Safeguarding Adult Review

Executive Summary Report:

Christopher

Independent Reviewer

Allison Sandiford

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the SSAB prior to publication.

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1. Introduction

1.1. Under Section 44 of the Care Act 2014, a Safeguarding Adult Board *must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –*

- *There is reasonable cause for concern about how the Safeguarding Adult Board, members of it or other persons with relevant functions worked together to safeguard the adults, and*
- *Condition 1 or 2 is met.*

Condition 1 is met if—

- *the adult has died, and*
- *the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*

Condition 2 is met if—

- *the adult is still alive, and*
- *the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

1.2. The purpose of a Safeguarding Adult Review is *not to hold any individual or organisation to account*. It is described in the statutory guidance as being to *promote effective learning and improvement action to prevent future deaths or serious harm occurring again*. The objective is that lessons can be learned from the case and can be applied to future cases to prevent similar harm from recurring.

1.3. The subject of this Safeguarding Adult Review is Christopher. The brief circumstances are that at the time of his death Christopher was bed bound due to cancer. Christopher had been taken to hospital by ambulance following an alleged assault by his partner (hereafter referred to as Steven). Christopher said Steven had punched him to the hip, and he alleged that Steven had been withholding medications, food and drink and had kept him alone in the bedroom. Christopher sadly passed away, in hospital.

1.4. This review is seeking to examine the role of agencies who came into contact with Christopher and Steven, to establish if there are any lessons to be learned and to identify any missed opportunities for agency involvement. The review also seeks to understand the ability of the individuals involved to be aware of, and to access, services they may have needed.

Terms of Reference

1.5 The Terms of Reference appear at Appendix 1 and detail the areas for consideration for this review.

1.6. For effective learning it was agreed that the scoping period for this review will be from January 2021 until the date that Christopher sadly died in February 2022.

1.7. However, it is recognised that some safeguarding processes were undertaken prior to this timescale and where relevant, they have been included if they relate to later agency involvement and/or decisions.

Methodology

1.8. On the 29th of September 2022, all the members of the Salford Safeguarding Adult Review Panel agreed that the criteria had been met for a mandatory Safeguarding Adult Review.

1.9. The decision was supported by the Independent Chair as per the policy/procedures and Care Act 2014 criteria.

1.10. At an initial scoping meeting and first panel meeting, held on the 23rd of November 2022, agency representation, terms of reference, the scoping period and the project plan were decided. It was also agreed for the Independent Reviewer to generate Agency Reports to be completed by some agencies involved to establish further information and panel members' preliminary views.

1.11. Due to concerns of domestic abuse, Christopher had formerly been considered for a Domestic Homicide Review, but it was decided that the criteria were not met. However, it was agreed at the initial Safeguarding Adult Review meeting that a similar process to a Domestic Homicide Review could be followed.

1.12. It was also agreed by panel members that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Safeguarding Adult Review process will drive Salford Safeguarding Adult Board, and its partner agencies, to develop an action plan that will respond directly to the identified learning.

1.13. The panel met on two further occasions to discuss the case and learning, and to monitor the progress of the review. The review process also incorporated a practitioner reflective session attended by professionals from the key agencies who had worked with Christopher. Contribution from the participants generated positive discussion around both good practice and areas of practice that could be developed and improved; this has formed the basis of this report.

1.14. Panel members had an opportunity to review the final draft of the report and discuss the learning prior to presentation to Salford Safeguarding Adults Board and following this report being accepted, a learning event will be held to share the wider learning.

Contributors to the Review

Agency/Organisation	Represented on the Panel	Completed Agency Report	Attended Reflective Session
Salford Safeguarding Adults Board	√		√
Independent Advisor on Domestic Abuse	√		
Northern Care Alliance - Adult Social Care	√	√	√
Greater Manchester Mental Health	√	√	√
Greater Manchester Police	√	√	√
Community Specialist Palliative Care Team		√	√
St Ann's Hospice		√	√
Northern Care Alliance (Acute and Community)	√	√	√
Safe in Salford	√	√	
Integrated Care Board	√	√	√
Community Safety Partnership	√		
North West Ambulance Service	√		√
Salford City Council Legal Services	√		

Independent Author

1.15. The review commissioned Allison Sandiford to act as Independent Reviewer. Allison is an independent safeguarding consultant with no current links to Salford Safeguarding Adults Board or any of its partner agencies. Allison has a legal background and has gained her experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

Parallel Reviews

1.16. Christopher's death was reported to the Coroner. Christopher's death did not proceed to Inquest. The cause of death is recorded as Metastatic Renal Tumour and Pneumonia.

1.17. Greater Manchester Police investigated Christopher's allegation of assault. The only evidence in the case was Christopher's initial report. Steven was arrested but denied all allegations. Christopher did not feel able to assist a prosecution; he did not want undue stress and ultimately realised that he would not be around long enough for any court case. Without any formal account from Christopher, there was no evidence with which to bring a prosecution against Steven and the investigation was closed with No Further Action.

1.18. Greater Manchester Mental Health have completed a 3-day Review. Initial findings are:

- An absence of professional curiosity
- Historical domestic abuse information not considered
- A lack of consideration of safeguarding risks and risk assessments
- Lack of discussion and sharing of information within the same Community Mental Health team
- Lack of multi-agency planning and working

There has been an internal facilitated learning event to explore the learning with their practitioners.

Involvement of Family and Wider Community

1.1. The Board, reviewer and panel members would like to extend their condolences to all members of Christopher's family.

1.2. The panel decided that on this occasion, the partner of Christopher should not be approached and invited to engage in the review process out of respect for Christopher. Before his death Christopher had expressed that his relationship was over, and he asked that his next of kin details be changed.

1.3. Additionally, on this occasion the independent reviewer and the panel all agreed that the family of Christopher would not be approached. This is an uncommon decision within Safeguarding Adult Review processes as family engagement is an important part of the review development. Discussion with family members is often hugely beneficial to helping the reviewer understand the individuals involved and identify both good practice and practice which can be improved upon. However, it was not possible to establish who in his family Christopher had maintained a relationship with, and/or how much he had wanted them to know of his personal life and circumstances.

Equality and Diversity

1.4. Whilst applying the principles of a Safeguarding Adult Review, the independent reviewer has considered the protected characteristics[1] under the Equality Act 2010.

1.5. Christopher was a gay man with a diagnosis of cancer, both of which are protected characteristics as codified by the Equality Act 2010.

1.6. Christopher and Steven are both male. It has not been possible to confirm whether Christopher and Steven were common law partners or legally married. Nor can it be confirmed how Christopher identified himself and what pronouns he would have used.

1.7. Both Christopher and Steven resided in the United Kingdom during the scoping period of this review. It has been established that Christopher was born and raised in a European Country and moved to the United Kingdom when he was 20 years old.

1.8. The review understands that domestic abuse can affect anyone, regardless of age, disability, gender identity, gender reassignment, race, religion or belief, sex, or sexual orientation and all may experience similar patterns of domestic abuse. But there are some specific issues that are unique to the experiences of lesbian, gay, bisexual, and transgender individuals which include threats of disclosure of sexual orientation, and/or a perceived belief that support services and the criminal justice system may be prejudice - resulting in little or no help anticipated to be available.

1.9. The domestic abuse and sexual violence manager for the Lesbian, Gay, Bisexual, Transgender (LGBT) Foundation assisted the panel to be better informed on issues relating to gay men experiencing domestic abuse and the support available.

2. Background Information

2.1. Information taken from records states that Christopher was born and raised outside of the United Kingdom in a European Country. He described himself as a quiet and reserved child.

2.2. Over the years, Christopher disclosed to mental health professionals that he had been sexually abused when he was 8 or 10 years old. Christopher also disclosed numerous suicide attempts from during his teenage years which included an overdose when he was 18, after his parents had discovered that he was gay and thrown him out of their address. Christopher has said that following this he had contact with psychiatric services in his birth country and a short period of psychotherapy.

2.3. Christopher completed a degree at University before moving to a city in the United Kingdom (when he was twenty) and commencing work.

2.4. Within a couple of years Christopher met Steven and they moved to Salford, living together in a privately rented property.

2.5. Christopher was a support worker but in 2009 he was dismissed from his post on the grounds of capability following sick leave.

[1] Age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation

2.6. In 2009 Police Officers visited Christopher and Steven after receiving an abandoned 999 call. It was established that there had been a verbal argument over money. No further domestic incidents were reported to the police but in 2016 Christopher disclosed to his GP that his relationship with Steven had been abusive for many years. He said that quite early in the relationship Steven would throw chairs and plates at the wall and that Steven's behaviour was usually related to alcohol use. Christopher described Steven (who he referred to as his carer) as 'cruel' and 'violent'. Christopher had said that the incidents of aggression and violence had increased in the last few months and more so over the last few weeks. Christopher had said that he was afraid of leaving Steven and also that he was concerned that if they separated, Steven would become homeless or die of alcoholism. As a result of the disclosure Salford Social Services referred Christopher to Multi-Agency Risk Assessment Conference[2].

