in order to support professionals to manage and appropriately respond to allegations of historical abuse.

The role of the GP

9.18. A factor in this review is the role of GPs when patients lead chaotic lifestyles and are difficult to engage. The three individuals in this case frequently attended Emergency Department but not at a level to trigger hospital frequent attendees procedures. GPs are notified of all attendances at hospital, outpatient reviews and discharges from health services. The GP is therefore the holder of all information pertaining to a patient and is therefore best placed to understand the issues. However whether the GP themselves have capacity to read all of the information they are sent and respond to it is unlikely and as such this questions whether the information sharing is purposeful or actually just adding to a 'central storage record'.

9.19. The CCG Hosted Safeguarding team have recently incorporated themes from DHRs (local and national learning) into face to face safeguarding adults training for GP's. At the last City Protected Learning Time event held in April 2016, this training was delivered to 85 GPs.

Finding: an alert system of frequent attenders at Emergency Departments should be considered within GP practices and efforts made to target those that are hardest to engage.

10. **Findings and Conclusions**

10.1. All agency training in respect of domestic abuse must include abuse outside of intimate partner relationships.

10.2. The review has considered that there is a requirement for a specific care pathway for the management of acutely intoxicated people. The review has also considered that the provision for adults in acute mental health crisis needs to be reviewed.

10.3. Agencies must ensure that adult safeguarding is a key priority within their strategic and operational service planning and ensure that their staff are equipped to make safeguarding referrals.

10.4. Robust procedural interagency guidance must be in place in order to support professionals to manage and appropriately respond to allegations of historical abuse.

10.5. An alert system of frequent attenders at Emergency Departments should be considered within GP practices and efforts made to target those that are hardest to engage.

10.6. Conclusions: The time period that brought Adult A, Adult B and Adult C together was brief – just a matter of weeks. Adult B and Adult C had not known of each other before this time and their relationship developed quickly, with Adult C spending time at the flat where Adult B and Adult A lived. Agencies were not aware of the connection between the 3 individuals.

10.7. The DHR panel has considered that Adult C did not appear to pose a risk of significant and serious harm to others. Adult C was not perceived by agencies working with him to be a violent and dangerous individual. In view of this, had the connection between Adult C, Adult B and Adult A been known, this would not have raised concerns regarding any risk posed by Adult C to Adult A.

10.8. The DHR panel has determined that the set of circumstances that led to the death of Adult A were so specific that it could not have been predictable that Adult A would die as a result of such a violent crime. His life appeared to be in danger as a result of alcoholic liver disease and not by any risks posed by those with whom he associated.

10.9. This DHR has identified areas where practice and interventions could have been improved which might have better supported Adult A, Adult B and Adult C. The DHR panel has considered that whilst the learning has led to recommendations for change, changes in practice would not have altered the final outcome for Adult A. The risk to Adult A on the day that he died was not, and could not have been identified, and as such his death could not have been prevented.

11. **Changes to practice**

11.1. The pathway of care for acutely intoxicated people in the context of a 'possible' mental health problem such as threats of self-harm has been considered by the Local Crisis Care Concordat group as a priority. The group has agreed that firstly a medical screen is required in the Emergency Department followed by a mental health assessment.

11.2. A pathway has therefore been agreed for acutely intoxicated people who may have a mental health problem to be firstly assessed medically in the Emergency Department and then have a mental health assessment in the Emergency Department within 1 hour of the Emergency Department staff being satisfied that the individual is 'medically fit'. University Hospitals Leicester and Leicestershire Partnership Trust are operationally working closely together under the Leicester, Leicestershire and Rutland Urgent and Emergency Care Vanguard Programme changes to this effect and are also aligning with the newly formed Public Health procured substance misuse services from Turning Point so that appropriate contact can be made, following a mental health assessment, with substance misuse services if required. The proposed model is an outreach model and the expectation is for Emergency Department and Mental Health staff to refer to the substance misuse team to determine an appropriate response in terms of time and location of assessment.

