

Cornwall Community Safety Partnership

Adult A

Year of Death 2017.

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Date the review report was completed: 28th March 2019.

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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.

1.0 Introduction

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by Cornwall Community Safety Partnership and examines agency responses and the support given to Adult A, prior to the point of her death on the 18th November 2017.

* 1. The key purpose for undertaking a DHR is to enable learning from homicides where a person has died as a result of domestic abuse. In order for the learning to be shared as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. In this particular case Safer Cornwall wanted to use this methodology to review the death of Adult A as there were concerns that domestic abuse may have been a contributing factor that had caused her to take her own life.
  2. This report will consider the contact and involvement that agencies had with Adult A between the dates of 1st January 2011 and 18th November 2017. The reason for choosing these dates is that they provide a comprehensive overview of the deterioration of Adult A’s mental and physical state. Some additional information has been included in the chronology as this provides context in relation to Adult A’s experience of domestic abuse.
  3. In addition to agency involvement this review has also sought to examine the past to identify any relevant background or specific risks to Adult A and whether there were opportunities to provide support to her. Consideration was also given to whether there were any barriers to accessing services. By taking a holistic approach the Review has sought to identify appropriate solutions to make the future safer. This report also summarises the circumstances that led to the Review being undertaken in this case.
  4. Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have sought the views of family members and have made every attempt to manage the process with compassion and sensitivity.
  5. Summary
  6. 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 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 support package was put into place to support her. Adult A was known to have been a victim of domestic abuse.
  7. 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.
  8. 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 then 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.
  9. 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 are likely to have affected cognitive behaviour and motor function. Mirtazapine 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).There was insufficient blood sample for further drug quantitation. The presence of atropine (used during cardiopulmonary resuscitation) is suggestive of therapeutic intervention’.
  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.

3.0 Timescales

3.1 Cornwall Community Safety Partnership commissioned this Review on the 2nd March 2018. The review adhered to the processes detailed in the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

* 1. The decision to commission a review was taken by the Chair of Cornwall Community Safety Partnership. The Home Office had been informed of the decision to undertake a review on the 11th January 2018. The delay in commencing the Review occurred as a result of there being no suitable independent chair and writer available.
  2. This review commenced on 2nd March 2018. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision made to proceed with the Review. For this reason an initial timetable was drawn up to ensure that agencies complied with this request. The Review was unable to be completed in the six-month time frame due to the Chair requesting additional information from a number of different agencies which needed to be cross referenced with the family.
  3. The Independent chair was appointed on 2nd March 2018 and the first panel meeting was held on the 27th April 2018. During this meeting, the draft terms of reference were discussed.
  4. The family of Adult A were contacted and invited to actively contribute to the review.
  5. The Chair met with the family on two occasions. Contact outside of these occasions was maintained at their request through email*.*
  6. Whilst the panel met on three occasions contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agencies involvement with the family.
  7. The review concluded on 28th March 2019. The Cornwall Community Safety Partnership was kept updated regarding the progress of the review throughout the process.
  8. A draft overview report was completed and the family were then contacted and provided with a copy of the report to enable them to contribute further to its contents.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers. The family of Adult A were provided with a copy of the report prior to submission to the Home Office and were also advised about confidentiality.

* 1. Before the report is published Cornwall Community Safety Partnership will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and the family members. The family will be notified of the publication date.
  2. The content of the overview report has been anonymised to protect the identity of the female who took her own life, relevant family members and all others involved in this review. The pseudonym/s agreed with the family are as follows;

Family composition and pseudonyms used.

* 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.

5.0 Methodology

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.

5.4The methods for conducting DHR’s are prescribed by the Home Office guidelines[[1]](#footnote-1). These guidelines state;

*‘Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions’*.

The panel chose the time period for the terms of reference to ensure that they met these criteria. This time period clearly shows the deterioration in Adult A’s health and her exposure to domestic abuse. The panel hoped that by reviewing this period of Adult A’s life they would be able to try an identify critical points that intervention should have taken place and which may have prevented the death from occurring.

* 1. Following the decision to undertake the DHR Cornwall Community Safety Partnership arranged for all relevant agencies to check their records about any interaction that they had with Adult A.
  2. Where it was established that there had been contact the Partnership ensured that all agencies promptly secured all relevant documents, and those who could make an appropriate contribution were invited to become panel members. Agencies that were deemed to have relevant contact were then asked to provide an IMR, and a chronology detailing the specific nature of that contact.
  3. The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could or should be made to agency policies and practice. Where changes were required then each IMR also identified how those changes would be implemented.
  4. Each agency’s IMR covered details of their interaction with Adult A, and whether they had followed internal procedures. Where appropriate the report writers made recommendations relevant to their own agencies. Participating agencies were advised to ensure that actions were taken to address lessons learnt as early as possible. As part of this process IMR authors, where appropriate, interviewed the relevant staff from their agencies.
  5. The findings from the IMR reports were endorsed and quality assured by senior officers within the respective organisations who commissioned the report and who are responsible for ensuring that the recommendations within the IMR’s are acted upon.
  6. On request from the Independent Chair some authors provided additional information to clarify issues raised individually and collectively within the IMR’s. Contact was made direct with those agencies outside of the formal panel meetings. This additional information included, recent DHR’s and policy and procedures.
  7. In addition to the IMR’s the Panel met with one of the Addaction support workers who had supported Adult A.
  8. The Independent Chair also met Adult A’s family and asked whether any additional friends should be contacted. They stated that due to her transient life they could not identify any other person who could assist with the Review. Contact was made with the person that Adult A was living with at the time of her death (Adult H) and whilst she initially agreed to meet she later declined to do so.
  9. The following agencies supplied IMR’s;
* Devon and Cornwall Police– IMR.
* Cornwall Foundation Trust – IMR.
* Addaction – IMR.
* Adult Social Care – IMR.
  1. The Independent Chair reviewed another DHR commissioned in Cornwall in view of similarities and also had sight of the Safer Cornwall DHR action plan.
  2. The FirstLight representative works for a registered charity that is independent of statutory agencies and which supports victims affected by domestic abuse and sexual violence across Devon, Cornwall and the Isles of Scilly. The panel had considered the impartiality of this individual and it was verified that they were not directly involved in this case. Due to their experience this individual was able to provide considerable advice in respect of domestic abuse and was able to offer advice and challenge to the panel and the Chair. As a consequence of this level of knowledge, and the fact that there were no specific concerns raised in respect to that organisation, the panel didn’t feel that further additional independent advice was required for this case.

6.0 Involvement of family, friends, neighbours and the wider community

6.1 Family members of Adult A were invited to contribute to the review and they were provided with a leaflet prepared by the Home Office about the DHR process. Initial contact was made through email and via the phone. Three family members chose to take up this invitation and were spoken too by the Chair. The initial meeting with two of the family members took place on 27th April 2018. One family member identified themselves as the single point of contact for the immediate family members and they agreed that they would keep the rest of the family updated regarding the progress of the Review.

6.2 During the review the Chair maintained an on-going dialogue with the family. Frequency and methods of contact were agreed at the initial meeting.

6.3In view of the fact that Adult A was not working during the time covered by the terms of reference no work colleagues were seen as part of this review.

6.4 The terms of reference were shared with those members of family that were seen by the Chair of the DHR to assist with the scope of the review. All members of the family were encouraged to review the terms of reference and make changes. No additional changes were made.

* 1. On the 14th March 2019 the family were given a draft copy of the review report. The family were left in private to review the report and given sufficient time to read it before a further meeting was held with them to discuss the content.
  2. The Chair looked at the viability of approaching those individuals who could be classed as the friends of Adult A. Due to the chaotic and transient lifestyle of these individuals this was not deemed to be a viable option. One of Adult A’s friends had initially agreed to meet with the Chair but later declined to be interviewed. The family of Adult A were also asked about others that could be contacted as part of the Review but were unable to provide any details of those that would have relevant information to share.
  3. Consideration was also given to speaking to Adult B. On Police advice this was not deemed to be suitable due to specific risk factors.

7.0 Contributors to the Review

7.1 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.

7.2 Independence and impartiality are fundamental principles of delivering Domestic Homicide Reviews and the impartiality of the Independent Chair and panel members are essential in delivering a process and report that is legitimate and credible. None of the panel members knew the individuals involved, 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.

8.0 The Review Panel Members

8.1 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

8.2 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference and the agreement and implementation of an action plan to take forward the recommendations in this report, are the collective responsibility of Cornwall Community Safety Partnership.

9.0 Author of the Overview Report.

9.1Cornwall Community Safety Partnership appointed Paul Northcott as Independent Chair and author of the overview report on 2nd March 2018.

9.2 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. Paul was a serving police officer in the Devon and Cornwall Police and had thirty-one years’ experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

9.3 Paul left the police service in February 2017 but had spent the previous seventeen months working regionally and nationally. During that time he had no involvement with Safer Cornwall nor the policy and practices of the Devon and Cornwall Police. Paul also had no operational oversight of the resources that were deployed in this case.

9.4 At regular intervals Cornwall Community Safety Partnership reviewed Paul’s independence. A specific review took place after the submission of the police IMR. No issues were identified.

10.0 Parallel Reviews

10.1 An inquest was opened and adjourned by HM Coroner in Cornwall. To date there has not been any inquest and therefore no additional information has been obtained from this process.

10.2 The Independent Office for Police Conduct (IOPC) had also completed an investigation into specific complaints that had been made by Adult A’s family. Contact was made with the investigating officer to establish if any issues had been raised during that investigation that would have been relevant to the review. Following discussions it was established that the terms of reference for their review were specific to issues raised in relation to the Police response post the death of Adult A. As a consequence a decision was made by the Panel that these issues fell outside of the scope of this Review and should not be duplicated within the content of the report.

10.3 The CFT initiated a serious incident (SI) investigation (internal incident number 97630) following the death of Adult A. When the notification for the DHR was made the SI and the Internal Management Review (IMR) were combined to provide one comprehensive report. The combined SI and DHR IMR findings and recommendations are shared across the whole organisation and with the Kernow Clinical Commissioning Group.

11.0 Equality and Diversity.

11.1The review adheres to the Equality Act 2010 and all nine protected characteristics i.e. age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation were considered by the Panel as part of the terms of reference and throughout the Review process.

11.2 Adult A was a white British national and a heterosexual. Adult A was aged twenty seven at the time of her death.

11.3 Adult A was the mother of one child from a previous relationship.

11.4 As far as the panel has been able to determine, Adult A did not hold any strong or religious beliefs or have any language or acute learning needs which would have impacted on any assessments or the services that were offered to her.

11.5 Although mental health concerns were inconclusive, the Panel considered this and the range of other factors that increased Adult A’s vulnerability. Adult A had been considered vulnerable according to organisational criteria based on national guidelines[[2]](#footnote-2). There has been nothing identified to suggest that she was discriminated against either directly or indirectly due to this characteristic.

11.6 There is no evidence that would indicate that Adult A was discriminated against by services or individuals with whom she came into contact with.

11.7 No barriers to accessing services in relation to inequality were identified.

11.8 The panel found no evidence that Adult A was directly discriminated against by any individual or agency based on the nine protected characteristics*.*

12.0 Dissemination

12.1 This version of the overview report is for discussion by the Review Panel. Circulation is restricted to staff directly involved in the review and the managers within the following organisations;

* Family members
* Cornwall Community Safety Partnership
* Devon and Cornwall Police
* NHS England
* Royal Cornwall Healthcare Trust
* Cornwall Foundation Trust
* Cornwall Housing
* NHS Kernow
* Addaction

12.2 In accordance with Home Office guidance all agencies and the family of Adult A are aware that the final overview report will be published. IMR reports will not be made publicly available. Although key issues have been shared with specific organisations the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.3 The content of the overview report has been suitably anonymised to protect the identity of the female who took her own life, previous partners, relevant family members and friends. The overview report will be produced in a format that is suitable for publication with any suggested redactions before publication.

12.4 The family of Adult A will be provided with the final version of the overview report prior to publication.

13.0 Background Information (The Facts)

13.1 Adult A was a twenty seven year old woman who had grown up in Truro, Cornwall and was one of seven sisters. According to Adult A (CFT records 13.10.2016) she had a difficult upbringing and her mother had a history of drug and alcohol misuse and may have had mental health issues.

13.2 Adult A reported being fostered at the age of three and her eldest sister had become her legal guardian (CFT records 13.10.2016). Adult A’s mother told the police that Adult A had started ‘going off the rails’ aged about eleven or twelve and by fourteen she was known to be injecting drugs and was involved in crime. Due to level of her addictions and the fact that she was being exploited Adult A had also reached such a low point in her life that sadly she felt that she had no choice but to become a street worker in order to fund her drug habit.