2.7. The Multi-Agency Risk Assessment Conference Referral Form outlined Christopher's responses to the Domestic Abuse, Stalking and Honour Based Violence risk assessment[3] which had been completed over the telephone by a Social Worker at the Contact Centre. It informed that Christopher had further disclosed how he used to have friends who visited, but that Steven would constantly pester them for money for alcohol and gradually the friends stopped visiting. Christopher had also said that he used to be very active within the church community, but Steven had started overdosing on tablets or cutting his wrists and arms every time Christopher was out at church. As a result, Christopher had stopped going to church and consequently lost the church's support and connection. Christopher had also alleged that Steven had threatened him with a knife and had pinned him to the floor/wall with his hands around his throat, on more than one occasion.

2.8. The Multi-Agency Risk Assessment Conference convened in February 2016. The recorded actions were for the Department of Work and Pension to be updated with the known information, and for Greater Manchester Police to confirm Christopher's telephone number with Women's Aid. It is not possible to confirm whether the actions were completed but following the Multi-Agency Risk Assessment Conference meeting, Christopher was visited at his home address by Police Officers who reported that Steven was not present during their visit, and that Christopher had made no disclosures of crimes. As such no crime reports were submitted but all the appropriate agencies were now aware of Christopher's disclosure.

2.9. With regards to Steven, in 2012 he reported local low level anti-social behaviour from local children to the police. Attending Officers became concerned for Steven who they recorded was in a confused and agitated state. Officers contacted Steven's employer, who said that they were aware of Steven's mental health and would be providing support for him internally. In 2013, police were called to a further incident during which Steven had become very irate. No offences were disclosed.

2.10. In 2014 Christopher contacted the police concerned for Steven who he said was suffering depression and was an alcoholic. Steven had failed to return home from a walk but did return of his own accord later that day safe and well.

[2] A multi-agency risk assessment conference is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

[3] The Domestic Abuse, Stalking and Honour Based Violence (DASH) form is a standardised risk assessment implemented across most police forces in the United Kingdom**.** It is intended to facilitate a structured professional judgment about the risk a victim faces of serious harm at the hand of their abuser.

2.11. It is not clear which agencies/professionals have worked with Steven throughout the years but in 2019 Steven was referred to mental health services following the death of a pet. He reported low mood and anxiety.

Chronological Agency Interaction and Overview prior to the Key Lines of Enquiry

2.12. Christopher was known to live with various physical and mental health problems including 'generalised anxiety disorder' and 'unspecified personality disorder'. He was known to mental health services from 2009 following reports of him hearing voices and having suicidal tendencies. At this time, he reported an 11-year history of auditory hallucinations, stating that they were always derogatory in nature, but they appeared to be becoming more aggressive in content. Christopher's engagement with mental health services over the years was sporadic and he was often discharged from services due to poor attendance and *'non-engagement'*.

2.13. Over the years Christopher's GP referred him to multiple hospital departments due to poor health. It is recorded that Steven was the main contact regarding Christopher's appointments and it was he who mostly arranged and cancelled them.

2.14. In 2015 Steven expressed thoughts of harming Christopher due to stress. The GP referred Steven to psychology services and to Adult Social Care for a carer's assessment. It was decided that this was not a safeguarding concern as the action needed was to address the carer stress. A package of care was implemented for a carer visit to support Christopher whilst Steven was at work. In 2018 the support plan was increased, and a referral was made to occupational therapy health services. Following an Occupational Therapist discussing Christopher's needs on the telephone with Steven (with Christopher's consent) and also visiting the property, equipment was renewed as required.

2.15. In May 2020 during a Covid check by Adult Social Care, Steven disclosed that his drinking had increased, and said that he had spoken to his GP for a referral back to alcohol services for support. It was established that the domiciliary care had stopped – Steven presumed because of Covid. Steven was referred for a carer assessment.

2.16. Just prior to the scoping period of this review, in May 2020, Steven refused a District Nurse entry to the home, stating that Christopher was asleep. The Nurse explained that the visit was to assess Christopher for pressure equipment and agreed a new date to visit but when District Nurses visited again, Steven denied all knowledge of the last visit and continued to decline entry. The District Nurses further explained that the reason for the visit was to assess and provide observation and support, but Steven would still not allow them entry to see Christopher. The District Nurses reported the access problems to their team leader.

2.17. Despite the District Nurses telephoning Steven prior to their next visit, access was still denied with Steven stating that he was going for a Covid test as he had symptoms and did not want a visit until his symptoms had stopped. Steven would not let the District Nurses speak to Christopher.

2.18. The District Nurses finally gained access to check Christopher's pressure areas on the 10th of December 2020, seven months after the initial visit in May.

3. Key Practice Episodes

To enable the review to meet the Terms of Reference, professionals explored the following key practice episodes with the Independent Reviewer. Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Christopher. The episodes do not form a complete history but are thought key from a practice perspective and represent the significant professional involvements that informed the review.

Key Practice Episodes	Dates
Professional's Initial Contacts	January 2021 – May 2021
Diagnosis of cancer and ongoing Care	May 2021 – 12 January 2022
Report of Domestic Abuse	12 Jan 2022 – 14 Feb 2022

4. Analysis by Theme

Following the multi-agency discussions of the Key Episodes and Terms of Reference, the following themes have been identified for practice and organisational learning:

Theme 1 - Agencies Understanding and Management of Domestic Abuse

4.1. Domestic violence is the most common type of violence in the United Kingdom. The Crime Survey for England and Wales[4] estimated that 5% of adults (6.9% women and 3% men) aged 16 years and over experienced domestic abuse on the year ending March 2022. This equates to an estimated 2.4 million adults (1.7 million women and 699,000 men).

4.2. Obtaining accurate data to gain an understanding of the extent of domestic abuse in the Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and others (LGBTQ+) community is problematic because despite widely available statistics on domestic abuse generally in the United Kingdom, there are no official figures.

4.3. Whilst an abandoned 999 call dating from 2009 evidences a verbal incident between Christopher and Steven - Christopher did not feel able to further disclose that he was experiencing domestic abuse until 2016. At this time, he disclosed to the GP that he would like to leave Steven due to aggressive drunken behaviour. The GP signposted Christopher to domestic abuse services which offered specific support to men. He also advised Christopher to contact psychology services. It is unknown whether Christopher followed up on this signposting, but the GP had notified Adult Social Care who referred Christopher to Multi-Agency Risk Assessment Conference. This review has not seen any evidence of further agency action following the Multi-Agency Risk Assessment Conference other than the police attending the home address to speak with Christopher regarding whether he wished to report any offences – which he did not.

4.4. A lack of other disclosures cannot be taken as an indication of no other incidents - research suggests that domestic abuse is widely underreported within the LGBTQ+ community with studies suggesting that the rates of under-reporting are between 60-80%[5]. This is concordant with the national underreporting rate which is at 79%, according to the Office for National Statistics[6].

[4] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)
[5] Galop_domestic abuse.indd
[6] Domestic abuse: findings from the Crime Survey for England and Wales - Office for National Statistics (ons.gov.uk)

4.5. Sadly, this review is now unable to establish from Christopher how comfortable he was speaking about his relationship and sexuality with other people. But all professionals and organisations providing support, must recognise potential emotional constraints born from a person's lived experience of their circumstances, which may include fear, anxiety, and/or embarrassment. Consequently, owing to past experiences, not all LGBTQ+ people may feel comfortable speaking to services about abuse experiences in their same-sex relationship. Professionals must be aware of potential communication issues and consider how best to put a person at ease and support them, or they could, in theory, prevent a person leaving a dangerous relationship.

4.6. There is evidence of Christopher having abuse to disclose as after his admission to hospital in January 2022 and following his disclosure of domestic violence abuse, an email from Christopher to the Palliative Care Nurse included *I need to apologise to you … I told you I was safe, and I have lied.*

4.7. Hence, disclosure must always be encouraged with the provision of safe environments and opening conversations. Particularly when a person is recognised as an adult at risk.

4.8. Professionals from the agencies encountering Christopher recognised he was at risk in respect of his physical and mental health. However, they did not recognise that he was potentially at risk of harm from Steven. Although pre the scoping period of this review (in 2016), many agencies were in possession of risk information provided by Christopher (when he had disclosed domestic abuse and said that Steven - who he had described as *cruel and violent,* had thrown chairs and plates at the wall and that this behaviour was usually related to alcohol misuse by Steven) this information had become invisible.

4.9. In 2016 following Christopher and Steven having been discussed in a Multi-Agency Risk Assessment Conference, a flag (i.e., a code) was added to the GP Practice data system to highlight the disclosed abuse. This review has been informed that the flag would only be apparent on Christopher's information. Flags are not added to perpetrators information whether both parties are registered at the same practice or not, particularly when the disclosure is an allegation. As per process, after a 12-month period with no more reported incidents, the flag on Christopher's information was removed. Consequently, when the GP spoke with Christopher during the scoping period of this review, the GP was unaware of any historic domestic violence abuse disclosure.

