WIGAN SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW CONCERNING 'PETER'

OVERVIEW REPORT v 0.3

20.07.17

Independent Chair: David Hunter

Author: Paul Cheeseman

Version Control			
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Note to panel members:

1. Any changes from V0.2 to V0.3 are highlighted in green.
2. Outstanding queries & actions are shown in red text

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1. INTRODUCTION

1.1 The main people[1] referred to in this report are:

Peter	61 years of age at the time of his death: White British
Male A	33 years of age. Perpetrator of the murder and robbery of Peter.
Male B	46 years of age. Perpetrator of acquisitive offences against Peter
Female A	Perpetrator of acquisitive offences against Peter
Male C	Friend/Associate of Peter, Male A and Male B

1.2 This review is about Peter. He was treated for depression from an early age and suffered from mental illness and misused alcohol for most of his life. Peter was gay, although he did not speak openly about his sexuality. Early health records indicate that Peter struggled with his sexual identity.

1.3 While originally from the Liverpool area, Peter moved to Wigan some years ago. He was known to many services in the Wigan area. Peter frequently referred to Male A as his nephew although no agency established a familial relationship between them.

1.4 From around 2012 agencies recorded many contacts involving Peter which raised concerns. These included presentations at hospital either self-presentations or by way of an ambulance. The presentations involved mental illness, overdoses of medicines, excessive consumption of alcohol and injuries.

1.5 Some of these injuries involved assaults upon Peter. He directly told some services, and inferred to others, that he was being financially abused. On some occasions, he named Male A as the perpetrator however he did not feel able to support a prosecution against him. Some of these events resulted in safeguarding alerts being raised with Wigan Council Support and Safeguarding Initial Assessment Team (IAT). This report analyses those events in more detail.

1.6 At 19.39hrs on 25 November 2015 North West Ambulance (NWAS) attended address F[2]. Peter was said to have been consuming alcohol heavily for three days. He was found in an unresponsive state on the kitchen floor and had bruising to the left side of his face. He was taken to hospital and treated in the intensive care unit where he remained unconscious.

1.7 Following information received by Greater Manchester Police (GMP) Male A and Male B were arrested and charged with causing grievous bodily harm with intent to Peter. Peter died in hospital on 13 March 2016 following which Male A and Male B were charged with his murder.

[1] Pseudonyms have been used to replace real names before publication
[2] See Table 2 for a list of the addresses referred to in this report

1.8 GMP conducted a comprehensive criminal investigation and subsequently charged Male A with offences of robbery, theft and fraud with Peter as the victim. Male B was charged with two counts of theft and a fraud with Peter as the victim. Male C was charged with the robbery of Peter. Female A was charged with four counts of theft and two counts of fraud with Peter as the victim.

1.9 During a trial at a Crown Court in the North West it was reported[3] that Male A argued with Peter, stamped on him and left him in a heap on the ground. He waited for nine hours before calling an ambulance. During that time, Male A withdraw £800 from Peter's bank account which he later spent on drink and drugs. Male A then met with friends and gave them disturbing details of how he attacked Peter.

1.10 On 8 December 2016 Male A was convicted of Peter's murder and the associated acquisitive offences and sentenced to life imprisonment. He must serve at least 18 years. On the same day, Male B was acquitted of Peter's murder and convicted of the acquisitive offences against him. Male C was found not guilty of robbing Peter. Female A was convicted in June 2016 of the acquisitive offences against Peter.

1.11 Following the trial Peter's family said[4];

'Peter was much loved by all his family and friends. He was taken from us in March following a terrible attack on him in November last year. He was attacked in completely unnecessary circumstances. We cannot express how devastated we are that his life has been stolen from him. Peter is missed every minute of every day. He was vulnerable and preyed upon by people he thought were his friends. We can try to repair our heartache although no matter how long the sentence is, it will not bring Peter back or make our loss any easier. We need to attempt to move on and hopefully today will now provide closure for our pain over the last year, however, we will never forget Peter or the many memories he has given us. On behalf of the family, we would like to take this opportunity to thank Greater Manchester Police, and the Crown Prosecution Service for their continued support and professionalism in this matter'.

[3] http://www.wigantoday.net/news/man-jailed-for-life-for-murdering-flatmate-in-savage-attack-1-8279682
[4] Op cit

2. ESTABLISHING THE ADULT SAFEGUARDING REVIEW

2.1 Decision Making

2.1.1 The Care Act 2014[5] gave new responsibilities to local authorities and Safeguarding Adult Boards (SAB). Section 44 of that Act[6] requires SAB's to arrange for a review of a case when certain criteria are met. These criteria appear in Appendix A.

2.1.2 On 8th December 2016 Wigan Safeguarding Adult Board decided that Peter's case met the criteria and that a Safeguarding Adult Review (SAR) should be undertaken.

2.2 Safeguarding Adult Review Panel

2.2.1 David Hunter was verbally appointed as the Independent Chair on 22nd December 2016. He is an independent practitioner who has chaired and written previous adult and child serious case reviews, domestic homicide reviews and multi-agency public protection arrangement reviews. He has never been employed by any of the agencies involved with this adult serious case review and was judged to have the necessary experience and skills. He was supported in the task by Paul Cheeseman also an independent practitioner who brings the same experience and authored the report. Ged McManus, who has similar experience, assisted in the running of the learning event on 5 May 2017.

2.2.2 The first of 3 panel meetings was held on 2 February 2017. The panel established key lines of enquiry and asked agencies for a chronology of contacts. These were discussed at subsequent meetings at which the learning was refined and recommendations developed. Attendance at the meetings was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

2.3 Panel Membership

2.3.1 The panel comprised of representatives from agencies that had contact with and/or provided services to Peter. A full list of panel members is provided at Appendix B.

2.4 Agencies Submitting Information to the Review

2.4.1 The following agencies provided written material to the review panel.

- Greater Manchester Police (GMP)
- Wigan and Leigh Homes (WLH)

[5] Enacted 1st April 2015

[6] The specific requirements placed upon a Safeguarding Board by S44 of the Care Act 2014 are set out in Appendix A.

- Greater Manchester Mental Health NHS Foundation Trust (GMW)
- Addaction
- Wigan Council Locality Social Work Team (Locality Team)
- The Brick Project
- 5 Boroughs Partnership NHS Foundation Trust (5BP)
- Bridgewater Community Health Care NHS Foundation Trust (BCHC)
- Wigan Council Adult Social Care & Hospital Discharge Services (ASC)
- Wigan Council Support & Safeguarding Initial Assessment Team (IAT)
- Wigan Council Clinical Commissioning Group (CCG)
- Wrightington Wigan and Leigh NHS Foundation Trust

2.4.2 When all the Individual Management Reviews (IMR) had been received a learning event was held on Friday 5 May 2017. This was attended by representatives from the agencies involved and included practitioners, managers and IMR authors involved in the SAR. The purpose of the day was to identify key events, fill gaps in knowledge and identify key learning that would inform the SAR process.

2.5 Notifications and Involvement of Families

2.5.1 On 6 February 2017 the review chair wrote to Peter's brother to inform him of the review and invite his participation. To date a reply has not been received. Later that month the chair wrote to Female A, who was a friend of Peter and former wife of Male A in the same vein, again no reply was received.

2.5.2 A further letter was sent to Peter's brother on 10 July 2017 informing him that the review was almost complete and inviting him to see the report.

2.6 Purpose of a Safeguarding Adult Review

2.6.1 Section 44 (5) of the Care Act 2014 specifies:

Each member of the Safeguarding Adult Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

2.7 Terms of Reference

2.7.1 Following an analysis of the screening papers by the SAR panel on 2 February 2017 the following Terms of Reference were agreed;

1. What indicators of abuse did your agency have that could have identified Peter as a victim of abuse, including financial exploitation and what was the response?

2. What knowledge did your agency have that indicated Male A and/or Male B might be perpetrators of abuse, including financial abuse and what was the response?

3. What was your agency's understanding of the relationship between Peter and Male A and where did Male B fit in?

4. What consideration did your agency give as to whether Peter was a victim of domestic abuse?

5. What would be different about your agency's approach had Peter's victimisation been recognised as domestic abuse?

6. What did your agency know about Peter's mental health, alcohol use and self-neglect and were his complex needs taken into account when providing him with services?

7. Were there any barriers in your agency that might have stopped Peter from seeking help for abuse?

8. What knowledge or concerns did Peter's family and friends have about his victimisation and did they know what to do with it?

9. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Peter?

10. How effective was inter-agency information sharing and cooperation in response to Peter's needs and was information shared with those agencies who needed it?

11. Were single and multi-agency policies and procedures followed and were any gaps identified?

12. What managerial support did your agency provided to front line practitioners dealing with abuse involving Peter and was it effective.

13. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Peter?

14. What lessons has your agency learned?

15. Are there any examples of good, outstanding or innovative practice arising from this case?

2.8 Period under Review

2.8.1 1 January 2009 and 13 March 2016

2.9 Other Processes

2.9.1 Greater Manchester Police conducted a criminal investigation into Peter's death. HM Coroner opened and adjourned an inquest into Peter's death. It is understood HM Coroner proposes to conclude the inquest using an administrative process[7].

2.10 Family's Concerns

2.10.1 At the time of submitting this report to Wigan Adult Safeguarding Board the family had not responded to invitations to contribute to the review.

[7] Rule 25 Coroners and Justice act 2009

3. BACKGROUND

3.1 Family Memories

3.1.1 This section of the report summarises what is known about Peter from his early life up to the point at which he appears to have moved from Liverpool and became visible to services in the Wigan area around 2009. Some of the information was drawn from a victim impact statement provided by Peter's only surviving sibling, a brother.

3.1.2 Peter was born and raised in Liverpool and was one of four, then surviving, siblings (two other siblings died before Peter was born). Peter and his three brothers were raised in Liverpool where he attended infant and secondary school. His brother says Peter was very studious and a 'straight A pupil'. He was a good singer and visited Switzerland with his school choir where he performed as a soloist.

3.1.3 Peter's brother believes Peter suffered sexual abuse at the hands of strangers when he was young. Later in his life Peter mentioned to at least one professional that he was abused as a young person. His brother knows little about the circumstances, other than there was a court case, as Peter and his parents did not mention the incident[8]. Peter's brother believes that after these events Peter's mental health suffered and it contributed to Peter drinking heavily in adulthood.

