Safeguarding Adults Review

“Mrs Moyo”

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Leicester
Safeguarding
Adults Board

WORKING IN PARTNERSHIP
TO KEEP ADULTS SAFE

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1. Introduction

1.1. This Safeguarding Adult Review (SAR) concerns inter-familial domestic abuse to an adult, 'Mrs Moyo' who had care and support needs. It considers learning surrounding an assault to Mrs Moyo by her son, 'Joseph.'

1.2. Both Mrs Moyo and Joseph were known to partner agencies of the Safeguarding Adult Board. The review explores whether there were opportunities for agencies to have worked together at an earlier stage to reduce risk of harm arising. The review also considers how effectively agencies responded to Mrs Moyo's family's concerns that she was at risk of harm from her son.

2. Summary of learning themes

2.1. Safeguarding minded practice:

- **Multi-agency working** increases opportunities for risk reduction as well as strengthening responses to safeguarding concerns.
- **Establish Support Systems**: The valuable role of Primary Care in providing preventative, supportive care as well as coordinating care in crisis.
- **Risk Assessment and Management:** – the need for a shared understanding of risk between agencies. The necessity of well formulated risk assessments that take account of current and historic risk factors, environmental and familial context, including potential risk to carers. Practitioners need to step back from the task, avoid episodic approaches and see the bigger picture.
- **Domestic Abuse**: People may face multiple barriers to disclosing domestic abuse; practitioners need to recognise these barriers, build trust, and make safe enquiry. Practitioners need to be vigilant to signs of inter-familial domestic abuse, recognising the additional vulnerabilities that being in a caring role can bring.

3. Context of Safeguarding Adults Reviews

3.1. One of the core duties of a Safeguarding Adults Board (SAB), under Section 44 of the Care Act 2014, is to review cases in its area (in this instance, Leicester City Safeguarding Adults Board (LCSAB)) where an adult with needs for care and support (whether or not the Local Authority was meeting these needs):

- Has died and the death resulted from abuse and neglect, or
- Is alive and the SAB knows or suspects that they have experienced serious abuse or neglect

3.2 Importantly, Safeguarding Adults Reviews (SARs) are about how agencies worked together to safeguard adults; they are in their nature multi-agency reviews. For a review to be conducted under S44(1) of the Care Act 2014, there must be reasonable cause for concern about how the SAB, its members, or others with relevant functions worked together to safeguard the adult.

4. How this case met the safeguarding adults review criteria

4.1. Mrs Moyo is an adult with care and support needs and received services from Leicester City Council, (LCC) Adult Social Care. In December 2019, Mrs Moyo was physically assaulted by her son, Joseph. The injuries sustained by Mrs Moyo constituted serious physical abuse that required her to be hospitalised.

4.2. Joseph had mental health needs and was known to Adult Mental Health Services (AMHS). Joseph was also under license to Probation. In the weeks leading up to the assault, Mrs Moyo’s family had made a request to LCC for Joseph to be assessed under the Mental Health Act 1983, but no assessment followed. The LCSAB felt that there was cause for concern about how organisations worked together to safeguard Mrs Moyo (S44 1a).

5. Summary of case

5.1. Mrs Moyo is a black woman of African heritage. She was in her sixties at the time of the incident and lived in a council property with her son Joseph who is a black man of African heritage and Muslim religion. Both are English speakers, with no communication or language adjustments required.

5.2. Mrs Moyo was supported through LCC Adult Social Care due to her physical health needs. She was provided with domiciliary calls twice daily. Mrs Moyo has another son, Aaron and she also received support from him and his wife, Jasmin.

5.3 Mrs Moyo’s son Joseph had a history of psychotic episodes that was induced by his use of illicit substances. At the time of the assault, Joseph was not engaged with AMHS but was under licence to probation, having been released from prison where he had been serving a sentence for supplying class A drugs.

5.4 In the six-week period leading up to the assault, Mrs Moyo’s son and daughter in law, had been in contact on nine occasions with Adult Social Care; Probation; NHS 111; ambulance service; police and mental health services, concerned about Joseph’s deteriorating behaviour and of Mrs Moyo’s wellbeing.

5.5. On the day of the assault, Joseph began a prolonged and sustained assault to his mother, punching, kicking and trying to strangle her. Mrs Moyo managed to call the police. Mrs Moyo was taken to hospital where she received treatment for soft tissue injury and a nasal fracture. Joseph was arrested and subsequently detained

for psychiatric assessment under the Mental Health Act 1983 and then recalled to prison.

6. Methodology and Terms of reference

6.1. This Safeguarding Adults Review combined agency reports with a learning event for practitioners who had been directly involved with Mrs Moyo and Joseph. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

Scope Period

6.2. The start date for the review scope period was January 2018, this being the most recent episode of involvement by AMHS with Mrs Moyo's son, Joseph. The end of the scope period was 31st January 2020, six weeks after the incident of assault. This enabled the review to consider practice following the assault, including Mrs Moyo's restorative care and Making Safeguarding Personal.[1] It also gave information from Joseph's psychiatric assessment, to offer insight into his mental health at the time of the assault.

Terms of Reference

6.3. In the context of Joseph's mental health needs, explore the visibility of Mrs Moyo as an adult with care and support needs being at risk of abuse (including domestic abuse) from her adult son.

1. To consider the effectiveness of responses to Mrs Moyo's and Joseph's needs
2. To consider how effectively agencies worked together.
3. To consider the systems in which services operated and how this supported or detracted from care provided.

6.4. Appendix 1 provides the detailed areas of enquiry that agencies were asked to consider.

Engagement with the Adult and Family

6.5. It is important that reviews understand the direct experience of the adult, their family, and carers, offering the opportunity for them to share their perspectives. However, recounting those events can be difficult experience. Mrs Moyo, Joseph and Aaron and Jasmin were aware of the review. The LSAB appreciates their support for the review. Joseph provided his views about what may have helped reduced risks. These are referenced within the report. The LSAB respects his family's wishes not to be directly involved. Pseudonyms have been used throughout

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to protect privacy. Personal information and dates have been deliberately generalised and smaller agencies anonymised.

6.6. The review team consisted of members of Leicester City Safeguarding Adults Board's Review Subgroup, which included senior safeguarding representatives and representatives from the following participating agencies:

Participating Agencies	Context of Involvement
DLNR Community Rehabilitation Company (CRC).	The CRC managed Joseph when he was released from prison in 2018 under license to Probation.
X Domiciliary Care Services	Providing Domiciliary Care Services to Mrs Moyo
Leicestershire Police	Past involvement with Joseph and responded to concerns in weeks leading up to the assault
Clinical Commissioning Group and GP Practice	Mrs Moyo was registered with a GP
Leicester City Council Adult Social Care (LCC ASC)	Assessed Joseph under the Mental Health Act. Provided care and support to Mrs Moyo. Responded to concerns in weeks leading up to the assault
Leicestershire Partnership NHS Foundation Trust (LPT)	Provided adult mental health services to Joseph. Historic provision of Community Health services to Mrs Moyo

In addition, the following agencies provided information to the review:

Participating Agencies	Context of Involvement
United Against Violence and Abuse (UAVA)	Domestic Violence Service providing support to Mrs Moyo following the assault
Derbyshire Health United (DHU)	Provider of online NHS 111

6.7. LCSAB commissioned an independent author to carry out this review. Sylvia Manson is an experienced chair and author of reviews and is independent of LCSAB and its partner agencies. Sylvia is a mental health social worker by background. She

has many years' experience in Health and Social Care senior management and commissioning, including regional and national leadership roles.

Review Timeline

6.8. Care Act 2014 statutory guidance identifies that Safeguarding Adults Reviews should be completed '*within 6 months of initiating it, unless there are good reasons for a longer period being required*[2]*'.* This review was initiated during the Corona Virus Pandemic. The LCSAB was mindful of the additional pressure agencies were under. Greater flexibility was required to enable agencies to provide good quality agency reports without compromising operational services. The SAR took 11 months from point of commissioning until its conclusion.

Structure of Report

6.9. The report is structured as follows:

- Section 7 provides background, and key events relating to Mrs Moyo and Joseph.
- Section 8 gives analysis and learning.
- Section 9 outlines changes made by agencies and their plans for improvement.
- Section 10 provides a conclusion.
- Section 11 makes recommendations for the LCSAB and its partner agencies.

7. Background and Key Events

7.1. Mrs Moyo first moved to the UK in **2002**. She has two sons, her older son, Aaron settled in a neighbouring city with his wife, Jasmin. Mrs Moyo's younger son, Joseph lived with her. He was in his early thirties at the time of the assault.

