



**Safer Leicester Partnership**  
*Working together for a safer City*

# **DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT**

**Report into the death of John in June 2017**

**Independent Chair and Author: Mark Wolski**

**Date of Completion: July 2021**

A Personal Tribute from John's sister included in a letter to the Chair/Author.

*Dear Mark,*

*Thank you for updating me about the inquest result.*

*I would like to take the opportunity to have my thoughts added into your report.*

*John (not real name) was one of three brothers and was 9 years older than me. Although I did not have much contact with him in the last few years, I have many fond memories of a brother who always looked after me as a child and young person.*

*When I was ten, I would go with him and his wife shopping into Leicester City centre on a Saturday morning. He always took me to the local Wimpy Bar and brought me lunch. At home we would listen to his music collection and his love of groups like T Rex had a profound influence on the type of music I enjoyed the most.*

*He was a very kind individual and his knowledge of music was incredible. Although we were not in contact, I have always sent him a Christmas card to let him know I was thinking of him.*

*It's tragic what has happened and I firmly believe preventable. He was not deserving of what happened to him. Whilst an unfortunate accident when he was younger took away his true potential to excel as an adult, he never lost his sense of humour and when he did work, he had a lot to contribute. Ill health did have a part to play in later years but I am very sad that he has left us and just knowing that he would have been opening my Christmas card made me smile. Now he has gone and in such a very sad way, it has left me with a little sadness.*

*He was my brother and I loved him very much.*

*Kind Regards,*

*'Elizabeth'*

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## **1. INTRODUCTION**

- 1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.
- 1.2 This report of the DHR, (hereafter ‘the review’) examines the agency responses and support given in respect of ‘John’ (not his real name), a resident of the City of Leicester prior to his death in June 2017. Pseudonyms have been assigned to individuals referred to in this review. Pseudonyms chosen were endorsed by the family members consulted as part of the review. John was married to ‘Audrey’ (not her real name), had one grown up son and three grandchildren
- 1.3 Following a call to the ambulance service, John was found on the floor of his home address, having been immobile on the floor over a weekend. He subsequently died as a result of medical complications arising as a result of dehydration and a prolonged period of immobility. Following a criminal investigation, his wife Audrey was charged with manslaughter by Gross Negligence. In the spring of 2019, the Crown offered no evidence at Leicester Crown Court.
- 1.4 The review was commissioned by the Safer Leicester Partnership to consider agencies contact/involvement with John. The DHR panel determined that they would review such contact for the three years prior to John’s death in June 2017. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.
- 1.5 The primary purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person died as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
- 1.6 The Report also reflects the views and thoughts of some of John’s family who contributed to this review. The Panel wishes to express their sincere condolences to them and all of John’s family.

## **2. TIMESCALES**

- 2.1 The Review Process began on 26th February 2019 and was concluded in September 2020.
- 2.2 Following a lengthy investigation the Crown Prosecution Service (CPS) concluded there was a realistic prospect of securing a conviction against Audrey for ‘Gross Negligence Manslaughter’. In August 2018 she was served with a Postal Requisition to appear at Leicester Magistrates Court the next month.
- 2.3 The complexities of the investigation and the decision-making process of the CPS had a direct impact on the timing of the police referral as without the decision to prosecute Audrey, the death would not have met the criteria required for a Domestic Homicide Review (DHR).
- 2.3 The Safer Leicester Partnership (SLP) was notified of the decision to summons Audrey and thereby alerting the SLP of the need to consider a DHR in September 2018. 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 in November 2018 and the Home Office was notified 7<sup>th</sup> January 2019.

- 2.4 The Initial Review Panel meeting took place on 26th February 2019. The terms of reference were agreed and matters of confidentiality were set out within a confidentiality agreement signed by all Stakeholders.
- 2.5 The Chair paid due consideration to issues of sub-judice and consulted with the Senior Crown Prosecutor in advance of the first panel meeting. She was further updated after the first panel meeting that the DHR would commence, but with the caveats that (a) contact with any potential witnesses would be disclosed in advance to the Senior Investigating Officer and (b) Audrey would not be contacted until after the pre-trial hearing on 16th April 2019.
- 2.6 The chair wrote to John’s wife and son shortly after the decision had been taken not to proceed with criminal proceedings. As there was no immediate response and as the coronial process had resumed, the chair decided not to intrude further until these proceedings had concluded.
- 2.7 Further delays were incurred to enable contact with wider family members who had become estranged over the years.
- 2.8 At the time of the 4<sup>th</sup> panel meeting, the coronavirus pandemic was starting to affect the UK and the country starting to go into lockdown. In addition, the coronial proceedings were close to conclusion, in that the coroner had written to the family offering a documentary inquest. It was again decided to delay further contact in order not to burden a vulnerable family or risk interfering with the coronial process by re-introducing the DHR process.
- 2.9 The coronial process concluded in May 2020 and the Chair wrote once again to John’s wife and son.

### 3. CONFIDENTIALITY

- 3.1 Details of confidentiality, disclosure and dissemination were discussed and were agreed between Panel Member Agencies at the first Panel Meeting.
- 3.2 All information discussed was agreed as strictly confidential and was not be disclosed to third parties without the agreement of the responsible Agency’s Representative.
- 3.3 All Agency Representatives agreed to be personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
- 3.4 It was recommended that all members of the Review Panel use a secure email system and that documents be password protected.
- 3.5 To protect the identity of individuals and with the agreement of family members, the following anonymised terms and pseudonyms have been used throughout this Review. Ages are at the time of John’s death.

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	Adult	White British
Barbara	Sister of Deceased	Adult	White British
Thomas	Brother-in-Law of Deceased	Adult	White British

## 4. TERMS OF REFERENCE

4.1 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 John and Audrey 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
  - identifying 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.

4.2 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'.

4.3 Whilst the terms of reference were agreed, the panel were careful throughout the review to take a broad holistic view of the circumstances, recognising that the final three points risked focusing on Audrey.

4.4 The timeframe for this DHR was agreed as from June 2014 to June 2017, as it allowed for an in-depth consideration of their relationship in recent years. Where appropriate, information outside of this time period is included to provide context and also to explore noteworthy events prior to the relevant period.

## 5. METHODOLOGY - REVIEW PROCESS

### 5.1 Legal Framework

5.1.1 The Review has been conducted in accordance with Statutory Guidance under S9(3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

5.1.2 There were no other reviews conducted simultaneously that impacted upon this review, but there were criminal proceedings ongoing during the early part of the review. Coronial proceedings resumed once the criminal trial ended and finally concluded before this review was completed.

## **5.2 Methodology Overview, Panel Meetings, IMRs and Chronologies**

5.2.1 Comprehensive initial scoping of Agencies involved was undertaken by the Safer Leicester Partnership (SLP). An initial period of three years showed that there had been very little contact with any agency during the relevant period. This lack of contact limited the scope of agency involvement in the DHR process.

5.2.2 Agencies responding no trace included:

- South Warwickshire CCG
- Leicester City Council – Crime and ASB team
- Community Rehabilitation Company
- Local Hospitals
- Local Urgent Care Providers
- Leicester City Adult Social Care
- Leicester City Council Children’s Social Care
- Leicester City Council Education
- Leicester City Council Neighbourhoods Services
- Leicester City Council Regulatory Services and Community Safety
- United Against Violence and Abuse
- Citizen’s Advice Debt Support Service
- Leicester City Council’s Debt Support Service

5.2.3 Agencies who had contact were:

- Housing Department for Leicester City Council
- General Practitioner
- Police
- Ambulance Service

5.2.4 The Medical Practice reported they had significant contact regarding medical conditions. The GP practice with support from Leicester City CCG completed an IMR and chronology based upon medical records held.

5.2.5 The Police had no contact during the scoping period of three years, and previously the only contact with John had been as a victim of Criminal Damage in 2003 and Audrey on two occasions in respect of low value shoplifting offences in 2012 and 2014.

5.2.6 The Housing Department for Leicester City Council had contact in respect of housing repairs and rent Issues. The Housing department completed a chronology and IMR based upon retrieval of records and interviews with housing staff,

5.2.7 The Police, CCG, Adult Social Care, Leicester City Council Housing, Leicester City Community Safety and the specialist domestic abuse provider ‘United Against Violence and Abuse’ were invited to form the DHR panel. The first Panel Meeting took place on 26th February 2019. At this Panel Meeting the Terms of Reference were agreed as described at 5.5. Five further panel meetings took place; 18<sup>th</sup> June 2019, 1<sup>st</sup> November 2019, 25<sup>th</sup> March 2020, 29<sup>th</sup> July 2020 and 6<sup>th</sup> August 2020.

5.2.8 Comprehensive chronologies, factual reports or IMRs were received from all parties that had contact that informed panel discussions.

5.2.9 In addition to the IMRs, documents reviewed during the review process have included:

- Statements from witnesses to the case
- Written transcripts of interviews
- Post-mortem and Toxicology Statements
- Care Quality Commission (CQC) reports for John’s surgery
- Local Safeguarding Adults Strategic plan

- Joint Strategic Needs Assessment
- Domestic and Sexual Violence Needs Assessment 2017
- Local Ward Profile (2013)
- Leicester, Leicestershire & Rutland DSVA Strategic Objectives and Vision 2019
- Leicester Safeguarding Adults Strategic Plan 2017-20
- CCG (GP) Policy on Domestic Abuse 2018
- Intercollegiate document: Adult Safeguarding: Roles and Competencies for Health Care Staff
- Leicester City Council Corporate Equality and Diversity Strategy 2018 - 2022

- 5.2.10 The Author expresses his thanks to all Agencies who completed IMR or factual reports.
- 5.2.11 There have been a number of delays in completing this DHR owing to the ongoing criminal trial through to an ongoing coronial process. Initially the chair set clear parameters regarding completion of IMR's and family contact before criminal proceedings were discontinued in mid-April 2019. Thereafter, there were delays in determining primacy between coronial and criminal proceedings, that again limited the engagement the chair was able to have with family. Also, as the review process was nearing conclusion, further delays resulted from the coronavirus pandemic.
- 5.2.12 The Community Safety Team on behalf of the chair sought information from the Department of Work and Pensions to determine the level of engagement and support to John and in particular whether he was in receipt of a disability living allowance/personal independence payment. They reported that John had claimed Employment Support Allowance from 4<sup>th</sup> June 2014 to 10<sup>th</sup> April 2018. No records were available having been destroyed after 14 months in accordance with policy.

## 6. FAMILY INVOLVEMENT

- 6.1 At the start of the Review Process, the criminal case was ongoing and the Trial had not started. The chair considered timing of initial family contact at the first panel meeting in February 2019 and took the decision to delay attempting contact for a number of factors including; - a criminal trial was impending with a pre-trial hearing due imminently (April 2019); - there had already been a significant delay in commencing the review, whose success would not be undermined by a further short delay and; – to ensure that issues of sub-judice were carefully managed.

### John's wife and son

- 6.2 The Crown Prosecution Service took the decision to offer no evidence at the April pre-trial hearing. As neither was in receipt of support from the Homicide Support Service, the Chair wrote to both John's wife and son (Audrey and Giles) to notify them of the DHR process. In early May 2019, this letter and a letter from the SLP were delivered to Audrey along with literature of advocacy and support services by Leicester City Council's DHR officer. She said she would discuss whether to take part with her son. The chair subsequently wrote to John's wife and son on 25<sup>th</sup> June 2019 and received no response.
- 6.3 The chair was mindful that coronial proceedings were ongoing at the same time that this review was taking place and decided that further attempts to contact the family ought to be delayed until the coronial process had concluded. Upon conclusion of those proceedings in May 2020, the chair wrote to John's wife and son and received no response.

### Wider Family

- 6.5 With the assistance of the police family liaison officer, the Chair was able to make personal contact with John's sister Elizabeth and his brother-in-law Thomas. In turn this enabled

contact to be made with another sister Barbara. None of these family members were in receipt of assistance of the Homicide Support Service. The Chair explained the DHR process drawing their attention to the availability of support and advocacy services such as AAFDA. The chair followed up telephone conversations with letters explaining about the DHR process and provided the family leaflets that described the support and advocacy available. This contact enabled a ‘pen picture’ to be drawn of John’s life as described in the report.

