SAFER CORNWALL

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DOMESTIC HOMICIDE REVIEW

&

SAFEGUARDING ADULT REVIEW

INTO THE DEATH OF MICHELLE (PSEUDONYM)

EXECUTIVE SUMMARY

Report Authors and Independent Chairs

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Report Completed – February 2023

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1 PREFACE

The Safer Cornwall Domestic Homicide Review Panel and the Cornwall and Isles of Scilly Safeguarding Adult Board would like to express their sincere condolences to the family members affected by the sad events which have resulted in this review. We hope this joint Domestic Homicide Review and Safeguarding Adult Review helps to answer some important questions relating to the events leading up to Michelle's tragic death.

The independent chairs and authors of the review would also like to express their appreciation for the time, commitment, and valuable contributions of the family and friends of Michelle and Robert, the review panel members and the authors of the Individual Management Reviews (IMRs) from which the foundation of the analysis of this overview report is formed.

It is hoped that in understanding the antecedents to the homicide from a holistic perspective, we can gain a better insight into professional practices that will protect future victims of domestic abuse. We believe there is important learning for all agencies from this approach, chiefly when working with individuals with complex needs, but without a formal mental health diagnosis.

In order to preserve confidentiality, this report has used pseudonyms for the victim and perpetrator of the homicide. We have used this approach (rather than initials) to assist the reader to navigate a great deal of complex information. The pseudonyms have been agreed with the family of the victim and perpetrator and were chosen from a list of popular names in the birth years of each subject.

2 INTRODUCTION

2.1 This domestic homicide review and safeguarding adult review was commissioned following the death of Michelle in October 2020. Michelle (age 52) was living alone in a housing association flat when she was killed by Robert (age 73). Michelle and Robert had previously been in an intimate relationship and Robert was described as providing considerable support to Michelle who had longstanding problems with alcohol and mental ill health. Robert was charged with murder; he admitted manslaughter on the grounds of diminished responsibility and was sentenced to 8 ½ years in prison.

2.2 Because Michelle and Robert had at one time been in an intimate relationship the case met the criteria for a domestic homicide review. Initial information gathering found that Michelle also had previous contact with various agencies in Cornwall who were concerned for her safety and wellbeing, and as a result, the death of Michelle also met the criteria for a safeguarding adult review. The two reviews were carried out in parallel to prevent duplication and the focus has been on jointly agreed

recommendations to improve services for people in similar circumstances to Michelle.

2.3 This joint Domestic Homicide Review and Safeguarding Adult Review report therefore focuses both on Michelle as an adult with care and support needs and as a person who died as a result of violence perpetrated by someone with whom she had been in a close (and previously intimate) relationship. The reviewers and the panel wish to explicitly state that Michelle was the victim in this homicide. The reviewers do not excuse or justify the actions of Robert and the focus on Michelle's challenges does not cast any blame or judgement about her life or the ways that she coped with her adversity.

2.4 The review followed the usual domestic homicide review process with agencies who had known Michelle and Robert producing individual management review reports which evaluated practice within their agency and identified recommendations for improvement. The review was jointly chaired by independent chairs who worked with a panel of senior agency representatives[1] to identify system learning and agree recommendations for service improvement. Michelle and Robert's families were informed of review progress and offered an opportunity to contribute as much or as little as they wished, including agreeing the final report.

3 MICHELLE

3.1 Michelle was a white British national of female gender. She trained as a health-care professional, served in the armed forces and experienced long standing issues linked to alcohol addiction and mental distress. These issues resulted in her children being removed from her care and she lived alone for many years. Michelle also experienced financial difficulties and had physical conditions which led to prescriptions for strong pain relief.

3.2 Those who knew Michelle in recent years described her as well liked in the local community and happy and cheerful when she was not under the influence of alcohol. She set up a small shop and would make bedding for babies in the local hospitals. She was reluctant to talk about her past and did not appear to have close friends who she confided in.

3.3 Michelle was seen regularly by her GP, was known to the drug and alcohol service and hospital mental health team. In 2007 a referral to adult social care resulted in her receiving help from a care agency.

[1] See appendix one

3.4 Michelle's mother and father died in quick succession which had a significant impact on her life. Her parents were extremely responsive to Michelle's needs and their passing was a much-felt loss to her support system.