4.10. This flag removal practice has been changed and the flag would now remain, although it should be noted that any change in recording systems runs a risk of previous coding not being effectively transferred from one system to another.

4.11. Similarly, other organisations including Adult Social Care, and Salford Royal Foundation Trust, had no knowledge of the historic disclosure by Christopher. Discussion suggested that this was largely owing to system changes. Further discussion established that some newer information systems don't have the facility to add warning flags, for example Liquidlogic which is now used by Social Care – and this is currently being explored.

4.12. The Community Mental Health Team have reflected that whilst their electronic records for both Christopher and Steven document the Multi-Agency Risk Assessment Conference involvement from 2016, many professionals working within the team were unaware of where to find Multi-Agency Risk Assessment Conference information because it is not recorded in a standard format. Consequently, there is no reference in their records from the scoping period of this review to possible domestic violence / abuse until Christopher disclosed in January 2022.

4.13. The review has been assured by Greater Manchester Mental Health that this has been addressed with new guidance about the recording of domestic abuse and Multi-Agency Risk Assessment Conference involvement being sent to all safeguarding leads across Greater Manchester Mental Health in January 2023,

with a request to disseminate widely with staff and discuss in team meetings. The guidance is also to appear in the next Greater Manchester Mental Health Patient Safety newsletter. This guidance should support professionals to incorporate the recording of domestic abuse and Multi-Agency Risk Assessment Conference into routine practice.

4.14. In the absence of the historic disclosure being visible, there is no evidence of professionals giving consideration as to whether Steven's behaviours constituted domestic violence abuse including coercive control. But panel members questioned whether, even in the event of the historic domestic abuse information being identified – would practitioners have recognised domestic abuse and/or coercive control within Christopher's and Steven's current relationship?

4.15. Male victims of domestic abuse are not always equally recognised or heard as much as their female counterparts (whether in a heterosexual relationship or gay relationship). Yet a report[7] carried out in 2020 found that male victims experience persistent and severe patterns of coercive control similar to those experienced by female victims. Even in areas that are often seen as affecting only female victims such as economic abuse and sexual coercion, the report found that over half of the male victims had their earnings controlled, and one in five men was forced to have sex as an ongoing pattern of abuse. The report's recommendations include a large-scale national study investigating the experiences of male victims of coercive control in terms of impact, and for the Police, Crown Prosecutors, judiciary, general practitioners, social services and Children and Family Court Advisory and Support officers to work together to develop a whole-system approach towards enhancing the understanding of the prevalence and specific experiences of male victims, including how men experience coercion, how they communicate this to others, what factors are more relevant to male victims, and what support they need.

4.16. In addition to Christopher's gender being a potential barrier to professionals recognising domestic abuse, the panel questioned whether professionals understand domestic abuse when it occurs within the LGBTQ community. There are forms of abuse that are specific to members of the LGBTQ community, including a partner using another's sexuality as an excuse to be controlling, threatening, or forcibly outing another, misgendering, and/or isolating a person from others in the LGBTQ community.

4.17. Such coercive control can be hard to recognise but it is a criminal offence. It is described by Research in Practice for Adults as *behaviour that underpins domestic abuse… a pattern of behaviour which seeks to take away the victim's sense of self, minimising their freedom of action and violating their human rights*[8]. The abuser will exert power over a victim through intimidation or humiliation, and this will not always be visible to others.

4.18. Since the Safe in Salford[9] Service commenced in April 2022, they have been working to deliver training around domestic abuse, including domestic abuse and young people, and work is ongoing to develop the training offer around perpetrators and domestic abuse and older people. In addition, a Bite Size Briefing on the Safe in Salford service has recently been held and there are plans to hold a Bite Size briefing in May on Multi-Agency Risk Assessment Conferences, Multi-Agency Public Protection Arrangements, and the Domestic Abuse Perpetrator Panel. This training is good progression, but it is imperative that domestic abuse training includes awareness raising around male victims of abuse and domestic abuse within the LGBTQ community.

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[7] Male-Victims-of-Coercive-Control-2021-Summary.pdf (mankind.org.uk)
[8] Coercive Control | from Research in Practice for Adults and Womens' Aid (ripfa.org.uk)
[9] Safe in Salford

Question 1:

How can partner agencies assure Salford Safeguarding Adult Board that their professionals understand and can recognise indicators of domestic abuse occurring within any LGBTQ relationship and are able to support victims?

4.19. Because domestic abuse behaviours were not being considered, Steven facilitating phone calls, for example, in February 2021 when the GP was exploring why Christopher had not attended hospital with his back pain, was constituted as Steven being helpful rather than controlling. Had the GP's attention been reminded of the possibility of domestic abuse within Christopher's and Steven's relationship, this communication may have been met with better professional curiosity. The GP may have potentially given consideration as to how freely Christopher was able to discuss his circumstances in the presence of Steven instead of assuming that Steven was acting in Christopher's best interests and that all was well.

4.20. Similarly, when Steven was cancelling appointments or refusing professionals access to Christopher, professionals could have afforded more reflection of potential coercive control and abuse. In the absence of this being contemplated domestic abuse procedures were not considered and Christopher was not assessed for additional support from domestic abuse services.

4.21. It must be acknowledged how difficult disclosure of domestic abuse would have been for Christopher who relied upon Steven for his care. It is possible that even had Christopher disclosed, he may have felt unable to pursue any remedies (such as non-molestation orders) and unable to engage with the police for fear of being left unsupported (around his care needs) and without care. Also, the criteria for a Domestic Violence Protection Order which would protect him from Steven, may not have necessarily been met. However, such potential possibilities should not prevent professionals from providing individuals with domestic violence advice. Domestic abuse support services rely upon professionals from all agencies to promote their domestic abuse services and to encourage individuals to contact them to engage.

4.22. The Greater Manchester RECLAIM[10] programme offers support to those who are currently experiencing domestic abuse. This service provides practical help, advocacy, and emotional support for those experiencing domestic abuse, whether this is from a partner, ex-partner, or family member. This service is available to all people identifying as lesbian, gay, bisexual and/or trans, and anyone falling under the umbrella term of LGBTQ+

4.23. Similarly, the Galop[11] Helpline is available to offer emotional support, provide information and help an individual to explore options, depending on their needs. Professionals can refer into the service, or an individual can contact them direct.

4.24. Safe in Salford has been commissioned to provide the Domestic Abuse service in Salford since April 2022. Safe in Salford brings together a number of providers under a lead provider model, to deliver a range of different services including support/services for victims/survivors, children, and perpetrators. Salford Foundation is the lead provider, and the other services are Trafford Domestic Abuse Service, Manchester Women's Aid and Talk Listen Change.

4.25. The Independent Domestic Violence Adviser service is open to all (male/female/LGBTQ+) but the city council makes a financial contribution to the LGBT Foundation which has specialist Independent Domestic Violence Advisers who have good relationships with the Safe in Salford service. Additionally, when a referral is made into the Multi-Agency Risk Assessment Conference process following a Domestic Abuse, Stalking and Honour Based Violence Risk Identification Assessment there is a marker on the Multi-Agency Risk Assessment Conference SharePoint site which can be flagged up if the victim would prefer to be supported

[10] LGBT Foundation - Domestic Abuse RECLAIM Programme

[11] Galop - the LGBT+ anti-abuse charity

by the LGBT Independent Domestic Violence Adviser. They are then picked up directly from the SharePoint by LGBT Foundation who provides that specialist support (working closely with the Safe in Salford service as appropriate).

4.26. Other services are signposted on the Salford City Council website[12].

4.27. Routine enquiry at appointments is necessary practice which helps individuals experiencing abuse to become aware of what options exist for them. Whilst it was very difficult to speak with Christopher alone at the home address, there were a few opportunities when Christopher managed to attend an appointment at the hospital. Routine enquiry should have been utilised within these appointments - particularly given the difficulties professionals were recording regarding Steven denying their access.

4.28. This review has been assured by Northern Care Alliance that Domestic Abuse training is included in the Adult Safeguarding Level 3 mandatory training. The section on domestic abuse includes video clips on a real case (male victim of abuse), how to complete a Domestic Abuse Stalking Honour Based Violence form and explains the role of Multi-Agency Risk Assessment Conference. Staff can access this training 24/7 but bespoke training is also available.

4.29. In addition, there are assessments in the patients electronic record which include routine safeguarding questions. However, on the 9th of January 2022 whilst a comprehensive assessment was conducted with Christopher by an Occupational Therapist and District Nurse in the Urgent Care Team (which records that the GP had made a safeguarding referral due to Steven's alcohol abuse), the further questions in the document, which ask if the person has ever been hurt or is frightened by someone they know, were not completed. The records evidence that Steven was present - which is why the questions were not asked on this occasion.

