THE EXECUTIVE SUMMARY

Richard

November 2022

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INDEPENDENT AUTHOR

August 2026

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1 The review process

1. This executive summary outlines the process undertaken by the Tamworth Community Safety Partnership (TCSP) [1] in reviewing the death of 28-year-old Richard [2].

2. On behalf of the TCSP, which commissioned this domestic abuse related death review (DARDR) and the people and various organisations contributing to the review, we extend our deepest sympathies and condolences to Richard's parents.

3. To protect the identities of Richard and the respective family members, pseudonyms are used in this DARDR.

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

4. Professionals are referred to by their roles, such as a GP or police officer, for example. Richard was not married or in a civil partnership, and he had no children.

5. 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, having found Richard in a very poor condition when visiting him at Keith and Mandy's home, where he had lived since 2015. Details of his condition are described in the overview report. Richard died less than a week after his admission.

6. The evidence of abuse, neglect and physical assault when Richard was admitted to the hospital meant that Richard's death was treated as a suspected adult family homicide (AFH) when considered for commissioning a DARDR. The DARDR was initially delayed pending further information about Richard's death. The cause of death and a decision about any criminal charges were still pending when the overview report was completed in the summer of 2025 and submitted to the Home Office.

7. The final pathology report subsequently confirmed that Richard's death was due to septic shock due to pneumonia and diffuse alveolar damage in a malnourished individual with multiple rib fractures. Based on this, the Crown Prosecution Service (CPS) authorised that Mandy and Keith

[1] The community safety partnership set up under the Crime and Disorder Act 1998.
[2] Pseudonyms are used for all named individuals in this report.

could be charged with murder. Keith and Mandy were subsequently convicted of Richard's murder in 2026.

8. The commissioning of the DARDR coincided with the publication of draft revised guidance for the conduct of DARDRs, which was used alongside the existing guidance.

9. The first meeting of the DARDR panel was in July 2024. Four further meetings of the panel were held. A glossary is included as an appendix to the full overview report.

1.1 Contributors to the review

10. The following organisations in Staffordshire provided an individual management review (IMR):
    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.

11. 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 about 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.

1.2 The review panel members

12. A suitably experienced and independent person chaired the panel; details are provided in section 1.3. All of the panel members were independent of any involvement or decision-making regarding the events and people concerned with the circumstances examined by the review. The membership of the panel is listed below.

Organisation	Job title or role	Attendances

Chair and author	Peter Maddocks Panel chair and author of the report	4/5
Advocacy Matters	Stefan Carter Senior Human Rights Advocate	5/5
Department of 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 Jane Lovell, 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.	4/5
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 Deputy Designated Safeguarding Lead (DDSL)	5/5

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

1.3 Author of the overview report and executive summary

13. 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 practice 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 (including BIA) and development that includes domestic abuse. He has completed domestic homicide reviews (now DARDR) with other community safety partnerships in England. He has completed other DHRs 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 or Stoke-on-Trent. He is not related to any individual who either works or holds an elected office in Staffordshire or Stoke-on-Trent.

1.4 Terms of reference

14. The timeline for the DARDR is from April 2015 (when Richard went to live with Keith and Mandy) until the date of Richard's death in November 2022. The DARDR considers the contact and involvement by different professionals and organisations with Richard, Keith or Mandy from April 2015. A referral was made for a Care Act assessment to be completed by adult social care just before Richard went to live with Keith and Mandy.

15. Agencies contributing reports or information to the domestic homicide review 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?
    b) 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?
    c) Is there any information that would suggest that either of the adults with whom Richard lived would present a risk of harm?
    d) Were there any opportunities for any service to seek, record and act upon Richard's views, wishes and feelings?
    e) Are there specific considerations around equality and diversity issues arising from Richard's disability that require special consideration? Were any reasonable adjustments considered?
    f) Were the two adults with whom Richard lived ever considered or expected to act as carers for Richard?
    g) 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?
    h) With the benefit of hindsight, is there anything that might have been done differently?

16. 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.

17. 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.

18. The panel also considered any other reviews (DHRs or SARs[3]) that had identified findings relevant to the circumstances being examined by this DARDR.

19. 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[4]. One in six domestic-related deaths involved a carer and care-dependent 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.

20. 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.[5]

21. 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 [6]) in ensuring the voice of people with a learning disability is heard and understood is another recurring issue in reviews nationally.

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

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

[5] 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.

[6] 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.

