Hertfordshire Domestic Abuse Partnership

Welwyn and Hatfield Community Safety Partnership

Domestic Homicide Review

Executive Summary

Into the death of Arthur (pseudonym) in August 2022

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A Tribute to Arthur

The Independent Chair and Domestic Homicide Review Panel offer their sincere condolences and deepest sympathy to all who have been affected by the death of Arthur, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Review Chair thanks the Panel for their enthusiastic engagement with this process and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individuals' agencies.

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1. Preface

1.1 Domestic Homicide Reviews (DHRs) came in to force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
b) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 There was also a change to the Multi Agency Guidance in December 2016 where Community Safety Partnerships have been encouraged to commission a review where an individual has taken their own life, and they were known to agencies as experiencing domestic abuse.

1.3 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence', as this is the term which has been adopted by the Strategic Partnerships Team in Hertfordshire.

1.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and agencies work individually and together to safeguard victims.
- 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.
- Apply those lessons to service response, including changes to inform national and local policies and procedures as appropriate,
- Prevent domestic abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing co-ordinated multi agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice

1.5 The criteria for a Domestic Homicide Review were met in relation to Arthur's death because during the criminal investigation of this incident information came to light that Arthur may have experienced some examples of domestic abuse in relation to social isolation, controlling behaviour and excessive use of restraint. Although the criminal investigation was closed in relation to Arthur's death, the Community Safety Partnership still felt that there may have been lessons to be learnt from Arthur's experiences. This review examines the circumstances surrounding the death of Arthur in a town in Hertfordshire in

August 2022. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016 and pseudonyms have been used.

2. Introduction

2.1 Arthur was 57 years old at the time of his death. He was the father to three adult children, Benjamin, Sophie and Jeremy. It is understood that he had lived in Hertfordshire since 2007 when he was compelled to move to the area following a court order. This was following a criminal conviction of Actual Bodily Harm in September 2007, which is also reported to be against his ex-wife. Also, during this same time, it is reported that Arthur attempted to end his own life by stabbing himself in the stomach, this triggered some involvement with Hertfordshire Partnership University NHS Foundation Trust. He continued to receive a level of support from this organisation in 2008 onwards until his death. Albeit there were periods of time where it was reported that he did not engage, this might also have been because he felt unable to.

2.2 Between 2008 and the time of his death Arthur was diagnosed with Aspergers, ADHD, Anxiety and Depression by two different mental health organisations. He was also assessed for an eating disorder in 2022 owing to concerns for his weight and relationship with food, however it was determined by clinicians that he would best be supported by a Community Mental Health Team and support from a community dietician.

2.3 It is reported as part of this review that Arthur's youngest adult son, Jeremy, moved in with Arthur in December 2021 to care and support Arthur. The family described the dynamic between Jeremy and Arthur as being 'odd', with Jeremy being controlling over access to Arthur and the pair of them being quite insular and detached all driven by Jeremy. It was recorded in one of the agency's records that a family member believed Jeremy had a controlling personality although his intentions were good.

2.4 Arthur's tenancy was with Paradigm Housing as a sole tenant. This housing provider contacted Arthur in August 2022 to ask that he vacate the property to enable maintenance works to be undertaken, Arthur gave permission for Paradigm Housing to speak with Jeremy his informal carer. Arthur and Jeremy were housed in temporary accommodation at a local hotel.

2.5 **Incident summary:**

2.5.1 On the evening of a night in August 2022, paramedics were called to the local hotel to reports of a male in cardiac arrest, the call having been made by Jeremy. Upon arrival of Police and ambulance staff, Arthur was declared deceased in the room at midnight and had a notable bruise to his neck. There was also evidence of a disturbance in the room, with some blood and a damaged shower hose.

2.5.2 Owing to the nature of their caring relationship and some concerns raised by family members during the course of the Police investigation. A referral was made to the Community Safety Partnership to explore whether the criteria was met for a Domestic Homicide Review.

