A DOMESTIC ABUSE RELATED DEATH REVIEW (DARDR)

Richard

November 2022

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Pen Picture

1. Richard [1] is described as a “gentle soul” who was a “lovely man” that people “were happy to see”.

2. Tributes on social media after Richard’s death included someone who helped provide transport for Richard when he was at school. Another person who also knew him from the school described him as “an angel at heart” and “a pleasure to know”. Others described Richard as being polite and a pleasure to see.

3. Contemporaneous school reports described Richard as kind and caring, and that he enjoyed music, playing musical instruments and occasionally dancing. He was a keen member of school drama productions and could be enthusiastic about art. Richard sometimes lacked confidence in his creative ability. He enjoyed physical education and represented the school in football and benchball matches with other schools. Richard had a good sense of humour, a positive and enthusiastic attitude and worked hard.

4. Richard’s class tutor’s last individual learning plan for Richard before he left school to go to college is commented on.

5. *“What a fantastic young man you have matured into. You have a wonderful, caring nature for everyone around you – staff and students alike, and that is why you are so popular and so highly thought of by the teachers and your fellow students. I wish you all the best at college; you deserve your place there, and they are lucky to have someone like you. You’ll be a real asset to them*”.

6. The school records say that Richard’s speech and language were difficult to understand. The school also says that Richard had a good understanding of money and was able to solve simple money problems, complete calculations in his head and check that they were correct.

7. The school also described Richard as having low self-esteem and experiencing difficulty in managing disappointment and controlling his temper. This is discussed later in the report within the context of his adverse childhood, including abuse, and his discriminatory experiences as a person with a learning disability.

8. The college that Richard attended after leaving school had information about people in Richard’s extended family who had been significant to Richard before their deaths. This included an aunt and an older sibling, along with an uncle and a cousin, whose deaths at different times were difficult and distressing for

[1] Pseudonyms are used for all named individuals in this report. The names were selected to reflect cultural and ethnic identity.

him. No other service had this information about multiple and significant bereavements.

Introduction

9. This DARDR examines the response of organisations and the appropriateness of professional support given to 28-year-old Richard, who was murdered in 2022 by Keith (54) and Mandy, his partner (60).

10. In addition to any recent agency involvement, the review also examines the past to identify any relevant background or trail of abuse or neglect before the death; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

11. The key purpose for undertaking a DARDR is to enable lessons to be learnt from deaths where a person dies as a result of violence, abuse or neglect by a person related to the victim, has been in an intimate relationship or is a member of the same household.

12. For lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

Condolences to Richard's family

13. Sincere condolences and sympathy are extended to Richard's family on behalf of the Domestic Abuse Related Death Review (DARDR) panel responsible for completing this review and the Tamworth Community Safety Partnership (the CSP), which commissioned this DARDR.

Timescales

14. The Chair of the Tamworth Community Safety Partnership agreed that the circumstances of Richard's death were likely to meet the criteria for a statutory DARDR, although they postponed commissioning work on the DARDR until the police and CPS were able to conclude what, if any, criminal charges would be made. Initial scoping information was collated in 2023, although a scoping panel was postponed until 2024, when it was hoped there would be better clarity about the circumstances of Richard's death and any potential charges.

15. The initial panel met in July 2024. The police investigation was still open and waiting for a pathology report. The independent reviewer wrote to Richard's

parents telling them about the review. This initial letter was delivered by the FLO and included information about advocacy and support, including AAFDA and the Home Office information for families.

16. A decision about criminal charges had not been made when the draft report was submitted to the Home Office in 2025.

17. The timeline for the DARDR is from 2015, when Richard moved to live with Keith and Mandy, until the date of Richard's death in November 2022.

18. In addition to recent agency involvement, the review also examined the past to identify any relevant background or trail of abuse or neglect before the death; whether support was accessed within the community and whether there were any barriers to accessing support.

Confidentiality

19. The findings of a DARDR are confidential as far as identifying the subjects of the review, their families or the professionals involved. Information is available only to officers/professionals and their line managers who participated in the DARDR. Pseudonyms are used in the report to protect the identity and provide privacy for the people who are the focus of the review. Professionals are referred to by their roles, such as health care professionals, GPs, etc. A glossary is included as an appendix.

Pseudonym	**Relationship**
Richard (28) (white British)	The subject of the review
Keith (54) (white British)	Stepbrother
Mandy (60) (white British)	Stepbrother's partner

Methodology, scope and terms of reference

20. The methodology of the review complies with national guidance. This includes identifying a suitably experienced and qualified independent person to chair and provide this overview report for publication.

21. The initial scoping panel agreed on the list of services that would be asked to provide an individual management report, although none of the services had substantial contact. The detail is provided in paragraphs 35-36.

22. The timeline for the DARDR is from 2015, when Richard moved to live with Keith and Mandy, until the date of Richard's death in November 2022.

23. The review gave careful and regular attention to how family, friends and support networks could be identified and encouraged to contribute to the review.

24. Agencies contributing reports or information to the DARDR used the terms of reference set out in national guidance with additional general areas arising from the particular circumstances of this DARDR as described in the following scope of the review. This included;

    a) Was Richard an adult at risk with care and support needs because of his learning disability, and did this mean that he might not be able to take care of or protect himself from significant harm or exploitation?
    a) Were there opportunities for the Care Act or other referral pathways to be used, and were they? Were there opportunities for Care Act assessments to be completed, and were these timely and effective in identifying Richard's care and support needs and the capacity of family or friends to meet those care and support needs?
    b) Is there any information that would suggest that either of the adults with whom Richard lived would present a risk of harm?
    c) Were there any opportunities for any service to seek, record and act upon Richard's views, wishes and feelings?
    d) Are there specific considerations around equality and diversity issues arising from Richard's disability that require special consideration? Were any reasonable adjustments considered?
    e) Were the two adults with whom Richard lived ever considered or expected to act as carers for Richard?
    f) Were Covid, organisational arrangements or working arrangements with other services a factor in how services were provided to Richard or other members of the household?
    g) With the benefit of hindsight, is there anything that might have been done differently?

25. Additionally, the panel considered terms of engagement with Richard's family, which was complicated by an active police investigation involving the extended family members with whom Richard was living before he died.

26. The review continued to give careful and regular attention to how any family, friends and support networks could be identified and encouraged to contribute to the review.

27. The panel also considered any other reviews (DHRs or SARs[2]) that had identified findings relevant to the circumstances being examined by this DARDR.

[2] Domestic Homicide Review (DHR) and Safeguarding Adult Review (SAR)

28. For example, the Domestic Homicide Project, based on the Vulnerability Knowledge and Practice Programme, established by the National Police Chiefs' Council and the College of Policing, published a spotlight briefing in November 2022[3]. One in six domestic-related deaths involved a caring relationship. Where neglect was present, most victims and perpetrators had no previous contact with police, but most had previous involvement with health agencies and/or adult social care. The pandemic made it more difficult for vulnerable carers and those receiving care to get access to support.

29. Specific reviews that reflect the circumstances of this DARDR have included *SAR Gemma* (WSAB) which identified inadequate arrangements for a person with a learning disability without a clear diagnosis to access specialist health and social care services, non-completion of Mental Capacity Act (MCA) assessments, adult safeguarding thresholds being focussed on single significant events rather than cumulative lower-level concerns about neglect, no systematic arrangements for agencies to give or request feedback following referral or contact. The *DHR Emma* (NYCSP) identified inadequate attention to the assessment of care and support needs. Poor transition from children to adult services, not well managed, is also highlighted in national reviews, along with economic/financial abuse.[4]

30. DHRs (now DARDRs) and SARs nationally consistently highlight how carers report how stressful they were finding caring for an adult with additional needs, such as a learning disability, and are not being offered an assessment of their support needs. A general lack of curiosity about how stress was manifested in their interactions is also a theme that consistently comes up. The role of advocacy (including IMCAs [5]) in ensuring the voice of people with a learning disability is heard and understood is another recurring issue in reviews nationally.

Involvement of family, friends, work colleagues, neighbours and the wider community

31. Richard's mum and dad did not want to have any involvement in the review. They accepted an initial letter from the independent reviewer, which was delivered in person by the police family liaison officer (FLO), but they declined to accept any other contact, including telephone discussions. They did not wish to talk about what had happened and said that it would "bring their nightmares

[3] https://www.vkpp.org.uk/publications-and-reports/

[4] There is a definitional distinction between financial abuse and economic abuse. Financial abuse is a part of economic abuse but is behaviour specifically targeting an individual's money and finances rather than wider economic resources, such as independent transportation, a place to live, employment, and education/training.

[5] Independent mental capacity advocates (IMCA) are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

back". The initial letter included information about advice, help and support, including specialist advocacy offered by AFFDA[6].

32. Richard's parents were told that this draft report had been completed and would be submitted to the Home Office.

33. It was not possible to speak to Keith or Mandy, with whom Richard was living at the time of his death, because of the ongoing police inquiry into the circumstances of Richard's death. As a result of those inquiries and consultation with the Crown Prosecution Service, Keith and Mandy were charged and subsequently convicted in 2026 of murdering Richard.

Contributors to the review

34. More than 30 organisations in Staffordshire were contacted as part of the scoping for the review to inquire about any contact and knowledge they had about Richard, Mandy or Keith. Of those who confirmed having contact and information, all were asked to provide a chronology. An individual management review (IMR) was requested for organisations with substantial contact or information. Reports were written by people who were independent of the events being examined and of suitable experience and knowledge.

35. The following organisations provided an individual management review:
    a) Department for Work and Pensions (DWP); IMR
    b) GP medical practice; IMR
    c) Staffordshire Police; IMR
    d) Staffordshire County Council Adult Social Care Services (ASC); IMR
    e) Tamworth Borough Council Housing (TMBC); IMR

36. Summary information was provided by

    a) Adult Learning Disability Team (ALDT)
    b) Assist Advocacy
    c) Children's services about any historical involvement with any of the subjects or their respective families.
    d) Education about any record of SEND, diagnosis and transitional arrangements from school to adulthood for RB.
    e) Humankind's historical contact with KMN and MJ
    f) Independent Futures about historical contact
    g) Midland Partnership Foundation NHS Trust.
    h) South Staffordshire College
    i) Staffordshire Carers
    j) University Hospitals Birmingham NHS Foundation Trust.

[6] Advocacy Following Fatal Domestic Abuse (AFFDA) provide expert and specialist advocacy for families and friends bereaved through deaths following domestic abuse.

The review panel membership

37. The panel was chaired by the author of this report. The first meeting of the panel was in July 2024. The panel members were independent of case management or decision-making involved in the events examined by the DARDR

Organisation	Job title or role	Attendances
Chair and author	Peter Maddocks Panel chair and author of the report	5/5
Advocacy Matters	Stefan Carter Senior Human Rights Advocate	5/5
Department for Work and Pensions (DWP)	Karen Hartley Advanced Customer Support Senior Leader	5/5
Midlands Partnership NHS Foundation Trust (MPFT)	Julie Turner Named Nurse Safeguarding	5/5
New Era Domestic Abuse Services	Chantelle Thompson Head of Service	5/5
North Staffordshire Combined Healthcare	Laura Collins Named Nurse for Safeguarding	5/5
Queen Elizabeth Hospital	Sarah Dempsey Safeguarding Nurse	5/5
Staffordshire Police	DI Lisa Holland (SIO) Samantha Tweats Statutory Review Manager	5/5
Staffordshire and Stoke-on-Trent Clinical Integrated Care Board (ICB)	Heidi Watts Designated Nurse for Safeguarding Adults.	4/4
Staffordshire County Council Adult Social Care Services	Charlotte Barr Safeguarding Team Leader	4/5
Staffordshire County Council Adult Learning Disability Services and all age carers	Rebecca Whiteman Service Lead ALDT South	4/5
Staffordshire County Council Adult Services	Heidi Poole Service Lead Transitions Team	4/5
Staffordshire County Council Children's Services	Oluwenmimo Kolawole, Deputy District Lead	4/5
South Staffordshire College	Nicola Truman Safeguarding Officer	5/5

	Deputy Designated Safeguarding Lead (DDSL)	
University Hospital North Midlands	Simone Rushton	1/1
Tamworth Community Safety Partnership	Lisa Hall Safer Communities and Homes Manager	5/5
Tamworth Community Safety Partnership	Joanne Sands Assistant Director Commissioning Officer – Community Safety	4/5
Staffordshire County Council	Alice Walters Commissioning Officer	5/5
Staffordshire and Stoke-on-Trent Adult Safeguarding Board	Helen Jones SASSAB Manager (attended the scoping panel before retirement)	1/1

The author of the overview report and chair of the review panel and the statement of independence

38. Peter Maddocks is the independent author of this report and chaired the panel. He has worked in local authority, voluntary and national services in senior and practitioner roles. These have included working with families and children harmed by domestic abuse, including work on policy and service development, as well as direct work. He is a qualified and registered social worker who continues to participate in regular professional training and development that includes domestic abuse. He has completed domestic homicide reviews with other community safety partnerships in England. He has completed other DARDRs in Stoke-on-Trent but not in Staffordshire. He has never worked for any of the organisations that contributed to this review, nor has he held any elected position in Staffordshire. He is not related to any individual who either works or holds an elected office in Staffordshire.