11.3. The local Crisis Care Concordat group are overseeing a programme of work that is fully integrated into the Better Care Together Mental Health Work stream, reviewing all provision for people in mental health crisis. For further details please see: http://www.crisiscareconcordat.org.uk/areas/leicester/

11.4. A regional multiagency sub group comprised of police, health and local authorities, for Individuals with Frequent Needs on a Range of Services has been established, and has the aim of identifying people who have multiple interactions with multiple agencies. The focus of the group will be to improve the long term well-being of vulnerable adults who have frequent needs relevant to multiple service sectors. This can include but is not limited to;

- Poor physical and mental health;
- Risk of self-harm or suicide;
- Drug and alcohol abuse;
- Crime and ASB victimisation or offending, including domestic abuse.
- Extreme social isolation

11.5. The expectation will be that the needs of the person will have been long term and that other multi-agency partnerships are not currently co-ordinating actions or are not able to do so effectively. Through intelligence gathering this will allow the group to identify people who may not meet the need or threshold for certain agency intervention, but collectively through a collaborative approach can have those needs met. The alternative is that there may be a decision to not meet those needs but agree a robust strategy for managing contact with that individual which all agencies are aware of so a consistent approach is adopted by all.

11.6. The group began in November 2015 and has so far met 4 times. There has been a number of cases already which having had a multi-agency input has led to a different pathway being explored which has yielded benefits to organisations but most importantly the individual. For more information see Appendix D.

12. **Recommendations**

12.1. The DHR panel endorses the single agency IMR recommendations. Each agency retains responsibility for the implementation of actions arising from their IMR.

12.2. Given the changes in practice identified above, the recommendations arising from this review are few in number, and although they will improve practice going forward, their implementation would not have altered the outcome in this case.

- LSAB to seek assurance that single agency domestic abuse training does not focus purely on abuse within intimate partner relationships and that learning from this DHR is incorporated into domestic abuse training.

- For there to be national and regional guidance regarding the management of historical or non-recent allegations of abuse

- For routine enquires regarding domestic abuse to be embedded within substance misuse services, in particular alcohol misuse services, given the link between domestic abuse and alcohol.

12.3. In addition, the DHR panel recommends that the learning from this DHR is taken forward by the Domestic Violence Delivery Group of the Safer Leicester Partnership for wider communication and awareness raising.

Appendix A: Terms of Reference

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Adult A
Domestic Homicide Review
Terms of Reference

1. The purpose of the Domestic Homicide Review is to:

a. Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

b. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their children.

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

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

e. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2. Panel members will ensure the DHR fulfils the following requirements:

1. Ensure the review is conducted according to best practice; with effective analysis and conclusions of the information related to the case.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including their dependent children.

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

4. Apply these lessons to service responses; including changes to policies and procedures as appropriate; and prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working.

5. Establish whether family, friends or colleagues want to participate in the review and if so establish if they were aware of any abusive behaviour by either Adult A or Adult B or Adult C on each other, or to other people. Whilst it is not the purpose of this review to consider the handling of child protection concerns related to the case, there may be issues that arise from the review that relate to the safeguarding of children and these will be specifically shared with the Safeguarding Children Board. Learning from this case will also be shared with the Safeguarding Adults Board.

3. In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report:

1. To review whether practitioners involved with Adult A and Adult B & Adult C were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator(s).

2. To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including
   - i) whether the risk management plans were reasonable response to these assessments,
   - ii) whether risk assessments and management plans of Adult C took account of his early history, including convictions for sexual assaults on minors and assessments of risk made during this period,
   - iii) whether there were any warning indicators of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals.
   - iv) Whether any of the adults concerned were assessed to be vulnerable adults and whether they would now meet the criteria for an adult at risk as per the Care Act 2014

3. To identify whether services that were involved with Adult A were aware of the circumstances of Adult B's & Adult C presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship(s).

4. Did agencies involved make routine enquiries about domestic violence when working with these adults and if so were any opportunities missed.

5. To establish whether agencies responded to alcohol dependence and offer appropriate services and support to Adult A and Adult B.

6. At each point of contact with emergency health services for assaults, self-harm and injuries –were enquiries made about domestic violence and procedures followed?

7. To establish whether the mental health needs of adults subject to this review were supported and managed appropriately by local agencies.

8. To establish if any agency or professionals considered that any concerns were not taken seriously or acted upon by others.

9. To establish if there were any barriers experienced by Adult A, Adult B or family / friends that prevented them from accessing help; including how their wishes and feelings were ascertained and considered.

10. To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.

11. To establish whether local Domestic Abuse procedures were properly followed; to include whether the case was, or should have been, considered for MARAC.

12. To identify whether child sexual abuse allegations, leading to the risk of sexual exploitation, were appropriately managed by local agencies and the transition to adult services.

13. To establish whether adult safeguarding concerns (Adult A, Adult B, Adult C) were recognised by agencies and whether multi-agency safeguarding procedures were followed.

