Safer Leicester Partnership
Working together for a safer City

DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of John in April 2018

Independent Chair and Author: Mark Wolski

Date of Completion: July 2021

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1. The Review Process

1.1 This summary outlines the process undertaken by Safer Leicester Partnership, Domestic Homicide Review panel in reviewing the circumstances of the death of John who was a resident in their area.

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

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
John	Deceased	62	White British
Audrey	Wife	60	White British
Giles	Son	Adult	White British
Elizabeth	Sister of Deceased	Not relevant	White British
Barbara	Sister of Deceased	Not relevant	White British
Thomas	Brother in Law of Deceased	Not relevant	White British

1.3 A criminal trial against his wife Audrey for Gross Negligence Manslaughter was discontinued in April 2019 when the Crown offered no evidence.

1.4 The coronial proceedings are not yet complete

1.5 SLP's DHR sub-group reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and recommended to the Chair of the SLP that a DHR should be undertaken. The Chair ratified the decision November 2018 and the Home Office was notified on 7th January 2019.

1.6 All agencies that potentially had contact with John and Audrey prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2. Contributors to the Review

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with John and Audrey. A total of eleven agencies responded saying they had no contact. Four agencies responded saying they did have contact.

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

Agency	Nature of the contribution
Leicestershire Police	Factual Report
Leicester City Council (Housing)	IMR
Clinical Commissioning Group	IMR
East Midlands Ambulance Service	Factual Report

2.3 IMRs and factual reports were completed by authors who were entirely independent of any prior involvement with John and Audrey.

2.4 The authors assisted the panel further, answering follow up questions as necessary.

3. The Review Panel Members

3.1 The review panel members included the following agency representatives.

Agency	Name	Job Title
Leicester City Council	Mark Fitzgerald	DHR Officer
Leicestershire Police	Siobhan Barber	Detective Inspector - Serious Crime Partnership Manager
Clinical Commissioning Group	Carol Richardson	Named Professional Safeguarding Adults Leicester City CCG Hosted
Leicester City Council - Adult Social Care	Jo Dyke	Principal Social Worker
Leicester City Council - Housing	Nick Griffiths	District Manager
United Against Violence and Abuse (UAVA)	Suki Kaur	Chief Executive Officer of UAVA
Foundry Risk Management	Mark Wolski	Independent Chair
Foundry Risk Management	Peter Stride	Co-chair

3.2 The review panel met on six occasions.

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

4. Author of the Overview report

4.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 30 years-service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding. (see Appendix A for Statement of Independence)

4.2 Mark has no connection with Leicester or any agencies involved in this case.

5. Terms of Reference for the Review

5.1 The primary aim of the DHR was defined as examining how effectively Leicester City's statutory agencies and Non-Government Organisations worked together in their dealings with the victim and perpetrator in this case. In particular the review panel aims were to:

- Establish whether there are lessons to be learned about the way in which local professionals and agencies worked together to safeguard domestic violence victims and their children
- Safeguard potential victims by:
  - reviewing policies and processes to improve inter-agency partnership working
  - analysing gaps in information and practice
  - identify and sharing lessons on behalf of the SLP

- recommending areas for improvement.
- Clarify what any lessons are, how they will be acted upon and what is expected to change as a result, and
- Improve inter-agency working and improve protection for domestic violence victims.

5.2 Discussion at the first panel meeting showed that there was very little contact with agencies with the exception of John's GP who had contact in relation to medical conditions. It was therefore agreed that the DHR would benefit from considering John's care needs and those of his wife as a carer. In particular it would explore:

- his wife's role in representing John with the GP.
- to what extent she was vulnerable as a 'carer'.
- whether there were barriers to her seeking assistance as a 'carer'.

5.3 The timeframe for this DHR was agreed as from 19th June 2014 to 19th June 2017. This was considered proportionate on the basis of the initial scoping carried out by Safer Leicester Partnership.

6. Summary Chronology

6.1 John and Audrey had limited contact with statutory agencies. John suffered from a number of medical issues that limited his mobility and required his regular attendance at his local GP practice. There was also regular contact with Leicester City Housing Department. There was no known history of Domestic Abuse.

6.2 He had been married for over 35 years and had one son and a number of grandchildren, living in a council house in one of the most derived areas in the UK.

Family Perspective

6.3 John was one of eight children, many of whom have passed away or are estranged.

6.4 The chair was able to speak to three surviving family members who described John as having financial worries, finding it difficult to make ends meet and who was becoming increasingly immobile.

6.5 Financial concerns were made worse by a reluctance to downsize to more suitable accommodation and thereby avoid what is known as a 'bedroom tax'. The family attribute this to a desire to have additional bedrooms so that they could babysit the grandchildren, allowing the parents to go to work.

