SAFER BUCKINGHAMSHIRE PARTNERSHIP DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Peter

October 2015

Independent Chair and Author of Report: John Trott

Associate, Standing Together Against Domestic Abuse

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1. Preface

1.1 The Incident

1.1.1 This Domestic Homicide Review (DHR) involves the murder of Peter by his partner Jacob.[1]

1.1.2 Peter was Ian's older brother by 5 years. They both grew up in a happy family environment. Sadly, their father died when both Peter and Ian were in their 20's. Peter was close to his mother and when Ian and Peter's father died, Peter helped care for his mother. Peter and his mother are buried together. As a result of the time Peter spent with his mother, he met many of her friends and he would often help them and others by driving them out or to the theatre. Peter loved the theatre.

1.1.3 Peter was extremely academic and arts orientated. He originally struggled at school and found science difficult however, at Sixth Form College he was able to specialise in the arts at which he excelled. Peter attended Cambridge University and subsequently Peter achieved his goal of becoming a teacher. Peter started at a school in Manchester before he moved to Stowe school where he was heavily involved in pastoral care.

1.1.4 Peter cared for all of his students and was passionate about helping others, especially if he felt there was any wrongdoing. On occasions he would write letters to companies on behalf of others in order change organisations attitudes towards their customers who were ignoring the customer's complaint. He was generally successful, obtaining refunds for them.

1.1.5 Peter was very clever and academic. Within the English department, he was seen as the 'go to' person for anything concerning literature. He adored Shakespeare, Dickens and Chaucer in addition to many modern novelists. He could be quite strict as a teacher but those who wanted to learn got a lot out of his teaching, and they often explained to him that Peter opened their eyes to literature. Some of his students never looked back and some went on to teach themselves.

1.1.6 Peter would always represent his students and he would fight their corner effectively. When it was clear that a student's exam had not been marked correctly, he would appeal on the student's behalf and have the papers re-marked. On many occasions correct marks were then issued which, had they not been altered, may have hindered a student's future.

1.1.7 Due to his excellent teaching, many students and their parents stayed in touch with Peter once they left Stowe School. After his death, there were many messages passed to the

[1] Not his real name

family by his former students. One such student (now a Major in the army and a veteran of Afghanistan), visited the family and explained how much Peter had influenced him and helped him at an early age.

1.1.8 Having become slightly disillusioned about politics interfering with teaching, Peter left teaching to concentrate on his own writing. However, Peter then started to feel lonely and concerned about his future. As a result, Peter offered to help with poetry at Buckingham University and this enabled him to mix more and assisted his creative writing.

1.1.9 Peter's family stated, *"Peter cared and loved people and this came out as a result of his Christian beliefs and could be found within his church life, in his work and within education."*

1.1.10 At the time of Peter's death in October 2015, Peter and Jacob were not living together. Jacob was living at his flat in Towcester. Peter was found by his cleaner who located him sat in the lounge. A whisky glass was found on the floor next to him. Peter's death at that time was recorded by the Coroner as alcohol toxicity.

1.1.11 The Review Panel expresses its sympathy to the family, and friends of Peter for their loss and thanks them for their contributions and support for this process.

1.2 Introduction

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2.2 This domestic homicide review (hereafter 'the review') examines agency responses and support given to Peter, a resident of Maids Moreton prior to the point of his murder at his home in October 2015.

1.2.3 The review will consider agencies contact/involvement with Peter and Jacob from 1st April 2011 to October 2015.

1.2.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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.

1.2.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.6 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.3 Timescales

1.3.1 This review has been commissioned in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the statutory guidance'), following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The Safer Buckinghamshire Partnership have commissioned this review. Having received notification from Thames Valley Police in April 2019, a decision was made to conduct a review. The Home Office was notified of the decision in writing in July 2019.

1.3.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the Chair') for this DHR on 7th August 2019. The completed report was handed to the Safer Buckinghamshire Partnership in November 2023. In November 2023, it was tabled at a meeting of the Safer Buckinghamshire Board and signed off, before being submitted to the Home Office Quality Assurance Panel in November. On 21 February 2024, the completed report was considered by the Home Office Quality Assurance Panel. On 11 April 2024, the Safer Buckinghamshire Partnership received a letter from the Home Office Quality Assurance Panel. Following further review, the report was submitted for publication in October 2024.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Delays occurred due to the Covid pandemic and then in September 2020, the review panel was informed that Jacob was appealing against his conviction. Therefore, the decision was made to halt the review until the Appeal Court had heard the case to avoid jeopardising any future re-trial. At the end of March 2021, the Chair was informed that Jacob's appeal against conviction was lost and therefore the review continued to proceed. However, at the end of April 2021, the Chair was informed that Jacob had now appealed to the Supreme Court, appealing against his conviction and a further delay ensued. This appeal failed and the review re-commenced but in July 2021, the panel were again informed that Jacob had appealed against the Supreme Court's decision.

1.3.4 The Home Office was contacted and advice was sought on this unprecedented delay. The Home Office confirmed that while the DHR could be delayed, this should be kept under review by the panel. In March 2022, the SIO updated the panel that the further appeal by Jacob had failed and therefore the review could continue. The Chair was then in a position to contact the family. The family were interviewed in April 2022 and the report was finalised and sent to the panel in July 2022 for final comments. The finalised version was updated and sent to the family in October 2022 and signed off by the family in November 2022. The updated report following the family's comments was then recirculated to the panel for their information. In February 2023 the Police and Diocese of Oxford requested further changes to the report. These were considered by the Chair

and any further necessary changes were made. In July 2024, Thames Valley police requested further changes to the report. As the Chair was no longer available to contribute to the report and as no substantive changes would be made to Conclusions and Recommendations, the Safer Buckinghamshire Partnership made further changes to reflect TVP comments.

1.4 Confidentiality

1.4.1 The findings of this review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim information has been available only to participating officers/professionals and their line managers

1.4.2 This review has been anonymised in accordance with the 2016 statutory guidance except for the victim, Peter and his brother, Ian. Ian wishes that his name and that of Peter are not anonymised with the rationale that he wishes his brother to be remembered for who he was and due to the amount of media coverage surrounding Peter's death. Besides Peter and Ian only the Independent Chair and Review Panel members are named. The specific date of death is also not included.

1.4.3 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

	Relationship to Peter
Jacob	Perpetrator
Nicholas	Alleged perpetrator
Mary	Another victim of perpetrator
GP 1 – GP 5	General Practitioners

1.5 Equality and Diversity

1.5.1 The chair and the Review Panel have considered the protected characteristics under the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.5.2 The Review Panel identified the following protected characteristics of Peter and Jacob as requiring specific consideration for this case:

- Sex (Peter was male and Jacob was male)
- Sexual Orientation
- Marriage and Civil Partnership
- Age

1.5.3 Peter was an older gay man with a faith background and in a relationship with a young man. The protected characteristics of sex, sexual orientation, marriage and civil partnership, religion and belief and age are relevant to this review. The Review Panel provided special consideration to these characteristics to determine if responses by agencies were motivated or aggravated by Peter's protected characteristics and were assisted by an expert from Galop (LGBT+ anti-violence charity) who joined the panel as an advisory member. Additionally, an expert from the Church of England (CoE) and the charity, Surviving Economic Abuse (SEA) joined the panel. The chair and panel are grateful for their time and input. Their contribution is a reminder of the importance to access local community and/or expertise and knowledge in the course of a review.

1.5.4 This review has taken an intersectional framework to consider the complex ways in which multiple forms of structural discrimination (based on divisions such as class, gender, migrant status, etc.) combine or intersect to create heightened and persistent forms of inequality, marginalisation, disadvantage and powerlessness. An intersectional approach to reviews is vital in identifying and analysing the multiple and overlapping barriers that create vulnerability and risks. It is key in determining questions of how Peter came to be at risk, the barriers he faced in reporting abuse, how he was treated, what support he had, and what options for protection were available to him. These issues are considered throughout this report and summarised in 5.5.125.

1.5.5 Additionally, the following areas have been identified as pertinent to this homicide:

- Mental Health
- Economic (and financial) Abuse[2] including fraud
- Coercive Controlling Behaviour
- Alcohol

1.6 Terms of Reference

1.6.1 The Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to preventing homicide and ensuring that individuals and families are better supported.

[2] This form of abuse is designed to reinforce or create economic dependency and/or instability; limiting victim's choices and their ability to access safety. 'Economic abuse' as a term recognises that it is not just money and finances that can be controlled by an abuser (known as 'financial abuse') but also things that money can buy, including food, clothing, transportation and housing. It now forms part of the Domestic Abuse Act 2021 - https://survivingeconomicabuse.org/

1.6.2 The Review Panel was comprised of agencies from Buckinghamshire, as Peter and Jacob were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.6.3 At the first meeting, the Review Panel shared information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from the beginning of April 2011 to the date after the homicide. This timeframe was chosen because Peter and Jacob were believed to have met in 2011. The decision for the timeframe to conclude the day after the homicide was chosen to ensure learning was captured as this case was not considered a homicide until the death of Mary. It was also agreed that agencies would summarise any relevant contact with either Peter, Jacob or Nicholas before this date if relevant.

1.6.4 *Key Lines of Inquiry:* The Review Panel considered both the generic issues as set out in the 2016 statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies
- The co-operation between different agencies involved with Peter and/or Jacob and Nicholas (and wider family)
- The opportunity for agencies to identify and assess domestic abuse risk
- Agency responses to any identification of domestic abuse issues
- Organisations' access to specialist domestic abuse agencies
- The policies, procedures and training available to the agencies involved in domestic abuse issues
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support

1.7 Methodology

1.7.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic abuse is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass,

but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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

"Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." Controlling or coercive behaviour in an intimate or family relationship became a crime on 29 December 2015.[3]

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.7.2 On notification of the death, agencies were requested to check for their involvement with any of the parties concerned and secure their records. A total of 15 agencies were contacted. Of these, 7 had only limited contact and submitted a Summary of Engagement (SoE) / Short Report. However, 8 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.

1.7.3 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The IMR's received were, for the most part comprehensive, and enabled the Review Panel to analyse the contact with Peter, Jacob and Nicholas and to produce the learning for this review. Where necessary further questions and individual meetings were held with agencies and responses form part of this review.

1.7.4 In some cases, IMRs/Short Reports reported changes in practice and policies over time and four made single agency recommendations of their own. These are described in the recommendations section (section 7).

1.7.5 *Documents Reviewed:* In addition to the above information, documents reviewed during the review process have been referenced in this report.

1.7.6 *Interviews Undertaken:* The Chair interviewed Ian during the course of the review. For more information, see 1.10 below. The chair is very grateful for the time and assistance given by the family, specialists and academics who have contributed to this review.

[3] Section 76 of the Serious Crime Act 2015.

1.8 Contributors to the review

1.8.1 The following agencies and their contributions to this review are:

Agency	Contribution
Alzheimer's Society	IMR and Chronology
Buckinghamshire Council Adult Social Care	IMR and Chronology
Buckinghamshire Clinical Commissioning Group (CCG) – GP for Peter	IMR and Chronology
Buckinghamshire Healthcare Trust	Summary of Engagement
Church of England – Diocese of Oxford	IMR and Chronology
Devon and Cornwall Police	Summary of Engagement
Milton Keynes University Hospital	IMR and Chronology
National Probation Service	Summary of Engagement
Oxford Health NHS Foundation Trust	IMR and Chronology
Nursing Home	Short Report
Roman Catholic Diocese of Northampton	Summary of Engagement
South Central Ambulance Service (SCAS) NHS Foundation Trust	IMR and Chronology
Thames Valley Community Rehabilitation Company	Summary of Engagement
Thames Valley Police (TVP)	IMR and Chronology
University of Buckingham	Summary of Engagement

1.9 The Review Panel Members

1.9.1 The Review Panel members were:

Name	Job Title	Agency
April Benson	Director of Services	Aylesbury Women's Aid
Anthony Heselton	Head of Safeguarding	South Central Ambulance Service
Carl Wilson	Detective Inspector	Thames Valley Police (TVP)
Chris Oliver	Community Safety Advisor	Buckinghamshire Council formerly Aylesbury Vale District Council
Debbie Johnson	Senior Operational Support Manager	Oxford and Bucks HM Prison and Probation Service
Elizabeth Pollard	Caseworker	National Safeguarding Team, Church of England (CoE)
Emily Williams	Patient Safety Lead	Oxford Health NHS Foundation Trust

Jo Smart	Milton Keynes Together Programme Manager	Milton Keynes Together
Julie Oliver	Principal Housing Officer	Buckinghamshire Council formerly Aylesbury Vale District Council
Katherine Francis (replaced Carl Wilson in April 2022)	T/Detective Inspector	Thames Valley Police (TVP)
Lisa Johnson	Lead Nurse Safeguarding Adults	Milton Keyes University Hospital (MKUH)
Lou Everatt	Director of Operations North	Thames Valley CRC
Louise Pegg	Named Nurse for Safeguarding Adults	Buckinghamshire Healthcare Trust
Ludmila Ibesaine	Safeguarding Adults Lead	Buckinghamshire Clinical Commissioning Group (CCG)
Marion Child	Service Manager	Buckinghamshire and Milton Keynes, Alzheimer's Society
Mark Glover	Senior Investigating Officer	Thames Valley Police (TVP)
Mark Prescott	Clinical Lead	One Recovery Bucks (part of Midlands Partnership NHS Foundation Trust).
Mary Buckman	Associate Director of Social Care	Oxford Health NHS Foundation
Nicola Sharps-Jeff	Chief Executive	Surviving Economic Abuse (SEA)
Nicola Webb	Head of Service	Oxford and Bucks HM Prison and Probation Service
Peter Kelley	Service Manager	GALOP
Richard Earl	Detective Sergeant	Thames Valley Police (TVP)
Richard Woodley	Diocesan Safeguarding Adviser	Oxford Diocese, CoE
Thomas Chettle	Head of Service	Buckinghamshire Adult Social Care (ASC)
Tim Beanland	Head of Knowledge Management	Alzheimer's Society
Tracey Braddock	Service Manager	One Recovery Bucks (ORB)

1.9.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct contact, or line management of anyone involved in the case.

1.9.3 The Review Panel met a total of 3 times, with the first meeting of the Review Panel on 16th December 2019. There were subsequent meetings on 3rd August 2020 and 3rd June 2021.Thereafter, the Overview Report and Executive Summary were agreed electronically, with panel members providing comment of a final draft and signing off the final report by email during April 2023.

1.9.4 The Chair thanks everyone who contributed their time, patience and cooperation to this review.

1.10 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.10.1 From the outset, the panel decided it was important to take steps to involve the family. The review did not include Peter's friends within or outside of the Church.

Family

	Relationship to victim	Means of involvement
Ian	Brother	Interview

1.10.2 Once the decision to conduct the review had been confirmed in April 2019, the then Aylesbury Vale Community Safety Partnership (Changed mid-review to Safer Buckinghamshire Partnership) notified the family of this decision in September 2019: In addition to providing information on the review process and how family could participate if they wish, the letters provided information on specialist advocacy support.

1.10.3 The family were kept informed of the progress of the review. They were invited to read the draft report and comment before submission to the Home Office. Ian agreed to be interviewed as part of the review and his wife was also present. The family provided a valuable insight into Peter's life and experiences and this is considered as an essential part of the review.

1.10.4 There was a period of time, (during the criminal trials) where it was not appropriate for the Chair to liaise with the family. The reasons were relayed to the family by the Chair. Contact was subsequently re-stablished once the appeals processes had concluded and then the family were interviewed by the Chair. The family reviewed the final draft of the report in October 2022 and liaised with the Chair thereafter regarding the report in November 2022. The family were "pleased to see such a deep review" having been completed and thanked the panel for all of their efforts on Peter's behalf, hoping the review has a positive future influence.

1.11 Involvement of Perpetrator

1.11.1 The chair held a discussion with the panel and liaised with the Home Office in relation to whether Jacob should be interviewed. During the course of the review, Jacob made an appeal against his conviction to the Supreme Court in which he was unsuccessful.

[4] Not their real name

Subsequently, he then appealed against the decision of the Supreme Court. This was highly unusual and appears to be indicative of Jacob trying to control not just the people around him but also the court system. On 26th August 2021, the DHR Home Office team concurred that this was a reasonable justification not to interview Jacob.

1.12 Parallel Reviews

1.12.1 The Diocese of Oxford (DO) commissioned an Independent Safeguarding Review Report[5] to review the circumstances highlighted by the trial and the conviction of Jacob. The purpose of the DO review was to identify learning to improve the safeguarding of potentially vulnerable adults attending church. The DO review was asked to consider whether the safeguarding responses were undertaken in accordance with recognised good practice and were compliant with Diocesan and/or CoE and statutory policy and legislation. A comprehensive internal review was undertaken in July 2017, and this was scrutinised by the external reviewer. It emphasised that actions taken to mitigate risks and protect potential vulnerable people need to be taken promptly and tailored to local circumstances. These need to be protective, reactive to need and conducted in liaison with partners e.g. police and social services. The internal review made recommendations that the Diocese has subsequently implemented to increase the capacity and capability of its safeguarding services. The Diocese and Church of England safeguarding policies and processes that were revised, improved and introduced in 2017/18 continue to support and prompt appropriate safeguarding actions to be taken. As such the independent reviewer of the DO review did not repeat the work that had already been undertaken.

1.12.2 It was agreed by the Chair of this DHR that the IMR completed by the CoE – DO could utilise information relevant to a DHR that came from the Independent Safeguarding Review that was completed by Dr. Adi Cooper, OBE. Therefore, much of the relevant information provided by the DO for this review is included in this report. The DO case review makes 13 recommendations for improving safeguarding awareness and prevention as well as supporting a shift to a more open culture within the Church around safeguarding in all its complexity. For this DHR only the relevant ones in relation to this case have been included and any differences are shown in paragraphs 7.1.5 of this review.

1.12.2 An internal review of the preparation for the Ordination process for Jacob was also completed by two Diocesan Director of Ordinands peers[6] in July 2017. An Initial Application Form regarding becoming a candidate for ordination was received in

[5] The Independent Safeguarding Review: lessons learnt from events in the parishes of Stowe and Maids Moreton, 2012-2019

[6] The Diocesan Director of Ordinands (DDO) is responsible for the recruitment, oversight of training and the guidance of those engaged in discernment towards ordination.

February 2016 from his Vocations Advisor. As his application occurred outside of the timescale that this DHR is concerned with, its findings are not discussed in this report.

1.12.3 *Criminal trial:* In November 2018, Jacob was charged with the murder of Peter among other offences. Jacob pleaded not guilty to murder but pleaded guilty to other offences related to Peter. He was convicted of the murder of Peter at Oxford Crown Court and was sentenced to life imprisonment with a minimum term of 36 years.

1.12.4 Nicholas was charged with conspiracy to murder and other offences and pleaded not guilty. He was found not guilty of all offences and acquitted.

1.12.5 The Senior Investigation Officer (SIO) was invited to the first meeting but was unable to attend. However, he attended the second meeting of the panel to share information about the criminal investigation and address issues in relation to disclosure.

1.12.6 *The Coroner's Inquest*: The death of Peter was referred to the HM Coroner, and an inquest was opened and then discontinued after the conviction of Jacob.

1.13 Chair of the Review and Author of Overview Report

1.13.1 The Independent Chair and author of this review is John Trott, an Associate of Standing Together Against Domestic Abuse, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. He has worked for over thirty-five years in the domestic abuse sector and has extensive knowledge of the Safeguarding Children and Safeguarding Adults arena having sat on the Cornwall Local Safeguarding Children's Board (LSCB), Safeguarding Adults Board (SAB) and the South West Regional SAB. He served with Devon and Cornwall police for over 28 years and retired as a Detective Chief Inspector in 2016. For the final four years of his police career, he was the Force Lead for Domestic Abuse, Stalking and Harassment, Forced Marriage, Honour Based Abuse, Female Genital Mutilation (FGM) and Safeguarding Vulnerable Adults/Adults at Risk. He has an excellent understanding of risk, safeguarding and promoting the welfare of children and adults, having led numerous Safeguarding Children, Adults at Risk and domestic abuse investigations up to and including homicide and delivers consultancy and training to organisations in respect of domestic abuse, coercive control and stalking.

1.13.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews across England and Wales.

1.13.3 *Independence:* John has no connection with the Safer Buckinghamshire Partnership or any of the agencies involved in this case.

1.14 Dissemination

1.14.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Buckinghamshire Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

1.14.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the Panel, the Safer Buckinghamshire Partnership, the Police and Crime Commissioner, the DA Commissioner, the Thames Valley Police Service Improvement and Investigation Review Team, and published on the Buckinghamshire Council's Community Safety web page.[7]

1.14.3 The recommendations will be owned by the Safer Buckinghamshire Partnership, with the Community Safety team being responsible for monitoring the recommendations and reporting on progress.

1.15 Previous case review learning locally.

1.15.1 This is the 10th DHR commissioned locally. The Safer Buckinghamshire Board and Domestic Abuse Partnership Board oversees the learning of the reviews and delivery of the Action Plans. Whilst this is a unique case in many ways, key elements of its findings are consistent with other current and previous DHR findings and recommendations, such as the co-location of the Multi-Agency Safeguarding Hub.

