Oxfordshire Safeguarding Adults Board

Safeguarding Adult Review – Adult J

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Introduction

1.1 Adult J died on his partner Adult K's houseboat on 4th December 2018. Although he had sustained head injuries, these were subsequently found to be relatively minor, and his cause of death was found to be acute alcohol intoxication. Adult J also lived on a houseboat. Whilst his houseboat was previously moored in Warwickshire in August 2017, Adult J sustained burns to 60% of his body after being covered in white spirit and set alight. His partner Adult K was arrested in respect of this incident but was not prosecuted because of a lack of evidence. After receiving specialist treatment for his burns in a hospital in Birmingham, Adult J was discharged to his houseboat, which was then moored in Oxfordshire and he, and his partner Adult K, came into contact with several agencies prior to his death.

1.2 In May 2019 Oxfordshire Safeguarding Adults Board (OSAB) decided to conduct a Safeguarding Adult Review (SAR) to explore how agencies had worked together to safeguard Adult J in order to identify learning with which to improve professional practice. A description of the process by which this SAR was conducted is shown at Appendix A.

1.3 David Mellor was appointed as independent reviewer for the SAR. He is a retired chief officer of police and has over seven years' experience of conducting statutory reviews. He has no connection to any agency in Oxfordshire.

1.4 An inquest into the death of Adult J took place on 4th March 2020.

1.5 Oxfordshire Safeguarding Adults Board wishes to express sincere condolences to the family and friends of Adult J.

Terms of reference

2.1 The timeframe of the review is from June 2017 until 4th December 2018. Relevant events which occurred prior to this timeframe will also be included.

2.2 The review will address the following questions:
Generic:

- What specific issues or questions does this case raise?
- Are there any unusual factors in this case, what are they?
- Are there any failings which appear obvious at this stage?
- Do there appear to be any gaps in multi–agency working?

Case specific:

- What information came over from Warwickshire
- Were risk assessments completed for each Domestic Abuse (DA) incident and were the history of incidents viewed as a whole when assessing risk?
- What single-agency assessments (care needs, MCA, etc.) were undertaken and what was the outcome, what support was provided, etc?
- What multi-agency activity was undertaken and how was this information shared with partners, across county borders, etc?

Glossary

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

The SafeLives **DASH** (Domestic Abuse, Stalking and 'Honour Based Violence') check list helps practitioners assess the victim's risk of domestic violence and abuse.

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

A **Domestic Violence Protection Order (DVPO**) is a civil order which fills a 'gap' in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

An **Evidence-Led Prosecution** is one where the victim of domestic abuse decides not to support a prosecution, and in turn prosecutors need to decide whether it is possible to bring forward a case without that support.

Independent Domestic Violence Advisor (IDVA) Their main purpose is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

Independent Mental Capacity Advocate (IMCA) - The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

The **Mental Capacity Act (MCA)** is designed to protect and empower those vulnerable people who may lack capacity to make their own decisions and applies to people aged 16 and over. Any assessment of a person's capacity is 'decision specific' as a person can lack capacity to make some decisions (for example, to decide on complex financial issues) but retain the capacity to make other decisions (for example, to decide what items to buy at the local shop).

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-Neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings, lack of self-care to an extent that it threatens personal health and safety, inability to avoid harm as a result of self-neglect, unwillingness to seek help or access services to meet health and social care needs and includes behaviour such as hoarding.

Synopsis

4.1 It is understood that Adult J attended university in London and studied product engineering. After leaving university he took as a lighting engineer for shows, especially fashion shows. He later worked as a cookery teacher in a Yorkshire secondary school before moving to Oxfordshire around five years prior to his death, where he found employment repairing boats along the canals. His move to Oxfordshire followed the break-up of his relationship with the mother of his two children.

4.2 In July 2016 Adult J visited a GP practice in Oxfordshire as a 'temporary patient'. He lived on a houseboat which appears to have been moored nearby at that time. During the GP appointment Adult J reported low mood and that he was drinking heavily – 'one bottle plus daily'. He said that his former partner was refusing to let his children stay with him due to his level of drinking. He was to be referred for treatment for a bilateral hernia once he registered with the GP practice.

4.3 In September 2016 Adult J again saw the GP. Some difficulty had been experienced in arranging follow up appointments. Adult J reported 'feeling better' and being back at work as a boatyard foreman. Adult J said that he had also seen a GP in Hampshire for blood tests for diabetes. The GP again recommended that Adult J register with the practice although he did not submit a permanent registration request until December 2016. It had been thought that Adult J had not been registered with a GP practice elsewhere in the country or that his registration had

lapsed. However, this review has been advised that there was no interruption in Adult J's registration with GP services.

4.4 In January 2017 Adult J saw the GP again and was referred to the Gastroenterology Unit at Hospital 1 as a result of a history of stomach ulcers. A self-referral to Turning Point was suggested but declined by Adult J (Turning Point Roads to Recovery promotes wellbeing and recovery from addiction). The GP documented that Adult J was in a relationship with a 'female friend', whose name was not recorded. Adult J also reported that he wasn't able to 'remember everything that is going on'.

4.5 In March 2017 Adult J saw his GP again and declined the opportunity to self-refer to Talking Space (Talking therapies for low mood, anxiety and depression). It is not known what specifically prompted this suggestion. Adult J reported that spring was a 'good time', things were going well with his girlfriend and he was busy at work as a boat builder.

4.6 During April 2017 Adult J was seen by a general surgeon at Hospital 1 and was listed for an operation for an inguinal hernia (An inguinal hernia usually occurs when fatty tissue or a part of the bowel, such as the intestine, pokes through into the groin at the top of the inner thigh). This operation was never carried out – see Paragraph 4.61.

4.7 In June 2017 Adult J attended the Emergency Department (ED) at Hospital 2 in Coventry following a head injury at work, resulting in a laceration, which was cleaned and sutured before discharge. Although his houseboat was moored in Oxfordshire, Adult J was working in Warwickshire. Adult J's Oxfordshire GP practice was notified.

4.8 On 6th July 2017 Adult J saw his GP and reported feeling drowsy over the past four days. The GP documented that an un-named friend had found four empty bottles of vodka and 'lots' of homebrew material on his houseboat. Blood and stool samples were taken and the GP made a follow up telephone call to Adult J in the evening.

4.9 On 17th July 2017 Adult J's GP practice was notified that Adult J had been taken to Hospital 2 ED by ambulance after his (un-named) partner, believed to have been Adult K, had rung his GP to say that Adult J was sleeping all the time, was not eating or drinking and was unable to stand up. The GP then made a 999 call to the ambulance service. The hospital carried out investigations following which Adult J was discharged with advice regarding his alcohol intake.

4.10 On 2nd August 2017 Warwickshire Police received a call from the ambulance service reporting that Adult J 'had set himself on fire' following an argument with his partner Adult K. When the ambulance and police first attended the scene, Adult K informed them that she had thrown white spirit over Adult J following an argument and he had set himself on fire. She was arrested and later interviewed under caution, answering all questions with 'no comment'. She was later bailed to allow the completion of further enquires. This incident took place in a village near the Warwickshire/Oxfordshire boundary and a few miles north of the Oxfordshire village where Adult J was registered with the GP practice.

4.11 Adult J was conveyed to Hospital 3 in Birmingham where he was admitted to the intensive care unit. He had sustained burns to 60% of his total body surface area, specifically to his whole upper body and anterior legs. Additionally a bronchoscopy disclosed an inhalation injury. He spent 51 days in intensive care requiring ventilation, inotropic support (supporting the muscular contraction of the heart) and renal replacement.

4.12 On 23rd September 2017 Adult J was transferred from the intensive care unit to the burns unit and was referred to psychology. Three days later he was seen by a consultant psychiatrist who questioned whether Adult J was experiencing delirium (sudden confusion). His family reported that he had been presenting with low mood, self-neglecting and increased his alcohol intake since the breakdown of the relationship with the mother of his children five years earlier. The plan was to contact the police to clarify whether his burns injuries could have been a suicide attempt or were inflicted by his partner. In the letter the consultant psychiatrist sent to Adult J's GP, she wrote that Adult J had been 'doused in white spirit by girlfriend and 30 minutes later set fire to self'. The letter went on to say that Adult J was not reporting suicidal ideation.

4.13 Adult J was again seen by the consultant psychiatrist on 5th October 2017 who noted some improvement in his delirium although he fluctuated between confusion and comprehension of his circumstances. Adult J was also noted to be worried about his finances but his sister was said to be assisting him with this. It was noted that the police wished to interview Adult J to enquire into the cause of his injuries. The plan was to continue with psychology input to assist Adult J to adjust to his injuries.

4.14 On 17th October 2017 the hospital rapid assessment interface and discharge (RAID) consultant saw Adult J. The RAID team provides a psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions. Adult J was documented to be more settled and making plans for the future. Although he said he did not feel depressed, there was evidence he was having difficulty in

adjusting to his injuries, becoming tearful when reflecting on his previous 'idyllic life'. He acknowledged drinking to excess prior to his admission but he said he planned to stop drinking and declined a referral for support. (Adult J was found with alcohol on two occasions during his hospital admission). He was discharged from the hospital RAID team but asked to be re-referred when fit for discharge.

4.15 Clinical psychology appointments continued throughout October and into November 2017 during which he expressed frustration at the length of his hospital stay and not being able to do the things he wanted to do. He discussed selling his houseboat as he did not think he would be able to return to it.

4.16 On 30th October 2017 Adult J's GP practice received a telephone call from Hospital 3 to confirm that Adult J remained an inpatient.

4.17 Discharge planning commenced in early November 2017 and Adult J was visited by a social worker from Oxfordshire Adult Social Care who provided support with a housing application to Cherwell District Council.

4.18 On 10th November 2017 the head of security at Hospital 3 was advised by the police that Adult K's bail conditions had 'expired' and that she may attempt to visit Adult J in hospital. Adult J was documented to have 'full capacity' and 'did not have a problem' with her visiting him. Hospital 3 has no record of Adult K visiting Adult J during his hospital admission.

4.19 Adult J was discussed at a hospital multi-disciplinary team (MDT) meeting on 29th November 2017 at which it was documented that his aim was now to return to his houseboat.

4.20 By 3rd December 2017 he was said to be medically fit for discharge, although this was dependent on a 'package of care' being in place. The hospital records indicate that efforts to contact Oxfordshire Adult Social Care to check the position in respect of the package of care were made both by the hospital and Adult J personally.

4.21 On 11th December 2017 the hospital documented that they received a telephone call from the Oxfordshire Adult Social Care social worker who had visited Adult J on 14th November 2017 to say that a package of care was not yet available for him. On the same date Adult J was documented to be willing to forego aspects of his care package in order to be discharged as quickly as possible and wished to be discharged that week.

4.22 On 12th December 2017 Adult J was reviewed by the plastic surgery outreach team which decided that he did not need specialist nursing care following his hospital discharge and it would therefore be appropriate for Adult J to receive wound care from his GP practice.

4.23 On 13th December 2017 Adult J's GP practice received a telephone call from the Hospital 3 Burns Unit consultant to inform them that Adult J was self-discharging the following day. The hospital records indicate that the GP practice was advised that a 'social care package' was still to be arranged.

4.24 The following day (14th December 2017) Adult J self-discharged from Hospital 3. Nursing staff arranged for Adult J to be safely transported to his houseboat. (Adult J was considered to be unable to drive safely and had been advised that he needed to contact his insurer and DVLA). The GP practice received several hospital discharge letters in respect of Adult J. A letter from the Hospital 3 RAID consultant expressed concern about his ability to cope, that he appeared to be 'quite stubborn' and was not taking in information about 'changes following his injuries'. He was said to be keen to get back to work. The letter noted that the Hospital 3 occupational therapist felt Adult J had mental capacity, including the capacity to decide where he lived although this had not been confirmed by the RAID team as 'he had already left the ward' and he had declined further care from the RAID team. The RAID consultant also wrote that several phone calls had been made to the Oxfordshire Adult Social Care social worker who was said to have advised that there was no package of care available until after Christmas. The letter expressed concerns that Adult J would struggle to cook and wash and dress although he was said to have friends who were available to support him. He continued to drink alcohol and was very clear that he did not want to stop. There were ongoing concerns regarding his alcohol intake, his capacity to cope and whether this put him at risk of further self-harm. The GP was requested to review Adult J's mental health and, if he attended a forthcoming scheduled Hospital 3 burns unit outpatients appointment and there were concerns about his mental health, he could be reviewed by RAID at that time.

4.25 A letter was also sent to the GP practice from the Hospital 3 burns unit in which the GP was asked to review his regular medications as he had been supplied with only one week of medications and to follow up with the local ophthalmology service, and to consider referring him to audiology if required as he had reported ongoing decreased hearing from his left ear. The proposed plan of care was to include twice daily calls to his houseboat although there is no indication that this happened.