13.3 Adult A had a difficult and complex life which had been compounded by years of domestic abuse, substance abuse, (crack, cocaine, heroin, alcohol) low level criminality, anti-social behaviour, and increasing vulnerability through these factors impacting on her mental health. During this time Adult A had sporadic contact with her family and despite repeated efforts they had struggled to support her due to her behaviour.

13.4 Adult A was the mother of a seven year old child (Child A) who was the subject of a child protection plan. As a result of Adult A’s chaotic behaviour and her inability to look after Child A she subsequently went to live with one of her sisters. Adult D was believed to be the father of Child A.

13.3 Adult A lived in social housing accommodation (Devon and Cornwall Housing) on a housing estate in Truro. Adult A had been resident at the premises for a number of years, and there were numerous reports of anti-social behaviour at the property. Adult A would often leave the property and stay with friends and on one occasion due to the chaotic nature of her life decided to live in a local car park. although on many occasions where she would temporarily vacate the property.

13.4 During the time period that has been covered by the Review Adult A had a number of different relationships. For the purposes of the Review only those that had a direct impact on her behaviour and welfare have been documented. A number of these relationships had resulted in Adult A becoming the victim of domestic abuse.

13.5 In 2009 Adult A commenced a relationship with Adult D and during her time with him there were a number of crimes (assaults) and non-crime domestic incidents (arguments) reported to the police. The details of these incidents have been recorded in the chronology at paragraph 14.0. Following the break-up of her other relationships Adult A would often return to Adult D.

13.6 In 2012 Adult A commenced a relationship with Adult E and there were two Multi Agency Risk Assessment Conferences (MARAC[[3]](#footnote-3)) in respect of that particular relationship. During this period agencies were concerned about the risk of domestic abuse and the impact that it was having on Adult A’s welfare.

13.7 In 2016 Adult A was drawn into a relationship with Adult B. During that relationship there was a significant history of domestic abuse and Adult B was classified as a Domestic Abuse Serial and Serious Perpetrator (DASSP)[[4]](#footnote-4). The relationship was discussed three times at MARAC in 2017. Despite Adult A being repeatedly abused by Adult B, the police were only able to secure one conviction which occurred in September 2017. This conviction was for common assault and resulted in Adult B being given a conditional discharge. Despite being aware of incidents Police efforts to secure a prosecution were frustrated by Adult A failing to cooperate with them and she would often withdraw her complaints. Alternative methods of protection (Domestic Violence Protection Order (DVPO), victimless prosecution) were considered but again these could not be progressed due to a lack of evidence or support from Adult A.

13.8 Adult A’s family were aware of the destructive nature of this relationship and its impact on Adult A and they had tried on numerous occasions to protect her from Adult B’s influence. Again this proved difficult due to the fact that Adult A would often distance herself from them.

13.9 In September 2017 Adult A started a relationship with Adult G and her family describe him as a stabilising factor in her life (this was also confirmed by Addaction). On the 27th September 2017 Adult G died in suspicious circumstances in Adult A’s flat. Adult G’s cause of death was determined to have been a drug overdose. Due to circumstances of the death and the fact that Adult A was present at the time when it occurred she was arrested on suspicion of supplying drugs to Adult G. Following an investigation Adult A was released with no further action taken in relation to this incident. Following this incident Adult A went back to having a relationship with Adult B.

13.10 Health records show that Adult A was assessed at each presentation to services and there were symptoms of drug induced psychosis. Adult A would often present to services stating that she had hallucinations and could hear voices (Police, Addaction and Health records – as detailed in the chronology at 14.0). In the months leading up to her death Adult A’s mental health continued to deteriorate. During this time she had numerous contacts with a variety of agencies (Addaction, Health, Police and Adult Social Care) who had tried to support her and provide her with assistance as evidenced in the chronology at paragraph 14.0.

13.11 The main point of contact for Adult A and the lead agency for her case was Addaction. Addaction had regular contact with Adult A and they had attempted to co-ordinate agency response in this case. There were numerous multi agency meetings held in order to discuss Adult A’s case and action plans put into place to address her behaviour and the risks that she was exposed to.

13.12 Adult A’s ability to make informed decisions and manage her life in a non-chaotic way was diminished by her continued substance abuse. Despite being assessed by Health services Adult A was never diagnosed with a specific mental health diagnosis.

* 1. Adult A had attempted to take her own life on number of occasions (hanging, stepping out in front of a vehicle and standing on a cliff edge), although a number of these incidents were never officially reported to agencies at the time that they had occurred. Within agency records (Police, Addaction, Social Care, Health) risk assessments had been completed but again the level of risk posed at any one time would fluctuate wildly due to her drug and alcohol use. The highest risk identified by agencies was that to herself due to the amount and type of drugs that she was addicted to.
  2. Adult A sadly took her own life on the 18th November 2017. She was found hanging from a tree by a member of the public.
  3. On being notified of the circumstances of Adult A’s death her family raised concerns as to whether the death could have been the result of a third party. Police commenced an investigation and after due consideration of an alternative cause of death they concluded that there were no suspicious circumstances in relation to her death. A note which had been left by Adult A was discovered by the Police following her death but due to its content it was not classified as a suicide note.

14.0 Chronology

14.1 The original chronology date of 2011 had been set for this Review as this time span clearly evidenced her exposure to substance abuse, domestic abuse, impact on mental health and the risks associated with her chaotic lifestyle.

14.2 As the Review progressed additional information was sought by the Panel from the Police. The reason for including this extended history was that it highlighted Police interaction with Adult A in relation to domestic abuse incidents involving her previous partners. This information was deemed useful as it provided an insight into her early engagement with services and her knowledge of the support that was available to her in Cornwall.