7.2. Mrs Moyo has multiple physical health needs including historic brain trauma, hyperthyroidism, insomnia and neuralgia. She has some difficulty with mobility and uses a stick, being unable to stand for long periods of time. Mrs Moyo received support from her GP and in the past had received some support from LPT, Community Health services. LCC had provided care and support to Mrs Moyo since

[2] Department of Health (2017). Care and support statutory guidance.
[online] Available at: https://www.gov.uk/goverJosephent/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed 21 August 2019].

2013. Mrs Moyo had two calls daily from a domiciliary care agency. Joseph's daughter-in-law Jasmin also provided her with support.

7.3. Mrs Moyo's son Joseph was well known to the police. He was released from prison in **2012** but soon after, was detained by the police, presenting as paranoid and carrying a knife. His family reported his behaviour had been bizarre for ten days. Joseph was detained for assessment under the Mental Health Act[3] During the admission it was necessary to nurse him in intensive care due to his disturbed behaviour. He was diagnosed with drug induced psychosis.

7.4 On discharge, Joseph was mentally stable for two years. He was concordant with medication and not using illicit substances. However, in **2014** he had a further episode of psychosis, precipitated by substance abuse.

7.5. Police were again involved. Joseph was arrested after becoming verbally and physically aggressive towards home carers who were supporting Mrs Moyo. Joseph's family had raised concerns about Joseph two weeks prior as he had been paranoid, was not sleeping, was irritable and verbally aggressive towards them. Joseph's brother was present during the assessment and Joseph had been threatening toward him with a flick knife. On discharge, Joseph was initially supported by the home treatment team who were recommended to visit only in pairs.

7.6. Joseph had follow-up care from AMHS for fifteen months although did not attend all appointments. In **October 2015** Joseph was sentenced to prison for six years for class A drug offences. He was sentenced with a Fast Delivery Sentencing Report[4] that was completed on the day at court**.** Joseph's mental health was not seen to be a factor in his offending, though his history of drug induced psychosis was noted. As Joseph was in prison, AMHS discharged him in **December 2015** and his GP discharged him in **2017** as contractually required when a patient is detained in prison.

7.7. As Joseph was due to be released on license, AMHS provided prison in-reach from **January 2018.** Joseph's mental health had been stable**.** He had been without anti-psychotic medication for the last five months of his prison term and shown no symptoms of mental disorder.

Key Events during the Scope Period

[3] This was section 2 of the Mental Health Act 1983(as revised 2007) –compulsory detention for a period of up to 28 days for the purpose of psychiatric assessment followed by treatment.

[4] Fast Delivery Report is designed for offenders in less complex and lower risk circumstances. The information is less detailed.

7.8. Joseph was released in **March 2018** on licence to probation until February 2021. He was assessed by probation as a low risk of harm and his offender management was provided by the Community Rehabilitation Company (CRC).[5] Joseph had ongoing immigration issues and could not claim benefits. He returned to live with his mother

7.9. Joseph was offered follow up care from AMHS**,** by a Consultant Psychiatrist seeing him at Outpatient Clinic quarterly and a Community Mental Health Nurse (CMHN) supporting and monitoring him in the community. Joseph was not registered with a GP, despite encouragement from his CMNH to do so. His prescriptions for anti-psychotic medication were issued by his Consultant Psychiatrist from **May to July 2018**.

7.10. In **July 2018**, Joseph was discharged from the CMHN's caseload. He was concordant with his treatment and the CMHN had no concerns about his presentation. Joseph had told his CMHN he had tried to register with different GP practices but without success. He remained open to his Consultant Psychiatrist.

7.11. Mrs Moyo phoned the CMHN in **November 2018** asking for a repeat prescription of Joseph's anti-psychotic medication. Joseph told the CMHN that he had been unable to register with a GP but that his Offender Manager had now found him a GP. The CMHN arranged for a further prescription.

7.12. Joseph missed an appointment with his Consultant in **December 2018** and in **April 2019**, so was discharged.

7.13. In **October 2019**, Mrs Moyo attended her GP for her physical health needs. She made no mention of Joseph and no concerns were raised or identified.

7.14. Later in **October 2019** Mrs Moyo's daughter-in law, Jasmin, rang to speak with Joseph's Consultant Psychiatrist. She spoke with a senior clinical secretary. Jasmin said that she and Mrs Moyo were worried that Joseph was having a psychotic episode and that he was not taking his medication. At the time, his whereabouts were not known. The secretary signposted Jasmin to her GP, the hospital Emergency Department Mental Health Team and the local walk-in centre. The secretary also gave her the contact number for LCC Emergency Adult Social Care Duty Team and advised them to call the police if necessary.

7.15 Jasmin then as advised, phoned LCC Contact and Response Team to request a Mental Health Act assessment on behalf of Mrs Moyo as Joseph's Nearest

[5] Community Rehabilitation Company (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. CRCs manage lower risk offenders.

Relative.[6] She described Joseph as presenting with paranoid thoughts, repetitive behaviour and being sleep deprived.

7.16. The LCC Contact and Response Team made some enquiries, noting Joseph was not registered with a GP and was closed to AMHS. They phoned Mrs Moyo. She confirmed Joseph had shown aggressive behaviour toward her, pushing things and pretending to hit her.

7.17. The team spoke with the Consultant Psychiatrist's secretary to ask advice about referring to the Crisis Team where the adult had no GP. The secretary repeated the advice given to Jasmin. The secretary also left a voicemail message for the Consultant to check if any other actions were required - no further action followed.

7.18. The Contact and Response Team phoned Jasmin back three days later. She confirmed Joseph had now returned but was less aggressive. The team advised Joseph should register with a GP and closed the referral.

7.19. Four weeks passed. Joseph attended his appointment with his Offender Manager toward the end of **November 2019**. Joseph talked about immigration matters and his mother's ill health but did not raise any concerns and the Offender Manager did not identify any. A further appointment was set for January 2020.

7.20. Two days later, Jasmin contacted NHS 111. She was concerned as Joseph had been phoning and shouting at her. She described Joseph as having bi-polar and schizophrenia, that he was not taking his medication and was not registered with a GP. She was worried as Joseph lives with his mother and he had been taking the phone from her if anyone rang up. NHS 111 called Mrs Moyo and spoke with both. Mrs Moyo reported everything was okay and that Joseph had no symptoms. NHS 111 phoned Jasmin back advising her to call police if concerned.

7.21. On the same day, Police received a 999 call. A disturbance could be heard in the background. The call was abandoned but police traced the number to Mrs Moyo's home and called her. Mrs Moyo stated that she was safe and well.

7.22. Jasmin phoned the police later that day, repeating the concerns she had shared with NHS 111. She told police that when NHS 111 had phoned Mrs Moyo,

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[6] Mental Health Act 1983 (as revised 2007) section 13(4) states that a nearest relative has a right to request to an assessment of their relative i.e. to consider the patient's case with a view to making an application for his admission to hospital.

Joseph had taken the phone from her, to say he was fine, and they did not need help. Mrs Moyo had verified this but only because she was scared of him. Jasmin wanted Joseph to be assessed by a mental health team. Jasmin was advised that she or Mrs Moyo should dial 999 and ask for an ambulance. Police asked the Mental Health Car[7] to view the incident.

7.23. Jasmin phoned police again, half an hour later. She had called Mrs Moyo through Facetime and could hear Joseph shouting in the background. Joseph took the phone from her and terminated the call. Jasmin confirmed Mrs Moyo appeared to be alright, and that Joseph had not been physically aggressive to her. Jasmin had tried to ring the ambulance service, but no doctor was available.

7.24. The information was passed to the Mental Health Car. They gathered background information about Joseph's mental health, the latest period of involvement with AMHS and his risk assessment at point of closure.

7.25. Police officers rang Mrs Moyo. Joseph had gone out and Mrs Moyo stated that she was safe and well. She described Joseph as struggling with his mental health. Mrs Moyo was advised to contact NHS 111 or the ambulance service on 999 if she felt his mental health was declining and to arrange for him in to see a Doctor as soon as possible. The officers also phoned Jasmin to update her. The incident was closed.