3.5 By 2017 there were escalating concerns about Michelle's mental health, alcohol use and self-neglect and the cyclical nature of her drinking and associated mental health problems was apparent. This pattern continued up until her death. Michelle was frequently admitted to hospital after experiencing delusions and making persistent 999 calls to the police. Whenever Michelle experienced a mental health crisis her presentation was assessed by psychiatric liaison services and largely attributed to intoxication, meaning she was not considered to have a severe and enduring mental health disorder and therefore was unable to access appropriate mental health support. Once sober, Michelle often declined other forms of support and treatment outside of secondary mental health services, making it far more difficult for abstinence to be achieved. Referrals were made to relevant agencies such as the substance misuse service but there was no coordinated multi-agency plan. As a result, it was not clear who would be leading the work with Michelle to identify why she may not wish to engage with professional agencies, discuss treatment or support options and consider how the cyclical nature of Michelle's hospital admissions could be interrupted.

3.6 What was known was that Michelle had experienced significant trauma in the past - possibly linked to childhood experiences as well as experiences in the armed forces. There does not seem to have been a holistic assessment which included understanding the causes of her behaviours and links to any relevant therapeutic approaches associated to past trauma. Professional agencies were caught in a reactionary cycle to Michelle's alcohol use, rather than a proactive and preventative plan that addressed the antecedents and root cause of her drinking.

3.7 Opportunities were missed to consider the possibility that Michelle may be at risk of abuse. There was a significant incident where Michelle was noted to have bruises that were thought to look like 'grab marks'. Although the ambulance service submitted a vulnerable adult form to adult social care this was not acted upon as a safeguarding alert and in addition there was no safeguarding referral from hospital. The police were not contacted by any agency and no one asked Michelle how this had happened. This episode was an opportunity to reassure Michelle that she was safe to disclose domestic or any other type of abuse and her report would be taken seriously. It was also an opportunity to explore the causes of the physical marks and the possibility that Michelle could have been defending herself against abuse from another person.

3.8 Later when Michelle made allegations of rape these were understood to be linked to her alcohol use and mental state and there was no discussion with her about the possibility of a referral to the Sexual Abuse Referral Centre. An allegation of assault was responded to by the police and attributed to her mental state. This was then

followed by a spike in Michelle's behaviour. It would have been good practice to follow up on the assault report with Michelle and to enquire more sensitively around Michelle's change in behaviour through a trauma-informed lens.

3.9 The potential risk to others through clutter and risk of fire in Michelle's property should have triggered a multi-agency assessment and a concerted effort to engage positively with Michelle around her hoarding and explore her therapeutic needs beyond alcohol treatment. In the months before her death the level of distress that Michelle was displaying was clearly escalating and leading to behaviour that caused distress to others (e.g. throwing faeces out of the window). A layperson living in the same building would be justified in thinking that Michelle would be the subject of a care plan or support by multiple agencies and there was a risk of local residents losing confidence in public services each time they witnessed Michelle vulnerable, undernourished and behaving antisocially.

3.10 Michelle's relationship with Robert was significant but poorly understood. Robert was known to provide physical help and support, and this increased in 2018 after Michelle declined further help from the care agency. Michelle also disclosed to the psychiatric liaison team in 2018 that her friend was using her opiate pain relief. Later in the assessment he is referred to as her partner and that they had a "difficult relationship". She also said he "needed help". This was not followed up and there was no referral to adult social care. Nor was Robert ever considered for a carers assessment. At this point there was an opportunity for information to be shared between agencies that could have given a more rounded picture of risk and the dynamics of the relationship between Michelle and Robert.

3.11 During 2019 Michelle was admitted to hospital with a fractured neck of femur and was discharged with a care package. During an occupational therapy assessment Michelle said that Robert would be available in the flat when she was showering, and he would assist with collecting groceries and carrying them upstairs. Records do not show if Robert was asked whether he was comfortable with this and offered a carers assessment. Michelle was discharged from hospital with a package of care from an agency in place twice a week. The carers subsequently referred to adult social care due to Michelle's aggressive behaviour.

3.12 There were subsequently indications that Michelle had fallen out with Robert and it seems that there was little consideration of any potential link between his use of her pain relief, their problematic relationship and other information from Michelle that she was stockpiling her pain medication. It is clear that this was a complex set of events and relationships that needed proper exploration and no one person had responsibility for doing so. The sharing of their prescribed doses of strong opiate pain relief had the potential to change the dynamic of their relationship from one of carer and cared for, to co-dependent or even controlling. This was a serious development that needed to be explored. Instead, any adult social care involvement

concentrated on physical care needs and the substance misuse service on alcohol use.