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| **13.2.2009** DV Assault. Police attended home address of Adult A due to reports that Adult D had attempted to strangle Adult A on the bed. DASH risk assessments completed. |
| **23.02.2009** Adult D was arrested for the assault on Adult A which occurred on the 13/02/09. Adult D admitted arguing with Adult A and holding her down by the throat but stated that this was in self-defence as she had punched him first. Adult D believed that the baby was his. The relationship was described as volatile and concerns were raised about the unborn child. |
| **02.03.2009** Adult A attended hospital after stating that she had taken an unknown quantity of unknown pills with alcohol. Adult A left hospital prior to receiving treatment. Adult A was thirty one weeks pregnant. |
| *All relevant information shared with Social Care who advised that there will be a full pre-birth plan.* |
| **19.06.2009** Domestic Incident with Adult A and Adult D. Verbal argument ensued. Both were accusing each other of cheating in their relationship. DASH risk assessment completed. |
| **16.07.2009** Child protection case conference. Child A was unanimously identified as being at risk of neglect and in need of a child protection plan. |
| **25.08.2009** Domestic Incident where Adult A had returned home with Child A to find Adult D drunk. Both parties were given words of advice. 121A completed. DASH risk assessment completed and graded as medium risk. Adult A signposted by letter. |
| **21.09.2009** Adult A had returned home to find Adult D drunk. A verbal argument had ensued. Police were called as Adult A feared that he would become violent and Adult D was arrested. Both parties were perceived in drink. |
| **22.09.2009** Police called to a report of criminal damage. Adult D had attended the home address of Adult A perceived in drink and caused criminal damage. Adult A was not willing to cooperate and would not make a complaint. Adult D was released with no further action due to his name being on the tenancy and the damage was to his own property. |
| **02.10.2009** Adult A and Child A were placed in safe accommodation following her breakup with Adult D. Adult I strongly advised not to contact Adult A because of their past domestic violence issues and that any resumption of their relationship was likely to defeat the purpose of his licence period in terms of rehabilitation. |
| **13.10.2009** Child protection review conference held on Child A. Adult A was present as was Adult C. Conference decided that Child A should remain the subject of a plan and new agreement to be drawn up between Adult A and Social Care. Adult C stated that Adult I had made repeated phone calls and sent many letters to Adult A whilst he was in prison. He was described as controlling and obsessed. |
| **19.10.2009** Police records stated that Adult I did not have any non-contact condition that would cover Adult A or Child A, nor any exclusion condition as part of his licence. The records state that Probation were actively considering these issues. Adult A was the subject of a contract with Social Care that she would not have contact with Adult I in order to protect Adult A. Records state that if Adult A were to break this contract then Social Care had stated that the matter would be taken to court. |
| **12.11.2009** Police records state that Adult A was given a final warning regarding her daughter Child A. This has been given to her by Social Services. |
| **31.12.2009** Police Intelligence was submitted which stated that Adult A was believed to be having sex with a male in the public toilets in Truro. Whilst they were doing this Child A was left outside of the toilets, unattended in her pushchair. The male is known to Adult A from the past when he administered drugs to her. |
| *Adult A had reached such a low point in her life due to the abuse and exploitation that that she had suffered, that she was forced to resort to desperate acts in order to support her addictions. Her life choices were being severely impacted by the pressures that had been forced upon her through her life experiences.* |
| **01.12.2010** Children Services expressed concern for Child A as Adult A had started to drink again and she had also started a relationship with an ex-partner (Adult J) who was known in relation to drugs and domestic violence. The males’ details were not recorded. |
| *Various agencies have raised concerns for Child A’s welfare and the fact this violent man is living with them gave the greater cause for concern. These details were appropriately shared with other agencies to manage risk to Adult A and Child A.* |
| **17.12.2010** Police and a Social Care completed a joint visit to Adult F’s home. She had her granddaughter Child A with her. Adult A asked Adult F to babysit on the 14.12.2010 for two hours but Adult A had not returned to collect her daughter. Adult A had not responded to telephone calls and messages. |
| *A Child Protection conference unanimously agreed that Child A was at risk of neglect due to and should be subject to a child protection plan.* |
| **22.02.2011** Adult A was arrested for theft. A custody risk assessment was conducted which acknowledged that Adult A was under the influence of alcohol and documents that there was a belief that Adult A ‘would hurt herself in the cell’. Adult A was seen by a Health Care Professional (HCP) to ensure that she was fit to detain in custody. When the HCP saw her they deemed her fit to detain but did state they were unable to fully assess her mental health as she was so intoxicated. |
| **25.02.2011** Despite being on police bail Adult A was again arrested for theft. When being booked into police custody she appeared drunk. The custody risk assessment was conducted and when asked - Have you ever tried to harm yourself? Adult A stated that she “Cut wrist and face a few years ago-not suicidal anymore”. Adult A was also offered a referral to speak to an independent drug/alcohol referral scheme worker which she agreed to. |
| *This is the first recorded indication with the chronologies that Adult A has a history of self-harm.* |
| **28.02.2011** Adult A entered a local store with a male and stole two bottles of wine.  When being booked into custody she gave differing responses to the risk assessment questions- responding ‘No’ to ‘have you ever tried to harm yourself’. |
| **22.03.2011** A problem solving profile enquiry was created by the police to deal with Adult A and ongoing anti-social behaviour issues. The police neighbourhood team, Addaction, housing officers and the Council’s ASB team met to discuss the case. Concerns were raised regarding her relationship with Adult E. |
| **23.03.2011** Adult A was arrested for causing criminal damage. When Adult A was being booked into custody she was under the influence of alcohol. She completed a risk assessment and confirmed that she had an old cut to her breast which was possibly infected, she also stated that she was due to go rehabilitation but declined being referred to the independent drug/alcohol referral scheme worker. In custody Adult A was seen by a Health Care Professional who deemed her fit to detain. |
| **23.07.2011** Adult A was one of two females who had entered a shop and committed theft. |
| **23.08.2011** Adult A was arrested for the theft on the 27.07.2011. On this occasion when booked into custody and undertaking a risk assessment she stated that she was dependant on alcohol and would drink “every day, what she can get her hands on”. She declined being referred to the independent drug/alcohol referral scheme worker. A HCP was not requested during her detention on this occasion. |
| **16.10.2011** Adult A was arrested on suspicion of theft. When being booked into custody Adult A was searched and the searching officer located a wrap of heroin on her. During the booking in process Adult A disclosed that she was dyslexic and also stated that she suffered from mental health issues with paranoid schizophrenia, depression and anxiety. On this occasion she had a bruise under her left arm which she stated had occurred two weeks previously. Adult A also disclosed that she was under the influence of drugs and was using £40 of heroin a day and that she had been drinking large quantities of alcohol. Adult A stated she was undergoing treatment for her addictions and was seeing a drug and alcohol worker, CPN, social worker and a councillor. Adult A was seen by a HCP whilst in custody and she was deemed fit to detain. |
| **09.01.2012** Adult A had a verbal argument with Adult E. No offences disclosed but this was subjected to a DASH risk assessment. The initial assessment was medium risk but following review this was changed to high risk to reflect the concerns regarding her relationship with Adult E. Police referred the matter to an IDVA, made MARAC referral and disclosed the information to Children’s Services. |
| **18.01.2012**  Adult A and Adult E discussed at the Carrick MARAC- Police, IDVA, Housing, Mental Health Team, and Adults Social care, Localities, Addaction Health and Children’s Social Care represented at the meeting. From the information passed it was established that Adult A had moved to Plymouth on 16/01/2012. |
| **25.02.2012** Adult A was assaulted by Adult E at her sister’s address. Adult E had made off prior to Police attendance. Adult A reported that they had a verbal argument as Adult E thought she was sleeping with other men. He then grabbed her by the throat and pushed her back on the bed. Adult A had no injuries. Adult A made a statement to Police. This incident was the subject of a DASH risk assessment and was graded as medium risk. The crime was referred to PDAS (Plymouth Domestic Abuse Service). Plymouth Domestic Abuse Unit supported Adult A. The matter was referred to the Carrick IDVA and was raised with Carrick MARAC. Adult E was later interviewed and he denied assaulting Adult A. This matter was NFA’d due to a lack of evidence. |
| **16.04.2012** Adult A attended Addaction or her assessment and stated that she was pregnant and was due to see her GP to discuss an abortion. Adult A reported that she had not used heroin for three weeks but continued to drink a 75cl bottle of vodka daily. |
| **20.05.2012** Adult A was taken to A&E after she was found collapsed. She claimed she had injected Ketamine and on that occasion she smelt of alcohol. |
| **24.05.2012**- Adult A was assaulted by Adult E at her home address. Adult E was located at a nearby pub and arrested. The DASH assessment was high risk. Adult A did provide a statement but when Adult E was interviewed he denied the offence. An IDVA and MARAC referral were made. A warning was placed on her home address on the Police IT system. Cocoon watch was initiated with neighbours. Sanctuary and a Home office alarm were going to be discussed with Adult A for her home address when she returned (Alarm not fitted and Sanctuary not authorised as Adult A continually allowed Adult E[[5]](#footnote-5) into the property). Adult A was staying at her mother’s address so was safeguarded whilst she remained there. There were some issues in contacting Adult A on her safe contact number with calls not being accepted. |
| **25.05.2012** Adult A attended Addaction and advised them that she was using heroin 2- 6 days a week and that she would use 8mg Subutex when it was available. Adult A requested a prescription so that she could limit her contact with other drug users. Adult A stated that she was drinking vodka. Adult A was advised to see her GP as she reported that she had a seizure the previous week. Her presentation was discussed with her GP. |
| **29.05.2012** Adult A contacted Police stating that she wished to withdraw her statement against Adult E. Police considered this case for a victimless prosecution and the matter was referred to the Crown Prosecution Service (CPS) for a charging decision. Their decision was for no further action. |
| **12.06.2012** MARAC meeting. |
| **28.7.2012** Adult A attended ED with a fractured right upper arm claiming that she had fallen and could not remember the details. She stated that she had thought that she injected Subutex but then thought that it could have been ketamine. |
| **09.08.2012** Adult A attended Addaction requesting an increase in her prescription as she was buying illicit diazepam due to suffering withdrawal symptoms. On this occasion it was noted that Adult A had attended her GP to discuss health concerns. Support provided by Addaction case worker. |
| **23.08.2012** Adult A attended Addaction and stated that her current script was 8mg. She reiterated that she was not ready to reduce it yet. Adult A reported an alcohol intake of a large bottle of vodka most days. Appointment made for Adult A to attend to see her GP later that day. Adult A advised that she had a new partner, Adult I who was not a service user. |
| **28.08.2012** Adult A attended a medical review with a doctor at Addaction. He recorded that Adult A had had contact with addiction services in Cornwall since she was fourteen. Adult A stated that her mother was a drinker who used to invite lots of homeless people back to their home. Adult A advised that she herself developed a pattern of regular heavy drinking from the age of twelve or thirteen and as her result was placed into foster care with her older sisters. Adult A reported drinking vodka, up to one litre a day depending on her finances. Adult A also reported injecting Subutex that she had bought off the street (possibly from her current boyfriend) and she felt that if her prescription was increased (consumption of which was supervised) this could stop. Adult A complained of paranoia and a sense that she is constantly being watched or followed and advised that she often heard voices talking to her. |
| **30.08.2012** Adult A was arrested for being drunk and disorderly The custody risk assessment documented the fact she was dyslexic, was working with Addaction and that she was taking Subutex. The assessment also stated that she was suffering mental health issues and that she was hearing voices. Adult A did not see a HCP during the period of her detention. |
| **27.09.2012** Adult A attended Addaction. Adult A stated that she was buying extra Subutex on top of her script (an extra 8mg daily)and was injecting this. The doctor who was in attendance agreed to increase her script to 16mg daily. Adult A admitted to stopping alcohol consumption ten days previously by buying diazepam. Adult A stated that her new boyfriend was not a drug user and the she was waiting to hear from Cornwall College about starting a course. A discussion ensued regarding Child A. Adult A requested that she be tested twice weekly to prove to her sister that she was not using street drugs. |
| *Adult A had attended a media course at Cornwall College in 2009/10. There was no other information that she had applied for or attended other courses in after 2010.* |
| **15.02.2013** Domestic incident reported to the Police. An argument had ensued with an ex-boyfriend (details not recorded) over money. No offences were disclosed. The DASH was declined by Adult A and reporting officer assessed the risk as STANDARD. |
| **15.03.2013** Email correspondence between a doctor and the Addaction case worker. The doctor advised that he considered Adult A to be high risk and vulnerable at present and that he would like Adult A to have a swab prior to her medical and If this showed positive signs for heroin that her script be increased to 16mg. |
| **11.07.2013** Adult A presented at Addaction to see her keyworker and stated that she was using illegal substances and she showed her recent track marks. Adult A requested a 30-40mg methadone script. Adult A stated she was not using her Subutex and admitted secreting it under her tongue and "palming it off ". Adult A stated that she was using around £80 of heroin daily and was in a relationship with a dealer. Adult A’s keyworker agreed to contact an appropriate doctor to see whether she could obtain a methadone script as a harm minimisation strategy to reduce her using and overdose risk. They discussed harm minimisation and completed a risk assessment exploring risk of accidental overdose and maintaining clean works. |
| **25.10.2013** The Addaction keyworker had a session with Adult A and she advised him that she had used once in the last week. The two of them discussed the reason why she had used. Discussed SIDS (seemingly irrelevant decisions) with Adult A and lapse prevention. Adult A expressed fears that her recent stability would be affected by a former partner exiting prison. Adult A was able to recognise that whilst he provided protection and love, he was unreliable and a relationship with him could end in death, street working and street homelessness. Adult A was challenged on her concepts of love and in particular difficulties giving up on former relationship and experiencing the loss associated with a relationship ending. |
| **09.01.2014** Adult A attended her keyworker session and she acknowledged using three times per week. Again discussions were had around harm minimisation with Adult A. She agreed that she was currently not motivated to stop using. She described her motivation as being around three out of ten. Adult A’s keyworker agreed to see her on a monthly basis unless she requested to be seen earlier. |
| **04.02.2014** Addaction keyworker saw Adult A and she advised that she was using between £35 and £70 of heroin daily. She also reported using quetiapine, an anti-psychotic and alcohol. Adult A reported that her sister had died in a car crash and that her family situation had deteriorated. The Addaction keyworker noted that Adult A looked in a poor physical state with blotchy skin. They reiterated to Adult A that she presents as extremely high risk and that the possibility of overdose was very high given her use of alcohol, heroin and benzodiazepines. Adult A was reminded that heroin was strong at present and to use small amounts initially as a precautionary measure. Concern was expressed to Adult A that she may become a fatality given her "blaze " attitude to mixing substances. She was also challenged on her idea that experienced users don't overdose and it was suggested that if she was intent on using, to use only one substance at a time. |
| **14.11.2014** The Non-Medical Prescribing (NMP) nurse agreed to see Adult A despite her late attendance at a meeting. They advised Adult A of the need for regular medical reviews. Adult A stated that she had cut down her heroin use from £70 daily four weeks ago to £10 daily currently. They discussed her current methadone prescription and agreed to increase it to a 60ml consumption daily. Adult A stated that she wanted to work towards interval prescribing. Adult A stated that she had been treated for depression in the past, last time when drinking approximately one and a half years ago. Adult A wanted to explore options to have a busier life e.g. day care with Addaction and potential voluntary work. The NMP provided her with the phone number of K9 crusaders[[6]](#footnote-6) as she wanted to be involved with animals. |