[7] https://www.buckscc.gov.uk/services/community/community-safety/domestic-abuse/domestic-homicide-reviews-dhr/

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to Peter**	**Age at time of Peter death**	**Ethnic Origin**	**Faith**	**Nationality and Immigration Status**	**Disability**
Peter	n/a	69	White British	Christian	British Citizen	No
Jacob	Partner	25	White British	Christian	British Citizen	No
Nicholas	Friend	28	White British	XXX	British Citizen	No
Ian	Brother	n/a	White British	Christian	British Citizen	n/a
Mary	Further victim	83	White British	Christian	British Citizen	n/a
GP1	General Practitioner		n/a	n/a	n/a	n/a
GP2	General Practitioner		n/a	n/a	n/a	n/a
GP3	General Practitioner		n/a	n/a	n/a	n/a
GP4	General Practitioner		n/a	n/a	n/a	n/a
GP5	General Practitioner		n/a	n/a	n/a	n/a

2.1 The Homicide

2.1.1 *Death:* The Thames Valley Police (TVP) investigation into Peter's death commenced in March 2017 as a result of another TVP murder investigation of Mary. The death of Peter was considered suspicious as the circumstances of Peter and Mary's death were similar – specifically the changing of both wills to the benefit of Jacob shortly before their deaths.

2.1.2 Peter and Jacob had a private betrothal ceremony[8] and lived together. Peter believed that they were both in a loving relationship.

2.1.3 In May 2017, Peter was exhumed and a post-mortem revealed evidence that Peter had been poisoned. Jacob had been covertly poisoning Peter with several drugs causing memory loss and confusion. Jacob was also abusing Peter by gaslighting and mentally torturing him. Jacob additionally lied to agencies/friends about Peter's alleged excessive drinking to create an appearance of Peter losing his faculties.

2.1.4 Peter kept detailed diaries. These showed that during the end years of his life, he was troubled by the decline in his mental capabilities. Peter attended medical appointments to try and address this however his mental decline was medically determined to be due to ageing. His drinking of alcohol was also considered a factor. Whilst Peter was a social drinker, he was not an alcoholic (as had been portrayed by Jacob) and tests on Peter's liver, post-mortem confirmed this.

2.1.5 *Post Mortem*: After Peter was exhumed a Post Mortem was conducted where additional samples were taken for testing. The cause of death was given as "Sudden death of an elderly man with acute alcohol intoxication and Flurazepam use who had been repeatedly exposed to various Benzodiazepines, both legal and illicit, over at least a 6 month period."

2.1.6 *Judge sentencing summary*: "In your evidence at trial you admitted that from late 2012 until mid-2017 you had lived by deception and deceit and had been a well-practiced and able liar – whether to [Peter] and [Mary] in pretending that you were in a genuine and caring relationship with them when you were not, or to others. You further admitted how you could manipulate and manoeuvre people, however sceptical they may have been, to achieve your ends without ever asking them to do so directly. You were, you accepted, a snake talker, as you were able to build pressure on your victims to believe what you needed them to believe and then to do whatever you needed them to do."

2.1.7 The judge added "You murdered him […] by covertly giving him the drug Dalmane[9] and getting him to drink a sufficient quantity of very strong whisky. I have no doubt that, if it was necessary, you then finished him off by suffocating him in a way that left no trace. His body was found the next day and, at that stage, your plan worked. It was thought that, whilst alone, he had drunk himself to death. In the result, you inherited the £20,000 in July

[8] A betrothal ceremony is not legally binding and is not recognised by the Church of England.

[9] Short-term treatment of insomnia when it is severe, disabling or subjecting the individual to extreme distress. Dalmane is helpful in overcoming difficulties in getting to sleep and also in the problem of frequent nocturnal awakenings. Its properties make it particularly indicated where the total duration of sleep is less than adequate. (Electronic Medicines Compendium (EMC), accessed 27/05/21

Dalmane should not be given in acute intoxication with alcohol, sedative agents, hypnotic agents, analgesics or psychotropic agents (neuroleptic agents, antidepressants, lithium). (EMC, accessed 27/5/21)

A lower dose should be used in the older patient (>65 yrs old). There can be psychiatric reactions to this medication – from the EMC: Abnormal psychological reactions to benzodiazepines have been reported. Rare behavioural effects include paradoxical aggressive outbursts, excitement, confusion, restlessness, agitation, irritability, delusion, rages, nightmares, hallucinations, psychoses, inappropriate behaviour and the uncovering of depression with suicidal tendencies. Extreme caution should therefore be used in prescribing benzodiazepines to patients with personality disorders. If any of these reactions occur, use of the drug should be discontinued. These reactions may be quite severe and are more likely to occur in children and the elderly.

2016 and ultimately agreed with the family that [his home] should be sold, and that you should be given half of the net proceeds. It was thereafter sold for £290,000 of which, in December 2016, you were paid £142,000."

2.1.8 The judge finished by informing Jacob; "the sentence that I impose on you is one of life imprisonment, with a minimum term of 36 years".

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2.2 Background Information on Victim and Perpetrator (prior to the timescales under review)

2.2.1 *Background Information relating to Victim:* At the time of his death, Peter was 69 years old. Peter had no known disability and was of the Christian faith. He lived with Jacob having held a private betrothal ceremony in 2014. Peter was retired and had previously worked as a senior lecturer at university which is where he met Jacob. Peter was also an author. Jacob was one of Peter's students.

2.2.2 *Background Information relating to Perpetrator:* At the time of the homicide, Jacob was 24 years old. He had no known disabilities, was of a Christian faith and had been raised within the Baptist church. He was employed as a Care worker at a Nursing Home and he lived with Peter. He had no previous criminal convictions.

2.2.3 Nicholas was 29 years old at the time of the homicide. He was a full time student but completed intermittent magic work, part-time teaching and was a library assistant.

2.2.4 *Synopsis of relationship with the Perpetrator:* Peter met Jacob in 2011. They commenced a relationship and in 2012 Jacob moved into Peter's home. In early 2014, Jacob proposed to Peter and Peter accepted. They held a private betrothal ceremony a couple of months later. Unbeknown to Peter, Jacob was having intimate partner relationships throughout their time together with other women and men.

2.2.5 *Members of the household:* In addition to Jacob living with Peter, Nicholas was also a lodger for periods from 2011 until Peter's homicide.

3. Chronology

3.1 Chronology from 2011 to 2015

2011

3.1.1 Jacob was a 20-year-old student at Buckingham University when he first met Peter in April 2011. Peter was one of Jacob's lecturers. There were no known safeguarding concerns recorded by agencies before this time.

3.1.2 At the outset of the period under review, Peter was registered with a local GP practice. He was seen throughout 2011 and 2012 for "normal" healthcare concerns.

3.1.3 In early October 2011, Jacob first stayed the night with Peter at Peter's home.

3.1.4 In late October 2011, Peter gave Jacob a key to his home.

2012

3.1.5 In late February 2012, Peter called Thames Valley Police (TVP) to report a suspicious telephone call. Peter informed TVP that the caller had told him that he was owed money. Peter informed TVP that he didn't disclose any personal details, but he did provide TVP with the telephone number that called him as he had dialled 1471 to recover the caller's number. The TVP call log was closed with information that it was actioned by the Local Intelligence Officer (LIO) however, there is no record of whether any action was taken in respect of this by TVP.

3.1.6 In mid-October 2012, Peter called TVP to report that he had received a suspicious call from someone claiming to be from Microsoft asking for his bank details so that they could fix his computer. Peter gave his bank details and then realised this was a scam and called TVP. Peter informed the call taker that he intended to speak to his bank to ensure no transactions had taken place. An appointment was booked with a Uniformed Patrol Officer and following the attendance of the police officer, Peter was informed that no crime had been committed. The case was then closed.

3.1.7 In November 2012, Jacob moved into Peter's home as a lodger whilst he was working at a local Nursing Home.

2013

3.1.8 In 2013 Jacob joined the congregation of St. Mary's Church, Stowe. He took on volunteer roles as Secretary and Deputy Church Warden.

3.1.9 Between 22nd and 26th April 2013, Peter and Jacob went on holiday together to Porto.

3.1.10 In September 2013, Jacob became the Parochial Church Councils (PCC) Secretary and Deputy Church Warden at St. Mary's Church, Stowe.

3.1.11 In late October 2013, Jacob was interviewed for a job as a Carer at a Nursing Home and was successful. His references were adequate and his DBS check was clear. The job was offered to Jacob which he accepted.

3.1.12 In mid-October 2013, Jacob commenced his employment at the Nursing Home. He later moved to 'bank work' and stopped taking shifts around April 2016.

3.1.13 In October 2013, Peter and Jacob went on a trip to Somerset together.

3.1.14 In late October 2013, Peter and Jacob bought a double bed and started sharing this bed in mid-November 2013. Jacob later informed Ian that this was out of respect for Peter.

3.1.15 In late November 2013, Jacob permanently moved into Peter's home.

2014

3.1.16 In early January 2014, Jacob proposed to Peter. Peter accepted.

3.1.17 In March 2014, a private betrothal ceremony to validate their relationship was held between Peter and Jacob. The vicar conducting the ceremony questioned Jacob about the age gap between him and Peter.

3.1.18 In 2014 Peter retired and, over time, he became socially isolated. The Criminal Court Judgement stated that Jacob manipulated Peter into thinking that he was in a relationship with him, whilst Jacob was also having relationships with women.

3.1.19 In early August 2014, Peter attended Milton Keynes University Hospital for a follow up appointment as part of a national screening program. Jacob accompanied Peter to the screening and Jacob was recorded as the person who was going to be responsible for supporting Peter at home, following the procedure.

3.1.20 In October 2014, Peter first mentioned memory loss symptoms to his GP. He attended the surgery alone. Arrangements were made for Peter to be seen at home by the Dementia Community Assessment Team. (DCAT – Alzheimer's Society).

3.1.21 On 30th October 2014, a Dementia Primary Care Worker (DPCW) from the Alzheimer's Society conducted a Camcog memory test with Peter at his home. Peter updated the DPCW of his memory concerns informing the DPCW that whilst retired, he was still delivering some private tuition and lecturing. Peter was also learning two languages and had set himself a target of learning 5 new words a day although he stated that this was becoming more difficult to achieve. He was also concerned as he had recently repeated himself in his detailed daily journal, forgot some familiar words in his language class and was struggling with new procedures on his computer after it had updated. He was forgetting names and places, although they would come to him within 5 minutes to an hour.

3.1.22 Peter said he took in lodgers from the local university and he informed the Alzheimer's Society that the current lodger had told him that he repeated himself sometimes. The lodger was not present at this visit.

3.1.23 The result of the Camcog was that there was ‘no present concern regarding memory and mood and daily living skills’. The DPCW provided Peter with a publication ‘Memory Handbook’ (tips on coping with memory problems). Peter requested further testing in 3 months’ time, which the DPCW agreed to. This was in line with the agreed procedure in the service specification. Peter’s patient records were updated and his GP was informed.

3.1.24 In November 2014, Jacob influenced Peter to amend his will. These changes provided Jacob with rights to live in Peter’s home after his death and gave Jacob a cash sum of £15,000 if Jacob lived with Peter for 24 months prior to his death.

3.1.25 Towards the end of November 2014, Peter contacted TVP reporting that he was receiving silent phone calls and that the calls were worrying and disturbing him. A crime of harassment was created and passed to the Office Based Research Team (OBRT) to conduct an investigation. Research was conducted into the phone number provided by Peter by the OBRT. They ascertained it was a number used by scammers who conducted surveys. TVP informed Peter to speak with his service provider and TVP closed the case.

3.1.26 In December 2014 Nicholas, a friend of Jacob and also a lodger with Peter, moved out of the house.

2015

3.1.27 In January 2015, Jacob started drugging Peter so that he appeared confused and mentally unwell. Peter was experiencing hallucinations and had numerous falls.

3.1.28 In early March 2015 Peter was visited at home by the DPCW as arranged in November 2014. CAMCOG tests were conducted and Peter completed a MOCA test (Montreal Cognitive Assessment) as he was still concerned about his memory. He scored 29/30. As a result, the DPCW had no concerns in relation to Peter’s mood or memory. However, due to Peter’s continued concerns after the test, the DPCW suggested getting advice from a Consultant Neurologist at the Memory Clinic which Peter agreed to.

3.1.29 The following day, the DPCW contacted a Consultant Psychiatrist for guidance and the Consultant advised that Peter be referred to a memory clinic as a result of Peter’s ongoing concerns. Peter consented to this and therefore care was handed from the DPCW to the memory clinic. A letter was sent by DPCW to Peter’s GP requesting Peter be referred to the memory clinic. Towards the end of March 2015 the referral was completed by the GP citing that Peter was complaining of short term memory loss but that Peter had no functional impairment. Peter was booked into the memory clinic for assessment on 14th May 2015.

3.1.30 On 14th April 2015, Peter recorded in his diary that he fell and that Jacob caught him.

3.1.31 The following day, Peter recorded in his diary that there was a 2cm movement of family photos upstairs and that he fell after a drink.

3.1.32 On 20th April 2015, Peter recorded in his diary that he was extremely tired.

3.1.33 On 22nd April 2015, Peter recorded in his diary that he was exhausted at a concert he attended. Two days later, Peter recorded that Jacob had informed him that he thought Peter was unwell.

3.1.34 On 11th May 2015, Jacob attended a workshop for people considering ministry within the Church of England (CoE).

3.1.35 On 14th May 2015, Peter was assessed in the memory clinic. He was accompanied by Jacob who was quiet and had little to contribute. Peter reiterated his concerns around his failing memory but conversely had found recently that his insomnia had abated and he no longer required sleeping tablets. He scored a high 97/100 on an ACE-III memory test, this was deemed to be a normal score and of little concern. Peter reported his previous history of falls, and that three of them took place in a single afternoon. Only normal signs of ageing were discovered and the clinic planned to review Peter 6 months later. Additionally, the memory clinic concluded that Peter should also receive an MRi head scan. The referral for the MRi was sent to Stoke Mandeville Hospital the following day. Peter had no suicidal ideation and stated that he drank 20 units of alcohol a week [approximately 9 standard glasses of wine per week]. There were no concerns for Peter continuing to drive, although Jacob demurred at this.

3.1.36 During mid 2015 (no other date known) Jacob started to prevent parishioners from Peter's church from visiting Peter. Jacob informed them that Peter was unwell. Jacob sent email updates to the parishioners which kept them away from Peter.

3.1.37 In early June 2015, following Peter's assessment by the memory clinic, a letter was sent to the GP stating the diagnosis as normal ageing and possible mild cognitive impairment. The letter stated that Peter attended the clinic with "his long-term friend Jacob". It also described a series of 3 falls in one afternoon and noted that Peter had become disorientated in a familiar part of London. It stated that Peter allegedly drank 20 units of alcohol a week.

3.1.38 On 9th June 2015, Peter underwent an MRI scan which showed nothing significant and therefore no further action was required. A follow up appointment was arranged for 5th November 2015.

3.1.39 On 14th June 2015, Peter introduced Jacob to Mary.

3.1.40 On 17th June 2015, the DPCW closed the Alzheimer's Society case records as no further action was required from them in Peter's case.

3.1.41 Also on 17th June 2015, Peter's blood tests and scan including liver function results were received. They were all normal.

3.1.42 At midnight on 30th June 2015, the South Central Ambulance Service (SCAS) attended the home of Peter. Peter stated that he had fallen off the toilet. He did not remember how his had happened. Jacob informed SCAS that the fall was the 3rd fall Peter had had in the previous 24 hours. Peter had a minor laceration to his eyebrow. Peter was conveyed to the A&E Department by the ambulance. MKUH, assessed Peter as being intoxicated and Peter reported to the staff that he had fallen several times over the previous 2 months and that apparently his GP was investigating the falls and that he had had a recent MRi scan

at Stoke Mandeville hospital. MKUH records show that Peter attended with Jacob who confirmed that Peter had fallen “a lot” recently. Jacob confirmed with the Doctor at the hospital that he was living with Peter. Peter informed the Doctor that he only drank alcohol occasionally. All investigations were normal and Peter was discharged home with GP follow up. Peter recorded that Jacob remained with him throughout the hospital stay and that he was informed by the doctor that he had low blood pressure and needed to drink more water.

3.1.43 MKUH notes were forwarded to Peter’s GP which referred to Jacob as a “younger friend” as opposed to by his name. The name of Jacob was not documented or their relationship.

3.1.44 Throughout June 2015, Peter recorded in his diary how tired he always was, how much he was sleeping and that he was falling asleep at concerts or at friends.

3.1.45 Sometime in July/August 2015 (actual date not known), Jacob informed the vicar at Stowe Church that Peter was becoming an alcoholic and that Peter should go the Alcoholics Anonymous (AA).

3.1.46 On 10th July 2015, Peter was seen by GP4. Jacob attended with Peter. Peter informed the GP that he had been feeling dizzy in the evenings but that he was now feeling better. Peter informed the GP that he was taking more care when standing and was drinking more fluids and that his alcohol intake was moderate. Peter did not feel alcohol was a reason for his falls or dizziness. However, Peter’s “younger friend” (Jacob) informed the GP that he was not sure that Peter’s assessment was correct. The GP advised Peter to further reduce his alcohol consumption and return to the GP if he has any further concerns. The records do not show whether the numbers of alcohol units were queried.

3.1.47 On 23rd July 2015, Peter was seen by GP4 and “a friend” (no name or relationship was taken). He described how over the previous 3 months, Peter had been suffering with shuffling gait, misunderstanding and hallucinations (believing that shadows on the floor were ants). Peter was described with clarity, feeling nauseous and unsteady 2 days prior, as well as suffering with headaches and diarrhoea. Additionally, Peter said he had been having visual hallucinations but believed his friends when he was told the things he saw were not real. Both physical symptoms and hallucinations happened together. Peter stated he was feeling better, but that he felt weak and tired. A follow up appointment was booked for the following week with a suggestion that Peter may need a neurology review.

3.1.48 On 27th July 2015, the GP attended the home of Peter as a result of Peter’s nausea at night, vomiting and hallucinations.

3.1.49 On 29th July 2015, Peter was seen by GP3 who noted Peter’s episode of memory disturbance and visual hallucinations over the previous 2 weeks and the GP referred him to the memory clinic.

3.1.50 Throughout July 2015, Peter recorded that he was mislaying things, that he was tired, falling asleep at concerts and that he nearly forgot to read a lesson at church. He wrote that he spent considerable amounts of time looking for lost items including car and house keys. He also recorded that on one occasion, he woke up feeling sick and unsteady and needed support to get to the bathroom. He was informed that he had been speaking in

German and ‘gibberish’ and that this had apparently been witnessed by others. He wrote that this made him want to die. Towards the end of the month he noted that he had no sense of balance and that Jacob and Nicholas supported him through the night. He seriously questioned his faith and doubted God’s existence. He wrote that no-one seemed to be listening and recorded feeling totally confused, weak and tired.

3.1.51 By the end of July 2015, Peter recorded that he was very unwell and distressed by what he was experiencing. He was regularly falling, sleeping 16 hours a day and hallucinating. He recorded that he was initially diagnosed by the GP with a urinary tract infection but continued to feel very ill and experienced psychotic episodes.

3.1.52 On 2nd August 2015, Peter contacted the South Central Ambulance Service (SCAS) as a result of persistent hiccups. He was referred by SCAS to the primary care service. Peter was given advice as to how to try and deal with the problem.

3.1.53 On 3rd August 2015, Peter was seen by GP1 as Peter stated he continued to be forgetful and his friends had described him as talking gibberish. Peter was referred to neurology and to the memory clinic.

3.1.54 On 5th August 2015, the GP received a letter from the memory clinic stating that they felt that a neurology referral would be best for Peter.

3.1.55 On 6th August Peter, wrote that he was having difficulty with his insurance and so cancelled his premium. He wrote that he had a total loss of his faith and that prayers were going ‘into oblivion’. Peter also noted that he was struggling to walk as he became more unbalanced and that he had spent most of the day looking for items which he had misplaced.

3.1.56 On 11th August 2015, the electronic health “care notes” record system was updated to show that Jacob was Peter’s Next of Kin and that the relationship between Jacob and Peter was as a “friend”.

3.1.57 On 12th August 2015, the GP received a letter from the neurologist stating that when Peter had attended the consultation, his GP records had not come through with background information. The referral did not arrive until 2 hours after Peter had left. The neurologist suggested referring him onto the NHS, as this was a private referral and there had been problems with the insurance company funding. The GP referred via the NHS the same day. Peter recorded that he had a huge difficulty regarding making an appointment with the Neurologist and that the phone call with them had been exhausting and unproductive.

3.1.58 Over the next week, Peter recorded that he was exhausted, confused, and kept losing things and spending hours looking for them which he stated was a ‘dreadful waste of time’. He also wrote that he felt deserted by God. During this week a close friend had additionally died and, as a result of his illness, Peter was unable to read at her funeral which he found very depressing.

3.1.59 On 17th August 2015, the neurologist’s secretary telephoned the GP surgery to inform them that Peter had booked a private appointment with the neurologist on 3rd September 2015. The neurologist’s secretary was concerned as she had found Peter to be quite

confused. The GP administrator did not pass this message on to any of the clinical team within the GP practice.

3.1.60 On 25th August 2015, Peter informed the vicar of Stowe Church that he had an awful vision during the night but on trying to wake Jacob, had hit him in the face. Peter believed this may have been caused by alcohol and so the alcohol was locked away.

3.1.61 Also in August 2015, Peter told fellow parishioners and the Stowe Vicar that there was 'evil' in the house and they came to pray with him as well as provide pastoral care. Nicholas moved back into Peter's house to help Jacob care for Peter.

3.1.62 On 28th August 2015, Peter recorded that he had fallen in the kitchen and had to be lifted and carried to bed. This together with other matters left him feeling utterly humiliated, exhausted and lacking in confidence.

3.1.63 On 3rd September 2015, Peter attended the Saxon Clinic for a consultation with the neurologist. Peter attended with two "close friends" although it was not documented who they were. The neurologist was concerned that Peter had cerebellar syndrome.10 Peter was referred for an MRI scan, was advised to stop driving and to cancel his upcoming holiday to 'Yugoslavia'.