7.26. Two days later, **November 2019** the ambulance service received a call. The caller was concerned about Joseph's deteriorating mental health and described Mrs Moyo as disabled and frightened of him – he had smashed items in the home. The caller said Mrs Moyo had tried phoning the ambulance service, but Joseph had taken the phone from her. The ambulance service asked for police assistance. The Mental Health Car was asked to view the incident and Police officers called to Mrs Moyo's house in advance of an ambulance attending. Both Mrs Moyo and Joseph denied phoning the ambulance service. Mrs Moyo denied any problems and said it must have been a malicious call.

7.27. The police officer phoned Aaron, who confirmed he had rung the ambulance service as Mrs Moyo was concerned about Joseph. Aaron thought that Joseph had been due to see the mental health crisis team that day however when officers checked, the crisis team had no record of Joseph.

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[7] The mental health car is a joint initiative where a Leicestershire Police officer and a mental health nurse from the LPT are partnered together in order to respond to people with mental health problems who come to the attention of the police.

7.28. The attending officers felt Joseph presented well and appeared to present no risk to himself or others. There was no apparent damage. Mrs Moyo told them she had no concerns and was happy to have Joseph at the address. Officers spoke with Mrs Moyo's carer who also had no concerns.

The two weeks leading up the assault

7.29. Two days later, **December 2019** Jasmin phoned LCC Contact and Response Team again with further concerns about Joseph. She told them Joseph had taken Mrs Moyo's, phone and that she was scared of him. Jasmin relayed what had happened when NHS 111 had tried to speak with Mrs Moyo. She feared what Joseph would do.

7.30. The team advised Jasmin that Mrs Moyo had the right as Nearest Relative, to request a Mental Health Act assessment. They advised her to call police or paramedics if there was a serious risk. The team offered to find out how to access mental health services as Joseph had no GP. They rang Jasmin back a week later to advise that access was through Emergency Department. They reiterated advise about contacting emergency services and gave information about mental health support groups.

7.31. That same day, Jasmin called the police again. There had been a telephone argument between Joseph and Aaron and Jasmin could hear Mrs Moyo screaming and crying in the background. When police attended, Joseph initially would not answer the door. He was agitated and Mrs Moyo was upset. Officers spoke to Mrs Moyo and Joseph separately. Joseph described it as a family dispute. He said he had cared for his mother for a long time, had never hurt her and never would. Mrs Moyo confirmed she had never been assaulted by Joseph but that he has mental health issues and gets angry. She was happy for him to stay at the address. Officers completed Public Protection Notification for Mrs Moyo and a DASH form[8] for assessment. No further action was taken.

7.32. The next day Aaron contacted the Probation CRC, to raise concerns about Joseph's mental health and his mother's wellbeing. Joseph's Offender Manager was not available, so Aaron spoke to a colleague. He told them of the involvement of police the previous day but that they had not taken any action as Joseph had not been manic when they saw him. Aaron rang again the following day, a Friday. The Offender Manager was not available again, but Aaron was advised he would arrange a home visit. Aaron confirmed that there had been no actual violence and was advised to contact police should this change. The Offender Manager when notified, planned a visit the following week.

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[8] DASH Checklist for domestic violence https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009-2016-with-quick-reference-guidance.pdf [Accessed April 2021]

7.33. The day before the incident, one of Mrs Moyo's carers phoned their services' on-call manager after their visit. They had felt uncomfortable as Joseph '*was acting strange'* and followed her around the house, in and out of each room. Mrs Moyo had not discussed anything of concern with either of her carers. That night, Joseph and Mrs Moyo argued.

7.34. From early on the following day, Joseph began a sustained assault. It lasted some three hours before Mrs Moyo was able to make a 999 call. Police Officers attended within twenty minutes. Mrs Moyo had swelling to her eye and pain in her knee. She told the officers that Joseph had punched her, kicked her, strangled her, and made threats to kill.

7.35. Mrs Moyo was taken to hospital. Joseph was arrested at the scene for assault and for drug possession. He was subsequently detained for assessment under the Mental Health Act and was nursed in seclusion because of his violent and aggressive behaviour. Neither Mrs Moyo, nor her family, wished to provide a statement.

7.36. Police made a referral to MARAC[9]which met the following day. Mrs Moyo still did not wish to make a statement of the incident. Joseph's Offender Manager began the process to revoke Joseph's license and recall him to prison following his hospital admission.

7.37. Mrs Moyo was allocated an Independent Domestic Violence Advisor (IDVA) and a Social Worker from Hospital Discharge Team. A Safeguarding Alert commenced.

7.38. The next day the IDVA, visited Mrs Moyo. Mrs Moyo described her last three weeks as 'terrible', as Joseph's mental health had declined, and she had had the police out to her house.

7.39. Mrs Moyo told the Social Worker she did not want Joseph to live with her and asked for her door locks to be changed, a new key safe number and agreed to a pendant alarm. When the IDVA contacted Mrs Moyo again, she did not wish any further support as Joseph was now detained in hospital and she felt supported by friends and family. Mrs Moyo was considering moving to where her other son and daughter-in-law lived. Mrs Moyo was discharged home after a two-week admission.

[9] Multi-Agency Risk Assessment Conference for the management of higher risk cases of domestic violence

7.40. Joseph was discharged from hospital after three weeks. The diagnosis for this admission was thought to be drug induced psychosis. '*Mental and behavioural disorders due to the use of cannaboids; Paranoid Schizophrenia; Personal history of non-compliance with medical treatment and regimen.'* He was recalled to prison until he had served his full sentence, early in 2021.

7.41. Joseph's recollection of events around the time described that he felt unwell leading up to the incident and was experiencing auditory hallucinations and paranoid thoughts. He had no recollection of the assault on his mother.

8. Analysis and Learning

The analysis and learning are considered against three episodes:

- Episode 1: Opportunities for Preventative Intervention March 2018 – September 2019
- Episode 2: Responses to the escalating concerns October 2019 – December 2019
- Episode 3: Restorative care following the assault December 2019 – January 2020

8.1. Episode 1: Opportunities for Preventative Intervention March 2018 – September 2019

8.1.2. The review considered opportunities for agencies to intervene at an earlier stage, potentially averting the circumstances that led up to the assault.

8.1.3. Joseph's episodes of acute psychosis were precipitated by polysubstance misuse. When acutely unwell, he could become paranoid, aggressive, and violent. Historically, this had been within a domestic setting. This knowledge offered an opportunity for preventative, risk reduction measures on Joseph's release from prison.

8.1.4. National reviews[10] highlight that many people living with mental health problems struggle to access the services that they need. NHS England recognise that for many people, '*release from prison can be a crisis point …moving from a*

[10] NHS England Five Year Forward View for Mental Health A report from the independent Mental Health Taskforce to the NHS in England 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [Accessed May 2021]

supported and regimented environment to one with little or no support and uncertainties.' [11]

8.1.5. Joseph had had a period of mental health stability while in prison. However, on release, he had many psycho-social stress factors. He had no employment, his relationship had ended, he had no recourse to state benefits and was reliant on his mother for accommodation. Historically, release from prison had been a high-risk period for relapse into substances misuse leading to de-stabilisation of his mental health.

8.1.6. NHS England 'Reconnect: Care After Custody'[12] describes the importance of continuity of care for prisoners on release but that there are often gaps in provision resulting in Health inequalities. The Centre for Mental Health reinforces the need for '*tailored, wrap-around approach that supports a person through the prison gate and into the community'*[13] with mental health support as an essential element of rehabilitation.

8.1.7. NHS England emphasises the need for coordination between the prison mental health care provider; the Offender Management Unit; the Probation Service; the AMHS and the offender's community GP. While there was some evidence of good practice on Joseph's release, there was also some gaps in provision and a need for communication between the agencies involved.

[Recommendation 1]

8.1.8. The fact of Joseph not being registered with a GP was a key factor in the events that followed. Primary Care is an essential component to support physical and mental health care. However, NHS England acknowledge a widespread failing in registering offenders with a GP.

8.1.9. Primary Care management of mental health will include:[14]

- Prescribing and monitoring medication
- Monitoring symptoms
- Coordinating across service, liaising with secondary services (including triggering mental health assessments and crisis care)

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[11] NHS England Reconnect: Care After Custody https://www.england.nhs.uk/ltphimenu/wider-social-impact/reconnect-care-after-custody/ [Accessed May 2021]
[12] NHS England Reconnect: Care After Custody https://www.england.nhs.uk/ltphimenu/wider-social-impact/reconnect-care-after-custody/ [Accessed May 2021]
[13] The Centre for Mental Health From Prison to Work 2018 https://www.centreformentalhealth.org.uk/publications/prison-work [Accessed May 2021]
[14] NICE Psychosis and schizophrenia: Scenario: Primary care management 2021 https://cks.nice.org.uk/topics/psychosis-schizophrenia/management/primary-care-management/

- Providing a contact point for family and carers and ensuring they are provided with support.
- Supporting abstinence from substance misuse and referring into specialist services where necessary.
- An annual mental health assessment as proactive mental health care

8.1.10. These were all essential components to help Joseph sustain his mental health, and thereby reduce the risk he posed to others. Joseph, when interviewed for this review reflected that having a GP was important to his mental health.