Parallel reviews

45. There were no parallel reviews. The criminal investigation remained open, and the coroner's inquest had been opened and adjourned pending the outcome of the criminal process.

Equality and diversity

46. From the 1st of August 2016, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible

Information Standard [7]. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. This is designed to support other legal obligations, which include the making of reasonable adjustments under the Equality Act and the maintenance of GP registers to promote effective access to health and well-being services.

47. The GP register should ensure that an annual review of health needs is completed and should also be linked to a record of reasonable adjustments to take account of needs associated, for example, with Richard's learning disability. This could and should have included how appointments were made with Richard to ensure that information about Richard's disability and any required adjustments were highlighted, ensuring follow-up on attending for appointments, flagging and reviewing of information such as contact with hospital emergency services.

48. Richard was on the GP register of patients with a learning disability, which should have prompted discussion with him about his potential support needs, as well as offering an annual health check. Primary health care staff can be an important source of contact for people to disclose information about abuse, either in terms of their physical presentation, for example or in more explicit disclosures.

49. Richard was invited to the annual reviews, but he did not attend. The reason for Richard's not attending is not known, although a fear or embarrassment of medical appointments is not uncommon for people with a learning disability[8]. Apart from making the annual appointment, there was no further action to encourage Richard to attend the GP. Richard's last contact with the GP was in 2016, which was a telephone consultation.

50. This is an example of where reasonable adjustments could and should have been used to encourage and support Richard to participate in the health reviews. Reasonable adjustments such as personalised appointments that allow more time for patients with communication needs, such as Richard, speaking to the person before making the appointment to check the day, time, and place is appropriate for them, providing easy-read information and having accessibility champions are examples of reasonable adjustments being used in primary care services. The GP practice had already revised its policy to have a nurse make contact with patients with a learning disability.

51. The CLDT used an easy-read letter with a clock face displaying the time of Richard's appointment in December 2022. There is no further information about whether Richard would have been contacted nearer to the date of the appointment to discuss other potential support arrangements.

[7] https://www.england.nhs.uk/publication/accessible-information-standard-overview-20172018/

[8] Codling M (2015) Helping service users to take control of their health. Learning Disability Practice 18(3):26–31, doi:10.7748/ldp.18.3.26. e1612

52. The police interviews with Richard in 2015 about the disclosures of abuse were informed by achieving best evidence (ABE), which sets out good practice [9]. The guidance promotes a victim-centred and trauma-informed approach.

53. Although Richard's vulnerabilities were noted at the time, the police had no flags on their system that Richard had a learning disability. A registered intermediary[10] was considered, but it was not followed up on.

54. The police have subsequently changed their process to ensure that the Niche system facilitates quick time lateral checks and have also introduced a system where the Harm Reduction Hub (HRH) completes a secondary review of the PPNs submitted by officers before the information is filed. In this case, it would have, for example, provided an opportunity to consider a referral to ASC. This is an example of where reasonable adjustments are applied.

55. A strategy meeting involving all relevant professional parties to discuss the original disclosures under the safeguarding procedures would have provided an opportunity to flag specific information about Richard's needs and vulnerabilities and to plan the respective enquiries by different professionals. It would have been good practice to have ensured that the discussion and planning of enquiries involved a professional with specialist knowledge of learning disability. The issue of evidential difficulties prevented this and subsequent investigations from progressing to a clear outcome.

56. The UK is a signatory to the UN Convention on the Rights of Persons with a Disability (CRPD), which includes rights relating to every aspect of life. Amongst the most significant rights relevant to the analysis of this DARDR are freedom from cruel, degrading or inhuman treatment (Article 15), freedom from exploitation, violence and abuse (16), right to live independently and be included in the community (19), as well as health rights (25), employment (27), social protection (28) and participation in public and social life (30).

57. The circumstances of Richard's death are evidence of cruel behaviour, and he was subjected to violence and abuse, and was not independent or able to escape from the abuse he had suffered through much of his life. His isolation and lack of participation in a job or other community activities rendered him more vulnerable and did not comply with the standard set out in law.

Dissemination

58. The organisations and people who participated in the review will receive a copy of the published overview report. The report will be shared with the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board and the Staffordshire Police, Fire and Crime Commissioner. Each member of the Community Safety Partnership will receive a copy; these are the Probation Service, Staffordshire Council (children's services, public health), Tamworth

[9] https://www.gov.uk/government/publications/achieving-best-evidence-in-criminal-proceedings
[10] https://www.gov.uk/guidance/ministry-of-justice-witness-intermediary-scheme

Borough Council (housing), Staffordshire and Stoke-on-Trent Integrated Care Partnership, Staffordshire Fire and Rescue Service (SFRS), Staffordshire Police, Youth Offending Services (YOS) and the voluntary sector members. Additionally, a copy of the report will be provided to the Staffordshire and Stoke-on-Trent Adult Safeguarding Board and the Tamworth Borough Council Health and Wellbeing Board.

59. The commissioning body and the independent author for this DARDR thank the various organisations and people who have participated in the DARDR process.

Background information and chronology

60. Richard was admitted to the hospital in the last week of November 2022 in a severely neglected condition. He had been taken to the hospital by his father, who found Richard in a very poor condition when visiting him at Keith and Mandy's home.

61. Upon admission to the hospital, Richard was found to have

    a) Multiple rib fractures
    b) Spinal fractures
    c) Stomach and intestinal distension with no transition point
    d) Multiple grazes/lesions and pressure sores on his body
    e) Very emaciated and physically neglected
    f) Likely to need abdominal surgery, but his predicted mortality was 81%. Without the surgery, there was still a high chance of death.
    g) Possible pneumonia, but more likely to have aspirated.
    h) Possible bowel obstruction.

62. Richard died in the hospital less than a week later in early December 2022. The cause of death was yet to be determined when the DARDR was commissioned and scoped. For the DARDR, this was treated as a death where Richard had been abused, neglected and subjected to violent assault.

63. The post-mortem investigations confirmed that Richard had sustained multiple injuries before his death, which included fractures to his ribs and spine, and multiple grazes and lesions. There was evidence that he had aspirated (choked), and there was evidence of malnutrition.

64. Richard had been living with Keith, his 54-year-old stepbrother and Keith's 60-year-old partner, Mandy, since May 2015. Keith and Mandy have a history of substance misuse and poor mental health. Mandy's adult child died as a result of a road traffic accident (RTA) in November 2018.

65. Richard had a learning disability, and there is a reference in some agency information that Richard also had autism. Disclosures about Richard being a victim of childhood sexual abuse (CSA) were reported in May 2015, although there had been earlier involvement by children's social care services due to concerns about neglect.

66. Mandy was an appointee for managing Richard's benefits, administered by the Department for Work and Pensions (DWP). Mandy did not apply for and was not paid a carer's allowance.

Agency Overview

67. Richard left school over 12 years before he died, and being outside the scope of the review, there is no further analysis about why this occurred over and above recognising the absence of transition planning for a person with a learning disability. The DARDR was provided with copies of reports completed by Richard's tutors at school, and this information is included later in the report.

68. Richard was enrolled at a local college between September 2013 and July 2017. He was supported by a mentor who provided information about their contact, which is included in the report.

69. The local authority social care services had contact with Richard at various times from 1997 up until 2022. Children's services had contact in 1997, 2009 and 2010 following concerns about the condition of neglect in the home. The first contact with adult social care (ASC) was in April 2015, when concerns about Richard not eating enough and disclosures of Richard being a victim of childhood sexual abuse were raised. Richard moved to Keith and Mandy's home, and ASC closed their involvement. This is discussed later in the report in terms of Richard's limited options to escape from abuse and the importance of people with a learning disability being well supported in their decision-making.

70. A second referral was made to ASC in August 2022 from the borough housing service, stating that Mandy was not coping with Richard's behaviour. The final referral was in September 2022, which was in response to Mandy reporting sexualised behaviour from Richard. The social worker visited the property in mid-October 2022, just over a month before Richard was admitted to the hospital.

71. ASC completed two Care Act assessments. The first assessment in 2015 concluded that Richard needed minimal, if any, support with daily living tasks, whereas the second assessment in 2022 concluded that Richard had care and support needs and that he needed support to understand information as well as prompts with daily living tasks. This second assessment resulted in a recommendation for a referral to supportive communities as well as to specialist

community learning disability nursing services. Appointments were scheduled, although Richard died before these could be followed through.

72. This second Care Act assessment was a crucial professional contact that the DARDR wanted to explore in greater detail, but the social worker had left the authority and was unavailable for interview or discussions. The assessment recognised that Richard needed support and intended to help him access health and social activities. There is no evidence that Richard was seen alone, and the assessment did not raise flags about Richard's safety. The panel acknowledged that hindsight bias can distort what might or could have been identified at the time, but the absence of an opportunity to examine and reflect on this in more detail with the professional is unsatisfactory.

73. Keith and Mandy rented their home from the borough council. They were in arrears with their rent and were subject to enforcement action on more than one occasion. The gas meter had been removed from the property several years before, and the property had no central heating. The condition of the property was a regular concern. Richard had no rights or security as a tenant.

74. Richard was registered with the GP Practice in July 2000. The GP had not seen Richard since February 2016, when he requested a sick note. This is significant information that is explored in the report. In May 2016, there was a telephone consultation with Richard, also requesting a sick note. This was the last contact with Richard. He was invited to attend an annual review in February 2022, which he did not attend. The issue of annual health reviews is discussed in the report. The GP practice had historical information that Richard was prescribed Ritalin for several years, but this was stopped in 2015. There is a reference to Richard having ADHD, and his parents having difficulty understanding how to respond to Richard.

75. In March 2019, Mandy was designated by DWP to be an appointee to act on behalf of Richard in dealing with his benefits. An appointee is appointed when a person cannot manage their affairs because they are mentally incapable or severely disabled. The appointee can be an individual (friend or relative, for example) or an organisation or their representative.

76. The appointee's responsibilities are to sign any benefit claim forms, inform the DWP about any change in circumstances, spend the benefits in the best interest of the claimant and inform the DWP if they cease being the appointee.

77. Richard's mental capacity to manage his benefits was not the subject of a formal assessment under the Mental Capacity Act 2005 (MCA). It is not a requirement under relevant law or operational protocols for the DWP's administration of benefits. The relevance of the MCA to the process of agreeing on appointeeship arrangements and other decisions is an area of learning explored in the DARDR.

78. The police opened an investigation in 2015 about Richard being sexually abused by a family member. The investigation resulted in no criminal prosecution due to evidential difficulties. The police acknowledged that there was no information on their system at the time about Richard's learning disability, although it was noted that he might be vulnerable. Richard was interviewed twice. In the first, no intermediary was used; in the second, an intermediary was used. There is no information about the intermediary's knowledge and experience of learning disability.