3.1.64 Later the same day, Peter recorded that he had a hallucination of flashing horizontal lights in his room.

3.1.65 On 4th September 2015, the vicar of Stowe Church and two others went to pray with Peter as Peter was convinced that "something evil" was happening in his home that was connected to his visions. The pastoral notes mention that Peter needed "much support and especially prayer".

3.1.66 On 8th September 2015, Peter recorded that he was anxious about losing things and the following day he had lost both pairs of his glasses and that he was dreading not being able to drive again.

3.1.67 On 10th September 2015, the vicar was informed by Jacob of an "overdose" taken by Peter and that Peter had struck him (Jacob). Jacob informed the vicar that this was why he was arranging for Peter to have respite in the Nursing Home for a week.

3.1.68 On the same day, Peter recorded that he seemed to be annoying Jacob quite a lot.

3.1.69 On 11th September 2015, Peter recorded that he had walked into town and then back home to sort out his will a further time with his solicitor. Peter was influenced by Jacob to remove the time condition clause and increase the cash sum payment to £20,000.

3.1.70 On 12th September 2015, Peter recorded that he had some normal balance and was walking well (albeit he was in an emotional state which was disturbing Jacob and

[10] Cerebellum is the part of the brain that controls muscle coordination – Cerebellum syndrome means that a person is was not able to control their fine motor skills/movement (i.e. writing, doing up buttons) and can lead to clumsiness.

Nicholas). However, by the end of the following day, he recorded that he was emotional and confused and had knocked over 2 glasses of wine.

3.1.71 On 14th September 2015, he recorded that during the night he had apparently emptied a drawer in his desk all over the floor, pulled a bookcase over, destroyed a laundry basket in the bathroom and destroyed the glass in his mother's last picture downstairs. He recorded that he felt 'wretched all day'.

3.1.72 After dinner on the same day Peter recorded that he was stood in the study when a wave of exhaustion struck him causing him to fall backwards, gashing his head and that Jacob drove him to A&E where he stayed overnight.

3.1.73 At 21:20 on 14th September 2015, SCAS were contacted via 111 by Jacob as a result of Peter having had a fall. Jacob was advised that Peter should attend the Emergency Treatment Centre.

3.1.74 At 22:16 Jacob attended MKUH A&E Department with Peter. The hospital was informed that Peter had fallen at home and had hit his head on a table edge. Peter was confused and Jacob stated that Peter was always confused. Peter was admitted for observation of the head injury. Records show that Peter was intoxicated and unable to give any history of the events. As a result, the history was taken from Jacob. Jacob informed the Doctor that it was normal for Peter to feel confused and that he was being investigated for frequent falls and was awaiting another MRi scan. It was noted on MKUH records that Jacob was an 'informal' 24-hour carer. Peter was discharged the following day and an MRI scan was requested by the consultant neurologist.

3.1.75 On the same day of his discharge from MKUH, Peter was seen by GP1 where he requested sleeping tablets for disrupted sleep. Peter was prescribed a short course of sleeping tablets.

3.1.76 At 19:17 on 16th September 2015, Peter contacted SCAS and informed them that he had drunk 350ml of whisky and a glass of wine. Peter stated he had called 999 because a friend (not named or recorded in any records) had returned home and found him to be slurring his words and not interacting as normal. Peter did not wish to attend the hospital and decided to stay at home with friends who lived with him.

3.1.77 Peter's records of that night were that when he arrived home and was alone in the house, he drank half a bottle of whiskey, was totally out of control, abusive and aggressive. He wrote that he fell in the bathroom and banged his head again. The ambulance was called but he refused to go to hospital. He wrote that Jacob and Nicholas tried to put him to bed but he was hysterical, abusive, and kept sitting up and prevented Jacob and Nicholas from going to bed. (It is unclear whether Peter recalled these acts of destruction during the night or whether he was informed of them afterwards by Nicholas and Jacob).

3.1.78 On 17th September 2015, Peter attended the Neurology outpatient appointment with his brother, Ian and Jacob. Ian and Peter both stated that Peter was improving, and that Peter had recently completed a will. Jacob however did not confirm any improvements but he was continuing to stay with Peter to look after him. Blood tests were actioned for further investigations. The letter sent to the GP from Neurology stated that the MRI brain scan

was normal and that Peter's eye movements were normal. Ian reported that recent telephone calls were more lucid than a month previously. However, the Neurologist stated, that the close friend that shared the home with Peter had reported that Peter walked around the house in a haze and was not sure what he was doing at times. It was noted that Peter continued to be off balance but that he had also recently completed a will to the satisfaction of his solicitor11 which to the neurologist also suggested that Peter had high levels of cognitive abilities. Peter recorded in his papers later that this was putting a huge strain onto Jacob and Nicholas.

3.1.79 On 18th September 2015, Peter recorded that he had a black eye from banging his head on the bedside table. He states that he later smashed glass on the kitchen floor and spilt a glass of water on his bed.

3.1.80 On 19th September 2015, Peter recorded that Jacob had accused Peter of 'trying to play Nicholas and him off of each other'. Peter recorded that this was not true but wrote that he was putting both Jacob and Nicholas under immense strain.

3.1.81 Peter continued to record that as Jacob tried to put him to bed, Peter hit Jacob hard and that Peter kept Jacob and Nicholas awake until 4am meaning that 'both boys were exhausted'. As a result, Peter gave Jacob and Nicholas an ultimatum that they must sleep and that Peter must go to the Nursing Home for 4 days of respite where no mobile phone contact would be available.

3.1.82 Dated the morning of 20th September 2015, Peter wrote that on waking he was informed by Jacob that he had hit his face in this night. As a result Peter was ashamed and mortified. This suggests that Peter was not aware of his actions and that he was told about them in the morning. Therefore, this raises the question of whether he was in fact responsible, and merely accepts what he was told by Jacob. This is supported by the consultant in his letter to the GP on 30th September 2015, which stated that Peter informed him that 'he apparently emptied the linen cupboard of bedding and threw these down the stairs before returning to bed to be met by the mess this morning.'

3.1.83 On 20th September 2015, Peter was admitted to the Nursing Home for respite leaving on 24th September 2015.

3.1.84 On 23rd September 2015, GP5 conducted a Home Visit on Peter but was informed by Jacob that Peter was in respite at the Nursing Home. The GP attended and met with Peter. Peter had no further falls whilst at the Nursing Home. Peter was lucid and had old bruises on his forehead. Peter had admitted that he was feeling low at times and had thoughts of suicide at times but that he had no intention of this. Whilst in the nursing home he was feeling well and Peter was keen to start on antidepressants. Peter informed the GP that after his neurology appointment he had returned home and drank half a bottle of whisky which was not normal for him.

[11] Numerous contacts were made with the solicitors practice to ascertain whether they would engage in the review but they did not respond.

3.1.85 On 24th September 2015, Peter wrote that he returned home after a peaceful time in the Nursing Home to a dreadful home of oblivion and a dreadful night. Peter recorded that Jacob and Nicholas had also suffered with Peter falling out of his bed and breaking his glasses.

3.1.86 It is noted that there were no incidents during the 4 days at the Nursing Home but they recommenced immediately upon Peter's return home under the care of Jacob and Nicholas.

3.1.87 On 25th September 2015, the day after returning home from respite, Peter contacted GP5 on the telephone and informed GP5 that during the night he was home with his partner and that he (Peter) had fallen. The GP advised Peter that he would follow up 2 weeks later but in the meantime if he had any further falls, headaches or dizziness then he should go to the A&E department. The records do not show who Peter's partner was.

3.1.88 Also on 25th September 2015, the GP surgery received a letter from the local Stowe church vicar informing the GP of Peter's lack of self-care, low mood and an inability to stand or move his legs (with these episodes lasting for 6 – 18 hours). The vicar mentioned that "2 young men" were looking after Peter and the vicar asked that tests were conducted with Peter as soon as possible.

3.1.89 On 28th September 2015, Peter contacted the Consultant Neurologist by telephone suggesting that he (Peter) could not explain why he was having symptoms and informed the consultant of his 4 day respite visit and that whilst he was there he had no symptoms. He informed the consultant that the day he returned home from respite he had a 2 hour visit from a friend and that night had fallen out of bed and was incontinent of urine. The consultant proposed Peter continue with his prescribed medication and for him to have an EEG on 6th October 2015.

3.1.90 On 30th September 2015, the GP surgery received a letter from the neurologist stating they had spoken to Peter on the telephone. It stated that Peter had an increase in erratic behaviour and had fallen during the day and night and that a housemate had videoed Peter. The neurologist agreed to review.

3.1.91 In October 2015, the Stowe vicar advised Peter to see a solicitor as Peter informed the vicar that he had bought and gifted a car to Jacob to say thank you to Jacob. The vicar felt a solicitor should record that the gift of a car was genuine to avoid misrepresentation. It is not clear whether this was done or whether any other referrals were made.

3.1.92 On 2nd October 2015, SCAS records show that Peter had a fall and was suffering with reduced mobility. He felt off balance and had a laceration to his temple.

3.1.93 At 00:39 on 3rd October 2015, Peter arrived at MKUH with the ambulance. Peter's head wound was cleaned and glued, and he remained in hospital for overnight observation. His "Carer" Jacob collected Peter in the morning.

3.1.94 At 18:17 the same day SCAS again attended the home of Peter as he had taken an overdose of Flurazepam and gin. Peter informed the ambulance crew that he had no idea why he took them and that he had no memory of taking them. Jacob was at the house on SCAS attendance and informed the crew that Peter always talked about wanting to take

his own life. Peter was transported to A&E and they made a safeguarding referral. Peter informed MKUH that he had not taken 14 Flurazepam tablets with a bottle of gin and that he had no suicidal ideation. He admitted to feeling in a low mood sometimes due to the unexplained physical issues and short-term memory loss. He was discharged home after seeing the Mental Health Liaison Team (MHLT) on 4th October 2015.

3.1.95 MKUH sent a letter to Peter's GP stating that Peter had been admitted as a result of an antidepressant overdose. It was recorded that Peter had denied taking the antidepressants and that Peter was intoxicated, frail and unkempt.

3.1.96 On 4th October, the MHLT sent a letter to the GP stating that Peter had taken an overdose. It stated that while Peter denied being suicidal, his friend Jacob instead stated that Peter would talk about killing himself. Jacob also described Peter's recurrent falls and short-term memory loss. The MHLT referred Peter back to the GP and suggested that he continue with the neurologist as an outpatient. They also suggested that the risk of further overdose be reduced by giving Peter just a 7 day prescription. They also advised that Peter should not keep any alcohol at home.

3.1.97 On 5th October 2015, Peter telephoned the consultant neurologist to state that he had been admitted to hospital following another fall but he was now safe and well and in Nursing Home receiving respite and that his friends had piece of mind. The consultant stated he would contact Peter after he had the results of Peter's EEG that was scheduled for the following day.

3.1.98 Also on 5th October 2015, a referral to the Buckinghamshire Community "Falls" Team was made.

3.1.99 Peter underwent an EEG[12].

3.1.100 On 7th October 2015, Peter was visited by GP5 at the Nursing Home. Jacob was present. Peter informed the GP that he had thought things through very carefully and that he did not want to end his life. GP5 arranged a follow up appointment for a week later.

3.1.101 On 8th October 2015, Peter attended a Neurology outpatient appointment with his brother, Ian and Jacob. The Neurologist noted that Peter did not have any falls or symptoms whilst he was in respite on either occasion. All Peter's tests were normal including liver function tests. A letter was sent to the GP informing them of the result of the appointment and that Peter had attended with his brother, Ian and Peter's "close friend". It noted that whilst there had been an increase in falls and two admissions to hospital where alcohol levels had been raised, there had been no such issues during Peter's time in respite. Jacob informed the neurologist that Peter drank 5 – 6 units of alcohol a day. Peter stated that this was not the case and that he would only drink between 1 to 2 units per day at the most. Peter's EEG was reported as normal. The letter stated that the consultant had recommended removing all alcohol from the Peter's home.

[12] EEG – Electroencephalogram – A test of brain activity.

3.1.102 Ian asked Peter to ask the Neurologist about the obscure cancer that Jacob had been regularly telling Peter that he was probably suffering from. Immediately, Jacob informed Peter, the Neurologist and Ian that he had conducted further research on the internet and that Peter did not have the cancer. This was a relief and new information to Peter.

3.1.103 On 9th October 2015, Adult Social Care (ASC) received the safeguarding referral submitted by SCAS on 3rd October 2015.

3.1.104 On 9th October 2015, the GP3 was asked by Peter to speak to the insurance company regarding whether Peter was fit to travel. GP3 informed Peter that had he known Peter was travelling, he would have discouraged it.

3.1.105 On 15th October 2015, the consultant neurologist received a letter from Peter. The letter explained that he had never been a heavy drinker and that he could not explain how this 'extraordinary' consumption of alcohol had occurred. Peter was concerned as to whether it was linked to a recent medical issue. Additionally, Peter asked if he could discuss the 'no alcohol' rule at his next outpatient appointment in two weeks' time even though he had not had any further symptoms and had not found the no alcohol rule a great deprivation. The Consultant replied and informed Peter that he would discuss the letter content with Peter when they next met on 5th November 2015.

3.1.106 On the same day, Peter's letter was placed on the GP's notes. The letter stated he had ceased drinking alcohol but requested if he could have a single measure of whisky before dinner and a glass of wine if visitors came for a meal. He also enquired as to whether the urine infections (GP dealt with in July 2015) could have started his problems of falling and dizziness.

3.1.107 On 15th October 2015, ASC records show that the SCAS safeguarding concern did not progress to an enquiry by the Safeguarding Adults Team. The rationale being that the concern did not warrant an enquiry to be undertaken under Section 42 of the Care Act and so it was resent back to the Community Response and Reablement Team to undertake a Section 9 Care Act Social Care Assessment.

3.1.108 On 16th October, ASC confirmed that Peter was open to Aylesbury Older People's Mental Health Team (Memory Clinic). The SCAS referral was also shared with the mental health team as requested. The Older People's Mental Health Team confirmed that Peter was an outpatient only and therefore no further work would be completed by the mental health Service as Peter did not have a care co-ordinator. This would therefore have to be dealt with by the Community Response and Reablement Team and this would need to be progressed to social care referral with Buckinghamshire.

3.1.109 On 20th October 2015, Peter was seen by GP4. Peter had no further episodes of dizziness or falls since seeing the neurologist. The GP was going to review further after Peter's neurology appointment in November 2015.

3.1.110 Also on 20th October 2015, ASC request that Aylesbury Older People's Mental Health Team do not follow up.

3.1.111 On 21st October 2015, the GP received a letter from the Neurologist to Peter for their records. The neurologist was happy that Peter was feeling well and had no further

episodes, falls or dizziness and advised him not to consume any alcohol until their next appointment in November 2015. He is also confirmed that he could not link a prolonged change of behaviour to the urine infections.

3.1.112 On 25th October 2015, Peter spoke at Stowe Church in an informal way and seemed much better and thanked the congregation for their support following his admission to the nursing home.

3.1.113 At the end of October 2015, SCAS attended the home of Peter where he was found deceased. He was found by his cleaner who located him sat in the lounge with a whisky glass on the floor nearby. Jacob was at the house and gave the ambulance crew a history of alcohol issues and of a previous suicide attempt. The police were contacted as the death was unexpected.

3.1.114 At 12:32 on the same day TVP received a call from SCAS in respect of the death. TVP attended and dealt with Peter's death as an 'unexpected death'. The undertakers took Peter to the Stoke Mandeville mortuary.

3.1.115 On 4th November 2015, OH (being unaware of Peter's passing) made a courtesy call to remind him of the following days appointment and a message was left on his answerphone.

3.1.116 On 6th November 2015, as Peter did not attend his appointment, OH sent a further appointment letter for 21st January 2016.

3.1.117 On 11th November 2015, at the request of a Doctor, phone calls were made to Peter's home regarding his non-attendance at the Memory Clinic but received no reply.

3.1.118 On 19th November 2015, Peter's case was discharged from the memory clinic.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

4.1.1 The Chair interviewed Peter's family. They provided a valuable insight into Peter's experience. In certain areas direct quotes have been used to reflect the feelings of the family.

4.1.2 The family were asked about Jacob, and Ian said that *"Jacob involved himself in all aspects of Peter's life in order destroy Peter and to obtain Peter's money."*

4.1.3 The family state that loneliness certainly played on Peter's mind and what Peter loved about Jacob was that Jacob had the intellect to match his. They said Peter greatly enjoyed the discussions that he and Jacob would have.

4.1.4 When the family arranged to travel and visit Peter, Jacob was rarely there but Ian's view of Jacob was that Jacob thought he was far cleverer than he actually was. This was demonstrated to Ian after Peter's death with an incident with an estate agent around finance and the selling of Peter's home, which Jacob did not have the permission to do.

4.1.5 Peter informed Ian he was gay when he was in his twenties. Being a devout Christian, Peter knew being gay went against Christian principle but he would say that:

4.1.6 *"I may be that way orientated but I'm not going to let it damage my relationship with the Lord."*

4.1.7 Peter maintained this stance throughout his prayer life and throughout his whole life; his faith always came before his sexuality. The family state that Jacob used this knowledge to manipulate Peter and used the church to ingratiate himself with Peter. The family believed that Jacob's manipulation made Peter doubt his Christian faith towards the end of his life.

4.1.8 The family stated that Jacob would try and persuade Peter that he was an alcoholic. Ian states this was incorrect, and that Peter was never an alcoholic. In fact, Ian and Peter realised when they were both in their 40s that perhaps they were drinking too much alcohol. They had a discussion together and whilst alcohol was not controlling their lives, they did not wish it to start doing so. They made an agreement that Ian would only have a drink at the weekend and Peter would never open a bottle of wine if he was alone.

4.1.9 *"We both kept tabs on each in relation to that decision. At no point was Peter an alcoholic but Jacob would tell me and others that he was. This was not true. Jacob used the subject of alcohol to manipulate Peter and he would also put drugs within Peters drink and his food. Jacob would tell Peter that he was an alcoholic and Peter would always insist to me that he was not and I knew he wasn't."*

4.1.10 The family mentioned that towards the end of Peter's life, people from the church would approach Ian and tell him that they felt sorry for Jacob due to Peter's behaviour towards him. They suggested that Ian should go and visit to help Peter. The family felt that the people within the church seemed to be grateful to Jacob for being the *"new, young, brilliant convert to the church"* but it was just another way of Jacob manipulating and taking over Peter's life.

4.1.11 This manipulation was also evidenced in relation to cancer. Jacob informed Peter that he believed Peter may be suffering from an obscure form of cancer that Jacob had researched on the internet. This worried Peter because at the time he had a urinary infection and thought it may be linked. The family state that Peter was totally *"under the spell"* of Jacob - Peter trusted Jacob and believed him. Peter spoke to Ian about the cancer and expressed his concerns about it. In October 2015, Ian attended a neurologist appointment with Peter and Jacob. In the presence of the neurologist, Ian asked Peter to ask the neurologist about the obscure cancer theory of Jacob. Jacob immediately interrupted and stated that he had done further research and that his cancer theory was not relevant. This was the first time Jacob told Peter this, and Peter was clearly shocked to hear that news. As the cancer did not exist, the neurologist did not pursue this any further.

4.1.12 The family state that they were generally unaware of what Jacob was doing to Peter. On one occasion when Ian visited Peter, Peter was not present and so Ian took the opportunity to speak to Jacob. Ian asked Jacob what his intentions were with his brother and whether Jacob himself was gay. Jacob informed Ian that he was not gay but that he slept with Peter out of respect for him. Jacob went on to say that if *"Miss Right"* came along, then he would marry her. Ian told Jacob that he did not think that his attitude was caring towards Peter, but Jacob did not appear to be concerned by that.

4.1.13 Ian stated that as Jacob became more involved in Peter's life, Peter began to rely on Jacob more. It was obvious to the family that Peter became more isolated and as a result, the family saw less of him.

4.1.14 After Peter's death, Ian spoke to Jacob and Jacob told Ian that he was absolutely fine and appeared to be *"totally unfazed by the so-called loss of this "great person within his life."*

4.2 Summary of Information known to the Agencies and Professionals Involved

4.2.1 **GP Practice**: At the outset of the review period Peter was registered with a GP Practice in Buckingham.

4.2.2 The IMR was completed by the Named GP for Safeguarding within Buckinghamshire Clinical Commissioning Group. The Chair took the view that the information provided should be considered in the overview report in order to provide a more complete picture of Peter's life throughout the period under review.

4.2.3 A thorough review of GP notes was conducted. These notes also contained a record of letters written to the GP from external agencies such as SCAS and local hospitals.

4.2.4 When the GP notes were initially requested, they were redacted with key information hence the panel was not able analyse it at the first review meeting. Following a further request for un-redacted notes to conduct this review, they were supplied. This has been addressed locally and will no longer be an issue for any review in the future

4.2.5 Peter was seen by the practice for routine medical appointments but also for his treatment in relation to memory loss and falls.

4.2.6 **Milton Keynes University Hospital (MKUH):** The Hospital is a district General Hospital which serves the people of Milton Keynes and its surrounding borders.

4.2.7 MKUH provided an IMR covering Peter's attendances at a number of MKUH departments. These included A&E, Neurology, MRI and EEG screening. Hospital records were used to formulate the IMR.

4.2.8 The majority of Peter's attendances were as a result of an incident happening at home and the subsequent outpatient follow up required following that incident and admission to hospital.

4.2.9 The IMR author critically analysed all records of contact with Peter. The author identified areas for improving assessment of safeguarding issues and referral processes.