4.30. A clear barrier to effective agency practice and management of risk throughout this scoping period has been the poor nature of information sharing between agencies. Not all professionals were aware of the difficulties that some professionals were experiencing gaining access to Christopher, Christopher's historic disclosure of abuse, or of Steven's operating role regarding cancelling and making appointments. A key mechanism for information exchange is to use policy and practice guidance that is already in place and to think widely about who needs to know what and/or what is needed to be sought. There were opportunities to do this. For example, consideration could have been had to convening a multi-agency meeting when Adult Social Care and the District Nurses raised their concerns to the GP early in 2021. A meeting could have been used to establish what other agencies knew about Christopher and Steven. Given the fact the review has established that significant background information did exist, this would have promoted the sharing of such information and the identification of risk, both for domestic abuse and for Christopher's increasing vulnerabilities.

Theme 2 - Safeguarding Concerns and Referrals to other Agencies

4.31. The District Nurses were vital to delivering tailored care to Christopher at the home address. Yet from May 2020 their access to Christopher was commonly obstructed by Steven. This review would highlight the outstanding persistence of the District Nurses to gain access to Christopher. Particularly when the magnitude of this key role is considered against the increasing demand on District Nurses to manage conditions in patients homes. It is estimated that around 15 million people across England[13] are living with one or more long-term condition, and it is believed that by 2025, this figure will increase to 18 million.

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[12] Domestic abuse: useful contacts • Salford City Council

[13] Health matters: physical activity - prevention and management of long-term conditions - GOV.UK (www.gov.uk)

4.32. Safety huddle meetings take place daily with all District Nurse teams. *The safety huddle is an essential aspect of district nursing as a way of preventing harm*[14]. It was devised and effected into community nursing in 2016, to ensure key harm would be addressed daily. The Safety Huddle is explained in the article 'Safety huddle in a Community Setting[15]' *as a meeting held among District Nurses, allied health professionals, specialist nurses, administrative staff, community matrons and healthcare assistants, also known as the wider Multi-Disciplinary Team. It was designed to focus on patients who are at risk of sustaining harm, highlight new patients on the caseload and discuss effective care regarding palliative patients.* Records of safety huddle discussions in Salford are not kept but it is documented by the District Nurses that Christopher was first discussed in a safety huddle in August and September 2020 as a result of the difficulties District Nurses were having gaining access to Christopher. This is in line with the Non-Concordance Process which was developed by Northern Care Alliance[16] to support *staff and recipients of care in situations where a person who has mental capacity is making unwise decisions about their health and social care needs, which places them at significant risk of harm.*

4.33. Records also show that in March 2021 it was discussed in a safety huddle that Christopher was unwell, and that Steven was struggling to manage. As a result of this, and again in line with the Non-Concordance Process, two senior staff arranged a visit but were initially denied access. They returned 4 days later and, on this occasion, did gain access.

4.34. Every Tuesday there is a 'team leader' safety huddle where each team presents cases where there are safeguarding concerns (although in 2020, due to the pandemic, they were initially suspended and then resumed virtually - in line with Government advice and local policy). A member of the Northern Care Alliance safeguarding team attends these Tuesday meetings, but the Northern Care Alliance Safeguarding team have no record of Christopher being mentioned.

4.35. Around the same time that the District Nurses were reporting their concerns into their safety huddle, following Adult Social Care informing the GP Practice of theirs and the District Nurses access problems to Christopher, it is documented that the GP referred Christopher into their safeguarding meetings. However, there is no record of the meetings taking place.

4.36. Referring Christopher's circumstances into the safety huddle and GP safeguarding meeting was good practice but underlines the uncertainty of the professionals involved as to whether their concerns for Christopher were within the remit of adult safeguarding.

4.37. Exploration of whether this was a missed opportunity to refer Christopher to safeguarding concluded that whilst there was a build of concerns regarding Steven denying professional contact with Christopher, just as professionals started to consider the threshold for a safeguarding referral to have been met, contact was had with Christopher, and concern alleviated. In addition, plausible excuses for no access were being given by Steven such as, Christopher sleeping (as he was struggling to sleep at night), or Christopher feeling anxious, and professionals were aware of Christopher's Right to Privacy under Article 8 of the Human Rights Act 1998 which outlines everyone's right to respect for their private and family life. Professionals were challenged by the ethical dilemma of balancing autonomy with fulfilling a duty of care.

4.38. Professionals attempting to gain contact with Christopher recognised that Steven refusing them entry did not automatically warrant any use of legal powers. The situation was sensitive and professionals attempted to gain access by building trust with Steven. This is evidenced by their explanations of their visits

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[14] Royal College of Nursing. Patient safety and human factors. 2017b https://tinyurl.com/yy6rcfum

[15] British Journal of Community Nursing - Safety huddle in a community nursing setting

[16] Issued in April 2020.

to Steven and their enquiries into when Steven thought would be the best time to see Christopher. Professionals demonstrated an open-minded non-judgmental approach.

4.39. The question is; when attempts to see Christopher failed - when did Steven's refusal to give access justify intervention? Professional opinion of threshold differed and fluctuated between those at the reflective session and demonstrated how this decision is one that would have benefitted at the time, from multi-agency discussion to identify risks, potential neglect and explore the hypothetical consequences of both intervention and non-intervention.

4.40. Whilst professionals recognised that had a Section 42[17] investigation been deemed necessary, express legal power of entry, or right of unimpeded access, to Christopher still would not have been provided for, they ultimately agreed that this was potentially a missed opportunity for a Multi-Disciplinary Meeting under safeguarding. Particularly as a subsequent duty to make enquiries could not have been negated by Steven's refusal to grant access or (had access been gained) by Christopher refusing to participate.

4.41. Had access not been gained to Christopher, there could have been a local authority led discussion regarding whether the use of any legal powers was necessary and justifiable, and what, if any, powers would be appropriate.

4.42. Ultimately, regardless of whether Christopher's circumstances would have warranted legal powers being drawn upon, it was important for multi-disciplinary meetings to convene (and/or safeguarding referrals to be completed) to develop a shared understanding of his situation which could have informed intervention.

4.43. Further challenges were identified at the reflective session when discussing where the initial lead responsibility lay. Discussion was had on how Adult Social Care could have led this process but there were three agencies with concerns at the time - and any professional could have led on a meeting and created a robust inter-agency infra-structure. Any professional convening a meeting would have started an ethos of shared ownership between the agencies whose interventions could make a difference to Christopher.

4.44. In August 2021 following GP referral, a Palliative Care Nurse from St Ann's Hospice became involved in Christopher's care. She was successful at gaining entry to the address, managing nine visits and multiple telephone calls. The Palliative Care Nurse liaised with Urology regarding Christopher's appointments, and it was discussed how Christopher's mental health difficulties were affecting his ability to attend. The Urology department had conveyed these concerns to the Community Mental Health Team. Whilst Urology had been proactive in seeking support for Christopher from the Community Mental Health Team at this time, information being requested or shared with other professionals was overlooked.

4.45. In addition, this review has been informed that there is no pathway for a service like Urology to make a referral to the Community Mental Health Team. Instead, the Urologist should have spoken to Christopher's GP and following discussion, the GP could have completed the referral document and included all the relevant detail needed to form an opinion re urgency. Records show that the duty officer at the Community Mental Health Team accepted the Urology referral to be helpful but bypassing the GP has affected the support offered to Christopher in two ways; Firstly, the Community Mental Health Team is made up of three clusters and each cluster has its own GP. The Urologist did not submit their referral into the correct cluster and thus it had to be redirected to the correct cluster. Secondly, the Community Mental

[17] Under Section 42 of the Care Act 2014, local authorities have a duty to make, or cause to be made, enquiries in cases where they reasonably suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect, and, as a result of those needs, is unable to protect themselves from this actual or risk of abuse and neglect.

Health Team has informed this review that the decision was made from the Urology communication to offer a routine appointment – not an urgent one. Which given how ill Christopher was and how his ability to attend crucial appointments would affect his prognosis, would have been more suitable. Current practice has been changed so that the level of response reflects the number of referrals received and the level of concern from other professionals.

4.46. Despite the incorrect referral, following the Urologist contacting the Community Mental Health Team, members of the team attempted two visits (on the same day) with Christopher but were denied access by Steven on both occasions. Christopher was consequently discharged from the service and referred back to his GP, as per usual procedure. (The team did not enter the address until the 12th of January 2022, the day after Steven's GP referred him as a result of him struggling to cope with Christopher's care. On this occasion, access was gained, and assessment of Steven completed which resulted in a referral to Adult Social Care.)

4.47. Multi-agency information sharing was pertinent regarding Christopher's mental health issues as his mental health hindered him from attending health appointments. If at the point of discharge, the Community Mental Health Team had been more professionally curious and explored Christopher's circumstances and vulnerability in more depth, they may have understood the importance of Christopher's mental health being addressed and may not have closed the case. Lack of professional curiosity resulted in the mental health team closing the case without any understanding of why Steven was denying them access and without ensuring that Steven's refusal to allow them access had been shared with other agencies and/or addressed.