2.5.3 A Home Office Postmortem was conducted which was inconclusive, the bruising on the neck was superficial and not a contributory factor. Therefore, all criminal investigations into Arthur's death have now concluded. There are no further investigations that can be done to ascertain whether there was third party involvement in Arthur's death which would meet the criminal standard.

2.5.4 The Coroner's Inquest is still outstanding, and likely to take place after the conclusion of both this Domestic Homicide Review.

2.5.5 The key purpose of this review is to enable lessons to be learned from Arthur's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future. Although there is not a lot of information known about Arthur and Jeremy and in particular their caring relationship. The Community Safety Partnership still recognised the importance to explore any learning opportunities in relation to identification of carers, support for carers, recognising the use of restraint by carers versus abuse.

2.5.6 The Review considers all contacts/involvement agencies had with Arthur and some contacts with Jeremy during the period January 2017 to August 2022, as well as any events, prior to 2017, which are relevant to mental health, violence, and abuse.

3. The Terms of Reference

Specific Terms of Reference for this Review:

3.1 To provide an overview report which articulates the life of the victim through his eyes to understand the reality of his experiences with professionals working with and offering support to him and being cared for by his adult son.

Each Agency will be asked to:

3.2 Comment on the specific areas set out in the key lines of enquiry found within section 10 of this document.

3.3 To identify the history and context of the relationship between Arthur and Jeremy who were father and son and provide a detailed chronology of relevant agency contact with Arthur; specifically, his experience of agencies and his relationship with Jeremy, who agencies have identified to have shown signs of abusive behaviour towards Arthur.

3.4 To examine whether there were signs or behaviours exhibited by Arthur as being a victim of domestic abuse or Jeremy as the alleged perpetrator, in their contact with services which could have indicated the level of risk.

3.5 To report their involvement with both Arthur and Jeremy to assess whether the services provided offered appropriate interventions, risk assessments, care plans and resources. Assessment should include analysis of any organisational and/or frontline practice level factors which impacted upon service delivery. Specifically, how Jeremy was identified as a carer to Arthur, and what was offered in support of this to both individuals.

3.6 To examine whether there were any indicators or history of domestic abuse and/or coercive control? If so, were these indicators fully realised and how were they responded to? Was the immediate and wider impact of domestic abuse between Arthur and Jeremy fully considered by agencies involved? And how was information shared between agencies?

3.7 To consider whether there was any collaboration and coordination between agencies in working with Arthur and Jeremy, individually and as a Father and Son? What was the nature of this collaboration and coordination, and which agencies were involved with whom and how? Did agencies work effectively in any collaboration?

3.8 To consider what learning, if any, there is to be identified in the care management of Arthur who had a number of mental health diagnoses, was cared for by his adult son and there was some albeit limited information that Jeremy appeared at times controlling of his father. Is there any good or poor practice relating to this case that the Review should learn from? Each agency is asked to examine best practice in their specialist area and determine whether there are any changes to systems or ways of operating that can reduce the risk of a similar fatal incident taking place in future?

3.9 To examine whether communication and information sharing between agencies or within agencies was adequate, timely and in line with policies and procedures?

3.10 To examine whether there were any equality and diversity issues or other barriers to Arthur and Jeremy in seeking help?

3.11 To examine whether either Arthur or Jeremy were assessed or could they have been assessed as an 'adult at risk' as defined within the Care Act 2014. If not were the circumstances such that consideration should have been given to this risk assessment? Was Jeremy identified as a carer and what did this look like in terms of carer's support and assessment?

3.12 To provide an assessment of whether family, friends, neighbours or key workers were aware of any abusive or concerning behaviour that occurred prior to Arthur's death, and if they were whether they shared this information with any agencies.

3.13 To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

3.14 To examine the level of domestic abuse training undertaken by staff who had contact with Arthur or Jeremy, and their knowledge of indicators of domestic abuse, both for a victim and for a potential perpetrator of abuse; the application and use of the DASH risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC), or to appropriate specialist domestic abuse services.