- 6.6 The panel wish to express their thanks to John’s family for their assistance in conducting this review.
- 6.7 The chair held a lengthy conversation with Elizabeth on the 30<sup>th</sup> September and fully updated her as to the process, the learning opportunities and how these had been translated into recommendations. Against a background of coronavirus restrictions, the chair offered the opportunity for arrangements to be made for her to read the report in person. This was declined.
- 6.8 The chair enquired about the remaining family members who he had been in contact with and learned that there had been some illness in the family and she advised against making family contact at this sensitive time.
- 6.9 A schedule of contact with family members is shown at Appendix A.

## 7. DISSEMINATION

- 7.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Leicester Partnership DHR sub-group and the chair of the Executive for approval and thereafter will be sent to the Home Office for quality assurance.
- 7.2 Once agreed by the Home Office, the Safer Leicester Partnership will ensure the learning is shared, by individual agencies or at multi-agency events. This includes DHR workshops.
- 7.3 The Executive Summary and Overview Report will also be shared with the Police and Crime Commissioner for Leicestershire and published reports are also shared with the sub-regional Domestic Violence and Sexual Abuse (DVSA) Operational Group.
- 7.4 The action plan will be monitored by Safer Leicester Partnership DHR sub-group. The Community Safety Team will be responsible for monitoring the recommendations and reporting on progress”.

## 8. CONTRIBUTORS

- 8.1 Individual Management Reviews or Factual Reports were requested from the following Agencies, all of whom were invited to form the Panel:

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

- 8.2 Factual reports were completed by the police and ambulance service owing to the limited nature of contact with those agencies.

## 9. REVIEW PANEL

9.1 The Review Panel consisted of:

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

9.2 The review panel met a total of six times, with the first meeting on 26th February 2019 and subsequent meetings on the 18th June 2019, 1st November 2019, 25<sup>th</sup> March 2020, 29<sup>th</sup> July 2020 and 6<sup>th</sup> August 2020.

9.3 Agency representatives were of appropriate level of expertise and were independent of the case

9.4 The chair of the review wishes to thank everyone who contributed their time, patience and cooperation to this review

## 10. AUTHOR AND INDEPENDENT CHAIR

10.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

10.2 Mark is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander at the Boroughs of Haringey, Harrow and at the Specialist Operations command of Aviation Security. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding. Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a MARAC Steering Group and as a DHR chair/co-chair.

10.3 During and since his MPS service Mark has had no personal or operational involvement with agencies comprising Safer Leicester Partnership.

- 10.4 Mark was supported by Peter Stride as co-chair. He is a former Metropolitan police officer with 30 years operational service, retiring in October 2015. As a Detective Chief Inspector, he led the strategic responsibility for criminal investigations, public protection and Safeguarding in Harrow. Peter has subsequently gained experience as a consultant in the field of Community Safety, Risk Managements and as a DHR chair/co-chair.
- 10.5 During and since his MPS service Peter has had no personal or operational involvement with agencies comprising Safer Leicester Partnership.

## 11. EQUALITIES AND DIVERSITY

- 11.1 The nine protected characteristics as defined by the Equality Act 2010 have all been considered; they are age, disability, sex, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief and sexual orientation.
- 11.2 One of the protected characteristics considered to have relevance to this DHR was John's disability through medical conditions that appears to have had a 'substantial' and 'long term' negative effect on John's ability to do normal day to day activities.<sup>1</sup> Whilst not noted within any of the IMRs, the panel agreed this merited consideration.
- 11.3 The panel also considered the question of whether Audrey had any 'learning disability', that is a condition affecting her intellectual ability.<sup>2</sup> The panel were not able to conclude whether this was the case, but learned she had not required an appropriate adult (AA) during two police interviews. The senior investigating officer taking into account the gravity of any potential criminal proceedings asked for the need for an AA to be assessed. This was undertaken by the custody nurse and she confirmed that an AA was not required.
- 11.4 In relation to other protected characteristics, it is recognised that domestic abuse is gender biased, with a greater proportion of victims being female. The panel in their deliberations were mindful of John being a potential male victim of domestic abuse, whether there were barriers he may have faced in reporting abuse and whether agency perceptions may have been affected by his sex.
- 11.5 It is further reported in the refreshed Domestic and Sexual Violence Needs assessment for the area, that those over the age of 55 are the least represented within reported incidents of Domestic Abuse (DA). It also reports that the same age group live with DA for an estimated period in excess of 12 years.<sup>3</sup>
- 11.6 In relation to 'marital status', John and Audrey were married, but beyond this the review did not identify any learning of significance.
- 11.7 John's ethnicity as a British White Male was considered by the Panel, but was not a factor in the services he received.

## 12. PARALLEL REVIEWS AND RELATED PROCESSES

- 12.1 At the start of the DHR process a criminal prosecution was pending. Audrey had been charged with Manslaughter by gross negligence. During the judicial process a decision was taken by the Crown to offer no evidence.

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<sup>1</sup> Source: <https://www.gov.uk/definition-of-disability-under-equality-act-2010> (Accessed December 2019)

<sup>2</sup> Source: <https://www.nrshealthcare.co.uk/articles/condition/learning-disability> (Accessed March 2020)

<sup>3</sup> Source: <https://www.leicester.gov.uk/media/186085/sexual-and-domestic-violence-and-abuse-needs-assessment-refreshment-2019.pdf> (Accessed Marc 2020)

- 12.2 Coronial proceedings commenced in July of 2017 and were concluded in May of 2020. The conclusion of the Coroner was recorded as “Natural causes contributed to by a fall and long lie on the floor”.

## **13. BACKGROUND INFORMATION - THE FACTS**

### **13.1 Family Make Up**

- 13.1.1 John and Audrey had been married for more than 35 years and had lived at their house in Leicester since 1978. They had one son ‘Giles’ (not real name), who had moved out of the family home when he married.
- 13.1.2 Whilst John and Audrey lived alone, they would frequently look after their four grandchildren, one of which was of secondary school age. Three of the grandchildren would often sleep over on Friday and Saturday evenings.

### **13.2 The Events of John’s death**

- 13.2.1 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.
- 13.2.2 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.

### **13.3 Post-mortem**

- 13.3.1 A post-mortem was subsequently carried out and the cause of death was recorded as acute kidney injury and pneumonia, dehydration, rhabdomyolysis and systemic effects of immobility following a fall and pressure sores.
- 13.3.2 The conclusion by the Pathologist was that John died as a result of medical complications arising as a result of dehydration and a prolonged period of immobility. The combination of dehydration and muscle breakdown due to immobility (Rhabdomyolysis) has resulted in acute injury to the kidneys and the lack of mobility has resulted in John developing pneumonia.
- 13.3.3 The areas of pressure ulceration had been included as contributory factors as they will have added an extra physiological strain on his already overburdened system, although had not directly caused his death.

### **13.4 The Investigation and Outcome**

- 13.4.1 The focus of the police investigation was that John had fallen two days prior to the day the ambulance service being called. It was his son Giles, that recognised the gravity of John’s situation and who called the ambulance service.

- 13.4.2 In September 2018, the Crown Prosecution Service instructed the police to summons Audrey for the offence of Gross Negligence Manslaughter. She appeared at court at the end of October 2018 and pleaded not guilty.
- 13.4.3 The offence of gross negligence manslaughter (GNM) is committed where the death is a result of a grossly negligent (though otherwise lawful) act or omission on the part of the defendant.<sup>4</sup>
- 13.4.4 The particulars of the charge read out at court were
- a) Knowing of his pre-existing medical conditions and following a fall at their home address, for a period of approximately 48 hours she did not seek assistance in moving John or medical treatment for his injuries or the medical consequences of the fall
  - b) This was a breach of the duty of care owed by Audrey to John
  - c) The said breach of duty caused the death of John
  - d) The said breach amounted to gross negligence

### **13.5 Court Outcome**

- 13.5.1 In April 2019 the Crown offered no evidence and the matter was discontinued.

### **13.6 Coroners Report**

- 13.6.1 The inquest opened in July of 2017 and was adjourned pending the outcome of the criminal proceedings. The inquest concluded in May of 2020. The medical causes of death were recorded as a) Pneumonia, b) Dehydration and effects of immobility following a fall and c) Pressure sores. The conclusion of the Coroner as to the death “Natural causes contributed to by a fall and long lie on the floor”.

### **13.7 Location Background**

- 13.7.1 Leicester is the 25th most deprived area of 324 Local Authority areas and life expectancy for men and women is lower than the England average. The ward where John and Audrey lived has higher levels of deprivation than the Leicester average. Life expectancy for men is 2.7 years lower than the Leicester average (75.4 years) and 5.9 years lower than the England average (78.6 years). In 2013, over 70% of the ward population lived in the most deprived quintile of deprivation, versus around 40% for Leicester as a whole and 20% for England as a whole.<sup>5</sup>

## **14. CHRONOLOGY**

### **14.1 Background History of Family**

- 14.1.1 The chair has sought the views of John’s wife Audrey and his wider family. Whilst it has not been possible to speak to Audrey, an insight has been secured from John’s wider family as described below.

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<sup>4</sup> Source: <https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter> (Accessed 25<sup>th</sup> September 2019)

<sup>5</sup> Source: Local Ward Profile 2013. (Accessed December 2019)

14.1.2 He was one of eight children who over time have moved to different parts of the country. Two siblings have passed away over the years, leaving a brother and four sisters surviving. It seems that over the years contact across the family had become infrequent, with only one sister and her husband (brother-in-law - Thomas) remaining in regular personal contact.

14.1.3 John had been married for over 35 years, had one son, Giles who in turn had four children.

#### **Sister - Elizabeth**

14.1.4 The chair was initially able to speak to one sister, Elizabeth, who explained that she had not seen John for over twenty years and would only contact each other at Christmas time, exchanging Christmas cards.

14.1.5 She recalls a normal upbringing and that she has fond memories as a child playing with John, of him carrying her through the snow and so forth. Over time, she described the family relationships becoming more fragmented and distant and only those who lived close by would see John.

14.1.6 Elizabeth says that she does not have any direct first-hand knowledge of John's life in the relevant period prior to him passing away. She described in her words, information being 'hearsay', with accounts from her sister, owning a sandwich shop and ensuring John was fed. This sister also described to Elizabeth, how she would give him food to take home because she knew things were financially difficult at home. Elizabeth also recalls accounts of John having dirty unkempt clothes and wearing shoes with no soles. In summary it was clear to Elizabeth, that John had difficulty in making ends meet, a fact that is cross referenced later by his interaction with Leicester City Council Housing.

14.1.7 Elizabeth also described how rarely she had ever gone around to John's before they became estranged, but recalls how dirty his house had been. She recalls one occasion when she had gone around to his house to help clean it and had to use a scraper on the carpet as it was so "filthy".

14.1.8 Notwithstanding the apparent difficulties, it was also clear that John had enjoyed a sociable relationship with the sister who owned the sandwich shop and his brother in law.

14.1.9 Through Elizabeth, the chair was able to speak to two further family members, another sister Barbara who had been the owner of the sandwich shop and a brother-in-law Tom

#### **Sister - Barbara**

14.1.10 This sister hadn't seen John for approximately five or six years before the relevant period. She described John as having disconnected himself from the family, though accepts this may have related to his mobility becoming limited.

14.1.11 She has fond memories of John growing up, recalling how he had looked after her when she was growing up.

14.1.12 On reflecting on her most recent memories, she feels sad about John, because one of her lasting impressions was of him 'having nothing'. She described how he used to pop into her sandwich shop on the way back from 'signing on'. He would grab some food and go home. She was concerned at how unhappy he seemed and sat him down to ask how things were. John explained that when he took food home, it was taken away from him and would go to the grandchildren and that he didn't see much of it. Barbara from that point made sure he at least had some food.

14.1.13 She also recalls that his brother-in-law Tom had been the one closest to John, trying to look after him and his interests. Whilst she wasn't able to comment on John's financial situation,

she noted he didn't even have a phone and didn't have the 'best of clothes. Again, she reiterated that Tom would be able to give greater detail.