4.48. Whilst there is no clear definition of professional curiosity, practice to include application of professional curiosity is embedded in safeguarding adult policies and the Care Act 2014, the main statutory framework which guides safeguarding adult practice. Consequently, professional curiosity is known to be an essential component of safeguarding procedures so why, after years of this good practice permeating safeguarding practice are we still finding examples of it not being considered?

4.49. A Research in Practice briefing[18] has identified that the *structure and service values of an organisation or partnership will have a deep impact on the likelihood that curiosity will thrive.* The briefing examines eight key areas that leaders could focus on to develop the conditions for professional curiosity to flourish:

- Involving people who use services – adapting practice to meet people's needs and outcomes.
- Time and capacity – creating space for professionals to reflect.
- Structure and working practices – maximise opportunities for managers to use strength-based practice frameworks to encourage professionals to focus on the individual and their situation.
- Supervision and support – provide good quality supervision which offers reflection, critical analysis, and respectful challenge.
- Legal and safeguarding literacy – enable practitioners to make connections between legal rules and professional practice.
- Learning and development – provide programmes of learning and development.
- Open culture – encourage challenge from frontline practitioners and promote innovative practice.
- Partnership working – share information, bring together different perspectives, manage difficulties between professionals.

4.50. This is a helpful list against which Salford could audit/review their system.

[18] The importance of professional curiosity in safeguarding adults. Helen Thacker, Dr Ann Anka and Bridget Penhale Published 9.12.2020.

4.51. Because as mentioned professional curiosity is a recurring theme in Safeguarding Adult Reviews, Salford Safeguarding Adult Board is currently developing work to promote it in 2023/2024. This is likely to include refreshed training and tools.

4.52. Starting from the 7th of October 2021 as concerns increased, the Palliative Care Nurse made several attempts to contact the Community Mental Health Team for an update on the Urology referral, but the two parties kept missing one another's calls. On the 18th of October 2021 the Palliative Care Nurse left a message asking for the referral to be re-opened due to Christopher's deterioration but when a member of the Mental Health Team returned the call to discuss, the Palliative Care Nurse was unavailable. Contact was not achieved between St Ann's Hospice and the Community Mental Health Team until December 2021, and this is when the hospice learned that Christopher was no longer open to the team.

4.53. Meanwhile in October 2021, the Palliative Care Nurse had submitted a safeguarding concern in view of Christopher's complex mental and physical health impacting on his ability to access services. A Social Worker was allocated on the 18th of November 2021[19] and on the 23rd of November 2021 the Palliative Care Nurse contacted the Social Worker and provided further information regarding the problems she was having contacting the Mental Health Team and concerns that Steven was withholding information from Christopher.

4.54. The Social Worker and the Palliative Care Nurse discussed a new referral to the Community Mental Health Team and the Social Worker concluded that a Strategy Meeting would be convened once Mental Health were involved.

4.55. The Social Worker has reflected that the focus of the support for Christopher was upon his mental health (which it was thought would achieve him a move downstairs and attendance at health appointments) rather than the holistic picture, and that much time was consequently lost whilst waiting for other agencies to respond.

4.56. The Palliative Care Nurse has reflected that she was confused about what to expect from Social Care involvement following her safeguarding concern. Consequently, whilst she was proactive in chasing the Social Worker for updates, she did not escalate any concerns as whilst she had hoped for a Multi-Disciplinary Team approach, she wasn't confident of what should happen anyway.

4.57. This confusion was reflected by other professionals at the reflective session who echoed a lack of understanding of what happens to safeguarding concerns and what action to suppose.

Question 2:

How can partner agencies assure Salford Safeguarding Adult Board that their professionals have a full understanding of the safeguarding concern process?

4.58. As mentioned, the Community Mental Health Team discharge was shared (as per usual practice) with the GP by means of a notification. Because it is not practice for a Urologist to refer to Community Mental Health, a notification of discharge was not sent to them even though they were the referrer. The notification sent to the GP was deemed as being for information sharing purposes only, with no expected action or follow up unless specifically directed by mental health services (which it was not). The GP Practice has offered the panel assurance of a development to practice with the employment of a Care Coordinator who will now consider GP notifications such as this one. This is a new role across Primary Care services. Care

[19] Adult Social Care has informed this review of low staffing levels on the Social Work Team at this time and of subsequent delays with allocation. The team is still reportedly low in staffing numbers.

Coordinators form part of a GP Practice's multidisciplinary team, working alongside GPs, social prescribing link workers[20], pharmacy staff, nurses, health and wellbeing coaches, and surgery administrative staff. A Care Coordinator would work to engage 'hard to reach' service users - similar to Christopher. However, this review can only seek assurance around the GP Practice involved with Christopher's care as the Care Coordinator role is only commissioned to specific practices in Salford funded by their Primary Care Network stream.

4.59. Upon the receipt of this notification from the Community Mental Health Team (and any others referring to Christopher having not attended an appointment), better practice would have seen the GP Practice following the Greater Manchester Guidance for Managing the Non Attendance of Adults with Care and Support Needs which *promotes effective communication and information sharing with multi-agency professionals and services when adults do not attend appointments (these appointments may be with other services who have sent a notification to the GP or these may be General Practice appointments) and there are suspected, or known, vulnerabilities identified.* The guidance suggests that following consideration of all reasonable adjustments having been made, a professionals meeting may be needed to share the information and agree the best management plan.

4.60. In addition, whilst the discharge of Christopher from the Community Mental Health Team back in October 2021 was in line with procedure, better practice would have been achieved if the Community Mental Health Team had discussed it with other professionals involved, particularly the referrer. This would have enabled a discussion about any safeguarding concerns and a decision about next steps. This review has been assured of a new triage system across the Community Mental Health Team which was established in December 2022. Staff must now speak with the individual referred to establish their wishes and feelings and seek their consent for the referral. Any incidents of being unable to speak with the individual should now be discussed with the referrer and a clear plan outlined.

Question 3:

How can partner agencies assure Salford Safeguarding Adult Board that professional meetings are being convened when an adult with suspected or known vulnerabilities is not attending appointments?

4.61. It is interesting that Christopher is recorded as *'not engaging'* with the Community Mental Health Team whereas in fact, Steven had been the one who had prevented staff from seeing Christopher. The language/terminology presents as factual and once applied to Christopher - labelled him. Such labels are in danger of having a dampening effect on professionals' curiosity as they suggest that Christopher had actively chosen not to engage as opposed to him having his access to the service barred by Steven.

4.62. For example, had it been documented in October 2021 that Steven had prevented access to Christopher instead of Christopher not engaging, a different and more robust approach may have been taken to accessing Christopher when the GP re-referred him to the Community Mental Health Team in December 2021. On this occasion Christopher was offered an appointment for the 30th of December 2021 but he was still not seen, and phone messages still remained unanswered. Had it been clear in records that Steven had previously prevented access – professional attempts to contact Christopher may have been more steadfast.

[20] Social prescribing link workers connect people to community-based support, including activities and services that meet practical, social, and emotional needs that affect their health and wellbeing.

4.63. In summary, Christopher's information - though shared inter agency within huddles and single agency meetings could have been shared more effectively multi-agency. This may have resulted in an earlier safeguarding referral being processed. In addition, professionals have demonstrated that a better understanding of each other's roles and safeguarding processes would improve their use of information sharing exchange policies already in place.

Theme 3 – Professional Understanding of Mental Capacity, Best Interest Decision Making and Executive Capacity

4.64. Christopher's mental capacity commonly appeared in practitioners' narratives at the reflective session and was recognised as a key determining factor of what intervention could and should take place. There was a common consensus that Christopher did have capacity to make decisions about his healthcare. However, whilst this decision is not in dispute it has to be said that the rationale for assuming Christopher's capacity is not documented, and this review remains unclear as to exactly how Christopher's capacity was fully considered.

4.65. A pattern was described of Christopher agreeing to attend appointments, and agreeing to changes being made within the house which would assist management of his health, but then anxiety and panic would become so great that he would become unable to proceed. Professionals report that this was described by Steven as *his mind stops his body doing what it wants to do.*

4.66. To help address Christopher's inability to attend health appointment, the Urologist reported to the GP (in a letter dated July 2021) of having convened a best interest meeting. The letter stated that Christopher had not attended as he had been sleeping but that his carer had, and that all in attendance had agreed that it was in Christopher's best interest to undergo a renal biopsy and a Magnetic Resonance Imaging scan. Exploration of this within the reflective session has established that this meeting was a telephone call between two people. The correct professionals to make such a decision had not been involved and neither had Christopher. Most importantly there is no evidence of any capacity assessment deeming Christopher to not have the capacity to make this decision. This poor understanding of the best interest decision making process is a recurring theme in Safeguarding Adult Reviews and has been the subject of previous recommendations directed to Salford Safeguarding Adult Board[21]. Consequently, Salford Safeguarding Adult Board have revised their strategy around implementation of recommendations and their audit, and the recurring theme of best interest decisions will be added to the business plan for 2023/2026.

