

Executive Summary

Safer Cornwall

Adult A

Year of Death 2017.

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## Preface

I would like to begin this report by expressing my sincere sympathies, and that of the Review Panel, to the family of Adult A. Adult A’s family describe her as a bright and bubbly woman who was fun to be with, and who had boundless amounts of energy. Having met the family I am deeply sorry for their loss and hope that in some way this report provides an insight into her life and a voice to her story.

I would like to thank the panel and those that provided chronologies and Individual Management Reviews for their time and cooperation.

## The Review Process

* 1. This summary outlines the process undertaken by the Safer Cornwall Partnership domestic homicide review panel in reviewing the death of Victim A who was resident in their area.
	2. The following pseudonyms have been used in this review to protect the identities of the relevant people who were involved;
* Adult A – Female who took her own life.
* Child A- Child of Adult A.
* Adult B - Adult A’s partner.
* Adult C - Adult A’s mother.
* Adult D - Adult A’s ex-partner.
* Adult E - Adult A’s ex-partner.
* Adult F - Child A’s paternal grandmother.
* Adult G - Adult A’s ex-partner.
* Adult H – Adult A’s friend.
* Adult I - Adult A’s ex-partner.
* Adult J – Adult A’s ex-partner.
	1. Adult A was twenty-seven at the time of her death. She was a white British female and was heterosexual.
	2. The process began with an initial meeting of the Community Safety Partnership on the 2nd March 2018 when the decision to hold the domestic homicide review was agreed. All agencies that potentially had contact with Adult A prior to the point of her death were contacted and asked to conform whether they had involvement with them.
	3. All of the thirteen agencies that were initially contacted confirmed that they had interaction with Adult A were asked to secure their files.
	4. At the time of completing this report HM Coroner had not held an inquest into the death of Adult A.

## 2.0 Contributors to the Review

2.1 The contributors to the DHR were;

* Devon and Cornwall Police– IMR.
* Cornwall Housing – Tenancy report.
* Royal Cornwall Healthcare Trust - Chronology.
* Cornwall Partnership NHS Foundation Trust (CFT) – IMR.
* NHS Kernow – Information.
* Children’s Services – Information.
* Addaction – IMR.
* GP Services- Information via interview.
* First Light - Chronology.
* Adult Social Care – IMR.
* National Probation Service
* Cornwall College – Information.
* Cornwall Anti-Social Behaviour (ASB) Team- chronology.
* Family members- Information.

2.2 All of the IMR authors were independent and none of them had previous involvement with Adult A or her case.

## 3.0 The Review Panel Members.

3.1 The panel for this review were made up of the following representatives;

* Paul Northcott-Independent Chair.
* Lerryn Hogg- Royal Cornwall Hospitals Trust (RCHT).
* Alex Morgan- Thompson – Cornwall Housing.
* Detective Sergeant Chris Cowd – Devon and Cornwall Police.
* Detective Inspector Ben Beckerleg - Devon and Cornwall Police.
* Julieann Carter – NHS Kernow
* Russ Hayton – Cornwall Council DAAT.
* Karen Howard – Adult safeguarding lead for the CFT.
* Tom Dingwall – First Light
* Jacqui Phare – NHS England
* Zoe Cooper – RCHT
	1. The panel met on three occasions. Contact was also made on an individual agency basis to clarify issues raised as part of the Review.
	2. None of the panel members knew the relevant individuals, had direct involvement in the case, or had line management responsibility for any of those involved. This was also confirmed by agencies at the initial panel meeting.

## 4.0 Author of the Overview Report.

4.1Cornwall Community Safety Partnership appointed Paul Northcott as Independent Chair and author of the overview report on 2nd March 2018.

4.2 Paul is a safeguarding consultant specialising in undertaking reviews (critical incidents, investigations, serious case reviews and safeguarding adult reviews) and currently delivers training in all aspects of safeguarding, including domestic abuse.

## 5.0 Terms of Reference for the Review

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, 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 he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death’.

5.2 Adult A had been involved in a number of relationships where she had become the victim of domestic abuse. Her last relationship, prior to her death, was with a male who had allegedly abused her physically, mentally and sexually. Safer Cornwall commissioned a DHR in accordance with a) above with a view to ascertaining whether this abusive relationship had contributed to Adult A taking her own life.