- 14.1.14 Upon asking whether she had ever been to his house, she explained that she had and described it as 'horrific'. She said it smelled strongly of smoke, it was absolutely filthy. She has one particular memory of when there was a conversation about them not moving and during the conversation, they spoke about two dogs he had. At this, she recalls they were under the sofa, not moving and discovered they were dead. In summary, she says it was the sort of house, where you would wipe your feet as you left and that she had never seen anything like it.

### **Brother-in-Law – Thomas**

- 14.1.15 Thomas had known John for around 45 years. They had been close friends, following Thomas marrying one of John's sisters who passed away in 2013.
- 14.1.16 Thomas recalls a friendship where they would as young men, socialize together, going into town at weekends and walking home. This friendship continued and they would see each other on a weekly basis with John visiting him at his home address.
- 14.1.17 When John did visit, in his later years, John would visit with the assistance of crutches. A lasting impression he had, was of a man suffering from poor health and struggling financially. John's clothes were threadbare, and he wore shoes with hardly any soles.
- 14.1.18 On exploring why John went to his address and not vice versa, Thomas explained that was because John's home wasn't very pleasant. It smelled strongly of smoke and was a bit antiquated, and all Audrey was interested in was smoking, knitting and watching TV. It seems that these regular visits had been a feature until about 4 years ago and tailed off, when Thomas's wife passed away from cancer.

### Financial Worries

- 14.1.19 He says that Audrey used to manage the money and described her as being the "dominant" one with money. John would moan that Audrey would spend money on the grandchildren, their clothes, spending more than the parents did. He says that he told John he should ask Audrey to keep receipts and slips from the cash point, but that she would just lose them. Thomas was led to believe everything was in his name, an account at the post office with one bank card that she would have.
- 14.1.20 Thomas described in further detail, the financial pressures including John not having a TV license and on occasion "falling foul" of this, with bailiffs attending to recover debt. John had been dependent on benefits, and he describes how John was 'forced' to attend an equivalent to a Job Centre to show willing. There were occasions when his benefits and allowances were stopped and this made matters worse. Thomas had attended and said to them, that John simply could not work. It was unfair to expect him to attend when mobility was an issue. Thomas made further enquiries on behalf of John, outlined the case and after a few phone calls and conversations it seems that the requirement to attend for the purposes of seeking employment was no longer required.

### Support from Others

- 14.1.21 Thomas explained that John received from Supporting Tenants and Residents (STAR) in complimentary terms, saying that they assisted in providing clothes for John. STAR provides housing support for council tenants in Leicester to people who have been homeless or are at risk of becoming homeless without support.<sup>6</sup> He is unsure whether STAR

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<sup>6</sup> Source: [Tenant support - STAR \(leicester.gov.uk\)](https://www.leicester.gov.uk/tenant-support/) (Accessed July 2021)

organised help in respect of food banks, but knows that John and Audrey were reliant on weekly food bank donations. Thomas explained that when John and Audrey didn't want some of the food, they would pass it to him. An example was brown bread that they didn't eat.

- 14.1.22 The chair asked about what support John had from other agencies and he said none, despite having attempted to seek help on behalf of John and Audrey. Thomas says that he was reasonably aware of what support may be available having nursed his wife through cancer and so he directly approached social services and John's GP.
- 14.1.23 Thomas recalls the difficulty that John had attending his GP, for regular tests and prescriptions for 'rat poison'. Thomas had contacted the practice and asked why they treated John like an animal, when he believed the GP could see him at home. It appears the member of staff interpreted this as Thomas calling the staff member an animal. The phone was hung up and John phoned back and attempted to clarify matters. The phone was disconnected again. Thomas then went to visit the practice and explained it was his personal experience that doctors or health visitors could do house calls. The practice has no record of him visiting the practice.
- 14.1.24 Regarding social services, Thomas approached them directly owing to John's mobility. He says that John lived in a house with an upstairs toilet and he couldn't get to it. He therefore thought social services would be able to assist with a stair lift. The chair asked whether he could be sure who he spoke to, whether it was housing or social services and he was adamant that it was social services. He recalls this being about 18 months before John passed away. There were no records found for either Leicester City or Leicestershire County Council social services.
- 14.1.25 As regards housing, Thomas was aware of attempts to secure a move. He recalls that two bungalows had been identified for potential swaps, that would better meet his needs. They were local, but Audrey refused to move owing to the fact that they did not have a spare bedroom that would enable her grandchildren to visit and stay over.
- 14.1.26 The chair asked about John's physical condition and what work John had undertaken in his life. He believes John had been involved in an accident and suffered some minor brain injury and some internal organ damage that may have been the cause of his long-term maladies that prevented John from working.

## **14.2 Narrative Chronology – Key Contacts with Agencies**

### **Relevant Contact Reported Outside the scope of the review**

- 14.2.1 On the 25<sup>th</sup> September 2013, John's brother-in-law phoned the doctor and expressed concern that John was not well, that his leg was swollen and asking for a home visit. The receptionist explained that home visits were completed for the day, but that patient could have an appointment later. Later that afternoon, his GP records that the brother-in-law had expressed concern about the social situation and that the patient was being treated like an animal, though no particulars were noted. Records show that no phone number left, but that the GP asks that if he calls back, please put him through to the GP. It was noted that if any specific concerns raised, Adult Safeguarding will be informed. An offer was made for a 3:30pm appointment.
- 14.2.2 At 3:20pm his brother on law phoned, explaining that John had fallen 7 days ago, that he was worried and that he was not keeping food down. The record shows 'wife and son not bothered about him'. The GP phoned the brother-in-law back, who explained that John could not get out of bed. It was noted that Thomas said he would phone for an ambulance. The IMR author has checked records and cannot see any record of an ambulance having

been called. The factual report by East Midlands Ambulance Service only shows the call in June 2017.

## 2014

14.2.3 During the relevant period **June 2014 to June 2017**, John had regular contact with his GP and Leicester City Council Housing, there being very infrequent contact with Audrey, one of which was with Leicester Police. These contacts are summarised below.

*For ease of reference all entries relate to GP contact, unless prefaced with LCCH*

14.2.4 On the 8<sup>th</sup> and 15<sup>th</sup> July and again on the 12<sup>th</sup> August John attended the GP practice for International Normalized Ratio (INR) monitoring by the Practice Nurse. INR testing is a test to see how well blood clots.<sup>7</sup> John had been diagnosed in 1997 with a deep vein thrombosis (DVT) requiring him to be prescribed with a drug called Warfarin

14.2.5 On 11<sup>th</sup> September 2014 John self-presented following a recent fall onto his right lower abdomen causing pain and also has had a cough over the past month. On examination an inflamed linear mark to his lower abdomen along with slight tenderness. He was provided with an Ibuprofen gel for the pain and cough linctus for his cough.

14.2.6 On 23<sup>rd</sup> September John was seen by the GP for INR monitoring.

14.2.7 On 2<sup>nd</sup> October Audrey was dealt with by way of Restorative justice regarding a low value shoplifting offence, where she had been seen to take food and confectionary.

14.2.8 On 18<sup>th</sup> November John was seen by the practice nurse for routine INR monitoring.

14.2.9 LCCH: On 15<sup>th</sup> December, a routine Gas Fire check was conducted by Leicester City Council Housing Department

## 2015

14.2.10 On 27<sup>th</sup> January 2015 John attended an NHS Health check appointment. This is a check offered to all patients between the ages of 40 and 74 years old with no chronic conditions. It is designed to spot the early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia.<sup>8</sup> He was advised of his ideal weight and given advice regarding his diet. It was noted that he enjoyed light exercise and no concerns were noted that his level of activity did not match his physical mobility.

14.2.11 LCCH: On 4<sup>th</sup> March a gas service was undertaken by one of a number of qualified gas engineers who are employed directly by Leicester City Council. As part of the landlord function visits are conducted on an annual basis.

14.2.12 On 24<sup>th</sup> March John attended routine INR monitoring.

14.2.13 LCCH: The following day on the 25<sup>th</sup> March, gas engineers returned to his home address to make repairs to the flue in the loft.

14.2.14 LCCH: On the 17<sup>th</sup> April, Leicester City Council Housing (LCCH) attended owing to non-payment of an under-occupancy charge, and a female answered saying that John wasn't home. A first warning letter was handed over and a request was made for John to call the

<sup>7</sup> Source:

[https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=167&contentid=international\\_normalized\\_ratio](https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=167&contentid=international_normalized_ratio) (accessed 10<sup>th</sup> September 2019)

<sup>8</sup> Source: <https://www.nhs.uk/conditions/nhs-health-check/> (Accessed December 2019)

council housing department urgently. This was then referred to ‘Supporting Tenants and Residents’ (STAR) and Housing spoke to STAR and discussed a large underpayment that had accrued. STAR is a “housing-related support service for people living in Leicester that helps people who are at risk of losing their home. They help people who are moving into a new home. STAR works with single people, couples and families from three months to up to two years.”<sup>9</sup> This had been successfully managed with the assistance of Discretionary Housing Payment (DHP). All local authorities are granted a DHP fund that allows payments to residents in the local authority area who are in financial difficulties. The aim is to provide this assistance for an interim period until the financial burden is alleviated. The plan was for John and his wife to move to more suitable accommodation where they would not be affected by the under-occupancy charge. They had been placed on the housing register and successfully bid on a suitable property. Notes record that John’s wife had been reluctant to move and so they refused an offer on this property. LCCH wrote to them and advised them of a proposed visit on the 24<sup>th</sup> with an offer to assist with completing a new DHP.

- 14.2.15 LCCH: At the follow up visit, John promised to begin paying the under-occupancy charge, but did explain he would struggle. Arrangements were made for John to visit offices later that month to complete a DHP application. It was explained that accessing the DHP fund wasn’t guaranteed as succeeding, owing to their refusing to downsize.
- 14.2.16 LCCH: John attended the follow up meeting on the 29<sup>th</sup> April and he explained he knew almost nothing about their finances and didn't have anything with him to help with completing a form. He explained that from his weekly income, he also had to pay for Severn Trent a local water supplier and court fines etc. It was also noted that John did have mobility issues and so home visits were advised. John also stated that his wife had made a payment over the weekend and they will make a fortnightly payment next weekend. It was also noted they were referred to STAR again after discussion about how John and Audrey were coping.
- 14.2.17 LCCH: On 4<sup>th</sup> June, LCCH visited John and the records show that an explanation of being confused was offered for not paying money owed. He promised to pay £24.68 per month. The log entry on 3<sup>rd</sup> June records that a STAR worker had been assigned.
- 14.2.18 On 16<sup>th</sup> June, John attended the GP practice for routine INR monitoring.
- 14.2.19 LCCH: On 9<sup>th</sup> July, records show that a Notice of Seeking Possession (NOSP) was sent to John in respect of rent arrears. This was owing to an erratic period of payment over a longer period of time.
- 14.2.20 LCCH: Between 20<sup>th</sup> July and 7<sup>th</sup> September entries show that STAR are working with John and that progress is being made to reduce the amount of arrears.
- 14.2.21 On 8<sup>th</sup> September, John attended the GP practice for routine INR monitoring.
- 14.2.22 LCCH: On 14<sup>th</sup> September Audrey attended LCCH offices to confirm that she was able to pay £20 per week.
- 14.2.23 Two further entries on 15<sup>th</sup> and 29<sup>th</sup> September show John attending his GP practice for routine INR monitoring.
- 14.2.24 LCCH: On 16<sup>th</sup> October, records show that STAR closed the case. It is noted that STAR is a short-term intervention service. Once the intervention has met its need, in this case management of rental arrears, the case is closed.

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<sup>9</sup> Source: <https://mychoice.leicester.gov.uk/Services/1667/STAR-Supporting-Te> (Accessed March 2020)

- 14.2.25 Three further entries on the 3<sup>rd</sup>, 10<sup>th</sup> and 13<sup>th</sup> November show that John did not attend his routine INR appointments. On each occasion, attempts were made to contact John. On the 3<sup>rd</sup> November a letter was sent to John and again on the 13<sup>th</sup> November advising him that his INR treatment would be suspended pending his attendance at the surgery.
- 14.2.26 LCCH: On the 11<sup>th</sup> November, LCCH housing visited John as he had not been paying sufficient money to reduce his arrears and because there was still a valid NOSP in place. LCCH spoke to both John and Audrey and advised them that their benefits (DHP) would soon be ending. They said they would pay a little more.