3.15 The Independent Chair in consultation with the Police Family Liaison officer will be responsible for making contact with family members to invite their contribution to the Review, to keep them informed of progress, and to share the Review's outcome.

Key lines of enquiry

The following are key lines of enquiry which will be explored further with the relevant agencies in the review:

3.16 The reasons for Arthur and Jeremy's temporary residence in the local hotel and the hotel's awareness of their relationship and Arthur's health and social care needs. What domestic abuse awareness training do hotel staff have in identifying the signs when individuals are placed in temporary public accommodation by the local authority?

3.17 The support offered to Arthur as a result of his multiple mental health diagnoses and Jeremy as his adult son.

3.18 The differences in how agencies should respond to carer's abuse and domestic abuse and specifically the use of restraint.

3.19 The timeline in how long Jeremy had been 'caring' for Arthur, how long had they lived together?

Legal advice and costs

3.20 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams are at their discretion.

3.21 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then this will be sought following discussion with the Panel.

Media and communication

3.22 The management of all media and communication matters will be through the Review Panel, supported by the Strategic Partnerships Team.

Roles and Responsibilities

Chair of Strategic Partnerships Team

3.23 To commission the DHR and seek assurance that the Terms of Reference have been met for the DHR before sending onto Home Office to be quality assured.

Independent Chair

3.24 To convene (with administrative support from the Partnership) and Chair the Review Panel meetings.

3.25 To liaise with the family/friends of Arthur and Jeremy, using the relevant family advocates or Family Liaison Officer.

3.26 To determine the brief of, coordinate and request Individual Management Reviews (IMRs)

3.27 To review IMRs ensuring that they meet the satisfactory criteria of the Home Office

3.28 To write the Overview Report and Executive Summary

3.29 To present the findings of the Overview Report to the Strategic Partnerships Team.

4. Involvement of family, friends and wider community

4.1 As per the Home Office guidance a letter together with the Leaflet on 'Domestic Homicide Reviews', was sent to Arthur's two other adult children, Benjamin and Sophie, inviting them to contribute and engage in this review, this was sent by the Independent Chair. Another letter was sent to Arthur's ex-wife and another to Jeremy. These letters were shared with Hertfordshire Police colleagues who had built a rapport with these individuals during the Police investigation, therefore the Independent Chair has assurance that the invitation letter was received and confidence that the process will have been explained.

5. Summary of agencies involved and their contact

5.1 The agencies listed in Section 8 were invited to attend the Panel meeting to discuss their involvement:

5.1.1 Hertfordshire Partnership University NHS Foundation Trust is the main provider of mental health services in Hertfordshire, and both Arthur and Jeremy accessed these services. They also provide some of the requirements relating to Social Care and Safeguarding under the Care Act 2014 following a formal delegation from the County Council. The (Adult Community Mental Health Service) ACMHS offers a multi-disciplinary service to adults experiencing severe and enduring mental illness. This service is comprised of a range of

professions: specialist medical professionals, nursing, social work, occupational therapy, psychological therapy, art psychotherapy, drama therapy, psychology, support workers and administrative staff. At the time of his death, Arthur was due to have his second appointment with the Adult Mental Health Service several weeks later.

5.1.2 Hertfordshire and West Essex Integrated Care Board is the main commissioner of health services within the Hertfordshire area including Primary Care services; GP. Arthur and Jeremy were registered at different GP Practices which was not unusual given they were Father and Son and hadn't long lived together. Arthur had some contact with his GP Practice during the timeframe of this review.

5.1.3 Hertfordshire Constabulary provide the Police service to the county of Hertfordshire. Neither Arthur nor Jeremy were known to this agency, however from the Police National Computer they were able to provide the Review with information relating to these parties which was held by the Metropolitan Police. This related to Arthur's assault on his ex-wife and Jeremy's car accident in 2007 when it is believed he further suffered with post-traumatic stress disorder as a result. There was only one relevant agency contact with Arthur in 2017 which was reported by the Community Mental Health Trust at the time with concerns for Arthur's welfare.