 The purpose of the Review was therefore set to;

* Establish the facts that led to the death of Adult A and whether there was learning from her taking her own life regarding the way in which local professionals and organisations carried out their responsibilities and duties, and worked together to safeguard Adult A;
* Identify clearly the learning, how this will be acted upon, and what is expected to change as a result;
* Apply the learning to service responses including changes to policies, procedures and practice of individual agencies, and inter-agency working, with the aim to better safeguard victims’ of domestic abuse in Cornwall;
* Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve single agency and inter-agency responses to all domestic abuse victims’ and their children through improved partnership working;
* Identify, on the basis of the evidence available to the review, whether the death was foreseeable and avoidable, with the purpose of creating a joint strategic action plan to address the gaps and improve policy and procedures in Cornwall and across the Southwest Peninsula;
* Identify from both the circumstances of this case, and the review process adopted in relation to it, any learning which should inform policies and procedures in respect to national reviews and make this available to the Home Office.

5.3 In addition to the above, the following terms of reference were set by the DHR panel and there was a requirement that these needed to be addressed in each of the individual Management Reviews and the Overview Report;

1. To provide an overview report that articulates the Adult A’s life through her eyes, and those around her, including professionals.
2. Establish the sequence of agency contact with Adult A, (between the dates of 1st January 2011 and 18th November 2017); and constructively review the actions of those agencies or individuals involved.
3. Provide an assessment of whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards her, whether this was known to any agencies and whether this was thought to have led to her taking her own life.
4. Seek to establish whether Adult A was exposed to domestic abuse prior to Adulthood and impact that this may have had on her.
5. Establish whether family or friends want to participate in the Review and meet the Panel.
6. Provide an assessment of whether family, friends, neighbours, key workers were aware of any abusive or concerning behaviour that may have led her to taking her own life.
7. Review of any barriers experienced by the Adult A/family/friends in reporting any abuse or concerns in Cornwall or elsewhere, including whether they knew how to report domestic abuse.
8. Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse;
9. Establish whether improvements in any of the following have led to a different outcome for Adult A considering:

(a) Communication and information-sharing between services.

(b) Communication within services.

(c) Communication to the general public and non-specialist services in Cornwall about the role services available to victims and perpetrators of domestic abuse.

1. Evaluate the effectiveness of training or awareness raising in agencies to ensure a greater knowledge and understanding of domestic abuse processes .

1. Establish whether the work undertaken by services in this case is consistent with each organisation’s:

(a) Internal policy and professional practices.

(b) Domestic Abuse policy, procedures and protocols.

and identify whether these policies and practices are effective to meet the needs of victims and their families.

1. Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.
2. Consideration of any equality and diversity issues that appear pertinent to the Adult A e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
3. To review any other information that is found to be relevant.

## Summary.

* 1. Adult A was twenty-seven years old at the time of her death and had been living at premises in Truro. From an early age Adult A had been forced into a life where she had become addicted to drugs and alcohol and as a result had been a frequent user of services. Adult A often presented to those services in crisis and due to concerns raised with regards to her behaviour a multi-agency package was put into place to support her. Adult A was known to have been a victim of domestic abuse.
	2. On the18th November 2017 Adult A had been staying at the home of Adult H. Also staying at the premises at that time was Adult B. Adult A had been in a relationship with Adult B.
	3. On the morning of her death Adult A had left the house and she had returned to her home address to wash and change. Whilst at her home address Adult A called the police saying that she could hear voices in the house. The police attended and on searching the premises they had found nothing untoward. When the officers spoke to Adult A she admitted that she had taken crack cocaine that morning and those in attendance felt that the noises that she had heard could be attributable to her drug use. Adult A remained at her property for about thirty minutes and she then left returning to the home address of Adult H. Adult A later left that address in order to walk to some local shops. On returning to Adult H’s address at about 1.30pm Adult B and Adult H had woken up. Adult A told her friends that she was going to see her niece and baby and she left the premise. Twenty-five minutes later Adult A was found hanging from a tree by a member of the public. Adult A was pronounced dead at the scene.
	4. On 29.11.2017 a forensic post mortem was conducted and the pathologist listed the cause of death as;
* Ligature suspension.
	1. The toxicology report received following Adult A’s death concluded that the results ‘show the presence of morphine at a potentially toxic / lethal concentration, which overlap due to the development of tolerance. There was also evidence of recent cocaine use. Both morphine and cocaine were at levels which were likely to have affected Adult A’s cognitive behaviour and motor function. Mirtazapine was identified at a therapeutic level and trace amounts of nortriptyline and diazepam were also detected. Aripiprazole, alprazolam, buprenorphine, methadone, pregabalin were also present (only buprenorphine was prescribed by her GP).
	2. An investigation was undertaken by Police as it had been suggested by Adult A’s family that there may have been third party involvement. Police found no evidence to support this claim and a file was completed for the purposes of a HM Coroner’s Inquest.