## 2016

- 14.2.27 On the 12<sup>th</sup> January 2016, John missed his routine INR monitoring and a letter was sent.
- 14.2.28 John did attend two further routine appointments at his GP practice on the 18<sup>th</sup> January and 2<sup>nd</sup> February before missing an appointment on the 1<sup>st</sup> March. A further letter was sent to him.
- 14.2.29 LCCH: On 1<sup>st</sup> March a gas service was conducted at John's house and a fence post was fixed a month later on the 7<sup>th</sup> April.
- 14.2.30 On 21<sup>st</sup> March and 4<sup>th</sup> May, John attended further INR appointments.
- 14.2.31 LCCH: On 18<sup>th</sup> May a gas engineer re-fixed John's gas fire.
- 14.2.32 Between 29<sup>th</sup> June 2016 and 10<sup>th</sup> November, John attended a series of INR monitoring tests, missing one on 26<sup>th</sup> October when a routine letter was sent.
- 14.2.33 LCCH: On 15<sup>th</sup> December a gas service was conducted at the address.
- 14.2.34 On 28<sup>th</sup> December it was noted that John had not been seen at his GP practice since 10<sup>th</sup> November and a letter was sent asking him to book an appointment.

## 2017

- 14.2.35 On the 1<sup>st</sup> February, John missed an appointment at his GP practice. It was noted that John was not attending appointments or ordering medication. His GP recorded on his notes that for patient safety reasons he would not be prescribed further medication until he attended further appointments.
- 14.2.36 On the 22<sup>nd</sup> February 2017, the practice nurse notes that John had explained that he was unable to attend appointments owing to swollen feet and also because he was struggling financially and unable to afford transport. His situation was discussed with the doctor who resultantly changed his medication to an alternative that did not require such regular international normalized ratio (INR) monitoring.<sup>10</sup> He was provided with patient safety information alongside the medication. This is standard practice.
- 14.2.37 LCCH: Two further visits were conducted, on the 2<sup>nd</sup> March to replace a light tube and the next on the 16<sup>th</sup> March regarding rent issues.
- 14.2.38 In June 2017 East Midlands Ambulance Service were called to John's home by his son Giles. They found that John had collapsed on the floor. He was unable to self-mobilise, was suffering from acute breathlessness and was unable to respond. They learned he had slipped or tripped a few days earlier and were offered no explanation as to why they had not been called earlier. They describe Audrey as unphased and smoking outside. The

<sup>10</sup> Source: <https://cks.nice.org.uk/anticoagulation-oral#!topicSummary> (Accessed June 2020)

ambulance service made a referral to Adult Social Care owing to the circumstances including the overall state of the house.

## **15. OVERVIEW**

### **15.1 CCG – GP**

- 15.1.1 John registered with the practice on 3<sup>rd</sup> May 1996. Soon after registering he was diagnosed with Deep Vein Thrombosis (DVT) that required him to be prescribed a drug called Warfarin. He had also been diagnosed with Osteoarthritis of the knees. Both these conditions required ongoing medication.
- 15.1.2 During the relevant period June 2014 to June 2017, John attended the surgery intermittently for blood tests regarding his diagnosis. He only attended on two other occasions including his self-presentation on 11<sup>th</sup> September 2014 following a fall, and on the 27<sup>th</sup> January 2015, he attended an NHS Health check appointment.
- 15.1.3 John attended for his routine blood tests on 23 occasions out of 30 appointments.
- 15.1.4 Records show that the GP practice followed up his non-attendance with letters asking him to make further appointments which he did. Records also show that the patient was encouraged to attend by advising that repeat prescriptions would not be made unless he attended blood tests owing to safety risks associated with Warfarin prescriptions.
- 15.1.5 An apparent barrier to attendance was identified at his appointment on the 22<sup>nd</sup> February 2017, when the nurse reported he was unable to attend appointments owing to swollen feet and because he was struggling financially to afford transport.
- 15.1.6 The IMR author notes there were no Safeguarding concerns noted and further clarifies that the GP practice uses certain criteria as flagging that a patient is potentially vulnerable; Learning Disability, Age, Lack of Family Support, Disability, Dementia.
- 15.1.7 There is one notable event reported on the IMR prior to the relevant period. On the 25<sup>th</sup> September 2013, John's brother in law referring to him being "treated like an animal".
- 15.1.8 His GP reports that over the years he had received physiotherapy regarding his mobility and that prior to the relevant period (2012) he had been provided with hand rails at home owing to a painful right knee to aid him going upstairs. It was also noted that he made use of crutches to get around.
- 15.1.9 His medical practitioner also reports that John did suffer from a number of falls that were attributed to a combination of osteoarthritis and tripping

### **15.2 Housing**

- 15.2.1 John and Audrey were in frequent contact with LCCH. These are summarised for the relevant period as;
- Nine (9) visits for maintenance of the house including gas repairs, fixing of lights and fence posts.
  - Five (5) visits by LCCH regarding rent
  - One visit by John to LCCH regarding rent
  - One visit by Audrey to LCCH regarding rent
- 15.2.2 John and Audrey were clearly struggling financially paying their rent and LCCH engaged the services of STAR to assist with this. STAR is a non-statutory intervention service whose role is to provide short term assistance to tenants aimed at sustaining tenancies. STAR

assisted John and Audrey in completing an application for Discretionary Housing Payment to provide short term support for the financial difficulty they found themselves in whilst they sought more suitable accommodation for their needs

- 15.2.3 One of the contributory factors to financial difficulty was the imposition of an 'under-occupancy charge, otherwise known as a 'bedroom tax'. The practical effect is that housing benefit will provide support for the number of bedrooms that a household needs.<sup>11</sup>

### **15.3 Leicester Police**

- 15.3.1 There is only one contact with John and Audrey during this period, where Audrey was dealt with for a low value shoplifting offence of food and confectionary.

- 15.3.2 During the investigation, police did submit an alert to children's social care as they learned that the grandchildren would often stay at John and Audrey's home at weekends. This was owing to the condition of the property, being extremely poor and unhygienic, reporting they had seen rats and mice running around upstairs. Given the overall circumstances, they were concerned over Audrey's ability to look after her grandchildren.

### **15.4 Adult Social Care**

- 15.4.1 There is one alert to Adult Social Care that was received from the ambulance service following their attendance on the day they took John to hospital before he died.

### **15.5 East Midlands Ambulance Service**

- 15.5.1 There are no alerts or contacts before the incident where John was taken to hospital in June 2017.

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<sup>11</sup> Source: <https://www.gov.uk/government/news/housing-benefit-reform-removal-of-the-spare-room-subsidy-fact-sheet> (Accessed 20<sup>th</sup> September 2019)

## 16. ANALYSIS

The analysis of this Domestic Homicide Review explores the reasons why events occurred, how and whether information was shared and, subsequently, whether the sharing informed decisions and actions taken. On considering the interaction of agencies, matters of ‘consideration’ are highlighted for ease of reference.

### 16.1 Domestic Abuse Definition

16.1.1 The Government definition of Domestic Abuse is: - Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited, to the following types of abuse: psychological, physical, sexual, financial, emotional.

16.1.2 Controlling behaviour is defined as: - A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

16.1.3 Coercive behaviour is defined as: - An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

### 16.2 Clinical Commissioning Group Perspective

16.2.1 The panel were able to consider a significant number of contacts John had with his GP that were routine in nature and a limited number of other contacts.

#### Routine Attendance at GP

16.2.2 John suffered from two medical conditions requiring medication, DVT and osteoarthritis. His thrombosis in particular required frequent blood testing and medication to manage the condition. It is reported that during the relevant period, he attended 23 out of 30 tests. The panel discussed the merits of ‘routine enquiry’ in respect of Domestic Abuse, broader safety and well-being. The CCG panel representative reported that whilst such screening does not take place, current domestic abuse policy for GP Practices provides guidance and helps them respond effectively to patients who are experiencing or perpetrating domestic violence or abuse, with the expectation that professionals are alert to indicators of abuse and wider needs.

16.2.3 The panel also noted the high demand on John’s GP practice in an area of high deprivation, serving 14,000 patients and the implications on time of routine enquiry. Whilst it may be deemed impractical for ‘every contact’, the panel debated the merits of other options such as routine enquiry when registering at a practice, at NHS health checks that use a template to assess physical health, examining the risks of physical disease such as; heart disease, diabetes, kidney disease and stroke.<sup>12</sup> During this discourse, the panel considered studies into routine enquiry, the subsequent evolution in professional practice at John’s GP, against John’s experience.

16.2.4 On the one hand, it was acknowledged there had been studies as to the benefits of routine enquiry, such as the Cochrane Report that found a two-fold increase in identification of Domestic Abuse. However, it also found that there was no increased uptake in accessing

<sup>12</sup> Source: <https://www.nhs.uk/conditions/nhs-health-check/what-is-an-nhs-health-check-new/> (Accessed November 2019)

specialist provision concluding while screening increases identification, there is insufficient evidence to justify screening in healthcare settings.<sup>13</sup>

- 16.2.5 Against this were the observations that the GP practice was ensuring its staff had received training in line with the intercollegiate document on Safeguarding training, that provides a clear framework which identifies the competencies required for all healthcare staff. Locally, staff are also made aware of signposting to the local domestic abuse specialist provider United Against Violence and Abuse (UAVA). This observation is further supported by a Care Quality Commission inspection of the GP practice conducted in December 2016, reporting an overall rating of ‘Good’ across all areas inspected and with regard to vulnerable patients it reported “*Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours*”.<sup>14</sup>
- 16.2.6 In addition, further reassurance as to the approach of GP practices to Domestic Abuse and broader concerns was provided by the CCG Panel representative, who drew the panels attention to a Domestic Violence and Abuse Policy introduced in March 2018 and the development of social prescribing in the area. Within the policy it states the obligation of GP staff to share concerns of abuse or neglect, stating ‘have a responsibility to share concerns appropriately and refer onto the relevant agency’. The obligations of the policy are the responsibility of all GP practice staff. There are also GP Safeguarding Leads who have an additional responsibility to be a source of advice and guidance for their practice staff. These leads are supported in this role through specialist training and attendance at bi-monthly Safeguarding Forums that specifically provide an opportunity for sharing and seeking information with the partners in respect of Safeguarding including Domestic Abuse. This obligation to share information with agencies has been reciprocated, in that from July 2019 the local Multi Agency Risk Assessment Conference (MARAC) has introduced a policy where a letter is sent to the GP for every victim discussed at the meeting. This demonstrates an evolution in the practice approach to Domestic Abuse and wider risk management processes.
- 16.2.7 Furthermore the introduction of social prescribing is a recent development for local practices, including John’s. Social prescribing works for a wide range of people, including people:
- with one or more long-term conditions;
  - who need support with their mental health;
  - who are lonely or isolated;
  - who have complex social needs which affect their wellbeing.<sup>15</sup>
- 16.2.8 The panel explored how social prescribing actually works. Upon exploring with the CCG representative and practice manager it was reported that, “If a patient highlights to a clinician or a member of staff that they are struggling socially, a task is sent to the social prescriber who will contact the patient’ or similarly the healthcare professional can refer the patient to a social prescriber with consent. The NHS provides further insight: *Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on ‘what matters to me’ and taking a holistic approach to people’s health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.*<sup>16</sup> In effect, this enables conversations to take place with the patient and for the link worker to act as a focal point for signposting and coordinating support. Social prescribing has been voluntarily undertaken by the GP practice and was

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<sup>13</sup> Source: [Screening women for intimate partner violence in healthcare settings | Cochrane](#) (Accessed November 2019)

<sup>14</sup> Source: <https://www.cqc.org.uk/search/services/doctors-gps> (Accessed December 2019 - specific link NOT provided to retain anonymity)

<sup>15</sup> Source: <https://www.england.nhs.uk/personalisedcare/social-prescribing/> (Accessed July 2020)

<sup>16</sup> Source: <https://www.england.nhs.uk/personalisedcare/social-prescribing/> (Accessed July 2020)

recognised by the panel as a positive development pertinent to many of the discussion points highlighted below.