5.1.4 Paradigm Housing is a charitable organisation which provides affordable homes across the Southeast. Arthur was housed in a Paradigm Housing property in 2009. His property had an issue with subsidence and therefore in 2022 he had to decant the property urgently owing to concerns over a fractured gas pipe resulting in no hot water and heating. Although Jeremy was living at the property he was not on the tenancy, and it was not clear to Paradigm that Jeremy was living there consistently and permanently.

5.1.5 The Probation Service is a statutory criminal justice service that supervises offenders serving community sentences or release into the community from prison. Arthur was known to this service owing to the assault he was convicted of in 2007 against his ex-wife. However, their involvement was very limited during the timeframe of this review and previous systems were used to record information when Arthur was accessing these services.

5.1.6 Turning Point is a community outreach support service for adults with mental health needs and other complex health and social care issues. This organisation did not provide information directly to the Review as their involvement with Arthur was outside of the timeframe of the review (October2016). However, there was some useful information held within the Hertfordshire Partnership University NHS Foundation Trust information system which related to this organisation.

5.2 A chronology was compiled as part of this review given the number of contacts that Arthur and Jeremy had had with these agencies. A brief summary of this is captured in 'The facts' section of this report.

5.3 As previously advised, other agencies also attended the Panel in order to provide expertise to discussions in relation to the area of Hertfordshire (local authority), domestic abuse (Refuge- specialist domestic abuse service- providing IDVA service across

Hertfordshire), and Carers in Herts (a voluntary sector organisation supporting carers and their families across Hertfordshire)

6. Conclusions

6.1 In reaching their conclusions the Review Panel have focussed on the following questions.

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the identification of caring responsibilities and working with couples who both present with mental health concerns?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

6.2.1 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Arthur's death in September 2022.

6.2.2 The Panel is of the opinion that the agreed recommendations as listed in Section 19 below appropriately address the points raised throughout the review, particularly in relation to key areas identified in the IMRs and described in the Analysis and Lessons to be learnt sections of this report.

6.2.3 The main issues identified as part of this review process were;

The identification of unpaid carers for Arthur noting that all of his adult children during various points were mentioned in agency records and they were not recognised in by agencies performing a 'caring role', as a result of this there were missed opportunities to offer support and reduce any carer's stress that may have been present and to better understand the relationships. As a result of unpaid carer's not being identified then support by valuable organisations like Carers in Herts cannot be offered or referred to, likewise carer's assessments are not undertaken.

In addition to the above, the use of restraint was questioned during this review owing to some of the injuries Arthur experienced. The Panel recognised that unpaid carers also are probably unaware what use of restraint can be safely used and that no training or literature is provided by any of the agencies about this which is potentially a gap.

Lastly, the Panel concluded that the Covid pandemic also had an impact on Arthur and his confidence and ability to access and engage with services when he found times challenging, as services had changed, he had become more reliant on unpaid carers and his confidence had decreased. This was recognised as a moment in time and learning has been extrapolated more widely on how services might recognise the impact on those with similar learning needs to Arthur if anything were to happen of a similar nature in the future.

7. Lessons to be learnt

Carers identification, use of Carers in Herts and importance of Carer's Assessments

7.1 The Panel discussed this theme several times during the course of the IMR presentations and review. The identification of Jeremy as a 'carer' or whom had a caring role for his father Arthur was not identified at the earliest point. There were missed opportunities where Hertfordshire Partnership University NHS Foundation Trust, Paradigm Housing or the GP Practice could have sought clarity on Jeremy's role. Had this occurred Jeremy may have been offered adequate support and a carer's assessment sooner, although it was recognised by the Panel that when Jeremy was invited for a carer's assessment he did not engage with this supportive offer.