8.1.11. Joseph had been discharged by his community GP Practice while in prison, with care transferred to prison GP as per standard practice. His resettlement plan was completed by another prison. Joseph informed that Case Worker that he had a community GP although this was not in fact the case. It is not clear whether Joseph believed he was still registered with his GP or that he was being deliberately misleading.

8.1.12. Joseph was provided with psychiatric in-reach by LPT AMHS, in advance of his release. This was good practice. However, this was also a missed opportunity for a multi-agency pre-release plan for Joseph between prison health care, offender management and AMHS. Had this been in place, this would have set the foundation for post release multi-agency work. There would have been a shared understanding of risks and an opportunity to discuss his mental health/substance misuse care needs. This would also have led to a shared knowledge that Joseph was not registered with a GP. Joseph confirmed that he would have been happy for this information to be shared about him between those key agencies. As will be discussed in the following section, this could also have established communication channels from AMHS to the Offender Manager when family began to express concerns.

[Recommendation 1]

8.1.13. When Joseph was released, this was a further opportunity to establish liaison between Joseph's Offender Manager and AMHS. Joseph had an induction appointment with his Offender Manager. Their records indicated that he was registered with a GP and the Offender Manager did not have cause to question this.

[Recommendation 1]

8.1.14. The induction pack used by the Offender Manager also noted that he had a care plan, but this was not followed up. The Offender Manager assumed Joseph's mental health was stable and he was in receipt of medication. This assumption was correct at that time but should not have been relied upon. The Offender Manager had no knowledge of Joseph's history of rapid relapse when using substances, nor

of the risk of aggression and violence at that point. AMHS was aware that Probation (CRC) was involved but the Offender Manager had no knowledge of AMHS involvement. There was no liaison by AMHS with the Offender Manager in the 16-month period that both services were involved with Joseph following his release from prison. Joseph confirmed that if asked, he would have given consent for information to be shared between mental health services and offender management. LPT has highlighted learning relating to this.

8.1.15. The minimal levels of contact and enquiry reflected that Probation services had assessed Joseph's risks as low. This was based on the information sourced pre-sentence for his Fast Delivery Sentence report. It had been drawn solely from Joseph's past offences and had limited information about his mental health needs and risk profile.

8.1.16. Probation confirmed that the levels of contact and enforcement by the Offender Manager, were in accordance with sentence management and national standards frameworks. This may be true, but there was a need to seek out corroborating information.

8.1.17. Had the Offender Manager had more information about Joseph's history, particularly his threatening behaviour with a knife, this *may* have resulted in assigning a medium level of risk management in accordance with their definitions of risk i.e., '*there are identifiable indicators of serious harm. The offender has the potential to cause such harm. But they are unlikely to do so unless there is a change in circumstances. For example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse*.' [15]

8.1.18. The review representative from Probation reflected that there had been a lack of professional curiosity over the issue of Joseph's mental health status, and this was compounded by the lack of communication prior to and on release.

8.1.19. AMHS do provide a Court liaison role to provide pertinent information to the Court, however mental health information is not routinely given to Fast Delivery Report authors. It is acknowledged that Fast Delivery Reports are necessarily used as a proportionate means to manage pressures on the criminal justice system. Nonetheless, as this incident demonstrates, vital information can be missed. Joseph, when consulted, agreed that having more background history about mental health needs was important to inform Court reports and release planning.

[15] HM Gov: Guidance Risk Assessment of Offender 2019 https://www.gov.uk/guidance/risk-assessment-of-offenders [Accessed may 2021]

8.1.20. Learning from Domestic Homicide Reviews highlights the need for improved recognition and understanding of risk factors. The analysis of risk factors most prevalent in the DHRs found the single largest category was previous violent behaviour (70%), followed by mental health problems (64%). Drug problems were prevalent in 37% of the reviews.'[16] These factors were common to Joseph and presented the combined 'trilogy of risks' that the Safeguarding Children and Adult Boards have been raising awareness of.[17]

8.1.21. Joseph's mental health history of drug induced psychosis and the risks he presented when unwell was not particularly unusual.[18] If learning from DHRs is going to make a difference to practice, there is a need for national policy and local practice to use that learning to strengthen information sharing and partnership working between AMHS and Probation.

8.1.22. Leicester's Strategic Offender Management MAPPA Board has a strategic plan for 2021-2022, with an action to improve publicity, pathways and gateways into mental health services. Learning from this review should be used to inform the development of that work, specifically to strengthen partnership working between AMHS and Probation at all stages in the offender's journey: pre-sentence, pre-release, and post-release.

[Recommendation 1

8.1.23. Learning from this review should also be used to inform national policy and guidance on information sharing and joint work between AMHS and Probation at those junctures on the offender pathway.

[Recommendation 2

8.1.24. Joseph was supported well on his release by AMHS through a Consultant Psychiatrist and by a CMHN. LPT report that Joseph had had multiple periods of non-engagement and the CMHN and Consultant Psychiatrist made efforts to engage with Joseph and ensure that assessments were completed, and that care and support were provided. The CMHN completed a good risk assessment that included reference to past incidents of violence and aggression.

8.1.25. The CMHN was aware that Joseph had no GP – they had had to arrange prescriptions of his anti-psychotic medication for him. The CMHN had repeatedly encouraged Joseph to register with a GP. There is nothing to suggest that Joseph was not capable of taking responsibility for this. However, when Joseph reported

[16] Chantler K, Robbins R, Baker V, Stanley N. Learning from domestic homicide reviews in England and Wales. Health Soc Care Community. 2020;28:485–493. https://doi.org/10.1111/hsc.12881 [Accessed May 2021]

[17] Leicester, Leicestershire and Rutland Safeguarding Children and Adult Boards Trilogy of Risk: Awareness Raising Resources https://lrsb.org.uk/trilogy-of-risk [Accessed May 2021]

[18] University of Manchester National Confidential Inquiry into Suicide and Safety in Mental health Annual report 2019 https://www.research.manchester.ac.uk/portal/files/162072409/NCISH_2019_Report.pdf [Accessed May 2021]

difficulties in getting any GP Practice to take him on, it would have been beneficial for AMHS to have supported him in this. He identified having a GP as a key factor that may have made a difference. The CCG representative to this review, has helpfully offered to disseminate information to agencies about the GP registration process.

8.1.26. Given Joseph's stable mental health it was reasonable that the CMHN ended their involvement when this stability was maintained for some months, albeit that he had missed some appointments.

8.1.27. When Mrs Moyo contacted the CMHN four months post closure to ask for help with accessing medication, the CMHN was responsive and arranged for a further prescription. When Joseph told the CMHN that his Offender Manager had found him a GP, the CMHN had no reason to question this. It is now known that it was fabrication that Joseph had had this discussion with his Offender Manager. It was also unlikely that GP Practices had refused to take him on, there being strict criteria regarding this. Mrs Moyo's GP Practice confirmed that he would have been able to register at their Practice.

8.1.28. Had there been communication between AMHS and his Offender Manager, this fabrication may have become known and led to further enquiry about the reasons for his disguised compliance. This in turn could have led to reappraisal of risk.

8.1.29. When the Consultant Psychiatrist also ended their involvement with Joseph six months later in April 2019, the discharge pathway would ordinarily be from AMHS to Primary Care. The Consultant was aware that Joseph was still not registered with a GP. He would not therefore have access to the annual mental health assessment offered to patients by GP's. Joseph had not been seen since the closure eight months earlier by the CMHN, having missed two outpatient appointments. However, the Consultant considered that Joseph had been well at that stage, and that it had been six months since he had last requested a prescription (assuming this meant he had stayed well). A discharge letter to Primary Care was written, as per standard practice, but remained on Joseph's file unsent.

8.1.30. The LPT policy for Did Not Attend[19] (DNA) references the need to consider risk factors and review the patient's risk assessment, documenting the decision-making process including where appropriate, consultation with other key professionals, carers and relatives. The policy also references informing the patient's GP and other professionals involved of the outcome.