4.2.10 **Oxford Health NHS Foundation Trust (OH):** Oxford Health provides all age mental health and social care for young people adults and older adults in Buckinghamshire and physical, mental health for people of all ages across Oxfordshire, Swindon, Wiltshire, Bath and North East Somerset. Its services are delivered at community bases, hospitals, clinics and people's homes. Part of Oxford Health NHS Foundation trust is Bucks Older Adult North Community Mental Health Team (CMHT). Within the CMHT there is a Memory Clinic which was used briefly by Peter.

4.2.11 The Memory Clinic is an outpatient service, so patients do not have an allocated Care Coordinator or any social care input or monitoring from the wider CMHT.

4.2.12 The IMR was completed on behalf of OH by the Serious Incident and Complaints Investigation Lead and provided a good quality analytical IMR detailing assessments of Peter, domestic abuse, training, policies and other matters.

4.2.13 **Thames Valley Police (TVP):** Thames Valley Police are responsible for policing the Thames Valley area covered by the counties of Berkshire, Buckinghamshire and Oxfordshire. It is one of the largest territorial Police Forces in England covering 2,200 square miles (5,700 km) and a population of over 2.1 million people.

4.2.14 Peter lived within the TVP area. His first police contact during the review period was when he contacted TVP to report suspicious telephone calls in February 2012. Other significant calls included reporting a potential computer hacking scam in October 2012, where Peter had been asked for his bank details which he provided and in November 2014, Peter reported that he was receiving silent phone calls and provided TVP with the telephone number that had been calling him.

4.2.15 TVP also conducted the investigation into the homicide of Peter following information that was ascertained during a fraud investigation for another victim known to Peter. (Mary DHR refers). The Senior Investigating Officer (SIO) and Receiver for the Major Crime Unit supported the DHR. The family of Peter thought the SIO and the Family Liaison Officer were outstanding and were impressed with the murder investigation once it commenced.

4.2.16 For the relevant time period covered by the review all appropriate databases and systems were checked by TVP. Additionally, a number of TVP employees helped inform the TVP IMR but not every employee described in the incidents were contacted.

4.2.17 **South Central Ambulance Service NHS Foundation Trust (SCAS):** SCAS provide a range of emergency, urgent care and non-emergency healthcare services, along with commercial logistics services. The Trust delivers most of these services to the populations of the South Central region – Berkshire, Buckinghamshire, Hampshire and Oxfordshire – as well as non-emergency patient transport services in Surrey and Sussex.

4.2.18 SCAS is a monopoly provider of 999 emergency ambulance services within the South Central region. With the expansion into Surrey and Sussex, SCAS serves a population of over seven million people across the six counties.

4.2.19 SCAS involvement with Peter or Jacob during the period of review was as a result of telephone calls made from Peter's home. The information for the IMR was ascertained after reviewing the patient's clinical records, 111 calls and SCAS 999 calls.

4.2.20 **Buckinghamshire Council Adult Social Care (ASC):** ASC were first notified of concerns in October 2015 by SCAS. Peter had not been known by the department before this date. ASC's work after the referral and before Peter's death, was trying to ascertain which was the most appropriate ASC department to deal with the concerns raised by SCAS.

4.2.21 **Alzheimer's Society (AS):** The Alzheimer's Society (also referred to as the Society) supports people affected by dementia, both those with memory concerns or a dementia diagnosis, and their family carers. The local service, at the time of their involvement in this review, provided the North Buckinghamshire's Dementia Primary Care Scheme, working in partnership with the GPs in North Bucks and the Memory Clinic based in Swan Practice, Buckingham. This was a 3-year pilot scheme conducted between 2012 and 2015 and was commissioned by Buckinghamshire's County Council and Oxfordshire NHS.

4.2.22 Following referrals from the GP in October 2014, AS assessed Peter during that month and then again in March 2015.

4.2.23 **Nursing Home:** The Home provides 32 beds for residents over the age of 65 who require general nursing and or dementia care.

4.2.24 Jacob applied for and was successful in interview for the role of a Carer at the Home in October 2013 commencing employment in November 2013 where he remained until his employment was formally terminated in April 2016.

4.2.25 Jacob's job entailed providing all personal care for the residents and care for their psychological needs.

4.2.26 Peter had two respite stays at the Home of 4 and 5 days respectably in late September 2015 and early October 2015.

4.2.27 **Diocese of Oxford (DO):** Stowe Church has some unique features in that it is a "gathered church" as it lacks a locality focus with parishioners attending from a broad geographic area, including staff from the former Stowe School within the grounds of which the St. Mary's church sits.

4.2.28 Stowe Church has a strong identity and is seen as "close knit community". It is isolated from other church communities as it is not part of a group of Parishes. It has an evangelical

theology and conservative culture which includes so called “traditional” views towards people who are classed as LGBT+.

4.2.29 Peter was a member of St. Mary’s Church, within the grounds of Stowe School. He was a long-standing member of the congregation, a volunteer Church Officer and he preached sermons on occasions. He attended bible study classes with Jacob and attended services with him.

4.2.30 Jacob started to attend Stowe Church in 2013 having been introduced by Peter who vouched for Jacob within the church community. Jacob became a Church officer as a result of taking on volunteer roles as the Parish Secretary and Deputy Church Warden.

4.2.31 The CoE’s involvement with Peter during the period of review centred around Peter’s concern that he believed that he had received visions and the vicar praying with Peter at Peter’s home.

4.2.32 The involvement with Jacob was in relation to his application and the subsequent process of becoming ordained. Additionally, conversations with the vicar about Peter and the isolation of Peter from the church by Jacob.

4.3 Any Other Relevant Facts or Information

4.3.1 **Police:** Checks were conducted on police databases on Peter, Jacob and Nicholas up until the death of Peter. Peter and Nicholas were not known to the police except in relation to reporting and being victims of crime. Jacob came to attention of TVP in 2010 for theft of a T-shirt but until the murder investigation, (post Peter’s death) there was no further intelligence in relation to him.

4.3.2 **Alcohol Misuse**: During the review it was maintained by Jacob that Peter had an alcohol problem, which Peter sadly believed. Whilst Peter was seen by GPs and neurologists in relation to memory loss and fall issues, and alcohol was discussed by Peter and Jacob, there was no information supplied suggesting that Peter had accessed local services or been referred to such services by any health professionals.

4.3.3 **Vulnerability:** Peter’s vulnerability was heightened not due to just age and possible loneliness but also by the combination of his sexuality and religious beliefs. Whilst his sexuality was known it was not generally acknowledged by those around him within his church. Peter was from a generation where being gay was illegal and criminalised for many years. Within Stowe Church, being gay was generally perceived as being wrong so Peter was unable to be honest about his emotional relationship with Jacob.

4.3.4 **Economic (including financial) Abuse:** This case is not just about financial abuse but also economic abuse. Jacob stood to inherit property in addition to receiving direct sums of money. This was the driving force for Jacob, and he was very aware of Peter’s vulnerabilities and, therefore, after meeting him in 2011, he very quickly groomed him into a relationship for his own economic gain. When and how much Jacob exploited Peter is hard to quantify as he also profited from many gifts. In terms of large sums of money, Jacob was going to benefit from the estate that Peter left to him once he died after his

abusive tactics convinced him to change his will in his favour. This is what occurred and soon after Peter's death, Jacob tried to sell the home even though he was not in a position to do so. Peter's home was sold for £290,000 of which Jacob benefitted to the value of £142,000. Jacob used his abusive tactics and deception to obtain a second-hand car. Additionally, Jacob convinced Peter to gift him £15,000 to live with Peter two years prior to Peter's death. Peter was subsequently convinced by Jacob to change this to £20,000 and to remove the time condition clause. Less than two months later Peter was murdered by Jacob.

5. Analysis

5.1 Domestic Abuse and Peter

5.1.1 The circumstances of Peter's death and the conviction of Jacob for his murder, clearly show that Peter was a victim of a Domestic Homicide in line with the definition under the Domestic Violence, Crime and Victims Act 2004.

5.1.2 Evidence of coercive and controlling behaviour was present in Peter and Jacob's relationship. This is evident from the disclosures that Peter's family and friends have made as part of this review and from the police murder investigation prior to this review taking place.

5.1.3 Whilst the panel can look at his case in hindsight in respect of the information obtained from the police investigation and Peter's family, it is clear from the information provided that Jacob was controlling Peter from an early stage in their relationship.

5.1.4 It is apparent from the police investigation and interviews with Peter's family and friends that Peter was subject to financial abuse. It is not generally apparent that any agency would have been aware of the control Jacob exerted over Peter on financial matters however there were some concerns that were bought to the attention of the DO. The panel have not found any information to suggest that agencies were aware of the sometimes dire situation Peter found himself in.

5.1.5 The responsibility for the tragic death of Peter rests solely with Jacob. The following sections outline the reflections of the Review Panel with regard to possible missed opportunities to help and support Peter as well as areas of improvement needed within Buckinghamshire.

5.1.6 Tragically, it will never be possible to know the full extent of Peter's experiences. However, as a minimum it appears Peter experienced the following:

- Physical abuse:
- Coercion, threats and intimidation:
- Emotional abuse and isolation:
- Economic (including financial) abuse:

5.2 Analysis of Agency Involvement / Responding to the Terms of Reference

5.2.1 **GP Practice:** Peter was initially seen alone in October 2014 during the period of review. He mentioned he had some memory issues so arrangements were made for the dementia community assessment team to review Peter at home. The results showed no concern of a memory problem, and plans were made to reassess him in February 2015.

5.2.2 Between the end of June 2015 up until the time of his death in October 2015 Peter was seen on six occasions by different GPs from the GP Practice. These consultations were in relation to falls that Peter had allegedly had, dizziness, nausea, and hallucinations. Additionally, there was a further consultation with Peter via telephone in relation to a fall

that Peter had at the end of September 2015. The fall was on the evening of the day Peter had left respite.

5.2.3 In five out of 7 of these consultations that Peter had with the GP, the records show that a "friend" was present. This "friend" was Jacob, but Jacob was only named on 2 of these occasions, otherwise he was referred to as a "friend". The panel discussed this in detail and the importance of professional curiosity and health services seeing people alone. Seeing patients alone should be default and built into policy, not just 'good practice'. Everyone should be given an equal opportunity to disclose.

> **Learning Point**: Health Services to build into practice speaking to patients alone so that if abuse is present in the patient's life they have the opportunity to be asked about it and be able to respond without a potential perpetrator being present during a consultation**.**

5.2.4 In this case, from a medical perspective, the different GPs that cared for Peter did so appropriately. He was referred to the memory clinic, to neurology and urology correctly. When Peter went into respite in the nursing home, he was also visited on the two occasions he was a resident there. On one of these occasions, the GP conducted a Home Visit on Peter but were informed by Jacob that Peter was in respite at the Nursing Home. The GP attended the Nursing Home and met with Peter. This was good practice. Additionally, Peter was prescribed medications requested by urology appropriately, and antidepressants when needed. The GP escalated the concerns of the vicar when he 'home visited' Peter in a pastoral capacity, writing to neurology asking for their escalated input which led to the consultant neurologist ringing Peter at home. Finally, the GPs listened to Peter and took his wishes into consideration- e.g., to be referred privately.

5.2.5 There was no documented evidence of domestic abuse within the medical records either from the reports from other medical areas supplied to the GPs or from their own consultations with Peter. Therefore, there could have been missed opportunities because professional curiosity probing during consultations may have led to Peter disclosing domestic abuse. However, at no point did the GPs appear to consider domestic abuse as they believed Peter's symptoms were an organic health problem that was being appropriately investigated. None of the GP's sought to understand Peter's home life and support networks and there is no record that he was he ever asked if he had a partner (in a non-gendered way).

5.2.6 Peter was seen by a maximum of five different GPs from the end of June 2015 until his death in October 2015. This would not assist with any of the GPs getting to know Peter well, nor potentially, would it assist with Peter feeling safe and comfortable enough to share sensitive, personal or distressing information with his GPs. The current configuration of GP services would make it unlikely that a patient would see the same GP on each occasion. This lack of continuity could place further constraints on the GPs ability to identify whether there were any changes or differences in Peter's presentation, mood or behaviour and therefore brings into focus the need for accurate recording and liaison between GPs.

5.2.7 Despite concerns raised by Peter and supported by his brother, Ian, about falls, hallucinations and alcohol consumption and the fact Peter would sometimes feel well within himself and that he was more lucid, Jacob would state the opposite. This was not followed up in terms of safeguarding concerns by the GPs. GPs appeared to follow guidance for memory loss but did not follow any guidance or seek other professional advice in respect of alcohol. Professional curiosity was not shown to rule out alcohol/substances being a factor in the change in Peter's presentation, or his psychiatric symptoms. There is no record in the notes as to whether other reasons alcohol use was explored and no link made that Peter's alleged alcohol consumption had increased since he had been living with Jacob. No alcohol issues had ever been recorded before their relationship started.

5.2.8 An increase in alcohol consumption can be a sign someone may be experiencing domestic abuse. Perpetrators of domestic abuse can force their victims to drink, or it can be a coping mechanism used by victims in order to deal with the abuse. The records do not show whether domestic abuse was explored by the GP having been given this information and was therefore a potential missed opportunity.

5.2.9 It has already been noted that Peter had a number of consultations with GPs and if done alone with Peter, could have been an opportunity to discuss whether domestic abuse was present. The symptoms Peter was experiencing could be due to the coercive and controlling behaviour exhibited by Jacob, whether that be alleged memory loss (being gaslit), alcohol usage, increased falls and hallucinations. With more professional curiosity applied during such conversations, it could have led to Peter opening up more about his current feelings. Further inquiry into both the situation at home and what that looks like, could have assisted with Peter's mental ill health and assisted professionals to understand what potentially was happening to Peter within his home.

5.2.10 Paragraph 5.2.3 refers to Peter's "friend". However, there was a lack of professional curiosity shown in respect of Peter's relationship with Jacob. GPs did not always write the name of the friend that attended with Peter nor their relationship status.

5.2.11 During the visit on 23rd September 2015 between Peter and the GP at the nursing home, Peter stated he had thoughts of suicide but had no intent. There does not appear to have been further exploration of this or consideration for other referrals to be made to other services. At this point of support, Peter may not have had the intent of suicide but he had been thinking about it. Therefore, there was a lack of professional curiosity around asking further about Peter's mental health and there was not a clear picture on how his frame of mind was at the time. It is not recorded whether any mental health needs were discussed with Peter or any other services. It is of concern that this was not explored further as within the domestic abuse sector it is widely known that in coercive control cases most victims and survivors will state that it is not the physical violence that hurts them the most (not that physical violence needs to have occurred for coercive control) but the mental and psychological harm that is done to the victim. Therefore, it is not unsurprising or unexpected that victims of domestic abuse will suffer with some form of mental health concern or deterioration. That does not make them any less of a victim and indeed professional curiosity by a GP should explore that with the victim further. Just 10 days later

Peter was admitted to hospital having allegedly taken an overdose of antidepressants that had been prescribed by the GP.

5.2.12 All professionals must maintain an attitude of respectful uncertainty. This means applying a critical eye to the information given by a victim and other people close to them (Ian and Peter's "friend" Jacob) rather than just accepting things on face value.

5.2.13 During the majority of consultations with Peter, Jacob was also present and was allowed to remain. It must be recognised that a victim, in a coercive controlling relationship with the perpetrator present, will be highly unlikely to divulge domestic abuse for fear of the consequences that they know will occur after the professional has left unless the victim believes that support from elsewhere is realistic. Whilst domestic abuse was never explored by the GP, had Peter been asked, the perpetrator would have been present.

5.2.14 Best practice recommends that patients are spoken to unaccompanied by friends and/or relatives. Jacob was present as already stated on the majority of occasions. This was a significant missed opportunity and had Peter been able to speak privately then potentially he would have disclosed concerns which could have been recognised as domestic abuse and this particular aspect of coercive control. It is appreciated that even given the opportunity to disclose, Peter may not have done so but the opportunity should be given to a patient to disclose and talk of their relationship, and professionals should try and look at the patient holistically.

5.2.15 There is no record to show whether Peter was given the option for Jacob not to be present but of course this question (if asked) would have to be when he was alone anyway. The records do show that there were potential power imbalances when Peter would inform the GP of one thing and Jacob would state the opposite e.g. alcohol consumption, walking around in a haze and seeming confused (notes forwarded to the GP from the neurology consultant) or coercion noted such as Jacob answering questions on Peter's behalf. There is no record in the notes as to who was being believed, Peter (the victim) or Jacob (the perpetrator).

5.2.16 There was no consideration that Peter may have been 'gas lit' or exploration from a domestic abuse point of view as to why he had alleged memory loss, hallucinations, dizziness, confusion, increased alcohol consumption and suicidal thoughts. 'Gas lighting' refers to a tactic perpetrators use in order to convince the victim they are losing their mind.

5.2.17 **Milton Keynes University Hospital (MKUH):** Peter attended MKUH on four occasions in 2011 for a medical reason that is not relevant to this review. Of interest at this time the records noted who was responsible for Peter and who was going to collect him after his appointment.

5.2.18 From the end of June 2015 to early October 2015 Peter attended hospital on three occasions having fallen whilst at home. In addition to that he reported that he had fallen previously which he could not explain. On two of the occasions recorded, Peter was intoxicated. Despite the number of falls no consideration was given to the fact that potentially the falls were non-accidental. Each fall resulted in some form of head injury. No external stress factors (such as domestic abuse or coercive control) were considered and it appears no professional curiosity was shown despite the escalation and the variance of

what Peter would inform the professionals and what Jacob would contradict. It appears that generally, it was Jacob that was believed over Peter or indeed Ian. This is despite the fact the actual relationship between Peter and Jacob was never concluded by health professionals. Jacob was shown as a “younger friend”, an “informal 24 hour carer” or a “carer”. He was not named as Peter’s partner.

5.2.19 In respect of the falls that Peter had, there was not an escalation process in place at the time within MKUH, however there was a safeguarding policy which covered escalation. This was not followed, however, the policy has since been updated to include more information about professional curiosity, not only relating to relative and partners, but also friends. This has also been built into current consultant training.

5.2.20 Research shows that nearly a quarter (23%) of victims at high risk of harm and 1 in 10 victims at medium-risk attend Accident and Emergency (A&E) because of acute physical injuries. In the most extreme cases, victims report that they attended A&E 15 times.[13]

5.2.21 If domestic abuse were to be responded to effectively when identified in hospital, through professional curiosity, routine questioning and identifying escalation not only would victims of domestic abuse be identified and therefore better protected through safeguarding but wider and more detrimental costs could be minimised. Evidence from research studies exploring the effectiveness of health professionals asking about domestic abuse shows that without a service to which they can immediately refer, such as a hospital-based IDVA service, the opportunity to intervene will be ignored or ineffective.[14]

5.2.22 Since 2015, MKUH have informed the review that the safeguarding policy has been updated and training within the hospital now focusses on domestic abuse.

5.2.23 The same day, after the third recorded “fall,” Peter was again brought to hospital stating the reason was due to taking an overdose of tablets and alcohol. Peter was seen by the MHLT who discharged him from their service and advised to remove all alcohol from his home. Peter stated that he had not knowingly taken an overdose and he had no suicide ideation. There was no consideration that Peter may have been “given” the tablets and alcohol or had been coerced or manipulated into taking them. There was no exploration from a domestic abuse point of view as to why Peter was having falls, was drinking (when he said it was not normal for him) or why he had taken an overdose. This was not explored further by the MHLT. Perpetrators can manipulate victims in order for them to believe that the victims are losing their mind. Jacob was always in attendance at the hospital, he was present throughout and therefore had Peter wanted to disclose domestic abuse he would have been unable to do so privately. These were significant missed opportunities and had Peter been spoken to alone he could have disclosed domestic abuse and the manipulation and coercive control would have become known. Whilst the consultant neurologist did have concerns, which were not linked to domestic abuse, the consultant did flag his concerns to the GP of Peter. In relation to the removal of alcohol from Peter’s home would

[13] Getting It Right First Time - SafeLives

[14] A Cry for Health - Why we must invest in domestic abuse services in hospitals (SafeLives 2016)

suggest that medical professionals were confident that Peter was not an alcoholic as medical advice is clear on the sudden cessation of drinking for alcoholics. Additionally, Peter would have had withdrawal when he was in respite at the nursing home if he were an alcoholic and would not have returned to normal cognitive function. Therefore, healthcare professionals should have raised further concerns about the cause of the falls, hallucinations and overdose. More professional curiosity should have been shown and had a recognised assessment been completed it may have shown the level of either alcohol dependency or alcohol withdrawal. There is no evidence that such an assessment was completed. If Peter had been dependent on alcohol, it is likely that a sudden cessation would have led to at least mild physical symptoms (sweating, shaking, and headaches) and increased levels of agitation and anxiety. More severe withdrawal symptoms may have included severe sweating, severe tremor, possible seizure, confusion, hallucinations and raised blood pressure. The post mortem revealed Benzodiazepines which can lead to memory loss, low blood pressure, dizziness, hallucinations, hiccups, feeling of humiliation, tiredness and a lack of confidence, all of which Peter had reported.

5.2.24 Peter did not attend MKUH again until 2014 when he attended for a follow up appointment as part of a screening program. On this occasion he attended with Jacob. Records show that Jacob was responsible for supporting Peter and MKUH notes were forwarded to Peter's GP, which referred to Jacob as a "younger friend" as opposed to by his name. The name of Jacob was not documented or their relationship except for the fact that Jacob was responsible for supporting Peter. The IMR does not explore further the "younger friend" aspect.

5.2.25 Peter underwent an MRI scan and then he was discharged. Protocol states he should have returned to the ward for review prior to discharge but he was not. There does not appear to be a record to show why protocol was not followed. The Ward Doctor later followed up with Peter via the telephone.