4.26 A further letter was sent to the GP from Hospital 3 dietetics advising on Adult J's prescription of nutritional supplements and that a referral had also been sent to Hospital 4 in Oxfordshire for dietetic follow up.

4.27 It is understood that the Oxfordshire Adult Social Care social worker had referred Adult J to the Home Assessment and reablement Team (HART) which could have supported him to regain as much independence as possible following his hospital discharge through support with managing meals, medication, assisting with washing, dressing and personal hygiene for example. HART would work with a service user until they had reached their 'reablement potential' which is the point at which it would have been determined that they needed longer term services or no longer required care. Adult J did not receive support from HART. It is understood that his decision to self-discharge from hospital meant that he was no longer eligible for HART services.

4.28 On 18th December 2017 Adult J was seen by his GP who documented that he had 'lost right hand fingers'. Adult J declined community mental health team support. He reported his sleep to be poor and had 'stopped all medication'.

4.29 On 20th December 2017 Adult J was interviewed by Warwickshire Police in respect of the 2nd August 2017 incident. The interview was conducted using 'Achieving Best Evidence' principles which apply to witnesses considered vulnerable, intimidated or significant (1). He stated that he could not remember the incident. In the information shared with this review Warwickshire Police have stated that, in interview, Adult J said that he believed that Adult K caused his injuries, but also said that 'he was sure that Adult K would not do anything like that to him', before adding that he was planning to continue his relationship with Adult K. The Crown Prosecution Service (CPS) subsequently decided that no further action would be taken against Adult K (Paragraph 4.64) An evidence led (victimless) prosecution was considered, but the CPS felt there was insufficient evidence.

4.30 Although the incident raised serious safeguarding concerns, Warwickshire Police did not refer this incident to any partnership agencies, which they have advised this review was in accordance with force policies. Adult J did not consent to a referral to Refuge - the local domestic abuse charity. This incident was Warwickshire Police's only involvement with Adult J and Adult K. A MARAC referral was completed in respect of the incident although Adult J's condition at the time - sedated in the critical care unit in Hospital 3 – precluded full details being gathered from him. The outcome of the MARAC referral, dated January 2018, is unknown.

4.31 Hospital 3 outpatient appointments had been arranged on 21st December 2017 for Adult J in respect of scar management, physiotherapy and 'hospital at home follow up'. It is unclear whether he attended or not.

4.32 Care was provided to Adult J by the GP practice nurses in clinic and on 22nd December 2017 an (un-named) friend watched dressings being applied to Adult J so that they could apply them over the holiday period. Adult J had declined support from a local Health Centre over this period.

4.33 On the same date Adult J's GP made an urgent referral to ophthalmology for follow up of eye damage from his burns but Adult J did not attend any of the appointments offered. During his hospital admission, Adult J had been seen by ophthalmology for lagophthalmos (inability to completely close the eyelids) but on discharge this was minimal and his vision had improved.

4.34 On 4th January 2018 Adult J did not attend outpatient appointments at Hospital 3 in respect of burns physiotherapy or 'hospital at home follow up'. He did not attend a 'hospital at home follow up' outpatients appointment on 11th January 2018. Occupational therapy burns and plastics follow up appointments at Hospital 3 scheduled for 18th January 2018 were cancelled by Adult J.

4.35 During January 2018 Adult J was seen regularly by GP practice nurses for dressings. He reported feeling 'a bit fed up' and frustrated with all his physical limitations but by the end of the month his mood was described as 'very upbeat' with no sign of his previous frustrations and he said he was 'getting on with it'. During a visit to the GP practice nurse on 25th January 2018 (unspecified) wounds were noted which were documented to be 'self-inflicted accidental (knocked gardening)'. At this time Adult J reported that his (unnamed) girlfriend had had a 'mental breakdown' two days earlier and that he was now her carer.

4.36 The care provided to Adult J by the GP practice nurses ceased on 25th January 2018 as his wounds had largely healed and he was able to manage any further dressings himself with the assistance of his (unnamed) partner.

4.37 On 28th January 2018 Thames Valley Police received a telephone call from a neighbouring canal boat to report that Adult J and Adult K were having a violent argument and that Adult J had requested the neighbour to call the police. The police also received a call from Adult K around the same time in which she disclosed that she had been assaulted by Adult J the previous evening but that she had only just escaped his boat. She said he had kicked her in the back and threatened her with an axe and a screwdriver and refused to let her leave.

4.38 Officers were unable to locate Adult K and attempts to recontact her by telephone were unsuccessful. The police managed to contact Adult K three days later and she said she did not wish to speak to them. The police had been able to speak to Adult J 'by his car on the canal bridge' on the evening of 28th January 2018 when he stated he did not wish to pursue a complaint. He said that Adult K had dropped his phone in the canal, which was confirmed by Adult K during her telephone conversation with the police on the same date.

4.39 Neither Adult J or Adult K engaged with the completion of a DOM5 (the local Domestic Abuse, Stalking and 'Honour' based violence (DASH) risk assessment), although there is a reference to an initial inability to complete the DOM5 due to an absence of lighting on the boat. On the basis of the available information, which did not include consideration of the 2nd August 2017 incident in Warwickshire, Adult J was assessed as at 'standard' risk of domestic abuse and Adult K at 'medium' risk. A risk management occurrence (RMO) between Adult K and Adult J was created. (Where no crime has been recorded and the risk of domestic violence and abuse is assessed as medium or above, an RMO is created in which referrals, safety advice and police action is documented). The information shared by Thames Valley Police with this SAR refers to 'DV history in Northants and Warwickshire' being overlooked.

4.40 On 29th January 2018 the police made an adult safeguarding referral in respect of Adult J on the basis that he had recently been discharged from hospital, was not looking after himself and not coping with living on a canal boat which was described as 'uninhabitable'. The referral also made mention of domestic conflicts with his 'girlfriend' in which alcohol was involved. Adult Social Care decided to progress the referral due to a significant risk of domestic abuse, self-neglect and fire. The possibility of a joint visit with police and fire was considered. The case was allocated to a social worker who began gathering information and documented that there was no information on police files on how Adult J's burns had been caused and that his GP practice were also unclear on this point although they shared that there was 'some suspicion that his girlfriend may have caused the injuries'.

4.41 On the same date (29th January 2018) Adult J was conveyed to Hospital 4 ED by ambulance after being found sitting in his car at the side of the road with blood on his face. He had sustained a laceration to the bridge of his nose and an abrasion on the top of his head. Adult J said he was unable to recall how he had sustained the injuries. On admission Adult J was described as alert, oriented and able to communicate. He was discharged home the following day after being prescribed medication for pain relief. Adult J's GP practice was notified of this admission and they shared this information with the social worker enquiring into the adult safeguarding referral.

4.42 On 31st January 2018 a neighbour of Adult J contacted his GP practice to report that Adult J was neglecting himself which was reported to Adult Social Care.

4.43 On 1st February 2018 Thames Valley Police opened a further risk management occurrence (RMO) following a referral from Warwickshire Police in relation to Adult J and Adult K in which Adult J was referred to as the victim. It is assumed that this was a formal notification of the 2nd August 2017 incident as a referral was made to the Cherwell and West Oxfordshire MARAC meeting which was due to take place on 14th February 2018. When the RMO was recorded on the Thames Valley Police Niche information system, Adult K was not listed on the 'involved' tab with the result that a search for her name on niche would not have found the RMO.

4.44 A 1st February 2018 Hospital 3 burns outpatients appointment was cancelled by Adult J. On the same date Hospital 3 burns and plastics wrote to Adult J's GP practice to advise that Adult J had cancelled several appointments saying he was unable to attend. The Hospital 3 consultant expressed concern about Adult J's current state and requested an update from the GP, asking him to stress the importance of follow up to Adult J.
A response was received from the GP practice to advise that Adult J had been seen in the GP practice nurse clinic 'religiously' until 25th January 2018 and that they had been so pleased with the healing of his burns that the nurses discharged him from their care. The GP noted that Adult J had not been requesting any medications and that there had been some 'adult safeguarding issues' that 'social services' had been involved with.

4.45 Shortly before midnight on the same date (1st February 2018) the police received a telephone call to say that there had been 'further fights' between Adult J and Adult K on a nearby canal boat. The police attended and located Adult J but were unable to trace Adult K who had left Adult J's boat. They visited her canal boat but she was not there. Adult J did not wish to make any complaint. He said that he and Adult K had had a verbal argument. He expressed concern for Adult K and her mental health. (As with the earlier incident on 28th January 2018 the person who called the police was not spoken to).

4.46 The next day the police received intelligence to the effect that Adult J regularly drove whilst under the influence of alcohol. It is not known whether Adult J had contacted DVLA as he was advised to do at the time of his discharge from hospital (Paragraph 4.24) and whether he was actually physically fit to drive. Adult K was also said to be a driver and a heavy drinker. The details of both of their vehicles were supplied.

4.47 On 4th February 2018 the police made initial attempts to contact both Adult J and Adult K for victim safety planning in respect of the RMO created in respect of the 28th January 2018 incident.

4.48 During the first half of February 2018 the social worker enquiring into the adult safeguarding referral in respect of Adult J made several unsuccessful attempts to contact him. On 13th February 2018 the social worker spoke to Adult K who said that Adult J was drinking and not caring for himself.

4.49 On 14th February 2018 the MARAC referral received from Warwickshire Police was discussed at the West Oxfordshire MARAC meeting. It was noted that Adult K was on bail for assault occasioning grievous bodily harm (GBH) in respect of the 2nd August 2017 incident in Warwickshire and was reporting to Abingdon police station. Her bail conditions had been changed at court to allow her live on her canal boat. The MARAC minutes recorded that Adult Safeguarding stated that the case had been discharged by them at the end of December 2017, but referred again by neighbours concerned about things being thrown in the canal and of a fire risk. It was thought that the couple were back together and therefore in breach of Adult K's bail conditions. The MARAC minutes recorded that Adult Social Care had been unable to engage with Adult J. The GP had seen both Adult J and Adult K and stated that Adult K was caring for Adult J. There were said to be no records relating to mental health services held in Oxfordshire for either party. Housing reported that Adult J had made an application for housing on discharge from hospital but had failed to supply additional details and so the application had been closed. Fire and Rescue were planning a 'safe and well' visit following a fire risk concern. Hospital 4 reported that Adult J had been admitted on 30th January 2018 after being found by police with head injuries in his car. (The police did not attend the 29th/30th January 2018 incident (Paragraph 4.41) and there is no record of the police being notified of it).

4.50 The agreed actions included visiting Adult J to check whether Adult K was breaching her bail conditions, to check which vehicle Adult J was alleged to be driving, to research the injuries for which Adult J was admitted to hospital on 30th January 2018 and to arrange a joint DAIU (Domestic Abuse Investigation Unit) and IDVA (Independent Domestic Violence Advisor) visit.

4.51 On 23rd February 2018 the police visited Adult J's canal boat but he wasn't there. Adult K's canal boat was moored alongside and the police spoke to her and established that her bail conditions had 'expired' and that she had been released under investigation. This was verified through a PNC check and contact with Warwickshire Police. Adult K also said that although Adult J had a vehicle he wasn't driving it as a result of his injuries.

4.52 On 26th February 2018 Adult Social Care were contacted by a social worker from Derbyshire Children's Social Care. Adult J's two children lived with their mother in Derbyshire and were 'under child protection procedures'. The Derbyshire social worker disclosed that Adult J's children, who had contact with him, had expressed concern about his relationship with Adult K. They said he had recently had a fractured skull, two black eyes and a broken nose which he told the children had been caused by a car accident. His children were concerned that Adult K may have caused these injuries and they alleged that she had smashed up his canal boat and that he was now living on her boat as a result. This information was then shared with Thames Valley Police.

4.53 On 27th February 2018 the Adult Social Care social worker spoke to Adult J by telephone. He said he was 'fine' and didn't need any assistance from Adult Social Care. He said that he and Adult K had experienced some 'teething problems' about a month ago which had led to the police being called out but that there was nothing to be concerned about. When asked about the injuries which had precipitated his hospital admission on 29th/30th January 2018, Adult J said that he had been walking across the canal bridge and been struck by a car.

4.54 On 9th March 2018 Adult J was seen by an IDVA. He was asleep on Adult K's boat. She described herself as his carer and woke him up. He was adamant he was 'fine', his medical treatment was ongoing and did not want any additional support. At that time the investigation into the 2nd August 2017 Warwickshire incident was still ongoing and Adult J said he wanted to 'drop the charges'. The IDVA noted that Adult J was wrapped up in a 'coat etc.' which made it difficult to see the burns he had sustained. He was said to minimise his injuries and it was noted that he would be reliant on Adult K to 'do most things for him'. The IDVA left her telephone number with Adult J but he made no contact with her subsequently. When asked about his relationship with Adult K, he said that 'the domestic incidents with Adult K are not always alcohol related'.