- 16.2.9 In John’s case, there were no clear indicators of domestic abuse, though arguably indicators of care and support needs. However, the panel notes there has been significant local development in practice such as policy, training and social prescribing

**Consideration / Learning Opportunity 1: Merits of routine enquiry**

**Barriers to Support**

- 16.2.10 Whilst John did attend his appointments regularly, there were missed appointments and one cluster of missed appointments. The response was recorded as attempts to contact John by letter. There was one cluster of missed appointments in quick succession, on the 3rd, 10th and 13th November 2014. Such patterns may be described as temporal sequencing, ‘happenings in a space of time’.<sup>17</sup> However, it is understood that John did not have a phone which is itself a barrier to support, and was open to speculation as to why there was no answer. The CCG panel representative reverted back to the GP practice and their records show that the phone number recorded belonged to John’s brother-in-law. The panel considered this and concur that in the case of a patient reliant on medication, a sequence of non-attendance would have merited improved professional curiosity to ascertain why, but needs to be seen against how non-attendance was dealt with three years later. (16.2.11)

**Consideration / Learning Opportunity 2: Exploring of changing patterns of attendance**

- 16.2.11 The panel considered the last occasion during the relevant period when John was seen by his GP. On the 22nd February 2017 a nurse reported that he was unable to attend as he had swollen feet and because he could not afford transport to get to the surgery. This was acknowledged in the IMR as a learning point, identifying the need to take a more holistic view and show greater professional curiosity for patients missing appointments. Whilst Professional Curiosity is required to identify reasons for missing appointments, John’s inability to attend through physical incapacity and ultimately his financial situation was a barrier to getting help and presented opportunities to consider his overall situation.
- 16.2.12 This was made worse by the fact he did not have a phone, either landline, or mobile. It is not within the terms of reference to seek solutions to this conundrum, but it struck the chair and panel as a matter requiring consideration in an area of high deprivation as outlined at 13.7 and for a GP practice serving over 14,000 patients. A report in the United States notes; “Lower socioeconomic status, ethnicity, and race are associated with reduced health care use in the United States. Patients who continually miss their appointments suffer significant negative results, including a disruption in continuity of care, complications with their chronic illnesses, and an increase in hospital readmissions”<sup>18</sup> A study in the UK, conducted in 1980 also found that “although overall health had improved since the introduction of the welfare state, there were widespread health inequalities. It also found that the main cause of these inequalities was economic inequality.”<sup>19</sup> Reflecting upon local deprivation noted at 13.7 and the relative deprivation of Leicester and the ward in which John lived, the panel agree financial difficulty was a barrier to accessing support.

**Consideration / Learning Opportunity 3: Financial hardship as barrier to accessing support**

<sup>17</sup> Source: <https://classroom.synonym.com/what-is-a-temporal-sequence-12573330.html> Accessed (July 2019)

<sup>18</sup> Source: <https://scholarworks.waldenu.edu> (Accessed 4<sup>th</sup> October 2019)

<sup>19</sup> Source : [https://en.wikipedia.org/wiki/Black\\_Report](https://en.wikipedia.org/wiki/Black_Report) (Accessed November 2019)

- 16.2.13 The GP’s response, in changing John’s medication was practical and a reasonable adjustment to reduce the necessity of John attending the practice so frequently. Hence, the panel welcomed the IMR author’s recommendation in respect of Professional Curiosity “all clinicians to be reminded to view their patients holistically, in this case to review the reason he could not attend for the blood test not just change the medication”. In this case, the IMR author has requested this matter is raised by the Safeguarding Lead GP at a practice meeting.

**Consideration / Learning Opportunity 4:** Professional curiosity on presentation of indicators of health and well being

- 16.2.14 John’s attendance at the GP practice and change of medication on the 22<sup>nd</sup> February was his last visit to the GP, before he died. Whilst his medication was changed, it is not known whether he or anyone else collected his new medication, or whether he took the medication. The panel did learn that since John was over 60, he was entitled to free prescriptions and therefore cost would not have been a prohibitive factor in taking medication.<sup>20</sup> This new medication did not require routine anticoagulant monitoring and the CCG panel representative advises that there would not have been a reason to recall or follow up with John during the period between the 22<sup>nd</sup> February and his death. However, the practice provided safety advice to John on change of medication in line with prescribing guidelines.

### Care and Support Needs

- 16.2.15 John’s inability to attend his appointments through physical or other incapacity and the manner in which he finally passed away posed the question whether he was vulnerable to the extent of being at risk of abuse or neglect, in effect a Safeguarding Concern under section 42 of the Care Act 2014 that would have obliged the local authority to make enquiries<sup>21</sup>, or had care and support needs to the extent of having a significant effect on his well-being<sup>22</sup> under section 9 of the Care Act, that would have merited the offer of an assessment. It was reported at the panel, that the GP practice whilst following local safeguarding procedures, works to a criterion for flagging broader vulnerability in the medical records as: Learning Disability, Age, Lack of Family Support, Disability, Dementia.
- 16.2.16 Eligibility for care and support needs is subject to a three-stage test;  
**Condition 1-** The adult’s needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors;  
**Condition 2-** As a result of the adult’s needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section, and;  
**Condition 3 -**As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult’s wellbeing.<sup>23</sup>
- 16.2.17 The requirement for a local authority to make an enquiry of an Adult Safeguarding Concern occurs, if it believes an adult is experiencing, or is at risk of abuse, or neglect.

<sup>20</sup> Source: <https://www.nhs.uk/using-the-nhs/help-with-health-costs/get-help-with-prescription-costs/> (accessed March 2020)

<sup>21</sup> Source: This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)— (a) has needs for care and support (whether or not the authority is meeting any of those needs), (b) is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.

<sup>22</sup> Source : The adult’s needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors, - as a result of the adult’s needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section, - as a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult’s wellbeing. <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp> (Accessed 7th October 2019)

<sup>23</sup> Source: <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp> (Accessed November 2019)

- 16.2.18 In order to consider the implications of having care and support needs or being at risk of abuse/neglect, the panel considered whether such concerns; (a) were clear and obvious or (b) being alerted to such a concern.

**Anything obvious**

- 16.2.19 With regard to local GP policy around recognising vulnerability, John had never presented the issues of Learning Disability or Dementia. The observation by John's brother-in-law that he had suffered an accident as a child resulting in some minor brain injury was checked by the panel representative. John had been involved in a car accident in 1961, but records suggest John's head injury was not an ongoing concern. However, he did suffer from limited mobility through osteoarthritis of the knees, having accessed physiotherapy regarding his mobility before the relevant period. John therefore had a physical impairment and one may contend met Condition 1 of the three-stage test.
- 16.2.20 However, there was nothing overtly obvious recorded within the IMR for the GP practice. Identification of any of the requirements for Condition 2, would have required screening, or enhanced professional curiosity as to his circumstances. In John's case, his brother-in-law has described his concerns that John was unable to go upstairs to the toilet. (a specific outcome under Care Act).<sup>24</sup> This information was known to others and it was 'knowable' had wider professional curiosity in respect of health and well-being been demonstrated, by asking questions of John (or Audrey)
- 16.2.21 The panel reflected on John's financial predicament and the overt effect on his appearance. His family reported that he wore threadbare clothes and shoes with no soles. It is contended that any such determination as to whether a medical professional ought to have noticed, would be entirely subjective and risks introducing the 'counsel of perfection' and hindsight bias. They do however agree that Professionals ought to be mindful of individual's appearance as part of an overall holistic view of a subject's well-being. The GP IMR has made a specific recommendation that addresses this learning opportunity regarding the need for staff to take a holistic view of the patient and not just the presenting problem. In addition, the introduction of social prescribing at the GP practice is seen as a significant development that encourages medical professionals to take a broader view.

**Consideration / Learning Opportunity 5:** Professional curiosity / being alert to indicators of health, well-being or neglect

**Being alerted to**

- 16.2.22 The panel considered two events as potential alerts in respect of John having Care and Support Needs.
- 16.2.23 The first event occurred outside of the relevant period, on the 25th September 2013. John's brother-in-law phoned the doctor, expressing concern that John was not well, that his leg was swollen and asking for a home visit. Whilst a home visit did not occur at the time, records show that the brother-in-law had expressed concern about (i) John's social situation, (ii) that he was being treated like an animal and (iii) an observation was made about his wife and son not being bothered about him. John's brother-in-law Thomas recalled this incident and describes phoning twice and attending the practice such was his concern for John. He could not recall who he had spoken to at the practice. There is no record of the brother in law's attendance at the practice.
- 16.2.24 John's brother-in-law is clear in his contention that he was raising a concern about John's situation and that he inferred the practice was treating John like an animal. In effect he was acting as an advocate on behalf of John. He believes he was misunderstood by the practice

<sup>24</sup> Source: <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/outcomes-care-support-needs.asp> (Accessed 7<sup>th</sup> October 2019)

staff. Whilst the Care Act was not in place at this time, it struck the panel that the observations made and recorded by the practice may have merited follow up with Adult Social Care and/or investigation as a complaint against the practice. Whilst neither was documented by the practice, the records do reflect they were waiting for the brother-in-law to phone back after he had called an ambulance. On exploring whether the GP ought to have called an ambulance, agencies agree that it would be usual to ask the person 'on scene' to phone the ambulance service, as they would be able to pass on the information directly to the ambulance service. (unless there were clear reasons for the agency to do so). There are no records of an ambulance having been called on this date

- 16.2.25 Since John's death, there have been county wide changes and requests by a family member to the GP would result in contact with the Clinical Response Team (CRT) who are part of the out of hours service. If the same circumstances occurred today, they would carry out a home visit and deal with medical and safeguarding issues arising.
- 16.2.26 With regards to whether a complaint ought to have been recorded, it has not been possible to speak to an individual member of staff about the circumstances. Thomas told the chair that he was not asked whether he wanted to make a complaint. There is a practice complaints procedure<sup>25</sup> in place and it seemed to the panel that the apparent frustration ought to have merited Thomas being asked whether he wanted to make a complaint and/or an internal management review of the circumstances. The complaints procedure would include offering information on how to make a complaint and who to speak to 'if' it was recognised that the person may want to complain. What we don't know is that whether it was recognised Thomas wanted to complain, whether the staff failed to offer the complaints process and if the person was denied information on the complaints procedure when they asked for it? The complaints procedure is available on line and is also signposted within the surgery.
- 16.2.27 The second example on 22nd February 2017 when John explained his difficulty in attending the surgery owing to his swollen feet and financial issues. Reflecting on the eligibility criteria of the Care Act, John not being able to attend his surgery was unable to make use of "necessary facilities or services in the local community", thereby satisfying one of the eligibility criteria for condition 2 described at 16.2.11.<sup>26</sup>The panel agree both incidents would have benefitted from taking a holistic view of his circumstances. The practice had limited information, but further exploration may have gained detail regarding other aspects of the eligibility criteria such as managing toilet needs and being appropriately clothed. These were issues of concern to John's brother in-law, but would not have been apparent to medical staff without improved professional curiosity.

**Consideration / Learning Opportunity 6:** Professional curiosity on presentation of indicators of abuse or neglect

- 16.2.28 Mindful of the risks of hindsight bias, the panel considered that on balance, it was debatable that the threshold for a s.42 Care Act Safeguarding Alert would have been met. The panel do however, agree this was a missed opportunity to offer a s.9 Care Act assessment, but that the individual agency recommendations and development of social prescribing make it less likely it would occur again.

**Consideration / Learning Opportunity 7:** Care and support needs as part of an overall holistic assessment.

- 16.2.29 The panel had examined the merits of routine enquiry regarding Domestic Abuse at 16.2.2 to 16.2.7 and recognised that there were merits in wider safety and well-being screening.

<sup>25</sup> Source: <https://www.merridalemedicalcentre.co.uk/info.aspx?p=10> (Accessed May 20)

<sup>26</sup> Source: <http://www.legislation.gov.uk/ukdsi/2014/9780111124185> (Accessed November 2019)

- 16.2.30 On broadening this concept of professional practice further, clarity was sought in respect of how far the NHS initiative “Making Every Contact Count (MECC)” had been adopted. Whilst the concept was not widely known, the GP Practice had recognised the potential of taking a more holistic view on patient care, introducing a “Social Prescribing” practitioner who would help support any social needs that a patient may have. This professional may see such patients at home or in the practice. Social Prescribing is described as “a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face-to-face conversation during which they can learn about the possibilities and design their own personalised solutions”.<sup>27</sup> This is seen as a significant and positive development for GP practices.