## 7.0 Key Issues Arising from the Review.

1. Evidence of Domestic Abuse in Adult A and Adult B’s relationship.
	* 1. Adult A had been the victim of domestic abuse in a number of relationships. All of the incidents had been assessed to an appropriate level and it was clear that those working in the main agencies had recognised the relevant risk factors.
		2. Due to the level of her addiction and the control that others had over her Adult A had a history of failing to make complaints to the police about those partners that abused her. Despite this failure to engage agencies went to great lengths to try and persuade her to report abuse. Over the years the police stated that they did see a shift in Adult A’s attitude towards cooperating with them but on those occasions when agencies were able to persuade her to come forward, she repeatedly withdrew from the process.
		3. In 2016 Adult A started a relationship with Adult B. During that relationship there was a significant history of domestic abuse which resulted in three MARAC’s being held in 2017. The relationship between the two adults was built around substance abuse with Adult A being totally dependent upon Adult B to feed her addiction.
		4. In terms of the nature and level of violence in the relationship with Adult B, agency records (Police, Health, Addaction) document physical assault, sexual assault, financial and emotional abuse. The frequency of the abuse that occurred in the relationship was difficult to determine as it would appear that many of the incidents were not officially reported.
		5. Whilst Adult A would be prepared to discuss some of the abuse she was suffering on other occasions she was protective of Adult B. What is apparent is that there was a consistent level of coercion and control in the relationship that Adult A had with Adult B and this would have undoubtedly affected the way in which she presented to professionals.
		6. Information held by the Police would tend to indicate that Adult A felt imprisoned by Adult B. It would appear that Adult A would not make any form of complaint against Adult B for fear of repercussions from him.
		7. As a result of the DASH risk assessment and multi-agency working arrangements Adult A’s case was discussed at three MARAC meetings in 2017 which involved numerous statutory and third sector agencies. On these occasions the agencies openly shared information and details regarding risks. Appropriate action plans were put into place to assist in safeguarding Adult A.
		8. What is clear is that Adult B exploited Adult A’s vulnerability and it is likely that on many of the occasions that Adult A presented to services it could be concluded that she did so in an attempt to seek escape from the situation in which she found herself. On these occasions however Adult A would often fail to provide any detail about the relationship which would have empowered agencies to take specific action in relation to Adult B.
		9. Despite repeated attempts to secure sufficient evidence to prosecute Adult B there was only one successful conviction (September 2017) for common assault. On this occasion Adult B was given a conditional discharge and despite the Police requesting a restraining order the court failed to grant one.
		10. In terms of safety planning there was clear documented evidence that there was a co-ordinated approach across agencies and that this had been led by Addaction.
		11. The CFT IMR has however identified that in the early stages (October 2016 – January 2017) of Adult A’s journey, there were missed opportunities by some of its practitioners to fully assess Adult A’s disclosures of domestic abuse. Adult A did not present as being frightened or afraid at most of her assessments and staff therefore became preoccupied with issues related to substance induced psychosis. Staff did not give ‘weight’ to the assessment made by others that alternative factors were involved. Whilst staff had asked Adult A about domestic abuse as part of their practice regarding routine enquiry they had, on some occasions, failed to explore the issues raised in any great depth. It would appear that the fact that staff knew that Adult A was being supported by numerous agencies for other issues in her life meant that they did not see the need to question her in depth about disclosures. These were missed opportunities.
		12. The CFT IMR also identifies that in hindsight had staff considered the disclosures and allegations that were made by Adult A with the same focus as they did in relation to substance misuse, and had they considered the other escalating risks (domestic abuse), then this may have prompted consideration that Adult A may become the victim of a ‘desperate act’. Had the possibility of a ‘desperate act’ in the context of domestic abuse, control and exploitation been considered, the risk of her taking her own life may have been foreseen. This could also have been applicable to all agencies involved in the care and welfare of Adult A. That said even if professionals had recognised the potential risk, the challenge for agencies would have been maintaining engagement with Adult A and reducing the risks beyond the work that was already taking place.
		13. Had CFT staff fully explored Adult A’s disclosures then there were identified opportunities to have signposted her to domestic abuse support services earlier. On presenting to PLS in October and December 2016 and January 2017, domestic abuse was disclosed. Adult A was signposted to domestic abuse services via either a leaflet or card. There was however the option for PLS to directly refer Adult A to REACH[[1]](#footnote-1), with or without her consent for high risk. Contributing factors in this was the lack of an IDVA post at RCHT at the time and the time limits for PLS staff to undertake work outside of assessment. Likewise, this option to refer direct to REACH was not considered when Adult A attended the Integrated Community Mental Health Teams (ICMHT) offices (14.10.2017) or when an in-patient at Longreach House (2 – 3.02.2017). This should have been standard practice. It should be noted however that on the information available to the Review, even if referrals had been made, getting Adult A to engage in support was likely to have been difficult.