4.67. Discussion was had at the reflective session around whether Christopher's executive functioning was explored and considered by professionals working with him.

4.68. Executive functioning is a set of mental skills that helps a person to get things done. These skills are controlled by an area of the brain called the frontal lobe. When executive functioning isn't working as it should, a person's behaviour is less controlled, and they are less focussed.

4.69. There is no formal diagnosis, or medication to correct weak executive functioning but had tests suggested that Christopher was experiencing it, behaviour therapy and cognitive behavioural therapy could have been explored to improve his decision-making capacity. However, it is recognised that such therapy would have been dependent upon professionals gaining access to Christopher and upon Christopher's ability to engage.

[21] SAR Kannu

4.70. Whether Christopher would have engaged with any therapy or not, it would have been helpful for professionals to establish whether he was experiencing weak executive functioning as (whilst executive functioning problems alone are not evidence of a lack of capacity), it could have affected Christopher's mental capacity.

4.71. This leads the review to consider the term executive capacity. In 2010 the authors (Naik, A et al) of the paper; *Patient autonomy for the management of chronic conditions: A two-component re-conceptualization*[22], summarised 'executive capacity' and wrote:

The clinical application of the concept of patient autonomy has centred on the ability to deliberate and make treatment decisions (decisional autonomy) to the virtual exclusion of the capacity to execute the treatment plan (executive autonomy) … Adherence to complex treatments commonly breaks down when patients have functional, educational, and cognitive barriers that impair their capacity to plan, sequence, and carry out tasks associated with chronic care. … [Therefore] assessment of capacity for patients with chronic conditions should be expanded to include both autonomous decision making and autonomous execution of the agreed-upon treatment plan.

4.72. Application of executive capacity to Christopher could have led professionals to consider his decision making with regards his health and care. For example, Christopher told several professionals that he wanted to attend his health appointments and that he understood the importance of attending - and the consequence of not attending. Similarly, Christopher agreed that he wanted the changes to be made within the house which would assist management of his health and, he was able to explain the benefits. However, this decision-making was very much based upon immediacy and did not incorporate his ability to execute. Christopher's real world decision-making included his anxiety, but this was not existent at the time he was making the decisions.

4.73. Caselaw[23] suggests *stepping back … rather than focussing on the more 'micro' questions about the specifics*. It suggests that by doing this an *assessor is less likely to assess interrelating issues in silos and so come to contradictory and unworkable conclusions on capacity.*

4.74. The caselaw also brings attention to the NICE[24] guideline: Decision-making and mental capacity[25] which states that *practitioners should be aware that it may be more difficult to assess capacity in people with executive dysfunction and that structured assessments of capacity for individuals in this group may need to be supplemented by real-world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability.*

4.75. Given the complexities of Christopher's health and ongoing health management best practice would have seen professionals considering his executive functioning alongside his capacity and documenting their thoughts and findings.

Question 4:

How can partner agencies assure Salford Safeguarding Adult Board that their Mental Capacity training is incorporating Executive Functioning/Capacity?

[22] Patient Autonomy for the Management of Chronic Conditions: A Two-Component Re-conceptualization - PMC (nih.gov)
[23] Sunderland City Council v AS and Others | 39 Essex Chambers
[24] National Institute for Health and Care Excellence
[25] Recommendations | Decision-making and mental capacity | Guidance | NICE

Theme 4 - Agencies Understanding of Christopher's Lived Experience

4.76. Christopher was a gay man living in England, having left his birth country in 2000. Christopher had said that his move to England was two years after his parents had thrown him out of the family home because he was gay.

4.77. Within the documentation provided, this review has not seen any reference to any professional who met Christopher, striving to understand his culture. Cultural curiosity is an interest in understanding and learning more about a person's cultural background, experiences, and viewpoints**.** It involves learning about someone's cultural heritage and appreciating how that person thinks or conducts themselves taking into consideration their cultural background. Understanding someone's culture can help you better empathise with them and provide appropriate services.

4.78. Whilst the details of Christopher's childhood and adolescence remain unknown, this review has tried to explore how accepted his sexuality would have been in his birth country. An Ifop opinion poll survey conducted with a representative national sample of 3,013 people in 2019 highlights a growing recognition of homosexuality and homosexuality in society. In 1975, 42% of the people in Christopher's birth country considered homosexuality a flaw, this figure had decreased to 8% in 2019. However, the director of Ifop reportedly commented that the *growing tolerance of homosexuality should not be confused with complete acceptance* as the survey also revealed a persistent malaise towards LGBT persons: 25% of respondents stated that they were uncomfortable with the idea of children seeing people of the same sex holding hands in public.

4.79. Data and research indicate that the people of Christopher's birth country and the United Kingdom have similar opinions about homosexuality. In fact, when the question; should homosexuality be accepted by society was posed across 34 countries in 2019, exactly 86% of the respondents in both countries agreed that it should.

4.80. The review has also attempted to explore if and how Christopher's European upbringing may have affected his understanding and views of domestic abuse. As it is for the United Kingdom, it has proven impossible to obtain accurate data to gain an understanding of the extent of domestic abuse in the LGBTQ+ community in Christopher's birth country due to there being no official figures, - but domestic violence abuse is an ongoing problem. It is reported that domestic violence increased by 10% in 2020 affecting 159,400 victims with 125 people being killed by violent partners. The data does not differentiate between the sex of the perpetrator but 23 of the people killed were men. The number of domestic homicides recorded in the United Kingdom for a similar period (March 2020 – March 2021) is 208 – considerably higher than the recorded data in Christopher's birth country.

4.81. Professionals may worry that acknowledging cultural differences could be perceived as negative stereo typing and be considered discrimination. And this review recognises that no individual necessarily represents what may be true of their cultural background. But research demonstrates that there are cultural differences. If professionals do not consider this, they will be unable to consider whether any accommodation is needed to ensure that a service user is not put at a disadvantage. This review understands that it is not possible for every professional to learn of every culture, but there are generic skills to competence, such as open-minded awareness of the differences that cultural background can produce. This should be regardless of how long a foreign-born person has lived in the United Kingdom and has sought to integrate with the United Kingdom.

4.82. On the 31st of January 2020, the United Kingdom withdrew from the European Union. Christopher, having been a legal resident in the United Kingdom since 2000 would have been eligible to apply for settled status[26] as it is available to those who have five years continuous residence in the United Kingdom. The deadline for applications was the 30th of June 2021[27]. Settled status is not an automatic right. European Union citizens such as Christopher need to apply for and be granted status. Had Christopher failed to apply for settled status before the deadline he may have had no legal right to live in the United Kingdom, and would have, amongst other things, been unable to legally use the NHS, or rent a home. Although it is possible that Christopher's ill health may have been considered as 'reasonable grounds' for missing the deadline and he may have still been allowed to apply.

4.83. It has not been possible to confirm whether Christopher had settled status post Brexit, but it may have proved useful for professionals who were attempting to support Christopher to have explored this with him. It may have potentially been an additional source of anxiety regarding his healthcare.

4.84. This review must also consider how the Coronavirus which had been identified as pandemic in December 2019, could have affected Christopher. The first lockdown had been lifted in July 2020 but in an attempt to contain the virus, there had soon followed months of local restrictions across England. These had developed into a "four tier system", and at times had affected further closure of non-essential retail and hospitality, and personal restrictions of movement.

4.85. The scoping period of this review begins in January 2021, and it was on the 6th of January 2021, that a rising number of coronavirus cases saw national restrictions being reintroduced. It wasn't until the 8th of March 2021, that England began a phased exit with a plan, known as the 'roadmap' out of lockdown. This was intended to 'cautiously but irreversibly' ease lockdown restrictions. England moved through the roadmap as planned but step four was delayed until the 19th of July 2021 to allow more people to receive their first dose of a coronavirus vaccine.

4.86. Consequently, professionals attending Christopher throughout the scoping period of this review were still adapting to everchanging working conditions introduced to manage the virus. In fact, the second phase of a UK wide study[28] exploring the impact of the Covid-19 pandemic on health and social care, has highlighted that social work and nursing were the most impacted occupational groups. A member of the Community Specialist Palliative Care Team who attended the practitioner reflective session, described the time as creating an exhausting and highly stressful environment for all community staff to work in.

4.87. Whilst a Palliative Care Nurse has informed this review of Gold Standard Framework meetings and District Nurse huddles being cancelled in support of infection control, and of delays to bariatric equipment[29], this review has been assured that Covid did not affect all aspects of the care and support offered to Christopher from professionals during the scoping period. Professionals still attempted to visit

[26] Settled status is also known as 'indefinite leave to remain under the EU Settlement Scheme.' Holders of settled status will be able to continue living and working in the UK for as long as they like, with no need to apply for future immigration status.

[27] Eligible individuals could still apply after this date.

[28] HSC Workforce Study

[29] This review has been told that there were already delays in equipment provision due to Brexit, but the Covid Pandemic exacerbated the issue because the equipment suppliers who sourced equipment from China (where some equipment was manufactured) did not have supplies of equipment in stock to deliver to Salford Equipment Services to issue to patients.