79. University Hospital Birmingham provided emergency care and treatment to Richard in November 2022, and this is where he died. Clinical staff established that Richard had a learning disability when accessing the electronic patient records. The hospital is the only service to have used the MCA when they recognised he was unable to make decisions about his care and treatment. A referral was made to an independent mental capacity advocate (IMCA).

80. Advocacy Matters (the IMCA service) was very briefly involved after Richard was admitted to the hospital in November 2022. The service was contacted to support best-interest decision-making about Richard's care and treatment plan.

81. Humankind was briefly involved with Mandy in 2021 and again in 2022.

82. Referrals were made to the mental health Access Team in 2022, who had two telephone contacts with Mandy in August 2022. Mandy reported difficulties with Richard's behaviour, as well as struggling with the death of her child in 2018. Two further calls were attempted without success, and Mandy was discharged from the service. The letter sent to Mandy's GP included Mandy's account that she "kicked and punched walls to relieve stress" and that she broke a knuckle by punching a brick wall. There is no other information about what triggered the incidents of stress or whether Richard had been in the house at the time or had been impacted by it.

83. In October 2022, ASC made a referral to the community learning disability team (CLDT), requesting an assessment and intervention to help Richard with his relationships and to help with his understanding of risks. The referral reported that Richard found it difficult to develop attachments and appropriate relationships and, as a consequence, made poor decisions. An appointment was scheduled in December 2022, which was after Richard died.

Combined chronology

84. The first referral to ASC in April 2015 was by the police following contact from a concerned member of the public (an RSPCA inspector who had been called to complete an animal welfare check at the request of a member of the public).

The concern was that 21-year-old Richard was possibly not being fed adequately.

85. The record of the visit by ALDT indicated that Richard was underweight, but he was “said to eat regularly”. The assessment in May 2015 by ALDT described Richard as “very slight in build”. It was recorded that Richard had told the social worker he had bought a sandwich at a local supermarket and had a large bag of sweets in his bag. His mum had also mentioned that the family would be buying a meal from the local chip shop the same day. The property was described as being of “a very poor standard” with “grave hygiene issues”. The assessment also referred to Richard saying he did not want to live with his parents because of their telling him when he should be home each night, and he also did not get on well with his siblings, with whom he sometimes fought. There is no other detail.

86. Referrals were made to a “health facilitator” to establish if there was an underlying health condition or if the weight was linked to Richard’s living conditions.

87. The housing service was contacted about the conditions in the home, and concerns about the neglect of the dogs in the property were reported to the RSPCA. The independent futures service became involved with Richard in May 2015. The independent futures worker noted in their visit to the parents' home that the property was “uninhabitable” with dogs locked in the living room.

88. A further safeguarding referral was raised from the Community Connect Service (the county’s information gateway to local area services) in May 2015 about historical sexual abuse. This information was referred to the police, who opened an investigation and completed two interviews with Richard. Following consultation with CPS, the investigation was closed without charges.

89. A complaint was subsequently made by Richard’s father, who did not want social care staff talking with Richard without a parent being present. Dad was concerned that his son did not understand what was being said to him and that talking to him like an adult was not appropriate because he is not an adult “in his head”.

90. The safeguarding referral was subsequently closed by the police in late May 2015 due to “evidential difficulties”.

91. In May 2015, Richard moved to live with Keith and Mandy, who reported being threatened by one of Richard’s siblings. Mandy did not want the police to take any action against the sibling, and neither she nor her partner felt threatened or scared by the sibling’s behaviour. A “low-level” common assault was recorded with no further action.

92. In early June 2015, a community connect worker visited Richard and noted that he “looked as if he had gained some weight”. Mandy reported that “everything was fine” and that Richard was going to work and managing his daily care needs. The worker talked to Richard about returning to college and becoming involved in community activities.

93. The same service recorded a contact in early June 2015 that reported a local school (identified in the record) had reported that Richard had been “stalking” one of their female students. The record of the contact does not include any detail about the referrer other than a first name, and there is no information about whether they were phoning from an agency or the school itself. It is recorded that Richard disclosed being sexually abused by a member of his immediate family and that he was being financially exploited by his parents, who were withholding his benefits (mum was an appointee at that time).

94. It was recorded that a social worker would complete a Mental Capacity Act (MCA) assessment “regarding Richard’s understanding of money,” and if it was assessed that Richard did not have mental capacity, the option of the local authority becoming the appointee would be explored. There is no further information about whether the MCA assessment was completed or any more information about what specific decision was to be assessed. There is further analysis later in the report.

95. Although the DARDR was informed that an advocate was appointed to work with Richard from July 2015, the advocacy service that had contact in 2015 has provided no information about providing such a service to Richard. According to ASC records, the community connect worker met Richard’s advocate in June 2015, and there was an email from the advocate in July 2015 to the community connect worker summarising a meeting with Richard in early July 2015. The summary reported that Richard said that he was OK and was due to go back to college. He was enjoying animal studies and was looking forward to seeing friends at college. He had a job at a newsagent's that he enjoyed. He was thinking of joining a gym and had no concerns at that time.

96. The contract for advocacy in 2015 would have been limited to a person who was a user of an adult social care service and had been assessed as meeting fair access criteria [11] for accessing a service.

97. In July, Richard stopped taking his regular medication of risperidone (an antipsychotic medication).

98. In February 2017, the CLDT closed their involvement with Richard.

99. In November 2018, Mandy’s son was killed in a road traffic accident (RTA).

[11] The Care and Support (Eligibility Criteria) Regulations 2015

100. In March 2019, Mandy was made Richard's appointee to deal with the DWP and benefits.

101. In May 2019, Mandy was referred to the mental health Access Team, suffering from a low mood following the death of her son. She is recorded as having a history of illicit substance use. Appointments were scheduled in June and July that Mandy did not attend, and she was discharged from the Access Team.

102. In August 2019, the housing service spoke to Mandy about rent arrears and the prospect of eviction processes being started. Mandy reported that Richard was not contributing to the household finances and was described as "gambling" and being "loud and violent".

103. During 2020, there were unsuccessful attempts by substance misuse services to engage with Mandy, and there were concerns by the housing support service about hoarding in the property.

104. In December 2020, the housing service was granted a warrant for possession of the property. Possession action was postponed until May 2021.

105. In August 2021, the police responded to neighbour complaints about Keith and ongoing issues with neighbours. Mandy reported being concerned about Keith's mental health and erratic behaviour, and she was "signposted to relevant agencies".

106. In May 2022, there was a further court application for possession of the property due to the accruing rent arrears.

107. In June 2022, Mandy informed a housing official during a telephone call that Richard had been sexually assaulted by family relatives (who are identified) and had been accused of sexually assaulting two girls. Mandy did not want Richard living in her home. There is no record of this information being referred to any other service.

108. In July 2022, the court granted a warrant for possession of the property in August 2022.

109. In early August 2022, the Tamworth Borough Council (TBC) income support service raised a safeguarding referral with ASC due to Mandy's imminent risk of becoming homeless (through eviction) and that an adult with LD (Richard) lived in the same household. Mandy had also told the income support officer that Richard's behaviour in the community was causing concerns. This included looking at girls on the street, urinating in the street and looking down Mandy's top.

110. The income support officer also described Mandy's poor health, which included COPD (chronic obstructive pulmonary disease), emphysema and heart problems.

111. Mandy had reported that she did not have a bank account and that the benefit income for Keith and herself was paid into Richard's bank account. Mandy had reported that she had "guardianship" (understood to be the wrong term for being an appointee). The household was due to be evicted within 7 days. ASC decided that it did not meet the threshold for an s42 enquiry, although Mandy required a carer's assessment and Richard needed an assessment of his care and support needs.

112. The Staffordshire Adult Safeguarding Team received a further safeguarding referral from Humankind the following day, which described Mandy's difficulty with her mental health and being abused by Richard, who had care and support needs. Mandy had described being physically, sexually, emotionally and financially abused, and Mandy was experiencing thoughts about death by suicide. Mandy reported that she did not feel at immediate risk from Richard, but said that Richard's behaviour was bringing back memories of abuse from earlier in her life. No other details are recorded about this. Richard was not washing, was wetting the bed, was looking at her breasts and was exposing himself.

113. Following telephone contact with Mandy, the safeguarding referral was closed on the basis that Mandy was able to protect herself, with a recommendation for the area LDT to complete a face-to-face assessment and a safeguarding referral was made for Richard. A referral to Staffordshire Carers was requested for an assessment. This was not actioned until early October 2022.

114. Humankind also made a referral to the mental health Access Team, the same day, who telephoned Mandy and discussed the difficulties she had with Richard. Leaflets about services were sent to Mandy, and a call was scheduled for the following week.

115. A further referral from the income support team described queries about the financial management of Richard's finances, his behaviour and Mandy's ability to meet his needs. A request was made for a care and support needs assessment to be completed.

116. The Access Team phoned Mandy three days later. Mandy wanted to move to another property without Richard being part of the household. The Access Team phoned the following day when Mandy talked about her continuing struggle with her son's death. She described Richard as never stopping eating and being awake all night. Telephone calls by the Access Team on the following two days went unanswered. Mandy was discharged from the Access Team in

mid-August 2022 after two appointments with the service had not been attended by Mandy.

117. A third safeguarding referral was raised by the income support team in late September 2022, reporting concerns about Richard's behaviour, financial arrangements and the impending court action to evict the household due to rent arrears. There was an unsuccessful attempt by ASC to speak to Mandy by telephone. ASC spoke with the referrer, who did not think Mandy had care and support needs, and it was confirmed that a referral for a Care Act assessment would be sent to the area LDT for Richard. This referral was subsequently rerouted from the area adults' duty team to the area LDT, "given the concerns raised". The assessment was completed in late October 2022 and is discussed in the analysis later in this report.

118. In August 2022, a referral to the Staffordshire Adult Safeguarding Team from Humankind was processed and forwarded to MPFT. There was a reference to sexual behaviour that represented a risk to Richard. The referral was closed to ASC based on no care and support needs being apparent. The referral recorded that Mandy had a drug addiction (no details about what substances and what impact) and was struggling with her mental health (no details), that she was being abused by Richard, and that this was exacerbating her distress. Mandy was an appointee for Richard but had no bank account of her own. The Access Team also had contact with Mandy about abuse from Richard, which was described as physical, sexual, emotional and financial abuse, but no other detail is recorded.

119. In mid-October 2022, the ALDT service visited Richard at home, and according to the record of the visit, "no significant concerns were apparent". According to information collated by the police, the social worker did not see Richard on his own. Mandy was present. Richard is described as "quite clean" and was not dishevelled, and his face and hair looked fine. The social worker reported in their statement to the police that Richard did not appear to be alarmed or frightened. Mandy is described as assisting Richard with his communication. Richard said that he wanted to continue living with Mandy and Keith. Less than six weeks later, Richard was admitted to the hospital for emergency care and died a week later. The social worker had left the employment of the county council and was not available for an interview or discussion in connection with the DARDR.

120. The police officers who attended the property after Richard's admission to the hospital submitted a PPN (Public Protection Notification) detailing significant concerns about the ability of Mandy or Keith to care for Richard themselves and describing very poor and inadequate conditions in the home.

Analysis

121. The protection of people with a learning disability from domestic abuse is the focus of learning in this DARDR. The SAR that was commissioned after the DARDR began work will have a focus on adult safeguarding. Applying the relevant legislation, such as the Care Act (CA) and the Mental Capacity Act (MCA), is a vital part of improving the detection and prevention of domestic abuse and family-based violence against people with a learning disability.

123. A significant driver of risk for people with a disability is their direct and indirect experience of discrimination associated with exclusion and social isolation, denial of opportunities to form intimate or significant relationships (this includes the impact of abuse, trauma, discrimination as well as socialising) and economic disadvantage (through lack of training and poor employment opportunities), which contributes to their poverty and limited or insecure housing [12].