		14. On the majority of occasions Adult A was repeatedly provided with information on domestic abuse support services at each presentation by all of the agencies concerned. Adult A was aware of the support that was available and this was constantly reinforced by her Addaction key workers. Adult A had also been offered IDVA support but despite numerous attempts she would fail to engage with them and had eventually declined their help.
		15. From reviewing the recorded information and speaking to the professionals involved there was a clear desire to try and support Adult A and divert her from the issues that she was experiencing. Many of the professionals that dealt with her often felt helpless as they believed that they had exhausted all available options to support her and yet she refused to change her lifestyle. What was apparent is that the decisions made by professionals in this case were made in the best interests of Adult A and were based on the information that had been disclosed. Agencies appropriately used this information when completing assessments, offering support and when attending multi agency meetings.
	1. Alcohol and drug abuse
		1. Adult A would regularly misuse substances and the effect on her behaviour was self-evident to both professionals and her family. This included abuse of amphetamine, ecstasy, crack cocaine, heroin, ketamine, Subutex, as well as alcohol.
		2. Illegal drugs had a huge impact on every part of Adult A’s life. Information held by agencies indicated that not only was Adult A personally addicted to such substances but she was also caught up in criminality as a result of it. Not only was Adult A committing acquisitive crime to support her habit but she was also transporting drugs for those that preyed upon her vulnerability.
		3. The impact that Adult B had on Adult A’s life in relation to drug abuse was also considerable. On the 14.02.2017 police received intelligence which stated that there were concerns for the welfare of Adult A as it was suspected that Adult B was injecting her with drugs. It would appear that Adult B was carrying out this act in order to make sure that Adult A remained addicted to drugs and that she stayed with him.
		4. Although there was an acceptance that Adult A struggled to engage with services due to her chaotic substance use and lifestyle, agencies were also aware that this behaviour was due to the controlling nature of Adult B. All agencies were also aware that Adult A was considered as a high risk as a result of her relationship. Adult B had introduced her to organised criminality and there was also information to suggest that she had drugs debts and that she had stolen drugs from him.
		5. There were periods when Adult A appeared to want to take back control of her life, however these moments were rare and often short lived. On those occasions where she had attempted to do so her efforts were frustrated due to a critical event occurring and this would push her back towards her life of addiction.
		6. There was clear evidence in the records of all agencies of effective intervention in relation to drug management, particularly Addaction. Throughout her journey with CFT, staff also had full knowledge of Adult A’s substance misuse and addiction and treated her accordingly.
	2. Adult A’s Mental Health
		1. When intoxicated Adult A would be incoherent, have a poor recollection of events and her capacity to make decisions was severely impaired. This made mental health examinations and assessments extremely problematic for practitioners. Professionals also found it difficult to identify whether the disclosures that she made in relation to abuse were real or imagined. In these circumstances, efforts were made by appropriate agencies to complete or repeat any assessments when Adult A was not intoxicated. Again these attempts were frustrated by Adult A’s lack of engagement.
		2. Adult A’s GP has stated that they had no concerns about her mental health (psychotic symptoms) during 2016 but these concerns increased during 2017. Her GP first prescribed anti-psychotic medication (Aripiprazole) in 2017 following advice received by Addaction’s Psychiatrist. Her commitment to taking this medication varied due to her fluctuating capacity and addictions .
		3. On each occasion when Adult A did present to Health agencies with mental health concerns she was, according to the CFT IMR writer, appropriately assessed. Following each assessment Adult A was deemed to have capacity and as such was not considered to be detainable in relation to the mental Health Act 1983. Based on the assessments that were made in this case health care professionals did not find any evidence of an underlying acute mental health disorder and they concluded that Adult A’s symptoms were indicative of substance misuse or withdrawal symptoms. There has been nothing identified through the review process that would contradict this view.
		4. Those within Addaction who worked with Adult A concluded that in their view her mental state did fluctuate hugely depending on which drugs she had taken. They also believed that she did have an underlying psychosis which she minimised at times when it suited her. Again this made an accurate diagnosis difficult.
		5. Clinical risk including the risk of domestic abuse and the risk of self-harm (including her taking her own life) was assessed eleven times during Adult A’s care with CFT with her overall risk rated as medium on two occasions and high on nine occasions. The risks of her taking her own life were always explored with Adult A.