3.1.4 Peter was very smart, always wearing suits and shirts that were immaculately pressed. After school Peter initially trained as a hairdresser before working a few seasons in various hotels. He then took employment with a firm of solicitors on welfare rights. He was employed in a large high street retailer's call centre and then by a large telecom provider as a team manager.

3.1.5 The death of a younger brother in 2004 seems to have been a turning point for Peter said his surviving brother. He says Peter seemed to blame himself for the death as he had not been at home, even though it was from natural causes. After this event Peter's surviving brother says Peter changed; he became belligerent towards people coming into the house and did not want them there.

3.1.6 Around 2008 Peter's brother says Peter told him he was moving out of his flat and was going into rehabilitation. However, his brother believes this was just some sort of cover story. After that point Peter's brother did not see him for some time. He says Peter telephoned him 'asking for a few quid'. After the death of their father Peter could not be found and it was only later that Peter telephoned and said he had heard their father had died. Peter had

[8] There was no information relating to this incident within the written material provided GMP for this SAR. However, given how long ago this incident occurred, it is unlikely that information about it has survived to be migrated onto computer records. The SAR panel believes Peter's brother's recollection substantiates the event took place and did not feel there was justification or value to be gained in asking agencies to conduct a long and potentially expensive search of archived records.

been left a small sum of money by his father. Peter asked his brother to pay this into a Halifax account. After Peter died his brother learned Peter did not have a Halifax account and he says he does not know who took the money. Someone close to Peter told his brother that Peter had asked Male A's aunt to lend him £1,000 because his father was dying. That person told Peter's brother they believed that was probably a fraud that Male A made Peter perpetrate.

3.2 Agency Records

3.2.1 Most of the information is drawn from records researched by Wigan CCG and held by GP services in Merseyside and Wigan. There are over 500 recorded contacts with Peter and these paragraphs summarise the importance issues from Peter's complex life. Peter had a history of anxiety and depression and poor mental health that stretched back many years. When 16 he visited his GP with depression having taken an overdose. He was compulsorily detained in hospital under the Mental Health Act on two occasions before he reached the age of 18 years. By the age of twenty he had made numerous attempts to take his own life by an overdose of prescribed medication or analgesia. During Peter's life, there are over twenty recorded incidents of this behaviour.

3.2.2 The panel felt it was noteworthy that within the medical records there are several early references to Peter's sexuality. The panel recognise the language used in those records and society's attitudes towards sexuality have changed significantly in the last nearly 50 years. The references indicate that, from his teenage years, there was concern about Peter's sexuality. One quote from 1971 states he was 'mixing with homosexuals as he finds them more interesting'. The panel felt that, given the prejudices that existed regarding sexuality in the 1970's, as an adolescent Peter would probably have been very guarded discussing his own sexuality.

3.2.3 The origins of Peter's depression may have been related to the deaths of two significant people in his life. The first related to a friend who died while Peter was an adolescent. Peter was supported by psychiatric services for some time following the death to help him come to terms with the bereavement.

3.2.4 In 1981 Peter disclosed to clinicians, following an overdose, that he had been gay since the age of 14 years. He also disclosed he was in a relationship with a male partner. The second death occurred when Peter was about 34 years age and lost his partner. It is not clear whether this is the same partner referred to in the entry from 1981. This second close bereavement precipitated an attempt by Peter to take his own life and bouts of excessive consumption of alcohol. Peter received counselling support for his loss.

3.2.5 From July 2004 there are references within Peter's records to a relationship with a male partner whose first name is recorded in medical records (It was not Male A). The notes state that Peter is having problems with this partner

who drinks too much and spends Peter's money on cocaine. This precipitated another overdose by Peter and his compulsory admission to a hospital mental health unit with acute paranoid symptoms. Peter expressed a desire to kill his partner and was said to have a history of cocaine, heroin and alcohol use. In October that year Peter was seen by a psychiatrist having complained of hearing voices telling him to kill his brother with whom he lived at that time.

3.2.6 Running parallel to Peter's depression throughout his adult life was his dependency on alcohol. Peter was known to be a heavy user of alcohol from his early twenties and his overdose attempts were accompanied by him consuming significant amounts of alcohol. There are many records within clinical agency notes that indicate continued attempts to control Peter's consumption of alcohol.

3.2.7 A letter to Peter's GP in March 2006 from mental health services is helpful in gaining insight into his mental state. In it Peter was described as 'manipulative', based upon the fact that he was telling people he would kill someone if the Crisis Team did not see him when demanded. That team reported Peter was making threats to harm others yet, when the police attended, he presented as being very nice.

3.2.8 Peter's mental health is described as deteriorating and then spiralling out of control from around December 2006. A risk assessment and management meeting heard he kept ceremonial swords and had thrown a sword at his partner before being questioned by the police. He continued to experience psychotic symptoms and received treatment.

3.2.9 In August 2007 Peter presented to the Royal Liverpool Hospital, he claimed to have fallen twice from a wall and suffered limb fractures. In November 2007, he rang his GP and said he had been beaten up the night before. In February 2008, he visited a hospital in Liverpool and had a crushed finger. While falling from a wall would be consistent with the type of injuries he had, no one appears to have explored the circumstances of this and the other presentations.

3.2.10 In September 2008 Peter was seen by the mental health team who wrote to his GP. Peter had taken an overdose claiming he had been beaten up and had money taken from him and this had been ongoing since 2006. The records do not indicate who the perpetrator was. It was around the beginning of 2009 that Peter was believed to have met Male A.

3.3 Peter's Relationship with Male A

3.3.1 One of the key issues this SCR has sought to explore, is what was known about Peter's relationship with Male A. Male A was frequently referred to by Peter as being his 'nephew'. There are many references in agency records which describe Male A as being a nephew and/or Peter as being his uncle, friend or his next of kin. On some occasions, Male A's first and/or second name appears. However, no evidence has ever been found to indicate there was a familial relationship between Peter and Male A.

3.3.2 The serious case review panel was assisted in its discussions at the professionals meeting on 5 May 2017 by a representative from the LGBT community. A strong possibility that was considered was that Peter and Male A may have been in an intimate relationship. The terms 'nephew' or 'uncle' may have been euphemisms for that relationship.

3.3.3 Before Peter's homicide no agency had a good understanding of the history of his relationship with Male A. A witness statement provided to the police as part of the homicide enquiry described how Male A met Peter after the former had been living rough on the streets of Liverpool. They had never met before. Peter bought Male A a drink, they got to know each other and Peter took him into his home and gave him somewhere to live. Male A later told WLH in a housing application that he was lodging with Peter in a flat in Liverpool. In the diversity section of that application Male A said he was heterosexual (see paragraph 3.2.5). Peter only disclosed his sexuality to one agency, the Brick Project.

3.3.4 The first reference to Male A in agency records is in July 2009 in a letter from Mersey Care NHS Trust to his GP. The letter spoke of a social worker who had seen Peter following an adult protection referral that had been made by a support worker. This worker expressed concerns that Peter had been beaten up by Male A, the pair were behaving in an anti-social way and bringing 'undesirables' back to the flat.

3.3.5 Since the homicide enquiry more information has emerged about the relationship between the two that clearly demonstrates the violence and abuse Male A perpetrated upon Peter. A witness has now disclosed to police that Male A bullied Peter into coming to Wigan to spend his money on alcohol. They describe two incidents when they saw Male A assault Peter. On the first occasion, the witness woke to the sound of Male A shouting, looked into the kitchen and saw him 'jump up off the ground like a wrestler…lifted his foot up and aimed a stamp with the heel on his foot that hit Peter on top of the head'.

3.3.6 The same witness also describes occasions when Peter and Male A were arguing. On the second occasion, the witness walked into a room and saw Male A punch Peter in the jaw. Having done this the witness says Male A got the money he had been asking for from Peter. The witness also described how the relationship continued to be abusive and Peter would say Male A was "was just the same and mithered him for money all the time". They also described how Peter arrived at their house with a black eye. He said he had fallen over although, when challenged, then said Male A had caused it.

3.3.7 This witness also corroborates what Peter later told a professional on 9.01.2013. Whilst at Douglas House Peter had white goods and a television that disappeared and were pawned. Peter disclosed he pawned his telephone because "Male A wanted some money".

3.4 Peter and Male A's Relationship with Male B.

3.4.1 There are no direct references within any agency records that connect the names of Male A, Peter and Male B. Male B first appears in agency records when he visited Housing Options and sought help saying his brother was paying for him to live in a hotel. In April 2013 Addaction recorded Male B as being discharged from treatment. He said he was staying at a friend's although he did not name him.

3.4.2 In January 2015 Male B started a housing application process with WHL. This was ultimately unsuccessful after Male B received a poor reference from a private landlord saying there had been anti-social events at the property.

4. TIMELINE OF SIGNIFICANT EVENTS

4.1 Appendix C sets out the known significant events in Peter's life during the period of the review. The source of the information is from records held by the agencies that submitted chronologies and reports following the decision to hold a SAR. During that period agencies recorded over 550 contacts or events involving Peter. To retain focus and clarity only those contacts or events judged by the SAR panel to be directly relevant are listed in the table. A commentary appears in section 5 of the report. The text in bold in Appendix C indicates occasions when Peter made a direct disclosure of abuse.

4.2 Peter, Male A and Male B were domiciled in several properties and table two at Appendix D sets out the known history of their housing applications and residency.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

5.1 Introduction

5.1.1 Each term is examined separately. Commentary is made using the material gathered during the SAR, including the family's views, and the panel's debates.

5.2 Terms One and Two

What indicators of abuse did your agency have that could have identified Peter as a victim of abuse, including financial exploitation and what was the response?

What knowledge did your agency have that indicated Male A and/or Male B might be perpetrators of abuse, including financial abuse and what was the response?

5.2.1 Terms one and two are considered together as there is some overlap between them.

5.2.2 There were at least twenty-three occasions during the period of this review when Peter made direct disclosures that he was the victim of physical, mental or financial abuse. These occasions are to be found in table one and the relevant comments are highlighted in bold text. There were several other occasions when information was known to agencies which, with further exploration, might have been an indicator that Peter was the victim of abuse.