2 Summary chronology

22. Richard was first referred to Adult Social Care (ASC) in April 2015 due to concerns about his low weight and living conditions.

23. Multiple referrals and assessments were made over the years, including concerns about historical sexual abuse when Richard was a child, financial exploitation, and neglect, with various services involved, such as the police, RSPCA, and mental health teams. Greater detail is provided in the full overview report.

24. Richard lived with Mandy and Keith from May 2015, but concerns about his care and well-being persisted, including reports of abusive behaviour, financial mismanagement, and poor living conditions, ultimately leading to Richard's hospital admission and death in late 2022.

25. Mandy experienced a series of personal challenges, including the death of her son in a road traffic accident in November 2018, and she was referred to the mental health Access Team in May 2019 due to her low mood, although she did not attend scheduled appointments and was discharged.

3 Key issues arising from the review

26. Richard was abused in his childhood and suffered other adverse childhood experiences that are described in the overview report. The disclosure of sexual abuse did not happen until after Richard left school, and therefore, the impact of this and other adverse childhood experiences, also described in the overview report, was not known and explored at the time of the abuse occurring.

27. The combination of Richard's communication difficulties, his learning disability and his adverse and abusive childhood experiences is an important context for understanding Richard's story and analysing the opportunities for professional learning.

28. Although there were many tributes to Richard following his death, most of the people had known him from school or college, whilst others had superficial contact with him in the community. Richard's social world was impacted by Covid, and he did not participate in any work or social activities, or have an established friendship group or a significant relationship. This isolation was a risk factor for Richard, which is also recognised in the research that is referenced later in the report.

29. None of the services had extensive contact with Richard. Adult social care (ASC) had a referral in April 2015. Following a visit and an

assessment by ALDT, the case was closed to ASC, with referrals being made to an advocacy service and a community and employment service.

30. People with a disability are a significant minority within England: one in five of the population is disabled[7]. However, people with a disability experience disproportionately higher rates of domestic abuse and face higher barriers to being helped. They are harmed by domestic abuse for longer periods, and it is more severe and frequent than for non-disabled people. They 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. People with a disability, just as Richard experienced, also encounter differing dynamics of domestic abuse, which include neglect, economic abuse, financial exploitation, more severe coercion, control or abuse from family or non-family carers.

31. Domestic abuse-related deaths in which there was a carer arrangement are an increasing part of reviews across England. The larger proportion (two-thirds) of these deaths concern victims who were being cared for by the perpetrators, compared to the other third being the carer who was the victim. Findings of an adult family homicide (AFH) Spotlight Briefing [8] highlight that AFH suspects were most commonly characterised by mental ill health, caring responsibilities, and a lack of previous police and agency contact.

32. In this case, there was a convergence of Richard being isolated from social and professional contact, having several vulnerabilities arising from his history of adverse childhood experiences (ACE) and trauma combined with his learning disability, and the associated history of Mandy, his carer, that included trauma, poor mental health and use of substances.

33. There had been referrals to social care services when Richard was a child, as well as more recently as an adult, with the last not long before he was found in the very neglected and injured condition described in the overview report. The childhood referrals included concerns about whether Richard was being fed and suspected childhood abuse. The focus of the response when Richard was an adult was on Mandy's reporting of Richard's behaviour and her increasing stress.

34. The assessments were focused on Richard's immediate circumstances without an account or consideration of Richard's history of abuse and trauma, and therefore, how it had an impact on him.

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[7] Department for Work and Pensions. Family Resources Survey: United Kingdom 2009-2010. London: Department for Work and Pensions, 2011.
[8] https://www.vkpp.org.uk/assets/Files/AFH-Spotlight-Briefing-Jan-2022-AC.pdf

35. An ASC social worker visited Richard at his home in October 2022, not long before he was admitted to the hospital. This professional had left the local authority before the DARDR was commissioned and was not available to provide information for the DARDR.

36. The panel noted the disparity between the social worker reporting no concerns about Richard's physical condition in October 2022 and the fact that Richard's physical presentation at the hospital in November 2022 indicated that he had suffered neglect and physical abuse over an extended period. It proved impossible to speak to the social worker to achieve further clarity due to their moving on from the local authority.

37. Although Richard had a lifelong learning disability, he had not been supported as a child in need [9] , and there had been no transitional planning to adult services. Although he was on the GP practice register of patients with a learning disability, Richard was not seen by the GP as part of that process, which involves an annual review of health needs. Richard had not seen a GP or primary health care worker since 2015.