* + 1. On her last contact (10.11.2017) with CFT staff from EIT they described how Adult A was not distressed or frightened and that she had clearly indicated a willingness to attend further appointments.
		2. Those on the review panel had looked at what could have driven Adult A to take her own life. One of the trigger events could have been the impact of the death of Adult G. Addaction have also stated that Adult A had disclosed that she had thought that she had been pregnant just prior to her death (although the true impact of this on Adult A could not be ascertained). Again the impact of this on her mental health could not be ascertained. There was nothing recorded in the post mortem report to suggest that Adult A was in fact pregnant.
		3. There has been nothing specifically identified by this review that would provide any rationale as to what lead Adult A to take her own life on that day. What is clear is that Adult A had suffered years of abuse and that her life had been plagued by substance addiction and mental health problems.
	1. Self Neglect
		1. Adult A did meet the definition of vulnerability used by statutory agencies[[2]](#footnote-2) and Adult Social Care had considered this as part of their assessment process. Adult A had suffered for years with exposure to domestic abuse and addiction to illegal drugs and alcohol, low mood and concerns about drug induced psychosis with questions whether there was an underlying mental disorder. Each of these factors made her vulnerable to self-neglect and in need of support.
		2. It is clear that Adult A’s family were also concerned about her mental and physical health and this resulted in a number of reports to services.
		3. Agencies during their interaction with Adult A continually noted changes in her appearance and demeanour and shared such information willingly, particularly with Health services. There were occasions where Adult A was considered to be emaciated and that she was actively failing to look after herself. Professionals were alive to this issue and continually provided advice and support to Adult A during this period.
		4. The level of support that agencies were providing to Adult A meant that after reviewing the issues that were apparent in the case Adult Social Care felt that there was little that they could gained from their direct intervention. There is nothing found in this review that would contradict this view.
		5. There is a Cornwall and Isles of Scilly Safeguarding Adults Board (SAB) multi- agency self-neglect, hoarding and rough sleepers’ protocol to support staff with management of self-neglect and or rough sleeping. From case review discussion meetings within CFT it was apparent that there was some awareness of this policy, although it’s relevance to Adult A had not been fully appreciated by some members of staff.
	2. Risk Management – Adult A
		1. There were significant high risks identified in Adult A’s life. These risks were known to professionals and identified in agency risk assessments.
		2. The review has identified that the risk management of Adult A was actively considered by all agencies in relation to mental health and substance abuse.
		3. Adult A’s ability to engage presented a significant issue for all agencies in the management of her risk. The risks identified were managed on a multi-agency level and significantly via the MARAC process.
	3. Operational Practice, Policy and Procedure
		1. All of the agencies involved in this case had policies in place with regard to safeguarding and domestic abuse. These policies were known to staff and are available to them through internal intranet sites.
		2. Whilst policies in the main were robust the Review has highlighted a number of areas of operational practice that require additional improvement. These have been reflected in the recommendations that are contained in this report.
	4. Information Sharing and Communication
		1. There is clear evidence of information sharing in this case, both internally within organisations and with other agencies. There was particular evidence of effective information sharing between Addaction, Health, Police and Housing.
		2. There were however, missed opportunities for sharing information with agencies. This included incidents involving the CFT, Primary Care and Addaction.
	5. Supervision
		1. In the main there was effective supervision demonstrated by all agencies involved with Adult A and this was evidenced within IMR’s. There was evidence that records were reviewed and that staff had supervisory input and support when making decisions.
		2. The Review did however identify that there were implications for the management and supervision around cases of substance misuse, self-neglect and consideration of capacity.
	6. Training
		1. From the detail recorded in the IMR’s and through the collective assessment of the panel it has been identified that there would appear to be good understanding of domestic abuse amongst those professionals who were involved with Adult A. All of the staff that were involved with Adult A would appear to have been trained to the standards expected, and all were equipped to identify her safeguarding needs, although on occasions they had failed to fully explore the incidents or exploit the information that they were given.

* + 1. During the Review there were additional opportunities to improve training standards within a number of agencies and these have been reflected in the recommendations within this report.