[19] Leicestershire Partnership NHS Trust, The Management of Attendance/Did Not Attend 2017

8.1.31. In terms of weighing those risk factors, LPT reported that Joseph was not considered to be a risk to others while he was mentally well and stable and there was no indication that he was using illicit substances at point of closure. However, on the other hand, the *nature* of Joseph's illness was of rapid relapse and violence when acutely unwell, he had no GP and was not taking any anti-psychotic medication. It is true he had had medication free periods in the past without any sign of deterioration. Abstinence from illicit substances was the primary protective factor. Nonetheless, anti-psychotic medication was prescribed as a protective factor and had been dis-continued in an unplanned way without review by his Consultant.

8.1.32. Given these circumstances although discharge appeared to be reasonable, there needed to be further consideration of the discharge plan as a step-down from AMHS. It would have been prudent, for AMHS to have sought consent (or considered grounds to share without consent), to notify Joseph's Offender Manager that they were intending closure. This would have enabled the Offender Manager to have a better understanding of Joseph's mental health needs, his risks, and signs of relapse. Joseph confirmed he would have given consent.

8.1.33. LPT need to assure that their policies for Did Not Attend and Discharge, (and application of those policies) take adequate account of circumstances when a patient is not registered with a GP i.e.

- Reasonable attempts are made to support service users to register with a GP.
- Lack of GP registration is factored into risk assessment and,
- Risk assessment is used to inform proportionate communications with other agencies, family and carers, in line with information sharing guidance.

[Recommendation 3

8.1.34. The review questioned whether 'hidden carers' was also a factor in missed opportunities for early intervention. The agencies involved, confirmed that the nature of the relationship between Mrs Moyo and Joseph was not well understood. Nor was the role of Aaron and Jasmin.

8.1.35. Mrs Moyo and Joseph had some mutual dependence within their relationship: Mrs Moyo was providing Joseph with practical and emotional support in relation to accommodation and his mental health; Joseph was providing Mrs Moyo with some support for domestic tasks. Research highlights that people in a caring role may not recognise themselves as carers but simply see it as part of family life.[20] Carers of people with a stigmatised condition such as substance misuse may also not wish to disclose their situation.[21]

[20] Social Care Institute for Excellence https://www.scie.org.uk/publications/guides/guide09/section1/hidden.asp

[21] Manthorpe et Al (2015) Supportive practice with carers of people with substance misuse problems http://wels.open.ac.uk/research-project/caren/node/2144 [Accessed April 2021]

8.1.36. It is likely that Mrs Moyo and Joseph's caring roles would not have met the Care Act 2014 thresholds for formal support i.e. requiring conditions of necessity or being unable to achieve their own outcomes due to caring responsibilities.[22] However, the National Institute for Health and Social Care Excellence (NICE) national guideline on psychosis and schizophrenia defines 'carer' in broader terms *'…anyone who has regular close contact with adults with psychosis and schizophrenia, including advocates, friends or family members.'*[23]

8.1.37. NICE sets standards for support to carers, including written and verbal information in an accessible format about:

- Diagnosis and management of psychosis and schizophrenia
- Positive outcomes and recovery
- Types of support for carers
- Role of teams and services
- Getting help in a crisis.

8.1.38. LPT stated that there was nothing to indicate that Mrs Moyo required support and that Joseph's CMHN felt it may be overly intrusive to explore family dynamics any further. They were also concerned it may have breached Joseph's confidentiality.

8.1.39. These professional judgements can be finely weighed. On the one hand, the home situation appeared calm and supportive. Joseph's mental health was stable, there was no evidence of substance misuse or that Mrs Moyo was at risk from her son at that time. On the other hand, the nature of Joseph's mental illness i.e. rapid relapse and history of aggression and violence, also needed to be taken into account.

8.1.40. The CMHN had done work with Joseph around contingency and relapse planning, with routes back into the service. LPT reported that historically (2014), Joseph had demonstrated awareness of how to access help by attending the emergency department. However, the fact that Joseph *could* access services, does not mean he necessarily *would*. In fact, Joseph's family had played a key role in

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[22] Social Care Institute for Excellence Eligibility criteria under the Care Act 2014 https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria [Accessed April 2021]

[23] NICE Psychosis and schizophrenia in adults https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-8-carer-focused-education-and-support)

identifying previous relapse and alerting services. On both past relapses, police and compulsory measures were needed.

8.1.41. Joseph was not asked whether he would consent for information to be shared with his family. Mrs Moyo was already aware of AMHS involvement and it would not have breached any confidentiality to provide her with contact points or to discuss her understanding of his signs of relapse. When interviewed for this review, Joseph said he would have consented to AMHS speaking with his family, recognising that they may be the first to recognise his signs of relapse. In the event, Mrs Moyo and Jasmin did find ways back to the AMHS – phoning the CMHN and phoning the Consultant's secretary. Nonetheless, this remains a point of learning for LPT in relation to working with family and carers.

8.1.42. At the Learning Event, attendees discussed the importance of understanding definitions of 'carer' and what constitutes 'significant others.' The nature of family and care relationships should be considered by Health, Social Care and Probation services as part of a holistic assessment that identifies assets, protective factors, stress factors and risks.

8.1.43. Mrs Moyo's GP Practice do ask for carer information when patients register. The Practice also periodically ask patients to alert the Practice if they take on a caring role. Posters are also available in the waiting area about carers. This is good practice.

8.1.44. Mrs Moyo had listed her daughter-in-law as carer and there was no record of Joseph living with her. The GP Practice had had limited contact with Mrs Moyo during the scope period and no concerns were expressed or identified. Mrs Moyo's relationship with Joseph was largely unknown.

8.1.45. The Offender Manager was aware that Joseph was living with his mother and that she had ill health but had limited information about their relationship. As no risk had been identified, there was no basis to make more detailed enquiry or carry out a home visit.

8.1.46. The Domiciliary Care Agency had received information from LCC when they were first commissioned to provide care for Mrs Moyo. This stated that Mrs Moyo did not have any responsibilities as a carer. Mrs Moyo had told them that Joseph helped her with meals. LCC had reviewed Mrs Moyo's support package in December 2018. There was no reference to Joseph being in the household.

8.1.47. Reviews must be cautious to avoid hind-sight bias i.e. judging outcomes on information that was not known at that time. It would be dis-proportionate, intrusive

and a breach of data protection, for Health and Social Care agencies to gather detailed personal information about others in the household without justifiable and lawful basis e.g. safeguarding concerns.[24] At this stage, there were no safeguarding concerns identified. Nonetheless, when LCC carried out a Mental Health Act assessment in 2014, their report referenced he had been verbally and physically aggressive to Mrs Moyo's carers. LCC was providing home care services to Mrs Moyo at that time. The LCC representative to the review identified a missed opportunity for LCC to have linked their electronic records for Joseph and Mrs Moyo. This could have 'flagged' this incident of Joseph's aggression as a future potential risk. This was important safety information for the Domiciliary Care Agencies' staff. It should also have prompted additional vigilance by LCC in their reviews and provoked further enquiry about Joseph and his relationship with Mrs Moyo.

[Recommendation 5]

8.1.48. Ultimately, the review concluded that there was no information to indicate Joseph was being aggressive or violent to Mrs Moyo during this period, March 2018 – September 2019, or that agencies missed indicators of abuse. Joseph has also stated this to be the case. There is also nothing to suggest that Joseph or Mrs Moyo needed more specialist or intensive services at that time.

8.1.49. However, the review has identified important factors for earlier intervention that may have made a difference to the events that followed. In summary:

1. Importance of a shared understanding across agencies of Joseph's mental health needs; relapse indicators and risk assessment when well and when in relapse
2. For agencies to understand the nature of carer roles and 'significant others' and incorporate this into assessments of assets, protective factors, stress factors and risks.
3. The need to improve communication between probation and AMHS in working with offenders, pre-sentence, in release planning and post release support and monitoring.
4. The importance of GP registration to support step-down from secondary mental health services and to coordinate response to relapse.
5. Where a person is not registered with a GP, the need to consider the impact of this within discharge planning and communications with others involved.

8.1.50. The following section considers the impact of these not being in place.

[24] Data protection Act 2018 https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted [Accessed May 2021]

8.2. Episode 2: Responses to the escalating concerns October 2019 – December 2019

8.2.1. It is poignant that in the 6-week period leading up to the assault, Mrs Moyo's family phoned agencies on nine occasions to raise concerns about Joseph's mental health, his behaviours, and the safety of Mrs Moyo.