6.6 Family described John's physical appearance in terms of his clothing, wearing threadbare clothes and shoes with no soles as indicative of financial problems and the fact that they believe Audrey was more focused on spending money on the grandchildren.

6.7 His family and friends also recall his immobility through physical problems with his knees and also in respect of his reliance on medication for a blood disorder. It seems that they also did not maintain contact with John and in part this is attributed to the fact that they did not like going around to his house, that was described in terms varying from not being very pleasant to horrific.

6.8 It was also clear to the chair, that those interviewed did not have fond feelings for Audrey, recalling someone who spent her time knitting and smoking.

John - Agency Contact GP

6.9 John maintained frequent contact with his GP to manage his ongoing physical ailments and in particular to have at times monthly checks on his blood

6.10 There were infrequent opportunities that may have been considered trigger events. In September 2013, his brother-in-law expressed disquiet as to how the GP did not visit him at home and also said that his wife was not bothered about him. The panel noted that practice had changed and a clinical response team would have visited him had it been available and that the Care Act was not in existence, but agreed that a comment about a spouse not caring ought to have prompted greater interest

6.11 In September 2014 he attended the surgery with a minor injury. This was treated, but there was no evidence in respect of exploring personal safety or domestic abuse.

6.12 The panel learned that there was no evidence of routine screening in respect of Domestic Abuse or wider social care issues, that may have been apparent by John's physical appearance, the clothes he wore or when dealing with injuries. However, A Domestic Abuse policy, training regarding recognition and response was introduced in March 2018. In addition, the GP practice has now voluntarily introduced social prescribing that enables patients to be referred to a social prescriber.

6.13 There were also occasions when John missed his appointments owing to John's immobility and also his financial difficulty that precluded his travelling to the GP. Follow up contact by the GP was frustrated by John not being able to afford his own phone reflecting his broad social circumstances.

6.14 In February 2017, John's medication was changed in order to avoid the need for such frequent attendance at the surgery for blood tests.

6.15 The panel explored whether Audrey had a recognised role as a carer and in the absence of her engagement, were only able to learn she was not registered as a carer.

Housing

6.16 There was frequent contact with the local housing department, in respect of managing rent arrears broadly resulting from the 'bedroom tax'.

6.17 In 2015, John and Audrey were offered practical advice and support by Support for Tenants and Residents (STAR) in managing their arrears. In their dealings with John and Audrey, it was clear that Audrey managed the budget within the household, with John saying that he knew almost nothing about their finances.

6.18 In July 2016, John and Audrey were served notice of an intention to seek possession, but this was not proceeded with as STAR supported them in managing budget payments for their rent and through arranging discretionary housing payments.

6.19 The housing department did also make efforts to secure house swaps for John and Audrey to alleviate the financial burden, but it seems that these were declined owing to Audrey's reluctance to downsize.

6.20 The panel explored the frequency of contact and keeping in mind family observations about the cleanliness of the house, sought clarity as to the state of the home. Housing officers did report that many of the transactional conversations took place on the doorstep, but that when they did enter the house it appeared cluttered and not out of the ordinary

6.21 Upon exploring the management of the finances, it was apparent that Audrey managed the day to day finances, John saying “Speak to the wife”. The panel were unable to triangulate whether management of money was of a controlling nature, or the agreement within the household.

Police

6.22 There is only one entry regarding either party. In October 2014 Audrey was dealt with by way of a Restorative Justice Outcome for a low value shoplifting offence.

East Midlands Ambulance Service

6.23 The ambulance service had no dealings with John or Audrey until the day they were called to his home in June 2018 and found John collapsed and unresponsive on the floor. The crew reported Audrey seem unperturbed and completed a Safeguarding referral as they learned he had been left on the floor for 2 days and owing to their observations about the condition state of the home. They conveyed him to hospital where he subsequently died.

Summary of Events Leading to John’s death.

6.24 John died as a result of acute physical conditions and systemic effects of immobility. One Friday in June 2017 John suffered a fall in his home. He was unable to mobilise and remained on the floor until the Sunday. On that Friday evening, John’s daughter in law brought all the grandchildren to John’s house as was usual for a Friday evening. Though his daughter in law tried to help him get up, she left and John remained on the floor. John’s son Giles also attended the address to collect one of the children and John was playing with his grandchildren on the floor at this time. On the Sunday of that weekend, John’s daughter in law returned and collected her children. John was immobile and his breathing laboured. She called John’s son and left with the children. When Giles arrived, he called the East Midlands Ambulance Service.

6.25 He was conveyed to the local hospital where he was treated for a number of conditions including sepsis, acute renal failure, cardiac congestive failure and a condition whereby the muscles break down from a continued period of lying down. His health continued to deteriorate, and he died in the early hours of that Monday.