5.2.26 Two days later, Peter attended a neurology appointment with Ian and Jacob. Peter and Ian stated there had been improvement in his symptoms, but Jacob stated there had been no improvement and therefore he was staying with Peter to look after him. There appears to be no concerns that two people are stating there is an improvement, but one is stating there is not. Jacob stated he was staying with Peter in order to look after him when in fact he was living with Peter. Additionally, it was explained that Peter had drawn up a new will, but no questions appear to have been asked about the change of will and indeed was taken as a positive that Peter was mentally in a place that he could change a will as opposed to the reasons for changing and who would now indeed benefit. When Peter contacted neurology at the end of September to seek reassurance as to why he had no memory of the incidents, the neurology department stated that Peter did not display symptoms of memory loss. However, it is at this point that domestic abuse and gaslighting should have been considered a possibility.

5.2.27 The Government Violence Against Women and Girls (VAWG) strategy recognises the importance of integrating domestic abuse within healthcare settings. It acknowledges that "GPs, midwives, health visitors, mental health, drug and alcohol services, sexual health and Accident and Emergency staff are well placed to identify abuse". Their ability to

intervene early and direct victims towards appropriate statutory and non-statutory services is highlighted. Supporting the governmental VAWG strategy, the NHS Mandate recognises the vital role of the NHS in tackling domestic abuse. It sets out expectations upon NHS England to ensure that the NHS helps to identify abuse early and provides or identifies the relevant support.[15]

5.2.28 Research shows that 29% of domestic abuse victims have been to A&E in the six months before accessing help from professionals for domestic abuse, and that almost all of their visits to hospital (86%) were related to domestic abuse – nearly two thirds (64%) specifically because of injuries by the abuser – indicates the important potential for hospitals to identify these victims earlier. [16]

5.2.29 It may also be possible to identify some hospital domestic abuse victims earlier: eighteen of the 41 (44%) of victims who had visited A&E in the six months before referral had visited more than once.[17]

5.2.30 There is considerable potential, for hospital A&Es to identify victims of domestic abuse earlier – patients they are already identifying who have visited previously, and those they are not identifying, who later come to the notice of the police who then refer them to a community IDVA. Not all victims would be prepared to disclose, but at least if such considerations were given by professionals within a healthcare setting then some may disclose if given the opportunity and within the right environment. i.e. not with the potential perpetrator present.

5.2.31 **Alzheimer's Society (AS):** At the time of Peter's interactions with the AS, the service specification was that AS would provide support for early diagnosis and intervention for patients with mild and moderate dementia. This included undertaking CamCog assessments with patients, communicating the results to the patient and their family, advising on next steps and signposting where appropriate to other community services. They would also keep GPs updated, request blood tests if appropriate and support patients and carers through the diagnostic process and patients (as required) after diagnosis.

5.2.32 Peter had two meetings with the AS through the DPCW that conducted tests on Peter at his home due to his concerns about his perceived memory loss. The DPCW worked well and in line with the agreed process, assessing Peter, communicating the results of the assessment to Peter, referring for further assessment, updating EMIS as required and exiting Peter from the service in line with eligibility. This was good practice.

5.2.33 The DPCW completed the initial CamCog assessment and responded to Peter's ongoing concerns and anxiety regarding his memory by completing the MOCA and referring to the Consultant Psychiatrist. The Consultant Psychiatrist responded promptly, and the Consultants advice was acted upon with the GP referring Peter back to the Memory Clinic

[15] NHS Mandate (2016)

[16] A Cry for Health - Why we must invest in domestic abuse services in hospitals (SafeLives 2016)

[17] A Cry for Health - Why we must invest in domestic abuse services in hospitals (SafeLives 2016)

for further assessment. The DPCW acted appropriately closing the case when they were informed that Peter's memory loss was the result of ageing and not dementia.

5.2.34 Normal signs of ageing are described in lay terms as the brain's structure and function deteriorating with age in the way that any other organ would (e.g. heart, eyes, lungs, kidneys etc.). This is primarily caused by shrinkage (atrophy) of the brain tissue and damage to the very small blood vessels that supply the brain; both of which can be detected on CT and MRI scans. These are normal features of ageing and potentially result in some subtle decline in an individual's ability to recall information (usually in the short-term). On a memory test, you might expect to see a small reduction in an individual's score (generally no more than several points) as a result of these changes. Sometimes, this is harder to detect in an individual (such as Peter) who was very intellectually able and functioned highly throughout life. These changes would not tend to affect an individual's ability to carry out day to day tasks (e.g. shopping, cooking, managing finances etc.) to any great extent.

5.2.35 There were no indicators of abuse within the referral to the service. The DPCW was new in post at that time and had recently completed the AS's induction training programme, which included a safeguarding e-learning and a one-day safeguarding practitioner's course. There were no indications of abuse identified during the interactions with Peter and the DPCW had no interactions with the lodgers. No disclosures were made by Peter during the limited time the DPCW worked with him but records do not show whether Peter was asked about abuse.

5.2.36 In 2015, the service closed as it was funded as a 3-year pilot. At the end of the pilot, a focus group took place with service users and surveys were sent out to GPs for feedback on the service. Commissioners used this information to commission a new service, Memory Support Service, which is delivered against the AS Dementia support service specification. This offers a much more robust service delivery against prescribed processes with the AS, which are quality assured on a regular basis by the Safeguarding and Quality team.

5.2.37 Safeguarding is now embedded well across the AS and its services.

5.2.38 **Oxford Health NHS Foundation Trust (OH):** Peter was referred to the Memory Clinic via the Alzheimer's Society (AS) as he was worried about memory loss that he felt he was having as detailed previously in para 3.1.20.

5.2.39 The AS could find no marked deterioration and Peter was assessed by OH's, Bucks Memory Clinic. Similarly, there were no significant decline noted on assessment. However, due to Peter's continued concern and his high level of functioning prior to raising his concerns, further testing through neuropsychology was suggested to him however, Peter declined it. As a consequence, a repeat assessment was planned for 6 months later and a referral for an MRI head scan was also planned to investigate further. However, no concerns were noted following the MRI.

5.2.40 Peter was offered various treatment options and alternative suggestions for care were explored with Peter and he was able to make informed decisions about the treatment available to him.

5.2.41 Peter was only seen once by Oxford Health's Bucks Older Adult memory clinic.

5.2.42 Patients are asked to bring their partner or carer with them to their diagnostic appointment. Best practice dictates that patients and caregivers are seen separately once they attend the appointment. This is not as a result of domestic abuse concerns, but it is predominantly to give the caregiver the opportunity to offer reliable collateral information that they may not feel able to disclose in the presence of the patient and the caregiver can raise any concerns around risk. Ordinarily the consultant would speak with the caregiver whilst the memory clinic clinician conducts a cognitive assessment with the patient. This may be a time that the patient (if a victim of abuse) can disclose the abuse to a professional. However, there are no records as to whether any discussions or routine questioning was asked of Peter in this case and it is not normal practice to do so. In this case Peter and Jacob were seen together as the usual professional who would have seen them separately was not available due to staffing levels.

5.2.43 In Peter's case because of Peter's high level of function, the consultant decided to carry out a more in-depth assessment (an Addenbrooke's Cognitive Examination (ACE-III)) that clinicians are not trained to complete. There are no records to show whether this assessment was done separately and away from Jacob. The consultant was spoken to as part of the review process and stated that if safeguarding issues had materialised during the assessment, each party would have been afforded the opportunity to speak with a clinician separately and follow appropriate policies and procedures including management of any risks identified.

5.2.44 OH note that there are infrequent occasions due to staffing pressures when a second clinician is not available and in these situations, that the patient and provider of collateral information (caregiver) are necessarily seen together. OH are governed by commissioned key performance indicator pressures which means appointments will go ahead and will not be cancelled. OH state that this is in keeping with practice across the wider service i.e. initial assessments in the Community Mental Health Team, which are generally conducted by a single clinician.

5.2.45 OH has access to specialist domestic abuse agencies in the form of domestic abuse champions who are the leads for domestic abuse within their work area and act as a contact in and out of that area. They advise their colleagues on management of individual cases and ensure they have access to local resources and support. These staff are able to support staff with completing Domestic Abuse, Stalking and Harassment (DASH) risk assessments and risk management plans as appropriate.

5.2.46 Additionally, (as all agencies should have), OH has designated MARAC Officers who represent the service / organisation at Multi Agency Risk Assessment Conferences (MARAC).

5.2.47 Whilst OH have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management, as staff were not aware or suspicious of the domestic abuse with Peter, domestic abuse policies and procedures were not used in this case.

5.2.48 Peter was really concerned about potential memory loss and this may have been as a result of the abuse he was experiencing at home and what he was being told by Jacob and Nicholas. In Peter's mind there was an issue, and therefore to be told he had no issues was a real concern for Peter. Peter was discharged and a concern raised by the panel was if there is no issue what else is causing the reason for a patient to be referred in the first place? Is it domestic abuse (as it was in Peter's case) or is there another underlying health concern? If so, should it be explored further before discharge? For OH, the number of patients assessed in the memory clinic who do not acquire a formal diagnosis of dementia after initial assessment is not insignificant and large number of people are diagnosed with mild cognitive impairment (a complex entity and almost includes a proportion of people with prodromal (Alzheimer's type) dementia). OH state that there are many reasons why people do not acquire a formal diagnosis of dementia after initial assessment. Often the 'worried well' present with subjective concerns regarding memory that are not borne out on objective testing. Sometimes other factors can cause cognitive impairment that is as a result of dementia (e.g. drugs, other medical conditions, pain, infection etc.). Some present with signs of 'normal ageing' as detailed previously and others might present with functional conditions (e.g. depression, anxiety or psychosis) that impact upon their memory. Some cases are so complex that further investigations (e.g. brain imaging, neuropsychological assessment, neurology opinion etc.) are required before conclusions regarding diagnosis can be reached. These subtleties are the reason a specialist, secondary care assessment is required to make a diagnosis of dementia (or rule out the likelihood, as was the case following Peter's assessment).

5.2.49 OH have three domestic abuse training sessions available to staff accessed through the local safeguarding boards, Domestic Violence and Abuse Training - Band 5, 6 & 7 (1 Day Training), IHV Domestic Violence Abuse Training (1/2 day Training) and the Domestic Violence and Abuse Clinical Skills Update. This is an update for practitioners who have already completed the IHV DVA training and is delivered as part of the Clinical Skills Updates at locality meetings.

5.2.50 The main purpose of the first two training programs is to look at the Routine Enquiry and the DASH risk assessment tool enabling practitioners to feel confident about asking people about their possible experience of domestic abuse. It also includes training in the use of the DASH risk assessment tool, locally available domestic abuse resources and referral to the MARAC so that practitioners are able to appropriately respond to a disclosure. OH recognise their responsibilities for ensuring staff are competent and confident in carrying out their responsibilities, commensurate with their role regarding domestic abuse and in addition to the training given OH have a domestic abuse policy and guideline to support staff when responding to disclosures of domestic abuse from service users.

5.2.51 This is good training, and they are good policies and guidance but unless patients (who are victims of abuse) are seen separately by professionals then routine enquiry training, policies and guidance become obsolete and victims are failed.

5.2.52 OH's employed clinicians working in the memory clinic diagnostic service are expected to follow safeguarding guidelines. The trust has a policy on safeguarding already mentioned

above. At the time, if concerns arise clinicians should have made a safeguarding referral to the MASH. There was an expectation that they would copy in the Older Adult Community Mental Health Teams Social Care lead and Social Care admin. The MASH had a standardised referral form that could have been found on the Adults Safeguarding Board website. The MASH also accepted phone calls, but a referral would still have had to have been made. A MASH referral should be also have been stored under correspondence within care notes. Now, there is a no longer an Adult Buckinghamshire MASH and other processes are in place.

5.2.53 Social Care admin keep a safeguarding spreadsheet on all referrals so the team can track referrals and any S42 investigations. Risk from others is already a section within the Electronic Care Record risk assessment and clinicians are expected to document safeguarding concerns there. If domestic abuse is a specific concern the staff would complete a DASH form and liaise with the designated MARAC officer, please see above for designated roles in the trust regarding MARAC.

5.2.54 In summary, Peter received generally good care and indeed the consultant as a result of the concerns raised by AS conducted additional ACE – III tests to try to ascertain the issue that Peter was experiencing but nothing of concern was found.

5.2.55 At no point did professionals appear to consider domestic abuse despite how well-equipped practitioners are in responding to domestic abuse following the training. There was no documented evidence of domestic abuse within the records either from the reports from other medical areas supplied to the GPs or from OH's own consultations with Peter.

5.2.56 It has been noted by the review that sexuality is not recorded by OH and potentially, therefore, Peter was not considered through an intersectional lens as an older Christian gay man who may have had feelings of shame which resulted in him being secretive. Institutions can be cautious about 'outing' someone or embarrassing them and the language of 'carer' or 'friend' might be used with questions about the nature of the relationship being asked, which can mean opportunities to notice domestic abuse and safeguarding needs are missed. So, it is possible that even if Peter had had been spoken to separately about his life at home and the relationship with his 'long standing friend that lived with him', Peter may not have disclosed abuse, however, he was not given the opportunity to do so. Peter describing his relationship in the terms of 'long standing friend that lived with him' should not have impacted on any safeguarding process indicated as within the Domestic Abuse Act, the definition would still cover this relationship. To their credit, OH acknowledge that there can be a lack of understanding of men as victims of domestic abuse and domestic abuse in same sex relationships, and realise that when a person is described as a 'friend', professional curiosity is important to delve deeper into the relationship.

5.2.57 It is also important to recognise that Jacob should have been asked questions separately to Peter in the same context (nature of relationship) and considerations given as to how Jacob presented himself.

5.2.58 As stated above, Peter was never spoken to alone, and his relationship with Jacob was not explored as the clinic were unaware that neurology had informed the GP that Jacob

would answer questions on Peter's behalf. Links were not made with the initial AS information about Peter's lodgers informing him he was getting his words mixed up and forgetting things. Peter's symptoms were concluded to be a 'mild cognitive impairment'.

5.2.59 **Thames Valley Police (TVP):** On 23rd February 2012 Peter called TVP to report that he had had a suspicious phone call telling him that he was owed some money and asking for his bank details. Peter did not supply these but he provided the Police with a telephone number for the suspicious caller having dialled 1471. There is an entry in the URN[18] to say that action has been taken by the LIO[19] but it does not say what action this was. The URN was then closed.

5.2.60 There is no record of any action that has been taken by the LIO following this. The LIO has now left TVP and has not been spoken to.

5.2.61 TVP have been unable to locate any specific guidance that was in place in 2012 for dealing with these types of incidents. Based on the information available it is not possible to say whether or not this should have been recorded as an Offence of Fraud.

5.2.62 No secondary investigation[20] was completed as was the Force Policy. Additionally, further interrogation of the telephone number should have been completed to ensure that a thorough investigation was conducted.

5.2.63 At 00:09 on 16th October 2012 Peter called TVP to report that he had received a suspicious call from someone claiming to be from Microsoft asking for his bank details so they could fix his computer. Following the call Peter realised this was a scam and called TVP. Peter informed the call taker that he intended to speak to his bank to ensure no transactions had taken place. An appointment was booked with a Uniformed Patrol Officer. The URN states that following Police attendance advice was given to Peter and on this occasion no crime had been committed. The URN was then closed.

5.2.64 From the original URN it appears that Peter gave over his bank details before realising that this was a scam. There is no mention of vulnerability from the original call taker. The information recorded in the URN at the time of the incident is vague.

5.2.65 It is not known whether there was a telephone number linked to this call or not. If there had been the expectation would be that secondary checks should have been conducted on the number which should have been documented.

5.2.66 Based on the limited information available, this should have been 'crimed' as an Offence of Fraud on CEDAR[21] and investigated fully. This was not done. Peter was not provided

[18] Unique Reference Number (URN) - Command and Control is a database and system for managing the allocation and progress of all incidents requiring Police involvement. Each incident has a URN for that date and will be either an 'open' incident which indicates that the incident is still active or shows as 'closed' when the incident has been concluded. The URNs will contain a log of events in chronological sequence detailing the history and resources attached to that incident.

[19] Local Intelligence Officer

[20] Secondary Investigation – is a vital tool in all areas of investigation. It involves research of all relevant databases so a full picture can be gained. It can include, victim, suspect and witness checks

[21] TVP's computer system to record offences before NICHE.

with the service that TVP expect, and the lack of a Crime Report may also have created inaccurate statistics in relation to Frauds recorded by TVP.

5.2.67 Peter was an elderly gentleman who lived alone, he received a telephone call asking for his bank details which he readily provided. All of these factors would have indicated vulnerability.

5.2.68 Since 2012 guidance has been updated and had this incident occurred with the current guidance in place and Peter had been identified as vulnerable by the original call taker, then 'Operation Signature'[22] would have been instigated. A URN would be recorded and an 'Action Fraud – Call for service' Occurrence created with a Uniformed Patrol Officer tasked to attend. The officer attending would remain as the Officer in the Case (OIC) and own the investigation. Current guidance states that in relation to vulnerability, a 'Safeguarding Against Fraud Risk Assessment' form would be completed, crime prevention advice given, and a 'Victims First' referral[23] would be offered to the victim. This would ensure that the Adult Protection marker is flagged within the NICHE report, to ensure that the relevant referrals to Adult Social care are made.

5.2.69 With the current guidance, had the call taker not identified any vulnerability, then Peter's complaint would have gone to Action Fraud[24]. It would then been reviewed and allocated back to TVP if there were reasonable lines of enquiry. If at any point during this process vulnerability had been identified then TVP would again be tasked with conducting safeguarding activities under Operation Signature.

5.2.70 SaVE[25] training has been in force for TVP since January 2016 with a number of SaVE training packages covering slightly different topics. SaVE 2 is a one-day training course offered to front line Officers and any Officers who respond to incidents that may involve cases of vulnerability. Contact Management Centre Officers[26] and Police Control Room staff[27] also receive a vulnerability input as part of their initial training and often have

[22] Introduced in 2018 - Operation Signature is a standardised response process, introduced to assist officers identify and support vulnerable victims of fraud preventing them from being re-victimised. The process provides preventative and support measures intended to protect victims and safeguard them from further targeting. An important strand of Op. Signature is its wider messaging and prevention advice and working with statutory and voluntary agencies both locally and nationally to influence change.

[23] Victims First is dedicated to making sure that all victims of crime receive the support they need to cope and recover from the impact of their crime. Victims First provides free emotional and practical support to all victims and witnesses of crime, as well as family members of victims. It is available across Berkshire, Buckinghamshire and Oxfordshire and can provide help regardless of whether or not the crime has been reported to the police.

[24] Action Fraud has been in place at TVP since December 2012, and now all police forces across England & Wales use Action Fraud. Generally most incidents of fraud and financially motivated 'e-crime' should now be reported by the public to Action Fraud using their website or call centre. The Action Fraud initiative has a number of benefits for victims of crime including a central point of contact to report all fraud providing consistency for victims. The system enables a nationally joined up response to fraud investigation, eliminating duplicity, reducing barriers to cross border fraud intelligence sharing, and also increasing opportunities to identify repeat and vulnerable victims. Action Fraud aims to identify all viable lines of enquiry; free police resources to focus only on those investigations with actionable lines of enquiry; and provide intelligence that can be used proactively for prevention.

[25] The Safeguarding Vulnerability and Exploitation (SaVE) programme brings together all aspects of safeguarding in order to ensure that, when responding to incidents, encounters & calls for services, TVP is equipped to deal with them effectively. The SaVE programme seeks to develop TVPs approach and enhance the professional curiosity of frontline staff. The training incorporated findings and recommendations of internal management reviews, serious case reviews and developments in the Protecting Vulnerable people (PVP) policing environment.

[26] Contact Management Centre Officers answer the majority of Emergency (999) and non- Emergency (101) calls within TVP.

[27] Police Control Room staff deal with emergency calls (999) and non-emergency (101) calls at times of high demand.

additional training incorporated into other training such as Anti-Social Behaviour or Mental Health.

5.2.71 Despite the improvement in Fraud Investigation guidance and addressing vulnerability, TVP would still be relying on individuals to identify whether or not a person was vulnerable. Both the call taker and the Uniformed Patrol Officer had received training on vulnerability and it may be that they considered vulnerability in relation to Peter and decided that he was not vulnerable. Unfortunately, TVP are unable to confirm this.

5.2.72 At 19:55 on 29th November 2014 Peter telephoned TVP to report that he was getting repeated silent calls from a specific telephone number. The report was created, and it was noted that Peter was elderly and that he found the calls worrying and disturbing. The report was allocated to the Office Based Research Team (OBRT) to investigate.

5.2.73 Research was conducted into the phone number which had been reported by others as a scam, stating they were conducting surveys. Peter was updated by OBRT and advised to speak with his telephone service provider. The police report was filed.

5.2.74 In addition to the details obtained that Peter was elderly and was worried and disturbed by these calls, it was also documented that Peter was concerned that the caller may be calling to identify when his property was empty in order to target him. In light of this, it is possible that Peter may have been vulnerable, but this was not identified by the call taker when making the initial report. The report was allocated to the OBRT and falls into their remit to investigate which, as an office-based team, they complete remotely.

5.2.75 The call should have been recorded by/or referred to Action Fraud as a 'Phishing attempt' as per the 2013 Action Fraud – Standard Operating Procedure. However, this was wrongly recorded as a Harassment case. The process of dealing with Fraud Offences has improved with the introduction of Action Fraud, and as mentioned, Operation Signature was the framework put into place for Officers to use when dealing with victims they suspect may be vulnerable. However, whilst this is a good operation it still needs officers to identify vulnerability initially.

5.2.76 OBRT is office based and it would have been beneficial for Peter to have been visited for reassurance as there were indications that Peter may have been presenting as an adult at risk. A face-to-face visit with him may have offered better insight into Peter's life at the time and had concerns arisen from this then support could have been offered to him.