5.2.3 On nineteen of the occasions when Peter made a direct disclosure of abuse he named Male A as the perpetrator or said it was his 'nephew'; a euphemism he used to describe Male A. On one occasion (26.03.2014) Peter named a man called Male C Jones as jointly perpetrating abuse upon him together with Male A. Peter never named Male B as a perpetrator nor did agencies have any direct or indirect information that he was perpetrating abuse upon Peter. One of the only references to Male B being present was on 16.05.2015 when police officers responded to a call from the Sanctuary that Peter could not cope anymore and Male B was present when the police attended.

5.2.4 When Peter did make direct disclosures of abuse, he would often later deny the event had taken place or would decline to report the matter. For example, on 19.02.2013 he contacted GMP by telephone saying he had been abused and assaulted. When visited by a police officer he denied anything had taken place. On 26.12.2014 following a call he made to NHS 111 to say he had been physically and financially abused, Peter was visited by a police officer. Again, he was reluctant to speak and did not wish to provide any further information. On 21.03.2015 Peter reported to GMP that he had been robbed by Male A. When a police officer attended Peter declined to pursue the matter stating it was 'all sorted'.

5.2.5 On only one occasion, other than the homicide enquiry, was a person arrested for an offence against Peter. This was on 26.03.2014 when Peter alleged he was set upon by Male A and Male C Jones, marched to a cash machine and forced to withdraw £50 which Male A took. Male A and Male C Jones were arrested although no action was taken against them as CCTV coverage was deemed not to corroborate the offence.

5.2.6 There were three occasions when agencies raised concerns that were passed to the IAT. These could have resulted in the referral being recorded and treated as abuse under the safeguarding policies then in place within Wigan. For several reasons that did not happen. On 27.03.2014 Peter disclosed that Male A had extorted money from him for ten years and had physically abused him. A member of staff from Recovery team North made a safeguarding alert to the IAT. In turn IAT passed the referral onto the Locality Team. While that was appropriate, consideration should have been given to formally identifying the issue as a safeguarding matter. That in turn may have led to a strategy meeting being held and the involvement of other agencies in trying to understand what was happening to Peter.

5.2.7 On 22.01.2015 Peter rang 111 and said he had been kicked in the kidneys. A police officer from GMP attended. While Peter did not wish to engage and made no complaint, GMP passed the information to IAT. Again, while the actions of IAT were correct in passing the contact on to the Locality Team, consideration should have been given to formally recording the matter as a safeguarding issue. Again, that might have led to a strategy meeting being held and the engagement of other partners in understanding the full picture of Peter's complex life.

5.2.8 On 26.05.2015 Peter contacted the Out of Hours Service. He said he did not feel safe at home and his front door had been kicked in. He said he had been staying with Male A and he had punched him. Peter refused medical treatment and did not want the police involved. The Out of Hours Service contacted IAT and made a safeguarding referral. Again, this was not formally recorded or progressed as a safeguarding issue and instead was passed to the Locality team to follow up.

5.2.9 The SCR panel felt these three events were missed opportunities to identify and assess the risks that Peter faced. The panel looked for explanations as to why these opportunities were missed. As part of its work the panel held a meeting with professionals on 5.05.2017 to explore these issues. The panel heard that much has changed since the time of these events in terms of policy and practice.

5.2.10 At the time of these events, the Safeguarding manager decided that Peter's case did not meet the threshold for safeguarding. The SCR panel recognise that threshold is subjective and there would have been several factors the manager had to consider in reaching a judgment. These may have included;

that Peter was inconsistent in what he said; there was difficulty in establishing the facts; he had been given advice and information and had declined support; he viewed himself as an independent person and he had capacity

5.2.11 The panel carefully considered whether the decision not to record this as a safeguarding matter was reasonable. The panel concluded that, based upon contemporary practice and the information available, the decision was reasonable. The panel felt that increasingly, in circumstances like this, the subject of these referrals is considered to have capacity. The panel recognised that professionals find this frustrating. They are being asked to support people with complex needs, yet these people choose to make choices that are contrary to the advice and pathways they are directed to[9].

5.2.12 In these circumstances, the panel understand that professionals can feel a sense of powerlessness. The panel felt that the case of Peter should serve to trigger wider conversations among professionals about complex needs. The panel felt a key issue for the future is that, just because someone demonstrates they have capacity, this should not be a barrier to a safeguarding referral being recorded. The panel felt that what professionals missed in the case of Peter was victimology[10]. They felt that, had this been a case of domestic abuse, then greater consideration would have been given to his experiences as a victim. The panel felt this was a more relevant point than whether or not capacity influenced the decision-making process.

5.2.13 In relation to the referral on 27.03.2014, while the matter was not recorded immediately as a safeguarding issue it was decided that the case would be discussed at the (then) 'safeguarding allocation meeting'. In practice, nothing happened until October 2014 by which time the decision was taken to close the case due to the time that had elapsed. The reason that happened is because there were then significant pressures and volumes of work within the Locality team and a lack of resources.

5.2.14 The SCR panel heard there is now a much better understanding of risk and greater capacity to deal with complex cases such as Peter's. While there is still a subjective test in place to determine whether a case reaches the safeguarding threshold, a complex dependency team is in place that steps in when a case, such as Peter's, does not meet that threshold yet requires intervention.

5.2.15 As well as direct disclosures of abuse, there were many occasions when Peter presented himself to agencies such as his GP and hospital with injuries. While Peter was supported and treated in terms of his immediate

[9] Since these events a Self-Neglect policy has been introduced in Wigan. The SAR panel heard that a case such as Peter's would now trigger the consideration of this policy.
[10] The study of the victims of crime and the psychological effects of their experience.

physical and mental health needs, there is no indication within his medical records that he was ever considered to be a victim of abuse.

5.2.16 The SCR panel considered why professionals may not have explored or questioned Peter more closely about these presentations. The panel were not able to identify with any certainty why this may have been and there are many possibilities. For example, Peter was deemed to have capacity[11] and that may have influenced his GP and other health professionals. Under the Mental Capacity Act people have the right to make unwise decisions and it may be that professionals accepted Peter's explanations on face value (i.e. he claimed to have fallen off a wall twice; on one occasion, he said he had been injured tripping over a child's toy-he was single and was not known to have children).

5.3 Term Three

What was your agency's understanding of the relationship between Peter and Male A and where did Male B fit in?

5.3.1 There is no evidence any agency ever closely explored the relationship between Peter and Male A. On most occasions Peter referred to Male A as being his 'nephew' or some occasions a 'friend' or 'flat mate'. It appears that most agencies simply accepted these explanations. Peter never referred to Male A as his 'partner' or said they were in an intimate relationship. On two occasions during the period of this review, when in contact with the Brick, Peter referred to himself as homosexual. This was the only direct disclosure of his sexuality that Peter made to an agency during the period of his review. However, there were direct references to his sexuality in historic GP and medical records although these were confidential and would not have been routinely disclosed to other agencies.

5.3.2 Similarly, Male A did not describe an intimate relationship and referred to Peter as his 'uncle' or someone he cared for. He frequently attended the GP practice and collected Peter's medication and introduced himself to staff there as his 'nephew'. When completing a housing application Male A was listed as claiming a carers allowance for Peter. On two occasions in 2013 and 2014, in the diversity section of housing applications, Male A referred to himself as heterosexual. In a witness statement provided to the homicide enquiry Male A was said to have introduced Peter to one his associates as an 'adopted grandad'. Male A never described himself as gay. Greater Manchester Mental Health NHS Trust recorded discussions with him that focussed upon his wife and children.

5.3.3 One of the factors as to why agencies were not able to fully explore and understand the relationship between Peter and Male A is because of their behaviour. Frequently either one, or both, presented to agencies having

[11] The Mental Capacity Act 2005 states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain.

consumed significant quantities of alcohol. This made it difficult for professionals to gain a coherent response. On many occasions Peter would make allegations while under the influence of alcohol and then would either have no memory when sober or, felt unable to make a complaint against Male A.

5.3.4 While Male B was also known to some of the same services used by Peter and Male A, other than a single contact by GMP on 16.05.2015, there is no evidence that any agency made a connection between the three of them. When the Community Safety Partnership was alerted to the death of Peter they screened the case to see if it fitted the criteria for conducting a domestic homicide review[12]. They concluded the criteria was not met.

Term Four

5.4 What consideration did your agency give as to whether Peter was a victim of domestic abuse?

5.4.1 An offence of domestic abuse is defined[13] as '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'. A nephew is not included within the definition of 'family member' which is restricted to mother, father, sister, son, daughter, brother and grandparents. In respect of the issue of intimate partners, there must have been some continuity and stability in the relationship and a reasonably supposed sexual aspect.

5.4.2 On 19.02.2013 the police officer who attended this incident was given varying accounts and asked a direct question as to whether this was an incident of domestic abuse. Peter denied it was. The incident was therefore not recorded as domestic abuse. The IMR author from GMP believes there was nothing to suggest the incident met the definition of domestic abuse. While the SCR panel now know much more about the relationship between Peter and Male A they have tried to base their findings upon the information professionals could have reasonably gathered at the time. As Peter denied the incident was domestic, and there was no other evidence to suggest it was, the SCR panel believe the conclusion reached by the police officer was therefore reasonable.

5.4.3 Wigan Locality Team were aware of both verbal and physical abuse that Peter suffered at the hands of Male A. The first of these occasions was on 10.01.2013 via a referral from the Recovery Team. The Locality Team offered Peter support which he declined. The same team were again aware on 27.03.2014 via a referral from the Recovery Team that Peter was saying Male A physically abused him and extorted money. While these incidents

[12] Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 and Domestic Homicide: Statutory Guidance: Home Office Dec. 2016. See also paragraph 5.4.1
[13] Greater Manchester Police Domestic Abuse Policy and Procedure V2.1 May 2015

were referred to as abusive they were not, at the time, referred to as incidents of domestic abuse. Except for the incident at 5.4.2, there is no evidence that any agency asked Peter directly if he was a victim of domestic abuse.

5.4.4 There were numerous occasions when Peter presented to his GP and at hospitals with physical injuries. There is little if any evidence that these injuries were ever satisfactorily explored and, on most occasions, either no explanation is recorded or the explanation given should have prompted more enquiry.