7. Conclusions and Key Issues Arising from the Review

7.1 This is a sad case of a man who suffered from ongoing health issues that contributed to his death. The actions of immediate family were subject to a police investigation and crown prosecution service decision making that resulted in his wife Audrey being summoned to court to answer a charge of gross negligence manslaughter. The decision was ultimately taken not to proceed with the prosecution. John’s limited contact with services, and unfortunately the absence of additional information from his immediate family, has meant that John’s voice is less well represented in this review than would have been hoped. The panel is grateful for the assistance provided by other family and friends, albeit their information pre-dates most of the relevant period.

Domestic Abuse

7.2 John died as a result of acute physical conditions and systemic effects of immobility following a fall. Considering the government definition of domestic violence and abuse,

which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was not able to determine whether there was a history of abuse.

Financial Hardship

7.4 Financial hardship was a factor in John's life, apparent in his engagement with housing and how he appeared to friends and family. He lived in one of the most deprived wards in one of the most deprived authorities in the UK and the panel learned that John's circumstances were not atypical. This was potentially isolating for John, such as being unable to afford transport to the doctor and arguably had an effect on his overall well-being. Housing services guided John and Audrey with budget management, and offered to help them 'down-size' to reduce outgoings associated with a bedroom tax. Ultimately John and Audrey decided not to move to reduce the issues of financial hardship. What one cannot determine, is the extent that financial hardship was owing to choices made, such as not down-sizing, how the family finances were managed by Audrey, spending on grandchildren, a combination of these or other factors.

Well-being, Safety, Professional Curiosity

7.5 Whilst the panel has not been able to identify a trail of abuse, there is evidence of a man with long standing medical needs, whose circumstances impacted on his health and well-being. Whilst he may not have met the threshold for a Safeguarding Alert, he may have benefitted from the offer of a care assessment

7.6 In his contact with agencies, there was a focus on the immediate issues presenting, in the case of housing his rent arrears, whilst his GP focused on the medical issues that beset John. And yet we now know that his family had described his home environment as horrific and that he wore threadbare clothes. Indeed, the ambulance service reported that the condition of the home was one of the factors prompting a Safeguarding Alert.

7.7 Balanced against these observations, it was reported John rarely gave cause for concern in respect of either his safety or well-being to medical or housing professionals. The panel does not conclude there were clear and obvious signs of having well-being needs, rather the need of professionals to be alert to the potential signs including physical appearance and environmental circumstances of the home.

Desensitisation

7.8 The potential for professionals such as housing operatives to be desensitised or normalising what they observe, when dealing with people in adversity was considered by the panel and agreed as a point requiring further reflection.

Screening

7.9 Whilst acknowledging the pressures that all agencies operate in, the panel considered the adoption of the principles of 'Making Every Contact Count' an ethos by which to encourage professionals to be alive to the possibility of the issues of well-being and safety that may encourage improved professional curiosity when presented with signs of difficulty such as financial hardship, injury and so forth

7.10 The panel also explored the merits of routine screening regarding Well-being and Safety. There appeared to be practical, resource related challenges in respect of routinely screening at every contact.

Equalities

7.11 Putting oneself in John's position, an individual suffering with medical ailments and disability, exacerbated by financial difficulty, it could be argued that the issue of intersectionality[1] was apparent in this case. That is an overlap of social identities that contributed to discrimination being experienced by John.

7.12 On considering the Equalities Act and the duty of public authorities to; remove or reduce disadvantages suffered by people because of a protected characteristic; meet the needs of people with protected characteristics and encourage people with protected characteristics to participate in public life and other activities[2] it is arguable as to how public authorities met his needs. It seems to the panel, that John's situation provides an opportunity for agencies to reflect on the needs of those in his situation. After all, as part of the analysis and findings of the panel meeting were that Leicester is beset by high levels of deprivation and Housing services did report that their overall circumstances were not that unusual.

7.13 The panel did note that the new Vision and Strategic Objectives for 2019-22 regarding Domestic Abuse contain the objective "Ensure the identification of bespoke approaches to key vulnerable groups and those not being identified/accessing service". [3] It seems that John's circumstances could fit into this category. It also noted that Leicester Safeguarding Adults Board Plan 2017-20 will be subject to revision.[4] The current plan does not specifically cite Equalities. Given what we understand about Johns circumstances, it seems opportune that the learning from this review are explored when formulating the next Strategic Plan.

8. Good Practice and Agency Developments

8.1 There have been a significant number of developments in local practice that informed panel discussions and ultimately final 'lessons to be learned' and recommendations needed.