14. To consider whether there were any missed opportunities for a multiagency response to consider the multiple issues of Adult A and Adult B

15. To consider how issues of diversity and equality were considered in assessing and providing services to Adult A, Adult C and Adult B (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership).

16. To establish whether safeguarding children procedures were properly followed in respect of Adult B's allegations of historical abuse made against Adult A.

17. To establish how effectively local agencies and professionals worked together.

18. To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.

19. Identify any areas of good practice

Family Participation

The family and significant others will be asked to contribute to this review process to establish any learning, and a strategy for engagement developed.

Scoping period

The scoping period is from January 2013 until February 2015, (capturing period when Adult B commenced living with Adult A, Adult C becoming involved with Adult B and up to the period of Adult A death).

The end date will be reviewed in the event that any new information arising from the criminal trial indicates that information needs to be considered post death.

4. Outside of Scoping

4.1. A summary of agency involvement from 2004 until the beginning of the scoping period is requested within the IMR reports in order to capture relevant background.

4.2. If there are important events outside of the scoping dates that are relevant and worthy of inclusion, a summary of those should also be included.

5. Membership of DHR Panel/ Requests for IMRs

Organisation/ Specialist Area	**Panel Member**	**Email contact**
Leicester City Council - Children Services - Housing Services - Community Safety	Paul Kitney Helen Bannister Steph McBurney	Paul.kitney@leicester.gov.uk Stephanie.McBurney@leicester.gov.uk;
Leicester CCG: - GP surgeries - Out of hours - SAAF	Mina Bhasvar / Adrian Spanswick	Mina.Bhavsar@leicestercityccg.nhs.uk; Adrian.Spanswick@LeicesterCityCCG.nhs.uk
SAFE	Sandra Green	Sandra.green@safedvs.co.uk;
University Hospitals Leicester	Michael Clayton	michael.clayton@uhl-tr.nhs.uk;
Leicester Partnership Trust	Di Postle	diane.postle@leicspart.nhs.uk;
Leicestershire Police	Jonathan Starbuck	Jonathan.Starbuck@leicestershire.pnn.police.uk; Gillian.davis@leicestershire.pnn.police.uk
Children's Social Care	Helen Bannister	Helen.bannister@leicester.gov.uk;
EMAS	Zoe Rodger	zoe.rodger@emas.nhs.uk;
Board Officer	Jackie Wilkinson	Jackie.wilkinson@leicester.gov.uk;
LSAB Administrator		
Independent Overview Report Author	Hayley Frame	

6. Timescales of Review

6.1. As per the government guidance for DHRs, this review should be completed within 6 months.

6.2. It is the responsibility of the Board Officer to keep the review on schedule and to note any foreseen deviations to the agreed timeline to the chair of the CSP.

Appendix B - Domestic abuse within Leicester

Leicester City Council Commissioned Specialist Domestic Violence and Sexual Violence Provision

Date Covered: April 2014-March 2015

Reaching People

- **2747** Referrals **(1853)**
- **7108 (7894)** calls to the domestic violence helpline (**2464** from public) **(1959)**
- **899 (155)** calls to the sexual violence helpline
- **4911 (963) children and young people** taking part in awareness sessions or support work SVDV

Equality & Diversity

- **25% (48%)** service users **BME**
- **86 (1%)** Identified as **LGBT 40 (1%)**
- **184 (2%)** aged 16-18 **185 (5%)**
- **36** at risk of Honour Based Violence **58**
- **14** Identified as at risk of Forced Marriage **19**
- **1328 (15%)** Noted a Disability **679/19%**
- **6896 (76%) 3237 (92%)** were **women** and **2221 (24%) 304 (8%)** were **male (victim-survivors)**

Risks & Vulnerabilities

- **345 (60%) DV victims had children (552/67%)**
- **130 (25%)** DV victims noted **suicidal thoughts** and/or previous attempts **(198/ 24%)**
- **83 (16%)** DV victims experiencing abuse from **multiple perpetrators (120/15%)**
- **59 (11%)** DV victims in receipt of **community care payments (14/2%)**
- **31 (6%)** DV victims reported problems related to **alcohol use (31/4%)**
- **25 (3%)** DV victims reported problems related to **drugs use (48/6%)**
- **76 (20%)** DV victims known to have involvement with **children and young people's services 110/20%)**