4.55 On 12th March 2018 Adult J saw his GP reporting ear ache, diarrhoea and prostatism. He smelled strongly of alcohol but claimed to have cut his alcohol intake 'right down'. He reported having an un-named carer now. It seems likely that he was referring to Adult K, but the name of the carer went unrecorded. The GP took the opportunity to discuss the safeguarding concerns shared with the GP practice on 31st January 2018 (Paragraph 4.42) and Adult J said that he had declined support offered to him.

4.56 On 22nd March 2018 the Canal and River Trust made a safeguarding referral in respect of Adult J which described the consequences of the injuries he sustained in the 2nd August 2017 incident in Warwickshire which included loss of the fingers of

his right hand, no mobility in the fingers of his left hand, face, head, chest and back heavily burned and very prone to infection. Adult J was said to be currently incapable of moving his canal boat and incapable of looking after himself. Adult K's canal boat was moored adjacent to his boat. He and Adult K were said to be 'an item again' and she was said to be attending to his needs and dressing his wounds. Adult J was said to be 'something of a recluse' and 'very reluctant' to answer phone calls. The boat licence support officer from the Canal and River Trust had made repeated attempts to engage with Adult J which had proved unsuccessful and had raised concerns that Adult K was a controlling influence on him and that Adult J may be at risk of further harm from her. The boat licence support officer described Adult J as 'frightened and controlled'. As a safeguarding enquiry was already open for this issue, Adult Social Care did not progress this contact.

4.57 During April Adult J reported a lump on his right breast to his GP and was referred to Hospital 1. He attended on 17th April 2018 as breast cancer was initially suspected although this appeared to have been ruled out by the Hospital 1 Breast Clinic on 24th April 2018. At this time complications arising from his burn injuries were noted to be 'overwhelming wound infection, renal failure, septicaemia, multi drug resistant pseudomonas'. There was some contact between the hospital and the adults social worker at this point.

4.58 On 14th May 2018 Adult J saw his GP and reported problematic left ear perforation arising from the 2nd August 2017 incident. An ENT referral was made. He also complained of anxiety, panic attacks and not sleeping well. He declined a referral to Talking Space but agreed to try medication. He was prescribed an antidepressant (Mirtazapine). He reported no mental health history.

4.59 On 17th May 2018 the safeguarding enquiry in respect of Adult J was closed after the social worker had liaised with the IDVA and been updated on the outcome of her visit to Adult J on 9th March 2018. The social worker had spoken to Adult J by telephone who said he wished to continue his relationship with Adult K. He was said to have the mental capacity to make this decision. The outcome of the safeguarding enquiry was recorded as 'inconclusive'.

4.60 On 4th June 2018 the Canal and River Trust made a further safeguarding referral in respect of Adult J. One of their Waterways teams had been trying to contact Adult J and received no response from his boat although it was believed he might have been staying there. The earlier concern that when Adult J was seen, his partner Adult K was always present and that he seemed frightened and unable to speak when in her presence, was reiterated. Neighbours were said to have reported (unspecified) concerns. Adult J was in debt to the Trust. The outcome of this safeguarding referral was that as the issues raised were largely the same as had

previously been involved and IDVA continued to be engaged with Adult J, the safeguarding referral was not progressed to a Section 42 Enquiry.

4.61 On 6th June 2018 Adult J saw his GP and reported feeling no better on Mirtazapine. He said he had reduced his consumption of alcohol. A self-referral to Talking Space was again suggested. In the GP records for this date it is documented that a GP practice nurse had called the police following domestic abuse concerns which had been raised by a neighbour. The police have no record of this.

4.62 On 27th June 2018 Adult J saw his GP and reported that his anxiety was no better and probably worse. He said he struggled to leave 'the house'. He had no thoughts of self-harm and suicidal ideation. He said he was receiving good support from a friend who was a psychotherapist (The details of who the psychotherapist was were not recorded). He added that there was a 'lot to get his head around' as a result of the changes to his life arising from the 2nd August 2017 incident. He said he was happy to try Talking Space and would self-refer. A self-referral to Turning Point was also discussed. His medication was changed to sertraline. The review has been provided with no indication that Adult J self-referred himself to either Talking Space or Turning Point.

4.63 On 25th July 2018 Adult J saw his GP. A sizable inguinal hernia had been noted during a colonoscopy but owing to his skin condition there were no options for repair of the hernia. Adult J was also experiencing memory loss symptoms and reported being unable to remember how to make tea. He was referred to the memory clinic.

4.64 On 27th July 2018 the Crown Prosecution Service decided to take no further action against Adult K in respect of the 2nd August 2017 incident.

4.65 On 8th August 2018 Adult J's memory was tested using the GP assessment of cognition (GPCOG) and he scored 5 out of 9. (If a patient scores 0-4 cognitive impairment is indicated. A score of 5-8 necessitates more information being gathered. If a patient scores 9, no significant cognitive impairment is present). Adult J was referred to the Adult Mental Health Services memory clinic. An appointment was offered for 5th September 2018 but subsequently cancelled and re-booked for 14th September 2018.

4.66 Shortly before midnight on 1st September 2018 Adult J called the police to report that his partner Adult K had attacked him whilst he was in bed on his canal boat. He disclosed that she had punched him causing cuts to his head. The police attended and arrested Adult K who had cuts to her nose and a black eye. She disclosed that her injuries were the result of an assault by her son whilst she and Adult J had been at the son's house earlier. Adult K said that her injuries may have

been made worse by Adult J assaulting her. She also said that she believed that Adult J had later assaulted her son which had upset her.

4.67 Adult J was conveyed to hospital 4 by ambulance and treated for lacerations to his left eye and head. He disclosed that Adult K had hit him around the head and face with an unspecified object. It was documented that Adult J disclosed that Adult K had covered him in white spirit and set him on fire about a year ago. Adult J was discharged to the police station.

4.68 Neither Adult J or Adult K would provide a statement to the police who created two incidents to reflect the fact that both Adult J and Adult K had sustained injuries and indicated that the other was responsible or partly responsible. No enquiries were made with Adult K's son. The risk of domestic violence and abuse was assessed as 'medium'. Alcoholism and undiagnosed mental health issues were noted to be factors. Adult J alleged that Adult K had 'serious mental health problems'. The police had requested an appropriate adult for their interview with Adult J. The police created a temporary flag on Adult J in order that all calls from him could be treated as requiring immediate attendance. It was not possible to place a flag on his address as a houseboat is not a static location with a post code.

4.69 On 3rd September 2018 a Domestic Violence Protection Order (DVPO) was issued by the court which prohibited Adult K from contacting or molesting Adult J. A power of arrest was attached to the Order which would be in place until 30th September 2018.

4.70 On the same date the police made a safeguarding referral in respect of the 1st September 2018 incident to Adult Social Care. Prompt contact was made by Adult Social Care, during which Adult J described his relationship with Adult K as 'volatile'. He added that he felt scared of Adult K and extremely vulnerable due to his physical injuries which were documented to be a 'missing right hand' and 'little movement' in his left hand. He was said to be supporting the arrest of Adult K. Adult J's needs were assessed by a social worker who was allocated to work his case (social worker 1). A separate social worker was allocated the safeguarding enquiry (social worker 2). Adult J was assessed as having the following eligible needs:

- As he could experience falls, he would benefit from a means to call assistance.
- He needed support to cook meals, including cutting his food into pieces which were small enough for him to feed himself.
- He needed some support with dressing such as fastenings, zips, shoe laces etc.
- He needed support to wash his whole body thoroughly and ensure he was safe in the shower/bath.

- He needed support to manage correspondence, fill in forms etc.
- Although assessed as having capacity to understand and manage risks to his personal safety from his 'ex-partner', he remained incredibly vulnerable to her potential actions.

The assessment concluded that without the provision of support there was likely to be a significant impact on Adult J's physical and emotional well-being. The plan for meeting Adult J's needs was stated to be 'support to apply for Extra Care Housing and appropriate social care support'.

4.71 On 14th September 2018 social worker 2 contacted Adult J by phone. He said he was 'still on his boat' as he had not gone to respite at a care home in Witney because of the distance involved. The records shared with this review make no prior reference to the offer of respite to Adult J. Social worker 2 planned to visit Adult J with the IDVA to discuss safety planning.

4.72 On the same day Adult J was assessed by the AMHT memory service. He presented with anxiety and poor memory over the year since the 2nd August 2017 incident. He said he had no recollection of life prior to that incident and was using photographs and information from friends to build memories. He said he often began a task before losing his way and leaving things unfinished. When going for a walk he did not venture far for fear of losing his way, although this was exacerbated by reduced mobility since the 2nd August 2017 incident. He also disclosed significant anxiety over the past year which he described as attacks of absolute fear which stopped him from doing day to day activities. He reported only feeling safe when he was with friends who he felt well supported and protected by. He said he felt that his anxiety had improved over the past month or so, although he was not able to identify a clear cause for this. It was decided that collateral history needed to be obtained (from a long term friend Adult J had identified) before diagnosis and a management plan could be completed. Neither the Montreal Cognitive Assessment (MOCA) visuospatial nor the Mini Mental State Examination (MMSE) memory test could be fully completed as Adult J was unable to hold a pen. A further appointment with the consultant psychiatrist was to be arranged. Medication was prescribed and a safeguarding referral was to be raised as Adult J was considered to be a vulnerable adult. The referral was completed on 18th September 2018. Adult J did not wish to engage with alcohol services to maintain abstinence as he felt that this was not required. He stated that he had stopped drinking alcohol for a week.

4.73 On 19th September 2018 a discussion took place between social workers 1 and 2. Adult K had been seen near Adult J's canal boat and the risk of further incidents was considered to be substantial. It was agreed that a strategy review involving the IDVA and the police DAIU would be arranged to consider actions to minimise the risk

of further domestic violence to Adult J. Social worker 1 said that AMHT had contacted him following their 14th September 2018 assessment and stated that they had assessed him as lacking capacity to 'make decisions in respect of care needs due to query around amnesia'. Social worker 1 expressed surprise at this assessment as he felt that Adult J appeared coherent. It was therefore decided to meet Adult J to assess his capacity to understand the risk of maintaining contact with Adult K and complete a new DASH risk assessment. The possibility of Adult J moving away from the canals into housing had been discussed and an appointment with Cherwell District Council was planned to take this further.

4.74 On 20th September 2018 the social worker 2 spoke to the boat licence support officer from the Canal & River Trust over the telephone following a report that Adult K had been seen near Adult J's canal boat. The boat licence support officer said he had recently spoken to Adult K and advised her that 'as she was no longer Adult J's main carer' her right to remain in the same place would no longer be relevant and she would need to move site every fortnight. (It is presumed that Adult K was on a short stay mooring. Adult J appears to have been on a permanent mooring as a result of an 'equality adjustment' which recognised his level of disability. It seems that Adult K was able to permanently moor her boat near Adult J's boat whilst recognised as his 'main carer'. It is assumed that having been advised of the DVPO, this enabled the Canal & River Trust to take the view that Adult K could no longer be considered to be Adult J's main carer. (Efforts to engage the Canal & River Trust in this review have been unsuccessful. The review has been advised that boat licence support officer involved in Adult J's case had since left the organisation)

4.75 On the same day social worker 2 contacted the AMHT community psychiatric nurse (CPN) to clarify their assessment of Adult J's mental capacity. The CPN advised that Adult J presented with symptoms of retrograde amnesia and struggled to recall details of his life prior to the 2nd August 2017 incident. Additionally his memory of events since the incident was also considered to be impaired although the degree of impairment required further assessment.

4.76 On 24th September 2018 social worker 1 spoke to the IDVA who had recently been in contact with Adult J who was said to be very keen to pursue housing, saying that he was worried about being on the boat for another winter, adding that he 'would not be able to survive without Adult K'. The IDVA suggested that Cherwell Housing should be invited to the forthcoming strategy meeting.

4.77 On 25th September 2018 a safeguarding meeting took place at which concerns were expressed that the DVPO was due to expire on 30.9.2018. Social worker 2 had seen Adult J earlier in the day and completed a DASH risk assessment which disclosed a 'high' risk of domestic abuse. The police had assessed the risk to Adult J

as ‘medium’ following the 1st September 2018 incident (Paragraph 4.68). It was agreed that Adult J would be provided with a hand-held personal alarm and Adult Social Care would continue to explore housing options for Adult J. Cherwell District Council had confirmed that Adult J had no active application for housing, although from the information he had supplied previously, it was thought that he may be unable to demonstrate a local connection to the area as he had moved around for a considerable period of time. However, mention was made of a room in a local town which was available with immediate effect. Adult Social Care had also been discussing Adult J’s needs for a package of care, whether or not he moved from his canal boat into housing. It is understood that Adult Social Care was to consider a referral to MARAC in the light of the ‘high’ DASH risk assessment. (No MARAC referral was ultimately made on the basis of advice from the IDVA manager that a referral was unnecessary as the IDVA was already actively working with Adult J).