8.2.2. From the family's perspective, Aaron and Jasmin tried repeatedly to access help from different services. They had good knowledge of Joseph's relapse indicators and knew from experience how aggressive he could be when mentally unwell and/or under the influence of substances.

8.2.3. Aaron and Jasmin also knew that Mrs Moyo was scared but was not able to freely express this because of intimidation from Joseph. They tried to convey this to services. When they contacted services, (AMHS, LCC and Probation), they were redirected to emergency services. When they contacted those services and those services phoned or visited Mrs Moyo., she would not disclose what was happening. From the family's perspective, they were going round in circles without getting any resolution.

8.2.4. In reviewing the whole chronology of events, it is now evident that:

1. There was a high volume of calls from family within a short period.
2. Concerns about Joseph's presentation mirrored features of past relapse.
3. There were unexplained inconsistencies: Mrs Moyo's assertions that all was well did not fit with Aaron and Jasmin's recurrent concerns and their description that she was fearful of Joseph.

8.2.5. At the time, this was not known to any single agency. The question for the review was whether there were opportunities for agencies to have seen this picture.

8.2.6. The concept of 'bringing together the jigsaw' is often used in safeguarding. Learning from a national review of SAR's found multi-agency coordination and information-sharing were most prevalent issues raised in the SARs.[25]

8.2.7. There were pockets of inter-agency communication – between AMHS and police; LCC and AMHS; ambulance service and police. However, without a GP there

[25] LGA: National Learning from Safeguarding Adult Reviews (SARs): Analysis of Safeguarding Adult Reviews: April 2017 - March 2019: Michael Preston Shoot et al 2021 Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk) [Accessed May 2021]

was no central coordination point. These pockets of inter-agency communication did not combine to bring together the full picture of concerns.

8.2.8. There was learning for individual agencies. LCC recognised missed opportunities and fundamental omissions in the response by their Contact and Response Team to the two phone calls from Jasmin.

8.2.9. The LCC Contact and Response Team, is staffed with Care Management Officers (CMO) and acts as the front door to Adult Social Care. This includes access to Approved Mental Health Professionals (AMHP). AMHPs have a statutory role to provide assessments under the Mental Health Act, to determine whether compulsory detention for mental health assessment and treatment is necessary.

8.2.10. LCC identified that there had been a blinkered, task led approach by the Contact and Response Team. This got in the way of the CMO using their professional skills in risk assessment. There was also an incorrect application of procedures.

8.2.11. The CMO had focused on taking information to see if a referral for an AMHP assessment should be made. However, the CMO should not be providing a gatekeeping role to the AMHP service. AMHP's have additional specialist training for the role, [26] and it is for the AMHP to decide whether an assessment under the Act is required.

8.2.12. The CMO was aware of the rights of the Nearest Relative under section 13(4)[27] of the Mental Health Act to request an assessment (with a view to detention into hospital) and the duty on the Local Authority to respond. However, the CMO and team leader's interpretation of this duty was incorrect.

8.2.13. The CMO had advised that Mrs Moyo (as Nearest Relative) had to be the one to make the request. This is incorrect as the request can be made *on behalf* of the Nearest Relative i.e. through Jasmin, and the Local Authority must respond as if it were a direct request from the Nearest Relative. The AMHP would have been under a duty to 'consider the patient's case' and if the decision were not to undertake a formal assessment, to write giving reasons to the referring relative.[28]

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[26] Health and Care Professions Council: AMHP Criteria https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/amh-criteria/ [Accessed May 2021]
[27] Department of Health Mental Health Act 1983 Code of Practice Ch 14
[28] Ibid

8.2.14. LCC Contact and Response Team do have an AMHP Referral Flowchart protocol that sets out the information required. The protocol is to inform the AMHP Manager of the referral so that an AMHP can be assigned to consider the referral.

8.2.15. AMHPs make enquiry into all circumstances of the case. It is likely that this would have uncovered:

- Past Mental Health Act assessments of Joseph, revealing the same pattern of relapse and risk to others within a domestic setting.
- AMHS records documenting his last prison sentence and the CMHN's last risk assessment.
- Identifying that Joseph was on license and had an Offender Manager.
- Mrs Moyo's care and support needs (and consequent additional vulnerabilities) and the involvement of Domiciliary Care agency.
- Absence of a GP to support mental health and access AMHS crisis services.

8.2.16. It is feasible that these enquiries would have led to a different chain of events.

The AMHP may have decided a full Mental Health Act assessment was warranted. It is not possible to say what the outcome of this would have been, but a decision not to detain Joseph would have led to an alternative care plan. Even had the AMHP decided a full Mental Health Act assessment was not required, other agencies contacted within their enquiries, would have been sighted on the concerns at an earlier stage. This gave an opportunity for an agreed contingency plan between the AMHP service, AMHS and Probation. This information would also then be accessible to police (via the Mental Health Car). The AMHP's involvement could also provide a central contact point to collate concerns from family as the situation escalated, triggering further assessment.

8.2.17. Once the LCC CMO made the decision not to refer to the AMHP, it appears they did not consider there was any further role. There was no reference within the record to a risk assessment and no check made to understand Mrs Moyo's vulnerability factors and that she was known to LCC.

8.2.18. The LCC CMO, did try and provide a supportive response, for example, sourcing information about how to access mental health services and phoning back for an update on the home situation. However, LCC identified a lack of safeguarding orientated practice to the clear indicators of concern expressed by family. Their concerns were not explored further to assess the potential for domestic abuse and the need to raise a safeguarding alert. Each contact was viewed episodically.

8.2.19. Had the matter been considered under the safeguarding arena, this would also have provided the multi-agency mechanism to pull together the information across agencies, revealing the picture of the escalating concerns. This was a missed opportunity for multi-agency safety measures and support.

[Recommendation 5]

8.2.20. Probation also highlighted that their service should have considered a safeguarding alert when Aaron raised concerns. They did provide advice about immediate safety and arranged a home visit, but Probation reflected the duty Offender Manager could also have asked the police about any call out information and to consider a visit.

8.2.21. Police also reflected the officer should have completed an Adult at Risk, Public Protection Notice for Joseph – this being the mechanism to notify other agencies of concerns. Police did complete a DASH risk assessment form following one of their attendances, in line with guidance for domestic abuse response. At the time, Mrs Moyo asserted that she was 'okay' and happy for Joseph to stay at home.

8.2.22. Attendees at the Learning Event discussed the challenges in responding to Aaron and Jasmin's concerns in the face of denial by Mrs Moyo.

8.2.23 The Care Act statutory guidance requires agencies to safeguard adults in a way that is 'Making Safeguarding Personal.' This means being person-led and outcome focused, enhancing choice and control as well as wellbeing and safety. The guidance also references the need to assess the risk of harm and to be confident that the adult is not being unduly influenced, coerced or intimidated and is aware of all the options. Information sharing between professionals enables them to check the safety and validity of decisions made.[29]

8.2.24 Research into domestic abuse recognises there are many well founded reasons why people at risk of, or experiencing domestic abuse, may chose not to disclose. Some of the reasons cited may have had significance for Mrs Moyo: coercion; fear for future safety; emotional attachment towards the abuser and the hope that their family member will change; feelings of shame or failure; religious or cultural expectations; previous experience and/or fear that the issues and concerns of people from their community will be poorly understood or ignored.[30] There may

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[29] HM GoverJosephent Statutory guidance Care and support statutory guidance Updated 21 April 2021 https://www.gov.uk/goverJosephent/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 {Accessed May 2021]

[30] Local GoverJosephent Association Adult safeguarding and domestic abuse A guide to support practitioners and managers 2015 https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf [Accessed May 2021]

have been many complex emotional and psychological reasons as well as practical and social/cultural barriers to Mrs Moyo talking opening to professionals.

8.2.25. Information from agencies suggests Mrs Moyo was an independent person and understandably, was protective of her son. This was maintained even after the assault. LPT observed that it seemed unlikely that Mrs Moyo would answer any direct questioning about domestic abuse truthfully. This may have been true, but there were moments when Mrs Moyo did appear to reach out for help – her confirmation to LCC of Joseph's aggressive behaviour and her 999 call to the police (albeit retracted). It remains beholden on agencies to give opportunities to disclose. Guidance references:

8.2.26. '*Whilst some people will have good and trusting relationships with professionals who can support them to report and deal with domestic abuse, others will not trust agencies to respond effectively or will fear further loss of independence. People with these concerns may need more time to build trust and confidence and require a positive indication that they will be supported before they disclose to professionals*.'[31]

8.2.27. The LCC representative to the review felt there was a missed opportunity by their service to visit the home to try and establish this relationship and make further enquiry. Joseph asserts that his mother would have been able to talk about any concerns she had.