| **02.12.2014** Adult A spoke with her Addaction keyworker who had arranged for Adult A and her partner to get debt support through the life-skills team[[7]](#footnote-7) on 09.12.2014. |
| **01.02.2015** Adult A and Adult D had a domestic incident. Neither party was deemed to be under the influence of alcohol or drugs. Adult D woke Adult A and accused her of cheating on him, and he had then spat in in Adult A’s face and punched her. Adult A had no visible injury. Police attended and arrested Adult D. Adult A provided a statement but would not support any court action. Adult A co-operated with the DASH process which was graded as medium risk. In the assessment Adult A stated that both of them were prescribed Methadone and both used Heroin. She added that they had money issues. Adult A was spoken to after the interview and reiterated her wish not to support a prosecution. She stated that she would not support a DVPN (domestic violence prevention order) if Police applied for one and wanted Adult D to return to his home address. Adult A she did not feel an IDVA was needed. The matter was NFA’d by Police due to the lack of evidence. |
| **12.02.2015** Adult A attended Addaction and it was reported that she and her partner demonstrated a change in their motivation at the time. Adult A had requested a referral to Resource[[8]](#footnote-8) in Bodmin, which her keyworker agreed to organise. Adult A planned to attempt a further week of abstinence from heroin. |
| **10.05.2015** Adult A had become concerned about her boyfriend Adult D and his mental health and behaviour. Although no domestic incident had occurred she stated that he had started to pace around the house and had started to punch the wall. Adult A stated that this concerned her and that he had been for a MH assessment but had walked out several times and knows what to say. Adult A stated that Adult D does have the occasional heroin hit but he can go for days without taking any. |
| **26.05.2015** Adult A attended the Addaction office requesting an urgent call from her keyworker as she wanted to be linked in with a counsellor. The duty worker noted that Adult A then had an animated and agitated conversation in in the foyer with a male (possibly Adult G) on the phone, expressing suicidal ideas and that she then left the building to meet up with the male. Keyworker was updated.Attempts were made by the key worker to contact Adult A. An appointment was made to provide support but Adult A did not attend. |
| **19.08.2015** Adult A attended Addaction to see her keyworker. The keyworker reported that Adult A was looking a lot better than at the last appointment and that she had gained 1/2 stone in weight. Adult A stated that was using Crack seven days per week and heroin four days per week. Adult A disclosed that her debt problems were spiralling out of control and was informed that she would again be referred to life skills for group support. Adult A advised that she was psychologically well at that time and when asked about reduction or detox she stated that she was happy with using on top of script at present. Advice given and appointments made. |
| *The keyworker set up a meeting with Life Skills to enable Adult A to get advice regarding her debts. Adult A did not attend.* |
| **23.09.2015** Intelligence received from the police stating that ‘a male like to give girls a slap and make them do sexual favours for heroin or crack’. It was alleged that he had some videos on his phone showing girls doing sexual acts for drugs. Adult A was been named as a possible victim. No other details were known. |
| **28.09.15** Addaction spoke to Adult A. At that time she stated that she was not drinking alcohol and that her physical and mental health was good. They discussed sexual health and advice was given. Adult A was clear that she enjoyed using heroin and crack and that she did not want to stop at this time. She stated that she valued a methadone prescription however she was not interested in any other recovery focussed work such as groups or voluntary work. The NMP outlined his concerns regarding her safety given her current drug taking behaviour and noted that she appeared complacent about the risks to her long term health and potential risk of overdose and death. They discussed a referral to Boswyns for detoxification, however Adult A acknowledged that this previous conversation was as a result of external pressure from her mother and that she currently had no desire to explore this treatment option. The plan at this stage was for Adult A to be maintained on her methadone script for harm minimisation, for her to keep engaging in her keyworker sessions and for her to be reviewed by the NMP in 3 months’ time. |
| **07.10.2015** Report received by Addaction from Devon and Cornwall Housing to advise Adult A’s keyworker that a safeguarding alert had been made for Adult A. Housing believed that Adult A was experiencing physical, financial and emotional abuse from her partner who was known to the service and wondered if Addaction had seen any evidence of this. Adult A’s Addaction worker informed DCH that they had not seen anything evidence of this and their main concern related to her substance misuse. Adult A’s mother had informed the DCH keyworker that she had been receiving money from an elderly gentleman on a regular basis, which was feeding her dependent needs. Safeguarding concern raised to Adult Social Care. |
| *This matter was raised with Adult A as part of a review with Addaction which shows good evidence of information sharing and effective follow up.* |
| **09.10.2015** Adult Protection strategy discussion/meeting. Adult Social Care took no further action at that time due to services already engaging with Adult A. |
| **08.01.2016** Addaction keyworker discussed Adult A and the text received from her mother at the team meeting. Adult A’s mother had text that she did not feel that Adult A would be going to a detox as she had fooled everybody and that she was using heavily and was in the company of a dealer (Adult B). Her mother stated that Adult A was a good liar and wanted nothing more to do with her as she had made her ill. Adult A’s keyworker was advised to place her script on hold from 15/01 if her appointment was not attended. |
| **11.01.2016**Addaction keyworker contacted the NMP and advised that Adult A’s script would remain on hold as she had not collected since the previous week. He messaged Adult A stating that the script will be put on hold until she saw a prescriber. Duty appointment offered to Adult A via pharmacist. |
| *Adult A was spoken to later that same day and the above was explained to her. It was recorded that she was incoherent throughout the conversation.* |
| **14.01.2016** - Intelligence received that Adult A is in a relationship with Adult B. It was reported that she had recently tried to leave him but when they got back together he had threatened her with violence should she try to leave him again. It was also reported that Adult A would carry drugs for Adult B but that that she didn’t not want to do it. |
| **21.01.2016** - Intelligence received by Police stating that Adult A was in a controlling relationship with Adult B and that he would give her lots of heroin ‘to keep her’ and to ensure that she would not leave him. |
| **05.02.2016** Intelligence received by Police stating that Adult B was looking for Adult A as she has stolen a large amount of heroin from him and he was not happy about it. The report stated that Adult B has the potential for violence and there were concerns that Adult A would be assaulted. Intelligence also stated that a group of drug dealers were operating from Adult A’s home address and that she was being forced to let them stay as she owed them a drug debt and they were pressurising. |
| **29.02.2016** Addaction manager reviewed the case and liaised Adult A’s keyworker. The manager encouraged them to further engage her in treatment and that closure was not appropriate at that time given her risks and vulnerabilities. |
| **22.04.2016**  A ViST was submitted in relation to Adult A’s current situation and highlighting her being vulnerable and exploited by drug gangs. The ViST was assessed by CST[[9]](#footnote-9) who did not disseminate the information due to their being no consent to share. Adult A was one of a number of people identified as being vulnerable and who was at significant risk from the group. This decision was raised to Police management who reviewed the ‘non consent issue’ and difficulties of the management of this information. It was deemed that there was sufficient risk to share a sanitised version of the information with multi agencies. Under the Safer Cornwall Partnership, the information was shared at a meeting of the ‘Serious Organised Crime Group’ for the purposes of devising safeguarding plans for the individuals. |
| *The dissemination of this information was good practice and demonstrates that quality assurance practices within Police safeguarding are robust.* |
| **14.07.2016**  Intelligence received by Police that Adult A was being given a lot of drugs from her partner Adult B to use. Concerns were raised that her health and wellbeing was deteriorating and that she was suffering with psychosis. |
| **28.07.2016** Intelligence received by Police stating that Adult A and Adult B are back in a relationship. It was reported that Adult A was using lots of drugs and was becoming more and more paranoid. Adult A apparently wanted to leave Adult B but because the drugs are so readily available she was reluctant to leave him and was vulnerable for this reason. |
| **13.10.2016** Adult A taken to RCHT by ambulance. She was seen by Psychiatric Liaison Service for an assessment. The assessment included a disclosure of domestic abuse, fear and sexual assault. No mental health issues were found. |
| **13.10.2016** Adult A found in road by a member of the public. She was having suicidal thoughts and delusions. Adult A was seen by CFT psych team who didn’t find any acute mental illness. There was no disclosure of domestic abuse. Adult A’s abusive ex-boyfriend was noted in the psych notes. The CFT nurse gave Adult A IDVA information. |
| **14.10.2016**Adult attended the Integrated Community Mental Health Team (ICMHT), although an appointment had not been made. It was believed that she attended in an attempt to obtain safety. It appeared that Adult A was withdrawing from heroin. Adult A was distressed and said she needed sectioning. She described a risk of "cutting" her wrists but this was reported in her notes as being said in an impulsive manner in an attempt to gain an admission to hospital. She was lying on the floor in a tearful state and appeared confused and describing people being "out to kill her". Adult A described on- going subjective psychotic symptoms. The way she described them indicated that she was insightful that they were related to her mental state and appeared to be said in an attempt to obtain safety with her situation. She did not appear distracted and the staff were of the view that she appeared to have capacity to understand the options posed to her. Adult A was advised there was little that could be done from the ICMHT office and encouraged to re-engage with Addaction and consider an urgent detox. Adult A did not disclose domestic abuse on this occasion nor was she asked about this. |
| **22.10.2016** As the Addaction duty workers were unable to reach Adult A or her mother a concern for welfare was raised to Police. Advised they would conduct a welfare check. |
| **07.11.2016** Adult A attended an appointment with her Addaction keyworker and advised that she was experiencing hallucinations and delusions and was at times confused about where she was and that this had led to her hospital admission three weeks before. Adult A was reluctant to talk about the disclosures of domestic abuse as her partner was outside of the window. Adult A declined domestic abuse support stating that the violence had been a one of incident. Adult A stated that she was using illicit Subutex and a urine screen showed positive for Benzodiazepine, Opiates, Methadone, Cocaine, Buprenorphine and Cannabis. Adult A was provided with harm reduction and overdose prevention advice. Adult A again requested an opiate substitute prescription. |
| **28.11.2016** Adult A presented at Addaction with her partner and was tearful and emotional. She stated that she was hearing voices and had presented as paranoid. Adult A stated that she wanted to go to a psychiatric hospital before she ended up killing herself. Her partner then ushered her out of the building and stated that they would return. Following this exchange Adult A’s keyworker contacted her GP and advised of his concerns for her wellbeing and the request that she had made to be sectioned. The GP directed her to use the duty doctor should she need immediate support, which she was advised of when she returned to the office later that day. Adult A was noted to be presenting better and with a more positive attitude on her return to the office. |
| **10.12.2016** Adult A was taken to ED due to concerns about her behaviour and that that she might have had drug induced psychosis. Adult A was shouting and paranoid. Adult A was seen by CFT psychiatric team. No evidence of acute mental illness. |
| **11.12. 2016** Adult taken to RCHT by one of her sisters as they were concerned for her welfare. Seen by Psychiatric Liaison Service. Adult A was assessed regarding her mental health. It was noted that her primary presentation was substance misuse. Adult A’s sister disclosed she had attempted to strangle herself the previous night. A routine enquiry identified domestic abuse but no further details recorded. No evidence of mental illness was found. There was no consideration of discussing any concerns with Adult Safeguarding Services at this contact (discussed later in this report). |
| **12.12.2016** Liaison Psychiatry Service Royal Cornwall Hospital - The Addaction SPOC informed Adult A’s keyworker that a letter had been uploaded to her record. The letter detailed that following a recent hospital admission that they had assessed Adult A as a high risk to self through low mood and substance use and as a high risk from her partner due to the domestic violence that had been disclosed. |
| **27.12.2016**  Adult A was seen by Police walking on the side of a road. She was crying and very upset. Police stopped and assisted Adult A. At that time she was under the influence of drugs and was convinced that she was being watched by people. Adult A was taken to hospital. The officer remained with her at hospital and she calmed down. Whilst waiting for the doctor the officer saw a text message whilst Adult A was sending it to Adult B.  Adult B- ‘sorry I am no good at sex’. Adult A- ‘I was crying my eyes out this morning and you still carried on. Why have you put cameras in my house? I am a decent person why would you want to watch me. I don’t deserve to be treated like that’. Nothing else was disclosed and no crimes were reported by Adult A. |
| *No cameras were ever found in Adult A’s house.* |
| **04.01.2017** Adult A attended Addaction. Adult A persisted that a script would really help with her heroin use and she was booked in for a medical review on 06/012017. Adult A stated that she was still experiencing paranoia and hearing voices but not as much. Her keyworker enquired about her recent hospital visits and she stated that she was depressed then but feeling better now. She also stated that her sister was interfering. Adult A reported no physical health issues and that she was eating however she appeared to be looking pale and thin. |
| **10.01.2017** Adult A was reviewed by a doctor at Addaction. He noted that she had been difficult to engage in recent months, and there had been concerns expressed about her well-being and her risk of exploitation. At that time she was clearly under the influence of alcohol. The doctor recorded that Adult A was wearing a tatty dressing gown and was incoherent and disinhibited, and made frequent lewd and suggestive comments. The recorded that her lower arms were covered in injection sites and she said, 'I'm using crack alcohol and gear'. 'I want a script. I've got to stop selling myself for crack and gear'.  She reported that she was supposedly living in a tent in the middle of Truro. Adult A still referred to Adult B as her boyfriend: 'I only see him for what I can get out of him'. 'He always comes back for more'. He observed that they seem to have a dysfunctional and abusive relationship. The doctor stated that it was impossible to complete a meaningful assessment and that she should be prioritised for treatment. |
| **12.01.2017** Adult A attended Addaction and stated that she was "clucking". She appeared calm and collected and requested drug screen and opiate prescription. She stated that "I can't carry on like this, I need a script". Addaction tested her and provided appropriate drugs. They discussed presentations at A & E and Adult A said that she had a diagnosis of paranoid schizophrenia for which she had previously received support but not at present. She said that when she was unwell and had taken drugs that she had said things that were not true. When asked if she ever felt at risk from Adult B she stated that "It's not a problem, it's me". She stated that she was currently living at her own address.  They discussed her script and the requirement for regular check-ups. Adult A was asked to attend the day programme and joined the group. |
| **16.01.2017** A local pharmacy contacted Adult A’s keyworker and stated that Adult A had picked up her script in her partner’s presence but did not consume all of dose. The pharmacist stated that they had concerns that she had been coerced into doing this by Adult B. Adult A would apparently take medication behind a screen and on one occasion Adult B was present. |
| **18.01.2017** Telephone call from adult mental health out of hours service to Adult B after he had left a message about Adult A. Adult B was concerned as Adult A was hearing voices, talking to herself, had tried to pour a kettle of hot water on herself and the previous week she had tried to jump in front of a lorry. He reported that she needed help. Out of hours service was unable to undertake an assessment that evening. Adult A was advised to refer Adult A to Carrick ICMHT or take Adult to the local hospital. There was no consideration of discussing any concerns with Adult safeguarding services at this contact. |