## Conclusions.

* 1. Adult A was forced to lead a chaotic lifestyle which was driven by her addictions to drugs and alcohol. On a daily basis Adult A would take a cocktail of drugs and those that supported her were continually concerned that she would die as a result of an overdose. All agencies worked together to manage her complex poly-substance misuse.
	2. Adult A would often present to agencies in crisis and suffered from what professionals believed to be drug induced psychosis. Attempts to effectively diagnose an underlying mental health condition were continually frustrated by her ability to engage with services and ongoing substance use. The ability for agencies to intervene was also frustrated by the fact that Adult A did have capacity and therefore she was able to make decisions in her life which to many appeared to be high risk and yet they were powerless to intervene.
	3. In this case the professionals concluded that there did not appear to be any justification for the use of detention at any stage of Adult A’s life, as she had capacity and didn't meet the criteria within the Mental Health Act. The diagnosis made by health professionals would appear to have been correct on the information that was available to professionals and the decisions that were made were in line with national guidance and policy. There were no obvious clinical shortcomings/failings in this case.
	4. Adult A had a number of relationships with males who were domestic abuse perpetrators. Her final relationship was with a male (Adult B) who according to reports was incredibly controlling and he would physically, sexually, financially and emotionally abused her. Adult A had become increasingly dependent upon this male due to her drug addiction. All agencies had recognised and were concerned about the risk that Adult B posed to Adult A. Interventions were put into place in an attempt to mitigate the risks that were identified and agencies had attempted to highlight the dangers of the relationship to Adult A.
	5. Despite the chaotic nature of her lifestyle Adult A’s family had remained supportive and had often offered help and support
	6. In this case there was evidence of effective multi agency working and there were numerous meetings held to discuss Adult A and manage the risks in her life. There were also excellent examples of agencies actively sharing information and being flexible in their approach.
	7. From the information presented by agencies operational practice and policies were in the main followed by professionals, although the Review has identified a number of areas where improvements can be made. Incidents were correctly documented and risk assessments completed. These risk assessments were graded correctly on the information that was provided by Adult A, and on the majority of occasions referrals were made to the relevant agencies.
	8. Overall the incidents of domestic abuse that were reported to agencies were correctly recorded and appropriately risk assessed. Domestic abuse advice and support was also provided to Adult A. There were some missed opportunities earlier in Adult A’s contact with mental health services to support her with the domestic abuse that she had disclosed. However, as previously noted, these opportunities were overshadowed by the focus and main presentation of substance misuse, intoxication or withdrawal.
	9. The Review has identified issues regarding capacity, particularly in relation to those suffering from drug induced psychosis and where there is information to suggest that individuals are unable to make choices due to the coercion and control of others. Professionals in all agencies need to think more laterally when undertaking assessments in order to make informed judgements about treatment and care.
	10. There were no specific indicators or risks identified in the days leading up to Adult A’s tragic death that would have indicated to professionals that additional intervention was required. On the information available to agencies and Adult A’s family no one could have predicted that she would have taken her own life on the day in question.
	11. Adult A had to cope with a daily struggle with drug and alcohol abuse and it is likely that she had become overwhelmed by her situation and was unable to see any other way out other than to sadly take her own life[[3]](#footnote-3).

## 9.0 Learning

9.1 This part of the report will summarise learning drawn from the case and how this will be translated into recommendations for action.

9.2 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 10.0

* Learning opportunity 1 (Recommendation 1)

The CFT IMR identified that whilst numerous members of staff had been trained in relation to domestic abuse and the use of DASH, some of them still lacked the appropriate knowledge and confidence to use the process effectively. The continued roll out of training was therefore seen as essential.

* Learning opportunity 2 (Recommendation 2)

As part of the Review CFT identified that there is a need to ensure that that the domestic abuse and adult safeguarding training that is being commissioned in Cornwall is jointly developed. Such a joint approach would ensure that service delivery is standardised within agencies and in multi-agency settings.

* Learning opportunity 3 (Recommendation 3)

The importance of the learning in this case have been acknowledged by CFT. The organisation has identified that there is an opportunity to improve operational practice in a number of areas through an effective communications strategy.

* Learning opportunity 4 (Recommendation 4)

On review staff within CFT had limited knowledge of the new SAB multi agency ‘High Risk Behaviours Policy’ and the ‘Self-neglect, Rough Sleepers and Hoarding Protocol’. These documents are invaluable in providing staff with a resource that can help them make decisions in complex cases. CFT have therefore identified that they need to raise awareness of these documents within the Trust.

* Learning opportunity 5 (Recommendation 5)

Staff awareness in relation to self-neglect was variable in CFT. The CFT have an opportunity to develop a campaign / strategy which should include training on self-neglect, testing/assessing capacity and executive capacity / legal perspectives. This strategy would ensure that staff have the training, confidence and ability to make effective decisions in complex cases.