38. Reasonable adjustments could and should have been used more effectively to help Richard access health services, and this would have opened opportunities for observing and checking his health. Concerns about Richard not eating enough were raised more than once, and the extent of injuries and physical decline by November 2022 underline the importance of ensuring regular contact with health services. These contacts should also be opportunities to routinely check for evidence of abuse, given the known vulnerability of people with a learning disability.

39. Mandy and Keith's motivation for providing a home for Richard has never been clarified. They both have long-term health conditions exacerbated by poor mental health and a history of substance use. They have not worked and have struggled financially to the extent that they faced eviction for non-payment of their rent.

40. Richard's decision to move to their home was not explored through any supported decision-making provided by the Mental Capacity Act (MCA) and its associated process for best interest decision-making, and no other options were discussed with him.

41. Richard's learning disability was likely to make it more difficult for him to make some decisions without a supported process. There was a misplaced reliance on believing Richard could make his own decisions and his right to make 'unwise' decisions.

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[9] Children Act 1989 (s17)

42. This does not reflect the spirit or principles of the MCA, which ensures people who have difficulty with some decisions will have support, including advocacy, to help explore options. The MCA begins with a two-stage test that should be used to ascertain whether a person with a learning disability may have a difficulty that impacts their ability, for example, to weigh up information and to ensure that the decision is in the person's best interest and is the least restrictive.

43. Important decisions were made without support. Moving to Keith and Mandy's was because Richard wanted to escape abuse, and he had no other options to consider. Significant details, such as what financial contribution Richard was expected to make to the household, were not clarified. Concerning the handling of his DWP benefits, although there was discussion with Richard about the appointee arrangements, it did not involve Richard with supporteddecision-making[10] to establish whether an appointee was necessary and who that should be. Arrangements for who had access to Richard's bank account were not clarified.

44. There were specific safeguarding concerns raised about sexual abuse and possible financial abuse. Although these were referred to the police, the enquiries did not involve advice and support from professionals with specialist knowledge about learning disability, did not involve advocates and were closed due to evidential difficulties. This would have eroded Richard's confidence in talking to anybody about any other abuse he suffered.

4 Conclusions

Social Isolation and Service Invisibility

45. The Domestic Abuse Related Death Review (DARDR) found that Richard's invisibility to services after completing his education, combined with his dependency on Mandy and Keith, created an environment in which he suffered cumulative and sustained harm from domestic abuse.

46. The importance of adults with learning disabilities, like Richard, maintaining social contact and access to appropriate services, including community activities and health services, is a crucial theme that emerged from the review, and it helps to support their health and well-being.

[10] Mental Capacity Act 2005 provides an important framework for ensuring that people who may have difficulty with specific decisions due to mental are given support to protect their participation in making decisions.

47. Richard had regular contact with people who could provide information about him while he was at school and college, but after completing his education, he had limited contact with anyone other than Mandy and Keith, which exacerbated his isolation and reliance on them.

48. The assessment completed for Richard did not make him more visible to services, and although there were intentions to involve him in social activities and link him with learning disability health services, these plans were not followed up on before his death.

Environmental and Housing Challenges

49. The collapse of Richard's social world as a young adult was further exacerbated by the Covid lockdown, making him more reliant on Mandy and Keith, who had their own multiple needs and difficulties, including a history of poor mental health and substance use, and the traumatic death of Mandy's child.

50. Mandy was not offered any assessment as a carer or of her care and support needs, despite her increasing difficulties in coping with the loss of her son and Richard's behaviour, which may have been a manifestation of his childhood abuse and trauma.

51. The conditions in Keith and Mandy's home were poor, with no adequate means of heating, and they faced eviction on multiple occasions, but there was no recorded consideration by the housing officer to refer the case to Adult Social Care (ASC) despite indicators of self-neglect and the presence of a dependent adult with a learning disability.

Vulnerability and Support Network Collapse

52. The loss of significant people in Richard's life removed important support for him, and the lack of complete records of his abuse and trauma across services hindered the understanding of his care and support needs, highlighting the need for nuanced assessments that explore complex and traumatic life experiences.

53. The review highlights that isolation from positive social networks and poor access to health and social care services create conditions in which people with learning disabilities, like Richard, are most vulnerable to abuse and other risks, emphasising the importance of maintaining social contact and access to appropriate services.

54. Richard's increasing isolation and invisibility from his wider family, community, and services made him more vulnerable to abuse, which ultimately contributed to his premature death, highlighting the specific

risks faced by people with learning disabilities who are often in vulnerable circumstances and dependent on others.