| **25.01.2017** Adult A was taken to RCHT (A&E) by a member of the public and seen by the Psychiatric Liaison Service for an assessment as she was hearing voices. She was offered Samaritans call back telephone support which she declined. Self-harm advice and mental health helpline telephone numbers provided. There was no evidence of hearing voices during her stay. A domestic abuse routine enquiry was made but there were no disclosures. Adult A left hospital before being discharged. There was no evidence of mental illness found. Her clinical risk was re-assessed and rated as high with high risks of risk to self and risk from others, with these risks recorded as emotional/psychological abuse, neglect, physical harm and sexual exploitation. It was noted that her only protective factor for her risk was that she was engaged with Addaction as she stated there was no contact with family. There was no consideration of discussing any concerns with Adult safeguarding services at this contact. |
| **25.01.2017** Adult A was found by a member of the public exhibiting bizarre behaviour and had slurred speech. Adult A was admitted for assessment by CFT psychiatric services who saw her on the 26.1.2017. There were no records of disclosure of domestic abuse. The case was referred back to Addaction worker. Adult A accepted a REACH leaflet. |
| **26.01.2017** Adult A attended Addaction. Adult A stated that she continued to hear voices "slagging her off" and also claimed to be seeing shadows and doors opening and nobody being there. Her worker queried her sleep pattern and she stated that it was good. She advised that she was also eating well. |
| **26.01.2017** Adult A attended RCHT and requested to see the Psychiatric Liaison Service. Adult A left prior to being seen. |
| **31.01.2017** Adult A attended the Addaction office . A discussion took place in regard to DV from her partner and she advised that they were no longer together. She was booked in for a medical review. Adult A was informed that her case worker would be submitting a MARAC referral and that she would be seen by an IDVA so that a DASH risk assessment could be completed. It was also recorded that a multi-agency approach was required to safeguard Adult A against the violence from her partner. Adult A was provided with a mobile phone so that contact could be maintained at this high risk time. The Addaction worker also discussed a possible detox for a two week stabilisation and stated that they would liaise with the housing team to identify ways to keep her safe. All of this was actioned. |
| **31.01.2017** Adult A was assaulted by an unknown male. Police were called by a neighbour who saw an unknown male grab Adult A around the throat in the front garden of her address. When Police attended Adult A would not give details of the incident. At the address was Adult D who stated that he had just arrived. Adult A stated that she was happy for him to stay. Police asked him to leave which he agreed to. No further action was taken in relation to this report. DASH completed. |
| **01.02.2017** Adult A attended RCHT and was seen by the Psychiatric Liaison Service who conducted a mental health assessment following self-harm. On this occasion there was some evidence of psychosis. Adult described experiencing distressing visions including;  - visions of shadows which belong to people that she can’t see.  - seeing her daughter and her dog decapitated and carrying her dog in a blanket in this state.  - her mother with her eyes gouged out.  - her sixteen year old niece allegedly saying that she might be dead.  - her TV changing pictures and seeing her family in various states and then in coffins.  - black figures with glowing eyes that she has tried to confront  - cameras in her house watching her  - her daughter being in a car at a petrol station and then disappearing.  - hearing a woman’s voice (3rd person), it had been derogatory in nature but not threatening or commanding.  Adult A had gone to the hospital with a stab wound to abdomen which she claimed was self-inflicted. Adult A agreed to a hospital admission and became an informal mental health inpatient at Longreach. During this assessment Adult A stated that she was is in a relationship with Adult B and also sees an ex-partner Adult D. Adult A disclosed abuse from her previous partner and stated that he had been physically and emotionally abusive to her in the past, but again denied that he had harmed her on this occasion. Adult A denied being abused by her current partner and claimed that Adult D had been in her house that day. She also disclosed other recent attempts to end her life and stated that she had felt suicidal due to her experiences and had considered jumping in front of a train/lorry and taking a large overdose of heroin. Those carrying out the assessment noted that she was not taking care of herself – dishevelled and thin. There was no record of any further discussion regarding these observations (indicative of self-neglect which will be discussed later in this report). Adult A also expressed concerns regarding the safety of members of her family. Adult A asked to leave prior to her transfer to the mental health inpatient unit. Adult A absconded from hospital but was returned by one of her sisters. Those carrying out the assessment were fully aware of Police and Addaction involvement. |
| **01.02.2017** Misuse of Drugs Act warrant executed at Adult A’s home address. Police attended the hospital to speak to Adult A in the presence of the IDVA. Adult A spoke about her relationship with her current boyfriend Adult B and she stated that she was fine and loved him. Adult A also stated that it was a good relationship, that he was lovely and that she was happy. Adult A stated that Adult B treated her to get her hair done and other ‘stuff’. Adult A stated that she was missing him and was worried about him as he was in custody. Adult A was asked what her plans where when she was released from Longreach and she said she was going straight back to Adult B . She stated that she only wanted to be with him. The police officer asked if it was a safe relationship to return to and Adult A stated that it was. Adult A was advised to engage with the IDVA. Adult A reiterated that there was no violence on going in this relationship other than shouting sometimes. When asked about her injury she said that she had stabbed herself when she was at home alone and then walked to the shop where she was found and then taken to hospital. There was good interaction between Addaction, Police and the hospital staff and all were encouraging her to report abuse. Safety planning was initiated and discussed with Adult A and she was also listed for MARAC. A DV victim management enquiry was also raised to record the safety planning and contact with Adult A. (This enquiry details her discharge from Longreach and the fact that a lack of effective planning of this event had prevented further safety measures being put into place). |
| **02.02.2017** Adult A was admitted as inpatient to Longreach House, Redruth. Adult A described experiencing distressing visions and voices some around family members including her daughter. Staff stated that it was difficult to obtain a comprehensive history from Adult A. Adult A described that she no longer wanted to end her life. Adult visited by her Addaction worker and her mother.  Those treating her stated that it is unclear how much of Adult A’s symptoms were related to her drug use and that they had not started any antipsychotic medication due to the fact that substance misuse seemed to ‘cloud these symptoms’. They further stated that the paranoia and psychotic symptoms appeared to be associated with withdrawal from heroin and when intoxicated with crack cocaine. No signs of mental disorder were observed during Adult A’s admission.  Adult A reported that she had not been well for the past year and that she had sought help, but no one would help her. She stated that she had been advised to go to Addaction but she did not think that they were helpful. Rehabilitation was discussed with Adult A, but it was not something that she wanted to do at that point.  Adult A described her relationship with her partner as up and down and that he would sometimes stay with her. During her admission the ward had contact with Adult A’s Addaction worker and the Addaction’s psychiatrist. Naloxone Hydrochloride was provided from Addaction to give to Adult A should she decide to leave the hospital.  On 03.02.2017, Adult A requested to leave the hospital. Her request, clinical presentation and capacity to make informed decisions were discussed at a ward review at which her Addaction worker was present. It was noted that she remained at high risk of placing herself in vulnerable situations and impulsively causing self- harm when in an emotional crisis. Whilst there was no evidence of psychosis during her stay in hospital Adult A she did complain of previously hearing voices and the ward consultant having spoken to the consultant at Addaction recorded – ‘Unclear if has psychosis and if should be on medication for psychosis. Definitely blips into psychosis’  A discussion around remaining on the ward over the weekend took place – but this was not what Adult A wanted. She appeared to both CFT staff and her Addaction worker to have capacity to understand the consequences of her actions. As there were no current signs of a mental disorder, Adult A was discharged and no follow up from psychiatry was felt to be warranted, although the Trust’s Home Treatment Team were tasked with the one week follow up, which is standard policy for discharged in-patients (this team were unable to make contact with Adult A over this time and on 8 February made a request to her Addaction worker to ask Adult A to make contact with the home treatment team).  The ward consultant advised her GP and Addaction that whilst no psychiatric follow up was warranted, the patient might benefit from a trial of a low dose of a prophylactic non-sedating anti-psychotic such as Aripiprazole via a discharge letter. No reference to any history of domestic abuse was contained within this letter to external agencies.  Addaction had raised concerns about the lack of an effective discharge plan on this occasion. |
| *Whilst there was good evidence of multi-agency interaction during her admission to Longreach this was not reflected in the discharge planning. This will be discussed in the Analysis section of this report.* |
| **05.02.2017** Adult A turned up a friend's address with head injuries stating that she had been hit by a car. Ambulance were called and they notified the Police who attended and they received a number of different accounts from Adult A. Adult A admitted to taking crack cocaine. Adult A was taken to hospital for treatment. When Adult A arrived at the hospital she then disappeared prompting further enquiries to locate her and check on her welfare.  Police eventually saw Adult A the following day at her mother’s address. When she was spoken too her mother disclosed that she had been assaulted by Adult B whilst at his home address. It was reported that Adult A and Adult B had an argument which resulted in Adult B punching her to the face and head. Her hair was also caught on fire causing it to melt. A crime was recorded due to a third party report made by Adult A’s mother. Adult A was spoken too and did not wish to make a complaint or support police action. A high risk DASH was submitted. This was reviewed by a supervisor who considered the evidence and the value of taking action without the consent of Adult A. This supervisor was concerned that any progression of the crime without Adult A’s consent could alienate and potentially increase the risk to her. The matter was referred to a specialist domestic abuse officer. |
| **06.02.2017** The CFT Home Treatment team made four attempts to contact Adult A but there was no answer from her. Addaction were asked if they could inform Adult A to contact the Home Treatment Team . |
| **07.02.2017** An entry was made by Adult A’s domestic abuse officer in Police records. That officer reiterated their disappointment regarding the lack of any discussion about Adult A’s release from Longreach in respect of safety planning. The officer tried to speak to Adult A but was unable to contact her. The officer instead spoke to Adult C. Safety planning was discussed with Adult C. Adult C had concerns for Adult A in that she might return to her home address and that she wouldn’t be safe there. Adult C stated that Adult B was a dangerous person and that she was worried for Adult A as she kept saying that she still loved him. The officer then called and spoke to Addaction who were with Adult A. The Addaction worker asked Adult A to talk to the officer and they could hear her saying "No I don't want to talk to police". The officer asked the Addaction worker to put the call on loud speaker and they explained to Adult A that they wanted to ensure that she was safe and to provide her with some safety advice. Adult A stated she was safe she didn't want to talk to the officer. She also stated that she was fed up of people calling her and had spoken to too many people. Addaction had to intervene as Adult A was scratching her face and the call needed to end. The officer then spoke to Addaction once Adult A had left and they asked for all available information. Information was freely exchanged between the agencies. Addaction had liaised with the Council and had arranged for the keys to be changed at her property. |
| **07.02.2017** Adult A referred to Carrick ICMHT by Addaction. Adult A had attempted to jump in front of a moving vehicle. The referral was discussed with Addaction and as there was no evidence of psychosis when she had previously been an in-patient the matter was discharged. |
| *There is information recorded by PLS and the admitting doctor after the PLS assessment which would appear to raise the question whether the psychotic symptoms were present outside of drug use*. *Consideration of whether Adult A suffered from psychosis outside of that induced by substance misuse does not appear to have been considered in response to this referral. The CFT IMR has concluded that this may have been a missed opportunity to try and engage and make an assessment.* |
| **08.02.2017** A joint visit was conducted by IDVA and Addaction. Adult A did not want to discuss domestic abuse. Adult A was experiencing hallucinations and was concerned about getting her prescription. The IDVA found it difficult to complete a risk assessment. Adult A agreed to further IDVA contact at a later date. |
| **12.02.2017** Adult A came to police attention on two separate occasions. The first occasion was a report of a burglary when Adult A was suspected of being one of three offenders who entered a house and stole items from that address. Adult A had then attended Adult C’s address and was aggressive towards her. Adult C felt that Adult A was hallucinating. Adult A had then assaulted Adult C by punching and slapping her. The DASH assessment was graded as medium risk. Adult A was arrested at Adult C’s home address and taken into police custody. When in custody Adult A was the subject of a risk assessment and arrangements put into place for her to be seen by a HCP. Adult A did not want to be seen or be examined. Adult A was eventually seen by the HCP and was even spoken to by the Liaison and Diversion Nurse. A full mental health assessment was made and a decision was taken to refer to the Early Intervention (Psychosis) team (EIT). Excessive alcohol intake over recent days was noted. A routine enquiry into domestic abuse was made but Adult A didn’t disclose any. The L& D nurse noted the presence of abuse from earlier records. Adult A denied that she was in a relationship and denied she was at risk from others.  Adult A stated that the trigger to her excessive drinking is her “head” but she stated that she found it difficult to explain what is going on. She repeatedly talked about concerns for her mother’s welfare, but she was unable to be more specific. When she was questioned further about this Adult A stated that her mother was fit and well, despite having crumbling bone disease. Each time that Adult A spoke about her mother she would become tearful. Adult A reported that she had been hearing voices for a few months. Adult A stated that she has heard various voices, including the voice of her daughter on one occasion. Adult A found it difficult to articulate what the voices were saying or explain where they were coming from. Adult A became quite evasive when this was explored further. The nurse was however able to elicit that Adult A heard them all the time and that they did not tell her to harm herself. On this occasion Adult A denied current thoughts of self-harm or of taking her own life, but it was acknowledged that she was prone to impulsive behaviour. The nurse concluded that although presenting with some possible psychotic symptoms, they were not of a nature or degree to be affecting her capacity or understanding of the legal process. The nurse advised custody staff that Adult A and was mentally vulnerable so an appropriate adult[[10]](#footnote-10) was called. The L&D nurse also devised a pre-release plan for Adult A on the custody record. The plan highlighted ensuring that Adult A was released into the care of friends/relative and that there were follow up appointments with Addaction & L&D and her GP. Adult A was in agreement with the plan. Following investigation Adult A was charged with Assault and given conditional bail to appear at Court. |
| **13.02.2017** Police intelligence stated that Adult A felt imprisoned in her relationship with Adult B and that the stab wound in the area of her abdomen had been was caused by him. |
| **14.02.2017** Police intelligence record concerns for the welfare of Adult A. It was suspected that Adult B was injecting her with heroin in order to make sure that she stayed addicted and remained with him. Adult A was staying with Adult B at his home address at that time. |
| **17.02.2017** Early Intervention (Psychosis) Team reviewed the referral from Liaison and Diversion Service. Adult A did not meet criteria for the team. |
| **17.7.2017** Adult A was seen at RCHT by Psychiatric Liaison Service. The records state that there was evidence of self-neglect (thin, pale and unkempt), and following disclosure from Adult A abuse from others (domestic abuse from partner). The records state that Adult A was now sleeping rough in a Truro car park with other homeless persons due to the domestic abuse from her partner. The plan was for Adult A to have a detox bed, organised by Addaction, once one was available. The information regarding this event was shared with Addaction and was incorporated into a referral to the Local Authority’s (LA) Adult Safeguarding Service on 20.02. 2017. An additional referral by PLS for self-neglect was made to the hospital’s medical team to enable Adult A to remain on the hospital site for slightly longer. |