4.78 On 2nd October 2018 social worker 2 assessed Adult J’s mental capacity and concluded that ‘based on probability’, Adult J had capacity to understand the risks of maintaining contact with Adult K.

4.79 On 3rd October 2018 Adult J visited ‘extra care’ housing in a local town. When completing the application for this housing with social worker 1 the following day, Adult J disclosed that Adult K had ‘beaten him up’, including smashing a bottle on his head ‘a few days ago’. Social worker 1 could see no signs of any head injury although Adult J refused to submit to medical examination or report the matter to the police. Adult J went on to say that he was ‘in hiding’ which included sleeping in his car, washing in supermarket toilets and returning to his boat only when he knew Adult K to be at work. Social worker 1 shared this information with social worker 2 and more urgent options than the extra care housing, which would take some time to set up, were explored including the aforementioned room in the local town and referral to domestic abuse support for men. Details of domestic abuse advice line were provided to Adult J but it is not known whether he contacted the service.

4.80 On 4th October 2018 Hospital 3 physiotherapy wrote to Adult J’s GP to advise that he had been formally discharged from their care after failing to attend several appointments. The GP was advised to re-refer if this was required.

4.81 On 8th October 2018 Adult J spoke with social worker 1 over the phone and said he had had ‘second thoughts’ about the extra care housing adding that he was ‘doing OK on my own’, and describing himself as a ‘survivor’. Adult J was advised to begin exploring private renting options.

4.82 On 10th October 2018 the safeguarding enquiry in respect of Adult J was closed. Social worker 2 noted that Adult J had decided to remain on his boat and

had admitted meeting Adult K whilst the DVPO was in place. He had been assessed as having the capacity to understand the significant risks of maintaining contact with Adult K. Personal safety advice had been provided to Adult J, including avoiding contact with Adult K particularly when she was under the influence of alcohol, keeping his mobile phone charged and in credit and a panic alarm had been provided. Adult J was considered to remain at 'very high risk' of further domestic violence but was considered to be choosing to make an unwise decision.

4.83 On 11th October 2018 Adult J's GP practice received a letter advising that Adult J had been discharged from the Hospital 3 scar management service. The letter stated that he had not attended several appointments including consultant appointments and that the service had been unable to contact him since January 2018.

4.84 On 15th October 2018 Adult J disclosed to the IDVA that Adult K was caring for him. The IDVA had supported Adult J to submit his housing application to Cherwell District Council. Adult J advised social worker 1 that he did not want any further social care support at this stage and, after a subsequent discussion with a practice supervisor, Adult J's case was closed to Adult Social Care.

4.85 On 18th October 2018 Adult K contacted the police to report an assault by Adult J the previous evening. She disclosed that he had poured white spirit on her feet and threatened her with a lighter saying that he was 'going to put her through what he had been through'. She said that she had initially been too scared to leave and had sneaked out early the following morning before contacting the police in the afternoon. Adult K declined to make a statement. A DASH risk assessment was completed disclosing a 'medium' risk and the RMO was updated. Efforts to locate Adult J and his canal boat proved unsuccessful. Adult J was not located until a subsequent incident was reported on 30th November 2018.

4.86 On 14th November 2018 Adult J's follow up appointment with a consultant psychiatrist took place. The impression gained by the consultant was that Adult J had significant retrograde and anterograde amnesia (the loss of the ability to make new memories) and general cognitive decline which was felt likely to be secondary to Korsakoff syndrome which is a chronic memory disorder caused by severe deficiency of thiamine and most commonly caused by alcohol misuse. Adult J was described as previously alcohol dependent following the ending of his relationship with an ex-partner five years earlier. It had not been possible to obtain any collateral history from friends or family as Adult J had not provided contact details. Adult J expressed the view that his memory problems had worsened about which he was feeling frustrated and low in mood although he felt that his low mood had preceded his memory problems. He reported feelings of despair in respect of the way his life

had changed following the severe burns he had sustained in the 2nd August 2017 incident. He reported fleeting suicidal thoughts since the incident but denied any intent. He added that if he was to kill himself, he would do so by drinking a large amount of alcohol and falling asleep out of doors during the winter months. He said he had started to drink alcohol again, around half a bottle of wine daily but did not consider this problematic or wish to consider any treatment in respect of this. The plan was for Adult J's collateral history to be obtained from his carer Adult K, for him to be referred to a cognitive disorders clinic for further assessment and for thiamine and multivitamin replacement to continue.

4.87 On 30th November 2018 Adult K contacted the police via the 999 system to say that Adult J was drunk and aggressive on her boat. She disclosed that Adult J had asked her to help him take his own life the previous day and on other occasions recently. She said that she didn't know how to help him anymore. The police attended some hours later and found Adult K intoxicated on her boat. Adult J was not present but following a call from a member of the public, they found him in his vehicle intoxicated and with a cut to his head. He was arrested for being drunk in charge of his vehicle and for the outstanding assault on Adult K which had been reported on 18th October 2018. He disclosed that he had attempted to commit suicide earlier that day by inhaling car fumes. After fainting in the police station Adult J was conveyed to Hospital 4 by ambulance. Hospital staff concluded that his presentation was the result of alcohol intoxication and he was discharged into the care of the police who decided not to charge him with the earlier assault given the lack of complaint from Adult K and the absence of other evidence. He was released under investigation pending the result of analysis of the alcohol in his blood in respect of being drunk in charge of a vehicle. The risk of domestic abuse was assessed as 'medium' for both Adult K and Adult J and both were issued with Memoranda of Understandings (this review has been advised that the purpose of a Memorandum of Understanding in this context is to advise the recipient of the action taken, and advice given by the police in response to the incident reported by the recipient). An appropriate adult had been called for the police interview with Adult J.

4.88 On 1st December 2018 Adult J was referred to adult mental health services by the criminal justice liaison and diversion nurse following his arrest the previous day. Adult mental health services made an unsuccessful attempt to contact Adult J the same day.

4.89 Adult J visited a local public house with Adult K at lunchtime on 4th December 2018 following which they drove to a shop to purchase items including bottles of wine and spirits. Adult J was seen to be unsteady on his feet and a verbal argument took place between himself and Adult K. At 8.30pm on 4th December 2018 Adult K contacted the ambulance service via the 999 system after finding Adult J collapsed

on her houseboat. After considerable difficulty in locating the houseboat, the ambulance service attended and at 9.39pm they contacted the police to advise they were responding to a call from Adult K to report that she had awoken to find her partner Adult J dead on her narrowboat. Due to the nature of Adult J's injuries –'to the front and back of his head', the apparent time delay in seeking medical help and previous domestic abuse concerns, Adult K was initially arrested on suspicion of murder but subsequently released without charge.

4.90 A post mortem found that Adult J's cause of death was acute alcohol intoxication and was unrelated to the head injuries noted.

Contribution of Adult J's family and friends

5.1 Adult K was contacted by letter and offered the opportunity to contribute to this review, which she declined. There is no obligation on family members or friends to contribute to a Safeguarding Adults Review. However, the police have shared the witness statement they obtained from Adult K as part of the enquiries they conducted on behalf of the Coroner. In this statement Adult K stated that she met Adult J three or four years earlier and they began a relationship. The witness statement was taken in October 2019 and so it appears that their relationship may have begun in 2015 or 2016.

5.2 In her statement, Adult K stated that Adult J had always been a drinker and was 'alcohol dependent'. She described him as a private man, a 'gentle spirit' who was always very fit, capable and strong. She stated that he began to drink more after his ex-partner, who was the mother of his children, began restricting his access to them during the summer of 2017. She stated that he started a routine at that time of purchasing a bottle of vodka each day and drinking it until he passed out. He would also drink at local public houses each day. Adult K added that she would often find him inside, or leaning out of, his car in the morning and would take him back to her boat. She stated that the impact of Adult J's alcohol dependency began to put his employment in jeopardy.

5.3 In her statement, Adult K made a brief reference to the 2nd August 2017 incident, stating that there was a fire on Adult J's boat in which he was severely burned which left him less able, slower on his feet and with damaged hands. Adult K made no mention of any conflict or violence in her relationship with Adult J.

5.4 She said that Adult J had been living with her on her boat at the time of his death, adding that due to his disabilities it was difficult to moor both of their boats

next to each other which would have enabled them to live on their separate boats whilst spending most of their time together.

5.5 One of Adult J's sisters contributed to the review. She said her brother loved his children and his life took a difficult turn after his relationship with their mother ended. She said that her brother was never 'great with money' so travelling to see his children became much more difficult. It was at this point in his life that Adult J's sister thinks that he began drinking heavily although she added that his family didn't realise quite how much he was drinking until he was admitted to hospital after the 2nd August 2017 incident. She recalled that, whilst recovering in hospital, he asked family members to buy him alcohol which they declined to do.

5.6 Turning to the events which took place on 2nd August 2017, the sister felt that it should be referred to as an 'incident' rather than an 'accident' and she did not believe that it represented a suicide attempt 'in the slightest'. His sister said that Adult J got 'really cross' that the police hadn't come to interview him whilst in Hospital 3. Despite the family telling him that the police were unable to interview him in hospital because he wasn't well enough, Adult J held this against the police. His sister added that once her brother formed a view about something it was difficult to dissuade him from that point of view.

5.7 The sister said that managing her brother's discharge from Hospital 3 was problematic as Adult J 'couldn't bear to be indoors' and so he wanted to get out of hospital as quickly as possible. She described him as being 'desperate' to get out of hospital no matter what his family said to the contrary. The sister went on to question the extent to which hospital staff discussed with Adult J the challenges of living on a houseboat following hospital discharge, in particular skin care and simply moving about on the boat.

5.8 The sister then highlighted some of the difficulties her brother experienced in accessing follow up care from Hospital 3. She said that he was unable to drive as a result of his injuries and the Oxfordshire village where his houseboat was moored and Birmingham were not well connected by public transport. Obtaining benefits to pay for travel was difficult as he couldn't use a computer to apply online because he had no fingers on one hand and only stubs on the other. His sister said that he hated being out in public and he received abuse because of the impact of the burns on his appearance. Had he been asked why he wasn't attending out-patient appointments and whether he needed additional support to get to these appointments, his sister felt he would not have shared the difficulties described above as he would not have wanted to disclose his vulnerabilities.

5.9 She added that contact with agencies by phone was also difficult for her brother as a mobile phone is difficult to use without fingers. Adult J's other sister bought him a mobile phone with larger buttons and tried to ensure that the credit on his phone was always topped up. The sister added that she wasn't convinced that agencies recognised how difficult it was for him to stay in contact with agencies by phone.

5.10 The sister went on to say that her brother would not have wanted to engage with Talking Therapies as this would involve talking about 'stuff' which he would not have wanted to do.

5.11 Turning to her brother's relationship with Adult K, she did not feel that she was the right person to look after him after his discharge from Hospital 3 as she would not have discouraged him from drinking, would not have had 'helpful conversations' with Adult J, nor would she have helped him to access support. She felt that Adult K exerted influence over Adult J and did feel that coercive control was present in the relationship. Overall, the sister did not feel that Adult K was able to bring out the best in her brother.

5.12 However, the sister felt that Adult J benefitted from some 'amazing' friends who would do a great deal for him, including friends from the boat network. She was also very appreciative of the support provided to her brother by the Canal and River Trust, particularly during his lengthy admission in Hospital 3.

5.13 His sister reflected that Adult J was a strong-willed person who did not wish to conform and 'railed against authority', preferring to do things his own way, even if this led to unwise decisions. She said that nothing would ever change him. She said that services could offer her brother help but he wouldn't always be prepared to accept it, even if accepting the help was in his interests. She added that he wouldn't necessarily perceive the offer of help as positively as the person offering the help probably intended. Support which involved moving indoors was unlikely to be accepted by Adult J as he would have hated that. And she felt that the level of his drinking was likely to be bring him into conflict with the providers of supported living or extra care housing.

5.14 Overall, the sister wondered whether agencies kept a sufficiently watchful eye on her brother. She accepted that he had been assessed as having capacity to decide whether or not to be in a relationship with Adult K and that he was allowed to make unwise decisions, but 'passing' an assessment under the Mental Capacity Act should not be a reason for agencies 'to shut up shop' and not to revisit his case.

5.15 His sister concluded by saying that her brother's alcoholism was at the root of his problems. She added that he began to neglect his health after the 2nd August

2017 incident but had struggled with life prior to that. She said that her brother's death had not come as a shock to her or her sister.

Analysis

In this section of the report identified learning themes will be analysed.