5.2.77 It cannot be confirmed whether OBRT received any vulnerability training as training records do not show this. Additional training for OBRT in relation to vulnerability would be beneficial together with Domestic Abuse Training regardless of the fact that the team is office based. They still speak to victims on the telephone and if the victim is subject of abuse then a victim may disclose over the telephone also.

5.2.78 In 2014, Jacob featured heavily in Peter's life and a visit to Peter by the Police at that time could have identified and recorded this.

5.2.79 If the offence had been correctly recorded as a 'Phishing Attempt' then it would have been allocated to a different department (or even agency) and the investigation would have been dealt with differently.

5.2.80 It should be considered that Peter's vulnerability to scams should have led to questions about his ability to understand financial abuse generally, across a variety of contexts. The protected characteristic of socio-economic status may be considered a vulnerability in this case, as Peter's higher socio-economic status made him vulnerable to being targeted, particularly when considered intersecting with his age, as economic abuse is more prevalent amongst older people.

5.2.81 OBRT staff are now receiving SaVE training. TVP now have a Cyber Protection Officer, who consults on individual cases and provides training internally.

5.2.82 Additionally, Contact Management staff are attending the Domestic Abuse training.

5.2.83 TVP have a predictive harm analytics system which is a mechanism that identifies repeat callers. However, despite the calls that Peter made he would not have reached the threshold of a repeat caller. TVP shares information regarding vulnerable high-volume callers with Adult Social Care and the need for multi-agency intelligence and a multi-agency response is recognised but because Peter would not have triggered as a repeat caller this information would not have been passed.

5.2.84 Towards the end of October 2015, TVP received a call from SCAS to report the unexpected death of Peter. Uniformed Patrol Officers attended and assisted SCAS, requested undertakers and spoke with Jacob and Ian (who had both arrived at the address).

5.2.85 The call was graded as an 'Urgent Attendance' as per the TVP Incident Resourcing Plan[28] and the Patrol Sergeant was notified. A Uniformed Patrol Officer was dispatched 5 minutes after the original call was received and arrived at the address within the response time target of one hour for incidents graded as Urgent Attendance. The attending officer no longer works for TVP and has not been spoken to in relation to this review.

5.2.86 As per the Standard Operating Procedures (SOP) for sudden deaths the priority has always been preservation of life, however SCAS had already confirmed in the original call to TVP that Peter was deceased.[29]

5.2.87 The Control Room Sergeant and Inspector were both notified within half an hour of the call coming in and made entries on the URN log. The Control Room Sergeant documented that the death was to be treated as "unexplained and suspicious" until the circumstances surrounding the death had been established. It was documented that Crime Scene Investigators (CSI) and the duty sergeant were to be advised. The duty supervisor requested that CID[30] were informed.

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[28] Incident resourcing plan - 'Immediate' response within the 'Incident Attendance Policy' which sets out response times for different classifications of incidents. An 'Immediate' is defined as an emergency which requires immediate officer intervention and has a target response time of 15 minutes from the time the incident is created to resource on scene. 'Urgent' attendance' requires attendance at the earliest opportunity, but no later than 60 minutes. 'By arrangement' is an intervention appropriate to the needs of the caller.

[29] TVP now have a revised sudden death policy (June 2018) meaning that the police no longer attend all sudden deaths, however even with the revised policy, police would still have attended PF's death due to the circumstances of his death being unexplained.

[30] Criminal Investigation Department – a department that deal with serious and complex criminal investigations.

5.2.88 After arriving at the scene, the initial attending officer spoke to the control room on the telephone, passing a scene update via the mnemonic COPEGS.[31] Telephone liaison also took place between the attending officer and the Uniformed Patrol Sergeant then documented that he was satisfied that there were no suspicious circumstances and did not attend. At this stage there was no pursuance of CID.

5.2.89 Jacob arrived on scene while the attending officers were present and provided information which informed COPEGS.

5.2.90 The non-attending uniformed patrol sergeant confirmed that they had clarified with the attending officer on the telephone that the pooling of the blood observed by the attending officer was as a result of where the body of Peter had settled. All medication appeared to be accounted for and a bottle of whisky was located close to Peter. The log shows that Peter was suspected to have had an alcohol problem and so the uniformed sergeant advised that undertakers could be called to attend the address of Peter.

5.2.91 The decision of the supervisor not to attend, and the lack of attendance by CID and CSI, was contrary to the SOP for dealing with Unusual, Unexplained and Suspicious deaths that was policy and procedure for TVP at the time. The SOP stated that a Uniformed Supervisor would attend the scene at an early stage and assess the circumstances surrounding the death. The SOP also stipulated that for Unusual, Unexplained and Suspicious deaths it was expected that a CID Officer (preferably a Supervisor or accredited Detective Constable) would also attend to support officers at the scene. While the OIC may not have regarded the death as suspicious, the fact that it was unexplained was sufficient to require the supervisor and a CID Officer to attend. In particular, the circumstances should have led the officer to suspect a possible suicide and, as a result, both CID and CSI should have attended.[32]

5.2.92 As part of this review the Uniformed Patrol Sergeant cannot recall attending Peter's death (he did not attend) but he would have usually attended all deaths and is surprised that neither he nor CID attended. The uniformed sergeant informed the review that not all supervisors routinely attended deaths in the Aylesbury area. He was aware that there were procedures in place for deaths at the time and was aware that the procedure has been updated recently. Additionally, the uniformed sergeant mentioned that the attending officer whom they spoke to on the telephone was an experienced officer but stated that this would have no bearing on whether they as a Supervisor attended or not.

5.2.93 The attending officer used BWV[33] but only recorded a total of 32 seconds of their attendance. It showed the location of Peter and in addition a bottle of whiskey and a glass

[31] C – Circumstances of Death, O - Other marks or suspicious features, P – Position of body, E – Examination of the deceased – describe the condition of the body, G – General Health of person prior to death if known, S - Supervisor to conduct a review of URN and approve any actions.

[32] In the revised Policy (June 2018) the above requirements remain the same with one exception being that if a Detective attends the scene then there is no need for the Uniformed Supervisor to attend.

[33] Body Worn Video - an overt recording method which can be used across a wide range of policing situations to obtain evidence.

next to him. It does not show the officers interactions with SCAS on initial arrival nor does it show their interaction with Jacob or Ian Farquhar.

5.2.94 TVPs Operational Guidance in place at the time stated that if a BWV user is present at an incident in a private dwelling and they are there for a 'genuine policing purpose' then they are entitled to make a BWV recording in the same way in which any other incident is recorded but should be mindful of the rights of individuals in relation to Article 8 of the ECHR.[34]

5.2.95 Also under the Operational Guidance and the National Principles of use for BWV, it would have been lawful to have recorded the encounter with Jacob and Ian as long as it was proportionate, legitimate and necessary. However, Peter's death remained unexplained and therefore the attending officer should have continued to use the BWV while at the address which included when they spoke to Jacob and Ian. In hindsight, this could have proven very useful. At the time BWV was new and expected practice was still developing and was predominantly used as a form of personal protective equipment as opposed to a tool for collecting evidence. Training officers received in the use of BWV at the time was focussed on how to use the equipment as opposed to gathering evidence.

5.2.96 Under the National Principles of use for BWV, narration of the scene is also recommended, and it is also written in guidance that it can prove very useful; however, this was not done. Additionally, the officer did not conduct any introduction at the start of the recording which was, and still is, written into guidance and should include (where possible), the date, time and location, the nature of the incident to which the user is deployed and confirmation to those present that the incident is now being recorded using both video and audio.

5.2.97 Uniformed Patrol Officers followed the undertakers transporting Peter's body to the mortuary. This task was not written in guidance at the time; however, the current guidance states that "if a death is suspicious the body must be escorted to the mortuary". Peter's death was negated as being suspicious by the supervisor shortly after COPEGS was passed so this task was not necessary.

5.2.98 A further Patrol Officer informed the review that, although they did not have any suspicions when attending Peter's death, they followed the body to the mortuary because they consider it best practice to do so and it is something that they have always done.

5.2.99 There is no record of Peter's death on NICHE. It is written into current guidance that occurrences should be created on NICHE for deaths; however, this was not guidance in 2015 but the Force Crime Registrar states that an "Unexplained death" Occurrence should have been created. Police investigate deaths on behalf of the Her Majesty's Coroner and while they do not have many investigative actions to record in NICHE an occurrence would have been useful. If there had been an occurrence, then the GEN 19[35] could have been uploaded into NICHE for future review. This was not a requirement at the time of Peter's

[34] Article 8 of the ECHR (European Convention on Human Rights) provides a right to respect for one's "private and family life, his home and his correspondence.

[35] Sudden Death report form

death, but it has now been added to the current policy. Lack of this occurrence could have had had a bearing on TVP subsequently bringing Jacob to justice. It is likely that if an occurrence had been created for Peter's death, then Jacob would have been named in the person screen as a 'witness' or 'other' in NICHE which may have alerted Officers to the existence of Jacob in the future (e.g. in the burglaries included in the IMR for Mary). In addition, a lack of an occurrence could also create inaccurate statistics in relation to deaths recorded by TVP. This aspect, however, would not have altered Peter's tragic death.

5.2.100 Peter's death was not treated as suspicious at the time of initial attendance by the attending Officer(s) and the SOP / guidance exists to maximise opportunities to identify suspicions and those opportunities were not taken. Peter's death was unexplained and should, at least, have led to suspicions of suicide and therefore a supervisor and CID Officer should have attended. CID specialise in unexplained deaths and had they attended they may have conducted a more thorough investigation. TVP believe that it would have been very unlikely that further investigation would have raised suspicions, not least because Jacob came across as a credible witness. However, additional enquiries should have been completed which could have revealed, for example, the recent change of Peter's will and Peter's diaries and journals may have also assisted as part of an investigation and links to other agencies. A more thorough investigation may have led to a forensic post-mortem which would have revealed the drugs as a result of toxicology.

5.2.101 The URN log was closed. Had this been reviewed fully prior to closure it would have revealed that despite the control room staff having designated the death as 'unexplained and suspicious' that CID and CSI did not attend and that the duty CID 'on-call' supervisor whilst attempted to be contacted never was. The attendance of such staff may have revealed a different outcome which ultimately could have led to the police becoming aware of Jacob which would have potentially stopped Jacob's offending against Mary.

5.2.102 **Buckinghamshire Council Adult Social Care (ASC):** A safeguarding referral in relation to Peter was raised by South Central Ambulance Service (SCAS) on 3rd October 2015 and on 9th October 2015 it was picked up by the ASC, Community Response and Reablement Team (CRRT) who forwarded it on to the Safeguarding Adults Team. The procedural timeline to respond to referrals in 2015 was 48 hours and therefore, it fell outside of that.

5.2.103 The SCAS referral indicated that Peter lived alone with friends staying occasionally and that Peter was undergoing tests for memory loss that he was increasingly frail and displayed strange behaviour. Apparently, Peter's 'friends' were concerned about his safety but there was no further information recorded by SCAS as to why the friends were concerned or what about. This did not indicate domestic abuse being a factor.

5.2.104 The Safeguarding Adults Team reached a decision on 15th October not to progress to a safeguarding enquiry. The rationale recorded was that the referral did not warrant an

enquiry undertaken under Section 42 of the Care Act[36]. As a result, it was sent back to the team to undertake a social care assessment under S9 Care Act.[37] There is no clear rationale recorded as to why the safeguarding concern did not meet the eligibility criteria for a safeguarding enquiry. The decision recorded to signpost to a social care assessment is presumed by the author of the IMR to confirm Peter's needs for care or support although as the rationale is not clear, this cannot be confirmed.

5.2.105 The receiving team initiated a social care assessment on the same day and contacted local hospitals and Peter's GP service. This was a prompt response.

5.2.106 The following day, 16th October 2015 the staff member telephoned the local mental health team who confirmed that Peter was open to their memory clinic and that they were actively involved with Peter. The memory clinic requested a copy of the SCAS report. Later that day the mental health team confirmed that Peter was a patient of the outpatient service only and did not have a care co-ordinator and therefore any further follow up needed to be undertaken by the CRRT.

5.2.107 On the 20th October 2015, the CRRT queried the response from the mental health team and requested a contact number for Peter. There is no response recorded or follow up recorded on the records so whilst it was good practice to query the decision, there appears to have been no follow up thereafter.

5.2.108 Buckinghamshire Council delegate its ASC duties for adults with mental health concerns via a Section 75 agreement. It appears confusion has arisen around social care responsibility when an adult is an outpatient for mental health services and a social care assessment is also required. ASC assumed the mental health service would undertake a social care assessment given that Peter was open to the memory clinic however, when the service confirmed there was no allocated care co-ordinated, no social care assessment progressed at all.

5.2.109 Records indicate that the social work intervention was with professionals rather than with Peter himself. It is noted there was no telephone number for the client recorded on the referral however, further enquiries could have been made to locate a telephone number for Peter or a personal home visit could have occurred. Neither were completed. A home visit to Peter's home would have prevented a delay in progressing the social care assessment and would have given social workers the opportunity to speak one to one with Peter, allowing them to ask questions in relation to any potential abuse. As a result, domestic abuse was not considered.

5.2.110 There is no reference to any working protocols between Adult Social Care and mental health services. Once the mental health service declined further involvement in

[36] The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

[37] Section 9 – Assessment of an adult's needs for care and support. Section 9 requires a local authority to carry out an assessment, which is referred to as a "needs assessment", where it appears that an adult may have needs for care and support.

addressing the concerns raised by the ASC team, who queried the decision, they did not progress the social care assessment further.

5.2.111 **Diocese of Oxford (DO):** Peter was an active member of St. Mary's Church, which is part of the Diocese of Oxford and is based within the grounds of Stowe School. He was a long-standing member of the congregation and was also a Church Officer[38] (meaning he was a volunteer) and he gave sermons at the Church. He attended bible study classes and services with Jacob.

5.2.112 Peter had strong, conservative Christian beliefs. He was a devout Christian. He was gay and celibacy was his way of reconciling his beliefs and sexuality. The CoE holds the position that sex should only take place within heterosexual marriage.

5.2.113 Jacob began attending Stowe Church in 2013 having been introduced to it by Peter who vouched for him within the church community. He became a Church Officer as a result of taking on volunteer roles as the Parish Secretary and Deputy Church Warden.

5.2.114 Nicholas did not attend Stowe Church or any other church in the Diocese and has no known church links.

5.2.115 Peter's Parish had some unique features: as a 'gathered church' it lacks a locality focus; the parishioners attend from a broad geographic area, including former staff from Stowe School. It has close associations with the Stowe School, being situated in its grounds, and shared a Vicar with the school. The Stowe Church has a strong identity: The Parish is seen as a 'closed' or 'close knit community'; it is isolated from other church communities as it is not part of a group of Parishes; and it has an evangelical theology and conservative culture, which includes 'traditional' views regarding same-sex relationships. These dynamics also generated a clear sense of internal trust which was shown when Jacob was first arrested as a collective denial of any allegations i.e. 'how can one of us do that?'

5.2.116 The demographic profile of the Parish is older and ageing. In this context there is a higher likelihood of people becoming vulnerable to exploitation and abuse. For example, vulnerability to financial scamming increases with age, social isolation and loneliness. Whilst Peter was retired, he was very able, mentally and physically, and led an active life when he first met Jacob. He became vulnerable due to Jacob's grooming activities and abuse. His specific vulnerability was the fundamental human need for emotional intimacy, heightened by his feelings of loneliness, which Jacob exploited for financial gain.

5.2.117 Peter's vulnerability was further exacerbated by the combination of his sexuality and religious beliefs; his sexual orientation was known but not acknowledged by most people who knew him. He struggled to reconcile his own conservative Christian beliefs with his sexual orientation. According to Ian 'he felt these two things did not go together entirely'. He was also of a generation with experience of living in a society where being gay was

[38] A Church Officer is anyone appointed/elected by or on behalf of the Church to a post or role, whether they are ordained or lay, paid or unpaid.

illegal and criminalised for many years. Peter looked for support regarding his sexuality and Christian faith from people who had a different view than the Stowe parishioners, for example Rev F, who conducted his 'betrothal ceremony' to Jacob. Rev F had questioned Jacob about his commitment to an older man at that time, which was appropriate for him to do, given the significance of the event he was officiating. Rev F reported that Jacob's response was believable, and he had no doubts about the authenticity of their relationship at that stage.

5.2.118 It is understood that Peter and Jacob agreed to keep their relationship secret although it is not known whether it was Peter or Jacob that suggested this. If Peter had suggested it, then it would be understandable in the context of the attitudes of many of the Stowe Church parishioners to being gay as well as Peter's own religious views. Peter had chosen to be an active member of a Parish that held very conservative views in respect of LGBT+, which seems to have had a negative impact on Peter. In Stowe Church, being gay was generally perceived as 'deviant and wrong'[39], so Peter could not be honest about his emotional relationship with Jacob. However, Peter's novels explored gay themes and he had talked about dilemmas regarding sexuality in a Stowe Bible Study group. Homophobic attitudes (unconscious or conscious, personal or institutional) in the Stowe Church Parish meant that Peter's sexual orientation was a 'well-known secret' that was not publicly acknowledged. The relationship between Peter and Jacob was not spoken about by Parish members and it was described and understood that Jacob was Peter's lodger.

5.2.119 Secrecy is a pervasive negative factor in safeguarding adults, not least because of the emotional impact of abuse on victims, and a 'culture of secrecy' has been identified as a significant inhibiting factor in safeguarding people in Church communities. Certainly, it was a factor in these circumstances. Raising concerns about safeguarding is not easy in this context, particularly if there is a culture of secrecy and non-disclosure generally regarding being gay i.e. 'don't ask, don't tell'. A cultural change is required to enable people to express their concerns in a way that is non-judgemental to counteract this culture of secrecy. This would support improvement in safeguarding adults' practice in terms of prevention as well as protection.

5.2.120 In the DO review, when the congregation were asked whether they may have been more critical and challenging, (in a supportive way), had Peter been heterosexual and Jacob been female, most said they would have taken more interest, particularly when there were gifts and large sums of money involved. They would have been more curious and suspicious […], asking for example 'are you sure this is a healthy relationship (considering the age gap)?' The DO's independent reviewer's view is that this 'common sense' response was suspended towards Peter because of attitudes that parishioners held towards being gay, based on a conservative theological interpretation of the Bible, which meant that Peter's sexuality and the relationship with Jacob were not questioned, explored or overtly discussed.

[39] The Independent Safeguarding Review: lessons learnt from events in the parishes of Stowe and Maids Moreton, 2012-2019

5.2.121 A further potential inhibiting factor was Peter's own uncritical attitude to his relationship with Jacob; he wrote to a friend 'this has given me happiness that I have long since never expected to enjoy'. In this context he may have defended his decision to give Jacob money and a legacy in his will if he had been challenged. Peter also never expressed any explicit concerns about Jacob. Further, other parishioners hugely respected Peter, and they trusted his judgement. Respect for him and his reputation meant that people were even less likely to question what was happening in Peter's personal life.

5.2.122 The recommendation from a previous review,[40] that the Church must promote an 'open and accepting culture in which everyone, regardless of their sexuality or their views about being gay, is clear about their responsibilities towards those who might be abused or who might want to raise concerns about abuse' is reinforced by this review. Negative attitudes towards being gay in the Church of England reinforce internalised homophobia. There is an issue for the wider church to consider how it offers support to its lesbian and gay members, and not seek to 'cure' and 'heal' them as this would be a deeply homophobic response. Establishing a LGBT+ chaplaincy within the DO is a positive step in this context. However, the institutional CoE faces challenges to resolve its own positioning on this before it can effectively support any individuals with their expressed tensions between sexuality and religious beliefs.

5.2.123 The issue of how to explore issues of personal relationships and sexuality is a complex area, particularly given current contradictory expectations from the CoE regarding being gay, which may lead people to lie about the reality of their sexual orientation. The current position taken by the CoE, continuing to insist that sex is for married couples only and that any other partnership has to be a sexually abstinent friendship, is not conducive to disclosure and as well exposes people to risk. The Church is considering how to make it possible for people to be honest about their relationships, as well as being a safe place for the LGBT+ community.

5.2.124 There are also challenges for parish officers and leaders when having difficult conversations about personal matters with other parishioners, where there might be safeguarding concerns. Proactive identification that someone may be struggling, and involvement of external agencies, even for advice, can be a difficult step to take by people who may not feel skilled and knowledgeable about this area. Safeguarding and awareness training are essential, but it needs to be more than familiarity with identifying the signs and symptoms of abuse. Developing the knowledge and skills necessary to build trust and have difficult conversations about potential grooming or scamming might have been helpful in this case.

5.2.125 A particular challenge for the Church community concerning not just how to recognise and identify potential perpetrators within its local community, but then what to say that will be heard without the person raising it being criticised. The negative perception of 'gossip' in evangelical settings, as spiritual wrongdoing, may inhibit concerns being

[40] Moira Gibb et al, (2017) The Independent Peter Ball Review, An abuse of faith, Church of England para 5.7.3 https://www.churchofengland.org/sites/default/files/2017-11/report-of-the-peter-ball-review-210617.pdf

expressed. In the context of safeguarding adults, disclosing concerns as an outcome of respectful curiosity and caring interest, speaking up for someone who is experiencing harm or abuse, must be encouraged.

5.2.126 The DO review acknowledged that the grooming and abuse of vulnerable elderly people within rural elderly congregations is not so unusual in the CoE and there are lessons from this case review that can be applied more broadly. Since the time period of this review, the role of Parish Safeguarding Officers (PSOs) has been supported and enhanced within the church and there is a better understanding of the CoE's responsibilities around safeguarding adults. This could be further enhanced through a developmental learning approach that developed core skills such as holding difficult conversations, offering feedback and routine inquiry. Developing the knowledge and skills of PSOs and other Church leaders in this area would be welcome.