5.4.5 Peter's GP would have been aware from 2009 onwards that there were concerns being raised by other health professionals regarding Peter being the subject of abuse at the hands of Male A. From June 2015 onwards, Peter's GP should have been aware that Peter had disclosed to his psychiatrist that Male A had beaten him. This is because the psychiatrist sent the GP a report in which Peter's abusive relationship is mentioned. There is no record that Peter's GP ever explored that issue with him.

5.4.6 The SCR panel discussed why professionals, like Peter's GP, did not consider Peter to be a victim of domestic abuse and did not enquire further into the disclosures. The panel felt there were many possibilities. Firstly, no agency recognised that Peter and Male A fitted the criteria as victim/perpetrator in the definition of domestic abuse. While that may have been the case, the panel felt that should not have prevented further enquiry. Disclosures of abuse, whether in domestic or none domestic circumstances should still alert professionals to a need to enquire further.

5.4.7 The panel could not identify a definitive reason as to why further enquiry did not take place. They considered the following were possibilities; Peter was often inconsistent in what he said; his intoxicated state meant there was difficulty in establishing the facts; he had been given advice and information in the past and had declined support; he was reluctant to discuss and disclose his sexuality and viewed himself as an independent person.

5.4.8 While the important issue was to address the abuse Peter suffered, had these incidents been ones of domestic abuse, Peter might have benefited from enhanced services. The SCR know there are many reasons why victims in abusive domestic relationships choose not to disclose what has happened to them. By treating the incident as domestic abuse Peter's case might have benefited from enhanced services as set out in section five.

Term Five

5.5 What would be different about your agency's approach had Peter's victimisation been recognised as domestic abuse?

5.5.1 Most agencies have identified that, had they recognised Peter was the victim of domestic abuse, they would have implemented their domestic abuse

policies. In the case of GMP this would have resulted in the completion of a DASH[14] risk assessment. This would have resulted in a fuller picture being obtained of the relationship and a review by a domestic abuse specialist. It is possible Peter's case would have been considered by a MARAC[15] this in turn might have led to the allocation of an Independent Domestic Violence Advocate (IDVA) skilled in same sex relationships. All IDVA in Wigan are trained to deal with abuse in same sex relationships.

5.5.2 In relation to the robbery on 26.03.2014, given that Male A was charged and convicted of this offence following the death of Peter, the original decision to take no further action was potentially flawed. Had the robbery been recorded as a domestic incident GMP policy would have been to refer the matter to the Crown Prosecution Service. It is a matter of speculation as to whether they would then have reached the original decision, to take no further action, or whether they would have recommended Male A and Male C Jones be charged. Had there been a charge, Peter might have been offered safeguarding measures such as bail restrictions being placed upon the accused.

5.5.3 Wigan Locality Social Work Team recognised there was the possibility of domestic abuse upon Peter by Male A. Because of inconsistencies in Peter's explanation and some concerns over the validity of his accounts these events were not treated as either formal safeguarding referrals or cases of domestic abuse.

5.5.4 The IMR author for the CCG believes the underlying cause for not making further enquiry appears to have been a lack of awareness regarding domestic abuse within Peter's GP practice. It seems that neither his GP, nor other health professionals ever tried to unpick and understand Peter's relationships and his background. Even after the conclusion of the criminal proceedings, which generated significant media coverage, the IMR author spoke to staff at the surgery who were unaware the perpetrator was Male A. Lack of knowledge about domestic abuse means it is therefore unlikely the GP would have done anything differently beyond referring Peter to specialist physical and mental health services.

5.5.5 The SAR panel discussed the role of the GPs in this case. The GPs knew a great deal about Peter over the years that he visited the surgery. While the GPs made appropriate referrals regarding Peter's presenting clinical conditions, they did not make appropriate enquiry into his welfare. There were numerous missed opportunities to do this and the panel believe Peter's GPs could and should have submitted safeguarding alerts.

[14] Domestic Abuse, Stalking and Harassment Risk Assessment.
[15] Multi-Agency Risk Assessment Conference is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (Idva), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential.

5.5.6 The issue of mental capacity is important in considering whether agencies recognised domestic abuse. Peter had obvious vulnerabilities; he misused drugs and alcohol and led a complex life. However, he was always considered to have capacity to make decisions. Although there is no formal record of a mental health capacity test being routinely undertaken by agencies[16], there are numerous letters and reports from psychiatrists which determine that Peter had insight and good judgment despite his vulnerabilities and chaotic lifestyle. The SCR panel therefore believe it is possible that health professionals simply took the view that Peter was an adult, had capacity and was entitled to make decisions they disagreed with. While not good practice that would explain why there was a lack of exploration. (see also paragraphs 5.6.4-5.6.6)

Term Six

5.6 What did your agency know about Peter's mental health, alcohol use and self-neglect and were his complex needs taken into account when providing him with services?

5.6.1 Peter's GP appeared to be fully aware of issues relating to his mental health, alcohol dependency and self-neglect. As the CCG IMR author pointed out to the SCR panel 'he never gave up' on Peter in terms of his presenting conditions relating to mental health and substance misuse. Communication between the surgery and mental health services was good. Peter was recognised as having complex needs and was appropriately referred to specialist services.

5.6.2 GMW MH NHS Trust gathered a significant amount of information in relation to Peter's misuse of substances and his mental health. They undertook a comprehensive assessment of his need, a risk assessment, a health care assessment and care planning. His complex needs were well documented and given specific consideration when he was treated. Peter's mental health was also well documented by agencies such as IAT and was the main cause of concern.

5.6.3 Peter's mental health was a significant factor in his contact with GMP. Table one contains several instances when GMP have been called to attend incidents that involved Peter's mental health. These incidents often saw Peter in a state of crisis, with attending officers checking on his welfare and ensuring his safety. Overall police officers appear to have responded appropriately ensuring Peter was referred to hospital of mental health provision. Referrals were also made on many occasions to either adult or mental health services. There was only one occasion on 21.03.2015 when

[16] You may need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness of disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone. Source: Social Care Institute for Excellence http://www.scie.org.uk/publications/mca/assessing-capacity

the attending police officer did not recognise that Peter was vulnerable and required referral.

5.6.4 The SAR panel considered the impact of intoxication on the decision making in respect of Peter's "Capacity" to make decisions and the extent to which professionals took account of it. The advice set out by the NHS in their 'Choices' web page makes it clear as to how decisions regarding capacity should be made[17]. The guidance states that a person's brain or mind may be impaired by intoxication caused by drug or alcohol misuse. Capacity should be assessed at the time that consent for a treatment or investigation is required.

5.6.5 With some conditions (drug and alcohol misuse being typical) capacity can change over time. If a professional feels a person has capacity to give consent, their decision will be accepted and their wishes will be respected. If the professional feels a person doesn't currently have the capacity to give consent, and they haven't made an advance decision or formally appointed anyone to make decisions for them, the professional needs to carefully consider what is in their best interests before making a decision. The guidance goes on to state that, if someone makes a decision about treatment that other people would consider to be irrational, it doesn't necessarily mean they have a lack of capacity, as long as they understand the reality of their situation.

5.6.6 The SAR panel concluded that professionals appeared to understand the impact alcohol misuse had on Peter's capacity and when he did and did not have capacity to make decisions (albeit this was not always clearly documented-see paragraph 5.5.6). The SAR also panel felt there was good evidence of two services, Addaction and GMW working together to address Peter's misuse of substance and mental health needs. The SAR panel felt that, had a dual diagnosis approach[18] been in place when Peter was in treatment, this might have presented better opportunities to address his misuse of substances. The panel were assured that such a service is now commissioned in the Wigan area.

Term Seven

5.7 Were there any barriers in your agency that might have stopped Peter from seeking help for abuse?

5.7.1 Most agencies did not feel there were any barriers within their service which would have stopped Peter seeking support. Wigan Locality Social Work Team believe that the lack of a timely response by them to Peter's complaint of abuse on 27.03.2014 acted as a barrier. They believe that, if the referral had

[17] http://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Capacity.aspx

[18] Dual diagnosis' is used in the health services to describe people with mental health problems, who also misuse drugs or alcohol. Traditional treatment has been sequential or separate, as in Peter's case (i.e. The addiction and the emotional problem are treated at the same time but by different providers). Dual diagnosis seeks to address a person's needs in a more holistic manner.

been addressed in a more-timely way, Peter could have received support. When the referral was addressed, six months later, any impetus to gather evidence was lost.

5.7.2 While agencies did not feel there were barriers, the SAR panel concluded that mental capacity, in itself, was a barrier. Because Peter was either formally assessed as having capacity (on very few occasions) or, was simply deemed to have capacity without a formal assessment (on many more occasions), there were few if any pathways for professionals to consider beyond trying to persuade Peter that his choices were unwise.

5.7.3 Consequently professionals did not appear to see Peter as a complete person. There was no conversation between agencies as to how Peter's needs could be addressed in light of his apparent unwillingness to accept traditional remedies such as reporting his victimisation as a crime.

5.7.4 SAR panel members told the Chair that, since the creation of the MASH, they believe a case such as Peter's would now be identified at a much earlier stage, information shared and professionals would work together to develop a plan. The Chair challenged SAR panel members to demonstrate that the MASH was making a difference. SAR panel members were able to provide a number of examples of cases in which the presence of the MASH had made a positive contribution.

5.7.5 While reassured that processes such as the MASH are now in place, the SAR panel recognised it was important to regularly review these processes. This means regularly assessing the MASH is working as intended and that there is sufficient capacity to develop and deliver plans to deal with the volume of need. To this end the SAR panel feel it would be useful for the Adult Safeguarding Board to receive regular assurances by means of an audit or another method such as mystery shopping.

Term Eight

5.8 What knowledge or concerns did Peter's family and friends have about his victimisation and did they know what to do with it?

5.8.1 There is no information within agencies records that any of Peter's family knew about his victimisation or contacted agencies to raise concerns. Other than the perpetrators considered within this report (see section one of the report) Peter did not appear to have any other associates. GMW MH NHS Trust recorded that he was estranged from his family, except for his 'nephew'.

5.8.2 In June 2012 Peter told a housing officer when making an application for 11 Douglas House that he had been living with his parents. The SCR panel has not seen any evidence to support that statement. There are some brief references within agency records to two brothers who lived in Liverpool and with whom Peter stayed for a time. Peter said he would stay with this

brother when he visited the Brick on 27.03.2014. There is also a reference to the natural death of another brother. Peter has some family as they are referred to in a media release following the trial (see paragraph 1.11). The Chair of the SCR wrote to the family inviting them to take part in this review; they did not receive a response.

