Suffolk Safeguarding Partnership

OFFICIAL-SENSITIVE

Peter Charles Carter

Learning Event

The details of the individual subject to this review

- Name: Peter Carter
  Age: 75

1. Purpose of the Learning Event

This event is designed to learn from Peter's case. The following principles will be applied:

The Learning Event should seek to determine what the relevant agencies and individuals involved in the case might have done differently. This is so that lessons can be learned, and those lessons applied to prevent similar circumstances arising again.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that the learning event is a trusted and safe experience that encourages honesty, transparency, and sharing of information to obtain maximum benefit from them.

Its purpose is **not to hold any individual or organisation to account,** other processes exist for that, including where relevant, criminal/civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC.

The Suffolk Safeguarding Partnership's (SSP) Safeguarding Adults Review Panel has considered the information available and agreed that in the case of Peter the learning event will:

- Hear the voices of the family.
- Identify any learning from Peter's case. What did and did not work well, and how could agencies improve to create better services for people in the future.
- Promote a culture of continuous learning and improvement across all organisations who have a responsibility to safeguard people at risk.
- Identify any examples of good practice that can be promoted and encouraged wider.

The event will include the professionals and family members listed in section 3 of these Terms of Reference and be chaired by Anthony Douglas, the Independent Chair of the SSP.

2. Peter's Story, written by his children.

Our Dad, Peter Charles Carter, was a respected Managing Director at Taylor Barnard, a local logistics company, for many years. Dad originally joined the Company as a Traffic Operator and over the years worked himself up to the position of Managing Director. In this role he developed the family business into a very profitable organisation and ultimately raised its profile enabling it to be sold to an international logistics company. Due to the sale of the Company, dad decided to retire at 55.

Growing up, dad was always around water and enjoyed sailing with his parents and siblings. His love of sailing remained into adulthood and our family which we were very fortunate to be part of. We had several 'boats' over the years from small sailing yachts to quite large motorboats! We as a family enjoyed numerous, very happy holidays and weekends exploring the local rivers, France, Belgium, and Holland on the boats with our parents.

Once dad retired, they continued their love of water by cruising around the world, several times. Dad also started playing golf in his 60's but due to arthritic pain in his shoulders and hands had to give up. After giving up golf, dad joined a local art class which he attended weekly up until recently. He had always had a 'knack' for drawing however again, due to arthritis in his hands, found it difficult and frustrating to hold a pen or brush.

During his working years, dad had several affairs which he admitted to. The most recent being around 25 years ago. Mum and dad had dealt with these at the time and obviously decided to stay together. Unfortunately, mum could not fully 'forgive and trust' dad especially when dad was away from the house playing golf or going to the art classes on his own. She was always questioning why he had the affairs and whether he was still having them. She explained to us that the reason she drank was to try and forget his infidelities. In fact, it had the reverse effect, as drinking reminded her that he was unfaithful and that he couldn't be trusted. This was paramount more in the last 10 years or so.

During his retirement, both of our parents took to drinking a lot of alcohol. My sister and I took Dad to the GP a number of times over the years to talk about his addiction and see what help was available. Although dad knew he had an issue and wanted to try and stop drinking, he refused specialist help and wanted to attempt to do this on his own. He admitted to being embarrassed about his alcohol consumption.

On one occasion, dad did stop drinking for nearly 18 months which we were very proud of, especially as mum was still drinking during this period.

As the years went by the verbal abuse between our parents got to a point where the Police & Ambulance staff were called on several occasions to their home address. In April 2022, Dad was arrested twice in 24 hrs for his abusive behaviour to Mum, my sister and I as well as the Police officers. We were hopeful that this would shock both of our parents into rethinking their ways but, sadly, it had the opposite effect.

Our parents continued to drink to excess daily.

Throughout the final year of Dads life, we lost count of the times that the emergency services were called to their home. Each time my parents explained to us, and the emergency services, that they both wanted to kill themselves and that they had had enough of their lives.

These conversations were recorded by the authorities as well as video evidence from the cameras being worn by those in attendance.

A couple of months before Dad passed away, mum was physically violent with Dad who had visible cuts and bruises present. Again, video evidence was provided to the authorities. He called the Police and mum was arrested. Mum spent the night in custody at Martlesham Police HQ.

This didn't deter either of them to stop or reduce the amount that they were drinking.

Mum was arrested twice more shortly after this and on the last occasion, as the Police were going to press charges (dad refused to make a statement), was only allowed home on ‘bail’ under the condition that there was no contact between mum and dad and that they were not alone in their house together.

For the first week of mum’s bail, she resided at Emma’s house but for the following 2 weeks mum resided in the Alice Grange Care home in Kesgrave. During the time at the care home the bail conditions were relaxed to allow dad to visit and talk daily.

During this period, dad was very lonely and depressed and basically ‘pining’ for mum, however, both Emma and I visited dad daily for assurance and company.