| **18.02.2017** Adult absconded from RCHT. Attempts were made by Adult Psychiatric Liaison staff to contact Adult A and her sister to check on her welfare. |
| **20.02.2017** Addaction records show that they received an email from the RCTH which stated that there was no confirmed rehabilitation bed for Adult A. The psychiatric liaison team felt that Adult A had mental capacity and did not have an acute mental health problem. They also stated that there was no reason to recall her to hospital or prevent self-discharge. RCHT advised that they would complete a MARU referral due to concerns around domestic violence, frequent attendances, homelessness, drug use, self-neglect, self-harm and psychosis. Addaction stated that the plan was for Adult A to be spoken to about rehab once she was in a position to have that conversation (not intoxicated, under the influence or psychotic). Once this was done Addaction stated that they would explore opportunities for a fast-track bed once one become available. It was however noted at that time that Adult A had consistently declined rehab in the past. Addaction also stated that they were going to arrange a professionals meeting. |
| **21.02.2017** Safeguarding concern raised to Adult Social Care by RCHT due to lifestyle, drug use and Adult A living in a car park. |
| **22.02.2017** Adult Protection strategy/ discussion held by Adult Social Care. A decision was made to take no further action under safeguarding process due to other agencies supporting Adult A. Adult Social Care felt that nothing further could be gained through their processes that was not already being provided to Adult A. Adult A had returned home and was engaging with services at that time. A community social worker was involved through the multi-agency working that was taking place. |
| **05.03.2017** Mental health out of hours service spoke with Adult A after being called by Police. Adult A had presented at a police station and wished to talk to someone regarding her mental health. Adult had stated that she had tried to throw herself off a cliff earlier that evening. Although a full assessment (mental health or clinical risk) did not take place, information was gathered through this contact. Adult A gave short answers to questions and did not give specific detail. Adult A said that she was no longer suicidal and then assured professionals that she had a safe place to go too that evening. Adult A was advised of the forthcoming multi-agency meeting that had been set up regarding concerns about her wellbeing and safety. Adult A was then signposted to other agencies and advised to make a GP appointment. When asked about the detox that she had been offered she said clearly she did not want to engage. Adult A was also encouraged to contact her Addaction worker.  Police questioned if Adult A should be open to iCMHT and a discussion ensued regarding what mental health services could offer when the primary issue that Adult A was presenting with was drug use. The outcome of contact was for information to be passed to CJLDS[[11]](#footnote-11) team in anticipation of their attendance at the professionals meeting. |
| **06.03.2017** A professionals meeting was held in respect of Adult A and this was chaired by Addaction. A safety plan was completed which included further liaison with mental health services and Adult Social Care which included assisting Adult A in keeping her flat. Self-neglect issues were also discussed at this meeting and the risk of domestic abuse from Adult B was also noted. The plan for CFT from this meeting was to establish, from discussion with wider mental health services, what could be offered to Adult A and to feed this back to Adult Social Care once any assessment outcome was known. An IDVA was tasked to support Adult A with making a statement regarding a recent incident where she had alleged that she had been raped. |
| **09.03.2017** Adult A and Adult B were discussed at the Carrick MARAC and the multi-agency response was reviewed. |
| **09.03.2017** Adult A was the subject of a mental health assessment by the Custody Liaison and Diversion Service. A referral was made to ICMHT due to concerns about Adult A’s on-going reported psychotic symptoms and the risk that she posed to herself due to her addictions. Adult Social Care, Addaction and Adult A’s GP were notified about the assessment. The clinical risk assessment identified that Adult A had no intent to harm herself and that she had reported that stressors such as relationship difficulties led her to stab herself. Adult A further stated that she was aware that increased substance use put her at risk of harming herself and she state that it was during these times if she felt distressed that she would consider ending her life. Adult A also reported that at times she could no longer manage the voice that she heard and that as a consequence she had considered taking her own life by jumping in front of buses. Adult A stated that she did seek help during these times and she agreed to use OOH numbers or A&E if she required further help. At that stage it was identified that a protective factor was her daughter. The assessment also noted that she was at risk from other people. |
| **13.03.2017** ACFT housing officer attended a multiagency meeting for rough sleepers which included Adult A’s case. Multi agency intervention discussed. |
| **13.03.2017** Carrick ICMHT received two referrals for Adult A from CFT Housing Support and CJLDS. This referral was for an assessment of Adult A’s on-going psychotic symptoms. The referrals were assessed by the team’s consultant and forwarded to the Specialist EIT Service . |
| **15.03.2017** A**n** Achieving Best Evidence Interview was conducted by Police in relation to the allegation of rape that had been made by Adult A. Adult a was supported by an IDVA. |
| **16.03.2017** Adult A’s IDVA had a meeting with her. Adult A declined to complete a domestic abuse risk assessment and would not discuss domestic abuse. Adult A was staying with her mum at that time. |
| **17.03.2017** A referral for Adult A was triaged by West Early Intervention Team (Psychosis). This triage process concluded that Adult A should be offered an assessment appointment. |
| **20.03.2017** Adult A’s GP prescribedprophylactic anti-psychotic medication following advice from Addaction and on consideration of the multi-agency information that was available to them. |
| **22.03.2017** Assessment appointment with EIT. Adult A did not attend. |
| **23.03.2017** Adult A called the police after she had returned home and believed that she could hear a number of male voices in her loft. A search of the loft was made and nothing was found. A ViST was submitted detailing officers concerns that Adult A’s mental health was deteriorating. The information stated that Adult A was continuing to smoke crack and heroin and this was impacting on her mental health and making her paranoid. Addaction advised Police that she would be undergoing a mental health assessment and a care package was being put into place. Adult A did not consent to the information being shared and would not engage further with the officer. The ViST was assessed by the CST and a decision was made not to share the information further. |
| **24.03.2017** Police attended a report that Adult B had entered Adult A’s property using a ladder whilst she was not home. Officers attended the address and saw Adult A and Adult B. The attending officers commented that Adult B was clearly very controlling over Adult A and that she did not want to leave his side. The officers did manage to separate them but all Adult A would say was Adult B was her carer and the only person who looks after her. Officers spoke to Adult A about her physical and mental health but she did not want to engage with officers. Appropriate paperwork completed and submitted. |
| **25.03.2017** Adult A had attended Adult B’s home address to give his mother a birthday card. An argument took place. Police attended but Adult A did not want to complete a DASH. The DASH was completed and graded as medium. |
| **27.03.2017** Adult A’s case notes were assessed by the personalisation team at Adult Social Care and a decision was made that she be supported for six hours a week. The social worker concluded that there was no requirement for a needs assessment. The personalisation team were working with other agencies to support Adult A with housing needs and records state that a mental health assessment was due on the 29th March 2017. |
| **29.03.2017** Assessment appointment with EIT. Adult A did not attend and therefore the appointment had to be rebooked. An Addaction worker advised EIT that Adult A had been arrested with Adult B two days previously. At that stage it was known by agencies that Adult A was open to MARAC and Safeguarding due to concerns about her vulnerability. There was a plan for Adult A to remain in her current DCH tenancy with an increased package of care (funded by Adult Social Care) going in to support her (approximately 8 hours per week). It was noted that Adult A had an IDVA and that she did not want to engage with them. It was noted that Adult A was not ready to address her drug use (crack cocaine and heroin) and that she had been offered an inpatient detox on several occasions but had declined this. Adult A’s Addaction worker believed that Adult A had not been open about her mental health at recent contacts with health staff as she had wanted to leave hospital in order to take drugs. Adult A’s Addaction worker believed she was psychotic due to the fact that she had reported that she could hear derogatory voices. Following the non-attendance at the appointments, Adult A was discharged from the EIT caseload, with the option for re-referral should she wish to engage. This decision was shared via a letter to Adult A’s GP and the Addaction worker. |
| **03.04.2017** An IDVA spoke to Adult A by telephone.Safety advice and the support that was available to help her was discussed. The IDVA updated Addaction and made a referral to WAVES[[12]](#footnote-12) and for sanctuary work. |
| **04.04.2017** Adult A did not attend an assessment appointment with EIT and this had to be rebooked. An assertive outreach approach was discussed after Adult A’s third non-attendance. Adult A did not attend an appointment with her IDVA. |
| **06.04.2017** Adult A was seen by PLS with her Addaction worker having been brought into hospital after jumping into a creek as she thought a baby was drowning. Adult A described experiencing hearing voices whispering to her and she believed that people were talking about her. A routine enquiry into domestic abuse made and abuse was disclosed. Those present noted that Adult A had taken amphetamine and alcohol prior to the incident. They concluded that there was no evidence of mental health and that her symptoms were related to substance abuse. Adult A was discharged. At that time Adult A’s clinical risk was assessed as high (harm to self – moderate to high, risk of neglect – high due to intravenous drug use, risk from others – high, risk of accidents – high due to IDVU). The safeguarding plan was to continue with support from Addaction as Adult A was keen to engage with rehabilitation at this point and was awaiting an EIT assessment. PLS were aware that Adult A had been referred to the Adult Safeguarding team and that a social care package had been arranged for her. Adult A’s GP was advised of this contact. |
| **07.04.2017** Intelligence was received by the Police. Adult B had been spoken too by the police in relation to another matter and he stated that he was unable to attend an interview because his partner had tried to hang herself in relation to what happened to her (rape incident). |
| **10.04.2017** Adult A received a conditional discharge for common assault on Adult C.  She was not made to subject to any statutory supervision with either National Probation Service or Community Rehabilitation Company. |
| **11.04.2017** Adult C called the police after Adult A told her that she was going out to town to get drunk and then she intended to hang herself because she could hear voices. Ambulance and Police were despatched. Police attended and located Adult A at home safe and well and in good spirits. No further concerns were raised about her welfare. |
| **12.04.2017** Assessment appointment with EIT. Adult A did not attend and therefore the appointment had to be rebooked. |
| **14.04.2017** IDVA closed Adult A’s case due to lack of engagement. Adult A was open to the ISVA service at that time. Addaction, ISVA and Police notified. |
| *There was clear evidence in the chronology from FirstLight of the attempts that they had made to contact Adult A.* |
| **19.04.2017** Adult A did not attend an assessment appointment with EIT. Her GP was advised (letter) of the attempts that had been made to assess Adult A. Adult A was discharged from EIT caseload with the option for Addaction to re-refer her if she wanted to engage with them in the future. |
| **11.05.2017** MARAC meeting. Case discussed in a multi-agency environment and support plan reviewed. |
| **24.05.2017** Adult A spoke to police and stated that she had tried to hang herself during the previous week. |
| **05.06.2017** Adult A spoke with the duty GP and advised that her medication was causing her to have seizures. |
| **16.06.2017** Police officers attended Adult A’s home address regarding reports from a neighbour that she had come to their door distressed and half naked. Adult A had been saying that people had broken into her house and were still present. Adult A then left her neighbour's address and went back to her own address, where the neighbour could hear shouting and a commotion. On attending the address Adult A unlocked the front door covering herself with a towel and she let the police in asking for them to check her house for the people who were there earlier. Police checked all the rooms in the house and the garden and they could not find anybody or any signs of a disturbance. Police spoke to Adult A who stated that there were people there earlier who she did not know and they wouldn't leave. Police stated that Adult A's mental health appeared to be deteriorating, and that she continued to use drugs and drink which was having an impact on her mental health. This behaviour in their view was making her extremely vulnerable. |
| *The ViST was reviewed by the CST they concluded that as ‘no safeguarding concerns had been identified by the attending officer and therefore the information would not be shared with partner agencies unless additional concerns or information came to light. This information should have been shared in view of the history in this case but even if it had the level of support that Adult A would have received would not have changed.* |
| **27.06.2017** A shop worker reported to the Police that they had witnessed a male (Adult B) ‘manhandling’ a female. The matter was dealt with and no complaint was made. A DASH was submitted by the attending officer which was reviewed on the 28.06.2017 by a domestic abuse officer who stated that;  “*this case is concerning as there is a long history of high risk DV and the female not engaging with police and other support services. This couple were on MARAC earlier in the year and since then there have been NCD's between them that did not meet MARAC criteria however this crime highlights a level of aggression and control by Adult B regardless of what can be proven. In the absence of a DASH I will be regarding this as a medium risk DASH and this case will be listed for repeat mention at Carrick MARAC on 13.07.17. Safeguarding has previously been addressed with the victim and she is not engaging now therefore there is little more I can do. I will make her IDVA aware of the situation but she is annual leave until next week and a letter will be sent signposting further support and myself as the new Carrick DAO*.” |
| *This is good proactive work by the DAO and should be seen as best practice.* |
| **30.06.2017** Adult A was discussed at the multi-agency meeting for rough sleepers. At this point Adult A was described by others at the meeting as doing well and asking for a little less intensive support from both Addaction and Independent Futures[[13]](#footnote-13). Efforts to assess Adult A’s mental health were noted. |
| **30.06.2017** Police referred Adult A back to FirstLight. |
| **05.07.2017** AnIDVA made phone contact with Addaction. The IDVA informed Addaction that Adult A did not have a current phone and asked them to contact her to offer IDVA support. The IDVA informed the Police that they were unable to contact Adult A. |
| **06.07.2017** Adult A went to see her GP. On this occasion she was reassured that her anti-psychotic medication was unlikely to have brought on the seizures that she had previously reported. Adult A was advised that the most likely cause of these seizures was her alcohol consumption. |
| **13.07.2017**- MARAC Meeting. Case discussed in a multi-agency environment and support plan reviewed. |
| **20.07.2017**- The CST received a referral from Adult Social Services in relation to concerns for the safety of Adult A. These concerns had been raised by the family. The CST Sgt held a strategy discussion and referred this matter to the domestic violence officer who updated the non-crime incident;  ‘*I have reviewed this safeguarding enquiry, police are already aware of the situation with Adult A and Adult B. There were 2 disclosed assaults earlier this month where Adult A was taken back to MARAC as a repeat mention following her refusal to complete a DASH and officers rightly grading the situation medium risk. There is no required to return to MARAC again next month as there is nothing new to report or discuss* [and the officer was aware of the support being delivered by other agencies]*. Adult A has refused all engagement with police with regarding to investigations and safety planning/safeguarding she is happy to still report crimes however and police at this time have taken the decision to not proceed with a victimless prosecution due to lack of supporting evidence and fear that it will alienate Adult A further and prevent her even reporting the crimes. It is believed at this time that Adult A is not living or staying with Adult B but we do not know where and they do still associate on a regular almost daily basis because of her drug dependency. Because police have not and cannot break the cycle of offending from the victim viewpoint it may be time to look more proactively at the perp for whatever offences can be established even driving offences if necessary. This may restrict his movements and help safeguard Adult A.”* |