#### Audrey as a Carer

- 16.2.31 The panel had been invited to consider John’s wife’s role as a ‘carer’ and in particular; her 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’.
- 16.2.32 It has been confirmed that Audrey was not registered as a ‘carer’ by the GP practice, nor is there particular reference as to her role or her attendance at the GP practice with John.
- 16.2.33 In order for Audrey to be considered as a carer within the terms of the legislation, there are three conditions to be met.  
**Condition 1:** The carer’s needs for support arise because they are providing necessary care to an adult.  
**Condition 2:** As a result of their caring responsibilities, the carer’s physical or mental health is either deteriorating or is at risk of doing so or is unable to achieve any of the outcomes as specified in the regulations.  
**Condition 3:** As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the carer’s wellbeing.<sup>28</sup>
- 16.2.34 Whilst a carer can be eligible for support whether or not the adult for who they care has eligible needs, in order for her to be considered eligible either Audrey herself or an agency would have to raise the possibility of such support being made available. This support could have been practical or financial such as carer’s benefits.<sup>29</sup> In the absence of information from agencies or Audrey herself as to the impact of John’s illness on her physical or mental health or the extent to which she was vulnerable, it is not possible to determine whether she would have been eligible for assistance or whether there were barriers to her seeking assistance as a carer. It was noted that the Leicester City Council<sup>?</sup> has contracted Age UK to provide its Leicester Carer Support Service.<sup>30</sup>

#### **Recognising and Responding to Injury**

- 16.2.35 The GP practice IMR author makes reference to John’s medical condition requiring medication for his blood, but also references John’s unsteadiness and use of crutches owing to physical ailments. Notwithstanding this comment, the IMR author has identified learning in respect of an incident on 11th September 2014, when John attended the GP after a fall causing pain and a linear mark to his abdomen. The physical ailment was treated, but was not met with professional curiosity in respect of potential Domestic Abuse. The IMR author reports that if the same incident occurred now, the clinician would ask about Domestic Abuse. NICE guidelines recommend that “Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or

<sup>27</sup> Source: <https://www.socialprescribingnetwork.com/> (Accessed 7<sup>th</sup> October 2019)

<sup>28</sup> Source: <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-carers-needs.asp> (Accessed December 2019)

<sup>29</sup> Source: <https://www.gov.uk/browse/benefits/disability> (Accessed December 2019)

<sup>30</sup> Source: <https://www.ageuk.org.uk/leics/our-services/support-for-carers/leicester-carers-support-service/> (Accessed May 2020)

abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.”<sup>31</sup>

**Consideration / Learning Opportunity 6 (repeat):** Professional curiosity on presentation of indicators of abuse or neglect

- 16.2.36 Whilst an individual agency recommendation was made “Practice to remind all clinicians to lower the threshold when asking whether there is Domestic Abuse in the family”, a question arose as to the familiarity of clinicians in respect of Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH), Risk Assessment. It was contended by the CCG representative that health practitioners receive Level 3 Safeguarding training that incorporates Domestic Abuse training and would therefore be able to recognise and respond to Domestic Abuse, referring to specialist agencies with consent as needed. Moreover, health practitioners are now also supported by a GP safeguarding lead who has enhanced training and responsibility in relation to safeguarding adults. Furthermore, the GP policy (referenced at 16.2.6) introduced after this incident, specifically sets out the responsibilities to share and seek information regarding Domestic Abuse between the GP and police, and to involve the GP practice in the MARAC process, referring appropriately in high-risk cases. The panel considered the merits of citing a learning opportunity in respect of DASH, but given that there was not a pattern of missed opportunities in identifying domestic abuse and there has been a significant evolution in practice, the case was not made.

**Consideration / Learning Opportunity 8:** Professional curiosity when presented with indicators of abuse and use of DASH

### 16.3 Leicester City Council Housing

- 16.3.1 This Review was conducted by reference to a review of the records recorded on the Northgate computer system and by the IMR author personally speaking to staff members who had made entries on the system
- 16.3.2 John and Audrey had been tenants of Leicester City Council Housing (LCCH) since 6th November 1978. Their contact with LCCH may be broken down into two main themes. The first related to routine maintenance and work on their home. The second relates to the financial difficulty that John and Audrey had in paying their rent. In both areas of contact, Domestic Abuse and other Safeguarding concerns were not identified.

#### Routine Maintenance

- 16.3.3 As noted at 15.2.1 above, there were nine recorded log entries related to maintenance during the relevant period. However, the volume of calls was not considered disproportionate, there being no patterns or details disclosed that would alert agencies as to concerns. The panel considered research by Safelives and Gentoo that found that approximately 13% of housing repairs were related to Domestic Abuse.<sup>32</sup> Furthermore the LCCH panel representative was able to report that LCCH alongside Leicestershire and Rutland Councils is in the process of seeking Domestic Abuse Housing Alliance (DAHA) accreditation. The Mission of DAHA is to improve the housing sector’s response to domestic abuse through the introduction and adoption of an established set of standards.<sup>33</sup> This was recognised by the panel as a positive step to tackling domestic abuse

<sup>31</sup> Source: <https://www.nice.org.uk/guidance/ph50/chapter/1-Recommendations#recommendation-5-create-an-environment-for-disclosing-domestic-violence-and-abuse> (Accessed 4<sup>th</sup> October 2019)

<sup>32</sup> Source: [https://safelives.org.uk/Safe\\_at\\_Home](https://safelives.org.uk/Safe_at_Home) (Accessed May 2020)

<sup>33</sup> Source: <https://www.dahalliance.org.uk/about-us/who-we-are/> (Accessed July 2020)

- 16.3.4 The maintenance records do not detail any conversation and appear transactional in nature, such as ‘a gas service was undertaken’. The panel learned that ‘operatives’ employed by Leicester City Council includes electricians, gas engineers and carpenters. Only on occasions of particularly high demand or where specialist skills are required, would an external contractor be called in. The daily demand may be as high as eight or nine repairs per day for an electrician and their role is transactional, in other words to attend the address and effect the repairs required. However, all operatives are trained in Safeguarding in respect of Adults and Children, Domestic Abuse and Prevent. They are therefore capable of reporting concerns or circumstances that appear out of the ordinary. The panel were informed of a relatively recent development in practice, moving away from paper-based reports to a PDA (personal digital assistant), that has an e-system for referrals and alerts regarding Safeguarding and Domestic Abuse. On attending a ‘job’, operatives, if any concerns are noted, are able to enter an alert which will result in an automatic referral to the Housing Officer who will then investigate further. The categories are very broad and include signs of abuse (both for adult and child); house in a poor state inside, garden in a poor state.

### **Financial Difficulty**

- 16.3.5 LCCH’s direct engagement with John and Audrey related to arrears in rent, that in part related to an under-occupancy charge for the rent due on their house. Under the Welfare Reform Act 2012, the government removed what it called the spare room subsidy. Under the changes, tenants in social housing have their benefit reduced by 14% if they have a spare bedroom or 25% if they have two or more. Two children under 16 of the same gender are expected to share one bedroom, as are two children under 10, regardless of gender. On average, a tenant affected by the bedroom tax is losing between £14 and £25 a week.<sup>34</sup> In John and Audrey’s case, their home is a three-bedroom property that would have resulted in their benefits being reduced by 25% owing to having two spare bedrooms.
- 16.3.6 LCCH staff spoke frequently with John and Audrey, with an overall plan to avoid further liabilities for ‘bedroom tax’, by swapping to more size appropriate accommodation. Notes record that Audrey was reluctant to move as their grandchildren who would often visit and stay over especially at weekends. This is apparent from speaking to family members and was also clear over the weekend that John fell seriously ill.
- 16.3.7 This refusal to downsize, no doubt contributed to their financial difficulties. The panel explored whether there were mechanisms to appeal decisions in respect of the under-occupancy charge, such as occupants like John and Audrey undertaking childcare for grandchildren and learned that there are no arrangements in place.
- 16.3.8 It was clear to LCCH professionals in their dealings, that Audrey managed the finances, with John quoted as saying “Speak to the wife”. A further record on 29th April 2015 quotes, John saying “he knows almost nothing regarding their finances” and not being in possession of all the information required to complete a DHP application, such as details of income/outgoings, national insurance numbers, etc. These quotes alone could be interpreted in many ways, with John directing how finances were managed or an alternative of John deferring to Audrey in respect of money management. John’s brother-in-law used the phrase ‘dominant’ to describe Audrey’s role in managing the money. It was also noted by one professional that she would do ‘all the dealing with the rent’ and it was observed by the same professional as not being unusual in respect of other tenants. The panel considered this point and whilst recognising financial control as being symptomatic of Domestic Abuse they agree it is not possible without further triangulation, to say whether there this was ‘abuse’ or the agreement within the household as to how the household budget was managed.

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<sup>34</sup> Source: <https://www.theguardian.com/society/2016/jan/27/the-bedroom-tax-explained> (Accessed 6th October 2019)

- 16.3.9 The Leicester City Council Housing IMR references a professional observing that Audrey had difficulty managing the circumstances, being described as someone without any sense of urgency and perhaps had a degree of learning disability. She was described as an individual who through a catalogue of errors had difficulty getting benefits paid and ensuring rent was paid on time. However, this was not tested and was not deemed necessary by Leicester City Council Housing in their contacts, as she was able to carry out usual activities to survive.
- 16.3.10 The only occasion that her cognitive abilities were tested, were in relation to the investigation into the incident of John's death. She was not deemed to require an appropriate adult and was formally assessed by a custody nurse. The Police and Criminal Evidence Act 1984 Code C states that: the police custody officer or custody staff shall determine whether the detainee is a juvenile and/or vulnerable and therefore requires an appropriate adult.<sup>35</sup> Put simply, a person is now vulnerable if a police officer has any reason to suspect the person may;- have difficulty understanding the full implications or communicating effectively about anything to do with their; -detention; - have difficulty understanding the significance or things they are told, questions, or their own answers; - may be prone to confusion, suggestibility, or compliance; or may be prone to providing unintentionally unreliable, misleading or self-incriminating information. Such vulnerability may be through, mental illness, learning disabilities, autistic spectrum disorders or brain injuries.
- 16.3.11 A further observation by LCCH staff was that much of their business was conducted on the doorstep. On exploration, it seems that when staff did access the premises, it appeared cluttered, not to the extent of hoarding, but cluttered. This observation is pertinent, in that it is not describing an environment that was inhabitable or unhygienic. Were this the case, one may have considered this as an indicator of individuals at risk of neglect.
- 16.3.12 The panel reflected on family comments about the accommodation. John's brother-in-law (Thomas) commented about the house being antiquated and smelling of smoke tending to reflect the observations of LCCH staff. On the other hand, a sister has described the living conditions as 'horrific', having to use a scraper to clean the carpets. Such judgements are subjective, informed by individual and personal circumstances and perhaps enforced by one's own norms, what one is used to experiencing, seeing and dealing with. The risk when considering these circumstances is making judgement based on hindsight bias. However, it is perhaps wise to be alert to the possibility of professionals being desensitised through repeated exposure to adverse circumstances.<sup>36</sup> This observation is supported by the commentary of the police and ambulance service, citing the condition of the house as one of the reasons for submitting a safeguarding alert. The panel did consider whether the condition of the house had deteriorated, but on balance considering family observations concluded the home circumstances had already been poor for a period of time.

**Consideration / Learning Opportunity 9: Risk of normalisation / desensitisation.**

- 16.3.13 In July 2016, owing to their level of debt, a Notice of Seeking Possession (NOSP) was served regarding John's arrears. The service of a NOSP and its being acted upon is discretionary and the actual notice lapses if not acted upon within 12 months. Notwithstanding the threat of enforcement action, LCCH also ensured a positive intervention for support was made with the deployment of STAR (Support for tenants and residents) to assist with managing their arrears and a debt reduction plan was put in place. This involved looking at their income from benefits and also outgoings including rent, utility bills and other outgoings. Such a support mechanism is recognised as effective and

<sup>35</sup> Source: <https://www.appropriateadult.org.uk/index.php/information/faq#support> (Accessed March 2020)

<sup>36</sup> Source: Desensitise "diminishes [emotional](https://en.wikipedia.org/wiki/Desensitization_(psychology)) responsiveness to a negative, aversive or positive stimulus after repeated exposure to it" [https://en.wikipedia.org/wiki/Desensitization\\_\(psychology\)](https://en.wikipedia.org/wiki/Desensitization_(psychology)) (Accessed December 2019)

supportive, enabling clients to make informed adjustments to personal expenditure to help manage the overall household budget. The chair also notes that records show LCCH were aware of John's mobility issues and asking that home visits were advisable, as opposed to meeting at council premises.