Term Nine

5.9 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Peter?

5.9.1 The Equality Act 2010 identifies several protected characteristics; age, disability, gender reassignment, pregnancy and maternity (which includes breastfeeding), race, religion or belief, sex, sexual orientation. It is unlawful for a business or public body to discriminate against anyone because of one or more of these protected characteristics. All the agencies involved in this case have policies in place to ensure they are compliant with the requirements of the Equality Act 2010.

5.9.2 The SCR panel found no evidence that Peter was treated less favourably because of any of these protected characteristics. Peter did not disclose his sexuality to any agency except the Brick when he visited there on 14.11.2014. Therefore, there were no opportunities for other agencies to ensure that services took specific account of this characteristic.

5.9.3 The Brick have identified that on 14.11.2014 more exploration could have taken place in relation to the risk that Peter faced of violence and sexual exploitation. However, the SCR panel do not feel the Brick provided Peter with a less favourable service because of his sexuality.

Term Ten

5.10 How effective was inter-agency information sharing and cooperation in response to Peter's needs and was information shared with those agencies who needed it?

5.10.1 Overall there appears to have been good sharing of information between agencies about the services they provided for Peter's immediate presenting health and social care conditions. For example, GMP made several referrals to agencies such as mental health and social care. Peter's health records are also very comprehensive and there is evidence of regular referral from his GP to specialist services. In return, there is evidence that specialist services such as mental health fed reports and information back to Peter's GP. There was also good evidence of information being shared between specialist mental health and substance misuse providers and GMW MH NHS Trust.

5.10.2 While agencies appear to have responded well and shared information on single issues of crisis involving Peter, each incident was dealt with as one

episode. No agency or group of agencies appear to have come together to try and unpick and understand what was happening in the complexity of Peter's life. Had Peter's case been assessed as reaching the threshold for safeguarding, that might have triggered a multi-agency strategy meeting. This would then have been an opportunity to bring agencies together and to form a collective understanding of Peter's vulnerabilities and led to a wider sharing of information and the development of actions that may have helped protect him. Whether those actions would have been successful are a matter of speculation. Certainly, some actions such as prosecuting perpetrators, would have required a degree of support and cooperation from Peter.

Term Eleven

5.11 Were single and multi-agency policies and procedures followed and were any gaps identified?

5.11.1 There were some occasions when policies and procedures were not followed. Most significantly this was the case in relation to the incident on 27.03.2014 when the Recovery Team made a referral that was passed to the Wigan Locality Mental Health Social Work Team (now known as Wigan Locality Social Work Team). This concerned Peter's disclosure that Male A extorted money from him and physically abused him. For the reasons set out in paragraph 5.7.1 this was not addressed as a safeguarding matter. While the incident should have been discussed at a meeting of the Locality Team that did not happen until 20.10.2014 when it was determined the case would be closed because of the amount of time that had elapsed.

5.11.2 Peter's GP held a significant amount of information relating to both direct disclosures of abuse and indicators of abuse such as injuries which were not satisfactorily explained. These were missed opportunities. A safeguarding alert from the GP might have been another opportunity to explore Peter's complex life and social circumstances.

5.11.3 The SAR panel has already concluded that Peter's GP's should have made safeguarding referrals (see paragraph 5.5.5). The SAR panel would like to have known why GPs did not make these referrals when they could have. They heard the practice was run almost entirely by locums and therefore it has been difficult to trace a GP who can personally recall dealing with Peter. The SAR panel feel it is very important that GPs are locked into local safeguarding processes, understand the important part they play and the value of the information they hold. Locum run practices do not lend themselves to the needs of complex people like Peter. Because there is no consistency between patient and clinician. The SAR panel feel there may be value in working with GP practice managers to develop an approach whereby vulnerable and complex people like Peter are 'flagged' and GP practices alerted that there are safeguarding concerns in respect of them.

5.11.4 While GMP identified that policy and procedure was followed on most occasions, they have identified a missed opportunity to identify Peter's

vulnerabilities. This relates to the use of 'flags' or 'markers' that can be placed on their Operational Policing System (OPUS) and on the Police National Computer (PNC). These allow records to be updated with information about a person's vulnerabilities; such as risk of harm on OPUS or mental health on both OPUS and PNC. The use of these markers may have alerted officers that Peter needed additional resource. For example, a function on OPUS allows for the creation of a 'Neighbourhood Policing Investigation' document. This might have been a useful tool to obtain a wider view and insight into Peter's life such as identifying his associates. However, the singular way in which each incident was responded to meant that no one person had an oversight of Peter nor took responsibility for coordinating a response.

5.11.5 The SAR panel identified occasions when it appeared that Peter or others made references to children being present. On 03.04.2012 Peter was admitted to a male psychiatric acute ward. When a care review was carried out on 05.04.2012 Male A spoke of an incident with a knife. He reported his wife telephoned the police as she was concerned for their two children's safety. Male A said he had a step daughter and a 7 month-old son at the property where he lived with his wife. Peter was living there as well.

5.11.6 On 04.04.2012 Peter applied for accommodation with Wigan and Leigh homes. He explained that his 'illness' had worsened and as such Male A's family feared for their safety and their children's safety and he would no longer allow him to stay.

5.11.7 On 10.01.2013 Peter said he was concerned about social care input as he said they had previous involvement with Male A and removed a child. This was reviewed at the time and no evidence could be found to substantiate any previous social care involvement with Male A.

5.11.8 On 18.03.2014 the Police National Computer records that Peter was served with a notice by Lancashire Constabulary under S2 of the Child Abduction Act 1984[19].

5.11.9 On 21.04.2015 the Tenancy Enforcement Team were involved with complaints concerning anti-social behaviour at address F. Residents said there had been an incident at the address that week, with people shouting and swearing and arguing between each other. A resident said it had now gone quiet and felt this was because Male A's children were staying with him.

[19] Section 2(1) of the Act provides that, subject to section 2(3), it is an offence for a person, other than one mentioned in section 2(2), to take or detain a child under the age of sixteen so as to remove him from the lawful control of any person having lawful control of him, or, so as to keep him out of the lawful control of any person entitled to lawful control of him without lawful authority or reasonable excuse.

5.11.10 On 22.01.2016, when Peter contacted 111 who in turn contacted the police, Peter expressed concern that Male As child would be removed from him. When the police attended Peter did not want to engage with them.

5.11.11 The SAR panel are concerned that none of these pieces of information appear to have been joined together and there does not appear to have been a robust assessment of what if any risks there were to children. It appears to the SAR panel that this represents a gap in policy compliance.

Term Twelve

5.12 What managerial support did your agency provide to front line practitioners dealing with abuse involving Peter and was it effective?

5.12.1 Most agencies identified that their professionals had access to managerial support and did not feel this was an issue in relation to the way in which Peter's case was dealt with.

5.12.2 Wigan Locality Social Work Team identified there was a lack of management resource within their service. They were without a manager until September 2014. The lack of resources did have a significant impact on the response to the safeguarding alert in March 2014.

5.12.3 The panel felt that, since these events occurred, there has been significant restructuring and additional resource provided within Wigan Council services. This means that a case such as Peter's would now be dealt with very differently.

Term Thirteen

5.13 Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Peter?

5.13.1 Several agencies did not identify any gaps in relation to capacity or resources, although some did. As set out earlier there has been significant restructuring of services within Wigan Council since these events. A revised and more efficient referral system is in place together with a Complex Dependency Team that would now take ownership for managing a case such as Peter's and coordinating support.

5.13.2 The SCR panel did not feel there was merit in undertaking a gap analysis in relation to the way Wigan Council Services were structured at the time of these events as so much has changed. However, the panel did feel it was important to acknowledge that a lack of capacity within Wigan Council Services did exist at that time and was a factor which impacted upon some aspects of the way in which Peter's case was dealt with.

Term Fourteen

5.14 What lessons has your agency learned?

5.14.1 These are set out in detail within section 6 of the report.

Term Fifteen

5.15 Are there any examples of good, outstanding or innovative practice arising from this case?

5.15.1 The fact that GP services prescribed medication fortnightly as opposed to monthly to reduce the volume of medication at Peter's disposal. This was helpful in terms of reducing the risk of overdose.

5.15.2 The Brick provided a very comprehensive service on 27.03.2014 and contacted every agency they felt could provide support or help to Peter.

5.15.3 GMW MH NHS Trust identified speed and ease of access of assessment for service and the multi-disciplinary approach to Peter's treatment and communication between health service providers.

5.15.4 GMP felt that the incident on 17.04.2014 was an example of an officer recognising that, although the matter did not meet the definition of domestic abuse, it was still worthy of considering applying the risk assessment and domestic abuse policy.

6. LESSONS IDENTIFIED

6.1 The panel's lessons, which are reflected in its recommendations, fall into the following seven areas.

1. The first lesson is that a lot of the work that was undertaken with Peter was isolated and not connected. The initial assessment lacked an understanding of the eligibility criteria for receiving a safeguarding referral and how the issues of mental health, alcohol misuse and depression fitted together. Peter's journey through services was punctuated, in many cases, by a lack of consistency in key workers and advocates who knew Peter and therefore owned and led the work in responding to his needs.

2. The second lesson follows from the first in that Peter was a member of a minority group and was someone who was hard to reach and/or engage. When working with someone like Peter there is a need for continuity and persistence that falls short of harassment. Peter would have benefited from consistent advocacy. It is important to ask direct and detailed questions to understand what is happening in the lives of people like Peter. It seems Peter was sexually abused as a child. Unresolved trauma in children can have significant consequences in later life which advocacy could have explored[20]. Assumptions should be avoided: because a service user has declined to report abuse on one occasion, that may not always be the position in the future. Abuse is abuse and each allegation needs to be thoroughly recorded and investigated and every contact with people like Peter made to count.

3. The third lesson concerns the number of occasions on which Peter presented at, or was conveyed to, the accident and emergency unit. Given the number of occasions this happened, questions should have been asked as to what was going on in his life. While the SAR panel recognised that Peter presented when the alcohol team were not available, it cannot be acceptable for patients to present at hospital intoxicated then sober up and walk out. The SAR panel have received reassurances that processes are now in place to identify and understand patients who have a higher than normal rate of attendance in accident and emergency units.