Multi-Agency response to Adult Safeguarding concerns

6.1 Adult J was safeguarded from harm during his admission in Hospital 3 following the 2nd August 2017 incident. There is no record of Adult K visiting Adult J during this period although there were concerns that she may do so after the police informed the hospital that her bail conditions had 'expired' (Paragraph 4.18). At that time Adult J was documented to not 'have a problem' with Adult K visiting him and to have 'full capacity' to make that decision. However, no mental capacity assessment was carried out by the hospital at that time. Hospital 3 has advised this review that their hospital safeguarding team were not made aware of Adult J's admission which would have been expected practice. However, Hospital 3 add that their burns unit treat high numbers of injuries sustained as a result of abuse and are therefore familiar with safeguarding procedures although Adult J was not transferred to the burns unit until 23rd September 2017, almost two months after his first admission. Planning for Adult J's discharge commenced in early November 2017 and by 3rd December 2017 Adult J was considered medically fit for discharge. However, the hospital was unwilling to discharge Adult J until a care package was in place. It appears that Hospital 3 understood Oxfordshire Adult Social Care to be unable to commission support before Christmas 2017. Adult J became frustrated at the length of his hospital stay and self-discharged on 14th December 2017. This potentially exposed Adult J to harm which was mitigated by the medical aspects of Adult J's discharge being managed well by Hospital 3 and communication between the hospital and Adult J's GP being effective.

6.2 It is fortunate that Adult J had been encouraged to register with the Oxfordshire GP practice, which he did, in December 2016. However, providing care to Adult J following his discharge from an out of area hospital following a period of in-patient care for very severe injuries - which had had a significant effect on his physical health and may also have impacted upon his mental health and emotional wellbeing - presented a substantial challenge to his GP practice.

6.3 The GP practice promptly arranged a follow up appointment (Paragraph 4.28) at which Adult J declined a referral to the community mental health team. The GP

practice had previously suggested referrals to Turning Point to address his alcohol addiction (Paragraph 4.4) and Talking Space to address his low mood (Paragraph 4.5) which Adult J had declined. The GP practice had been made aware of the fact that Adult J had discharged himself from hospital prior to a care package being put in place by Adult Social Care (Paragraphs 4.23 and 4.24). Given the likely impact of his burns injuries on his ability to care for himself, the GP practice could have considered contacting Adult Social Care at this point but there is no indication that this happened. The GP practice could also have considered making a safeguarding adults referral given Adult J's risk of self-neglect and the circumstances in which his burns injuries had been caused, which the 26th September 2017 letter from the Hospital 3 consultant psychiatrist to the GP practice stated were self-inflicted. A safeguarding adults referral would not have required Adult J's consent, although it would have been good practice to obtain it. This review has been overseen by the Safeguarding Adults Sub Group of Oxfordshire Safeguarding Adults Board and members of that group felt that GP practice awareness of self-neglect as a potential adult safeguarding issue may not have been high at that time.

6.4 Patients with burn injuries often present with unique clinical, psychological and social challenges; burn injury can be one of the most severe forms of trauma and therefore treatment in specialised services is required (2). In the contract for specialised burns care, NHS England states that although significant advances have been made in burn care over recent decades, it is recognised that to achieve the best possible clinical outcome for burn injured patients, burn care must be delivered by expert multi-disciplinary teams in specialised burn services (3). Adult J was offered outpatients appointments for scar management, physiotherapy and occupational therapy for burns and 'hospital at home follow up'. There is no indication that he attended any of these appointments despite the encouragement of his GP practice. There is no documentation to suggest that the barriers to attendance at these appointments described by Adult J's sister (Paragraph 5.8) were explored, although his sister acknowledged that Adult J may have been reluctant to divulge them.

6.5 However, the GP practice provided care and support to Adult J through the practice nurse who dressed his wounds and demonstrated how to do so to his un-named carer, presumed to be Adult K, until such time as the wounds were largely healed (Paragraph 4.36). The practice also referred Adult J to ophthalmology (Paragraph 4.33) - although Adult J did not attend the appointments offered - and encouraged Adult J to attend Hospital 3 outpatients appointments without success.

6.6 Adult Social Care had been involved in planning for Adult J's discharge from Hospital 3. They had assisted him in making a housing application to Cherwell District Council at a time when Adult J appeared to have concluded that he would be

unable to return to his houseboat and attempted to commission support from HART which appears not to have been in place at the time he discharged himself from Hospital 3 (Paragraphs 4.17, 4.21 and 4.24). This review has been advised that by self-discharging himself he was no longer eligible for HART. It is understood that Adult J became increasingly reluctant to accept help from HART as his determination to be discharged from hospital and return to his houseboat intensified. Overall, this seems to have been an unsatisfactory hospital discharge in which communication between Hospital 3 and Oxfordshire Adult Care does not appear to have been particularly effective. Adult J's insistence on leaving hospital and reluctance to accept help were complicating factors but there is no indication that Adult J's capacity to make the decision to self-discharge was assessed and there is no indication that a multi-agency discharge planning meeting took place at which the risks accompanying Adult J's self-discharge were considered.

6.7 It is not known how much Adult Social Care had been able to ascertain about the circumstances of Adult J's admission to Hospital 3 following the 2nd August 2017 incident, so it is difficult to reach a conclusion over whether they could have considered an adult safeguarding referral at the time they were involved in the Hospital 3 discharge planning process in November and December 2017.

6.8 Adult Social Care received an adult safeguarding referral in respect of Adult J from the police on 29th January 2018 (Paragraph 4.40). Police concerns included his recent discharge from hospital, self-neglect, poor living conditions on his houseboat and domestic conflicts with Adult K in which alcohol was a factor. Adult Social Care decided to progress the referral to a Section 42 safeguarding enquiry on the basis of domestic abuse, self-neglect and fire risk. The information gathering by the allocated social worker may, or may not – see Paragraph 6.7, initially have been hampered by a lack of clarity over how Adult J sustained his burn injuries although by 1st February 2018 the formal notification from Warwickshire Police had been received. The social worker struggled to make contact with Adult J although she made contact with Adult K who said that Adult J was drinking and not caring for himself.

6.9 During the course of the safeguarding enquiry the MARAC meeting took place which facilitated wider multi-agency information sharing and Adult Social Care was contacted by a social worker from Derbyshire on behalf of Adult J's children who were concerned that Adult K had assaulted their father and 'smashed up' his houseboat so that he had been forced to live on hers. This information was shared with the police.

6.10 The social worker was able to contact Adult J by telephone on 27th February 2018 when he said he was 'fine' and needed no assistance. He went on to minimise the conflict in his relationship with Adult K and provided an explanation for his

hospital admission on 29th/30th January 2018 (walking across the canal bridge when struck by a car) which was not consistent with the account he provided to the ambulance service at the time (unable to recall how his injuries had been caused) who had found him sitting in his own car at the side of the road. It would have been preferable to have visited Adult J given the range of concerns detailed in the original safeguarding referral. There is no indication that Adult J was offered an assessment by Adult Social Care at this time. (No assessment appears to have been carried out as part of the earlier Hospital 3 discharge planning).

6.11 Adult Social Care received a further safeguarding referral - from the Canal and River Trust - on 22nd March 2018 (Paragraph 4.56) which highlighted a number of concerns, namely that the physical injuries sustained by Adult J in the 2nd August 2017 incident had left him prone to infection and incapable of looking after himself, incapable of moving his houseboat, that Adult K's houseboat was moored next to his, he had become reclusive and was reluctant to answer phone calls, that Adult K was a 'controlling influence' on him, that he was 'frightened and controlled' and that he may be at risk of further harm from her. Adult Social Care decided that as a safeguarding enquiry was already open 'for this issue', the contact from the Canal and River Trust would not be separately progressed. Thus the Canal & River Trust referral was effectively amalgamated with the ongoing safeguarding enquiry. Whilst it was true to say that the Canal and River Trust referral raised similar issues to the earlier safeguarding referral from the police, the former was much more explicit than the latter about the risk to Adult J of domestic violence and abuse and could have necessitated the completion of a DASH risk assessment, particularly when considered alongside the concerns raised on Adult J's children's behalf by the Derbyshire social worker.

6.12 Adult Social Care closed the safeguarding enquiry on 17th May 2018 after liaison with the IDVA and further telephone contact with Adult J who said he wished to continue his relationship with Adult K (Paragraph 4.59). He was said to have capacity to make this decision although there is no indication that a formal capacity assessment was carried out at this point or that there had been any face to face contact with Adult J.

6.13 Adult Social Care received a further safeguarding referral from the police in respect of Adult J on 3rd September 2018 after the DVPO had been issued. On this occasion they were able to engage much more successfully with Adult J who co-operated with an assessment which found him to have eligible care and support needs. Whilst he rejected the offer of respite in Witney on the grounds of distance, he appeared open to the prospect of moving away from the canals into housing and he was supported to make a housing application to Cherwell District Council. Adult J appeared to be particularly worried about spending another winter on his houseboat

given his deteriorating health. Adult Social Care were also considering a package of care to meet the needs identified in their assessment, whether or not he moved from his houseboat into housing.

6.14 However, Adult J had 'second thoughts' and decided not to move off his houseboat and declined further support from Adult Social Care. After assessing his mental capacity to understand the risk of maintaining contact with Adult K, Adult Social Care closed the safeguarding enquiry. It is worthy of note that Adult J appeared much more open to working with Adult Social Care during the period in which the DVPO afforded him some protection from Adult K and that his change of heart arose shortly after the DVPO expired. However, the social worker to whom the September 2018 safeguarding enquiry was allocated attended the practitioner learning event arranged to inform this review and expressed the view that whilst Adult J was initially clear in his decision to leave his houseboat, 'deep down' he had a very settled lifestyle on the water to which he had become attached.

6.15 A further safeguarding referral in respect of Adult J was submitted by the AMHT memory service on 14th September 2018 (Paragraph 4.72) on the grounds that the service considered him to be a vulnerable adult. It is not clear what happened to this referral but it is assumed that it was subsumed within the ongoing safeguarding enquiry by Adult Social Care.

Multi-agency response to risks to Adult J of Domestic Violence and Abuse arising from his relationship with Adult K (first phase from 28th January until 17th May 2018).

6.16 The incident which took place in the Warwickshire Police area on 2nd August 2017 in which Adult J suffered burns to 60% of his body was extremely serious. Adult J suffered life changing injuries and could easily have died. It seems likely that his proximity to the canal may have saved his life as he put out the fire with canal water. Adult K was treated by the police as a suspect but ultimately no criminal prosecution ensued. She acknowledged that she had thrown white spirit over Adult J following an argument but claimed that he had subsequently set himself on fire (Paragraph 4.10). When Adult J was initially fit to be interviewed he said that he was unable to remember what had happened. When he was formally interviewed after he had made a fuller recovery from his injuries, Adult J reiterated that he could not remember the incident but said that he believed that Adult K caused his injuries, whilst also saying that 'he was sure that Adult K would not do anything like that to him', before adding that he was planning to continue his relationship with Adult K (Paragraph 4.29)

6.17 In their contribution to this Safeguarding Adults Review, Warwickshire Police state that they did not refer the incident to any partnership agencies which they state was in line with force policies. They went on to state that they did not make a referral to 'NHS' or Adult Safeguarding, adding that Adult J did not consent to a referral to Refuge, the local domestic abuse charity. This review has insufficient information on which to comment on Warwickshire Police's response to the incident and to do so would entail going beyond the terms of reference of the review. However, from the information provided by Warwickshire Police, the severity of Adult J's injuries prevented the police and any agency not involved in his immediate care and treatment from communicating with him for some time, and the fact that he was considered to be in a safe place in hospital may have limited the scope for fully assessing the risks to which he was exposed, clarifying his needs and making appropriate referrals.

6.18 From the statement Adult K provided to the police in advance of the inquest, it would appear that the relationship between Adult J and Adult K began in 2015 or 2016.
Warwickshire Police have advised this review that they had no contact with either Adult J or Adult K prior to the 2nd August 2017 incident. When he saw his Oxfordshire GP in January 2017, Adult J disclosed that he was in a relationship with a female friend and in March 2017 he told the GP that 'things were going well' with his girlfriend. On neither occasion was the name of his partner recorded. Adult J's 'partner' contacted the GP on his behalf on 17th July 2017. Again, her name was unrecorded although Adult J's GP, who attended the practitioner learning event, believed the partner to have been Adult K. A learning point for all services is the importance of documenting the names of partners if the service user is willing to disclose this information. Even after Adult J had been discussed at MARAC in Oxfordshire, his GP practice was not recording the name of his 'carer' (Paragraph 4.55).

6.19 Agencies in Oxfordshire did not formally become aware of the 2nd August 2017 incident until 26th September 2017 when the Oxfordshire GP practice received a letter from the consultant psychiatrist at hospital 3, where Adult J was being treated for the injuries sustained in the incident. However, Adult J's GP has advised the review that the incident was well known within the local community which is only a few miles from Warwickshire village where the incident took place and strongly linked by the canal network and movement of houseboats along that stretch of water.

6.20 Warwickshire Police did not formally notify Thames Valley Police of the 2nd August 2017 incident until 1st February 2018 (Paragraph 4.43) despite the fact that they were aware that Adult J's houseboat was moored in Oxfordshire at the time

they formally interviewed him on 20th December 2017. However, they may not have been aware that Adult J was using this as a relatively permanent base.