Transition Planning and Trauma-Informed Care

55. The importance of effective transition planning and support from children to adult services is emphasised, as Richard's experiences as an adult with a learning disability who had been abused and suffered adverse experiences in his childhood made him particularly at risk, and this should have been a starting point for any Care Act assessments and responding to referrals.

56. Trauma and abuse are significant factors in the lives of people with disabilities and those subjected to domestic abuse, and can be a reaction to discrete adverse events or chronic circumstances, such as ongoing abuse or living in a violent neighbourhood, which can have far-reaching implications for their health and well-being.

57. Health and social care professionals need to have knowledge and understanding of the significance of trauma and its implications for individuals like Richard, and should collate sufficient detail about specific experiences and events that impact them, to provide effective support and complete Care Act assessments.

58. Richard's history of trauma, combined with his learning disability, made him more vulnerable to abuse, exploitation, or neglect, and professionals need to have a clear understanding of the additional risks faced by people with disabilities and be proactive in using reasonable adjustment practice and developing professional curiosity.

59. The review highlights the importance of recognising the long-term impact of childhood abuse and other forms of victimisation on individuals with learning disabilities, and the need for professionals to be aware of the potential adverse consequences of abuse and to provide effective support and interventions to mitigate these effects.

Behavioural Effects of Abuse and Survivor-Centred Approaches

60. The best experts on understanding the impact of domestic abuse on an individual are the victim survivors themselves, and any attempt to comprehend their situation should begin with them, taking into account additional needs such as learning disabilities and their ability to understand, communicate, and process emotions and experiences.

61. Behavioural problems, including aggression, self-injury, and sexual behaviour problems, have been suggested by studies, such as those by

Jay, Evans, Frank, and Sharpling[11], Oaksford and Frude[12], Scott, Williams, McNaughton Nicholls, McManus, Brown, Harvey, Kelly, and Lovett[13], Domhardt, Münzer, Fegert, and Goldbeck[14], Allnock[15], and Sequeira and Hollins[16], as potential effects of domestic abuse on individuals.

Safeguarding Practices and Social Relationships

62. Ensuring that safeguarding inquiries involve people with specialist knowledge of learning disability is crucial to help plan and support the inquiries, and the importance of trauma-informed practice should be prioritised to understand how life experiences influence interactions and responses to risk.

63. Having strong social relationships, acquiring appropriate skills, and nurturing attitudes of self-respect, self-efficacy, and self-esteem are essential for promoting inclusive and effective support, as recognised by researchers such as McConnell and Phelan[17].

Legal Frameworks and Decision-Making Processes

64. The absence of a clear diagnosis or assessment of how an individual's learning disability affects their daily life and interaction with people can add to their vulnerability, and the use of the Mental Capacity Act's (MCA) supported decision-making process is vital to ensure that individuals are involved and empowered to make informed decisions.

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[11] 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

[12] 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**

[13] 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.

[14] 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**

[15] 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**

[16] 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.

[17] 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**

65. The MCA enshrines the right for people not to be treated as lacking capacity simply because they make a decision that others might view as unwise, and the structured process of supported decision-making ensures the continued involvement of the person rather than being left to fend for themselves or having others make decisions on their behalf.

66. Decisions about significant aspects of an individual's life, such as where to live and who to live with, have substantial implications and should be made with the individual's involvement and empowerment, as seen in the case of Richard, where the absence of a clear diagnosis and inconsistent use of advocates added to his vulnerability.

Systemic Service Weaknesses and Support Gaps

67. The review highlights the challenges faced by Richard, including a lack of secure housing, economic security, and access to healthcare, which can be addressed by services through improved accessibility, identification, and support for disclosure of abuse.

68. To better support individuals like Richard, it is essential to provide training for health and social care professionals on understanding learning disability and trauma-informed care, as well as improving integration of services by engaging directly with disabled people and ensuring the use of trained advocates.

5 Lessons to be Learned

69. People like Richard with a learning disability are three times more likely to be victims of abuse and face multiple barriers in disclosing abuse or accessing help.

70. Trauma-informed care and safeguarding assessments are crucial in exploring cumulative adverse experiences and providing support to individuals with a learning disability.

71. Professional practice should include reasonable adjustments, easy-read documentation, and access to well-informed and trained advocacy to ensure effective support and protection from domestic abuse.

72. The appendix at the rear of the overview report includes the recommended actions identified by agencies in their management reviews.

6 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 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.

6.1 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.