124. A central and enduring assumption was that Richard made a positive choice to live with Mandy and Keith. In reality, Richard was moving away from the abuse experienced over several years, and he had very limited options and few opportunities to form trusting relationships outside the home or to talk to anybody about his circumstances.

125. The Equality Act 2010 defines age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation as protected characteristics. The Act makes it illegal to discriminate against a person because of any of these protected characteristics.

126. All three adults were white British and English-speaking. There is no record of any formal or informal religious affiliation, belief or faith for any of the three adults. No issues were identified by the panel about discrimination or a requirement for reasonable adjustment for the protected characteristics of age, race or religion.

127. Richard was not in an intimate relationship when he died and had no children. The college was told by Richard in late 2015 that he had a “new girlfriend”, although there is no other information about this or any other relationship. Richard was biologically male and identified as male.

128. Keith and Mandy were not married and were not in a formalised civil partnership. Keith and Mandy were born biologically male and female, respectively, and self-identify as such and are heterosexual.

[12] https://doi.org/10.1080/1034912X.2020.1736522

129. No issues were identified by the panel about discrimination or a requirement for reasonable adjustment for the protected characteristics of marriage, sexual orientation, sex or gender reassignment.

130. The panel were aware that research consistently indicates that when gender and disability intersect, experiences of violence tend to intensify in 'frequency, extent and nature' [13]. Data indicates that more than 70% of women with disabilities have been victims of violent sexual encounters, women with disability are 40% more likely to be the victims of domestic violence, and women with learning disabilities are at a "considerably heightened risk" of experiencing sexual assault compared with other women with disabilities[14] Women's experiences of violence will likely be exacerbated where additional aspects of diversity such as indigenous, socio-economic or immigration/refugee status, intersect with gender and disability[15].

131. Richard's learning disability is a protected characteristic under the Act and is an area where the review identifies issues relating to discrimination [16] or inadequate use of reasonable adjustments (which contributes to discriminatory practice that disadvantages access to services).

132. Data gathered as part of the Crime Survey for England and Wales shows that disabled people, such as Richard, are almost three times as likely as their non-disabled peers to experience domestic abuse. The statistics record that 17.5 per cent of disabled women, compared to 6.7 per cent of women in the general public, and 9.2 per cent of disabled men, compared to 3.6 per cent in the general public, reported experiencing domestic abuse in the year ending March 2020 (April 2019 – March 2020 ONS[17]).

133. Public Health England published information in 2015 about the risk and impact of domestic abuse and disability[18]. People with a disability experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods and more severe and frequent abuse than

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[13] Dowse, L., Soldatic, K., Didi, A., Frohmader, C., & van Toorn, G. (2013). Stop the violence: Addressing violence against women and girls with disabilities in Australia. Background Paper. Retrieved from https://researchdirect.westernsydney.edu.au/islandora/object/uws:36865 and accessed on 23rd August 2024.

[14] Didi, A., Soldatic, K., Frohmader, C., dowse, L. (2016). Violence against women with disabilities: is Australia meeting its human rights obligations? Australian Journal of Human Rights. 22(1): 159-177. and from https://dpoa.org.au/factsheet-violence/ accessed 23rd August 2024

[15] McCulloch, J., Beavis, K., Maher, J., Spivakovsky, C., McGowan, J., Sands, T., Cadwallader, J. and Lea, M., 2018. Women, disability and violence: barriers to accessing justice; Final report. ANROWS Horizons. As well as Didi p 160.

[16] Discrimination includes failure to make reasonable adjustments as well as describing how someone with a learning disability is put at a disadvantage or treated less favourably because of the disability. Examples explored in this DARDR include how safeguarding concerns were processed for example.

[17] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/datasets/disabilityandcrime accessed on 13th June 2024

[18] https://assets.publishing.service.gov.uk/media/5a806673ed915d74e622e3c8/Disability_and_domestic_abuse_topic_overview_FINAL.pdf accessed on 13th June 2024

non-disabled people. They may also experience domestic abuse in wider contexts and by greater numbers of significant others, including intimate partners, family members, personal care assistants and health care professionals. Disabled people also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers.

134. Disabled women are significantly more likely to experience domestic abuse than disabled men and experience more frequent and more severe domestic abuse than disabled men [19]. However, as being disabled carries a further risk of domestic abuse, disabled men also experience higher rates of abuse than non-disabled men. Disabled men experience a similar rate of domestic abuse as non-disabled women. How gender and disability are structured within society affects the risk of experiencing domestic abuse and has implications for how professionals develop and use their informed professional curiosity.

135. People with a learning disability are at a higher risk for developing post-traumatic stress disorder (PTSD) compared to people without a learning disability[20] , although PTSD is still largely underdiagnosed and undertreated within this population due to misinterpretation of symptoms [21]. Men with PTSD are over seven times more likely to experience domestic abuse [22]. People with a disability are significantly more likely to

    a) be threatened with violence
    b) be physically abused
    c) be sexually assaulted by intimate partners or strangers
    d) experience physical, sexual, emotional and financial domestic abuse than people without disabilities[23].

136. People with a learning disability are more at risk of abuse at home and in the wider community. The type of abuse includes economic or sexual

[19] Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. Hughes, K. et al. The Lancet, 2012, Vol. 379.
[20] Mevissen, L., & de Jongh, A. (2010). PTSD and its treatment in people with intellectual disabilities. A review of the literature. Clinical Psychology Review 30, 308-316.
[21] Mevissen, L., Didden, R., & de Jongh, A. (2016). Assessment and Treatment of PTSD in people with intellectual disabilities. In Martin, C.R., Preedy, V.R., Patel, V.B, Comprehensive Guide to Post-Traumatic Stress Disorder, 1st ed. (pp. 281-299), Switzerland, Springer.
[22] Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. Hughes, K. et al. The Lancet, 2012, Vol. 379.
Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. Treviliion, K. et al. 12, 2012, PLoS One, Vol. 7.
[23] Disability, gender and intimate partner violence: Relationships from the behavioural risk factor surveillance system. Smith, D. 1, 2008, Sexuality and Disability, Vol. 26, pp. 15-28.
Adding insult to injury: intimate partner violence among women and men reporting activity limitations. Cohen, M. et al. 8, 2006, Annals of Epidemiology, Vol. 16, pp. 644-651.
Intimate partner violence, health status and health care access among women with disabilities. Barrett, K. et al. 2, 2009, Women's Health Issues, Vol. 19, pp. 94-100.
Physical and Sexual Assault of Women with Disabilities. Martin, S. et al. 2006, Violence against Women, Vol. 12.

exploitation, as well as neglect, which can remain invisible to family, friends and professionals, as occurred with Richard.

137. Key findings from an analysis of DHRs published in 2021 found that 61% of victims had a vulnerability, such as a disability or mental health needs [24].

138. A DWP medical referral in June 2015 connected to Richard's employment support allowance (ESA) included a reference to autism as a condition. There is no other reference to Richard and autism. According to the NHS, about 3 in 10 people with a learning disability also have an autism diagnosis. Around one in three people with a diagnosis of autism have a learning disability, and people with a learning disability are 26 times more likely to be diagnosed with autism[25]. For clarity, autism is not a learning disability.

139. A learning disability starts before adulthood and significantly reduces the ability to understand complex information or learn new skills. It reduces the ability to cope independently without appropriate support. Many people with a learning disability will have greater health needs than the general population. This can include mental health as well as physical health problems or physical and sensory disability. This is why it is important for primary health care services to routinely review health needs on at least an annual basis and be proactive about how appointments are arranged and supported through reasonable adjustments, for example. Simply inviting them to attend or arrange an appointment is unlikely to be successful in giving a person with a learning disability access to health care or a review of their needs. Not making reasonable adjustments is an example of discrimination.

140. The anticipatory duty in the Equality Act applies to services and public functions to anticipate (in this DARDR) the needs of a person with a disability and to remove any barriers to accessing a service. The Court of Appeal clarified the scope of the duty of service providers or public authorities to think about and provide for features which might impede access to a service by a person with a particular kind of disability[26].

141. Richard, along with other people with learning disabilities, experienced significant inequality in their health and well-being compared to their non-disabled peers.

142. Broad causes of health inequalities have been identified [27]. The social determinants of health include poverty, poor housing, exclusion from

[24] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews Accessed on 13th June 2024
[25] https://www.autistica.org.uk/what-is-autism/learning-disability-and-autism
[26] MM & DM (n 12) para 43; Roads v Central Trains (n 37) para 11.
[27] Emerson E., Hatton C. (2014). Health inequalities and people with intellectual disabilities. Cambridge University Press.

community participation, impairment effects, communication barriers, personal health risks and poor access to health care. All of these impacted Richard's health and well-being.

143. These social determinants of health for people with learning disabilities have been described as the "causes of the causes [28]", the factors that structure discrimination, exclusion, social isolation, and disparity in participation by people with a learning disability. Exclusion and isolation are important additional risk factors for a person living in a household where people abuse, exploit and otherwise harm them and are a factor in Richard's circumstances and his experience of discrimination.

144. Violence plays a significant role in the lives of disabled people, and disabled people experience violence at disproportionately high levels compared to non-disabled people in the UK[29].

145. Violence towards people with a disability takes many forms and includes abuse and neglect, hate crime, targeted violence, bullying, and harassment, as well as intimate partner, gender-based violence, and interpersonal violence [30].

146. The violent victimisation of people with learning disabilities is therefore well established. Much less well understood is the specific experience of domestic abuse or the impact that persistent victimisation has on the lives and well-being of people such as Richard who live with a learning disability.

147. There is limited research exploring the incidence and experience of domestic abuse for people with a learning disability, although the studies that have provided some information have consistently shown that when victims have interactions with a range of professionals, including the judicial system (police, courts) and health and welfare services, they feel unsupported and unjustly treated [31].

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[28] Marmot M. (2018). Inclusion health: addressing the causes of the causes. The Lancet, 391(10117), 186–188.

[29] Mikton C., Maguire H., Shakespeare T. (2014). A systematic review of the effectiveness of interventions to prevent and respond to violence against persons with disabilities. *Journal of Interpersonal Violence*, 29(17), 3207–3226.

[30] Balderston S. (2013). Victimized again? Intersectionality and injustice in disabled women's lives after hate crime and rape. In Segal M. T., Demos V. (Eds.), *Gendered perspectives on conflict and violence: Part A* (pp. 17–51). Emerald Group Publishing Limited.

Emerson E., Roulstone A. (2014). Developing an evidence base for violent and disablist hate crime in Britain: Findings from the life opportunities survey. *Journal of Interpersonal Violence*, 29(17), 3086–3104.

[31] Douglas, H., & Harpur, P. (2016). Intellectual disabilities, domestic violence and legal engagement. *Disability & Society*, *31*(3), 305–321. https://doi.org/10.1080/09687599.2016.1167673

McCarthy, M., Bates, C., Triantafyllopoulou, P., Hunt, S., & Milne Skillman, K. (2019). "Put bluntly, they are targeted by the worst creep's society has to offer": Police and professionals' views and actions relating to domestic violence and women with intellectual disabilities. *Health, Risk & Society* 59

148. Investigations that have inconclusive outcomes due to evidential difficulties are examples of where professional practice needs to be informed by a good enough understanding of learning disability, and this is discussed later in the report.

149. Abuse and violence shape health and well-being, and place barriers on people with learning disabilities' ability to participate in communities. People with learning disabilities often live isolated lives and feel excluded from their local communities [32].

150. Violence against people with a learning disability in all of its forms is profoundly underreported. This is not evidence of lower rates of violence; rather, the converse is that violence is more prevalent but is not being reported or detected [33].

151. People with learning disabilities face barriers to reporting abuse and violence. People with learning disabilities are concerned that they will not be seen as credible, or, as in Richard's case, they face barriers to reporting, as the person "supporting" them may also be the perpetrator of violence [34].

152. People with learning disabilities have more difficulty than others in identifying ordinary health problems and getting treatment for them. It is therefore likely that they will also have difficulty in identifying or describing abusive behaviour to another person.