3.13 The pattern continued whereby episodes of alcohol use, deteriorating mental health and hospital admissions do not take account of the number of times Michelle had been admitted previously having been assessed as distressed, delusional, self-neglecting, suicidal and lacking mental capacity. Seen on its own, each attendance at hospital may have represented a snapshot of one incident, but when looking at Michelle as a 'whole person', there was an escalating and serious pattern to her lifestyle that required a cohesive and holistic approach to bring about long-term recovery.

3.14 By 2018, Public Health England had published guidance on how to provide better care for people with co-occurring mental health and alcohol/drug use conditions, which included a key principle of 'No wrong door. Providers in alcohol and drug, mental health and other services having an open-door policy for individuals with co-occurring conditions and making every contact count. Treatment for any of the co-occurring conditions being available through every contact point'. Despite this, no treatment options were discussed to interrupt Michelle's harmful and repeated episodes of crisis and the key contact point did not bring about any meaningful engagement or care.

4 ROBERT

4.1 Robert is a white British national. There is little detailed information about him in records and his son told the review that he had separated from his wife and moved to Cornwall about 30 years ago, subsequently obtaining a flat with the housing association where he was living at the time of Michelle's death. He has not worked since the early 1990's due to an industrial injury which from GP records seems to have resulted in back and neck pain for which he received prescription pain relief from time to time. He also suffered from chronic obstructive pulmonary disease (COPD). His health issues are significant as from 2007 onwards he was known to be providing informal care to Michelle without any additional support. He is identified as making 999 calls to summon help for Michelle and there are occasions where there were clearly tensions as she was refusing to leave his flat.

4.2 Robert's role as a carer was accepted without question and no enquiries were made directly with him to establish if he was capable and content to provide practical help to Michelle and whether he had care and support needs of his own. It is known that Robert's experience of chronic pain worsened and in 2018 he had been prescribed opiate pain relief. The need for a more proactive approach to work with unpaid carers has been a theme of other reviews in Cornwall.

4.3 Meanwhile, during late 2018 GP records indicate that Robert was becoming increasingly distressed by noise from a neighbour and requested an increase in his

pain relief because of ear pain as a result of putting cotton wool in his ears. Robert was asked to keep a diary of his concerns and behind the scenes, the housing provider was working closely with other agencies to manage the complex situation. However, Robert was not aware of this intense work and therefore may have felt that his concerns were not being treated as a priority. His family have described him as becoming more and more stressed and distressed and suffering from chronic sleep deprivation and looking after Michelle. This was not given adequate attention or priority from professionals supporting Michelle.

4.4 Covid restrictions were an additional factor at the time of Michelle's death and coping mechanisms such as going out and seeing family were less available to society at this time. Conversations between Robert and his GP suggest that he was finding this hard to manage.

4.5 The housing association described Robert as a quiet tenant and were extremely shocked that he killed Michelle.

5 A SUMMARY OF LEARNING

5.1 This is an extremely sad and complicated set of circumstances, and no one could have predicted that Robert would commit such a violent act. There had been no previous indications that he could be aggressive or violent, and the relationship between Robert and Michelle was considered to be one of friendship and caring. Any recorded anxiety or irritation expressed by Robert was aimed at another resident in the block who lived below him and whose behaviours included shouting and other noises that kept him awake at night. He was also affected by physical pain and discomfort due to health conditions.

5.2 No psychiatric or pre-sentence reports were requested by the court and this review has had no access to any information that might help gain an understanding of Robert's mental state at the time.

5.3 Alongside this, Robert was a friend of Michelle. Michelle over many years had experienced chronic pain alongside extreme mental distress. There was a cycle of alcohol use, extreme behaviours (which could put herself or others at risk of harm) and periods of relative calm. Throughout, Michelle was clearly ambivalent about receiving help from professionals and relied on Robert as a source of support. Although there were times when support was mutual it is clear Robert struggled to cope with Michelle's needs alongside the behaviour of another resident living below him in the flats.

5.4 The overarching message from this review is that the system as it is currently designed failed both Robert and Michelle. Both individuals had a number of interlocking needs which were treated discreetly. The challenges facing people with complex needs and their families are significant, and the review has been told that

there are many others in a similar situation to Michelle who do not fit neatly into commissioned service remits. Commissioners of services in Cornwall are now working to address this issue but during the period explored during this review responses from individual agencies were determined by factors including:

- specific criteria and thresholds (mental health services for Michelle)
- availability of resource (housing for people with complex needs)
- a focus on only one aspect of a person's life (prescriptions for pain relief for both Robert and Michelle / practical support via care packages/alcohol treatment)
- assumptions about relationships and coping capacity (reliance on Robert as a carer).