* Learning opportunity 6 (Recommendation 6)

In order to improve adult safeguarding supervision the CFT identified that they need to review MDTs, referral meetings and one to one supervision to ensure that adult / children safeguarding is included as part of these discussions. As part of the review current supervision to the CFTs Adult Safeguarding Team for advice, support and specialist safeguarding supervision should be promoted.

* Learning opportunity 7 (Recommendation 7)

The CFT IMR identified that there was variable practice in staff dealing with adults with complex needs such as self-neglect and high risk behaviours. Current SAB protocols were not being considered by staff. An audit of cases would provide an opportunity to reconsider capacity issues and where appropriate make referrals through current adult safeguarding processes.

* Learning opportunity 8 (Recommendation 8)

All agencies present at the Review Panel stated that service delivery was more effective when they had access to an IDVA at Treliske Hospital. The IDVA was able to provide an immediate response to domestic abuse victims. This service had been withdrawn but arrangements are place for a reintroduction of a broadly similar model.

* Learning opportunity 9 (Recommendation 9)

Adult Social Care identified that their service was not adhering to agreed time scales for the completion of safeguarding meetings. A failure to adhere to timescales could delay the co-ordinated delivery of services to victims. This issue should be addressed through an audit of cases and adherence to current policy.

* Learning opportunity 10 (Recommendation 10)

Whilst reviewing this case the Adult Social Care IMR writer identified that case recording within the service was weak. They identified that there were gaps in recording on case notes which meant that additional searching was required to identify relevant documents. The author concluded that whilst there was a great deal of information held it was not easy to find. Referencing in case notes to specific documents would ensure that professionals have a comprehensive overview of a case.

* Learning opportunity 11 (Recommendation 11)

Whilst Addaction staff have considerable experience and expertise in relation to dealing with people with complex needs, this case, and others like it, have highlighted that additional training with regards to ‘crack users’ would be invaluable.

* Learning opportunity 12 (Recommendation 12)

Devon and Cornwall Police identified that the current mobile data technology that is used by frontline officers to access and research ‘subjects’ is not working effectively and this is impacting on operational performance. This IT requires additional refinement and there needs to be a timely upload of DASH information onto force systems.

* Learning opportunity 13 (Recommendation 13)

The Review identified that agencies shared information regarding Adult A’s domestic abuse disclosures with her GP. The GP, however, didn’t explore these issues further with her at appointments. This was seen as a missed opportunity. In future the GP practice should make it standard practice to explore identified domestic abuse issues with patients.

* Learning opportunity 14 (Recommendation 14)

Adult A’s GP identified that information sharing between Addaction and the surgery could be more effective.

* Learning opportunity 15 (Recommendation 15)

Adult A’s GP identified that in order to ensure that Addaction know of all concerns and risks in relation to high risk patients then a formal communication process needs to be implemented.

Multi Agency Learning

* Learning opportunity 16 (Recommendation 16)

Whilst staff have identified that the working relationship between Addaction and the CFT is good those working in both organisations acknowledge that further improvements could be made to improve service delivery. CFT and Addaction are currently working to contract but need to continue to develop a shared understanding and joint approach for working with clients with addiction who present with mental health problems. These issues have previously been acknowledged in the ‘ Dual Diagnosis Strategy’ which was initiated in 2016 but not fully implemented.

* Learning opportunity 17 (Recommendation 17)

Those on the Review Panel identified that there is limited capacity in respect of refuge facilities in Cornwall for victims of domestic abuse who are experiencing addiction or mental illness. The availability of such a facility would enable agencies to deal effectively with victims of abuse and reduce risks. Current provision needs to be reviewed and where appropriate alternative placements commissioned.

* Learning opportunity 18 (Recommendation 18)

There is an opportunity to improve service delivery in respect of those individuals who are identified as having high risk behaviours. The Local Authority needs to ensure that the new SAB[[4]](#footnote-4) multi-agency ‘High Risk Behaviours Policy’ and the ‘Self-Neglect, Rough Sleepers and Hoarding Protocol’ is communicated effectively across agencies and circulated to staff. The implementation of these policies should be reviewed to ensure that they are being complied with.

* Learning opportunity 19 (Recommendation 19)

This case has identified that the issue of capacity is extremely complex and difficult for staff to navigate. In order to provide some clarity on this matter all agencies need to develop current domestic abuse training so that it includes detail on executive capacity, duress and freewill (including modern slavery). This would enable staff to make informed decisions about such cases.

* Learning opportunity 20 (Recommendation 20)

The instigation of an escalation policy between Addaction and CMHT in Cornwall would ensure that high risk clients are not screened out without the appropriate discussion and risk assessment. At present such a policy does not exist and therefore needs to be developed.