Making a difference

- **899 (96%) Felt safer** post intervention from a specialist DV service **542/89%**
- **184 (86%)** Felt better **able to cope** after support from a specialist SV service **47/85%**
- **188 (85%)**Reported **improved sense of well-being** after accessing a specialist SV service **44/80%**
- **92%** Perpetrators **reported reduction in domestic violence 78%**
- **453** Staff **received training** on domestic violence and sexual violence and **94% improved their knowledge** (94% of 222 completed evaluations from DV training to LCC staff) **353 (no evaluation data held)**

Figures in red denote the comparable performance at Q4 2013/14

Provision	Numbers reached and impact	
	2013-14	**2014-15**
CYP Support and Parent/Carer DV	188 referrals	209
	2745 support hours delivered	3379
	244 cases opened	315
	963 CYP accessing service	765
	376.5 creche hours	575
	96% greater understanding	97% average
	75% engaged (CYP)	79% average
	92% reduction in DV	99%
	90% feel more positive regarding parenting capacity	100%
	39% service users BME	**43% service users BME**
Prevention & Education SV	87 staff trained	332
	9 schools delivering HR programme	56
	1498 CYP completing HR programme	4146
Safe Home Service DV	706 referrals	1055
	706 cases opened	1055
	167 homes secured	133
	3 perpetrators accommodated	0
	92% safer at home	100% average
	89% increased confidence in independent living	95% average
	59% service users BME	**59% service uses BME**
Victim-Survivor Service DV	7819 people accessing service	7429
	13049 telephone support hours delivered	20,332
	378 counselling sessions delivered	1345
	851 intake forms completed	1136
	3793 safety plans completed	4281
	89% safer following intervention	93% average
	87% reduction in DV	92% average
	85% improvement in health and WB	93% average
	84% engaged	93% average
	47% service users BME	**44% service users BME**
Perpetrator Interventions DV	108 referrals	99
	88% referrals eligible	98%
	65 started group modules	60
	309 assessment sessions	320
	145 individual interventions	178
	25 self-referrals	29
	296 partner support 1:1 sessions	273
	78% reduction in DV	92% average
	87% motivated to change	88% average
	86% engaged in support plan	81% average
	31% service users BME	**38% service users BME**
SV therapeutic	273 service users accessed	200 (new)
	1156 counselling sessions delivered	3167
	93 assessments completed	146
	24% service users BME	**25% service users BME**
SV helpline, outreach and ISVA	155 accessed helpline	899
	63 cases opened	178
	70 outreach sessions delivered	199
	44% service users BME	**42% service users BME**

NB: sexual violence services only started November 2013

Appendix C – IFNRS subgroup

Memorandum of Understanding: SPB Board Sub-Group Individuals with Frequent Needs on a Range of Services

The Strategy

This group will encourage a strategy towards vulnerable adults in Leicester, Leicestershire and Rutland that;

- Takes a cross agency, cross locality approach with the needs of the individual being at the core as opposed to the remit of any individual agency or locality;
- Targets a long term improvement in well-being working towards individual independence;
- Targets intervention on the root cause of need(s);
- Shares information appropriately to identify needs and their root cause;
- Is proactive to address needs before they reach a high need or crisis point;
- Coordinates actions across service areas to deliver a more effective, efficient service;
- Engages with the vulnerable adult using a consistent, single point of contact wherever possible;

The Focus

The focus of the group will be to improve the long term well-being of vulnerable adults who have frequent needs relevant to multiple service sectors. This can include but is not limited to;

- Poor physical and mental health;
- Risk of self-harm or suicide;
- Drug and alcohol abuse;
- Crime and ASB victimisation or offending, including domestic abuse.
- Extreme social isolation;

The expectation will be that the needs of the person will have been long term and that other multi-agency partnerships are not currently co-ordinating actions or are not able to do so effectively.

The Actions

The actions the group will take will be:

- To be a 'critical friend' panel which can advise on successful strategies utilising the expertise of the 'expert practitioners' present.

- To offer strategic leadership which encourages flexibility from all relevant partners to adopt the strategy detailed above.

The Membership

The group will be made up of a small 2-3 person strategic panel of representative from the following key partner agencies;

- Police;
- Leicester City, Leicestershire and district local authorities;
- Leicestershire Partnership Trust;
- University Hospitals Leicester;

The strategic panel will be there to chair the meeting and to lead the group towards a cross agency, cross locality strategy for each individual case.

The group will also be made up of 'expert practitioners' from the following areas:

- Crime investigation and policing;
- Fire and household safety;
- Housing law and applications;
- Drug and alcohol services;
- Adult social services;
- Probation Service & Community Rehabilitation Company;
- East Midlands Ambulance Service;
- Domestic abuse services;
- Mental health;

- Community and social support services.