Christopher at home and hospital appointments were still arranged. However, it is recognised that it was because of Covid that Christopher's care package had stopped. This necessitated more of Christopher's care and support needs demanding to be met by Steven.

4.88. In addition, Covid introduced a testing requirement before Christopher could attend some of his health appointments and this added an extra layer of organisation that needed to be tackled both emotionally and physically by Christopher. This review has not been able to confirm whether Christopher was comfortable undertaking such tests or whether it was a traumatic experience for him.

4.89. Also, during some of this scoping period, the public was still being urged to exercise caution regarding the Covid situation. And whilst not always a legal requirement, any person pinged on the Test and Trace app, was expected to self-isolate. This meant that reduced staffing levels - one of the problems that had arisen initially from the Covid pandemic, still remained a problem for all agencies as staff who had been exposed to the virus, still had to self-isolate, and staff who had been unfortunate enough to contract Covid-19 were off work.

4.90. Covid also further stifled professionals' ability to gain access to the property and engage face-to-face with Christopher as it provided Steven a legitimate reason not to allow access to the property - he could defer contact by stating that he was feeling unwell or isolating.

4.91. Whilst the last few years of Christopher's life were undoubtedly affected by the Covid Pandemic, the most significant issue was possibly the pandemic's personal effects upon Christopher - as a vulnerable person who was at risk of domestic abuse particularly when his partner consumed alcohol.

4.92. This review is unable to confirm whether Steven's alcohol use increased during the pandemic, but the lockdowns did see an overall increase in people's alcohol consumption. In July 2021 Public Health England released a paper called 'Alcohol consumption and harm during the Covid 19 pandemic'[30]. The findings show an increase in the heightened risk level of alcohol consumption from 2020 to 2021. It was following this period that Steven was seen by professionals to be under the influence of alcohol, but professionals were frequently struggling to gain access into the house in 2020 and 2021 and cannot therefore rule out Steven's alcohol use as being a factor in Christopher's lived experience of Covid.

4.93. In addition, to how Covid affected people's alcohol consumption, the environment created by Covid, increased Christopher's risk of domestic violence. When the first 'lockdown' was announced in March 2020, charities, such as Women's Aid, highlighted the increased risk of harm and isolation for those affected by domestic abuse. Because domestic violence is often a hidden crime that is not reported, data can only provide a partial picture of the actual level of domestic abuse experienced. But the Office for National Statistics report that in mid-May 2020, there was a 12% increase in the number of domestic abuse cases referred to victim support. Between April and June 2020, there was a 65% increase in calls to the National Domestic Abuse Helpline, when compared to the first three months of that year.

4.94. Whilst this review has no up-to-date record of Christopher's weight or body mass index, it is recorded that he was obese. Currently NHS guidelines define a healthy weight as a body mass index of 18.5 up to 24.9. People who are overweight have a body mass index of 25 to 29.9 and a body mass index of thirty or above is considered obese. Extreme or severe obesity is defined as forty and above[31]. Health records show

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[31] What is the body mass index (BMI)? - NHS (www.nhs.uk)

that Christopher attempted to engage with the weight management clinic with a view to considering bariatric surgery in 2017. However, Christopher was unable to engage with the appointments.

4.95. Christopher's obesity was a factor that further complicated his attendance to hospital appointments as his mobility decreased; Christopher required support from North West Ambulance Service to leave his bedroom to leave the house.

4.96. Both Salford Royal Foundation Trust Hospital and St Ann's Hospice have manual handling policies regarding bariatric manual handling, and it is good practice that the Occupational Therapist consulted both during her planning of Christopher's care. It is also good practice that the Occupational Therapist discussed the challenges of Christopher moving downstairs at the joint Hospital and Community Specialist Palliative Care multi-disciplinary meeting and at the St Ann's Hospice caseload review meetings.

4.97. Overall, whilst the transportation of bariatric individuals was noted to be problematic in a previous Safeguarding Adult Review[32] undertaken by Salford Safeguarding Adults Board it would appear that the main contributory factor that hindered Christopher's transportation both downstairs and to hospital appointments was his mental health. Christopher shared this information with the professionals who attended his address and with the health professionals who were encouraging him to attend appointments. It was good practice that professionals attempted to help Christopher overcome this with a referral to the Community Mental Health Team. However, Steven refused members of the team access to Christopher.

4.98. What this review has been unable to ascertain from documentation and/or professionals is how Christopher felt about his weight management, which suggests that it wasn't explored with Christopher. Health and care professionals are in a unique position to talk to patients about weight management and the first step to offering support is to initiate conversation. Professionals should not be wary of asking questions about a person's weight management. Public Health England has developed a resource[33] to support professionals to appropriately discuss the topic[34].

4.99. Steven's monitoring behaviour was a consistent factor throughout the scoping period. He did not take Christopher to hospital when advised, nor did he call for an ambulance. No professional was given access into the home address by Steven to see Christopher for the first few months of the scoping period and hereafter, entry was sporadic. To recap, it was known at the beginning of the scoping period of this review to the Community Mental Health Team that Christopher had previously disclosed being subject to domestic abuse from Steven and that Steven could become violent when he drank alcohol. The GP Practice should have known this but as mentioned previously, the flag had dropped off the system. Adult Social Care, and Salford Royal Foundation Trust also should have known, but had no knowledge as records had not been correctly transferred to new systems during the transfer process and consequently this valuable risk information was lost. This review has also been informed that neither the Occupational Therapist nor the Palliative Care Nurse would have known of the domestic abuse history. Both parties now have access to any GP records where they would hope to learn of such information, but this is dependent upon the GP Practice utilising the EMIS database software.

4.100. The Palliative Care Nurse and the Occupational Therapist appear to the professionals with the most success regarding engagement with Steven and consequently, Christopher. This is evidenced by her, and the Occupational Therapist being told by Steven that they could attend the property without prior

[32] final-safeguarding-adult-review-report-sar-jayne-sept-2022-accessible.pdf (salford.gov.uk)
[33] Let's Talk About Weight - step by step guide (publishing.service.gov.uk)
[34] Professionals wishing to understand more about bariatric care are advised to read SAR Jayne – footnote 36.

communication. It remains unknown why Steven allowed them entry, but the Palliative Care Nurse has outlined to this review her clear and prompt communication with both Christopher and Steven. This incorporated many methods of contact including email which upon reflection, the Occupational Therapist has said (that an email address) was only requested from Steven as a back-up method of communication on the 17th of November 2021. She reflected that better practice could have seen this being considered earlier. It is recognised that it is preferable to always speak with in person, but email is another channel of communication that can be utilised.

4.101. Further reflection had upon this communication in line with the discussions had around Christopher's cultural background questioned whether Christopher should have been offered a language interpreter given that English was not his first language.

4.102. This review has been informed that Christopher spoke fluent English and conversed in English in day-to-day conversation. When a foreign-born speaker uses the English language as fluently as Christopher did, it is understandable that professionals will assume that the person will be able to understand the whole conversation. However, this could be untrue and in verbal exchanges across a cultural divide it is unsafe to presume that a full mutual understanding is being achieved even when both parties are using English fluently. Best practice would see an interpreter being offered and a professional explaining the full benefits. A foreign-born person may overestimate the level of English they have and/or underestimate the level of English that can be required in a medical setting and turn down an interpreter.

4.103. It is also reasonable to expect that a person finding themselves experiencing a health-related experience with the seriousness of which Christopher did, may find their fluency in a second language reduced. Particularly as their mind becomes confused as Christopher said his was when he was in hospital in January 2022.

4.104. Sadly, the chronology of documentation provided to this review, shows a steady decline in Christopher's health. It is highly likely that within this timeline Steven was the only non-professional person that Christopher came into contact with. Consequently, Christopher was mostly alone in his address in an increasingly vulnerable state with Steven who he had previously reported for abuse and described as *cruel and violent.* Also, Steven was known from past reported police incidents to have anger issues, particularly if he used alcohol and there is no record of this having been addressed.

4.105. By January 2022 when Christopher disclosed domestic abuse, he had been living in a vulnerable immobile state, upstairs, mostly alone with Steven for several months (the exact timescales of when Christopher became bedbound are unknown). In that time, he had been totally dependent on Steven for access to professionals, (and consequently unable to speak with the Community Mental Health Team for support with his anxiety) been informed of a cancer diagnosis and was experiencing pain.

4.106. When professionals did gain access to Christopher, they were very good at managing his immediate apparent concerns. For example, the GP prescribed the medication he required, the Occupational Therapist provided equipment, the Palliative Care Nurse attended to his immediate health needs, but did any professional understand how Christopher really lived. Were opportunities to explore Christopher's lived experience maximised? Did professionals discuss with Christopher their struggles to access him and explore how Christopher could contact them if he needed to if Steven was either unavailable or not willing to help.