5.5 The event that occurred was a homicide with tragic consequences for all concerned. There was a catastrophic breakdown in multi-agency work based on a compassionate approach which seeks to understand and work with the causes of mental distress. Professionals worked in silos, were not sufficiently curious even when behaviour was quite extreme and did not recognise or collectively assess risk.

6 FINDINGS AND RECOMMENDATIONS

Finding One:

Where an adult has physical care needs, substance misuse concerns and mental health needs that do not reach the threshold for a formal diagnosis, the way that services are commissioned and delivered in Cornwall did not promote a holistic and integrated multi-agency approach to ensuring their safety, wellbeing, and long-term recovery.

6.1 Services in Cornwall are commissioned by several separate bodies who set the boundaries and remit for provider organisations. Each provider will agree the criteria for access to services in their contract with the commissioner, with the result that some people "bounce" between services with no one person having oversight of them as a person with interlocking needs. This was clearly the situation for Michelle.

6.2 Alongside this, the multi-agency system for working with adults with complex needs is in the process of development. Other reviews have also identified this issue with a thematic review into seven Safeguarding Adult Reviews in Cornwall noting that agencies were working in silos with little evidence of a multi-agency approach.

6.3 This review specifically shines a light on the restrictions and limitations of the medical model of mental health (which relies on a diagnosis of a severe and enduring mental health condition before a person reaches the threshold for commissioned mental health treatment). Michelle was assessed multiple times by psychiatric services

including as an in-patient under a mental health section but was deemed not to have a severe and enduring mental illness. This meant that she was never open to the Community Mental Health Team as her mental health did not meet diagnostic criterion, but her needs were too great for services such as IAPT (improving access to psychological therapies).

6.4 This raises the important issue of how non-specialist mental health services could provide services to alleviate mental distress where the criteria for a formal diagnosis has not been met. Michelle would have benefitted from understanding her emotions and threat responses through a non-stigmatising, non-medicalised trauma informed lens. Although training is being implemented to address this gap, it is early days and the impact of this on day-to-day practice will need to be evaluated.

6.5 Social workers could be in a good position to engage with approaches which move beyond a compartmentalised episodic approach to providing help in complex situations. The Care Act 2014 signalled a move away from care management as the overriding approach to working with adults and a clearer expectation of a relationship-based approach, combined with a coordinated multi-agency response might have made a difference in this case.

6.6 Another important aspect of Michelle's needs that could have been considered was her rights under the Equality Act 2010. Although Michelle's presentation did not meet the threshold for commissioned mental health treatment, there were times throughout the scope of the review when Michelle's physical impairment (liver condition) caused by her alcohol misuse did meet the criteria of a disability, a protected characteristic under the Equality Act. As such, Michelle would have been entitled to reasonable adjustments, if necessary, which may have included home visits instead of an expectation to attend a service, a written schedule of appointments or extra time in appointments, for example. It is important that professionals understand the broad definition of disability under the Equality Act and make provisions as required by legislation when necessary. This may have improved Michelle's engagement with services.

Recommendation One

There is an urgent need for commissioners of services for people with complex co-occurring needs across Cornwall to evaluate the impact of the Complex Needs Strategy on front line services. The result should be that people experiencing mental distress or adversity due to social and environmental challenges should receive the help they need without having to navigate convoluted professional boundaries or thresholds.

Recommendation Two

All commissioning strategies should be reviewed to ensure that the definition of protected characteristics and need for reasonable adjustments under the Equality Act is integral in all cases.

Recommendation Three
Commissioners and Providers should agree and implement a model which supports non mental health practitioners to work with people experiencing mental distress and co-occurring conditions that do not meet the diagnostic criteria for commissioned mental health treatment services.

Recommendation Four
Adult Social Care should clarify the role of social workers to ensure that it is in line with the intentions of the Care Act 2014 to move beyond care management, and to ensure that it provides the opportunity for relationship-based work which seeks to understand the whole person within their networks, assess risk and ensure a coordinated response.

Finding Two

There was insufficient exploration through a multi professional lens of the interrelationship between physical pain and mental distress, the potential misuse of medication and impact of medication withdrawal.