6.21 The delay in formally notifying Thames Valley Police of the 2nd August 2017 incident impacted on that force's response to the domestic abuse incident on 28th January 2018 (Paragraph 4.37). Their DASH risk assessments were uninformed by the 2nd August 2017 incident (although it is assumed that had Thames Valley Police checked the Police National Computer (PNC) the details of the incident would have been available to them) and their adult safeguarding referral in respect of Adult J (Paragraph 4.40) was similarly uninformed by the 2nd August 2017 incident. The initial information gathering by Adult Social Care in response to the safeguarding referral may also have been hampered by a lack of information about how Adult J's burns had been caused.

6.22 Once formal notification of the 2nd August 2017 incident was received, a prompt referral was made to the West Oxfordshire MARAC, although the opening of a second risk management occurrence (RMO) by the police in response to the Warwickshire Police referral created the potential for confusion. The RMO is the repository where the police document relevant information about the case including referrals, safety advice and police actions. However, an RMO had already been opened in respect of Adult J and Adult K after the 28th January 2018 incident but this had been opened with an incorrect spelling of Adult J's name. The second RMO was also completed in error as Adult K was omitted from it. There is no indication that the duplicate RMO's, or the errors within them, affected the police response.

6.23 West Oxfordshire MARAC considered the referral prompted by the Warwickshire Police notification and initiated positive actions which included establishing whether Adult K was in breach of her bail conditions by contacting Adult J and requesting a joint visit to him by the IDVA and the Domestic Abuse Investigation Unit. There was an inaccuracy in the information presented to, or minuted by, the MARAC (Paragraph 4.49) but this does not appear to have affected decision making in any way. It was quickly established that Adult K was not in breach of bail conditions and Adult J's case was not further considered by the MARAC. MARAC will have taken comfort that the IDVA was now involved with Adult J and that Adult Social Care were conducting a formal Section 42 safeguarding enquiry following the safeguarding referral from Thames Valley Police.

6.24 However, the safeguarding enquiry was closed on 17th May 2018 despite further concerns about the risks Adult J was exposed to by his relationship with Adult K having been raised (Paragraphs 4.52 and 4.56).

6.25 The IDVA attempted to engage with Adult J, but her only face to face contact with him was in the presence of Adult K (Paragraph 4.54). He declined IDVA support at that time although there was renewed contact during September 2018 when Adult J told the IDVA he was keen to pursue housing (Paragraph 4.76) and October 2018 when the IDVA helped him to submit his housing application to Cherwell District Council (Paragraph 4.84).

6.26 The police were unable to place a flag on either Adult J or Adult K's houseboats as they are not static homes with a post code. Flagging an address enables the police to provide an immediate response to subsequent calls to that address, thereby enhancing the safety of potential victims residing at that address. However, the police were able to place a flag Adult J as an individual which afforded him an increased level of protection. The flagging of houseboats is an issue which could be usefully explored with the Canal and River Trust.

6.27 During this phase of the multi-agency response to the domestic violence and abuse concerns all opportunities to fully exploit potentially valuable sources of information were not taken. The members of the public who reported the domestic incidents to the police on 28th January 2018 (Paragraph 4.37) and 1st February 2018 (Paragraph 4.45) were not spoken to as part of police enquiries into the incidents. Additionally, there is no indication that Adult J's children (or their mother) were spoken to by Adult Social Care after the children's concerns were passed on by a Derbyshire social worker (Paragraph 4.52) or that the boat licence support officer from the Canal and River Trust's concerns that Adult J was 'frightened and controlled' by Adult K were fully explored (Paragraph 4.56).

Multi-agency response to risks to Adult J of Domestic Violence and Abuse arising from his relationship with Adult K (second phase from 1st September until 4th December 2018)

6.28 After Adult Social Care closed the safeguarding adults enquiry on 17th May 2018, no further concerns about the risks to Adult J of domestic violence and abuse came to the notice of partner agencies until 1st September 2018, apart from a further safeguarding referral from the Canal and River Trust on 4th June 2018 which was not taken further by Adult Social Care on the basis that the issues raised were largely the same as had previously been raised. It was not unreasonable to take the view that this second safeguarding referral from the Canal and River Trust raised issues which were largely the same as had previously considered as part of the Section 42 enquiry but the fact that they were being raised again indicated that things were not improving for Adult J.

6.29 The volatility in Adult J and Adult K's relationship came to notice again on 1st September 2018 when Adult J alleged that Adult K had assaulted him whilst he was in bed on his houseboat. However, it was evident that Adult K had sustained injuries which she alleged that Adult J was partially responsible for. The police created two incidents to reflect that both parties had made allegations against the other and both parties had sustained visible injuries, a Domestic Violence Protection Order (DVPO) was applied for by the police, and granted by the courts which prohibited Adult K from contacting or molesting Adult J. It is assumed that the severity of the 2nd August 2017 incident and the injuries which Adult J had sustained during that incident which had left him particularly vulnerable may have been factors in this application.

6.30 The DVPO gave partner agencies a period of 'breathing space' in which to offer support to Adult J which could reduce his dependence on Adult K, and increase his independence and resilience. However, the 'breathing space' is a relatively short period. The Order, to which a power of arrest was attached, would expire on 30th September 2018. The police rapidly made a safeguarding referral to Adult Social Care (3rd September 2018) and Adult Social Care assessed Adult J the following day (4th September 2018). Respite in Witney appeared to have been offered and rejected by Adult J before there appeared to be something of a lull prior to a discussion taking place between social workers 1 and 2 (19th September 2018) and social worker 2 gathering further information before completing a DASH risk assessment which disclosed a 'high' risk. This led to a meeting with the police on 25th September 2018. On the basis of the fresh DASH risk assessment, Adult Social Care could have referred Adult J to MARAC once again but took the pragmatic view that as he was already in contact with the IDVA and Adult Social Care were actively exploring options to support him, including supporting him to move away from the canals into extra care housing with a package of support in place, a MARAC referral would probably have added very little to the equation.

6.31 As the DVPO was expiring, Adult J disclosed a further assault by Adult K and said he was going to great lengths to avoid contact with her by sleeping in his car, washing in supermarket toilets and returning to his houseboat only when he knew she would be at work (Paragraph 4.79). Adult J was appropriately referred for domestic abuse support at this point although a further DASH risk assessment may have better informed any safety plans and risk assessments.

6.32 The police did not appear to actively manage the DVPO. They appeared to take the view that Adult Social Care was the agency which was best placed to offer support to Adult J during the 'breathing space' period, which was an appropriate judgement. However, the College of Policing guidance suggests that DVPOs should

be actively managed by the police including reviewing and updating risk assessments and safety planning at the point of issue and expiry of the Order (4).

6.33 However, the opportunity provided by the DVPO probably did not succeed in changing the dynamic of the situation because Adult J was unwilling to leave behind the lifestyle to which he had become accustomed, and to which he appeared to be strongly attached.

The dynamics of the relationship between Adult J and Adult K

6.34 Whilst there is no trace of Adult J on police systems, Adult K was documented to be the perpetrator in two incidents of domestic violence in which no formal action was taken. In 2012 it was alleged that she bit her partner on the arm after he grabbed her and the following year it is alleged that whilst at their home address she hit the other party over the head with a remote control. Adult J is not believed to have been the victim in either of these incidents.

6.35 The injuries Adult J sustained in the 2nd August 2017 incident left him unable to care for himself without support as is clearly illustrated by the Adult Social Care assessment carried out over a year later - in September 2018 (Paragraph 4.70). It became increasingly apparent to professionals that the person he was relying on to provide him with care and support was Adult K. She sought emergency medical help for Adult J in July 2017 (Paragraph 4.9), she described herself as Adult J's carer to the IDVA in March 2018 (Paragraph 4.54), Adult J said he was reliant on Adult K to 'do most things for him' (Paragraph 4.54), she was said to be attending to his needs and dressing his wounds whilst her houseboat was moored adjacent to his (Paragraph 4.56) and Adult J told his social worker in September 2018 that he 'would not be able to survive without Adult K' (Paragraph 4.76).

6.36 It is possible that coercive control was present in Adult K's relationship with Adult J. Coercive control consists of behaviours perpetrated by one person against another with whom they have an intimate or family relationship and is exercised in situations where the behaviour of an individual is shaped into conformity to the wishes of another person (5). However there also appeared to be a degree of co-dependency at times with Adult J indicating that Adult K experienced mental health issues which led to a reversal of their carer/cared for roles. Adult K's mental health issues have not been confirmed as her medical records have not been shared with this review. Additionally, it seems clear that Adult J represented a risk of domestic violence to Adult K at times, such as when she disclosed that he assaulted her by kicking her in the back and threatened her with an axe and screwdriver (Paragraph 4.37) and poured white spirit on her feet and threatened her with a lighter (Paragraph 4.85). Alcohol consumption appeared to be a key factor in the violence

each disclosed about the other. Cases of dual perpetrator domestic violence have been found to include the highest number where both partners were alcoholics or heavy drinkers, with alcohol present in 88% of such cases, significantly higher than sole domestic violence perpetrators (63%) (6). Alcohol has also been found to be associated with victimisation, with research finding victims of domestic assault to have higher alcohol consumption that non-victims, and that the risk of violence increased with levels of consumption (7).

6.37 As previously stated, Adult K decided not to be involved in this review, and was under no obligation to do. It would therefore probably be unwise and unfair to attempt to further analyse her relationship with Adult J. It should also be acknowledged that the review is largely perceiving her actions through the information Adult J reported to the agencies he came into contact with and the information agencies gathered in response to Adult J's reports.

Alcohol services

6.38 Given the apparent significance of alcohol consumption in this case, it is appropriate to consider the support offered to Adult J in this regard. During his initial appointment with the Oxfordshire GP, when he was a temporary patient, he disclosed that he was drinking heavily – 'one bottle daily' – and that this was significantly impacting on his life as his former partner was refusing to let his children stay with him due to his level of drinking (Paragraph 4.2). There is no reference to any referral to alcohol support services at this time, although his status as temporary patient may have been a factor in this.

6.39 In January 2017 Adult J declined the GP's suggestion he self-refer to Turning Point. During his admission to Hospital 3 following the 2nd August 2017 incident, Adult J acknowledged that he had been drinking to excess prior to his admission but declined a referral for support, saying he planned to stop drinking (Paragraph 4.14). During his hospital admission he was found to have alcohol on two occasions. At the time of his discharge from Hospital 3, the RAID consultant advised Adult J's GP practice that Adult J was very clear that he did not want to stop drinking and suggested that his alcohol intake combined with concerns about his capacity to cope as a result of his injuries might put him at risk of further self-harm (Paragraph 4.24). Adult J also declined a referral to alcohol services when he was first assessed by AMHT memory services in September 2018 (Paragraph 4.72). In the month prior to his death from acute intoxication the memory clinic consultant psychiatrist attributed his amnesia and cognitive decline to Korsakoff syndrome which is a chronic memory disorder caused by severe deficiency of thiamine and most commonly caused by alcohol misuse (Paragraph 4.86). At that time, the consultant described Adult J as

alcohol dependent following the ending of his relationship with his ex-partner five years earlier.

6.40 Adult J's GP practice made several gastroenterology referrals for chronic diarrhoea which revealed pancreatic insufficiency. This has many causes although chronic alcohol abuse is a prominent cause. Adult J was treated with Creon (enzyme replacement medication) although there appeared to be a delay of almost two months (19th September to 13th November 2018) before this was prescribed.

6.41 The accepted approach practitioners adopted to Adult J's problematic relationship with alcohol was that the onus was on him to recognise he had a problem and be willing to seek help to moderate his intake. However, efforts to encourage him to reconsider his alcohol misuse and seek help were unsuccessful. His alcohol misuse may have been perceived by practitioners to be a second order problem compared to the impact of his burns injuries on his ability to care for himself and the risks he was assessed as facing from his relationship with Adult K, although it appears to have been his excessive alcohol consumption which significantly contributed to his cognitive decline and premature death at the age of 52. It is assumed that to have brought together all the ways in which excessive alcohol consumption was adversely affecting his life, would have required Adult J to have referred himself for support from alcohol services.

Mental Health

6.42 Adult J reported low mood during his first consultation with the Oxfordshire GP and later declined three opportunities to self-refer to Talking Space (Paragraph 4.5, 4.58 and 4.61) before deciding to self-refer in June 2018 (Paragraph 4.62). It is not known whether he followed through on this. He reported to be obtaining help from an un-named friend who was a psychotherapist, although this was not further explored or verified. The GP later prescribed antidepressants which Adult J reported feeling no benefit from. He self-reported no mental health history.

6.43 He reported that his low mood affected his life, telling his GP on one occasion that he struggled to leave 'the house' (Paragraph 4.62).