153. Annual learning disability health checks have been a key part of NHS plans to improve health and reduce premature mortality since 2008 (and should be an opportunity to enquire about the overall safety and well-being of the patient).

Journal of Applied Research in Intellectual Disabilities, *32*(1), 71–81. https://doi.org/10.1111/jar.12503
Pestka, K., & Wendt, S. (2014). Belonging: Women living with intellectual disabilities and experiences of domestic violence. *Disability & Society*, *29*(7), 1031–1045. https://doi.org/10.1080/09687599.2014.902358
Walter-Brice, A., Cox, R., Priest, H., & Thompson, F. (2012). What do women with learning disabilities say about their experiences of domestic abuse within the context of their intimate partner relationships? *Disability & Society*, *27*(4), 503–517. https://doi.org/10.1080/09687599.2012.659460

[32] Power A., Bartlett R. (2018). Self-building safe havens in a post-service landscape: How adults with learning disabilities are reclaiming the welcoming community's agenda. Social & Cultural Geography, 19(3), 336–356.
Hall E., Bates E. (2019). Hatescape. A relational geography of disability hate crime, exclusion and belonging in the city. Geoforum, 101, 100–110.

[33] Macdonald S. J., Donovan C., Clayton J. (2017). The disability bias: Understanding the context of hate in comparison with other minority populations. *Disability & Society*, 32(4), 483–499.

[34] Sin C. H. (2014). Hate crime against people with disabilities. The Routledge International handbook on hate crime (pp. 193–206). Routledge.

154. GPs are asked to keep a register of people, such as Richard, whom they know to have learning disabilities. These learning disability registers were established in 2006 as part of the quality incentive scheme called the Quality and Outcomes Framework (QOF). Up until 2014, QOF learning disability registers included only people aged 18 or over. In 2014, their scope was officially expanded to cover people with learning disabilities of all ages. Only around a quarter of patients with a learning disability are on their GP's learning disability register [35]. Although Richard was on his GP's register, it did not result in him seeing a GP or other primary health care professional. This is discussed in the report.

155. To summarise, people with a learning disability are vulnerable to abuse, are more likely to be isolated and highly dependent on family or other carers, and are unlikely to use services or know where to go for help. Regular visits to a primary health care professional are a vital part of promoting better health and being able to identify potential concerns about care and relationships.

156. People with disability have some of the greatest health needs, are more reliant on people with whom they share a household and experience some of the most significant barriers to accessing services. Making a reasonable adjustment to facilitate access to health and other services is a statutory requirement under the Equality Act.

157. This means paying attention to the identification of a person's disability and recording their need and right to reasonable adjustments, with a summary of what specific adjustments are required. It requires taking time with the person to understand their specific needs, and for effective communication and collaboration with other relevant people and services. It has implications for how things like appointments are arranged and managed, including additional time and being suitably curious and persistent about exploring their circumstances and understanding.

158. It requires organisations and individual professionals to think about how policy and their practice promote reasonable adjustment to promote equal access to services. Identifying the specific nature and implications of individual disabilities, extending appointment times, ensuring a consistent professional is dealing with the person, providing pre-appointment contact, arranging appointment times to avoid crowds or multiple stimuli and reducing waiting times and use of advocates.

159. Richard experienced adverse experiences as a child as well as an adult. As a child, Richard was the victim of sexual abuse and neglect. Young age and exposure to interpersonal trauma are characteristic of all CSA cases and are associated with increased risk for later psychological difficulties, such as

[35] Emerson E, Glover G. The 'transition cliff' in the administrative prevalence of learning disabilities in England. Tizard Learning Disability Review 2012; **17(3):** 139–143.

those exhibited by Richard. Other CSA characteristics that increase risk include sexualized assaults, violence, intrusiveness of assaults, peri-traumatic reactions [36], impact on attachment to caregivers, and anxiety about other people's responses to an assault disclosure.

160. Little information was recorded about the CSA and other abuse that Richard had experienced or how it impacted him.

161. Resilience about CSA might be enhanced by individual factors such as positive self-esteem, better intellectual functioning, a favourable coping style, and good self-control and by relational factors such as positive social support, at least one caring parent, and good peer relationships. Early therapeutic intervention can also enhance resilience. These positive factors were largely absent from Richard's life and circumstances.

162. People who have experienced CSA are at increased risk for later psychological difficulties that can be quite varied and can include psychiatric disorders such as anxiety or depressive conditions, substance abuse, impaired psychological development, or significant difficulties in behaviour, relationships, intellectual function, education, occupation, or employment. In some cases. CSA may therefore preclude or disrupt the person's access to adult services or arrangements intended to support normal development or remedy earlier difficulties. This is further impeded by a learning disability.

Richard's ability to take care of or protect himself from significant harm or exploitation

163. The GP told the DWP that Richard would be *"at substantial mental or physical risk if he were found capable of work or work-related activity because of his autism, learning difficulties (rather than disability) and episodes of behavioural impairment".*

164. The reference to autism and behaviour impairment is not clarified anywhere else.

165. Richard's first contact with social work services was as a child in 1997, when he would have been just three years old. There were further referrals in 2009 and 2010. They were about the poor living conditions in the home. The focus appeared to be on the adverse physical conditions of the family home. No information has been forthcoming to suggest that Richard's learning disability or the impact was given detailed attention. There was no formal intervention, either via a child protection plan or supporting Richard as a child in need (CIN)

[36] Distress occurring during or in the immediate aftermath of a traumatic event, including cognitive, emotional, physiological, and behavioural responses. Involves appraisal of the threat and degree to which coping resources are exceeded

on the grounds of disability and neglect. Children's Social Care was unable to provide any other detailed historical information about their involvement.

166. Richard did not have the benefit of an education, health and care plan (EHCP), which was brought in nationally in 2015, which coincided with Richard leaving school and going to college.

167. The absence of formal assessment and planning with Richard as a child, despite the concerns about neglect and the fact of his learning disability, removed an important part of transition planning and support as Richard became an adult, including contact with specialist services. It also removed the opportunity to complete assessments that would have improved the opportunity to identify the abuse and trauma that was becoming evident in 2015 when Richard disclosed being sexually abused by a family member.

168. The first referral to the ASC in 2015 was in response to concerns about whether Richard was eating enough and about Richard being sexually abused by a family member. These referrals closed when Richard moved to Mandy and Keith's home, where he remained until his death. The absence of supported decision-making leaves doubt about how much this decision to move was a positive choice, rather than a vulnerable young adult with few options trying to escape abuse.

169. Two further referrals were made in August and September 2022. The referral in August was closed after referring Richard to the community learning disability team as well as to Supportive Communities. The referral had reported that Mandy was struggling with Richard's behaviour. The referral in September 2022 was also about Mandy's reports of Richard's sexualised behaviour, and a Care Act assessment was completed in October 2022.

170. ASC made a referral to the CLDT in October 2022, requesting an assessment of relationships and an understanding of risks. The referral reported Richard's difficulties in developing attachments or developing "appropriate relationships". An appointment was made for December 2022, which was after Richard had died.

171. In 2015, a clinical psychology assessment of Richard's cognitive and adaptive functioning concluded that he would need support to work on his understanding of relationships. This was around the time that Richard first described being sexually abused by a family member. There is no further information about work being done with Richard, either to address the legacy of abuse or to help him with relationships. Some of the behaviour that Mandy was describing in 2022 is suggestive of Richard struggling with relationships.

172. A Speech and Language Therapy (SALT) assessment in 2017 concluded that Richard would continue to need support for daily living and to keep him safe.

173. To summarise, without consistent support that helped Richard to address the legacy of abuse and trauma, as well as ongoing support, Richard would be at risk. Additionally, Mandy's emotional and mental health was a concern. In a letter from the CLDT to the GP in August 2022, they described Mandy disclosing that she had kicked and punched walls to relieve stress, managing to break a knuckle on one of these occasions.

Use of the Care Act and other referral pathways and assessments

174. The Care Act 2014 is the statutory framework in England that legislates the responsibilities towards adults with care and support needs due to disability or impairment. The local authority has a statutory duty to undertake enquiries and plan action where an adult at risk (a person with care and support needs), who, as a result of these needs, may be unable to protect themselves, is, or may be, subject to abuse (Section 42).

175. Whilst the statute does not explicitly reference domestic abuse, the care and support statutory guidance, which accompanies the Act, identifies domestic abuse as a form of abuse requiring investigation through the safeguarding process (Department of Health & Social Care (DHSC), 2022)[37].

176. The Care Act 2014 makes local authorities responsible for protecting people who are at risk from abuse or neglect (sections 42 – 47). Many public services (together with locally commissioned and third-sector organisations) play a key role in helping people with learning disabilities to be safe.

177. The research evidence already cited shows that people with a learning disability are at a higher risk of abuse and harm from multiple sources. They are also people who are at high risk of discrimination and exclusion from economic and social participation and therefore becoming invisible, marginalised and more susceptible to exploitation and harm. This is why assessments need to take account of individual history, and a good knowledge and understanding of risk factors associated with learning disability.

178. Two Care Act assessments were completed between 2015 and 2022. The significance of the Care Act is multiple. It provides a framework for determining the care and support needs of a person with a learning disability and is a vital check on whether there are safeguarding concerns. The Care Act provides a right to have an advocate for people who find it difficult to communicate or understand something.

[37] Care and support statutory guidance - GOV.UK (www.gov.uk)

179. The Care Act is also significant for giving rights to carers to have an assessment, and local authorities are obliged to meet a carer's eligible needs (subject to financial assessments). In this case, Mandy's history of trauma and poor mental health, together with the evident difficulties she had with Richard's needs, should have prompted the offer of an assessment on more than one occasion.

180. To do the assessment effectively requires the assessor to be professionally curious and to be well informed and trained about the particular risks and discrimination that people with learning disability experience. They need to be aware that a learning disability can contribute to fluctuating needs over time (as evidenced by Richard) and that communication difficulties introduce a level of complexity in understanding what is happening to a person with a learning disability who can be highly reliant on a person they are sharing a household with, and in the absence of any other housing options or social support.

181. The influence of adverse experiences, including abuse and exploitation, can have a detrimental influence on a person whenever they happen. An act of abuse might be historical in that it happened years before, for example, in childhood, but it continues to have profound and damaging consequences.

182. The ASC practitioners did not have access to children's social care (CSC) records. This remains an issue for the local authority. It is not evident that ASC practitioners would have been aware of the details of earlier concerns, although the 2015 assessment noted that Richard's childhood had been "dysfunctional". This type of recording is not appropriate or helpful, providing no detail either about what had happened to Richard or how it had an impact on him.

183. In the 2015 assessment, Richard reported that he did not like living at his parents' home. This was "due to issues in the home", which again does not provide clear enough information about what was happening and for example, exploring whether he was, for example, frightened or being coerced. It is noted that he fought with his siblings, which could be a disguised description of Richard being bullied.

184. The behaviours being reported in 2022 included Mandy's concern that Richard was being "sexually inappropriate" at home and in the community. There is no record of anybody inquiring into and exploring the earlier disclosures of Richard being neglected and sexually abused as a child. None of the reports about Richard's behaviour resulted in enough clarity about what had happened or led to any assessment and work with Richard as a victim with a learning disability.

185. Communication was an issue for Richard, as for many other people with a learning disability. They may not be able to report what has happened or describe the impact or symptoms, which can include PTSD and depression, loss of self-esteem and self-destructive behaviour, anger and self-harm, amongst other effects. The sort of behaviour that Mandy was describing about Richard (sexualised behaviour, anger management) is frequently formulated as relating to past histories of abuse and neglect [38].

186. The absence of detailed information about Richard's childhood and the absence of curiosity to inquire and contextualise his behaviour contributed to Richard's continuing trauma being untreated, or to addressing the risk it continued to pose for his emotional and mental health.