7.2 The term 'carer' is defined by NHS England as 'anyone, including children and adults who look after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid. Many carers don't see themselves as carers and it can take an average of two years to acknowledge their role as a carer' (NHS England, 2023).

7.3 Carers in Herts provided some excellent reflection to the Panel as a subject matter expert based on what they had observed and heard from the Panel discussions. It was highlighted that to fulfil a caring role for another person, it is critical that a carer's own level of stress is managed. This was relevant for this review because Jeremy showed signs to agencies that he was frustrated by Arthur's behaviour and set of circumstances. George et al (2000) supports this view, where they found that between one third and a half of carers have been estimated to experience significant psychological distress which in turn has shown to have an impact on a caregiver's mental health more often than the general population. They added that the level of stress associated with caregiving varies but it can be influenced by level of care required, physical or cognitive impairment experienced by the care recipient or the duration of the caring relationship.

7.4 To this end, Carers in Herts emphasised the importance of referrals into specialist services like theirs for carers rather than a reliance on individuals to self-refer. The Panel supported the acknowledgement that more should be done to raise awareness of how individuals can access support if they have a caring role and how family or friends who are concerned about how a loved one is being cared for can also access support. Further to the research findings above by George et al (2000) this research also suggested that public health campaigns should recognise the burden that psychological stress can have on caregivers.

7.5 The Panel also reflected that based on the information known for this review there may well be stigma that still exists in relation to caring roles and accessing help and support. However, it is vital that agencies challenge this owing to the stark statistics that we know about carers and their own health and wellbeing. Carers in Herts shared that a local statistic about their own population was that before support 47% of carers reported low wellbeing[1].

[1] https://www.carersinherts.org.uk/our-impact/

7.6 Lastly, as has been previously mentioned above it was also highlighted by Hertfordshire Council that domestic abuse as a factor in carer's stress should also be referenced and described in the local authority Carer's strategy. This will affirm the principle that domestic abuse can feature in a caring relationship and should be distinguished from carer's stress. Refuge, Hertfordshire's specialist domestic abuse service provider, also supported this recommendation highlighting that collaboration between Refuge and Carers in Herts should be stronger.

Use of restraint

7.7 The second learning point discussed at length was Jeremy's use of restraint of Arthur during this time whilst caring for him. As part of the criminal investigation that took place after Arthur's death, it came to light that Jeremy would restrain Arthur when he struggled to manage his behaviour. This was not shared with any agencies prior to Arthur's death. Some of Arthur's injuries found during the postmortem could have been caused by Jeremy's use of restraint however this was inconclusive. The Panel therefore discussed the use of restraint by carers and how carers are educated on this topic. The Panel described collectively that the use of restraint should only be used proportionately, time-limited and in a person's best interests. Carers in Herts were clear that they will talk about this with their service users. The Panel did not confirm that there is any specific training for carers on use of restraint or any literature. However, they did provide assurances that if practitioners found that use of restraint by a carer to be unreasonable then this would meet the criteria for a safeguarding concern into Adult Social Care and/or Police concern.

7.8 Andres et al (2024) found in their research that the pervasiveness of restraint is concerning and suggests a lack of evidence-based guidance and support for caregivers to prevent use of restraint. Following a small-scale review of research, 'Understanding restraint: A guide for unpaid carers'[2] written and published by Lambeth Safeguarding Adults Board was found. This is a short two-sided page document that describes restraint and when it should be used. It would appear that something like this could be created in Hertfordshire with the support of Carers in Herts which could act as an education tool and resource for unpaid carers on use of restraint.

7.9 The Panel lastly reflected that this review created an opportunity to explore this theme and learning point owing to information that became known after Arthur's death. As has previously been mentioned, although there was evidence of various injuries from Arthur's postmortem, owing to his own health needs and concerns, it could not be ascertained that these had occurred as a direct result of Jeremy's use of restraint on his father. Therefore, the learning point was more broadly discussed in terms of use of restraint by carers both paid and unpaid, what it is and when it is acceptable or not, and most importantly what organisations might do to assure themselves further that the appropriate use of restraint is used by all carers.