Whilst mum was at Emma’s house, the first week of her bail, dad was extremely distressed one evening and we received a call from the Police (and paramedics) advising that dad had made a hangman’s noose. When we arrived at the property, the noose was laid on the carpet in front of us all. Even though dad was extremely distressed and drunk, the authorities were unable to get dad to agree to go to the hospital with them for an assessment.

The noose was left on the floor and not removed from the property.

When mum was finally allowed to leave the care home, and bail restrictions were lifted, they treated the occasion as if it was a celebration and within a few hours of being home were both drunk. The arguments had started all over again and worse than ever and back to square one.

Sadly, just a week later, Sunday the 16th of April, dad committed suicide by hanging himself in the garden. He sadly died in hospital 3 weeks later on May 4th, 2023.

3. Learning Event Attendees

Role	Organisation (if applicable)
Peter's daughter	Family
Peter's son	Family
Independent Chair	Suffolk Safeguarding Partnership
Multi Agency Safeguarding Hub, Inspector	Suffolk Police
Associate Director for Patient Safety & Safeguarding	Norfolk and Suffolk Foundation Trust (Mental Health)
Safeguarding Lead	East of England Ambulance Service
Adult Safeguarding Operational Manager	Adult Social Care, Suffolk County Council
Deputy Director of Nursing	Suffolk and North East Essex Integrated Care System (Health)
Social Care Manager	Adult and Community Services
Partnership Co-Ordinator	Suffolk Safeguarding Partnership
Professional Advisor (Adults)	Suffolk Safeguarding Partnership

Invited but unable to attend	
Detective Chief Inspector	Suffolk Police
Partnership Manager	Suffolk Safeguarding Partnership

4. Focus of the Learning Event

The focus for Peter's learning event centred around how he was supported. Some key areas explored were:

- Was adequate support available to Peter as a person who had declining mental health and anxieties (particularly alcohol addictions)?
- Was capacity used as a threshold for no further support?
- When Police are investigating multiple allegations, what management oversight is there and what support is available to people who are repeat callouts? Is there a disconnect between what mental health can/will pick up and where Police responsibility ends?
- Are risks properly considered when people show suicide ideation or make threats?

5. Learning event outcomes

	Learning point / Action
1	The GP supported the family and Peter's children, Tony and Emma as the family carers. It was recognised how vital the GPs role was in Peter's case, in stark contrast to the low impact of other agencies. **ACTION:** SSP to write to the GP to thank them for the work with the family. This aligns to a previous case where family members wanted supportive professionals to be thanked (see Brian Lloyd's case on the SSP's website).
2	The coordination of partners' involvement was missing in Peter's case, resulting in partners working in isolation from one another with no one seeing the bigger picture in the family (Think Family). To learn from Peter's case, a stronger and more coherent Multi-Disciplinary Team (MDT) approach needs to be implemented at the earliest point of increasing risk. **ACTION:** An MDT for Susan, Peter's wife, is to be convened including Emma and Tony, so the support is coordinated from all agencies to them as the main carers for their mother, Susan.
3	A Think Family approach should have been applied so that Tony and Emma as carers were seen and supported themselves while they were struggling to help their parents. Tony and Emma were 'hidden in plain sight' and professionals did not exercise enough curiosity about their plight. **ACTION:** Ensure a single point of contact is provided for carer support and mainstream a 'Think Family' approach and methodology.

4	The police to understand that language matters when attending suicide calls, along with leaving items that could be used to harm. **ACTION:** A verbal apology provided by the police and accepted by Emma and Tony. Police to update training for officers on language matters and the interpretation of their role in suicide threats. The SSP will carry out a wider piece of work about the importance of what professionals say, as well as what they do.
5	The Suicide Prevention Policy is currently being refreshed and it was suggested that Peter's case was considered in the refresh to ensure the learning is woven in to updates. (Emma and Tony have agreed to share this). **ACTION:** Peter's story to be shared with the Public Health Suicide Prevention Lead
6	Partners to review management oversight of cases and follow up on recommendations within any assessment as to the impact, and what would trigger a review of the care working and not working. **ACTION:** Management oversight and case management to ensure actions are carried out, consider audit of cases for learning. NB This should be part of a more pro-active approach to the use of MDT's
7	To use Peter's story for learning purposes, putting the focus on the impact on families when they are caring for loved ones, and also subject to abuse themselves, which can go unrecognised. **ACTION:** Webinar to be arranged with Emma and Tony if they wish to go ahead to tell their story to operational staff
8	Over a period of twelve months there were multiple calls to the home address by Police and Ambulance services. The number of calls did not trigger any processes to highlight Peter as a frequent caller. The opportunity to coordinate and assess available information to better support, and to escalate the concerns from a wider agency involvement did not take place. **ACTION:** The SSP to convene a working group to assess and seek assurances of how risk is escalated, how information is shared, when policy and process thresholds are not met to trigger a Multi-Disciplinary Team (MDT) meeting to better support families in crisis.