187. The DWP arguably had two occasions when a referral to ASC may have been appropriate. In January 2019 the ESA (Employment Support Allowance) questionnaire completed by Mandy included information about Richard's learning disability and specifically described that "he cannot be left on his own, has no fear of danger, and puts his self *(sic)* in danger" and continued to say that "you have to talk slowly because he cannot understand", that Richard "will go off with anybody and will not say anything where he goes (sic) and "he has had bad things happen to him" This questionnaire was processed by an externally commissioned health care provider on behalf of the DWP although a copy was retained on the DWP claimant records. There is no record of any of this information being explored further either by the external health provider or anybody in the DWP, or the potential care, support and safeguarding issues considered in terms of a referral to ASC.

188. In May 2019, it was noted that Mandy had recently lost her child in an RTA and was not coping well [39]. Mandy had been the appointee since December 2018. DWP routinely ask claimants about whether they have carer responsibilities when they initiate a new claim. Mandy (and Keith) were claimants when Richard began living with them and did not make any further applications or declarations about carer responsibility while Richard lived with them. If the DWP had been aware of the carer arrangement, a discussion about whether a referral to ASC for a carer assessment would have been an opportunity for a social care visit to the household.

Information that Richard could be at risk in the household where he lived.

189. Richard's learning disability was known by all the services, although there was much less information recorded about how it impacted his daily life.

[38] Peckham. NG, (2007) The Vulnerability and sexual abuse of people with learning disabilities. British Journal of Learning Disabilities. Vol 35, Issue 2 pp 131-137 https://doi.org/10.1111/j.1468-3156.2006.00428.x

[39] The death was in November 2018.

Records from school and the college provided the most detail. ASC records say that Richard was able to complete most of his daily living tasks with little support and was able to make basic meals and drinks. The recurring issues about Richard being underweight and looking undernourished up until he was admitted to the hospital are not consistent with this. The assessment in 2022 identified that Richard needed help and support with daily tasks.

190. A learning disability can create social isolation, which, along with the need for assistance with health and care and the potential increased situational vulnerabilities, raises the risk of domestic abuse for disabled people. Physical and environmental inaccessibility, stigma and discrimination can also exclude and isolate them. The reliance on care increases the situational vulnerability to other people's controlling behaviour and can exacerbate difficulties in leaving an abusive situation.

191. The referral in 2015 was closed when Richard "chose" to move to Keith and Mandy's. Although it was at Richard's instigation to move out of his parents' home, Richard realistically had one choice as an alternative to remaining in a household where he had been abused.

192. It was generally assumed that Mandy and Keith were appropriate people for Richard to live with. The arrangement was not organised by the local authority, and as such, no assessment was required of either Mandy or Keith or their property.

193. Keith and Mandy have a history of poor mental health and substance misuse, which attracted little curiosity or enquiry, even when Mandy was reporting difficulties with Richard in 2022.

194. Mandy's mental health deteriorated following the death of her adult child in late 2018. It is an example of when a carer's assessment would have been helpful. In 2022, Mandy was speaking about her increasing difficulty continuing to care for Richard. Again, a carer's assessment would have been helpful and good practice. This did not happen when a referral was raised in 2022. In August 2022, Mandy had disclosed kicking and punching walls to relieve stress and had managed to fracture a knuckle on one occasion. This information was only known (or in the record of) the CLDT and the GP, along with the Mental Health Access Team, who wrote the letter.

195. The only service to record concerns about Richard's welfare is the police in a PPN (public protection notification) concern for safety, completed and sent to ASC on the day that Richard was admitted to the hospital. The PPN states that the property is not adequate, especially given the medical conditions of Mandy and Keith, who, according to the PPN, both appeared to require support.

196. The PPN highlights that they both suffer from COPD and that Keith had one lung, impairing his physical activity. They were both using inhalers and were on a variety of medications. There was no gas supply to the property (a long-standing issue), and the PPN considered the electric heating to be inadequate to warm the property. The PPN found that Mandy and Keith were accepting of their conditions and had not sought help for themselves. Richard, by this stage, had been admitted to the hospital, showing signs of severe neglect and physical abuse.

197. The PPN is the only agency report to provide an account of what conditions were like in the property and its unsuitability for Richard.

Finding out about, recording and acting upon Richard's views, wishes and feelings and how he was supported in decision making, including the use of the Mental Capacity Act.

198. Richard's learning disability was a factor that could cause difficulties for him in making specific decisions. This is why the supported decision-making of the MCA is an important protection, along with access to effective advocacy. The four categories of decisions identified by the Everyday Decisions Project [40] cover everyday choices (food, clothing, activities), life choices (education, employment, housing), difficult decisions (financial, medical, legal) and relationships and friendships (family, friends, intimacy).

199. The law recognises that the difficulties may fluctuate, and this is why MCA assessments (that are linked with a structured process for best-interest decisions) are not treated as a one-off procedure. Access to advocacy is also enshrined in different statutes, including the MCA and the Care Act.

200. The MCA sets out a two-stage functional test. The first part is whether a person can make a particular decision (with support if it is required, for example, they have a learning disability).

201. The second and equal part of the functional test, which can often be overlooked, is to determine the ability of the person to make the decision; they have to be able to understand relevant information being given to them, retain that information long enough to make the decision, weigh up the information and communicate their decision. The Code of Practice [41] describes 'reasonable belief' as taking reasonable steps to establish whether a person does or does not have MCA capacity to make decisions or give consent to arrangements. The Code of Practice also describes the importance of establishing whether an act or decision is in the person's best interests.

[40] https://legalcapacity.org.uk/wp-content/uploads/2017/12/Everyday_Decisions_Project_Report.pdf
[41] Mental Capacity Act: making decisions - GOV.UK

202. In other words, without going through the second stage of the functional test, it is dubious practice to simply rely on a presumption of mental capacity when it is known that the person's circumstances, such as a learning disability, indicate they may have difficulties with a decision without support.

203. It would therefore be expected practice to see evidence of an MCA two-stage functional test being used to support Richard's decision-making as a person who had a learning disability to ensure that he was empowered to make decisions that reflected his best interests. There were none. Choosing where to live, with whom and who to act as an appointee are examples of where mental capacity assessments have an important and legal role.

204. The MCA assessment is not an assessment of whether a decision is risky or not. In this case, it would not have been an assessment of Mandy and Keith, for example. It would, however, have provided an opportunity to work through with Richard the reasons for his decision and helped him consider options that may have been more independent of the family, where Richard had experienced abuse from neglect and child sexual abuse. Specific decisions included what contribution Richard was expected to make to the household in terms of daily routines, such as food choices and eating (given long-standing concerns about Richard's weight), cleaning, washing, etc, as well as financial contribution. As a person with a learning disability, Richard was vulnerable to exploitation or neglect.

205. Richard was given no options about where to live or who could act as his appointee. He may still have chosen to live with Mandy and Keith even if he had been able to consider different options.

206. Richard had significant communication needs since childhood. The school records have the clearest account of how this impacted Richard. He was described, for example, as becoming frustrated and susceptible to anger. Behaviour is influenced by the challenges of impaired communication. It is also how the victims of abuse (in childhood and as adults) are processing the impact and the damage of trauma caused to them.

207. The Care Act requires that an advocate be used when a person has communication difficulties. An advocate was not involved during the assessments to support and help Richard. Most of the recording of the Care Act assessment is about Mandy's responses.

208. The Care Act assessment in 2022 noted that Richard was able to communicate verbally. It comments that Richard might need information broken down into short sentences and needs time to process and understand.

Assessment and support for Mandy or Keith.

209. Mandy and Keith have longstanding health conditions and have struggled to pay their rent. Although this would not have precluded them from providing Richard with a home, it is information that deserved more professional curiosity when Richard initially said he wanted to live with them. The arrangement under which their benefits were paid into Richard's bank account is unusual, and the reason has not been explained.

210. A carer's assessment was never offered or completed. Although there were safeguarding referrals from the Access Team and Humankind when Mandy was presenting with deteriorating emotional and mental health, these were declined on the basis that there were no safeguarding concerns [42]. The Care Act does not require there to be a safeguarding concern for the local authority to decide to complete an assessment [43].

Impact of Covid, organisational arrangements or working arrangements between services

211. The higher risk of premature death among people who have a learning disability is well-known and discussed earlier in the report. This is why GP practices are required to establish and update a register of patients with a learning disability and, as a minimum, ensure an annual review of health.

212. Covid mortality risk factors, such as poverty (and obesity, which does not apply in Richard's case), intersect with risk factors associated with learning disability.

213. Living with a carer should have mitigated the risk for Richard. Covid coincided with Mandy's traumatic loss of her child, which exacerbated her longer-term health problems.

214. Richard was not in regular contact with any service before Covid. His invisibility to services and the lack of opportunity for health and social care professionals to see the physical decline in the weeks before his death are areas of learning from the review.

With the benefit of hindsight, is there anything that might have been done differently?

215. The absence of effective engagement by children's services with Richard as a child in need and ensuring there were effective transition arrangements meant that Richard was unknown to adult services.

[42] Section 42 requires a 'reasonable cause to suspect' that an adult has needs for care and support, is experiencing or is at risk of abuse or neglect and as result of those needs is unable to protect themselves.
[43] Section 9 of the Care Act requires the local authority to assess anyone who 'appears to have needs for care and support' regardless of whether those needs are likely to be eligible.

216. Safeguarding concerns were never discussed between services, although there had been a recommendation for a strategy meeting. A strategy meeting involving the police, social care, learning disability service and advocacy service would have been better practice to plan a strategy to plan inquiries that took account of Richard's learning disability. Under current commissioning arrangements, access to advocacy is only available when prescribed in statute, such as the Care Act.

217. The DWP appointee procedure did not involve any formal MCA process or consultation with other services. It is not a requirement of the DWP to do this. The only time that DWP had information about potential financial abuse was in late November 2022, and it immediately suspended the appointee arrangements pending further investigation. This happened just before Richard's death. Given the concerns about financial abuse of people with a learning disability, the involvement of an independent advocate in dealings with the DWP would be a more robust practice, although it would require national leadership on policy within the DWP.

218. Use of the GP register to ensure annual health checks and as an opportunity for professional curiosity about circumstances, and ensure support to access services.

Conclusions

219. An overarching finding from this DARDR is Richard's invisibility to services after he completed his education, and his dependency (and arguably control by Mandy and Keith) created the circumstances in which he suffered cumulative and sustained harm from domestic abuse.

220. The importance of adults with learning disabilities maintaining their social contact with the people important to them, as well as maintaining their access to appropriate services, including community activities, and being supported to maintain or improve their health and well-being, is a recurring theme in reviews and research discussed throughout the report.

221. It was whilst at school and college that Richard had regular contact with people whose contemporaneous records gave the DARDR the most information about him.

222. Once Richard completed his education without going into employment or any further training, apart from a few weeks of casual employment at a local shop, there was nobody other than Keith and Mandy who saw Richard with any regularity.

223. When an assessment was completed, it did not make Richard any more visible to services. Although there were recorded intentions to involve Richard in social activities and link up with learning disability health services, this was not followed up on before his death (although appointments had been made).

224. It is striking to read the descriptions from school and college of Richard being sociable and well-liked. The collapse of his social world as a young adult was exacerbated by the Covid lockdown and made him more reliant on the two people he shared a household with, who had their own multiple needs and difficulties; both have a history of poor mental health and substance use, and the death of Mandy's child was traumatising.

225. Mandy was not offered any assessment either as a carer or of her care and support needs when she made clear her increasing difficulties in coping with the loss of her son and Richard's behaviour. The traumatic death of Mandy's adult child harmed her ability to care for herself and any other person. Mandy's reports of Richard's behaviour did not prompt any professional curiosity or reflection about how some of this was possibly a manifestation of childhood abuse and trauma.

226. The conditions in Keith and Mandy's home were poor for many years. It had no adequate means of heating, according to the police and the housing service (but not commented on by ASC), and had tried to install central heating, but this had been declined.