4. The fourth lesson is, that when making a referral there needs to be clarity as to what is being asked from the agency to which the referral is being passed.

[20] An increasing body of research identifies the long-term harms that can result from chronic stress on individuals during childhood. Such stress arises from the abuse and neglect of children but also from growing up in households where children are routinely exposed to issues such as domestic violence or individuals with alcohol and other substance use problems. Collectively such childhood stressors are called ACEs (Adverse Childhood Experiences). Exposure to ACEs can alter how children's brains develop as well as changing their development. Those with greater exposure to ACEs are more likely to go on to develop health-harming and anti-social behaviours, often during adolescence, such as binge drinking, smoking and drug use. Public Health Wales 2015: Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population

Making a referral must not just be a 'box ticking' exercise and needs to add value to the safeguarding process.

5. The fifth lesson is that processes for safeguarding need to have an escalation element built in so that staff who continue to have safeguarding concerns or receive further information know what to do if an initial referral is rejected. The SAR panel have received reassurances that the MASH, and complex dependency processes, have such a mechanism built in.
6. The sixth lesson is that GPs continue to be a weak link in safeguarding processes. They often hold the most valuable information and, while respecting patient confidentiality, GPs need to be encouraged to engage in the MASH and safeguarding processes.
7. The seventh lesson concerns the issue of children. Peter and Male A were involved in a complex and chaotic relationship. On at least six occasions that are documented by agencies there is information that indicates children have been present. That information was never connected and no agency appears to have adequately assessed whether there was any risk to children.

7. CONCLUSIONS

7.1 Peter was a vulnerable person who led a complex and sometimes chaotic life. He had suffered mental health issues from his teenage years and had misused alcohol from his 20's. Little is known about his early life and it is an issue of some regret that the SCR panel have not been able to engage with his family. They would have been able to help provide a more complete history of Peter and help paint a picture of who Peter really was.

7.2 In the absence of a contribution from his family, it is Peter's medical records that provide the most comprehensive picture of his life and stretch back the furthest. It is clear from an early age that Peter struggled with his sexuality. The SCR panel recognised that, for a young man like Peter in the late 1960's/early 1970's, given the prevailing culture, he would have been reluctant to disclose that he was gay. Indeed, the tenor of the medical notes from nearly 50 years ago, suggest Peter's sexuality was treated as a 'condition' as opposed to a matter of fact.

7.3 The loss of a close friend and then a partner (which the SCR panel feel it is reasonable to assume may have been a same sex relationship) clearly had a profound effect upon Peter. His misuse of alcohol and his frequent presentations with overdoses appear to have their genesis in respect of those losses.

7.4 The exact circumstances as to how Peter and Male A met are unclear. Male A had been married and had children. It seems he found himself homeless and in the Liverpool area where he met and formed a relationship with Peter. Who initiated that relationship is unclear, as is the motive for it. A witness who knew them both well suggests that it was Peter who took Male A into his home as he had nowhere to stay. The SCR panel considered the possibility as to whether Male A identified Peter from the outset as being vulnerable and initiated the relationship to extort him financially.

7.5 There is no evidence that Peter and Male A had any familial connections. However, they both referred to each other as being connected in that way. Peter frequently referred to Male A as his Nephew and Male A referred to Peter as his Uncle or adopted Grandad. Sometimes they said they were friends and on occasions Male A referred to himself as Peter's carer.

7.6 Neither of them ever made a direct or indirect disclosure that they were in an intimate relationship. While Peter disclosed that he was homosexual, Male A maintained that he was heterosexual and at one time he was known to have been married with children. The SCR panel have found no direct evidence from which they can conclude, with certainty, that there was an intimate relationship between them. However, this cannot be excluded. The SCR panel therefore believe it was reasonable that, based upon what they knew, agencies were also not able to reach a conclusion as to the nature of the relationship Peter and Male A.

7.7 Only one agency appears to have tried to explore whether there was a relationship between Peter and Male A that was domestic in nature. That

occurred on 19.02.2013 when a police officer asked Peter a direct question as to whether the incident he attended was one of domestic abuse. Peter said it was not. The SCR recognise the right to a private life[21] and that Peter was under no obligation to disclose the exact nature of his relationship with Male A. However, knowing the nature of that relationship might have helped agencies understand better why Peter chose not to engage and follow through his allegations of abuse by supporting a prosecution or other more assertive action[22].

7.8 It is now clear from the evidence adduced as part of the homicide investigation that Male A, and others, physically, mentally and financially abused Peter over a long period of time. There is direct evidence of at least one witness of Male A using significant physical force to assault Peter. The same witness provides evidence that Male A forced Peter to hand over money and made him pawn his own goods and property. The SAR panel felt it was entirely possible that Male A picked on Peter because he was vulnerable and would not fight back.

7.9 Peter made at least twenty-three direct disclosures of physical and financial abuse and named Male A as the perpetrator on at least nineteen occasions. The SAR panel gave careful consideration as to why none of those instances resulted in any positive action against Peter's perpetrators, save for the single occasion on 27.03.2014 when Male A and Male C Jones were arrested and released without charge.

7.10 The SAR panel recognise that, at the time these events happened, services within Wigan were configured differently. They heard there was a lack of capacity in teams such as Locality Mental Health and this led to a lack of clarity as to what action should be taken when someone like Peter does not reach the threshold for safeguarding. They were reassured that a Complex Dependency Team is now in place that will step in when someone like Peter does not meet the safeguarding threshold. They will now establish clear ownership for a case such as this and implement a package of care.

7.11 The SAR panel heard that there were continued efforts to try and engage Peter. In particular, good work was undertaken in responding to his mental health and his misuse of alcohol and drugs. However, when responding to support Peter could be inconsistent. This was particularly so when intoxicated. This meant it was sometimes difficult to get to the facts.

[21] Article 8 of the European Convention on Human Rights provides a right to respect for one's "private and family life, his home and his correspondence", subject to certain restrictions that are "in accordance with law" and "necessary in a democratic society".

[22] In a survey carried out by Her Majesty's Inspector of Constabulary (HMIC) the reasons the victims surveyed gave for not reporting the domestic abuse to the police were: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent). HMIC 2014: Improving the Police Response to Domestic Abuse https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf

7.12 Another factor the SAR panel identified was that many, if not all, of the incidents Peter was involved in were dealt with in isolation. Agencies dealt with the presenting condition, mostly to a good standard and then moved on. This meant incidents were dealt with in isolation and no agency or multi-agency looked at the 'bigger picture' and tried to find out what was going on in Peter's life. Again, the SAR panel was reassured that the development of the MASH[23] within Wigan has now changed the way professionals deal with incidents, share information and connect incidents. The MASH is co-located and there is sufficient resource to ensure the timely management of referrals. Enhancements include the presence of drugs and alcohol workers who can now be deployed a police officer to attend to people like Peter.

7.13 As well as direct disclosures of abuse, there were many occasions when Peter presented with indicators that might have suggested he was the victim of abuse. For example, Peter made twenty-seven attendances at Accident and Emergency in three years. Nobody at that time explored why there were so many. The SAR panel heard there have now been changes within the local accident and emergency department that means questions are asked when a significant number of presentations occur.

7.14 While there was good information sharing between health professionals and the GP practice, Peter's doctor did not probe Peter on how he came by injuries and there was no questioning of his social circumstances. The GP has now left the practice and has not been asked for an explanation. The SAR considered it was possible that his GP deemed Peter to have capacity and this meant he simply accepted Peter was not vulnerable and was therefore free to make unwise choices.

7.15 The presence of letters on Peter's GP file from mental health professionals stating Peter had insight might have been a factor. None the less the SAR panel felt there were several 'calling card' appointments that warranted further exploration. For example, 'slipping on a toy' which appeared implausible when Peter had no children in his house.

7.16 The SAR concluded its work by carefully considering whether, if these circumstances occurred again in 2017, would someone like Peter be better protected from abuse and would they receive a different response? The SAR panel believe policy and practice has improved and there has been significant investment in additional resources and partnership shared services like the MASH.

7.17 However, those alone will not guarantee vulnerable people like Peter will be protected. That will always rely upon the actions and judgments of individual practitioners. The SAR feel that Peter's case demonstrates how complex the lives of some people like him can be. Professionals need to be vigilant. While recognising that everyone has the right to privacy and can make unwise

[23] The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all professionals to report safeguarding concerns.

choices, professionals need to be prepared to ask direct questions when necessary.

9. RECOMMENDATIONS

9.1 The Safeguarding Adult Review Panel made the following recommendations:

1. Place Based Steering Group should construct a process and pathway through which consultation and engagement with GPs is developed and enhanced to ensure that safeguarding activity is inclusive of primary care identification and input. Group to provide evidence back to the Board that this framework is impacting positively on reduced demand and outcomes for individuals and families

2. Public Service Reform Steering Group and Board should implement and test the development of more appropriate service intervention and response to ensure the right intervention at the right time by the right service is offered across public sector entrance points across the Borough (to incorporate out of hours response, Live Well workforce expansion, Place Based roll out etc.)

3. Wigan Safeguarding Adults Board should assure itself the changes that have been implemented in relation to the receipt and handling of safeguarding referrals (MASH), and the service provided by the complex dependency team, take account of the lessons identified in this report, are robust and meet the demands of service users;

4. Wigan Safeguarding Adults Board and Children's Board should acknowledge and proactively plan for a redesigned approach regarding the current systems for children and adult safeguarding needing to align into a whole family framework and life course approach when the two issues are interdependent in terms of safeguarding solutions and resolution of risk.