* Learning opportunity 21 (Recommendation 21)

In this case Addaction took the role as the lead agency. Adult A’s caseworkers felt ill equipped to take on this role and they have questioned whether this was in fact best practice. In cases where there are concerns about high risk individuals consideration should be given to a statutory agency taking the lead role.

* Learning opportunity 22 ( Recommendation 22)

A joint meeting structure between CMHT and Addaction would be beneficial to discuss work on joint care plans. This would enable a co-ordinated approach by services to deal with individuals with complex needs.

## Recommendations.

* 1. This section sets out the recommendations made by the DHR panel and the recommendations made in each of the IMR reports.

Single Agency Recommendations

* Recommendation 1

CFT to continue to roll out its two day domestic abuse training module to all appropriate staff.

* Recommendation 2

CFT to assist with the development of the adult safeguarding (including domestic abuse) training commissioned by Safer Cornwall Partnership.

* Recommendation 3

CFT to deliver a learning from experience workshop about this case and share learning and changes to practice.

* Recommendation 4

CFT to implement and disseminate to all staff the new SAB multi agency ‘high risk behaviours policy’ and the ‘self-neglect, rough sleepers and hoarding protocol’.

* Recommendation 5

CFT to develop a self-neglect campaign / strategy to raise awareness in services which includes providing training on self-neglect, testing/assessing capacity and executive capacity / legal perspectives

* Recommendation 6

CFT to review MDTs, referral meetings and one to one supervision to ensure that adult/children safeguarding is part of these discussions (including appropriate referrals to CFT’s Adult Safeguarding Team) and there is evidence of challenge.

* Recommendation 7

CFT to audit all cases of adults who use substances to identify numbers where there are concerns about capacity, self-neglect and exploitation to consider whether a review of case is needed under SAB protocols.

* Recommendation 8

CFT to implement plans for a health based IDVA to be available at Treliske Hospital within the new Service Level Agreement/Contract with Firstlight.

* Recommendation 9

 Adult Social Care services to undertake a review of all current cases to identify issues impacting on adherence to agreed time scales for the completion of safeguarding meetings.

* Recommendation 10

Adult Social Care to reinforce the need for comprehensive recording practices to all staff and review current supervision practices to ensure that quality assurance measures are effective within the service.

* Recommendation 11

Addaction staff to undertake additional training specific to dealing with ‘crack users’.

* Recommendation 12

Devon and Cornwall police to review and improve the current mobile data technology to ensure frontline officers access to research subjects on their devices and to ensure a timely upload of dash information onto force systems.

* Recommendation 13

GP surgery to review current practice to ensure that domestic abuse is routinely explored with patients.

* Recommendation 14

 Addaction to review its information sharing processes to ensure that all relevant material is shared in a timely manner with GP’s.

* Recommendation 15

The relevant GP surgery to implement a formal process where risks and concerns are clearly communicated to Addaction in relation to high risk patients.

Multi agency recommendations

* Recommendation 16

Health and Local Authority Commissioners to jointly oversee the implementation of the Dual Diagnosis Strategy, including multi-agency service leads.

* Recommendation 17

Safer Cornwall to review current refuge facilities in the County to identify capacity for victims of domestic abuse who are experiencing addiction or mental illness.

* Recommendation 18

 Cornwall Local Authority to ensure that the new SAB multi-agency ‘High Risk Behaviours Policy and the ‘Self-neglect, Rough Sleepers and Hoarding Protocol’ is effectively implemented across all relevant agencies, incorporated into training and circulated to staff.

* Recommendation 19

 All agencies to ensure that current domestic abuse training programmes include relevant input in relation to executive capacity, duress and freewill.

* Recommendation 20

 Addaction and mental health services to write, publish and implement an escalation process.

* Recommendation 21

 The current high risk behaviours policy should be amended to ensure that in complex cases a statutory agency should take the lead role in coordinating services.

* Recommendation 22

 CMHT and Addaction to implement a meeting structure to enable discussions to take place regarding joint care plans.

1. [↑](#footnote-ref-1)
2. *Adult at Risk - An Adult at risk of abuse or neglect is defined as someone who has needs for care and support, who is experiencing, or at risk of, abuse or neglect and as a result of their care needs - is unable to protect themselves; Care Act (2014).* [↑](#footnote-ref-2)
3. A ‘desperate act of resistance’- [↑](#footnote-ref-3)
4. Safeguarding Adult Board. [↑](#footnote-ref-4)