227. It is noted that Mandy and Keith were in arrears with their rent for several years and faced eviction on more than one occasion. The condition in which the property was kept by Mandy and Keith was the subject of regular interventions by the housing officers, who were concerned by the cluttered, poorly heated and sparsely furnished property. There was no recorded consideration by the housing officer as to whether a referral to ASC was required, given the indicators of self-neglect and the presence of a dependent adult with a learning disability living in the household.

228. The only person to raise concerns about the suitability of the property was a police officer at the property after Richard had been taken to the hospital. A social worker had visited only a few weeks before and reported no concerns. It has not been possible to interview this professional as part of the DARDR.

229. The loss of significant people removed important support for Richard, and he was only known to the college. None of the services had a complete record of all the abuse and trauma. This is an example of where assessments, particularly under the Care Act, need to have the scope and nuance to explore, record and analyse complex and traumatic life experiences. This is important in understanding a person's care and support needs, as well as

understanding any increased vulnerability to abuse (domestic or from outside their home).

230. Isolation from positive social networks and poor access to health and social care services create the conditions in which people with a learning disability are most vulnerable to abuse and other risks.

231. Richard's increasing isolation and invisibility from his wider family, community and services made him more vulnerable to abuse, which cumulatively led to his emergency admission to hospital and his subsequent and premature death.

232. Anybody who is subjected to domestic abuse faces broader risk factors, but as Richard's experiences show, people with a learning disability face specific risks. They are often in particularly vulnerable circumstances that may reduce their ability to defend themselves and are more dependent on other people, or to recognise, report and escape abuse. They have difficulties with communication and may have an antipathy to professionals.

233. The importance of effective transition planning and support from children to adult services is highlighted by the DARDR. As an adult with a learning disability who had been abused and suffered other adverse experiences in his childhood, Richard was particularly at risk. This should have been a starting point for the Care Act assessments and responding to referrals.

234. Trauma and abuse are embedded in the lives of many people who have a disability and in the lives of people who are subjected to domestic abuse. Trauma and its sequelae are increasingly recognised as disproportionately impacting and being a morbidity factor for people with learning disabilities[44].

235. Trauma can be a reaction to discrete adverse events or experiences, such as abuse or the death of a significant person, as Richard experienced. It can also include chronic circumstances such as ongoing abuse, domestic abuse or living in a violent or unsafe neighbourhood. Some of this is also reflected in Richard's circumstances. Trauma responses are also associated with experiences of discrimination and hate crimes, which Richard also experienced.

236. For health and social care professionals in particular, to be effective, they need to have the knowledge and understanding about why trauma is significant and collate sufficient detail about the specific experiences and

[44] Austin A, Herrick H, Proescholdbell S, et al. (2016) Disability and exposure to high levels of adverse childhood experiences: effect on health and risk behaviour (sic). North Carolina Medical Journal 77: 30–36.
Scotti, J.R., Stevens, S.B., Jacoby, V.M., Bracken, M.R., Freed, R. & Schmidt, E., (2012) Trauma in people with intellectual and developmental disabilities: Reactions of parents and caregivers to research participation. Intellectual and developmental disabilities, 50(3), 199 206.

events that impact someone like Richard and their far-reaching implications. It has implications for how the purpose and function of Care Act assessments are understood and completed, and how, for example, the annual health reviews should not be just focused on immediate physical presentations.

237. Richard's history of trauma, combined with his learning disability, made him more vulnerable to abuse, exploitation or neglect. A lesson from this and other reviews is that professionals need to have a clear understanding of the additional risks that people with a disability face and need to be proactive both in terms of their use of reasonable adjustment practice and developing and deploying professional curiosity. With hindsight, some of the behaviour that Richard displayed at school and as an adult can be interpreted as the adverse impact of being abused in childhood and as an adult.

238. Richard's childhood abuse was treated as a historical event, and the absence of an effective outcome to investigations and the negative message of inaction that this gave Richard was not recognised.

239. Victim survivors can feel the impacts of child sexual abuse at different points throughout their lifetime [45], and the ways they are impacted can change from childhood to adulthood [46]. Other forms of victimisation as a child and/or an adult, and frequently experienced by people with a learning disability, can compound the impacts of sexual abuse [47]; as research cited elsewhere in the report, a person with a learning disability is more likely to have experienced victimisation.

240. Some adults who are sexually abused as children do not report significant adverse consequences in adulthood [48], although the evidence on long-term impact is still building [49]. Victim survivors are the best experts on how they have been and are being affected, and any attempt to understand how an individual is impacted should begin with them and needs to take into account additional needs such as a learning disability and their ability to understand, communicate and process emotions and experiences. Behavioural problems

[45] Jay, A., Evans, M., Frank, I. and Sharpling, D. (2022) *The Report of the Independent Inquiry into Child Sexual Abuse*. London: Independent Inquiry into Child Sexual Abuse.
[46] Oaksford, K. and Frude, N. (2003) The process of coping following child sexual abuse: A qualitative study. *Journal of Child Sexual Abuse,* 12(2):41–72.https://doi.org/10.1300/J070v12n02_03
[47] Scott, S., Williams, J., McNaughton Nicholls, C., McManus, S., Brown, A., Harvey, S., Kelly, L. and Lovett, J. (2015) *Violence, Abuse and Mental Health in England: Population Patterns. (Responding Effectively to Violence and Abuse [REVA Project] Briefing 1.)* London: Nat Cen Social Research.
[48] Domhardt, M., Münzer, A., Fegert, J. and Goldbeck, L. (2015) Resilience in survivors of child sexual abuse: A systematic review of the literature. *Trauma, Violence, & Abuse*, 16(4):476–493. https://doi.org/10.1177/1524838014557288
[49] Allnock, D. (2017) Memorable life events and disclosure of child sexual abuse: Possibilities and challenges
across diverse contexts. *Families, Relationships and Societies*, 6(2):185–200. https://doi.org/10.1332/204674317X14866455118142

are suggested by some studies [50]. These include aggression, self-injury and sexual behaviour problems, such as the behaviour that Mandy was reporting about Richard in 2022. This has implications for how processes such as the Care Act and single-access mental health assessments are completed, for example.

241. Ensuring that safeguarding inquiries involve people with specialist knowledge of learning disability to help plan and support the inquiries is to be encouraged and mandated by local procedures.

242. The importance of trauma-informed practice is to first of all be curious about and understand how the life experience of people like Richard will influence how they interact and can recognise or respond to risk.

243. Having strong social relationships, acquiring appropriate skills and nurturing attitudes of self-respect, self-efficacy and self-esteem are recognised as important to promoting more inclusive and more effective support [51].

244. The absence of a clear diagnosis or assessment of how Richard's learning disability affected his daily life and interaction with people, or attention to how he might need help with specific decisions through the use of the MCA or an IMCA, added further to his vulnerability. Although advocates were involved at various times, they were not consistently used and were not part of significant procedures, such as when safeguarding concerns were raised.

245. The use of the MCA's supported decision-making process to ensure that people are involved and empowered to make informed decisions is an important mechanism for ensuring their views are sought and considered. The MCA enshrines the right for people not to be treated as lacking capacity simply because they make a decision that others, including professionals, might view as unwise. This should not prevent professionals from showing care and curiosity about particular decisions. The structured process of supported decision-making through the MCA and associated best-interest processes ensures the continued involvement of the person rather than being left to fend for themselves or having other people make decisions on their behalf.

246. Decisions about where to live and who to live with, who to have as his appointee, were decisions that had significant implications for Richard.

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[50] Sequeira, H. and Hollins, S., 2003. Clinical effects of sexual abuse on people with learning disability: Critical literature review. *The British Journal of Psychiatry*, *182*(1), pp.13-19.
[51] McConnell, D. Phelan, SK. (2022) Intimate partner violence against women with intellectual disability: A relational framework for inclusive, trauma-informed social services. Health and Social Care in the community **https://doi.org/10.1111/hsc.13932**

247. Richard faced multiple barriers and challenges in having secure housing (he had no legal status as far as his position in the household); lacking economic security in not having a regular job, or ready access to care and support services; and accessing routine health care, including annual reviews.

248. Services can address this by closing knowledge gaps, by improving accessibility and identification and by providing more opportunities for disclosure of abuse and support. The training of health and social care professionals and staff in domestic abuse services about understanding learning disability and trauma-informed care, improving integration of services by engaging directly with disabled people and ensuring the consistent use of trained and knowledgeable advocates.

249. An appointee is a person who is authorised to act on behalf of someone who cannot manage their affairs because of mental incapacity or a disability. This is an arrangement that can be made when financial arrangements are being made with the DWP or financial institutions such as banks and building societies. The DWP visits the claimant, interviews the proposed appointee to satisfy themselves that they are a suitable person and requires an application form to be completed.

250. The process does not involve a formal assessment of Richard's capacity to make decisions either about the fact of appointeeship or who would take on that role. The process involved an interview with Mandy (and previously Richard's mother when she was the appointee), but did not seek information, for example, from other agencies. This is not an expectation in DWP's national or local protocols.

251. The DARDR was advised that the DWP does not expect its staff to undertake MCA assessments.

252. DWP are reviewing the processes for decisions about appointees. People who are put in positions of trust, such as being appointees, may not use a person's money in the right way. When this occurs, there can be a heightened risk of other forms of abuse, including neglect, emotional and physical violence.

253. Lessons for DWP from this DARDR include ensuring the principles of the MCA are applied in ensuring that the claimant is empowered to make decisions for themselves, which begins with whether an appointee is required or whether the agency makes reasonable adjustments to serve the needs of customers with a learning disability. Checking on the suitability of a person to act as an appointee and having clear processes for raising referrals are also raised by this DARDR.

254. The county arrangements for SEND (special education needs and disability) were reviewed in 2018, and a joint approach by adults, children's social care and the Special Educational Needs and Disability (SEND) Assessment and Planning Team was implemented to achieve improvements.

255. The DARDR was commissioned by the Tamworth Community Safety Partnership (TCSP), although the county safeguarding partnerships for adults and children (SSASPB and SSCP, respectively) are the appropriate bodies for considering and overseeing much of the learning from the DARDR.

256. The development of effective professional practice on matters such as Care Act assessments and applying the MCA does not come within the scope of the TCSP's remit. Issues such as neglect are areas of overlap, given that neglect is both a safeguarding concern and potentially a manifestation of domestic abuse. The two safeguarding partnerships are responsible for ensuring that local safeguarding arrangements are in place as defined in the relevant statutes and guidance.

257. Issues such as the transition arrangements between children and adult services are not overseen by the TCSP or the safeguarding partnerships.

258. The Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) was considering whether to commission a SAR when the DARDR was completed.

259. The chair of the SSASPB and the Staffordshire Safeguarding Children Partnership (SSCP) may wish to seek further information and assurances about the following;

a) County safeguarding protocols being sufficiently clear about the involvement of people with expertise in learning disability being involved in safeguarding strategy discussions, planning of safeguarding enquiries and interviews where victims have a learning disability.
b) About the effectiveness of transition planning and support for children and young people moving into adult services.
c) That people with a learning disability have access to appropriately trained and skilled statutory and non-statutory advocacy.

260. The SSASPB may wish to seek further information and assurance about

a) Whether staff who complete Care Act assessments have appropriate training about learning disability;
b) That policy and practice guidance provides sufficiently clear direction on how traumatic life experiences are explored and analysed;

c) About how the Care Act assessments include consideration of the impact of personal history, relationships, disability, and substance abuse;
d) About how health and social care practitioners are encouraged to complete MCA-compliant assessments.

261. A learning summary will be circulated. This should ensure clear messaging about why people with a learning disability are especially vulnerable to risk from abuse as well as neglect, why professionals need to be proactive and legally literate, understand the importance of advocacy, ensure a person is seen on their own in safe and suitable places and to be vigilant about bias, for example, assuming that a male cannot be a victim of domestic abuse.

262. The appendix at the rear of this report includes the recommended actions identified by agencies in their management reviews for the DARDR. Details of the report's distribution are included in paragraph 58.

