Lewisham Safeguarding Adults Board

A working partnership to prevent abuse

7 Minute Briefing

# SAFEGUARDING ADULTS REVIEW ARTHUR

## THE ADULT

Arthur was an 81-year-old Black British Caribbean man who lived in a private residence in the London Borough of Lewisham with his wife, who was also his carer. In September 2021, Arthur was unlawfully killed by his son, [Anthony].

Arthur had diagnoses of type 2 diabetes, hypertension and had been disabled by a stroke in March 2017. Arthur was also sight impaired and apart from his GP, Arthur had not been in recent contact with local services.

At the request of Arthur's family we have used his real name, but to protect the identity of his son, Anthony is a pseudonym.

## BACKGROUND TO THE REVIEW

Anthony was 54 years old at the time of the incident and was also of Black British Caribbean ethnicity, and lived alone in a flat provided by the local authority.

He had been known to the police since the 1990's when he came to notice for a number of offences including actual bodily harm and possession of an offensive weapon. He did not come to police attention again until 2015 when a report of noise disturbance was received from neighbours. These reports escalated between 2019 and 2021.

Anthony also had a diagnosis of Treatment Resistant Schizophrenia and had been known to local mental health services since 2000.

## WHAT HAPPENED

Anthony was deemed unfit to plead to the murder of his father and was found by a jury to have committed the act of stabbing and killing Arthur. Anthony was made subject to a Hospital Order under Section 37 of the Mental Health Act, with a Section 41 restriction.

Following Arthur's death, the police investigation has established from family members that Anthony had suffered with mental ill-health issues for some time, spanning back to his early twenties when he lost a child at 14 months, assaulted his partner, and was hospitalised. Family told police they had recently become concerned that he was not taking his medication as prescribed and had lost vast amounts of weight. Upon visiting him they noted that Anthony's flat was in disarray, and he had painted aliens and strange creatures on the walls.

Risk assessment for Anthony was sporadic and did not reflect the escalating reports of Anti-Social Behaviour and decline in his mental health. Despite entitlement to Mental Health Act 1983, s.117 Aftercare Services, there was no evidence of this being provided or an aftercare plan being in place, his social care needs had not been assessed since 2017 and no request for such had been made.

## KEY LEARNING

**Crisis plans should be regularly reviewed and demonstrate what a decline in mental health looks like for the person and the threshold for escalation. Assessments and care plans should be regularly reviewed and should involve and consider significant others such as family members and carers.**

**Practitioners need to be aware of, and professionally curious about, familial abuse, with recognition of the hidden nature of older people who experience such abuse. Any concerns of familial abuse should be responded to appropriately including risk assessment, safeguarding procedures and referral to support services.**

## KEY ISSUES FOR YOU TO CONSIDER

**Equality issues and protected characteristics:**

- Ethnicity was not considered by any agency which meant that they were unable to consider factors contributing to, and therefore understanding Anthony's lived experience. Doing so may have resulted in a more effective approach in responding to Anthony and his family's needs.
- Age and gender was relevant in this case with respect to Anthony's parents who were both older people. As older people, they were less likely to be identified as potential victims of domestic abuse, Arthur even more so, given that he was also a man.

**Information sharing:**

- There should be clear guidance in each agency which dictates the threshold for information sharing and onward referrals following an assessment of risk.
- Care plans should also detail arrangements for sharing information between the agencies involved in the person's care and with their families/carers.
- Organisational systems should allow the easy retrieval of information and intelligence gathering, so that links can be made between separate incidents that highlight a risk to the person or others.

## FAMILIAL ABUSE & OLDER PEOPLE

**You should measure the quality, impact and effectiveness of awareness raising activities in relation to familial abuse experienced by older people (including recognition and response), and consider new methods to better embed this into practice.**

- **For 44% of domestic abuse victims over 60 years of age an adult family member is the primary perpetrator, compared to 6% for those under 60.**
- **As this group is hidden, they are less likely to access domestic abuse services and therefore professionals tend to believe that domestic abuse does not occur amongst older people.**
- **Older people are also statistically more likely to suffer from health problems, reduced mobility, or other disabilities, which can exacerbate their vulnerability.**
- **Adult familial abuse also presents challenges when adult children experience mental health issues whereby, unless they are a risk to the community, services are less likely to intervene.**

Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk)

www.safeguardinglewisham.org.uk/lsab

**Adult Safeguarding Information and Resources**