- 16.3.14 The panel representative explored whether the original records are available and reports that these had been destroyed. This is subject to an individual agency recommendation.

#### **16.4 Leicestershire Police**

16.4.1 There was no contact with John during the relevant period.

16.4.2 There was only one contact with Audrey during the relevant period. This sole incident may be considered relevant when considering the broader picture, as it relates to a low value shoplifting offence of food.

#### **16.5 Adult Social Care**

16.5.1 There were no alerts or contacts with Adult Social Care prior to the events immediately prior to John's death.

#### **16.6 East Midlands Ambulance Service**

16.6.1 Whilst the ambulance service had no contacts prior to the attendance resulting in John's admission to hospital, they did submit an alert to adult social care owing to the circumstances in which they had found John. They noted that the house was in a 'bad state' and cited its general condition as one of the factors requiring a safeguarding alert to be made. This prompted the question as to whether the condition had deteriorated over time. Given, the family accounts, it seems that the condition of the house was always likely to have been subjectively dirty/poor. This is explored further below.

## **17. CONCLUSIONS AND LESSONS LEARNED**

17.1 The chair and panel are mindful of 'Hindsight Bias', highlighting what might have been done differently and avoiding the 'counsel of perfection'. This review panel has attempted to view as broadly as possible what happened, to understand the circumstances of John and Audrey's lives to help explain the circumstances of his death. The panel has also carefully considered the views of available family and friends to shine a light on the broader circumstances of John and Audrey's life, though it is accepted their contact with John had become less frequent over recent years and the chair was unable to speak to immediate family members. The panel has also reflected on local service developments, deliberating over the final two panel meetings on what difference these changes would have made for John if they were in place before his death, before considering how lessons learned would translate to meaningful recommendations.

#### **17.2 Overview**

17.2.1 John and Audrey had been married for over 35 years and it is clear that John's life was blighted with ill health that limited his mobility significantly in the latter years of his life. It is also apparent from the accounts given by family members as well as Leicester City Council Housing and his GP, that there was significant financial hardship. They had difficulty paying for their rent, they could not afford to have a phone, cost was cited as a barrier to attending his GP appointments and family members report how his sister who had run a café would ensure he was well fed. The panel learned that this level of deprivation would not have been

unusual in the locality where he lived. However, no one had any concerns that domestic violence and abuse, or that neglect was a concern.

- 17.2.2 Whilst, this was a challenge for the panel, it has been possible to get an insight into their circumstances from the accounts of Leicester City Council Housing and family. It seems from comments made to Housing “Speak to the wife” when asked about money, that John deferred to her in the relationship regarding the management of their finances and arguably their overall relationship.
- 17.2.3 The panel considered whether the extent to which the management of household finances may have amounted to financial abuse as ‘an aspect of a pattern of controlling, threatening and degrading behaviour that restricts a victim’s freedom’<sup>37</sup> or economic abuse by Audrey restricting how John ‘acquired or used money regarding accommodation, food and clothing’.<sup>38</sup> Whilst the panel recognised features such as John not having a phone as being isolating and comments having been made about food and clothing, they were unable to draw a conclusive opinion as to whether management of household finances was the agreement between a couple or a form of controlling behaviour. The panel were also mindful of other factors such as the relevant deprivation in the area where they lived and John’s lack of mobility that restricted his ability to carry out practical tasks such as shopping. (Learning Opportunity 10 refers) Furthermore, comments within an IMR that “John gave permission to speak to Audrey on the doorstep” tend to go against her controlling him. Nevertheless, the panel agree that professionals need to remain vigilant to the possibility of financial abuse when dealing with clients.
- 17.2.4 Whilst there was not clear evidence of domestic abuse, John was never asked about feelings of safety and well-being, though there were opportunities to ask screening questions and there was one incident where John had sustained a physical injury, that could be cited as a trigger incident inviting a greater degree of Professional Curiosity. However, this was an isolated incidence.
- 17.2.5 The panel agreed that there were signs of neglect, but insufficient to determine that John had care needs sufficient to warrant a Safeguarding alert, that would have obliged the local authority to undertake enquiries.<sup>39</sup> However, it is arguable that given his physical incapacity an offer of a needs-assessment under section 9 Care Act could have been considered. His brother-in-law had sought assistance from John’s GP prior to the relevant period, recognising John’s difficulties getting to the surgery and also inferring that his family were ‘not bothered’ about him. He also reported that he tried to seek assistance from Social Services in securing a stair lift, though there is no evidence of a referral being made. He cites John’s inability to get to the toilet upstairs as a reason for seeking help and this alone, one may argue, required consideration in respect of Care Needs.
- 17.2.6 In weighing up the extent of any potential recommendation, the panel reflected on practices at the time, versus practices that have developed, avoiding the temptation of outcome bias, thereby judging the tragic outcome more harshly. In particular the GP practice has implemented a clinical response team (16.2.4) that would have responded to the event before the relevant period. It has also voluntarily introduced social prescribing (16.2.6-8) that has developed holistic practice to support people such as John. Similarly, in housing,

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<sup>37</sup> Source: [Financial and economic abuse - Womens Aid](#) (Accessed March 2021)

<sup>38</sup> Source: [Economic Abuse: Regaining financial independence - Lexology](#) (Accessed March 2021)

<sup>39</sup> Source: This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)— (a)has needs for care and support (whether or not the authority is meeting any of those needs), (b)is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (2)The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.

<http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted> (Accessed 10th October 2019)

the implementation of PDA's requires proactive consideration of the state of premises that may alert the professional to safeguarding concerns.

### **17.3 Lessons Learned**

17.3.1 This review has afforded the panel a number of 'considerations' that have been highlighted during the review process. These are drawn together under various headings below.

#### **Impact of Financial Hardship**

17.3.2 The impact of financial hardship was isolating for John, hindering his attendance at his GP and housing and even his ability to communicate with agencies as he could not afford a phone. It also seems that his financial circumstances effected his overall well-being. What one cannot determine, is if the extent of 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.

17.3.3 It may also be argued that where a patient such as John is reliant on the use of 'his brother's' phone, this may have prompted some curiosity with John. The point herein, is recognising the effect of financial difficulty on, and as a factor that merits consideration regarding a person's health, well-being and safety. However, the panel acknowledges that recent developments in social prescribing makes it more likely that such difficulty would not go unnoticed.

#### **Well-being, Safety, Professional Curiosity and Desensitisation**

17.3.4 In his dealings with agencies, they have focused on the immediate issues presenting to them, as opposed to taking a more holistic view. In the case of housing, dealing with his rent arrears and in the case of his GP, tackling the medical issues that beset John. And yet we know from his family, that John lived in a home that family members have on one occasion described as 'horrific' and that it also sees that John wore threadbare clothes and was to a degree reliant on foodbanks.

17.3.5 Balanced against these observations are that John rarely presented circumstances giving 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, environmental circumstances of the home or in the case of LCCH conducting business on the doorstep. After all, family members commented about the condition of John's home, as did the ambulance service when they attended and conveyed him to hospital. It is therefore also suggested professionals who are in frequent contact with clients need to also be alive to the risk of desensitisation.

17.3.6 However, there were occasions where his General Practice could have shown greater professional curiosity in respect of his well-being and merited offering a Care Assessment, such as when he had been unable to attend his GP owing to swollen feet (2017), if considered holistically as part of a whole picture of financial difficulty and wearing threadbare clothes.

17.3.7 It was also acknowledged that his attendance at the GP with an injury merited improved professional curiosity in respect of his safety, though developments such as a new practice policy in relation to domestic abuse shows an evolution in the approach to domestic abuse, involving GP practices in MARAC processes by way of example.

## Screening

- 17.3.8 The panel acknowledge the pressure that all agencies operate in, be it the GP with ten minutes to see a patient or the gas engineer with a long list of appointments to attend. Mindful of looking through the lens of perfection, the adoption of the principles of ‘Making Every Contact Count’ was raised as a discussion point as 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. This may prompt professionals to ask more probing questions that could open the door for offers of Care Assessments, identification of abuse and appropriate risk assessments that informs an overall holistic approach to Health and Personal Safety.
- 17.3.9 A further discussion point arose, as to the merits of routine enquiry regarding Well-being and Safety. Whilst considered positive, the panel acknowledge the practical resource limitations of attempting this at every contact. The panel also considered the potential of ‘Making Every Contact Count’ and ‘routine enquiry’ against recent developments in respect of local policy and social prescribing described at section 16.2. These are recognised as a positive evolution in local practices to safeguard the vulnerable. The panel concurred that had social prescribing been in place at the time, John would have been a patient signposted to this service.

## Equalities

- 17.3.10 The Human Rights Act 2010 defines disability as “A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities”.<sup>40</sup> John undoubtedly met this definition. On considering the Equalities Act, it places a duty on public authorities to;
- remove or reduce disadvantages suffered by people because of a protected characteristic
  - meet the needs of people with protected characteristics
  - encourage people with protected characteristics to participate in public life and other activities<sup>41</sup>
- 17.3.11 Whilst his GP made reasonable adjustments in respect of his medication to avoid the need to visit the practice so frequently, it is arguable that his immobility and effect on him may have been considered earlier by agencies who came into contact with him. Greater professional curiosity, asking him what the effect of immobility was on his health and life could have resulted in the offer of a Care Assessment or other practical assistance.
- 17.3.12 Putting oneself in John’s position, an individual living with medical ailments and disability, exacerbated by financial difficulty, it may be argued that the issue of intersectionality<sup>42</sup> is apparent. That is an overlap of social identities that contributed to John’s experience such as having difficulty accessing GP services. As part of the analysis, the panel learned that Leicester is beset by high levels of deprivation. Housing services also commented at panel meetings that their overall circumstances were not that unusual. However, the review showed that LCCH and STAR worked with John and Audrey to advise and guide them, offering budget advice and attempting to secure a house move to mitigate their financial difficulties. Whilst we cannot determine whether John suffered from Domestic Abuse, it

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<sup>40</sup> Source : <https://www.equalityhumanrights.com/en/equality-act/protected-characteristics#disability> (Accessed December 2019)

<sup>41</sup> Source: <https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/> (Accessed December 2019)

<sup>42</sup> Source: <https://www.dictionary.com/browse/intersectionality> (Accessed January 2020)

remains that authorities need to be alert to the effect on individuals through overlapping of multiple issues.