4.107. Professionals had snapshots into Christopher's life when Steven permitted. As such there was no understanding of Christopher's lived experiences at the times when access was being denied. Had

professionals been aware of the historic abuse and Christopher's disclosure of Steven being *cruel,* Christopher's increasing reliance upon Steven may have generated concern.

4.108. Had the GP and the Palliative Care Nurse been aware of the historic disclosures, Steven's drunken presentation when they visited on separate occasions in January 2022 may have been considered differently by both of them. Christopher's subsequent disclosure evidences that at the time of these visits Steven had been hitting Christopher with a blunt instrument, had been abusing his Tramadol prescription and when the Palliative Care Nurse visited on the 10th of January, had been withholding food.

4.109. For reasons that we can no longer learn from Christopher, he was unable to disclose this abuse to either visiting party at the time. However, we do know how dependent Christopher was upon Steven for his care, particularly as he was in a different country to his family from whom he was also estranged.

4.110. Christopher was clearly vulnerable to carer's abuse. His disability generated by his failing health decreased his ability to physically defend himself and also to escape.

4.111. Dr Justin Varney's report on disability and domestic violence published by Public Health England in 2015[35] confirms that disabled people experience disproportionately higher rates of domestic abuse. It also highlights that they experience domestic abuse for longer periods of time. The report explains that there is a wide range of abuse that may be experienced by a person with a disability which includes coercion and control from the person who is acting as their carer. For example, abuse can happen when someone withholds, destroys, or manipulates medical equipment, access to communication, medication, personal care, and transportation. People with disabilities have also reported abuse through the form of intrusion and lack of privacy.

4.112. This highlights that undoubtedly more needs to be done to alert professionals to the heightened risks of domestic abuse that people dependent upon carers can potentially face. Professionals need to be aware of how abusive carers may attempt to portray themselves as victims. In January 2022 Steven spoke to his GP and informed him/her that he was struggling to meet Christopher's needs. This focussed him as a carer - not an abuser. Dr Ravi K. Thiara is a principal research fellow at the Centre for the Study of Safety and Wellbeing at the University of Warwick. On the SafeLives practice blog[36] she refers to a study undertaken at the centre within which a disabled women spoke about how abusive partner-carers presented themselves as 'caring heroes' to outsiders but in fact used this to exert greater damage. Another individual described the collusion of agencies and professionals thus: *"People pity him because he is taking care of you… people are reluctant to criticise this saint or to think he could be doing these terrible things."*

4.113. Only Christopher and Steven truly know the extent of control that Steven potentially had over Christopher but his dependency on him for his care undoubtedly served to dramatically reduce his ability to seek support. It could also be argued that agencies unintentionally contributed to Steven's ability to control as he had the power to decide when and which professionals were able to gain access to Christopher in the home.

4.114. Understanding Christopher's lived experience was crucial as without it, professionals were unable to take Steven's behaviours into consideration within their care and support plans regarding Christopher's health. This realisation serves as a further reminder as to how important professional curiosity is when working with vulnerable adults. Though not recognised at the time, professionals needed to actively seek and utilise 'windows of opportunities' to speak with Christopher alone. Such junctures were infrequent for

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[35] Microsoft Word - Disability and domestic abuse topic overview FINAL.docx (publishing.service.gov.uk)
[36] Understanding disabled women's experiences of domestic abuse | Safelives

Christopher but when they did arise it was imperative that they were utilised to their maximum potential and used to ask him about his personal experience within his relationship and gain an understanding of what support he needed. This review endorses awareness of the value of speaking with all service users alone - even when domestic abuse is not a recognised concern.

5. Good Practice

The agency reports submitted to this review and the discussions around Christopher, have highlighted examples of good practice[37] from professionals involved with him. Including:

5.1. Following a call to Greater Manchester Police in January 2022 reporting Christopher had been assaulted and was a victim of coercive and controlling behaviour from Steven. The police took positive action on receipt of this third-party professional report and arrested Steven.

5.2. Once the process on how to move a bariatric patient downstairs was clarified the Occupational Therapist circulated this information to immediate team colleagues. This information was also shared with the Salford Royal Hospital End of Life Care strategic meeting attended by hospital, hospice and community nurse managers and leads.

5.3. The Occupational Therapist and Palliative Care Nurse were proactive and regularly communicated and updated each other re Christopher's case because it was complex and because of the many challenges.

5.4. Christopher's case was discussed on at least 3 occasions at the joint Hospital and Community Specialist Palliative Care multi-disciplinary team meeting attended by hospital and community staff. And also discussed at the St Ann's Hospice Caseload Review meetings which is attended by hospice staff.

5.5. There was a great deal of flexibility to arrange an admission into hospital. Although Christopher did not attend appointments, alternative arrangements were discussed between radiology and the Urologists.

6. Developments Since the Scoping Period

Agencies have already made some important amendments to practice since the scoping period of this review. Some of these developments have been included in the body of this report. Others include:

6.1. Since undertaking this review, Greater Manchester Police's overarching domestic abuse policy has been revised and published in August 2022, incorporating all aspects of dealing with Domestic Abuse incidents from initial attendance through to custody processes and post-incident victim and perpetrator support. This policy was published via Chief Constable Orders 2022/33 and then the updated Procedure in October 2022. This has been supplemented by training inputs across all districts delivered by Greater Manchester Police's Public Protection Governance Unit and Investigation and Safeguarding Review Team to inform the changes and focus on the onward referral of all triaged Domestic Abuse incidents. To supplement this, a "Domestic Abuse Matters" continual professional development input is also being rolled out by charity SafeLives across Greater Manchester Polices until March 2023.

6.2. A Liquidlogic warning indicator for domestic abuse cases is to be explored.

[37] Good practice in this report includes both expected practice and what is done beyond what is expected.

6.3. Adult Social Care LIASON Domestic Abuse lead now attends all teams to share information on domestic abuse services.

7. Conclusions

7.1. There is a report of domestic abuse in Christopher and Steven's dating from 2009 but no further incidents are reported to professionals until 2016 - when Christopher disclosed to his GP that their relationship had been abusive for many years. Consequently, opportunities for agency interventions existed from 2016 but these early opportunities for multi-agency support for Christopher did not develop and the abuse was not recorded effectively to inform future risk management and support.

7.2. Throughout the scoping period of this review, Christopher's health deteriorated. Both Steven and Christopher reported that Steven was Christopher's carer but Steven commonly obstructed professional contact with Christopher.

7.3. Agencies predominantly managed their interactions with Christopher on a single agency basis. Professionals referred concerns into their own agency safeguarding meetings but, challenged by the ethical dilemma of balancing autonomy with fulfilling a duty of care, professionals demonstrated some uncertainty regarding whether the concerns warranted a multi-disciplinary safeguarding concern. Commonly as professionals deemed the threshold for a safeguarding referral to have been met, contact with Christopher would be achieved, and concerns would be temporarily alleviated.

7.4. Opportunities to ask Christopher routine safeguarding questions (when alone) were not executed, and there is little evidence of professional curiosity being applied to Christopher's home circumstances. This effected professionals having little understanding of Christopher's lived experience.

7.5. Christopher's unwise decisions around his support and healthcare were deemed to be a consequence of his mental health. Consequently, referrals were made to help Christopher address this by professionals who clearly cared but they were ineffective due to Steven's obstruction.

7.6. Christopher with Steven as his carer, was isolated and unsupported. This review hopes that its reflection upon professionals understanding of Christopher will serve as a driver of change moving forward and that his history will lead us to better practice.

8. Questions

In order to address the learning, the review would ask the Salford Safeguarding Adult Board to deliberate the following questions. It is the responsibility of Salford Safeguarding Adult Board to use the ensuing debate to model an action plan to support improvements to systems and practice.

Question 1: How can partner agencies assure Salford Safeguarding Adult Board that their professionals understand and can recognise indicators of domestic abuse occurring within any LGBTQ relationship and are able to support victims?

Question 2: How can partner agencies assure Salford Safeguarding Adult Board that their professionals have a full understanding of the safeguarding concern process?

Question 3: How can partner agencies assure Salford Safeguarding Adult Board that professional meetings are being convened when an adult with suspected or known vulnerabilities is not attending appointments?

Question 4: How can partner agencies assure Salford Safeguarding Adult Board that their Mental Capacity training is incorporating Executive Functioning/Capacity?

9. Appendix 1

- Multi-agency working
- Was every opportunity taken to safeguarding Christopher?
- Domestic Abuse in same sex relationships - Supporting Christopher to access support regarding his abusive relationship.
- Risk Management
- Making Safeguarding Personal; ensuring the voice of the adult is heard and not just heard through family members.
- Professional Curiosity
- Recognising the signs of domestic abuse, coercion, and control in adults
- Nonattendance/missed medical appointments.
- LGBTQ+
- The connectivity between the trio of vulnerability – Domestic Abuse/Mental Health/Alcohol
- Bariatric care and support
- Needs of the carer
- Abuse from the carer
- Christopher was not born in the United Kingdom – there may be cultural needs to consider.