5.2.127 The Diocese of Oxford should strengthen its practice when working with volunteers within Church settings and support the crucial role of volunteering. At the time of Jacob becoming a volunteer for roles within the church and for him seeking ordination, it was and continues to be the practice that the CoE undertakes DBS checks of different types for different roles, as appropriate, regarding all volunteers. Jacob had a clear DBS check; however, this only identifies prior police notifications. Jacob had no previous criminal record. Jacob presented as a nice, intelligent young person and appeared keen to become active in the Church. He had Peter's support and sponsorship and was considered Peter's 'prodigy'. Jacob volunteered and took on positions as the Parish Secretary and Deputy Church Warden without challenge. His Baptist family background gave him the language and knowledge to present credibly; this was described by one interviewee as part of the DO review that Jacob was 'God's person' and he had 'assumed authority'. Jacob's interest in older people, as a care assistant in the Nursing Home and informal carer for Peter, was seen as evidence of his Christian faith in action.

5.2.128 More rigorous background checks may have exposed inconsistencies in his personal narrative e.g. exaggerating his role at Stowe School, and his status at Buckingham University. It is unclear to what extent these were done at the time. Latest government guidance regarding volunteers working in charities is that references should be followed up as well as checking gaps in work history. Further, the ageing profile of the Stowe Church community and the emphasis of the church on 'growing younger', meant that there could have been a suspension of rigorous judgement and an uncritical welcoming of younger talent.

5.2.129 Jacob was accepted because Peter's judgement was respected and because Jacob presented as intelligent, articulate and keen. Jacob's friendship with Peter provided him with a convincing 'cover'. In the context of ongoing struggles to get people to volunteer for Parish roles, Jacob's interest was welcomed without formal process. For example, when training for a chalice bearer role, he was not asked why he wanted to do it and he did not convey the common view that it was a 'privilege' to help the Vicar and undertake this task. Similarly, being able to give communion is a task that takes people into the homes of others, which makes both parties vulnerable. In these roles proportionate practices are advisable to protect those who are housebound and the volunteers. This

could include working in pairs, offering supervision and support, having policies and protocols to protect the volunteer and the person being visited.

5.2.130 In 2017, the CoE introduced ‘Safer Recruitment’ practices which provide a clear framework for improved practice in terms of volunteer recruitment, setting out the processes for recruitment of volunteers and a more robust approach. This has been updated since in 2022 and is now the ‘Safer Recruitment and People Management Guidance’ and includes asking for references. The Charity Commission’ Guidance on safeguarding regarding volunteers must be adhered to and reinforced in all Parishes. Therefore, a code of conduct is essential, which should include expectations of how people should behave. The principles in the Safer Recruitment model volunteer job role go some way to making this explicit, but they do not include the aspect of inter-personal relationships. The DO review suggested that it would be timely to audit practice in the Parishes regarding volunteer recruitment to establish how robust processes are and how consistently they are applied. This review concurs with those findings.

5.2.131 Other national organisations that rely heavily on volunteers, and organisations that advise non-statutory agencies on safeguarding adults, current best practice and processes in terms of safer recruitment are as rigorous as those regarding permanent staff. When volunteers work with adults who may be at risk of harm, these include: detailed application forms; self-disclosure; robust interviews that cover safeguarding, equality, and diversity knowledge and skills; reference checks; a thorough induction process; verification of qualifications, training and experience; and risk assessments. During probationary periods there is monitoring and review. There are codes of conduct, clear policies and guidelines that volunteers follow, with mechanisms such as ‘buddies’ and ‘facilitators’ as well as volunteer managers to ensure that volunteers are appropriately trained and supervised. These mechanisms ensure that any organisation delivers its duties of care to the volunteers as well as to its members.

5.2.132 The recruitment, support and supervision requirements for volunteers should be proportionate to the role. In this context the roles and responsibilities of the PCC Secretary and Deputy Church Warden are important, as both roles have access to financial and confidential information, whereas the role of chalice bearer has status and religious significance. Once appointed into any role, formal mentoring or supervision and support might identify learning and support needs as well as any risks. If these had been in place, Jacob’s deceitfulness, lack of real vocation, exaggerations of his experience and qualifications and his narcissistic tendencies might have been identified.

5.2.133 Every organisation has a responsibility to ensure they have processes for the identification and referral of care and support needs for people alongside any potential risk of harm and abuse. For Peter, the specific circumstances of his experience of abuse meant that, whilst he was aware of his deteriorating mental and physical health, and very distressed by this, he does not appear to have identified that Jacob was harming him. This is not unusual for victims of abuse for a myriad of reasons none of which are the victims fault. Peter presented as his ‘carer’. Indeed, this was part of the ‘scam’. Peter was being coerced but did not seem to perceive this as such e.g. when giving Jacob a second-hand car or changing his will. Peter did try to talk to other Stowe parishioners

but, because of their reluctance to discuss personal matters, due to his sexuality, he was prevented from potentially disclosing any concerns.

5.2.134 Peter articulated his vulnerability and explained his hallucinations in terms of the presence of 'evil' or 'evil spirits' in his home. His distress was responded to spiritually, as it was believed to be a spiritual matter. The Vicar and other parishioners went to pray with Peter to support him and try to reduce his distress and anxiety. They saw his suffering and reacted to it through prayer. The Vicar did express concerns and enquire about his physical and mental health. However, the medical consultations had not provided clarity regarding his condition.

5.2.135 In 2015, Peter had care and support needs and he was being abused. He was seen by doctors and his symptoms were understood firstly as due to a urinary tract infection, then, when dementia was ruled out, as due to alcohol consumption or an obscure diagnosis, which Jacob promoted. Jacob presented as an experienced carer providing care rather than abusing Peter.

5.2.136 Jacob further exploited his situation by presenting as a 'vulnerable carer', saying he had been attacked by Peter, perhaps to gain sympathy and hide his role as abuser. This incident could have been a trigger for referring a safeguarding concern to the Local Authority Social Services and possibly prompting a safeguarding enquiry.

5.2.137 When Peter told the Vicar he was gifting a car to Jacob, the Vicar advised him to record this through his solicitor, so that there was some awareness of the need to properly record such expensive 'gifts'. This was good advice by the Vicar.

5.2.138 There have been changes in the CoE's approach to safeguarding adults, which have resulted in significant improvements in safeguarding adult practice at all levels, including introduction of revised national and local policy and guidance in 2017 and a national programme of training, including training needs assessments.[41] There is new guidance that supports safeguarding adults at national, Diocese and Parish levels, promotes safer recruitment and offers a full spectrum of training at different levels to everyone involved in the church.

5.2.139 **South Central Ambulance Service (SCAS):** SCAS attended the home of Peter a number of times. All staff followed National Clinical Guidelines to aid their decision making and there are no concerns in the treatment provided.

5.2.140 The 999-call handing and the care and treatment provided were in accordance with expected practice.

5.2.141 SCAS has in place a safeguarding adults and children's policy and practice guidance. Safeguarding concerns were appropriately made and information shared, all in accordance with the SCAS policies and procedures. SCAS policies include domestic abuse and when the crew complete a safeguarding referral for a victim of domestic

[41] Church of England, House of Bishops, 2017, Promoting a Safer Church; Church of England, House of Bishops (2019), Practice Guidance, Safeguarding Training and Development

abuse, additional questions are asked as the DASH risk assessment is used within the safeguarding referral. Crews look out for possible injuries in respect of physical violence that may be linked to domestic abuse. Jacob was convincing to the crews that attended (each of the crews had no prior dealings with either Peter or Jacob) as nothing more than a person caring and supporting Peter.

5.2.142 SCAS receive annual face-to-face safeguarding training and continual E-Learning.

5.2.143 A referral was made by the attending crew on the final attendance prior to Peter's death. The details that Peter gave to the crew were of concern and so SCAS submitted a referral to ASC.

5.2.144 **Nursing Home:** Jacob was interviewed for a position at the nursing home in October 2013. He was suitably qualified, lived locally and was very pleasant.

5.2.145 Jacob received two satisfactory references and a DBS check was clear. He accepted the permanent Healthcare assistant for 36 hours per week.

5.2.146 Jacob's job entailed providing all personal care for the residents and care for their psychological needs.

5.2.147 On the two occasions that Peter attended the Nursing Home, Jacob arranged the respite care.

5.3. Equality and Diversity

5.2.148 The panel considered Peter's single status prior to meeting Jacob, his age, religion, and belief and concluded that these had no impact in the response he received. The protected characteristics of pregnancy and maternity and race are not pertinent in this case.

5.2.149 The panel considered the protected characteristics that were apparent in this case. Peter was an older white gay man in a relationship with a younger man, though that relationship was unclear to the professionals and was described differently by Peter and Jacob. Peter was not disabled, but he believed that he may have health problems including memory loss and alcohol misuse and that therefore made him vulnerable within the context of his life.

5.2.150 The panel considered that it was likely that, professionals did not identify this as domestic abuse – Peter was male, gay and older, and Jacob was younger – and the presentation may have been more familiar to them in a carer relationship. When Jacob confirmed or intimated that, they asked no further questions.

5.2.151 Therefore, it is likely that the fact that Peter did not fit the more common picture of domestic abuse – of a woman abused by a man – that any training they had received was not translated into practice. It was felt that the combination of his sex and his 'presumed' problematic alcohol misuse may have affected the care he received.

5.2.152 It may be that Peter had suffered discrimination in the past because he was gay. It is common for victims of domestic abuse to be ashamed of what is happening to them and for gay people to feel shame about their sexual orientation. The combination may have

made it more difficult for Peter to disclose abuse, taking into account his religious beliefs and that of the church. Such barriers to getting help make it vital that the professionals whom they tell and for professionals who suspect abuse, to be pro-active in their response. A poor response may end a victim's efforts to get help at all.

5.2.153 ***Analysis:*** *The panel identified the importance of ensuring that training on domestic abuse addresses issues for specific communities of interest, so that professionals are aware of whom this may affect and any unique barriers to accessing help. This should include that introductory training on domestic abuse has information on these communities and, where appropriate, more advanced training is developed to further develop practice response.*

6. Conclusions & Lessons to be Learnt

6.1 Conclusions (key issues during this review)

6.1.1 The aim of this review was to consider whether agencies in the area of the Safer Buckinghamshire Partnership are responding appropriately to victims of domestic abuse, offering support measures, procedures and interventions to prevent and avoid future incidents of domestic abuse. All agencies contributing to the panel have made positive contributions to the process. They worked with candour and openness and showed a willingness to actively review and change policies if required.

6.1.2 Domestic abuse is a complex social problem. It harms the whole of society. The outcomes are the responsibility of all the agencies with a remit for health, social care and crime.[42]

6.1.3 **Themes**

6.1.4 The following areas have been established as key issues in this Review: Alcohol, loneliness, economic (including financial) abuse, professional curiosity/multi-agency working

Alcohol

6.1.5 Peter kept detailed diaries. These showed that Peter, in the end years of his life, was troubled by the decline in his mental capabilities. Peter attended medical appointments to address this, and his mental decline was determined to be due to ageing. His drinking was also considered a factor. However, tests on Peter's liver post mortem showed that Peter was not an alcoholic, although he was a social drinker.

6.1.6 Whilst it was likely that drug and alcohol issues would have been considered and screened out early on in Peter's engagement with the memory clinic – additional (expensive) tests are unlikely to have been ordered without the possibility of alcohol dependency having been considered and discarded as a likelihood.

6.1.7 It must also be noted that Peter's prescription of 30mg of Flurazepam is a high dose for someone of his age. If Peter had any additional Benzodiazepine this would have been a significant dose. Peter had been using Flurazepam since the 1970s. It was considered his use was so consistent that he had a significant tolerance, as such he was prescribed a higher dose later in his life (30mg). Benzodiazepines can have an effect on coordination and memory, which are similar to the effects of alcohol. Distinction can be made based on other factors however, notably the smell of alcohol, however SCAS are the only service that noted that on one occasion when they attended Peter's home and took him to hospital did he smell of alcohol.

[42] Wills, A. and Standing Together Against Domestic Violence, 'In Search of Excellence: A Guide to Effective Domestic Violence Partnerships, 2013, p.3.

6.1.8 There was a clear disparity in Peter's account of his alcohol consumption of (1-2 drinks a day) and Jacob's account (6-7 drinks a day) yet it appears that it was Jacob that was believed over Peter and his brother, Ian. OH acknowledge the trend of patients under reporting alcohol consumption to health professionals. Blood tests, particularly around liver function should therefore completed to ascertain information around substance dependency. Peter was relatively young to be experiencing signs of dementia, someone of his age would have alcohol dependency as a concern screened out therefore professional curiosity needs to be displayed in such cases to ascertain what (if any) other factors are causing the issue for the patient attending a service in the first place.

6.1.9 In the past there has been a breakdown in communication when an individual from Buckinghamshire attends MKUH. The hospital refers the patient to a Milton Keynes substance misuse services, but the GP is not updated by them. A patient with a Buckinghamshire address needs to be referred to Recovery Bucks if there is a concern over alcohol/substance use.

6.1.10 Despite the possible concern given Jacob's assertion that Peter was a heavy drinker, no agency ever referred Peter to an alcohol substance misuse service.

6.1.11 Peter maintained that he drank twenty units of alcohol a week [approximately 9 standard glasses of wine per week] and Peter believed his alcohol intake to be moderate and denied that it caused him dizziness or was the cause of falls.

6.1.12 In respect of the Flurazepam, Peter had no recollection at all that he had taken them on top of alcohol.

6.1.13 Just a few days prior to his death Peter wrote in his journal that he did not believe he had an alcohol addiction.

Loneliness

6.1.14 Peter was older and ageing. In this context there is a higher likelihood of people becoming vulnerable to exploitation and abuse, for example vulnerability to financial scamming increases with age, social isolation and loneliness. Although Peter was fairly recently retired, he was very able (mentally and physically), and led an active life before he met Jacob and Nicholas. Peter became vulnerable due to Jacob's grooming activities and abuse. Perhaps Peter's vulnerability was the fundamental human need for emotional intimacy, connected with feelings of loneliness, which Jacob recognised at an early stage and was able to exploit for financial gain.

Economic (including financial) Abuse

6.1.15 Peter's vulnerability to scams should have led to questions about his ability to understand financial abuse generally, across a variety of contexts.

6.1.16 Jacob moved in with Peter in 2012, by 2014 the relationship was established. When and how much Jacob profited from the relationship is hard to quantify as he profited from boarding and lodging, paid outings, holidays and gifts. In terms of large sums of money Jacob benefitted from the estate that Peter left to him. This links into the importance of framing this case within the context of economic abuse rather than just financial abuse,

as Jacob benefited economically from his coercion of Peter beyond just direct sums of money.

6.1.17 The vicar advised Jacob to log the gifting of a car from Peter with a solicitor but did not display any further curiosity about why this car was being gifted. Nor did the vicar seem to consider the possibility of coercion and economic abuse. This reflects the understanding by professionals of Jacob as a carer for Peter. The kind of potential abuse of elderly people by carers should be picked up on as a safeguarding concern.

6.1.18 In November 2014, Jacob influenced Peter to amend his will. These changes provided Jacob with rights to live in Peter's home after his death and gave Jacob a cash sum of £15,000 if Jacob lived with Peter for 24 months prior to his death. Peter subsequently changed his will again just prior to his death to increase the cash sum to £20,000 and removing the time limit.

Professional Curiosity/Multi-Agency working

6.1.19 Domestic abuse can be a complex matter and may not always be apparent to practitioners when engaging with clients. If it is recognised then practitioners must complete the necessary risk assessments, create safety plans within their own organisations for the victims, and have knowledge of and use the relevant referral pathways so that the information is shared with other agencies. This is important because many agencies may have different information on a survivor or perpetrator, each holding parts of the jigsaw but unless the information is being shared and organisations liaise with each other the jigsaw will not be complete and victims of domestic abuse and stalking will continue to be seriously harmed.

6.1.20 As with many reviews, there must be continued momentum to train and provide tools and policies to ensure that professional curiosity and identification of domestic abuse is fostered in all settings. This is particularly true in relation to healthcare settings where there is opportunity to engage with both the victim, the perpetrator, and the wider family. This could be the place of earliest intervention. If these tools are available, then they must be effectively marketed so that practitioners are fully aware of them and supervisors must ensure they are being complied with.

6.1.21 It is the responsibility for all agencies dealing with health, social care, education and crime to make sure that persons vulnerable to abuse are kept safe. In this case there is evidence to suggest that the agencies involved had information that Peter was a victim and at risk of abuse from Jacob and Nicholas. Some agencies responded appropriately with referrals and in compliance with protocols, but for many there was a lack of professional curiosity when presented with information that would suggest that there was a potential risk of domestic abuse. It is not known whether adherence to those protocols would have made a difference to Peter. However, it is clear that between agencies, Peter was subjected to potential abuse which was not ever considered to be domestic abuse.

7. Recommendations

7.1 Single Agency Recommendations

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency.

7.1.2 These recommendations are also presented by agency in the single agency recommendation action plan template in **Appendix 2**. These recommendations should be acted on through the development of an action plan, with each agency reporting on progress to the Safer Buckinghamshire Partnership. These are as follows:

7.1.3 **Thames Valley Police**

Recommendation 1: OBRT staff to be included in the relevant pool to receive safeguarding training commensurate with their role. This was signed off on 19th June 2020 and assigned to a Superintendent and a Contract Management Manager for action.

Recommendation 2: TVP Policing Strategy Unit to develop a Moodle Package to refresh knowledge of Operational guidance in relation to Unusual, Unexplained or Suspicious Deaths.

Recommendation 3: The importance of conducting proportionate secondary investigation when formulating an investigation plan should be re-visited in relation to student officer training and the IDP programme. Stronger emphasis needs to be embedded into the revised training in order to ensure understanding and competence.

Recommendation 4: Consideration should be given to converting the current secondary investigation guidance on the 'Knowzone' into dedicated Operational Guidance (http://knowzone/kz-inv-si). The Guidance needs to include the importance of checking primary information systems including Command and Control and CMP for investigative actions. Reference should be made to Endeavour principle 5 and particular emphasis given to the understanding of proportionality of secondary research and subsequent lines of enquiry.

7.1.4 **Adult Social Care**

Recommendation 1: Working protocols between Buckinghamshire Council and Oxford Health NHS Foundation Trust should be reviewed. This review has already commenced.

Recommendation 2: Buckinghamshire Council to promote home visits when undertaking safeguarding visits or assessments. This has also commenced.

7.1.5 **Diocese of Oxford**

Recommendation 1: Promote safeguarding prevention, especially awareness of the impact of social isolation and loneliness, recognising the need for intimacy, and challenging ageism and attitudes towards sexuality, and promote this nationally within the CoE (Dr. Cooper 2020, para 7.1).

Recommendation 2: Within the Diocese, work on LGBTI+ inclusivity, should focus on raising awareness of the safeguarding risks for some older people and the Diocese should promote this nationally within the Church of England. (Dr. Cooper 2020, para 7.1)

Recommendation 3: Address any culture of 'secrecy' and promote an open culture in the context of duties to care and provision of community support for vulnerable adults so that safeguarding concerns can be expressed and addressed and promote this nationally within the Church of England (Dr. Cooper 2020, para 7.1).

Recommendation 4: Work with Parishes asking them to regularly audit their volunteering processes and practices against CoE and Charity Commission standards regarding safer practices in volunteer recruitment, training, monitoring, support and supervision, including expectations regarding volunteer conduct to establish if proper processes and practices are being consistently delivered and are effective in identifying risks, volunteer support and development needs. (This could include reporting through the Archdeacons visits and peer review processes with other local groups) (Dr. Cooper 2020, para 7.4).

In February 2023, the DO informed the DHR that Recommendations 1 – 4 have been implemented. However, they remain within the report to ensure transparency and the analysis considered by the IMR author, the DO Independent review and this review.

Recommendation 5: Consider how to improve awareness of the complexities of risks for people with care and support needs who may be at risk of abuse or neglect, in particular:

- issues of mental capacity and safeguarding adults
- issues when carers prevent/hinder access to people they provide care for
- having difficult conversations with people who may be subject to harm and advocate for inclusion of these areas in the national safeguarding training programme (Dr. Cooper 2020, para 7.5)

Recommendation 6: A concerted effort to be made to reduce the stigma of being gay within the wider Church of England communion, so that it can provide a safer place for LGBTQ+ men and women to worship, as is its intent (Dr. Cooper 2020, para 5.10)

Recommendation 7: Training that develops the knowledge and core skills of PSO's and other Church Leaders e.g. holding difficult conversations, offering feedback and routine inquiry (Dr. Cooper 2020, para 5.12)

Recommendation 8: The CoE to develop a process to audit whether the recruitment, management and support of volunteers are consistently following the Church of England's guidance on Safer Recruitment and other relevant policies, as well as meeting the Charity Commissioners' standards. The audit would also need to check whether the mechanisms for safe recruitment, training, monitoring, support and supervision, including expectations expressed in codes of conduct, regarding volunteer roles are effective (Dr. Cooper 2020, para 5.40).

Recommendation 9: Training to be devised and delivered to include raising awareness of mental capacity, the impact of coercive control, identifying signs of abuse in changes of behaviour and temperament, and where there are concerns about 'unwise decisions' that are out of character, and what can help the person and those around them understand what is occurring. This can be included in basic awareness, foundation and leadership levels of training as appropriate to the roles and responsibilities of those attending. Particular focus should be on the prevention aspects of

safeguarding as well as the reactive protection aspects and should be covered at all levels of training (Dr. Cooper 2020, para 5.48).