[2] https://www.lambethsab.org.uk/sites/default/files/2020-10/Understanding%20restraint%20-%20info%20for%20unpaid%20carers%20v2.pdf

Impact of Covid-19 pandemic on individuals and couples experiencing mental health issues

7.10 The Covid-19 pandemic began in 2019 and was the transmission of a virus which sadly had deadly results for many people from all walks of life. Patients were first admitted with Covid into acute hospital beds in England during 2020 and the first lockdown came in March 2020, followed by further lockdowns over the rest of that year and into early 2021. These restrictions had a huge impact on all members of society, but the Panel identified by discussion and reflection that this was also significant for Arthur. As previously articulated in section 14, Arthur shared himself that he changed as a result of the pandemic and that this impacted his confidence and mental health to socialise and leave the house.

7.11 Services, in particular health services, which were relevant to this review also were affected in terms of their delivery to patients like Arthur. The Panel reflected that Arthur's rescheduling of appointments during 2022 may also have been as a result of health services recovering from the Covid-19 pandemic. Consistency of care-coordinators that may or may not have been able to build a rapport with Arthur would have also been impacted by the pandemic and the way services operated and delivered services to patients.

7.12 The Panel explored the impact of the pandemic on Arthur and as organisations they shared their reflections of how services were delivered during this time and what changes or improvements could be made next time. Changes felt limited owing to Arthur's needs and asks of services that changed. At times, Arthur was proactive in reaching out to organisations for support or intervention and other times Arthur felt unable to access or engage with services.

8. Recommendations

Hertfordshire County Council

8.1 To ensure that domestic abuse features in the local authority and partnership Carer's strategy, making note of the importance of carer's stress versus domestic abuse, and how carer's assessments can be helpful tools to ascertain further information that will determine risk, actions and relevant agency support.

8.2 To remind and encourage practitioners working across Hertfordshire who identify an individual with a caring role to refer to Carer's in Herts rather than signpost to this service. This should improve the accuracy in terms of numbers of carers there are living within the county and improve engagement.

Hertfordshire Integrated Care Board – GP Practice

8.3 Discussion of unexplained deaths to be had at Practice's Significant Event Meeting routinely.

Hertfordshire Partnership University NHS Foundation Trust

8.4 Learning from this review to be circulated to divisional leads and Social Care Team through appropriate forums such as Quality and Risk Management Group for consideration alongside existing workstreams.

8.5 Hertfordshire Partnership University NHS Foundation Trust/ Hertfordshire County Council Adult Social Care Cross service protocol to be recirculated to all relevant teams through practice governance meetings.

8.6 Hertfordshire Partnership University NHS Foundation Trust Adult Community Division First Contact Task and Finish Group to consider how to capture when social care support may be responsibility of Local Authority to ensure that this is explored and actioned appropriately.

8.7 Did not attend/Not brought in policy to be reviewed in line with learning regarding use of opt-in letters

Paradigm Housing

8.8 To review the 'Emergency Decant Process' to ensure that all relevant information including health and social care factors are ascertained from residents including any other persons occupying the property.

8.9 To hold monthly meetings to discuss any residents who have complex needs and what Paradigm Housing's role is within this.

Hertfordshire Domestic Abuse Partnership

8.10 The Partnership should add the following learning points to their communications plan in relation to learning from Domestic Homicide Reviews:

- Educate professionals, including domestic abuse specialist support services, and citizens of Hertfordshire to refer and access specialist services like Carers in Herts which aims to support carers and reduce their stress and to report concerns to relevant agencies; Police or adult social care when there are concerns for how individuals are being cared for by paid or unpaid carers.

8.11 Hertfordshire Safeguarding Adults Board should create a similar document to Lambeth on use of restraint by unpaid carers, which could be used as an educational resource to ensure that unpaid carers known what proportionate use of restraint is.