APPENDIX A

SAFEGUARDING ADULT REVIEW CRITERIA

1. Section 44 Care Act 2014

Safeguarding adults reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

APPENDIX B

SAFEGUARDING ADULT REVIEW PANEL MEMBERSHIP

Name	Agency	
David Hunter	Independent Chair	
Paul Cheeseman	Independent Author & Support to Chair	
Ged McManus	Independent Support at the Learning Event	
Paul Whitemoss	Service Manager, Safeguarding	Wigan Council
Sarah Owen	Service Manager, Partnerships	Wigan Council
Rick Bolton	WSAB / WSCB Business Manager	Wigan Council
Carolyn Whalley	Independent Reviewing Officer, Adult Safeguarding Team	Wigan Council
Martin Ryan	MASH Implementation Manager	Wigan Council
Shona Speakman	Service Manager, Support & Safeguarding	Wigan Council
Annette McDonald	Advanced Practitioner, Adult Social Care & Health	Wigan Council
Leisel Pilling	Advanced Practitioner, Adult Social Care & Health	Wigan Council
Alison Troisi	Detective Sergeant, Specialist Protective Services, Serious Case Review Unit	Greater Manchester Police
Andrea Edmondson	Safeguarding Practitioner	North West Ambulance Service
Reuben Furlong	Assistant Director, Adult Safeguarding	Wigan Borough Clinical Commissioning Group
Margaret Jolley	Head of Adult Safeguarding	Wrightington, Wigan &

		Leigh NHS Foundation Trust
Nicola Compton-Jones	Senior Nurse Adult Safeguarding	Wrightington, Wigan & Leigh NHS Foundation Trust
Sarah Martin	Named Nurse, Adult Safeguarding	Bridgewater Community Healthcare NHS Foundation Trust
Sarah Shaw	Named Professional Safeguarding Adults	North West Boroughs Partnership NHS Foundation Trust
Nick Woods	Advanced Practitioner, Safeguarding	North West Boroughs Partnership NHS Foundation Trust
Lauren Crews	Team Leader, Housing Options	Wigan Council
Rebecca Beardsworth	Assistant Business Partner, Customer Services	Wigan Council
Aron Moss	Team Manager	Greater Manchester Mental Health NHS Foundation Trust
Daphne Dean	Operations Manager, Addaction	Wigan & Leigh Recovery Partnership
Louise Green	Operations Director	The Brick
Zak Bretherton	Chair and Co-Founder	BYou+ Wigan & Leigh
Jill Cunliffe	WSAB Business Support Officer	Wigan Council

Appendix C

TABLE 1-TIMELINE OF SIGNIFICANT EVENTS		
Date	**Event**	**Commentary**
22/3/12	Male A reports concerns to police about Peter's mental state and alcohol consumption.	Police visit Peter who is sober, can't remember previous night and says he is not at risk
3/4/12	Peter attends A&E saying he can hear voices telling him to harm himself and others. Male A is noted as living with Peter as his next of kin and his nephew. He is admitted to a psychiatric acute ward. Male A reports he is concerned about threats Peter has made and an incident with a knife. Male A says he had a wife and children and concerned for their safety.	
13/6/12	Peter attends A&E with head injury after fall. Had consumed alcohol and cannot recall how the injury occurred. He leaves the unit and the police are informed.	He leaves the unit and the police are informed.
13/8/12	A&E contact police with concern for Peter. He attended A&E with head injury, expressed suicidal thoughts and left.	Police find Peter with Male A. Peter says he injured himself after falling over. Refuses to attend hospital or speak to crisis team.
16/8/12	Male A telephones ambulance saying Peter has taken an overdose. Police attend and Peter taken to A&E. Male A reported as saying Peter had a knife. No weapon found.	
5/9/12	During comprehensive assessment by Substance Misuse Practitioner Peter said he lived with his nephew. He denied being in a relationship and said he had not fathered any children. Peter said he had threatened his Nephew with a knife. A multi-disciplinary team meeting followed and a planned treatment pathway started.	A risk assessment was conducted and there were no issues in relation to adult or child safeguarding
14/10/12	Information from a fast track incident report form **discloses that Peter is being financially abused** by Male A. Peter says he had reported this to the police.	This information was not passed to the Safeguarding Team.
23/10/12	During home visit by 5BP Peter talks about debt and	There is no indication

	says he has been assaulted by Male A who is his friend.	that any action was taken with this information.
8/11/12	Peter detained under S136 MHA. Admitted to MH Unit. Peter speaks about his 'friend' and **8 years of him financially and physically abusing Peter. He says Male A demands money from him** for Peter to see Male A's son who Peter cares about. Peter says he called police on 14/10/12 because of physical aggression by Male A. He says Male A encourages him to drink so that Peter will give him money. Peter said 'as long as I'm alive and he's got the child he's got a hold over me'	The 5 Boroughs Partnership record states 'Safeguarding Adults to be updated'. There is no indication this ever happened.
9/1/13	During appointment with substance misuse practitioner Peter says he received £1,000 inheritance and gave half to a friend he owed money to. Peter says he is aware that a community mental health nurse has made a referral about him being a vulnerable adult. **Peter says Male A has sold his TV, taken loans out in his name and is encouraging him to drink to try and obtain money from him.** [Administering a noxious substance?]	Peter was advised to contact the police. A referral was made by Recovery Team North to the Central Duty Team (now known as initial assessment team).
10/1/13	5BP make call to Adult Social Care and referral re Peter being vulnerable adult and victim of financial abuse. **Peter says Male A is the perpetrator**. He has taken Peter's brand new large screen TV and pawned it at Cash Converters. Male A has taken out a loan on the internet in Peter's name. Peter alleges this abuse has been going on a long time. Peter is concerned about social care involvement as he has experienced previous involvement when a child was removed. Professionals who visited Peter do not recall seeing a large TV.	It was decided this was not a safeguarding matter as Peter did not appear to be a vulnerable adult. A referral was made to the Locality 1/2 Mental Health Social Work Care Team.
15/1/13	Mental Health Team contact police after Peter tells them he is going to kill someone. Police attend. Peter is intoxicated and persuaded to attend A&E. He says voices are telling him to stab and kill other people. When assessed under the MHA he admits he is a danger to himself and others. During an assessment he **spoke about problems with his friend 'Male A'**. He says Male A asked for half of his benefits payment and sold Peter's TV at Cash Converters. He said he was not being blackmailed or bullied but just gave in willingly. He is often intoxicated but says Male A has no significant hold on him. He said Male A gives him alcohol. Peter is reluctant to contact the police.	
19/2/13	**Peter reported to police that he and Male A had been abused by a friend Male C Jones**. Police attended and are unable to obtain a coherent story other than there had been a dispute 2-3 days	Police attend. Peter denies he has been threatened with a knife and also denies

	ago. No crime was recorded.	this is a domestic incident
18/3/13	Peter attends A&E following heavy drinking and a fall. Doctor found no evidence of fall or head injury.	
23/3/13	Peter brought to A&E after being found unconscious and intoxicated in a taxi. Found to have a minor swelling on his left temple. Discharged home.	
24/4/13	Peter admitted to hospital after attended A&E with swelling to right eye and face following alleged assault.	
3/5/13	Peter attended A&E saying he had been assaulted. Kicked to back and ribs. Peter said it happened when he was walking his dog and a man asked him for a cigarette.	
13/5/13	Peter visited his GP surgery requesting analgesia for rib injury following an assault.	No record that enquiry was made into the circumstances.
14/5/13	Addaction call to see Peter yesterday at his home address. Full Risk Screen completed. Peter said he and a group of friends were abused as a child. Since then he has suffered with anxiety and more recently with hallucinations**. Peter explained that he put a lot of his drinking down to a friend who comes around to his flat and demands money and also brings round alcohol.**	
15/5/13	Peter disclosed to Addaction that he drank a lot because of his friend (no name recorded) who comes around to his flat and **demands money and brings alcohol**.	No safeguarding procedures initiated.
22/5/13	Peter was distressed and said Addaction he was **having trouble with his ex-flat mate Male A**. Peter said Male A let himself into his flat with spare keys and took all the food from his freezer.	Liaison between Addaction and CPN. No further exploration of the relationship and no safeguarding procedures initiated.
30/6/13	Peter reviewed by Wigan Mental Health Assessment Team after admission to hospital when intoxicated. Deemed low risk to self and may increase when under the influence of alcohol. Peter discharged home.	
3/7/13	Peter told Addaction he was still at Male A's house. Peter said he had received about £3,000 in benefits. Peter said **Male A took £1300. He said Male A had done this before**. Peter will never phone the police.	No safeguarding procedures initiated.
16/10/13	Peter attends appointment with CPN. Peter said he had stopped drinking and was hearing voices. Peter said he was £3,500 in debt with utilities, loans etc. He was signposted to citizens advice bureau.	
27/1/14	Police visit 8 Scholes Wigan looking for a young missing person. Male A and Peter present and	

	under the influence of drink.	
17/2/14	Male A makes housing application. Names Peter as a friend. Male A states he is heterosexual. No evidence of a relationships.	
5/3/14	Peter attends Claire House (5BP). Requests urgent assistance, says matter of life or death; either his or someone else.	No safeguarding procedures initiated and no follow up
18/3/14	On behalf of Lancs Const. Peter served with child abduction notice[24] regarding association between him and a young person.	
26/3/14	Member of public witnesses **Peter being robbed at cash point.** Male A and Jones are arrested. Peter refuses to press charges. Male A and Jones say Peter was repaying them money.	Male A and Male C are arrested. No further action is taken
27/3/14	A member of recovery team north makes a safeguarding alert to adult social care with concerns about Peter. Peter has told him that **Male A has been extorting money from him for 10 year**. **There has also been some physical abuse**. Peter talks about the incident at the cash machine. Peter says Male A has sold all Peter's 'stuff'. He is said to be frightened to go back to his flat and he has been threatened.	Initial Assessment Team pass the alert to the manager of the Mental Health 1/2 Locality Team. The referral is reviewed on 20/10/14 (see entry for that date).
27/3/14	Peter attends the Brick. He spoke about his friend being violent towards him and extorting money. **Peter said he had money stolen from him by Male A**. He said he is stopping with Male A. The Brick make calls to the Tenancy Service, Housing the Police and duty officer Mental Health. Peter spoke to the police and gave a statement over the phone. The police said the statement did not match the CCTV evidence. Peter wanted a move but he was not considered suitable at that time. Peter said he would stop with his brother in Liverpool area. The police provided reassurance it was safe for Peter to return home.	Risk Assessment completed. Significant work undertaken to provide support and assistance. This included enquiries with other agencies including police, duty mental health officer.
2/7/14	Peter was seen at Claire House. During a meeting he said he wanted to move from his present address at Scholes as he did not feel safe there.	No record that he was asked any questions as to why he did not feel safe.
8/8/14	Peter calls Care coordinator and describes 'dreams' of stabbing someone but acknowledges he has no plans to act on these.	
28/8/14	Police (DA Unit) make a safeguarding referral with concerns for Peter's mental health. Peter had contacted someone and said he 'wanted to kill	When visited by police Peter said he could not remember