6.7 Throughout contacts with Michelle, the combined use of prescribed medication and alcohol was not recognised.

6.8 The substance misuse service worked with Michelle, but the picture is of a lack of integration of the substance misuse service into the multi-agency network. Although the alcohol liaison service within the hospital were informed when Michelle was admitted to hospital, the community teams were not consistently invited to multi-agency meetings or informed each time Michelle came to the attention of other agencies with behaviours linked to excessive alcohol use. This failure to pass on important information about a person's substance use to the drug and alcohol treatment agency is a major oversight and had the potential to alter the outcome.

6.9 Alongside concerns for Michelle's alcohol dependency, self-neglect and extreme behaviours, any consideration of her long-term use of strong pain relief and evidence that she was sharing this with Robert was not given sufficient attention by any professional. It seems that she used alcohol in possible combination with varying levels of prescribed medication to alleviate mental and physical suffering and how far pain relief for Michelle was considered as linked to trauma and mental distress was not explored. This would have been more likely with a strong multi-agency approach.

6.10 With the benefit of hindsight, it now known that Robert was latterly also receiving pain relief medication and the GPs control of Robert's medication and withdrawal plan could have therefore been compromised by his transactions with Michelle. This was potentially an important dynamic within their relationship.

6.11 GP's need to make finely balanced decisions in the management of pain maintaining a focus on possible misuse of medication. These decisions are more likely to be accurate if GPs are in receipt of all information and there were occasions when knowledge of Michelle's stockpiling and sharing of opioids were not shared with the GP. Multi-agency information sharing was not consistent, and this enabled the informal arrangement between Michelle and Robert to continue for far longer than it should have.

Recommendation Five

It is recommended Safer Cornwall commissioned Domestic Abuse and Sexual Violence training (both that for Primary Care and the multi-agency training) is amended to ensure the link between chronic pain and domestic abuse risk is included. This should include the link between chronic pain, unresolved childhood trauma and its effect on relationships in terms of increased agitation, reduced coping potential and heightened exposure to abuse.

Recommendation Six

Organisations (ICB, Cornwall Council) responsible for the commissioning of the Domestic Abuse and Sexual Violence Primary Care service, should review the possibility of extending the 2-year pilot by a further 2 years with the view to including a formal evaluation to support future service provision and provide an update to Safer Cornwall in relation to this decision.

Recommendation Seven

The substance misuse service (We Are With You) should be an integral partner and source of expertise in any situation where there are concerns about misuse of prescribed medication, alcohol or other substances.

Finding Three

The use of safeguarding procedures to respond to signs and indicators of potential abuse was inconsistent.

6.12 Throughout this review there were instances where Michelle's disclosures should have been considered through a safeguarding lens. Too often it seems that her alcohol misuse diverted people from considering the possibility that she was being harmed or was at risk of harm. Assumptions were made and decisions effectively discriminated against Michelle who received a lower standard of care due to her alcohol use than others.

6.13 The police did try to follow up one rape allegation and give Michelle a further opportunity to speak. However, a more proactive multi-agency approach with a plan

to attempt engagement with her over time, alongside referrals to the Sexual Assault Referral Centre would have been a better course of action.

Recommendation Eight
The Safeguarding Adult Board should seek evidence that all disclosures of concerns about abuse are receiving a response in line with expected procedures.

Finding Four

Our current system underpinned by legislation and guidance is not able to effectively keep people safe when the behaviour of one adult impacts on the wellbeing of others, but consent is not given to share information or continue with a plan. This extends to concerned family members and friends.

6.14 This is a crucial issue within this review. When Michelle was in a period of recovery from alcohol dependency she would tend to disengage from services and refuse offers of help. In doing so she increased her dependency on Robert as a source of support. If Michelle refused consent to information sharing between professionals and/or with concerned family and friends, current legislation does not allow for this to be overridden as a means to enhance wraparound support and care. This can be extremely frustrating for family friends who want to help, and it can also damage public confidence in professional agencies if vulnerable citizens are seen to be unsupported in the community.

6.15 The potential for engaging with Michelle and her close friends when she was well to agree a plan for intervention when she was unwell was not considered. This may still have met with an unwillingness to engage but it might have provided a sound basis for a more proactive approach at times of crisis.