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement Peter, Jacob and Nicholas following the death of Peter on 26th October 2015. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Peter, Jacob and Nicholas during the relevant period of time 1st April 2011 to 26th October 2015 (inclusive).

2. To establish what lessons are to be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

5. To prevent domestic abuse and homicide and improve service responses for all domestic abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6. To contribute to a better understanding of the nature of domestic abuse.

7. To highlight good practice.

Role of the DHR Panel, Independent Chair and the CSP

8. *The Independent Chair of the DHR will:*
   a) Chair the Domestic Homicide Review Panel.
   b) Co-ordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.
   d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. *The Review Panel:*
   a) Agree robust terms of reference.
   b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior

to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to Aylesbury Vale Community Safety Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

Aylesbury Vale Community Safety Partnership:

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forward Home Office feedback to the family, Review Panel and STADV.
d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

10. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross government definition states that domestic violence and abuse is:
    "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
    Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
    Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of Peter, Jacob and Nicholas (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child). There were no local area characteristics identified.

12. The Review Panel identified the following protected characteristics of Peter, Jacob and Nicholas as requiring specific consideration for this case;
    i) Sex (Peter was male and Jacob was male)
    ii) Sexual Orientation
    iii) Marriage and Civil Partnership (Peter and Jacob may have been in a civil partnership with each other)
    iv) Religion and Belief
    v) Age

13. The following issues have also been identified as particularly pertinent to this death:
    i) Mental Health
    ii) Financial Abuse including Fraud
    iii) Coercive Controlling Behaviour
    iv) Alcohol dependency

14. Consideration has been given by the Review Panel as to whether the victims were an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."
    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.
    If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.
    The Care Act 2014 states; "Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances."
    The conclusion by the panel is that Peter was an "Adult at Risk."

15. *Expertise:* The Independent Chair will invite services with expertise in relation to Religion and Belief and also memory loss and alcohol dependency to be on the review panel to provide appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide:

i) Church of England
ii) Roman Catholic Church
iii) Baptist Church
iv) Alzheimer's Society
v) Substance Misuse

16. If Peter, Jacob and MF have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.

17. The Chair of the Review will make the link with relevant interested parties outside of the main statutory agencies.

18. The Review Panel agrees it is important to have an intersectional framework to review Peter, Jacob and Nicholas life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

19. There are no known parallel reviews at this time however there is a possibility that there will be Child Safeguarding Review following a future meeting of the partnership board and sub-committee.

Membership

20. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

21. The following agencies are to be on the Review Panel:
    a) Clinical Commissioning Group
    b) Community Health Services
    c) General Practitioner for Peter, Jacob and Nicholas
    d) Local Authority Community Safety
    e) Women's Aid
    f) Mental Health Trust
    g) Thames Valley Police (SIO or representative and IMR author)
    h) Buckinghamshire Adult Social Care
    i) Oxford Health NHS Foundation
    j) Milton Keynes Together
    k) Community Safety Partnership, Aylesbury Vale
    l) Buckinghamshire Health Care Trust

22. As set out in paragraph 15 the following will contribute to the review as experts:
    a) Religion Safeguarding
    b) Alzheimer's Society
    c) Substance misuse services

23. If there is to be a parallel review during the time of this Domestic Homicide Review then the decision as to whom will be the panel member to ensure good cross communication between both reviews will be reviewed on notification. (See paragraph 19).

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

24. Standing Together have been commissioned by Aylesbury Vale CSP to independently chair this DHR. Standing Together have in turn appointed their DHR Associate John Trott to chair the DHR. The DHR team consists of a Support Officer and a DHR Manager. The DHR Support Officer Helena Canavan will be the main point of contact and will coordinate the DHR and the DHR Team Manager Hannah Candee will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

25. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

26. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Peter, Jacob and Nicholas during the relevant time period:
    a. Thames Valley Police
    b. Clinical Commissioning Group
    c. Milton Keynes Together (Milton Keynes Hospital)
    d. Oxford Health NHS Foundation
    e. Alzheimer's Society
    f. Buckinghamshire Adult Social Care
    g. Bucks Health Trust
    h. South Central Ambulance Service
    i. Church of England
    j. Roman Catholic Church
    k. Baptist Church
    l. Buckingham University
    m. Stowe School
    n. Red House Nursing Home

27. Further agencies may be asked to completed chronologies and IMRs if their involvement with Peter, Jacob and Nicholas becomes apparent through the information received as part of the review.

28. Each IMR will:
    - Set out the facts of their involvement with Peter, Jacob and Nicholas;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

29. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Peter, Jacob or Nicholas in contact with their agency.

Key Lines of Inquiry

30. In order to critically analyse the incident and the agencies' responses to Peter, Jacob or Nicholas, this review should specifically consider the following points:

a) Analyse the communication, procedures and discussions, which took place within and between agencies.
b) Analyse the co-operation between different agencies involved with Peter, Jacob or Nicholas
c) Analyse the opportunity for agencies to identify and assess domestic abuse risk. If domestic abuse was not known, how might the agency have identified the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct, routine or clinical questioning on domestic abuse and how were they followed in this case?
d) Analyse agency responses to any identification of domestic abuse issues including the nature of assessments, decision making and responses and whether they met the expected standards of practice and procedures.
e) Analyse organisations' access to specialist domestic abuse agencies.
f) Analyse how well equipped were practitioners in responding to domestic abuse? How were staff supported to respond to issues of domestic abuse through policies, procedures, training, supervision, management and sufficient resources available at the time?
g) Analysis should pay particular attention to the following issues:
1) Mental Health
2) Financial Abuse
3) Coercive Controlling Behaviour
4) Religion
5) Substance Misuse

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

31. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to Aylesbury Vale Community Safety Partnership on their action plans within six months of the Review being completed.

32. Aylesbury Vale Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and other informal networks

33. The review will sensitively attempt to involve the family of Peter in the review once it is appropriate to do so in the context of on-going HM Coroner proceedings. The chair will lead on family engagement

with the support of Advocacy After Fatal Domestic Abuse (AAFDA) and the Police Family Liaison Officer.

34. Jacob and Nicholas will be invited to participate in the review.

35. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

36. The Review Panel discussed involvement of other informal networks of Peter, Jacob and Nicholas and agreed it was proportionate to the DHR to invite selected friends and colleagues to be involved in the DHR.

Media handling

37. Any enquiries from the media and family should be forwarded to Aylesbury Vale Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. Aylesbury Vale Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

38. Aylesbury Vale Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

39. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

40. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

41. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

42. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.

43. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.

44. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

45. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

46. The sharing of information by agencies in relation to their contact with the victims is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs (Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
        - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
        - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
        - partial redaction of record content.

    c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
    d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
        i) It is needed to prevent serious crime
        ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

Appendix 2: Single Agency Action Plan- Peter

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommendation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*
OBRT(office based research team) staff to be included in the relevant pool to receive safeguarding training commensurate with their role. This was signed off on 19th June 2020 and assigned to a	Local	The OBRT was staffed by temps but changes have been made meaning that the OBRT is now the Volume Crime Triage Team (VCTT) which consists of Police Officers who receive safeguarding training	**Thames Valley Police**		17.5.21	The OBRT was staffed by temps but changes have been made meaning that the OBRT is now the Volume Crime Triage Team (VCTT) which

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Superintendent and a Contract Management Manager for action.		as a matter of course. An additional safeguarding training day was held for the staff in April 2021. The Inspector who leads the VCTT also informed the recommendations panel that a new training package was being designed and would be a mandatory training for all of the staff to complete on a yearly basis.				consists of Police Officers who receive safeguarding training as a matter of course. An additional safeguarding training day was held for the staff in April 2021. The Inspector who leads the VCTT also informed the recommendations panel that a new training package was being designed and would be a mandatory training for all of the staff to complete on a yearly basis.
TVP Policing Strategy Unit to develop a Moodle Package to refresh knowledge of Operational guidance in relation to		The Operational Guidance around sudden deaths was amended in June 2021 and clarifications were made to it. This was communicated to staff in TVP by way of email	**Thames Valley Police**	Rewriting the sudden death operational guidance	27.4.22	The Operational Guidance around sudden deaths was amended in June 2021 and clarifications were made to it. This was

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Unusual, Unexplained or Suspicious Deaths.		and also included as 'news' on the default home page on all of the TVP computers. A Moodle training package was negated.				communicated to staff in TVP by way of email and also included as 'news' on the default home page on all of the TVP computers. A Moodle training package was negated.
The importance of conducting proportionate secondary investigation when formulating an investigation plan should be re-visited in relation to student officer training and the IDP programme. Stronger emphasis needs to be embedded into the revised training in order to ensure understanding and competence.	Local TVP only however it is suspected that this could be an issue force wide.	This was assigned to L and PD (Learning and Professional Development). There have been changes to the action owner since the recommendation was assigned. The latest update as of 20th April 2022 is from the action owner to say that secondary investigation training is covered on all of the entry programmes within TVP's IDP and it is also covered in various places on the Endeavour training.	Thames Valley Police	It was discussed at a meeting on 28/04/22 and was agreed that more detail is needed from L and PD before it can be considered for closure. Update 11/05/23 Same as previous update Secondary Investigation are covered in all entry programmes with in IDP. It also covered		Secondary Investigations are covered in all entry programmes with in IDP. It also covered in Endeavour sessions.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				in Endeavour sessions. This recommendation is being discussed at the June Panel for possible closure. 10/11/23 Awaiting Further update on additional work being done on secondary investigations.		
Consideration should be given to converting the current secondary investigation guidance on the 'Knowzone'[43] into dedicated Operational Guidance (http://knowzone/kz-inv-si). The Guidance needs to include the importance	Local TVP only however it is suspected that this could be an issue force wide	TVP have now written operation guidance in relation to conducting secondary checks. This was published in March 2021.	Thames Valley Police	Completed March 2021		TVP have now written operation guidance in relation to conducting secondary checks. This was published in March 2021.

[43] Knowzone – a forum used by Thames Valley Police for obtaining information.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
of checking primary information systems including Command and Control and CMP for investigative actions. Reference should be made to Endeavour principle 5 and particular emphasis given to the understanding of proportionality of secondary research and subsequent lines of enquiry.						
Working protocols between Buckinghamshire Council and Oxford Health NHS Foundation Trust should be reviewed.	Local	During 2021/22 there has been a full review of how Buckinghamshire Council and Oxford Health work together daily. The recommendations from this review will be fully implemented by September 2022.	**Adult Social Care**	"A full review of the S.75 partnership arrangements between Buckinghamshire Council and Oxford Health has taken place. This review of statutory Social Work Professionals and Approved Mental Health Professionals	September 2022	The new arrangements have improved the integrated working with Oxford Health. The new arrangements are monitored via a monthly meeting where performance and quality is reviewed. The new arrangements have improved the integrated working with

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				has recommended a new staffing structure to work on a locality footprint alongside existing services. A staff consultation will begin in July 2022. The review of the S.75 arrangements between Buckinghamshire Council and Oxford Health will improve outcomes for Buckinghamshire residents ensuring that the professionals are working closer together. We will capture the outcomes of these changes via regular reviews but also via our auditing of practice which takes place on a monthly basis.		Oxford Health. The new arrangements are monitored via a monthly meeting where performance and quality is reviewed.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				"		
Buckinghamshire Council to promote home visits when undertaking safeguarding visits or assessments.	Local	An updated Safeguarding Adults policy and procedure will be developed to highlight the importance of person-centred Safeguarding.	**Adult Social Care**	A new and refreshed Safeguarding Policy was launched in July 2021. The policy and procedure documents stress the importance of making safeguarding personal to the individual. The promotion of home visits when undertaking safeguarding visits or assessments has begun. We do promote home visits for Safeguarding and Sec.9/10 assessments- or see people in our community café settings where people are able to do so.	1.7.21	Monthly Safeguarding Audits have shown an improvement in quality in relation to Safeguarding work completed across Adult Social Care. The promotion of home visits when undertaking safeguarding visits or assessments has begun. We also have a daily duty rota to facilitate urgent/crisis/risk priority visits. The Early Resolution and Safeguarding

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				We also have a daily duty rota to facilitate urgent/crisis/risk priority visits. The Early Resolution and Safeguarding Team (First Response & Short-Term Intervention) assess any concerns raised, any immediate risk and ensure that the adult is supported, and their safety needs are met in a timely manner.		Team (First Response & Short-Term Intervention) assess any concerns raised, any immediate risk and ensure that the adult is supported, and their safety needs are met in a timely manner.
Promote safeguarding prevention, especially awareness of the impact of social isolation and loneliness, recognising the need for intimacy, and challenging agism and	Local and National		**Diocese of Oxford** Head of Safeguarding and Director of Mission and Ministry	All recommendations have been shared with the National Church for implementation in training programmes. Updated national leadership training (April 2023) explores unconscious bias to a		Updated national leadership training (April 2023) explores unconscious bias to a greater extent than previously. The diocesan safeguarding leadership training discusses adult

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attitudes towards sexuality, and promote this nationally within the CoE.				greater extent than previously. The diocesan safeguarding leadership training discusses adult vulnerability with specific reference to this case. We have encouraged parish engagement with Living in Love and Faith' when the learning materials were published in November 2020. We have established an active network of LLF Advocates across the diocese who have been supporting parishes in engaging with the LLF process and resources. A review of curates skills training was carried out in 2020-21 improving pastoral care skills in IME (Initial Ministerial Education) training.		vulnerability with specific reference to this case. We have encouraged parish engagement with Living in Love and Faith' when the learning materials were published in November 2020. We have established an active network of LLF Advocates across the diocese who have been supporting parishes in engaging with the LLF process and resources. A review of curates skills training was carried out in 2020-21 improving pastoral care skills in IME (Initial Ministerial Education) training.
Within the Diocese, work on LGBTI+ inclusivity, should focus on raising awareness of the safeguarding risks for	Local and National		**Diocese of Oxford** Head of Safeguarding			We acknowledge and celebrate the contribution that LGBTI+ Christians

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some older people and the Diocese should promote this nationally within the Church of England.			Director of Mission and Ministry			are making to the Church in this Diocese. We have created a dedicated LGBTI+ chaplaincy service in early 2020. The chaplains will continue to consider issues of sexuality for people of all ages. We have encouraged parish engagement with 'Living in Love and Faith' when the learning materials were published in November 2020.
Address any culture of 'secrecy' and promote an open culture in the context of duties to care and provision of	Local and National		**Diocese of Oxford** Head of Safeguarding			All recommendations have been shared with the National Church for

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community support for vulnerable adults so that safeguarding concerns can be expressed and addressed and promote this nationally within the Church of England.						implementation in training programmes. The congregation at Stowe has developed a much more open culture following the trial and conviction of Jacob with support from senior clergy. We actively encourage a culture of openness and speaking out about matters of concern. New emphasis on appropriate boundaries for confidentiality within curacy and ministry was introduced into the 'Getting Up to Speed' day from 2021 as part of the

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						curacy induction, balancing the framework from the Guidelines for Professional Conduct of Clergy with pastoral risks where information is not shared well. These topics are covered within our leadership safeguarding training which is taken by all clergy and people in positions of leadership in the church and form part of regular Ministerial Development Reviews (MDRs).
Work with Parishes asking them to regularly	Local	Following the independent report, we carried out a rapid	**Diocese of Oxford**		June 2021	Following the independent report, we

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audit their volunteering processes and practices against CoE and Charity Commission standards regarding safer practices in volunteer recruitment, training, monitoring, support, and supervision, including expectations regarding volunteer conduct to establish if proper processes and practices are being consistently delivered and are effective in identifying risks, volunteer support and development needs. (This could include reporting through the Archdeacons visits and peer review processes with other local groups)		review of our policies and procedures for volunteers. These are in good order and consistent with national guidance. New Safer Recruitment Guidance was introduced in June 2021. A Safer Recruitment and People Management training module was designed and delivered to about 600 Parish Safeguarding Officers, Incumbents and Churchwardens. This has now been superseded by the CoE online training module available to all across the diocese. A new self-auditing tool for parishes, the Safeguarding Parish Dashboard, collates safeguarding information at the parish level and Archdeacon Articles of Enquiry gather information on safeguarding in parishes.	Director of People and Head of Safeguarding			carried out a rapid review of our policies and procedures for volunteers. These are in good order and consistent with national guidance. New Safer Recruitment Guidance was introduced in June 2021. A Safer Recruitment and People Management training module was designed and delivered to about 600 Parish Safeguarding Officers, Incumbents and Churchwardens. This has now been superseded by the CoE online training module available to all across the diocese. A new self-auditing tool for parishes, the Safeguarding Parish Dashboard, collates

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						safeguarding information at the parish level and Archdeacon Articles of Enquiry gather information on safeguarding in parishes.
Consider how to improve awareness of the complexities of risks for people with care and support needs who may be at risk of abuse or neglect, in particular: •issues of mental capacity and safeguarding adults; •issues when carers prevent/hinder access to people they provide care for; •having difficult conversations with people who may be subject to harm and advocate for	Local and National		**Diocese of Oxford** Head of Safeguarding and Director of Mission and Ministry	All recommendations have been shared with the National Church for implementation in training programmes. Churches, like many of the organisations they partner with, offer a lot of support to people with high levels of need. Our safeguarding team helps parishes supporting vulnerable parishioners with appropriate sources of advice and support.	December 2023 Outstanding action: Development of difficult conversations module within ministerial clergy development.	All recommendations have been shared with the National Church for implementation in training programmes. Churches, like many of the organisations they partner with, offer a lot of support to people with high levels of need. Our safeguarding team helps parishes supporting vulnerable parishioners with appropriate sources of advice and support. The national safeguarding training

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inclusion of these areas in the national safeguarding training programme.				The national safeguarding training programme for the Church of England focusses on key learning and awareness of abuse. During 2022 training was held with Area Deans in handling conflict and we will also develop a 'difficult conversations' module within our own Continuing Ministerial Development (CMD) programme during 2023. All diocesan-trained ordinands and Licensed Lay Ministers-in-training now receive Domestic Abuse Awareness safeguarding training as integral part of training prior to licensing or ordination.		programme for the Church of England focusses on key learning and awareness of abuse. During 2022 training was held with Area Deans in handling conflict and we will also develop a 'difficult conversations' module within our own Continuing Ministerial Development (CMD) programme during 2023. All diocesan-trained ordinands and Licensed Lay Ministers-in-training now receive Domestic Abuse Awareness safeguarding training as integral part of training prior to licensing or ordination

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A concerted effort to be made to reduce the stigma of being gay within the wider Church of England communion, so that it can provide a safer place for LGBT+ men and women to worship, as is its intent.	Local and National		**Diocese of Oxford** National Church, Bishop of Oxford, Head of Safeguarding	We have created a dedicated LGBTI+ chaplaincy service in early 2020. We have encouraged parish engagement with 'Living in Love and Faith' when the learning materials were published in November 2020. The Safeguarding Leadership Training emphasises the need for inclusivity in a healthy Christian culture. Recommendations have been shared with the National Church.	ongoing	We have created a dedicated LGBTI+ chaplaincy service in early 2020. We have encouraged parish engagement with 'Living in Love and Faith' when the learning materials were published in November 2020. The Safeguarding Leadership Training emphasises the need for inclusivity in a healthy Christian culture. Recommendations have been shared with the National Church.
Training that develops the knowledge and core skills of PSO's and other Church Leaders e.g., holding difficult conversations, offering			**Diocese of Oxford**			All recommendations have been shared with the National Church for

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feedback and routine inquiry.						implementation in training programmes. PSO induction training gives PSOs the opportunity to develop core safeguarding skills and further opportunity is given through PSO drop-in sessions and 1:1 sessions with diocesan Area Safeguarding Advisors where there is space to gain advice and support in managing safeguarding concerns at a parish level. All leaders undertake safeguarding leadership training which develops core

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						skills through the use of scenarios.
The CoE to develop a process to audit whether the recruitment, management and support of volunteers are consistently following the Church of England's guidance on Safer Recruitment and other relevant policies, as well as meeting the Charity Commissioners' standards. The audit would also need to check whether the mechanisms for safe recruitment, training, monitoring, support and supervision, including expectations expressed in codes of conduct, regarding volunteer roles are effective.	Local and national		**Diocese of Oxford** Head of Safeguarding, Director of People and National Church			Following the independent report, we carried out a rapid review of our policies and procedures for volunteers. These are in good order and consistent with national guidance. New Safer Recruitment Guidance was introduced in June 2021. A Safer Recruitment and People Management training module was designed and delivered to Officers, Incumbents and Churchwardens. This has now been

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						superseded by the CoE online training module available to all across the diocese. A new self-auditing tool for parishes, the Safeguarding Parish Dashboard, collates safeguarding information at the parish level and Archdeacon Articles of Enquiry gather information on safeguarding in parishes.
Training to be devised and delivered to include raising awareness of mental capacity, the impact of coercive control, identifying signs of abuse in changes of behaviour and temperament, and where there are concerns about			**Diocese of Oxford** Head of Safeguarding and National Church.			All clergy, pastoral visitors, parish safeguarding officers and ordinands are required to undertake Domestic Abuse training which explores these areas in detail. Mental capacity, power and vulnerability are also explored in Foundation Training. The

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'unwise decisions' that are out of character, and what can help the person and those around them understand what is occurring. This can be included in basic awareness, foundation, and leadership levels of training as appropriate to the roles and responsibilities of those attending. Particular focus should be on the prevention aspects of safeguarding as well as the reactive protection aspects and should be covered at all levels of training.						signs of abuse are explored at all levels of safeguarding training and re-enforced using scenarios discussed in training. All training emphasises the need to develop a healthy Christian culture and prioritise both prevention and reactive safeguarding.

All actions have been monitored by the Safer Buckinghamshire Partnership and are all complete.