| **21.07.2017** An initial strategy discussion was held with relevant partner agencies following concerns raised by one of Adult A’s friends about her ongoing abuse of drugs and alleged abuse by Adult B. It was also noted at that time that Adult A had attempted to take her own life on a number of occasions and that she was struggling with mental health. The discussion identified interim support measures and the need to progress the inquiry. |
| **21.07.2017** Adult A was referred to ICMHT by Adult Safeguarding. The referral was passed to EIT (psychosis). ICMHT were advised that Adult A would not enter her home as she believed that people were in there. They were also advised Adult had attempted to throw herself in front of cars. |
| **28.07.2017** IDVA case closure due to non-engagement. The IDVA updated all agencies of the closure and case notes state that they would re-open her case if Adult A engaged with support. |
| **31.07.2017** Referral triaged by EIT. EIT made six attempts (31 July to 9 August) to contact Addaction and Devon and Cornwall Housing to arrange appointment. Appointment booked for 17.08.2017 at the Addaction offices. |
| **06.08.2017**- Adult A called the police stating that she is hearing voices and not feeling well. She also stated that she had stopped taking her medication and she had thought of harming herself. Adult A stated that she wanted to die and she needed to go back to hospital. This incident was passed to the ambulance service to deal with and no police officer was despatched. Adult A made a further call to the Police stating that she was going to take her own life. The call handler thought she was possibly drunk. Police checked Adult A's home address as she believed, through her paranoia, that persons were inside. No one was found. The ViST was assessed by CST and re-graded from RED to AMBER with consent. It was established that Adult A was staying with her sister, therefore it was believed that immediate safeguarding was in place. The CST sent a letter to her GP. |
| **08.08.2017** Addaction arranged for a CMHT assessment for Adult A on the 17.08.2017 due to her deteriorating mental health. |
| **14.08.2017**Addaction were contacted by DCH regarding Adult A’s recent hospital admission. The DCH worker advised that Adult A was now staying with her sister and that they planned to see her that afternoon. A plan was made between Addaction and DCH for Adult A to be seen daily, Monday to Friday. |
| **14.08.2017** The IDVA also advised that Adult A’s case had been heard at MARAC on 07.07.2017 and that sanctuary works was completed and a SIG warning was in place. Addaction informed IDVA that Adult A did not want to engage with them. |
| **17.08.2017** A strategy meeting was held with key professionals with a view to seeking Adult A’s views and her desired outcomes. This meeting was also used to scrutinise multi agency practices and ensure that the safeguarding arrangements that were in place were sufficiently robust. Adult A did not attend this meeting but actions were agreed in her absence which were designed to encourage her to engage with services and minimise the risk of homelessness. |
| **17.08.2017** Adult A did not attend an EIT assessment appointment. Attempts had been made to support Adult A to attend the EIT assessment, by a worker from Devon & Cornwall Housing. This worker had agreed to collect Adult A from Adult B’s address. On this occasion however Adult A could not be persuaded to accept the lift. In Adult A’s absence, her Addaction worker, the Devon and Cornwall Housing worker, and representative from the Local Authority’s Adult Safeguarding team provided background information on Adult A’s mental well-being (they reported that she was hearing voices and the frequency of this was increasing, that she was no longer taking Aripiprazole as believed it was giving her seizures, drug use and abuse (domestic and self -neglect)). |
| **18.08.2017** Adult attended RCHT and was seen by the Psychiatric Liaison Service. Adult A left the hospital and was informed to return later that morning for a psychological assessment. An Addaction worker supported Adult A in collecting her prescription and then took her back to Treliske to see a CFT nurse. Adult A stated that her mental health was very poor and that she wanted to be in hospital as she felt that she was a risk to herself and others. It was agreed that a discussion would take place with the consultant psychiatrist. The Addaction worker spoke to the CMHT early intervention team and they offered an assessment on the 24.08.2017. Adult A left before Health staff could complete the assessment. During the assessment that had taken place Adult A described how she was experiencing current auditory hallucinations which she believed were linked with people being against her and being derogatory. Adult A was described as being preoccupied and kept looking at unseen stimuli which she described as shadowy things. She denied any crack cocaine or heroin use for over a month but was evasive when challenged. A routine enquiry was made into domestic abuse which was disclosed, although the details of the disclosure were not recorded in her health record. Her clinical risk was rated as high (risk to self- moderate, risk from others and neglect – rated high). Adult A was advised to take Aripiprazole for her psychotic symptoms and she was reassured that this medication was unlikely to cause a seizure. Her GP, Carrick ICMHT, EIT and Treliske’s emergency department were informed of the consultation and outcome. |
| **24.08.2017** Adult A did not attend her CMHT assessment. The adult safeguarding team were advised of the non- attendance and Adult A was discharged from EIT. Again it was reiterated that she could be re-referred by Addaction when she was ready to engage. |
| *Although EIT was required to record referral closures on the clinical systems the team had agreed a longer assessment was needed and clearly communicated with Addaction that the service was ‘ready’ and would attend any appointment at short notice to undertake assessment, a phone call was all that was required. This was recognition that this was a complex situation that required flexibility from services. This should be seen as best practice.* |
| **31.08.2017** Adult A reported to Addaction that she had ended the relationship with her abusive partner due to the way that he was treating her. Addaction provided harm reduction advice. |
| **03.09.2017** Information was received by the Police that Adult A was no longer using drugs but that Adult B was attempting to encourage her to take them. |
| **04.09.2017** Adult A was assaulted by Adult B. Adult A who was staying with her sister. Adult B went to the address and accused Adult A of stealing his drugs and sleeping with her sister’s boyfriend. Adult B then hit Adult A to her face using an open palm and this had caused her to fall back and hit her head. This assault had caused a one and a half inch cut to her head which was later glued at hospital. Adult B had then left the scene. Police attended and Adult A provided a statement. A DASH risk assessment was completed a and graded as high risk. Despite attempts to find Adult B he was not located straightaway. |
| **06.09.2017** Adult A again called the Police asking them to stop looking for Adult B and that she wanted to retract her statement. Adult B was heard in the background being abusive due to the fact that Police were looking for him. Adult B was later arrested (12.09.2017) and charged with common assault. Adult B received a conditional discharge on the 13.09.2017. |
| **12.09.2017** AnIDVA made telephone contact with Addaction who informed them that Adult A was engaging well and that a Home Office alarm had been put into property. The IDVA informed by Addaction that Adult A did not want IDVA support. |
| **14.09.2017** Case discussed at MARAC. |
| **14.09.2017** The case was closed forIDVA support due to adult A not engaging with the service. IDVA informed all agencies of case closure. |
| **20/09/2017**- Adult B was raised as a Domestic Abuse Serious and Serial Perpetrator by the Police. |
| *A proactive management plan was implemented by the Police.* |
| **25.09.2017** Addaction called Adult A to check on her welfare and she reported that she was at home and that she was putting on a brave face but was struggling with anxiety. Adult A stated that she was fearful of her ex-partner and disclosed that he had beaten her on many occasions. Adult A stated that she was unhappy with the court outcome following her previous statements and that she wanted a restraining order (RO) against him. The process for obtaining an RO was explained to her. Adult A stated that she was too fearful to follow through this process. Adult A advised that she thought that her ex-partner had been waiting outside of her property and she requested that the HO alarm be installed again. The Addaction worker advised Adult A that she would request this and reminded Adult A of the importance of attending the safeguarding meeting so that she could share her concerns. The Addaction worker again informed Adult A that a CMHT assessment was available to her at any stage if she wanted it. |
| **26.09.2017 –** Adult A attended an appointment with her GP. The GP spoke to her with regards to her lack of engagement with mental health services and Addaction. Adult A was described as competent and not under the influence of medication/drugs. Adult A stated that she preferred not to engage although she wished that she was able to come off drugs. |
| **27.09.2017-** Ambulance reported to the Police that they were attending a sudden death at Adult A’s home address. Adult A had been in a relationship for some weeks with Adult G and when she awoke she had found him deceased in her front room. It was suspected that he had taken an overdose. Police and Ambulance attended and made enquiries into the circumstances around the death. There had been no DV reports between the pair. Adult A’s initial account stated that Adult G had discussed taking her own life in recent weeks and with the presenting scene it was regarded by those in attendance as a potential overdose / suicide. There were a number of prescribed medications at the scene. |
| **29.09.2017** Adult protection initial conference held. A ‘Signs of Safety’ approach was adopted and a safety plan was put into place. Evidence from the minutes documented a willingness for Adult A to engage with agencies to move forward. There is no specific evidence at that time to show that Adult A was at a high risk of taking her own life. |
| **29.09.2017** Adult A attended the Addaction office and was coherent but distressed. She stated that she was devastated by what had happened to Adult G and that he had been the only person who had been treating her well. Adult A was very tearful and stated that she felt like she couldn’t go on but that reiterated that she was not suicidal. Adult A then went out for a cigarette and did not return to the appointment. DCH contacted Addaction to state that one of their staff had seen Adult A nearby with an unknown male. The Addaction worker drove down to the location but could not see Adult A. |
| **29.09.2017** Safeguarding meeting held in respect of Adult A. Adult A also attended the meeting and she presented with slurred speech and had difficulty with focusing on the conversation. Agency concerns were explained to Adult A and she stated that she wanted to stay in her property and that she did not want to go to safe accommodation out of County. A HO alarm was offered and accepted by Adult A and she also agreed to CCTV being installed at the property. Adult A had a personal alarm and agreed to keep the doors locked at all times. She advised those present that she needed no additional support other than what she was receiving at present. Adult A also confirmed that she had naloxone and all relevant emergency contact numbers. After she had left the meeting Addaction requested that the Police complete a welfare check on her over the weekend (which was conducted) due to the risk of her taking her own life and risk from her ex-partner. Cocoon watch was also commenced. A plan was again agreed for Adult A to be seen daily by support services. |
| **06.10.2017** Adult A did not attend an appointment with her GP. |
| **09.10.2017** Adult A attended Accident and Emergency Department but left before she could be seen or triaged. |
| **11.10.2017** Adult A attended a GP appointment withher sister. The GP spoke to Adult A with regards to her lack of engagement with Addaction and support services despite the numerous efforts that had been made to encourage her down this route. The GP recorded that her sister was clearly frustrated by the inability for agencies to make her attend these appointments but concluded that ‘it was clear that Adult A had the ability and capacity to choose whether or not would attend except when she was under the influence of alcohol or drugs’. |
| **30.10.2017** Adult A did not attend an appointment with EIT service at Addaction offices. Addaction had tried to find Adult A to ensure that she went to the appointment but they were unable to locate her. |
| **02.11.2017** Adult A discussed at an EIT MDT meeting. An appointment was booked with EIT for 10.11.2017. |
| **02.11.2017** Adult A’s GP surgery was contacted by a paramedic who was concerned about her mental health. The paramedic was concerned as Adult A had sustained a serious head injury which she had sustained after she had broken a mirror over her head. Adult A had also been hearing voices. An appointment was made which Adult A did not attend. Attempts were made to contact Adult A (including through Addaction) without success. |
| **02.11.2017** Adult Protection initial conference held. A Safety plan was discussed and put into place . |
| **03.11.2017** CFT EIT spoke by phone with Adult A’s GP who was advised of her previous non-attendance at the assessment appointments. They also discussed Addaction support. The GP advised that they were trying to contact Adult A. They shared information stating that they had recently seen the Adult A after she had broken a mirror over her head. Adult A had previously stated that she wanted to be sectioned as she was hearing voices. EIT planned to attend the next Addaction meeting where it was hoped that psychiatric services would be able to review Adult A. |
| **07.11.2017** Adult A attended the emergency department having overdosed on alcohol and ‘spice’. |
| **12.11.2017** Adult A was seen by two staff from EIT including the team’s consultant psychiatrist. At that time she was accompanied by her Addaction worker. This appointment was planned without Adult A’s knowledge as there were concerns that she was avoiding appointments with mental health services. Prior to seeing Adult A (she arrived at the appointment late and intoxicated), the Addaction worker updated CFT’s staff. After arriving Adult A spoke of hearing voices for around a year, seeing people who are not there and getting “paranoid”. – people “watching me” or “chasing me”. She reported that she had not been using heroin recently but over the last six months had moved onto using ‘crack. Adult A stated that the drugs made the voices and visions worse. Adult A also stated that the voices were still present in the absence of substance use. Adult A stated that she had slept poorly recently, that she was not eating and that she had lost weight. Routine drug testing on that date showed her to be positive for Benzodiazepines, Buprenophine (Subutex), opiates and cocaine. The assessment was unable to be completed as Adult B looked in through the window of the appointment room and advised Adult A that it was time to leave.  The records state that the clinical impression of Adult A was of a complex picture in that Health professionals found it difficult to separate out drug related phenomena from true psychosis. A clinical risk assessment was completed and Adult A’s overall risk was rated as high (risk of harm from self and others – high, other risks – moderate or low). The risk of Adult A taking her own life was not explored due to the shortened assessment, but those staff that were present recalled that Adult A did not appear fearful or present as being suicidal. On that occasion Adult A agreed to a further appointment. The EIT team planned for Adult A’s case to be discussed at the next MDT meeting and agreed that contact should be made with the Addaction consultant to discuss drug/medication use and effects, and to consider joint working with Addaction. Those present had hoped to arrange a further two to three appointments. No specific risk management plan for safeguarding was discussed or actioned due to the brevity of the appointment. |
| **15.11.2017** Addaction discussed the case with Adult Social Care and agreement was reached that a further safeguarding meeting would not be beneficial in this case due to Adult A attending a mental health assessment on the 17/11/2017. |
| **16.11.2017** Adult A was discussed at the EIT’s MDT meeting and it was agreed to continue to try to engage with her for an extended assessment (preferably when drug free) with a plan to meet with her at the Addaction office later that week (20.11.2018). The team made contact with the Local Authority’s Adult Safeguarding Team to advise that someone from EIT would attend the next safeguarding meeting. Those present also agreed to contact the EIT consultant and for them to establish from the Addaction psychiatrist a view on the relative effect on Adult A of her drug/medication use. |
| **17.11.2017** The Home Office alarm that had been installed at Adult A’s home address was removed due to Adult A allowing numerous people, including Adult B, to frequent the premise. On the ViST submitted by the Police it stated that Adult A had informed them that she was in a relationship with Adult B and that she was using heroin. Adult A also stated that she wanted help getting into rehabilitation. Adult A was provided with safeguarding advice and the details were shared with her GP. |
| **18.11.2017** Adult A called the Police from her home address believing someone is in the premise. Adult A stated that she could hear voices and sometimes the conversations were nice and sometimes not. Police attend and identified that the premise was locked and secure. On this occasion Adult A admitted that she had taken crack cocaine and could more than likely be hearing things. |
| **18.11.2017** Adult A found deceased. |