8.2.28. The guidance also discusses the need to undertake safe enquiry, for example, talking with the person on their own and providing sufficient time to help the person talk about their situation and what they want to happen.

8.2.29. The review identified learning as well as good practice in relation to safe enquiry. When Jasmin contacted NHS 111, she described concerns about Joseph's mental health and that he took the phone from Mrs Moyo if anyone rang her. NHS 111 then phoned Mrs Moyo. DHU Healthcare, who provide the NHS 111 service, reported that due to their limited contact, they were not able to carry out any risk assessment or to consider coercion.

8.2.30. It is not known whether the caller had recognised the indicators of domestic abuse or had considered how to make safe enquiry. NHS 111, being a phone-based service is challenged in how to ensure safe enquiry. However, given the information that was available, the call handler should have considered potential risks and considered making a Safeguarding Adult notification. NHS 111 should also notify the

[31] Ibid

patient's GP of any call. DHU Healthcare confirmed that details of all NHS 111 contacts are automatically sent through to the patient's GP within minutes of the call being completed. However, as Joseph was not registered, there was no GP to notify. The call did also entail considering Mrs Moyo's health and safety. However, there is no record that Mrs Moyo's GP Practice was notified of the call and nature of the concern. NHS 111 did however, contact Jasmin and gave advice to contact police if concerned.

8.2.31. DHU Healthcare confirmed that staff receive training on safeguarding. Learning from this review should be used within their training on safeguarding adults and domestic abuse.

[Recommendation 4]

8.2.32. Responses by police did demonstrate safe enquiry. The initial response was by phone, but they confirmed that Mrs Moyo was on her own. Mrs Moyo reported she was safe and well. As police received further reports of concern, these were linked and resulted in home visit by police. On the first occasion, it is not clear whether, Mrs Moyo was spoken to on her own. Officers did speak with her home carer for corroboration. On their second home visit, officers spoke with Joseph and Mrs Moyo separately and completed a DASH form. This was good practice, albeit expected practice.

8.2.33. As noted, despite this safe enquiry, there may have been multiple barriers to Mrs Moyo sharing what she really thought or disclosing if there had been any further incidents of threatening behaviour or violence. Mrs Moyo has maintained her privacy in relation to the detail of what she experienced in the period leading up to the assault.

[Recommendation 4]

Episode 3: Restorative Care Following the Assault December 2019 – January 2020

8.3.1. Following the assault, agencies were responsive and demonstrated effective multi-agency practice that was in line with Making Safeguarding Personal.

8.3.2. Police responded quickly and efficiently, protecting Mrs Moyo by arresting Joseph and making a referral to MARAC. Probation initiated recall procedures for Joseph. LCC and AMHS carried out a Mental Health Act assessment and began safeguarding procedures.

8.3.3. UAVA assigned an Independent Domestic Abuse Advisor (IDVA) to support Mrs Moyo and LCC allocated a hospital Social Worker. Those practitioners endeavoured to help Mrs Moyo to talk through her traumatic experience, helping her

work through options for her restorative care. Mrs Moyo's decision not to press charges was respected. LCC developed a Safeguarding Protection Plan, based on Mrs Moyo's wishes to reduce risks in the future. This had agreed actions for UAVA, police and the Social Worker.

8.3.4. Mrs Moyo did not wish any further support. LCC recorded that the Safeguarding Adults alert met the threshold for a Care Act section 42 enquiry[32] but was not progressed. The LCC review representative raised a learning point relating to this. Their view was that the Safeguarding Alert should have proceeded with a section 42 enquiry. They noted that in situations where the risks are high, a safeguarding alert can progress without consent from the adult.

8.3.5. As a Safeguarding Protection Plan had been made, in practice, this appears to have been a matter of recording practices rather than affecting the outcomes for Mrs Moyo. Nonetheless, accurate recording of safeguarding activity is important in collating a chronology of concerns for future responses to the person, as well as providing reliable data for the Local Authority reporting on their statutory duty and for the Safeguarding Adult Board.[33]

9. What has changed

9.1. There have been some national and local changes that are relevant to the learning, that have taken place since the incident of assault to Mrs Moyo.

9.2. Nationally, there has been work by the National Offender Management Service and the NHS to improve support and monitoring of offenders on release. The 'Through the Gate' programme aimed to produce a plan for the offender's resettlement, prior to their release, including a requirement to ensure the person was registered with a GP before they leave prison. NHS Digital has also introduced a Health and Justice Information Service[34] and NHS England has also documented a process for the prison healthcare service provider to register the offender with a GP.[35]

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[32] Care Act 2014 section 42 Duty on the Local Authority to make a safeguarding adult enquiry subject to specific criteria https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

[33] Local GoverJosephent Association Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording 2018

[34] NHS Digital Health and Justice Information Service https://digital.nhs.uk/services/health-and-justice-information-services

[35] NHS England Process for registering patients prior to their release from the secure residential estate 2020 https://www.england.nhs.uk/publication/process-for-registering-patients-prior-to-their-release-from-prison/ [Accessed May 2021]

9.3. There have been radical reforms within probation service as a result of the Governments probation reunification programme.[36] The 'Through The Gate' programme has been disbanded. However, probation practitioners will work in both HM Prisons and in community settings which should aide continuity of care plans and the flow of information. The Strategic Offender Management MAPPA Board is working to improve partnership working between probation and mental health services. Learning from this review will be helpful to inform these developments and improve communication and coordination of care between AMHS and Offender Management.

[Recommendation 1]

9.4. Locally, since March 2020, the Adult Safeguarding Hub has been reviewing DASH Public Protection Notifications from the police so that these lead to safeguarding adult and/or domestic abuse referrals where appropriate.

9.5. LCC is also proposing strengthening processes and training for staff within their Contact and Response team so that staff are more risk aware on receiving AMHP requests, especially with regards to carers. Staff will be encouraged to make enquiries about anyone in the household with care and support needs and all referrals will go to the AMHP service for their decision on further actions required.

9.6. Since 2020, LPT has opened a Crisis Mental Health Hub at the Mental Health Unit where people and their families can self-refer for urgent mental health support to a central access point by telephone. Calls are triaged, and if a face-to-face assessment is required, this can be provided at the Mental Health Hub. This service can be used by patients who are not registered with a GP.

9.7. LPT has also proposed adding a standard question to all LPT assessments where carers are involved, enquiring how they are coping and whether they need more support. If the adult has declined to consent to the carer's involvement and where risks are present, practitioners will be directed to the LPT Safeguarding Team for advice. LPT also proposed adding a question into the assessment documentation used by all their services, regarding whether people have experienced abuse, either historically or currently.

10. Conclusions

10.1 This review arose following a serious assault to Mrs Moyo by her son. The review has considered whether there were earlier opportunities for preventative, risk reduction measures by agencies involved. The review also considered the

[36] HM Gov. Strengthening probation, building confidence https://www.gov.uk/guidance/strengthening-probation-building-confidence [Accessed June 2021]

responsiveness of agencies to the family's mounting concerns. In both these aspects, there were elements of good practice but also learning for agencies.

10.2 There were missed opportunities for agencies to collaborate at an earlier stage. Although there were no concerns of domestic abuse at that time, this would have developed a fuller understanding of risks and vulnerabilities and established key components of care. Registration with a GP was an important element of this. Had these foundations been in place, it would have provided a contact point for family concerns and aided communication between agencies.

10.3 There were some effective responses by individual agencies to the concerns raised by the family. However, the family's concerns should have triggered consideration of a Mental Health Act assessment and a Safeguarding Adult Enquiry. Had these assessments taken place, this would have revealed an escalating picture and the opportunity to agree safety measures.

10.4 Ultimately, it is not possible to say whether agencies could have prevented the assault to Mrs Moyo. The review recognised the multiple barriers that people may face in disclosing domestic abuse, many of which may have been faced by Mrs Moyo. Agencies have a responsibility to work together to try and reduce those barriers, supporting the adult to reduce risks of harm.

10.5 The recommendations aim to address these learning points from the review.

11. Recommendations

Recommendation 1: Procedural Development, Monitoring and Review
11.1. Leicester's Strategic Offender Management MAPPA Board should use learning from this review to inform their strategic plan for 2021-2022, specifically, the action to improve publicity, pathways and gateways into mental health services. 11.2. The Strategic Offender Management MAPPA Board should seek to develop mechanisms to strengthen partnership working between AMHS and Probation pre-sentence, pre-release, and post-release. This Board should also seek assurance on the quality of the release plans and that registration with a community GP is a component within the release plan.

