Salford Safeguarding Adults Board

7 Minute Briefing – Joint Safeguarding Adult Review / Domestic Homicide Review 'Peter'

1. Introduction

A joint **Safeguarding Adult Review / Domestic Homicide Review** was commissioned following Peter's murder. **Peter was beaten to death by a 'friend' in his own home**.

Peter had been dependent on alcohol' for many years and had multiple complex needs including: alcohol dependency, mental health difficulties, physical health problems, self-neglect and exploitation by others.

Due to his complex needs, he was in contact with a number of agencies.

2. Background

Peter was 55 years old and was living in social housing at the time of this death. He would often drink alcohol for a few days, until his money ran out, then attend hospital (A&E) due to severe withdrawal symptoms. He had cognitive problems because of long term alcohol use and difficulties managing his finances. Peter often had 'friends' in his flat who would go with him when he collected his money. These 'friends' were thought to be exploiting him. Peter was receiving support from predominantly health and social care professionals.

3. What happened?

A 'friend' of Peter's was released from prison and began staying at Peter's flat. The 'friend' had told his Offender Manager that he was staying somewhere else. Peter was intimidated and scared of this 'friend'. A few days before his death, Peter told a professional that this man had taken his only door key, was coming and going as he pleased and was sleeping in his bed. Peter agreed the professional could speak to his housing provider and arrange for the locks to be changed.

4. What happened next?

Just 3 days later, a 999 call was made to Police reporting that Peter had been found dead. Peter had died from internal injuries caused by 'blunt force trauma'.

Peter's 'friend' who had been living at his flat was subsequently charged, convicted and imprisoned for his murder.

5. Learning

The review found that opportunities were missed to trigger **a formal safeguarding process.** This may have enabled other agencies to be involved in supporting or protecting Peter such his housing provider or the police. **There was a lack of awareness of the support and/or legal powers of wider partners,** especially the housing provider and therefore information wasn't shared with them regarding Peter who was their tenant.

Opportunities were missed to check the suitability of the 'friend's' accommodation following his release from custody.

It was felt that Peter would benefit from moving to supported accommodation, however there was **a lack of understanding of housing options available** and this was not progressed.

There was **no evidence of formal mental capacity assessments** or despite evidence that Peter would have had fluctuating capacity.

6. For more information, please see:

- Read the full report or the executive summary
- Familiarise yourself with local safeguarding policies and procedures and seek prompt legal advice.
- Salford Safeguarding Adults Board
- Salford Community Safety Partnership
- Self-Neglect Policy and Procedure
- Mental Capacity Act
- Housing Information Pack

Salford Safeguarding Adults Board

Contact Details:

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