GP Practice

8.2 The Clinical Commissioning Group had developed a comprehensive DA Policy in 2017 that was signed off in March 2018 that provides a framework and guidance for Domestic Abuse. This incorporates raising awareness of the policy and has implications that encourages professional curiosity, guidance around record keeping, disclosures to other agencies such as MARAC as well as advice to victims. There are now also GP Safeguarding Leads who have an additional responsibility to be a source of advice and guidance for their practice staff. This demonstrates an evolution in the practice approach to Domestic Abuse and wider risk management processes.

8.3 The GP practice now has social prescribing in place. This demonstrates a significant commitment of resource in an area of high deprivation to address the varied needs of vulnerable patients. The panel agreed this shows a commitment to a holistic approach to patient care.

[1] Source: https://www.dictionary.com/browse/intersectionality (Accessed January2020)
[2] Source: https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/ (Accessed December 2019)
[3] Source: https://www.leicester.gov.uk/media/186377/llr-dsva-strategic-objectives-and-vision.pdf (Accessed March 2020)
[4] Source: https://www.leicester.gov.uk/media/184161/strategic-plan-2017-2020-leicester-safeguarding-adults-board.pdf (Accessed March 2020)

8.4 The GP practice and health professionals receive training in accordance with the first edition of the Intercollegiate document entitled Adult Safeguarding: Roles and Competencies for Health Care Staff, the first edition of which was published in March 2018 after John's death. This guidance sets out minimum training requirements across all staff roles in healthcare settings, including competencies, knowledge and skills. It specifically references, recognition, response, referral. Subjects covered include, abuse, harm, neglect generally as well as poverty. These are all pertinent in John's case and in the locality of Leicester City.

Leicester City Council Housing

8.5 Good Practice: Leicester City Council Housing provided practical support through Supporting Tenants and Residents (STAR) that assisted John and Audrey in managing their financial difficulty. John's brother in law recalled how complimentary John was of STAR.

8.6 LCCH now have the ability to record and report welfare and safeguarding concerns via a PDA, as opposed to previous paper-based systems. This now ensures proactive consideration in respect of Safeguarding concerns and the condition of a premises inside and outside.

8.7 Leicester City Council Housing alongside Leicestershire and Rutland Councils is in the process of seeking Domestic Abuse Housing Alliance (DAHA) accreditation.

9. Lessons to be Learned

9.1 The review identified a number of learning opportunities that have been summarised as key issues above, themes as financial hardship, Well-being, Safety, Professional Curiosity, Desensitisation, Screening and Equalities.

9.2 These have then been considered against a background of significant agency and policy development already undertaken/underway and good practice. The implementation of social prescribing by the GP in area of deprivation is welcomed as a significant development of a holistic approach that would have benefitted John had it been in place at the time.

9.3 Leicester City Council Housing has further addressed the issue of the identification of Safeguarding concerns by the introduction of electronic devices that proactively ask questions around indicators such as the condition of a house/garden that would have been relevant in this case. They are also seeking DAHA accreditation that shows further support and evolution of practice. Notwithstanding these developments, it was agreed there is a need to seek reassurance that the phenomena of normalisation does not result in missed opportunities to identify welfare concerns.

9.4 These developments collectively mitigate the need for a number of recommendations that may have otherwise arisen, save the need to ensure that the learning and circumstances of the review are shared more broadly by the CSP, that the circumstances of this review inform Leicester Safeguarding Adults Board Plan 2021 onwards.

10. Recommendations

10.1 Local Recommendations

IMR authors identified recommendations that should be implemented internally. If an agency is not listed, then no recommendations were made.

10.1.1 GP Practice

- GP Practice to remind all clinicians to lower the threshold when asking whether there is Domestic Abuse in the family
- All clinicians to review patients holistically 'example in this case to review the reason he could not attend for the blood test not just change the medication.'
- All staff to be reminded at practice meetings to always look at the patient holistically not just with the presenting feature

10.1.2 Housing

- Improved record keeping by STAR
- Retention policy to be reviewed

10.2 Local Recommendations

Recommendation 1:
Leicester City Council Housing Division consider how to reassure themselves that opportunities to assess tenant welfare are not missed through either (1) normalisation of poor living conditions that could indicate neglect or (2) being 'door-stepped' and not gaining entry to a Council property where there might be concern.

Recommendation 2:
Learning from DHR to be shared across Safer Leicester Partnership in support of its response to Domestic Abuse and its Vision and Strategic Objectives 2019-2022 that includes "Ensure the identification of bespoke approaches to key vulnerable groups and those not being identified/accessing service "

Recommendation 3:
The learning from this review is shared with the Leicester Safeguarding Adults Board so they can consider how it may inform their strategic plan 2021 onwards.