- 17.3.13 Notwithstanding the above, the panel kept in mind the question as to whether being a man was a barrier to accessing support, as it is often suggested that ‘men find it harder to report abuse than women’. Indeed, a recent government paper ‘Male Victims Position Paper’ reported that ‘whilst all victims and survivors face barriers to reporting, a research study found five key themes explaining men’s reluctance to seek help: service target perception; shame and/or embarrassment; denial; stigmatisation; and fear’<sup>43</sup>. In John’s case, these barriers were not clear and apparent. That is not to say they weren’t present and there remains a need for professionals to be alert to these potential barriers.
- 17.3.14 Whilst the panel were unable to discover any trail of domestic abuse, it is clear that the local provider for domestic abuse services emphasises its services as an organisation providing ‘Help and Support for ANYONE suffering abuse’.<sup>44</sup> Also, the ADAM project (Action against Domestic Abuse for Men)<sup>45</sup> in Leicester is one of very few locally based services for men in the UK. This project provides free, confidential support to males aged 16 and over living in Leicester, Leicestershire and Rutland, who are experiencing or at risk of domestic abuse. Together, the panel agree these services support the local Vision and Strategic Objectives for 2019-22 regarding Domestic Abuse that contains the objective “Ensure the identification of bespoke approaches to key vulnerable groups and those not being identified/accessing service”.<sup>46</sup> It seems that John’s circumstances could fit into this category.
- 17.3.15 The panel also considered whether there was a risk of any gender bias that is usefully described by Kirwan Institute for the Study of Race and Ethnicity as “*biases, which encompass both favourable and unfavourable assessments, are activated involuntarily and without an individual’s awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness. Rather, implicit biases are not accessible through introspection*”.<sup>47</sup> Whilst gender bias was not raised within individual IMR’s nor apparent in the review panels deliberations, they agree that the potential for gender bias must be kept in mind by professionals.
- 17.3.16 The panel also considered Leicester City Council Corporate Equality and Diversity Strategy 2018 – 2022 that specifically cites the council’s legal obligations in respect of Equalities and recognises the particular financial challenges faced locally. It includes an aim to “put into place actions which will either reduce or eliminate any negative impacts on people who have any particular protected characteristic.”<sup>48</sup> Within the strategy are four areas of work précised here as; service delivery, awareness, inclusion and fairness. These are underpinned by an action plan. It seems this strategy introduced after John’s death has some relevance to his circumstances.
- 17.3.17 It was also noted that Leicester Safeguarding Adults Board Plan 2017-20 will be subject to revision.<sup>49</sup> Given Johns circumstances, it seems opportune that learning from this review is

<sup>43</sup> Source: [Male victims position paper \(March 2019\) \(accessible version\) - GOV.UK \(www.gov.uk\)](#) (Accessed March 2021)

<sup>44</sup> Source: [LWA | lwa.org.uk : LWA](#) (Accessed March 2021)

<sup>45</sup> Source: [How Many Leicestershire Men Experience Domestic Abuse? - Bray and Bray Solicitors Leicester - Expert Local Solicitors \(braybray.co.uk\)](#) (Accessed March 2021)

<sup>46</sup> Source: <https://www.leicester.gov.uk/media/186377/llr-dsva-strategic-objectives-and-vision.pdf> (Accessed March 2020)

<sup>47</sup> Source: The Disturbing Science Behind Subconscious Gender Bias. <https://medium.com/the-establishment/the-disturbing-science-behind-subconscious-gender-bias-cda0a44261e5>

<sup>48</sup> Source: <https://www.leicester.gov.uk/media/184953/corporate-equality-strategy-2018-2022.pdf#:~:text=Leicester%20City%20Council%20is%20committed%20to%20equality%20of,belief%2C%20sexual%20orientation%2C%20marital%20or%20civil%20partnership%20status>. (accessed August 2020)

<sup>49</sup> Source: <https://www.leicester.gov.uk/media/184161/strategic-plan-2017-2020-leicester-safeguarding-adults-board.pdf> (Accessed March 2020)

explored when formulating the next Strategic Plan. Within the current plan, Equalities is a bullet point of the first of seven Values that one may argue would merit greater status.

**Consideration / Learning Opportunity 10:** Intersection of disability and financial hardship, impact on health, well-being, risk of neglect and abuse.

## 17.4 Good Practice Identified and Significant Developments

### GP Practice

- 17.4.1 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. The chair has also been provided with a copy of the training power-point used alongside to raise awareness of the policy and implications for practice that encourages professional curiosity, guidance around record keeping, disclosures to other agencies as well as advice to victims. There are also GP Safeguarding Leads who have an additional responsibility to be a source of advice and guidance for their practice staff. These leads are supported in this role through specialist training and attendance at bi-monthly Safeguarding Forums that specifically provide an opportunity for sharing and seeking information with the partners in respect of Domestic Abuse. This obligation to share information with agencies has been reciprocated, in that from July 2019 the local MARAC has introduced a policy where a letter is sent to the GP for every victim discussed at the meeting. This demonstrates an evolution in the practice approach to Domestic Abuse and wider risk management processes.
- 17.4.2 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. One may contend that social prescribing is in effect a “bespoke approach to key vulnerable groups and those not being identified/accessing service” that is cited as one of the objectives in respect of domestic abuse noted at 17.3.13.
- 17.4.3 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.<sup>50</sup> 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

- 17.4.4 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.
- 17.4.5 During the review process, it was learned that LCCH now have the ability to record and report welfare and safeguarding concerns via a Personal Digital Assistant (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.
- 17.4.6 Leicester City Council Housing alongside Leicestershire and Rutland Councils is in the process of seeking Domestic Abuse Housing Alliance (DAHA) accreditation.

### Leicester Safeguarding Adults Board (LSAB)

<sup>50</sup> Source: <file:///C:/Users/mark-/Downloads/PDF-007069.pdf> (Accessed August 2020)

- 17.4.7 The LSAB has recently agreed that one of its priorities for 2021/22 is that of “hidden harm” that includes “self-neglect”. This is in response to trends identified nationally in serious adult reviews as well as concerns arising locally through the Covid pandemic that less physical contact had diminished opportunities to fully understand need and circumstances. The focus of activity will be on community culture shift across practitioners and public to help people to: a) see concerns b) have confidence to want to respond and c) respond. The conclusion of this review appears suitable for referencing in working towards this priority.

## 18. RECOMMENDATIONS

### 18.1 Local Recommendations

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

#### 18.1.1 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.’

#### 18.1.2 Housing

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

### 18.2 Panel Recommendations

18.2.1 The review panel devoted the final two meetings to explore a number of potential recommendations in respect of the ‘Considerations/Learning Opportunities’ highlighted throughout the report as summarised under the Lessons Learned. These have then been considered against a background of significant agency and policy development already undertaken or underway and good practice. These developments collectively mitigate the need for a number of recommendations that may have otherwise arisen, save those described below.

18.2.2 The Review Panel has made the following recommendations that are also presented collectively in Appendix B. These recommendations should be acted on through the development of an action plan, with progress reported on to the Safer Leicester Partnership.

18.2.3 **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.

- Reference point 16.3.12
- Consideration / Learning Opportunity 9: Risk of normalisation / desensitisation.

18.2.4 **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 “

- Reference 17.2.3
- 17.3.13-17.3.17

- Reference point 17.3.13-15
- Consideration / Learning Opportunity 10: Intersection of disability and financial hardship, impact on health, well-being, risk of neglect and abuse

18.2.5 **Recommendation 3:** The learning from this review is used to support the 2021/22 LSAB priority of tackling hidden harm that includes ‘neglect’, to ensure that signs of neglect are recognised and responded to accordingly.

- Reference point 17.2.5-6, 17.4.7
- Consideration / Learning Opportunity 10: Intersection of disability and financial hardship, impact on health, well-being, risk of neglect and abuse

**APPENDIX A – CONTACT WITH FAMILY**

<b>Date and time of contact (or attempt)</b>	<b>Name and relationship to victim of individual contacted</b>	<b>Mode of contact</b>	<b>Outcome of contact</b>
3 <sup>rd</sup> May 2019	Audrey	Personal visit and letters	Declined to take part
25 <sup>th</sup> June 2019	Audrey and Giles	Letter from chair	No reply
13 <sup>th</sup> Sept 2019	George – brother in law 1	email	Contact with Elizabeth
20 <sup>th</sup> Sept 2019	Elizabeth - sister	Phone	Initial Summary
2 <sup>nd</sup> Oct 2019	Elizabeth - sister	Phone	Clarification
4 <sup>th</sup> Oct 2019	Thomas – brother in law 2	Phone	Message left
10 <sup>th</sup> Oct 2019	Elaine - sister	Email	Re-provide DHR guidance and leaflets
11 <sup>th</sup> Oct 2019	Thomas – brother in law 2	Phone	Initial Summary
22 <sup>nd</sup> Oct 2019	Thomas – brother in law 2	Phone	Clarification
26 <sup>th</sup> Oct 2019	Elizabeth - sister	Phone	Clarification
4 <sup>th</sup> Nov 2019	Elizabeth - sister	3 calls	3 <sup>rd</sup> successful, clarification
11 <sup>th</sup> Nov 2019	Thomas – brother in law 2	Phone	Clarification
18 <sup>th</sup> Nov 2019	Elizabeth - sister	Phone	Arrange call another sister
18 <sup>th</sup> Nov 2019	Barbara - sister	Phone	Initial Summary
19 <sup>th</sup> Nov 2019	Barbara - sister	Phone	Clarification
20 <sup>th</sup> Nov 2019	Elizabeth - sister	Phone	Update
<b>20<sup>th</sup> May 2020</b>	<b><i>Inquest concluded</i></b>		
27 <sup>th</sup> May 2020	Audrey and Giles	Letter from chair	No reply
5 <sup>th</sup> June 2020	Elizabeth – sister	Phone	Update re inquest and verbal update re overview
5 <sup>th</sup> June 2020	Thomas – brother in law 2	Phone	As above
8 <sup>th</sup> Sept 2020	George – brother in law 1	Email	New phone number for Elizabeth
22 <sup>nd</sup> and 29 <sup>th</sup> Sept 2020	Thomas – brother in law 2	Phone	No reply
22 and 29 <sup>th</sup> Sept 2020	Elizabeth	Messages left	No reply
30 <sup>th</sup> Sept 2020	Elizabeth	Telephone Meeting	Fully appraised of outcome

## APPENDIX B – DHR ACTION PLAN

Recommendation	Scope	What is the desired OUTCOME of this recommendation? (What does your Agency want the RESULT to be?)	Action to take	Lead Agency	Date of completion and outcome
<p><b>Recommendation 1:</b> 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</p>	Local	<ul style="list-style-type: none"> <li>• Opportunities to assess tenant welfare are not missed.</li> <li>• Poor living conditions that could indicate neglect are not normalised by Housing Staff.</li> <li>• Housing staff are empowered to gain entry to a Council property where there might be concern.</li> </ul>	<p>Housing to arrange a meeting to discuss the learning from this review and debate what processes could be put in place to support staff to;</p> <p>(a) Move beyond subjectivity and support accurate recording and action where appropriate regarding poor conditions within council properties (see <a href="https://lrsb.org.uk/llr-neglect-toolkit">https://lrsb.org.uk/llr-neglect-toolkit</a> as an example of the kind of tool that could be developed)</p> <p>(b) Notice and respond appropriately when repeatedly ‘door-stepped’</p>	Leicester City Council Housing	<p>(a) March 2021 Solutions identified</p> <p>(b) June 2021 Findings implemented</p>
<p><b>Recommendation 2:</b> Learning from DHR to be shared across SLP 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 “</p>	Local	<p>The LLR Operations Group considers any joint work in relation to vulnerable and hard to engage groups, arising from the learning in this review.</p>	<p>The learning from this DHR to be shared with the LLR Operations Group at the earliest opportunity, for it to consider any joint work in relation to vulnerable and hard to engage groups.</p>	DHR subgroup	<p>June 2021 - Assessment of current situation Sept 2021 - Implementation of changes to “Ensure the identification of...”</p>
<p><b>Recommendation 3:</b> The learning from this review is used to support the 2021/22 Leicester Safeguarding Adults Board (LSAB) priority of tackling hidden harm that includes ‘neglect’, to ensure that signs of neglect are recognised and responded to accordingly.</p>	Local	<p>The LSAB’s priority is informed by the learning from this review.</p>	<p>Share the findings of this overview report with the LSAB</p>	Safer Leicester Partnership	<p>April 2021 – Report shared.</p>

**APPENDIX C: GLOSSARY**

<b>Abbreviation / Acronym</b>	<b>Full meaning</b>
AA	Appropriate Adult
AAFDA	Advocacy After Fatal Domestic Abuse
ASB	Anti-Social Behaviour
CCG	Clinical Commissioning Group
CPS	Crown Prosecution Service
CRT	Clinical Response Team
CQC	Care Quality Commission
DA	Domestic Abuse
DAHA	Domestic Abuse Housing Alliance
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHP	Discretionary Housing Payment
DHR	Domestic Homicide Review
DVSA	Domestic Violence & Sexual Abuse
DVT	Deep Vein Thrombosis
GNM	Gross Negligence Manslaughter
GP	General Practitioner
IMR	Individual Management Review
INR	International Normalised Ratio
LCCH	Leicester City Council Housing
MARAC	Multi-agency Risk Assessment Conference
NHS	National Health Service
NOSP	Notice of Seeking Possession
PDA	Personal Digital Assistant
SLP	Safer Leicester Partnership
STAR	Supporting Tenants and Residents