6.44 Whilst admitted to Hospital 3 he was seen by psychology on several occasions. The delirium initially observed gradually diminished. He was noted to be having difficulty in adjusting to the impact of his injuries on his life. He did not report suicidal ideation although the hospital psychology service appeared to be unable to explore whether the 2nd August 2017 incident may have represented an attempt to take his own life.

6.45 He began reporting memory loss symptoms in July 2018 and was referred to the Adult Mental Health Services memory clinic by his GP the following month (Paragraph 4.63 and 4.72). During this appointment Adult J disclosed significant anxiety over the year which had elapsed since the 2nd August 2017 incident which he described as attacks of absolute fear which stopped him from doing day to day activities. He reported only feeling safe when he was with friends who he felt well supported and protected by. He said he felt that his anxiety had improved over the past month or so, although he was not able to identify a clear cause for this. It is worthy of note that this first appointment with the memory clinic took place during the period in which the DVPO was in place which may have contributed to the recent improvement in anxiety he reported.

6.46 During his second appointment at the AMHS memory clinic (Paragraph 4.86) Adult J reported feeling frustrated and low in mood because he felt that his memory problems had worsened although he felt that his low mood had preceded his memory problems. He also reported feelings of despair in respect of the way his life had changed following the severe burns he had sustained in the 2nd August 2017 incident. He said he had had fleeting suicidal thoughts since the incident but denied any intent, adding that if he was to kill himself, he would do so by drinking a large amount of alcohol and falling asleep out of doors during the winter months.

6.47 Despite the 2nd August 2017 incident, which may have represented a very serious attempt to take his own life which he may immediately have regretted, thoughts of self-harm and suicidal ideation were only infrequently documented by practitioners. On 30th November 2018 Adult K reported to the police that Adult J had asked her to help him take his own life the previous day. During the same incident, Adult J told the police that he had attempted to commit suicide that day by inhaling car fumes and they later conveyed him to hospital. The hospital concluded that his presentation was the result of alcohol intoxication and discharged him back into the custody of the police (Paragraph 4.87). The hospital did not document any safeguarding concerns although it is unclear whether the police had shared information about Adult J's reported suicide attempt. Had this information been considered, there may have been an opportunity for the hospital to have referred him for an assessment of his mental health at that point. In the event, the criminal justice liaison and diversion nurse subsequently referred Adult J to mental health services but they were unable to contact Adult J prior to his death (Paragraph 4.88).

Self-Neglect

6.48 Concerns that Adult J may be neglecting himself arose frequently during the period under review. The ending of his relationship with the mother of his children and consequent difficulties over his access to their children appeared to be a key

factor in his self-neglecting behaviour. His family attributed his self-neglect to this (Paragraph 4.12) and Adult J later disclosed to the AMHT memory clinic that it had 'broken his heart' (Paragraph 5.6). His excessive drinking appeared to compound this loss as he told his GP that his former partner was refusing to let his children stay with him due to his level of drinking (Paragraph 4.2).

6.49 Adult J's excessive use of alcohol also contributed to his self-neglect, sometimes leading to injuries for which he did not seek medical attention (Paragraph 4.41). Although Adult K's witness statement should be treated with caution, she said he was in the habit of drinking a bottle of vodka each day until he passed out, exposing himself to harm. His excessive drinking also appears to have been a factor in a deterioration in other aspects of his health such as his memory loss which left him less able to perform essential daily tasks such as making a cup of tea (Paragraph 4.63).

6.50 Another factor in his self-neglect were the life changing injuries he sustained in the 2nd August 2017 incident which had a profound effect upon him both physically and medically. The September 2018 Adult Social Care assessment of Adult J highlighted some of the impacts of his injuries on his daily life including difficulties in washing, dressing and preparing food without support (Paragraph 4.70). And Adult J disclosed to the AMHT memory service that in the year since the 2nd August 2017 incident he had experienced anxiety and attacks of absolute fear (Paragraph 4.72). Attending the outpatient appointments offered by Hospital 3 may have helped to mitigate the impact of the burns injuries on his physical and mental health but it appears he did not attend any of these, prompting a Hospital 3 consultant to write to Adult J's GP to express concern (Paragraph 4.44). In her contribution to this review, Adult J sister described the barriers he faced in attending those appointments (Paragraph 5.8).

6.51 Given his self-neglect, in which alcohol misuse and adapting to fairly recent physical disability were significant aspects, reorienting himself to life on his houseboat probably proved very challenging for Adult J. A certain amount of physicality would be required to travel in the houseboat and quite a high degree of organisation would be required to manage the limited space aboard. At the end of January 2018 Adult J's houseboat was described as 'uninhabitable' by the police (Paragraph 4.40). It is not known whether it had been damaged by fire in the 2nd August 2017 incident.

6.52 A further factor in Adult J's self-neglect was his relationship with Adult K. She appears to have been his carer for much of the period between his discharge from Hospital 3 in December 2017 and his death a year later. She also appeared to be a heavy drinker and so their drinking would have been mutually reinforcing.

Additionally there are indications of coercive control in the relationship which may have isolated Adult J from support on occasions. There were indications that Adult J was neglecting himself whilst avoiding Adult K in early October 2018 when he told his social worker that he had been sleeping in his car and washing in supermarket toilets (Paragraph 4.79).

6.53 Understanding of self-neglect has been greatly enhanced by the following series of reports by researchers Suzy Braye, David Orr and Michael Preston-Shoot (8):

- "Self-neglect and adult safeguarding: findings from research". (2011)
- "A scoping study of workforce development for self-neglect work". (2013)
- "Self-neglect policy and practice: building an evidence base for adult social care". (2014)
- "Learning lessons about self-neglect? An analysis of serious case reviews". (2015)

6.54 The research highlights a number of challenges presented by self-neglect, some of which were present in this case. The highlighted challenges include:

Competing moral imperatives between "respect for autonomy and self-determination" and "duty of care and promotion of dignity". In Adult J's case partner agencies took their duty of care very seriously and made substantial efforts to safeguard him from domestic violence and abuse, particularly during the period when the DVPO was in force. His decision to ultimately decline support as the DVPO expired was accepted after an assessment of his mental capacity to understand the risk of maintaining contact with Adult K.

Physical, mental and social factors including personal history. Some insights into Adult J's personal history were obtained although his unwillingness to engage with mental health and alcohol addiction services reduced the opportunity to further explore why he used alcohol excessively and neglected himself at times. He was noted to be quite guarded in discussions about his past life which his retrograde amnesia subsequently made it difficult for him to remember.

Complex interplay of inability and unwillingness. In Adult J's case unwillingness to alter his behaviour and a strong attachment to his lifestyle on the canals appeared to be a strong feature although the impact of the burns injuries limited his ability to care for himself. He also appeared to be unwilling – or possibly unable - to attend outpatient appointments at Hospital 3, although his reasons for doing so do not appear to have been successfully explored. Adult J's self-image was one of being a 'survivor' (Paragraph 4.81) which may have limited his ability to honestly reflect on his vulnerabilities.

Integrated, parallel or missing inter-agency communication. There was much effective multi-agency working to safeguard Adult J although the MARAC referral added little value. It has been suggested that a 'team around the adult' approach could have been of benefit to Adult J.

Nobody 's or somebody else's business. Adult Social Care took ownership of Adult J's case during the 'breathing space' afforded by the DVPO and worked effectively with partner agencies during this period. At other times difficulty in contacting Adult J and a tendency for contact to be away from his houseboat or the houseboat he periodically shared with Adult K, may have limited practitioner's appreciation of the extent of his self-neglecting behaviour.

Workflow patterns. The self-neglect research suggests that Adult Social Care 'care management models' are based on a time limited journey through a series of stages, which does not allow for the kind of work which will secure engagement of the service user. In Adult J's case Adult Social Care were able to engage effectively with Adult J whilst the DVPO was in place until such time that he had 'second thoughts' about accepting support to move away from the canals. Otherwise, the episodic nature of contacts between Adult J and agencies appeared to provide practitioners with insufficient opportunity to work with Adult J to consider interventions which might have been effective in addressing his self-neglecting behaviour.

Little evidence of effective interventions. There is not a large repository of evidence of the types of interventions which appear to be effective in addressing self-neglect. In Adult J's case, the DVPO proved to be effective in providing him with an opportunity to reflect on his life and seriously consider making changes which may have helped to enhance and prolong his life had he not had 'second thoughts'.

Mental Capacity

6.55 During his admission to Hospital 3 following the 2nd August 2017 incident, Adult J was recorded as being confused at times but no formal capacity assessment was conducted. In their contribution to this review the hospital have stated that it is not clear from Adult J's notes whether confusion was expected as part of his potential withdrawal from alcohol, other medical issues or because he was having medications (pain relief) which may have affected him cognitively.

6.56 Adult J's deteriorating memory also gave rise to concerns about the impact of this on his mental capacity. Social worker 1 was contacted by AMHT following their 14th September 2018 assessment to advise that they had assessed him as lacking capacity to 'make decisions in respect of care needs due to query around amnesia'

(Paragraphs 4.73 and 4.75). The social worker expressed surprise at this assessment as he felt that Adult J appeared coherent. It was therefore decided to assess his capacity to understand the risk of maintaining contact with Adult K. There is no indication that Adult J's capacity to make specific decisions had been previously assessed although there were occasions when he was assumed to have capacity (Paragraphs 4.24 and 4.59).

6.57 Adult J's capacity to understand the risks in maintaining contact with Adult K was assessed by social worker 2 in September 2018. She contributed to the practitioner learning event and described how she approached the assessment, consulting with a community psychiatric nurse from the AHMH memory clinic (Paragraph 4.75) and the IDVA (Paragraph 4.76) before meeting Adult J to conduct the assessment on 2nd October 2018 and concluding, on a balance of probabilities, that he had capacity to understand the risks of maintaining contact with Adult K.

6.58 She said she considered whether he was making this decision freely and whether his capacity to make the decision was affected by issues of coercion and control, acknowledging that this was a complex area to assess. The Local Government Association (LGA) guide to support practitioners and managers 'Domestic Abuse and Adult Safeguarding' (9) draws attention to fact that being at risk of harm can limit an individual's capacity to safeguard themselves due to the psychological process that focusses an individual on acting within the immediate context of the threats that they face, in order to limit the abuse and its impact. This can lead victims to identify with the perpetrator and can prevent them from acknowledging the level of risk they face. It commonly prevents people leaving or ending a relationship.

6.59 Social worker 2 also said that the task was made more challenging by Adult J tending to be quite guarded and reluctant to revisit what had happened in the past.

6.60 There is no indication that practitioners working with Adult J considered the use of 'inherent jurisdiction' in which the High Court may intervene to protect adults who possess capacity but still require protection for certain reasons. However, it seems highly unlikely that Adult J's vulnerability would have been sufficient for this option to have been progressed.

Reasonable Adjustments

6.61 All public authorities have a legal duty to make 'reasonable adjustments' to the way they make their services available to people with a disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff training

and service delivery to ensure they work equally well for people with a disability (10).

6.62 In Paragraph 5.8, Adult J's sister highlighted some of the difficulties her brother experienced in accessing follow up care from Hospital 3. He was unable to drive as a result of his injuries and the Oxfordshire village where his houseboat was moored and Birmingham were not well connected by public transport. Obtaining benefits to pay for travel was difficult as he couldn't use a computer to apply online because he had no fingers on one hand and only stubs on the other. In Paragraph 5.9 the sister also highlighted the difficulties Adult J encountered in contacting agencies by phone given the injuries to his fingers. It is unclear whether this was considered in safety planning for Adult J. In Paragraph 4.72 the memory clinic was unable to fully complete the Montreal Cognitive Assessment (MOCA) visuospatial nor the Mini Mental State Examination (MMSE) memory test as Adult J was unable to hold a pen.

6.63 There is little indication that agencies in contact with Adult J acknowledged that his burns injuries may have left him with a degree of physical disability which could make it more difficult for him to access services. There is no evidence that any reasonable adjustments were considered to ensure he had equal access to services.

Good practice

6.64 At the time of Adult J's discharge from Hospital 3, the hospital made a referral to Hospital 4 in Oxfordshire for dietetic follow up. In general, the communication between Hospital 3 and Adult J's GP was very effective.

6.65 The GP practice had substantial contact with Adult J and persistently encouraged him to engage with services which could offer him support for needs relating to his mental health and his use of alcohol.

6.66 The safeguarding referrals made by the Canal and River Trust on 22nd March and 4th June 2018 (Paragraphs 4.56 and 4.60) indicated positive awareness of domestic violence and abuse particularly coercion and control.

6.67 The police made a prompt adult safeguarding referral to Adult Social Care as soon as the DVPO was issued and Adult Social Care immediately assessed Adult J's needs (Paragraph 4.70).

6.68 Social worker 2 consulted the AMHT community psychiatric nurse and the IDVA to inform the capacity assessment of Adult J (Paragraphs 4.75, 4.76 and 4.78).

6.69 The DASH risk assessment of Adult J conducted by social worker 2 informed efforts to take advantage of the 'breathing space' provided by the issue of the DVPO (Paragraph 4.77).