[24] Child Abduction Warning Notices (or just 'notices' in police parlance) were formerly known as Harbourers' Warnings. They can be issued against individuals who are suspected of grooming children by stating that they have no permission to associate with the named child and that if they do so they can be arrested under the Child Abduction Act 1984 and Children Act 1989. Source: Parents Against Sexual Exploitation: http://paceuk.info/for-parents/advice-centre/disruption-tools-available-police/

	somebody'. Peter had not been taking his medication.	making the call. Male A was present when the police attended.
8/10/14	Peter attends A&E saying he has thoughts to injure 'jihadi people'. He was arrested for carrying an offensive weapon, racially aggravated graffiti. He was seen and assessed by the RAID team and deemed fit to detain. He told the police he could not return home because he had an argument with Male A.	He was charged with the threats to kill and carrying an offensive weapon and remanded in custody.
9/10/14	Seen in custody by care coordinator following his arrest at Wigan Infirmary. He said he could not return home due to an argument with Male A.	This information was not shared with safeguarding.
20/10/14	Strategy discussion regarding safeguarding referral of 27/3/14. Case closed.	A decision was taken to close the case due to the time elapsed and whether any interventions would now be effective. Peter was deemed to have capacity to make decisions about his relationship with Male A and in respect of reporting matters to the police.
14/11/14	Peter released from custody and presents at welfare desk customer services seeking support as he had not been paid benefits. He then visited the Brick during which he disclosed that he was homosexual.	No record as to whether Peter was with someone when he visited. Following what Peter disclosed on 27/3/14 questions could have been asked as to whether he was still suffering violence from Male A.
25/11/14	Assessment team informed care coordinator that Peter rang saying he didn't feel safe in the Wigan area. The care coordinator telephoned Peter. He said he was OK and was returning to Liverpool to be near his family. He did not want to return to Male A's as they had argued.	There is no record that any action was taken to address Peter's concerns. The matter was not reported as a safeguarding issue.
26/12/14	NHS 111 call police and say **Peter has informed them that 'nephew' Male A is physically and financially abusing him.** Complains of kidney pain following assault but says he does not want police involved. He says he is obliged to live at Male A's address as Male A has sold all Peter's belongings. Police attended and Peter refused to discuss the content of the call. Peter asked the officer to leave when the officer started asking	A police officer attends. Peter is reluctant to speak or provide further details. A referral is made to Adult Social Care. No enquiries made with 111

	direct questions about abuse.	
29/12/14	Peter told the deputy team manager in the recovery team that he did not feel safe in the Wigan area or where he resided. He was questioned and did not say where he was moving to, only that if he stayed in Wigan he would 'end up in a box'. He said his probation officer had concerns about him remaining in the Wigan area and that people were out to target him.	Peter was advised to contact the police. No contact was made with his probation officer or his care coordinator. No record that a safeguarding alert was made.
22/1/15	Peter rang 111 and said he had been kicked in the kidneys by Male A. Police attended and Peter did not want to engage.	GMP pass this information to the Initial Assessment Team. A safeguarding alert is not raised and a contact is sent to the Mental Health 1/2 Locality Team.
3/2/15	Peter visits Psychiatric Outpatient Clinic, Claire House. Says he is living with nephew whom he supports and looks after. Describes feeling safe in his current living environment.	
21/3/15	Peter called the police and **said he was the victim of a robbery by Male A who had kicked him in the face and stolen his wallet.**	A police officer attended. Peter was intoxicated and declined to provide details. Peter's vulnerability was not recognised and no referrals were made.
24/3/15	Peter attended GP surgery stating he had been kicked in the ribs by a drunk man.	No record that enquiry was made into the circumstances.
25/3/15	Peter attended A&E. Said he had been kicked to chest. X-ray showed old rib fracture.	
10/4/15	Peter attends the walk-in centre with a rib injury. He says he was kicked about 3 weeks ago.	Peter was not asked about the event or who the perpetrators were.
17/4/15	The resident of a neighbouring property on Withington lane called the police reporting that a male had knocked on the door asking him to call the police as the people inside 114 were 'falling out.'	
21/4/15	Peter attended his GP surgery with ongoing pain following assault.	No record that enquiry was made into the circumstances.
21/04/2015	Tenancy Enforcement Team contacted residents of 112 Withington Lane . The tenancy enforcement team had been ringing the resident on a weekly	

	basis, to discuss any incidents at the property. The resident advised that there had been an incident at the address that week, whereby visitors to the property where shouting and swearing and arguing between each other. The resident advised that things had been quiet following this incident however they felt this was due to the fact that Male A's children were staying with him, when the children are there; there are no issues however the problems start again when they leave. Arrangements made to contact resident again the following week to see how things had been.	
30/4/15	Peter told his care coordinator his flat had been broken into and he was desperate to leave the Scholes area.	Peter was not asked why he wanted to move out of the area.
16/05/2015	Police received a call from the Sanctuary crisis centre in Wigan expressing **concern for the welfare of Peter who had disclosed he could not cope any more as his 'nephew' had taken away his medication.**	Police officers attended and found Peter at a bus stop where he had taken quantities of medication. He was left in the care of Male A and Male B awaiting an ambulance. Peter was not spoken to about the information he provided to the Sanctuary. The incident was reviewed by PPIU but no referrals made to other agencies.
17/05/2015	Attended A&E, 'nephew' brought him to A&E stating that he had taken an overdose Peter denied this, however it is documented that he later admitted he had taken an overdose of Quetiapine. CT on head carried out no acute intra cranial haemorrhage. It is stated on his A&E notes that a referral to be made to RAID. Peter denies he has a nephew or cousin.	
18/05/2015	Reviewed by ASN, he stated he was living with his nephew as his door had been kicked in. previously worked with alcohol services discharged June or July 2014. **He expressed a concern his nephew will take all his money out of his bank account as he has his bank cards**. Stated he had previously taken £700 when he was in prison. Plan: Refer to Vulnerable Adults team, Referred to Community Alcohol services, appointment made 19/05/15 13.30. EC was discharged on 18/5/15	
26/05/2015	Peter contacted out of hours service advising that he doesn't feel safe at home. His front door had	A safeguarding alert is not raised. A

	been 'kicked in' a few weeks ago and he has been stayed with various people since. **Peter was staying with Male A who has punched him and he was told to leave.** Peter refused medical attention or police involvement. It was agreed that Peter would go and stay with another friend tonight and visit housing the following day.	contact is sent to the Mental Health 1/2 Locality Team.
27/05/2015	EC seen by his care coordinator, states that he has not had the new door on his flat yet and is therefore unable to gain entry to his flat. States that he has been to housing and they cannot give him a date for new door to be put on. Having difficulties with friend Male A and that he stayed at another friend's yesterday evening.	
03/06/2015	Peter telephone probation officer and expressed inability to cope and intention to kill himself by taking all tablets. **Stated he is being exploited by friend Male A who is taking his money** and has been living with him for some time now as own flat inhabitable. Peter does most of the domestic chores. However, Male A allegedly beats him at times. They have been friends for approximately 10 years. He was experiencing auditory/command hallucinations and remained extremely paranoid.	Peter lacked insight re his rapidly deteriorating mental health. He is a risk to himself and others, therefore necessary to admit him to psychiatric unit for assessment, treatment and management. He agreed to informal admission.
03/06/2015	Admitted to MH Ward informally He spoke of **struggling to cope with his friend Male A exploiting him.** On admission, he reported voices telling him to kill Male A (friend/nephew) and himself. Peter reported living with nephew and not having any problems with living arrangements. On ward was reviewed 04/06/15 – was unwilling to fully disclose details of his dispute with his friend.	
08/06/2015	While on a ward Peter reported he lived with **Male A who sold his possessions** so they were unable to buy a flat to live in. Peter said he did not like it previously where he had resided before as he was 'beat up' in the area. Peter has outstanding debts due to damage that he made inside his accommodation. EC has been taking out loans which may come to a total of around £5,000 with interest. **He says Male A makes him take the loans out and that he is then put into a position where he can't say no. Male A takes half of the money, mainly which has been spent on alcohol.** Peter was encouraged to contact the police and give a statement regarding his alleged exploitation but he declined. He has capacity to understand his choices and make a decision.	Peter Discharged on 11/06/15 when the records show a safeguarding referral was made and that the hospital ward would contact the police. The safeguarding team state they were not made aware of this referral.

25/08/2015	Further visit to the Brick by Peter for a food parcel. He says he drinks, uses cocaine and cannot manage his money.	No record as to whether Peter was with someone when he visited. Following what Peter disclosed on 27/3/14 questions could have been asked as to whether he was still suffering violence from Male A.
20/10/2015	Peter made an application to transfer properties from 11 Douglas House, Scholes to another WALH property. Peter was supported in completing this application by senior nurse practitioner. Peter stated on the application that his reasons for moving were further to him being attacked whilst he was out walking his dog in June that year. Peter also explained that he had been burgled on 3 occasions. Senior nurse practitioner feared that Peter was at risk of exploitation and that Peter had already had money and furniture taken by residents in the Scholes area.	
25/11/2015	Peter brought to A&E by ambulance with head injury, was last seen out at 06.00hrs, found unconscious, lying in vomit, significant head injury. Admitted to ICU.	
13/03/2016	Peter died in Wigan royal Infirmary.	

Appendix D

Table Two: List of Properties				
Address	**Date**	**Peter**	**Male A**	**Male B**
Address A-Wigan	2011			Claimed he lived here for 10 years when attending homeless interview.
Address B-Ince	April 2012	Stated on housing application he lived there with a friend.	Listed on housing application as nephew and living there.	
Address C-Atherton	June 2012	Temporary accommodation while waiting for permanent address.		
Address D-Wigan	June 2012 & Jan 2013	Tenancy agreed.	Gave this as his co-address when making a housing application.	
Address E-Ince	April 2013		Tenancy agreed.	
Address F-Wigan	February 2014		Obtained tenancy because 8 Scholes Ave too small.	
Address G-Atherton	February 2015	Offer of sheltered accommodation made following request by Peter. He refused it.		

End V0.3 Wigan SAR 'Peter'