6.16 In relation to Robert there are provisions within the Care Act 2014 for a carers assessment. A professional should refer for a needs assessment if they believe it is in the person's best interests, or they believe the person is at risk of abuse or neglect. In the case of Robert, this was never offered even when Michelle was in hospital and identified him as her main carer. This has been identified in other Safeguarding Adult Reviews in Cornwall[2] and is the second DHR this year in Cornwall where a carers assessment has not been considered, highlighting a significant training gap.

Recommendation Nine
Cornwall Adult Social Care should provide assurance to the Safeguarding Adult Board that carers assessments are being offered in all appropriate circumstances.

Recommendation Ten

[2] https://ciossafeguarding.org.uk/assets/2/cios_sab-thematic_carers_sar-2022.pdf

When an adult is assessed as having mental capacity but is exposing others to risk through such activities as hoarding, fire risk and threatening behaviour, the Safeguarding Adult Board should ask all agencies to provide assurance that practitioners are aware of steps that should be taken to reduce risk of harm to all involved.

Finding Five

When family and friends have significant concerns about the wellbeing of someone close to them, there are limited published options available for talking about these concerns and receiving advice as to the best response.

6.17 In this case, friends and family did have concerns about Michelle's mental distress and Robert's capacity to cope. They have told this review that they were not clear about who to go to share these concerns. The added complication is that if the concerns had been shared the limits of information sharing linked to the right of individuals to privacy is likely to have limited responses.

6.18 Managing to balance the right to privacy with providing a listening ear and signposting for family and friends could have meant that important information would not have been lost and additional care and management of risk could have been achieved through informal networks.

6.19 Professionals are very effective at training other professionals and sharing knowledge about safety, risk and acting on concerns including where to refer in a crisis. However, the professional system is not as efficient at sharing its knowledge with the general public, and with friends and family for the purpose of safety planning a risk assessment. This has recently been the focus of new Government Guidance: Information sharing and suicide prevention: consensus statement (Aug 2021)[3]. The aim is to improve information and support for families concerned about a relative and encourages professionals to seek the views of family members and friends, who may offer insight into the individual's state of mind or predisposing conditions which can aid care and treatment.

6.20 This guidance sets a good precedent for information sharing with families to assist with risk assessments, care planning and treatment and therefore it provides a sound basis for wider health and social care issues and could be used as a benchmark for local discussions on family engagement.

Recommendation Eleven

[3] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement

The Community Safety Partnership should work with the Adult Safeguarding Board to develop a strategy for working with family friends and communities which:

- Disseminates information about who to contact if you are concerned about the mental health of a family member or friend.
- Develops and delivers community education regarding how to support people who are experiencing mental distress.
- Clarifies for professionals how to best engage family and friends within care and safety plans within the bounds of information sharing laws.

Finding Six

Where people with multiple and complex needs are living in close proximity, there is the likelihood of additional stress on residents, housing providers and the local community. In this case, the multi-agency system was not able to adequately recognise and manage the significant safeguarding impact on the living environment of those involved.

6.21 Robert and Michelle lived in a building of multiple occupancy where there were residents with a range of needs and a significant issue for Robert was the stress caused by noise from a neighbour (not Michelle). The housing provider did listen to Roberts concerns about this stress, there were also multi-agency discussions with agencies responsible for the care of the residents concerned. To this extent all reasonable action was being taken.

6.22 The broader issue is the suitability of placing people with a range of vulnerabilities together in multiple occupancy buildings and how risks can be managed. There is longer-term issue of housing supply alongside considering what active steps can be taken to mitigate any risks. The review has been told that there was at one time a multi-agency "triggers meeting" where the top 15 addresses attended by Police and Ambulance were discussed. This seems to be a helpful approach that could be reinstated.

6.23 In addition to the stress described by Robert there is also evidence that Michelle's behaviours were extremely distressing to others and could potentially put her neighbours at risk. This links to the issue explored in Finding One concerning the inadequacy of our system to work with people with co-occurring complex needs who fall through the remit of thresholds but continue to exhibit dangerous coping behaviours.

6.24 Michelle's hoarding represented a significant fire risk to other members of the building, and this was noted at a strategy discussion. Progress was noted soon afterwards, and the fire service deemed the property to be safe. There is then evidence of the flat deteriorating a few months later. The original International

Classification of Diseases (ICD) did not list Hoarding Disorder separately in ICD-10, however on the 1st October 2017 the World Health Organisation added Hoarding Disorder as a new category under OCD (Code: 42.3). In ICD-11, 'Hoarding disorder' will be formally listed under the OCD category[4]. Michelle's hoarding was never given the priority it deserved as a symptom of mental distress, perhaps because of the lack of a classification at the time. This decision placed her neighbours at significant risk, and it is only a matter of luck, not design, that a serious incident did not occur. In future, it is hoped the new classification will reduce the likelihood of someone like Michelle slipping through the net of care.