The Process

1) Vulnerable adults are considered for referral to the group by any agency. Referral criteria will not be tightly defined so as not to exclude, but will centre on the themes identified in 'The focus' section above.

2) Key professionals involved with the case will be invited to group meetings to present their case. They will be asked to consider what the root cause and strategies to success could be.

3) The group will identify potential strategies to success from their agency expertise. The strategic panel will offer direction encouraging a flexible cross agency, cross locality response. They will also encourage the involved agencies to take the strategy detailed above. This often may include an appropriate statutory or voluntary partner to take the role of single point of contact.

4) The involved agencies will report back to the group with progress against agreed indicators.

5) The involved agencies will then continue long term engagement with vulnerable person to continue to deliver the strategy.

The Need for Change

1) The needs of an individual vulnerable adult are often relevant to multiple service sectors and sometimes are across local authority boundaries. For example an individual may have needs in relation to alcohol abuse and poor mental health at their home address and be a victim of domestic violence in another locality.

   However specialist service provision is often allocated to address these needs in isolation e.g community mental health support, drug and alcohol support, specialist

domestic abuse support OR it is focused on only one local authority geographical area.

2) The needs of a vulnerable adult are often long term in nature and originate from a significant historic life event and/or learned behaviour over a long time period.

   However specialist service provision is often delivered on a short term basis, when the vulnerable person is in crisis or at a level of high need. Once the level of crisis or need is reduced then the service offered is often reduced or removed.

3) The needs of any person receiving a service are often best met by delivering a consistent point of contact, allowing rapport and a positive working relationship to develop. This is often even more vital for a vulnerable adult who may have a history of negative social relations with others and particularly persons seen as authority figures. This relationship can be the basis for putting in place the long term social support that can give the individual independence in their life.

   However specialist service provision for a vulnerable adult with multiple needs are often delivered by a range of professionals from different agencies each working with the individual for a short time and typically only focusing on one need. There is a risk that services are being duplicated and the vulnerable person has multiple contacts offering a confusing picture.

This model unwittingly encourages a strategy which:

- Focuses on individual agency remits when delivering services;
- Addresses issues in the short term;
- Targets intervention on the symptom rather than the root cause of the need;
- Shares information only when cases are in crisis or of high need;
- Is reactive;
- Is un-coordinated and inefficient across agencies;
- Does not build engagement with the vulnerable adult often creating further barriers to successful delivery.

Instead it is hypothesised that a more successful and cost effective strategy would be:

- Taking a cross agency, cross locality approach with the needs of the individual being at the core as opposed to that of any individual agency or locality;
- Targeting a long term improvement in well-being and movement towards independence rather than short term one which often is not able to address any root cause of need;
- Targets intervention on the root cause of need(s). This is often dysfunctional relationships or social isolation which then influences mental health, substance misuse and causes further isolation/dysfunctional relationships.
- Shares information regularly to plan and prevent crisis's rather than to respond to them;
- Is proactive to address needs before they reach a high need or crisis point;
- Coordinates actions across service areas to deliver a more effective, efficient service;
- Engages with the vulnerable adult using a consistent, single point of contact wherever possible;

Through its work this group will influence multi-agency partners to adopt this strategy.

Appendix D - Domestic violence specialist representation

Known Risk Factors – Violent Resistance.

Usually defined as an act of violence towards primary perpetrator

Categories: Victim who has used Violence: a victim who has used or is using violence. This includes violence used for defending themselves or their children or property, or as a way of preventing a likely attack on them or their children. This is likely to be legal 'reasonable force'. It also includes violence as a means of resistance against, or expressing frustration with, the patterns of coercive control and fear of being used against them. They may need legal and other help and also consideration of how their own violence may be or become illegal or unsafe. They will also need safety planning which incorporates an understanding of their own use of violence and strategies for reducing this if possible. (Respect Toolkit, 2013)

Little research on risk factors for 'violent resistance' but:

- History of being a DA victim
- History of previous violence – towards intimate partners and others
- Previous sexual abuse (women – came out in small scale PHD research)
- Substance misuse
- Mental health
- Pregnancy

Violence within family but outside of HBV or intimate violent relationships – there is no programme available due to being not intimate partner.

The context of violent resistance in this review:

- Police callouts
- Injuries
- Disclosures of sexual abuse
- In 2011 possible escalation with increased A&E callouts
- We can't know if he was a victim of her violence. If the sexual abuse allegations made by her were true, she would be considered the most vulnerable in the relationship.