Recommendation 2: Procedural Development, Monitoring and Review
11.3 Learning from this review should be shared with the relevant Ministry of Justice and Home Office departments (Her Majesty's Prison and Probation Service and Domestic Abuse). The learning should be used to influence national policy and guidance on the need for information sharing and joint work between AMHS and Probation at key junctures in the offender pathway: pre-sentence (including Fast Delivery Reports), pre-release, and post-release.
Recommendation 3: Procedural Development
11.4. LPT need to assure that their policies (and application of those policies) for Did Not Attend and Discharge, take adequate account of circumstances when a patient is not registered with a GP i.e. • Reasonable attempts are made to support service users to register with a GP. • Lack of GP registration is factored into risk assessment and, • Risk assessment is used to inform proportionate communications with other agencies, family and carers, in line with information sharing guidance. 11.5. It is important that all agencies play a role in encouraging people to register with a GP. The contribution of the Leicester City CCG in providing guidance and raising awareness of access routes to register with GPs, will assist in this.
Recommendation 4: Staff Support
11.6. LCSAB and its constituent agencies, should use learning from this SAR to inform training and supervision, in relation to safeguarding and domestic abuse: i) Reinforcing the value of multi-agency collaboration ii) Recognition of carers and significant others within assessments, including consideration of assets, protective factors, stress factors and risks. iii) Fundamentals of a robust risk assessment; understanding and working with barriers to disclosure (including safe enquiry).

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Date: June 2021

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12. Key to acronyms / abbreviations

Key to acronyms/ abbreviations

AMHP Approved Mental Health Professional

AMHS Adult Mental Health Service

CMHN Community Mental Health Nurse

CMO Care Management Officer

CRC Community Rehabilitation Company

DASH Domestic Abuse Stalking Harassment

IDVA Independent Domestic Violence Advisor

LCC Leicester City Council

LCSAB Leicester City Safeguarding Adult Board

LPT Leicestershire Partnership NHS Foundation Trust

MARAC Multi Agency Risk Assessment Conference

PPN Public Protection Notification

SAR Safeguarding Adult Review

UAVA United Against Violence and Abuse

13. References

Chantler K, Robbins R, Baker V, Stanley N. Learning from domestic homicide reviews in England and Wales. Health Soc Care Community. 2020;28:485–493. https://doi.org/10.1111/hsc.12881 [Accessed May 2021]

DASH Checklist https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009-2016-with-quick-reference-guidance.pdf [Accessed April 2021]

Data protection Act 2018 https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted [Accessed May 2021]

Department of Health (2015) Mental Health Act 1983: Code of Practice

Department of Health Responding to Domestic Abuse A Resource for Health professionals https://assets.publishing.service.gov.uk/goverJosephent/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf [Accessed April 2021]

Health and Care Professions Council: AMHP Criteria https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/amh-criteria/ [Accessed May 2021]

HM Gov: Guidance Risk Assessment of Offender 2019 https://www.gov.uk/guidance/risk-assessment-of-offenders [Accessed May 2021]

HM Gov. Strengthening probation, building confidence https://www.gov.uk/guidance/strengthening-probation-building-confidence [Accessed June 2021]

HM Government Care and support statutory guidance Updated 21 April 2021 https://www.gov.uk/goverJosephent/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1 {Accessed May 2021]

Leicester, Leicestershire and Rutland Safeguarding Children and Adult Boards Trilogy of Risk: Awareness Raising Resources https://lrsb.org.uk/trilogy-of-risk [Accessed May 2021]

Leicestershire Partnership NHS Trust, The Management of Attendance/Did Not Attend 2017

LGA; ADASS Adult Safeguarding and Domestic Abuse A Guide to Support Practitioners and Managers 2015 https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf [Accessed April 2021]

LGA Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording 2018

LGA: National Learning from Safeguarding Adult Reviews (SARs): Analysis of Safeguarding Adult Reviews: April 2017 - March 2019: Michael Preston Shoot et al

2021 Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk) [Accessed May 2021]

Manthorpe et Al (2015) Supportive practice with carers of people with substance misuse problems http://wels.open.ac.uk/research-project/caren/node/2144 [Accessed April 2021]

NHS Digital Health and Justice Information Service https://digital.nhs.uk/services/health-and-justice-information-services NHS England Five Year Forward View for Mental Health A report from the independent Mental Health Taskforce to the NHS in England 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [Accessed May 2021]

NHS England Process for registering patients prior to their release from the secure residential estate 2020 https://www.england.nhs.uk/publication/process-for-registering-patients-prior-to-their-release-from-prison/ [Accessed May 2021]

NHS England Reconnect: Care After Custody https://www.england.nhs.uk/ltphimenu/wider-social-impact/reconnect-care-after-custody/

NICE Psychosis and schizophrenia in adults: prevention and management https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#support-for-carers [Accessed May 2021]

NICE Psychosis and schizophrenia: Scenario: Primary care management 2021 https://cks.nice.org.uk/topics/psychosis-schizophrenia/management/primary-care-management/ [Accessed May 2021]

Royal College of Nursing Domestic Abuse Guidance for Nurses and Midwives to Support those affected by domestic abuse 2020 file:///C:/Users/sylma/Downloads/009-301.pdf [Accessed April 2021]

Social Care Institute for Excellence Eligibility criteria under the Care Act 2014 https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria [Accessed April 2021]

The Centre for Mental Health From Prison to Work 2018 https://www.centreformentalhealth.org.uk/publications/prison-work [Accessed May 2021]

University of Manchester National Confidential Inquiry into Suicide and Safety in Mental health Annual report 2019 https://www.research.manchester.ac.uk/portal/files/162072409/NCISH_2019_Report.pdf [Accessed May 2021]

Appendix 1: Terms of Reference

1. To consider the effectiveness of responses to Mrs Moyo's and Joseph's needs I. To understand the factors precipitating Joseph's violent behaviour e.g. mental disorder, substance abuse and/or other behavioural or personality traits II. What were the quality of risk assessments of Joseph and Mrs Moyo as carer of Joseph? III. How visible was Mrs Moyo as an adult with care and support needs being at risk of abuse (including domestic abuse) from her adult son? IV. Did practitioners recognise that 'Trilogy of Risk' was present in this case and was a 'Think Family' approach taken? Where this was recognised, what supported this recognition? V. What prohibited practitioners from identifying Mrs Moyo as a potential victim of domestic abuse in this context? VI. How well did agencies recognise and respond to safeguarding concerns including potential indicators of domestic abuse? Are practitioners aware of appropriate urgent and non-urgent referral routes for an adult with care and support needs at risk of domestic abuse? Where practitioners are aware, what has supported this awareness? VII. What was the quality of the care plans, including risk management and contingency plans for Joseph? Were reasonable steps taken to proactively engage Joseph in care, proportionate to risks presented? VIII. What was the quality of agencies' assessments and interventions in responding to i) Mrs Moyo's own care and support needs ii) her needs as a carer for Joseph? IX. How well did agencies involve Mrs Moyo in the assessment, care and treatment of Joseph? X. How was Making Safeguarding Personal demonstrated in the care and support offered to Mrs Moyo? How well was mental capacity and the potential for coercion considered? XI. How well did agencies consider equality and diversity and make reasonable adjustments accordingly?
2. To consider how effectively agencies worked together. i. How effective was multi-agency working in communication, critical decision making and coordination of care for Joseph and Mrs Moyo?

3. **To consider the systems in which services operated and how this supported or detracted from care provided.**

i. How were practitioners supported by managerial oversight and supervision at critical points in decision making?
ii. Was relevant legislation, guidance, policies and procedures followed by staff involved in the process? To include (as relevant to agencies):
    - Care Programme Approach
    - Did Not Attend policy
    - NICE guidance
    - Domestic Violence guidance
    - Care Act 2014
    - Mental Health Act 1983(revised 2007) including section 13(4)
iii. Were policies and procedures adequate in supporting staff to provide effective care and support?
iv. Joseph was not registered with a GP. What impact did this have on responses to Joseph and to Mrs Moyo? Are there adequate systems in place to support people and their carers, in need of care and support but who are not registered with a GP Practice?
v. Were there organisation or wider systems factors that aided or presented barriers to providing effective response to Mrs Moyo or Joseph?