6.25 Michelle exhibited extreme antisocial behaviours and it would not be unreasonable for the public to ask why someone exhibiting these behaviours was not supported within a coordinated package of care. When neighbours and residents observe vulnerable people in the community behaving in extreme ways, but supposedly unsupported, it reduces their confidence in the professional system and increases their belief that the state is not able to keep people safe. This lack of confidence has a knock-on effect for all statutory agencies.

Recommendation Twelve

Safer Cornwall and the Safeguarding Adult Board should revisit all training policy and procedure to ensure that it incorporates knowledge of hoarding as a mental health disorder and the pathway to follow in such circumstances is clear and compatible with the pathway to follow in situations of self-neglect.

[4] https://www.ocduk.org/related-disorders/hoarding-disorder/clinical-classification-of-hoarding-disorder/

7 APPENDIX ONE – REVIEW PANEL

Quality and Information Manager – Cornwall Housing

Safeguarding Business Lead, SW Ambulance Service

Adult Safeguarding Service Manager, Adult Safeguarding

MARAC Chair

Consultant Nurse for Integrated Safeguarding Services for Cornwall Foundation Trust and Royal Cornwall Hospital Trust

Kernow Clinical Commissioning Group

DASV Strategy Manager, Cornwall Council

Safeguarding Adult Reviews and Business Development Manager, CIOS Safeguarding Adult's Board

Director of DA Services, First Light

Interim Safeguarding Service Manager, Adult Social Care

Detective Sergeant, Criminal Case Review Team, Devon and Cornwall Police

Detective Chief Inspector, Devon and Cornwall Police

Senior Probation Officer, National Probation Service

8 APPENDIX TWO: REVIEW QUESTIONS

General Questions for the review

1. What are the facts about events leading up to the death of Michelle on 26th September 2020 – including any facts known about the duration of an intimate relationship with Robert.
2. What were the roles of the organisations involved in the case and the appropriateness of single agency and partnership responses?
3. What factors were driving responses at an individual and organisational level?
4. Are there lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard Michelle's wellbeing.
5. As a result of these lessons is there a need for changes in organisational and/or partnership policy, procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

Specific Questions

6. Were all opportunities taken to identify that Michelle may need help and support to stay safe? If opportunities were not taken, why did this happen – were there any barriers at an organisational or practice level?
7. How effective were the safeguarding referrals in respect of Michelle in identifying and implementing support that she might need to stay safe?
8. Was there sufficient professional curiosity in all agencies about the relationship between Michelle and Robert, whether this was an intimate relationship, and any implications of this relationship for the wellbeing or safety of Michelle?
9. What was known and understood about Robert's mental health and any implications this may have had for the safety of Michelle?
10. Were Robert's support needs understood and responded to?
11. How effective is the system at providing advice and support to friends and family who may have concerns about risks to an adult in their area.
12. Establish whether there is learning from these circumstances which will include considering the way professionals from across the range of services worked together as a collective and review the whole system function.

9 APPENDIX THREE – INDEPENDENT CHAIRS AND AUTHORS OF THE OVERVIEW REPORT

9.1 Jane Wonnacott qualified as a social worker in 1979 and has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed well in excess of 200 child safeguarding reviews, a Safeguarding Adult Review and two Domestic Homicide Reviews. She is currently chairing seven active DHRs. Jane is a member of the National Child Safeguarding Practice Review Panel pool of reviewers and in this role has completed national thematic reviews. Jane is the author of 'Mastering Social Work Supervision', and 'Developing and Supporting Effective Staff supervision' published by Jessica Kingsley Publishers and Pavilion.

9.2 Martine Cotter holds a Level 7 Post Graduate Diploma in Strategic Management and is a Fellow of the Chartered Institute of Management with over 18 years' experience working in the field of domestic abuse and sexual violence. She has just completed an MSc in Neuroscience and Psychology of Mental Health at Kings College London and has a specialist interest in the link between relationship aggression and adverse childhood experiences (ACE). Martine has previously chaired and published four Domestic Homicide Reviews. She is currently chairing seven active DHRs.