Lessons to be learnt

263. The policy and professional practice that make a difference include;

a) Good transition preparation and planning that begins in childhood ensures access to effective support as an adult with a learning disability.
b) Policies and professional practice that promote access to strong social networks, contact with appropriate services and trauma-informed responses by health and social care services.
c) Trauma-informed Care Act and safeguarding assessments that are appropriately nuanced and scoped to explore cumulative adverse experiences as a person with a learning disability and their increased risk of experiencing trauma, abuse and premature death; people with a learning disability are three times more likely to be victims of abuse and face multiple barriers in disclosing abuse or accessing help.
d) Seeing people on their own when it is safe or suitable to do so and not relying on family members to interpret, translate or assist with communication;
e) Ensuring that investigations of domestic and other forms of abuse involving a victim with a learning disability involve professionals or intermediaries with expertise in learning disability to assist in planning strategies for enquiries and providing support to the person, take account of communication needs and the involvement of advocates or intermediary, access to an IDVA with significant learning disability training or experience; the

importance of professional curiosity and broaching domestic abuse.

f) Commissioning arrangements and professional practice that ensure well-informed and trained advocacy is routinely available, particularly as part of significant events such as completing a Care Act assessment, decisions about where to live, and making arrangements for an appointee.

g) Using legally compliant decision-making provided through a well-planned MCA assessment, and if necessary, a good and inclusive best-interest decision-making process.

h) Making reasonable adjustments and easy-read documentation as a routine part of contact and providing services should be based on consultations with the person to find out what helps them use services, such as attending appointments and promoting annual reviews. This includes attending routine health care, having regular contact with social care services and knowing about and seeking help from domestic abuse services.

i) Encouraging and supporting GP practices as important resources for people with a learning disability who may have a fear or antipathy about seeing health professionals;

j) Recognising that all services have an important role in helping protect children and adults from harm including adult neglect; DWP and housing staff are well placed to potentially identify care and support needs and safeguarding including domestic abuse and should make referrals if and when there are concerns about adults or children at risk; the importance of Think Family[52] and No Wrong Door; is that all services should offer an open door into a system of joined-up support.

Recommendations

1. The Tamworth Community Safety Partnership (TCSP) should seek information and assurances that local borough and county guidance and training include specific descriptions of the particular risks that a person with a learning disability has from domestic and family-based abuse.
2. The Tamworth Community Safety Partnership (TCSP) should seek assurances that the report will be considered by the chairs of the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and the Staffordshire Safeguarding Children Partnership and referred to the relevant sub-groups to consider drawing attention to the questions posed in the conclusions of the report.
3. The Tamworth Community Safety Partnership (TCSP) should seek information and assurances from the Director of Housing about arrangements for identifying and responding to tenancies that include

[52] https://data.parliament.uk/DepositedPapers/Files/DEP2008-0058/DEP2008-0058.pdf

household members who may be at risk from domestic abuse or neglect, and/or are vulnerable to risk by a learning disability or cognitive impairment, and have care and support needs arising from abuse and/or self-neglect.

4. The Staffordshire and Stoke-on-Trent Clinical Integrated Care Board (ICB) should ensure that a targeted learning brief is provided to GP practices, highlighting the learning from the DARDR and the importance of applying reasonable adjustments, the use of the register of patients with a learning disability, the importance of annual health checks and promoting take-up of domestic abuse and learning disability training.
5. The DWP should;
    a) Take into account learning from this DARDR as part of the review of appointee arrangements.
    b) Ensure that externally commissioned providers of health assessments are clear about their responsibilities for ensuring that potential safeguarding concerns (including domestic abuse) and/or care and support needs are followed up.

National policy

1. The DWP does not have a national policy on the applicability of the Mental Capacity Act in empowering people to make decisions for themselves, wherever possible, such as appointee arrangements. As a non-statutory member organisation, the DWP use MCA information in a supporting capacity, on a case-by-case basis. Where the DWP believe a claimant may need an MCA, this is referred to the local authority via the established SAB protocol process.
2. The DWP does not provide any policy and guidance on circumstances when consultation with other professionals and public bodies should take place, such as when arrangements for an appointee are being considered and establishing whether the person being considered as an appointee is a fit and proper person. The DWP has protocols in place, developed in partnership with the National Network of Safeguarding Adult Board Chairs, which guide DWP staff on sharing information (including referrals) with appropriate organisations where there are concerns that a benefit claimant is suffering from abuse or neglect, including self-neglect.

Individual management review recommendations

GP practice

1. The learning disability nursing team to work in partnership with patients to facilitate reviews for those who do not attend or are not brought in for their annual reviews

Staffordshire County Council Adult Social Care

1. Further work is to be completed with the First Contact team around risk, documenting this and ensuring assessments are holistic.
2. Lessons learnt sessions to be completed around Mental Capacity and the documentation of this.
3. Safeguarding concerns and ensuring those that concerns are being raised against are contacted.
4. Further sessions are to be given to Adult Social Care in regard to the use of Advocacy and how this is best used.

Staffordshire Police

1. Staffordshire Police to promote the proactive use of person flags within Niche where a Learning disability is diagnosed.

Glossary

Advocate	Advocates can be provided voluntarily or as part of legal processes, such as under the Care Act, the Mental Health Act (MHA) and the MCA. It describes a person who helps professionals and others to understand the care and support needs of someone who has difficulty in doing this without help and support. An advocate ensures the person is heard, can understand processes, how the person feels about arrangements, can make decisions or challenge decisions and have their rights upheld. Advocates can have particular roles in assessments, care and support planning, safeguarding and reviews.
ALDT	Adult Learning Disability Team (ALDT)
Appointee	An Appointee is someone who manages a person's benefits. Appointeeship is granted by the Department for Work & Pensions (DWP)
Autism	Autism is a spectrum condition that affects people in different ways. Being autistic does not mean having an illness or disease. It means that the brain works differently from other people. Like all people, autistic people have their strengths and weaknesses. Autistic people may: • find it hard to communicate and interact with other people • find it hard to understand how other people think or feel • find things like bright lights or loud noises overwhelming, stressful or uncomfortable • get anxious or upset about unfamiliar situations and social events • It takes longer to understand information. • Do or think the same things over and over.
Best interest decision	If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests (principle 4 of the MCA).
Care Act assessment	An assessment under the Care Act 2014 is an assessment of needs for care and support, or an assessment of a carer's needs for support. It includes assessing any safeguarding concerns.
Carers assessment	Section 10 of the Care Act 2014 requires the local authority to complete an assessment where a carer may have support needs. This includes whether the carer is able or is likely to continue to be able to provide care for an adult requiring care.
Care Plan	A care and support plan states what type of support is needed, how the support will be provided, how much money the local authority will spend and what charges will be the responsibility of the person receiving the care and support.
Child sexual abuse	Involves the coercion or enticing of a child or young person to take part in sexual activity, whether or not the child victim is aware of what is happening. We know from research that many

	victim-survivors report adverse impacts on their mental health and well-being, including anxiety disorders, depression, eating disorders and disturbances, sleep disruption and insomnia, and dissociation. Long-term clinical psychiatric diagnoses associated with child sexual abuse include post-traumatic stress disorder and personality disorders.
Court of Protection (COP)	The Court of Protection was established under the terms of the Mental Capacity Act 2005, which came into force on 1st October 2007. It is a specialist court which makes specific decisions or appoints other people known as deputies to make decisions on behalf of people who lack the capacity to do so for themselves
DWP	The Department for Work and Pensions (DWP) is responsible for welfare, pensions and child maintenance policy. It administers the State Pension and a range of working-age, disability and ill-health benefits.
Economic abuse	Economic abuse is a legally recognised form of domestic abuse and is defined in the Domestic Abuse Act 2021. It often occurs in the context of intimate partner violence and involves the control of a partner or ex-partner's money and finances, as well as the things that money can buy, such as goods and services associated with care and support needs.
Education, health and care plan (EHCP)	An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.
GP's learning disability register	People with learning disabilities have more difficulty than others in identifying ordinary health problems and getting treatment for them. As a response to this, annual learning disability health checks have been a key part of NHS plans to improve health and reduce premature mortality since 2008.GPs are asked to keep a register of people, such as Richard, registered with them who they know to have learning disabilities. These learning disability registers were established in 2006 as part of the quality incentive scheme called the Quality and Outcomes Framework (QOF). Up until 2014, QOF learning disability registers included only people aged 18 or over. In 2014, their scope was officially expanded to cover people with learning disabilities of all ages.
IMCA (independent mental capacity advocate)	Introduced by the MCA, the role of IMCAs is to be a legal safeguard for people who lack the capacity to make specific, important decisions: this includes making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who can represent the person's best interests, or there is a conflict of opinion, as occurred in this DARDR.

Learning disability	A learning disability is a reduced intellectual ability and difficulty with everyday activities. For example, household tasks, socialising or managing money affect someone for their whole life. A learning disability is different for everyone. No two people are the same. A person with a learning disability might have some difficulty: • Understanding complicated information • learning some skills • looking after themselves or living alone A learning disability is different for everyone. Lots of people who have a learning disability can work, have relationships, live alone and get qualifications. Other people might need more support throughout their lives.
Mental Capacity Act	The MCA refers to a specific decision made at a specific time. The MCA sets out a two-stage test of capacity; Firstly, does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use? Secondly, does the impairment mean the person is unable to make a specific decision when they need to? People can lack the capacity to make some decisions but have the capacity to make others. Mental capacity can also fluctuate with time – someone may lack capacity at one point in time but may be able to make the same decision at a later point in time.
Niche	A police records management system.
PPN	A public protection notification (PPN) is an information-sharing document used by the police to record safeguarding concerns by a police officer.
PTSD	Post-traumatic stress disorder (PTSD) is a mental health condition caused by very stressful, frightening or distressing events. People who repeatedly experience traumatic situations, such as severe neglect, abuse or violence, may be diagnosed with complex PTSD. Complex PTSD can cause similar symptoms to PTSD and may not develop until years after the event. It's often more severe if the trauma was experienced early in life, as this can affect a child's development.
TBC	Tamworth Borough Council (TBC)
Transition planning	Transition planning refers to the process of moving into adulthood and the things that need to be in place to live independently. It also refers to the process of moving from child services to adult services. Transition planning normally starts around the age of 14 and can include everything from work experience and employment to housing and benefits.

	If a child, young person or their carer is likely to have support needs when they turn 18, the local authority must assess them if it considers there is a “significant benefit” to the individual in doing so. This is regardless of whether the child or young person currently receives any services. This *assessment* can be requested by the young person's parents. There is no particular age at which this assessment request should be made, and in some cases, it would be reasonable to request an assessment when the young person is 14 or 15. This is likely to be necessary for young people with complex needs who are going to continue to need significant levels of support from adult services. The complexity of their needs will mean that meticulous planning and a gradual transition to new services will be required. The assessment is the starting point and could be requested years in advance of their 18th birthday to allow sufficient time for this planning and transition to take place. There should also be no gap in services. In England, when the transition between children’s and adult services takes place, a local authority must continue to provide the individual with any children’s services they were receiving throughout the assessment process. This will continue until adult care and support are in place to take over, or until it is clear after the assessment that adult care and support do not need to be provided.
UN CRPD	The UN Convention on the Rights of Persons with a Disability (CRPD). Includes rights relating to every aspect of life. It includes civil and political rights that are familiar from previous international treaties and conventions, like the right to life (article 10), the right to liberty and security of the person (article 14), freedom from torture or cruel, inhuman or degrading treatment (article 15), respect for privacy (article 22), and respect for home and the family (article 23). Alongside these, there are important new protections specifically targeted at improving the lives of persons with disabilities, including the right to equal recognition before the law (article 12), freedom from exploitation, violence and abuse (article 16), living independently and being included in the community (article 19). Finally, the CRPD includes provisions about a wide range of economic, social and cultural matters, including rights relating to education (article 24), health (article 25), employment (article 27), social protection (article 28), and participation in public, political (article 29), cultural and social life (article 30).