6.70 There was a prompt referral of Adult J to adult mental health services by the criminal justice liaison and diversion nurse following his arrest on 30th November 2018 (Paragraph 4.88).

Findings and Recommendations

7.1 Adult J had complex needs. He drunk alcohol to excess for many years and the underlying reasons for this had not been fully explored, he suffered very serious burn injuries which left him with substantial care and support needs, he struggled to adapt to these changed circumstances and was neglecting his health at times, he was suffering from significant retrograde and antegrade amnesia and general cognitive decline and was frequently reluctant to accept help from services. Additionally, he was in an intimate relationship in which domestic violence and abuse was present and which may have contributed to isolating him from the support of family and friends to an extent.

7.2 Professionals experienced some challenges in working effectively with Adult J. In addition to his frequent reluctance to engage with, or accept support from, services, living on a houseboat sometimes made contacting him more difficult. The physical impact of his burns injuries made some forms of communication much more difficult for Adult J. These challenges were compounded by many services only becoming aware of him some time after the 2nd August 2017 incident which occurred, and for which he received treatment, in another county. When people with vulnerabilities and who are at risk move across county and other boundaries it can often increase the risks they face until professionals in the area to which they have moved get to know them better, gain their trust and begin to understand their needs. In this case, the risks associated with moving from one area to another were mitigated by the Oxfordshire GP practice's prior involvement with Adult J and their encouragement of him to register with the practice.

7.3 Despite the complexity of Adult J's needs and the challenges of engaging with him, several agencies achieved some success in their efforts to work with him to address his needs and safeguard him from harm. In particular, the risks associated with Adult J moving from one area to another were mitigated by the Oxfordshire GP practice's substantial involvement with him and their encouragement to register with the practice, Adult Social Care worked very effectively with Adult J during the 'breathing space' provided by the DVPO, the police made prompt adult safeguarding

referrals and the Canal and River Trust raised very appropriate concerns about the risks to Adult J arising from his relationship with Adult K.

7.4 However, in this case, the formal approaches adopted achieved mixed results. For example, the MARAC referral focussed quite narrowly on establishing whether Adult K's contact with Adult J was in breach of her bail conditions, the first Adult Safeguarding Enquiry was closed after it was concluded that Adult J had the capacity to decide whether or not to continue his relationship with Adult K and the assessment carried out by Adult Social Care focussed on eligible care and support needs and did not consider underlying issues. The lack of a holistic approach to understanding Adult J's needs may have partially obscured some of his needs, particularly the chronic and ultimately fatal impact of his relationship with alcohol and his risk of suicide and self-harm.

'Team Around the Adult'

7.5 At the learning event arranged to inform this review, practitioners suggested that it may have been beneficial on this occasion to have arranged an ad hoc multi-agency strategy meeting to more holistically consider the concerns arising from Adult J's complex needs and the risks arising from his relationship with Adult K. As an independent reviewer, I not infrequently find that policies and procedures have not been followed when it would have been beneficial to do so. In this case, it may have been preferable to consider an approach outside the confines of expected policy responses and adopt a 'team around the adult' approach.

7.6 The Team Around the Family approach is an important component of the whole system for safeguarding children. This approach focusses on assessing and meeting needs in order to prevent concerns escalating whilst also drawing upon the strengths of the family. The Safeguarding Adults Board may wish to consider how the Team Around the Family approach might be successfully adapted to the safeguarding of adults.

Recommendation 1

That Oxfordshire Safeguarding Adults Board considers how the Team Around the Family approach might be successfully adapted to the safeguarding of adults who are at risk of abuse or neglect.

7.7 When the Safeguarding Adults Board disseminates learning from this review, it may be of value to emphasise to practitioners that whilst it is important to follow policy and procedures, it is also important to examine issues holistically and be prepared to consider novel approaches.

Recommendation 2

That Oxfordshire Safeguarding Adults Board disseminates the learning from this SAR and highlights the potential benefits of adopting a 'Team Around the Adult' approach in circumstances in which indicate that this may be of benefit to the person concerned.

Self- Neglect

7.8 The GP practice provided good care to Adult J in the quite challenging circumstances of his self-discharge from an out of area hospital after sustaining severe injuries. Additionally, the GP from the practice (which is a single GP practice) engaged very fully with the practitioner learning event arranged to inform this SAR. However, no contact with Adult Social Care or any adult safeguarding referral appeared to be considered when the GP practice became aware that Adult J had discharged himself from hospital in December 2017. It has been suggested to this review that GP practices awareness of self-neglect as a potential adult safeguarding issue may not have been well developed at that time.

7.9 However, Adult J's self-neglecting behaviour may not have received sufficient attention from agencies in addition to the GP practice. In this case, Adult J's self-neglect appeared to arise from a complex interplay of factors including a sense of loss arising from reduced contact with his children, excessive use of alcohol, the impact of the injuries sustained in the 2nd August 2017 incident on his physical and mental health, the difficulty in re-adjusting to life on his houseboat and his exposure to violence, coercion and control in his relationship with Adult K. The 'breathing space' allowed by the DVPO enabled some effective holistic work to be accomplished with Adult J for a time but generally professionals appeared to perceive the components of his self-neglecting behaviour as separate issues.

7.10 When disseminating the learning from this SAR, the Safeguarding Adults Board may wish to use this case as a self-neglect case study to highlight the interplay of factors which contributed to Adult J's self-neglecting behaviour.

7.11 Additionally, the Safeguarding Adults Board may wish to ask the CCG to remind GP practices of the key role they play in adult safeguarding, including adult safeguarding concerns arising from self-neglect.

Recommendation 3

When disseminating the learning from this Safeguarding Adults Review, that the Safeguarding Adults Board makes use of this case to develop a self-neglect case

study to highlight the interplay of factors which contributed to Adult J's self-neglecting behaviour. Additionally, that the Board asks the CCG to remind GP practices of the key role they play in adult safeguarding, including adult safeguarding concerns arising from self-neglect.

The Domestic Violence Protection Order (DVPO)

7.12 The issue of the DVPO provided a valuable 'breathing space' during which much positive work was done to support Adult J. However, to capitalise on this opportunity, it does require fairly rapid and sustained single agency and partnership working which may not always be achievable given the pressures of competing demands. Additionally, although the police quickly made a safeguarding referral to Adult Social Care, which was entirely appropriate, there is no indication that they actively managed or monitored the DVPO.

7.13 However, there were a number of areas of good practice in the response to the DVPO, including the prompt adult safeguarding referral by the police, the immediate assessment of Adult J's care and support needs by Adult Social Care, the DASH risk assessment carried out by that service, the efforts to support Adult J in his initial wish to move away from the canals and the thorough capacity assessment conducted.

7.14 The Safeguarding Adult Board may wish to share this SAR report with the Community Safety Partnership so that the factors which contributed to successfully exploiting the opportunities provided by the issue of the DVPO in this case can be replicated in future and areas which might have been improved in this case may also be learned from.

Recommendation 4

That Oxfordshire Safeguarding Adult Board shares this SAR report with the Community Safety Partnership so that the factors which contributed to successfully exploiting the opportunities provided by the issue of the DVPO in this case can be replicated in future and areas which might have been improved in this case may also be learned from.

DASH risk assessments

7.15 There were occasions when opportunities to conduct DASH risk assessments may have been missed, particularly when Adult Social Care were notified of additional concerns about the risk of domestic violence to Adult J from Derbyshire Children's Social Care (Paragraph 4.52) and the Canal and River Trust (Paragraph

4.56) and when Adult J disclosed his fear of Adult K to social worker 1 and the lengths he was taking to keep away from her (Paragraph 4.79). Additionally the DASH risk assessment conducted by the police following their attendance at the 28th January 2018 incident (Paragraph 4.39) was not informed by the Warwickshire incident, the details of which would have been available from PNC. However, social worker 2 proactively conducted a DASH risk assessment (Paragraph 4.77).

7.16 The Safeguarding Adults Board may therefore wish to share this SAR report with the Community Safety Partnership so that they can seek assurance that professionals from a range of relevant agencies are able to conduct DASH risk assessments and that when the police conduct DASH risk assessments the PNC is checked for information about relevant prior incidents in that or other police force areas.

Recommendation 5

That Oxfordshire Safeguarding Adults Board shares this SAR report with the Community Safety Partnership so that they can seek assurance that professionals from a range of relevant agencies are able to conduct DASH risk assessments and that when the police conduct DASH risk assessments the PNC is checked for information about relevant prior incidents in that or other police force areas.

Recording the names of partners and carers

7.17 There were several missed opportunities for Adult J's GP practice to record the name of Adult J's partner and/or carer which, if had he been willing to divulge this information, would have been helpful in gaining as full an understanding as possible of the risk of domestic violence and abuse he faced.

7.18 The Safeguarding Adults Board may wish to request NHS Oxfordshire CCG to advise GP practices of the importance of recording details of partners and carers of adult patients.

Recommendation 6

That Oxfordshire Safeguarding Adults Board requests NHS Oxfordshire CCG to advise GP practices of the importance of recording details of partners and carers of adult patients.

The Canal and River Trust

7.19 The Canal and River Trust made two safeguarding referrals in this case (Paragraphs 4.56 and 4.60) which indicated positive levels of awareness of domestic violence and abuse, including coercion and control. However, the potential benefits of working in partnership with the Canal and River Trust were not fully exploited in this case. For example, the Trust appear to have had the authority both to allow Adult J to moor his houseboat in Oxfordshire for an extended period because of his level of disability and the authority to insist on Adult K moving her houseboat elsewhere when the DVPO prevented her from contacting Adult J and therefore fulfilling the role of his carer. Working more collaboratively with the Canal and River Trust may have helped to safeguard Adult J.

7.20 The Canal and River Trust website states that it 'works with support partners such as local health services, council departments or specialist charities, to point boaters to the help and advice available to them if they are identified as having a vulnerability such a suffering from poor mental health'. The Safeguarding Adults Board may wish to approach the Canal and River Trust to explore opportunities to further engage them in safeguarding vulnerable boaters from abuse or neglect. Issues which could be explored might include the flagging of houseboats by the police and overcoming difficulties in demonstrating a local connection when a boater might wish to leave the canals and move into supported housing.

Recommendation 7

That the Safeguarding Adults Board approaches the Canal and River Trust to explore opportunities to further engage them in safeguarding vulnerable boaters from abuse or neglect.

Reasonable Adjustments

7.21 Reasonable adjustments, as required by law, were not always considered for Adult J (Paragraph 6.62). It is therefore recommended that Oxfordshire Safeguarding Adults Board seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with disabilities in the light of the learning which has emerged from this review.

Recommendation 8

That Oxfordshire Safeguarding Adults Board seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with disabilities in the light of the learning which has emerged from this review.

Warwickshire Police

7.22 The delay in formally notifying Thames Valley Police of the 2nd August 2017 incident had the potential to increase the risk of domestic violence and abuse faced by Adult J following his discharge from Hospital 3. The Safeguarding Adults Board may wish to share this report with Warwickshire Safeguarding Adults Board for any action they wish to consider relating to cross border communication of high risk domestic violence and abuse victims.

Recommendation 9

That Oxfordshire Safeguarding Adults Board shares this SAR report with Warwickshire Safeguarding Adults Board for any action they wish to consider.

Single Agency Learning

7.23 It would be beneficial for each partner agency involved in this case to consider this SAR report in order to identify any single agency learning they need to address and advise the Safeguarding Adults Boards of their plans to do so.

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Appendix A – SAR Process in this case

Process by which safeguarding adults review (SAR) was completed

The Safeguarding Adults Review was overseen by the members of the Oxfordshire Safeguarding Adults Board Safeguarding Adults Review Sub Group.

The review will follow a blended approach incorporating elements of traditional SAR methodology and Appreciative Inquiry (AI). This combines approaches rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change while providing assurance of a thorough investigative process.

Practitioners involved in the case were invited to a learning event which was also conducted under an appreciative inquiry model which seek to create a safe, respectful and comfortable environment in which people look at the interventions that have successfully safeguarded; and share honestly about the things upon reflection could have been done differently. The aim is to look at where, how and why events took place and use their hindsight wisdom to design practice improvements. The learning event was attended by several key practitioners.
The following agencies participated in the review:

- Oxford University Hospitals
- Oxfordshire Clinical Commissioning Group
- Oxfordshire County Council Adult Social Care
- University Hospitals Birmingham
- Thames Valley Police
- Warwickshire Police

Adult J's sister contributed to this review and it is planned to provide her with an opportunity to read and comment upon the final report. Adult K was offered the opportunity to contribute to the review but did not respond. As she has not contributed to the review it has not been possible to seek her consent for her medical and any other relevant records to be shared with this review.

The independent reviewer has developed a report which reflects the chronological information provided by partner agencies, the contributions of practitioners and managers who attended the learning event and the file of information prepared for the inquest into Adult J's death.