14.0 Overview

15.1 This overview will summarise what information was known to the agencies and professionals involved with Adult A and her family. It will also include any other relevant facts or information about the Adult A.

15.2 In relation to her earlier years Adult A had been fostered at the age of three. Adult A’s oldest sister later became her legal guardian.

15.3 Adult A had a supportive family and was the mother to her daughter Child A who was born in 2009. That same year Child A was made the subject of a child protection plan due to Adult A’s inability to appropriately care for her. Child A was later adopted by one of Adult A’s sisters. Those working with her have stated that Adult A never gave up hope that she may at some stage be allowed to bring up her daughter.

15.4 Adult A would appear to have struggled to manage her finances effectively (evidence of debt 11/06/2013 being managed by CAB), and this was confirmed by her family. These financial difficulties were compounded by the fact that Adult A found it impossible to work due to her addictions and chaotic lifestyle and the benefits that she received were often spent to support her addictions. Due to this lifestyle Adult A had also became involved in acquisitive crime to fund her habit and on occasions she had become so desperate that she felt that she had no choice but to sell herself for sex.

15.5 Agency records document that on a number of occasions Adult A had tried to change her behaviour and assert control back in her life. In 2012 she had stated to Addaction that she was intending to go to Cornwall College to complete a course and on the 2.10.2012 she had attended an assessment. Adult A however never started the course. On each occasion where progress was made Adult A would repeatedly relapse into a chaotic lifestyle. Agencies were unable to identify critical events in her life that may have caused this to happened although it would appear that her level of addiction would simply overwhelm her. One support worker that had spent a great deal of time with her described how she was on an emotional rollercoaster ride. On one occasion she might be lucid, bubbly and enjoying life and on another depressed, chaotic and unwilling to engage.

15.6 Adult A had no consistent contact with any of her family despite the many occasions that they had tried to engage with her. Her family desperately tried to support her through the difficult times in her life and on many occasions she had gone to stay with them. Addaction and then more latterly Devon and Cornwall Housing were cited by CFT staff as Adult A’s main point of contact and they had provided regular support for her.

15.7 Adult A lived alone in social housing accommodation in the Truro area. Despite being provided with a flat Adult A would often fail to stay there for long periods of time and when she did there were often reported incidents of anti-social behavior at the address. Adult A would let people stay at the address and drugs were being dealt from there. On occasions Adult A would also sleep rough in the local area as a result of not feeling safe in her own home. Agency records show that she had slept in public car parks due to her desperate lifestyle (the reasons for this will be explored in paragraph 16.0). This erratic behaviour later led to conflict with the housing provider who whilst supportive was not prepared for the premise to remain under utilised. Despite these differences, and due to effective liaison with her support workers, the housing provider did support her to remain at the premise.

15.8 Adult A was extremely vulnerable. She was addicted to illicit drugs including heroin, and cocaine, and was known to frequently drink alcohol. Adult A was being supported by numerous professionals including Addaction, who had regular and sustained contact with her. Adult A was however difficult to manage as often she refused to engage with professionals and appeared to be blasé about the consequences of her behaviour. Adult A also appeared to be prepared to take unacceptable risks in terms of her own wellbeing. This was seen when she would sleep rough, even though she had a premise to return to and support services in place. This behaviour was driven by the impact of drugs and alcohol and the influence of Adult B.

15.9 Adult A had been involved in a number of relationships that involved domestic abuse. The first such relationship was recorded in 2009 and involved Adult D. In 2009 she was the victim in a number of non-crime domestics[[14]](#footnote-14) which were reported to the Police.

* 1. In 2016 Adult A started a relationship with Adult B. During that relationship there was a significant history of domestic abuse and Adult B was classified as a Domestic Abuse Serial Serious Perpetrator (DASSP). The first crime of assault involving the two was recorded on the 14th October 2016.
  2. The relationship between Adult A and Adult B was discussed three times at MARAC in 2017, however, there was only one conviction (September 2017) for common assault for which Adult B was given a conditional discharge. There was a concern that there was a strong drug motivation keeping Adult A and Adult B together and the Police believed that Adult A was at high risk of serious harm from him.
  3. In September 2017 Adult A met Adult G who was a stabilising factor in her life. Adult G however died of an overdose later that same month and Adult A was arrested as part of the police inquiry. The death of Adult G apparently had a huge impact on Adult A and shortly after this she returned to having a relationship with Adult B.
  4. Adult A and Adult B had an abusive relationship and this was known to all of the agencies that were involved in supporting her. Adult B was physically, sexually and mentally abusive to Adult A and there is clear evidence that he would control her. The level and extent of this abuse is documented in agency records and has been confirmed by Adult A’s family. It would appear that Adult A was trapped in the relationship due to her drug dependency, much of which would appear to have been exasperated by Adult B who ensured that she stayed addicted through supplying the drugs to her. Concerns had also been raised that Adult B would regularly inject Adult A although there is no specific evidence to confirm this.
  5. Adult A was also a frequent user of Health services. This contact included appointments with primary services who had attempted to manage her addiction through a coordinated approach with other agencies. There were also numerous presentations at the local Accident and Emergency Department for substance abuse issues and the injuries that she had sustained as a result of her chaotic lifestyle. There were also six referrals to PLS, two to the L&D service[[15]](#footnote-15) and six to community mental health services.
  6. Adult A’s GP had known her since 2005 and stated that they had become aware of her alcohol dependency in 2007 and her heroin addiction one year later. The GP has indicated that there were varying levels of engagement with the surgery – often Adult A would only visit when sober and clean, and she did not readily engage with the services that were offered to her due to the choices that she was forced to make because of her addiction. Adult A was also described as displaying erratic and unpredictable behaviour. Adult A’s GP has stated that in his opinion she had capacity when she was sober and they never deemed her suitable for detention as a result of her mental health.
  7. Aside from one short episode of outpatient care with Child and Family Health Services in 2005 aged 15, Adult A’s first contact with CFT mental health services was in October 2016 when she was referred to the Trust’s Adult Psychiatric Liaison Service (PLS) at Treliske Hospital. On this occasion Adult A was brought in by ambulance, having been found confused, disorientated and drowsy in the street due to heroin withdrawal. Adult A was referred to the Adult Psychiatric Liaison Service a further three times (11.12. 2016, 25.01.2017 and 31.01.2017) for an assessment of her mental health after she presented as hearing voices and considering self -harm. On these occasions her there was no evidence of mental illness. Consequently Adult A was discharged from CFT’s mental health services.
  8. In the latter stages of her life Adult A’s there were concerns about her mental health and questions about drug induced psychosis, although there was no formal diagnosis. She would often present to professionals in a confused state of mind and she would recall how she would see disturbing and graphic images, some of which involved her daughter and family. Adult A would also state that she could hear voices. Agencies attempted to provide the support that Adult A required but were hampered on many occasions by her non-engagement which will be explored further in section 16.
  9. Adult A had stated to professionals that she had considered taking her own life on several occasions over the years and had attempted to do so on a number of occasions. It is not clear what events had led her to considering or taking this action. Adult A was predominantly considered ‘high’ in respect of the level of risk to herself. All agencies were concerned about the risk of overdose due to the amount and variety of substances that she would take.
  10. Adult A had been known to Adult Social Care following a period of residential rehabilitation at Broadreach from the 26.04.2011 and the 13.07.2011. She had further contact with the agency in October 2015 in relation to alleged financial abuse by her partner and others. The Service describes her lifestyle as being chaotic.
  11. All agencies were aware of Adult A’s ‘chaotic lifestyle’ and also of Adult B’s controlling nature towards her. Agencies regularly shared information and there is evidence in all agency records of a coordinated approach to the case.

16.0 Analysis

16.1 This part of the overview will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

16.2This analysis considers the previous sections within this report and the content of the IMR’s, including the chronology of events. The information obtained from Adult A’s family has also been used in this analysis.

* 1. Evidence of Domestic Abuse in Adult A and Adult B’s relationship
     1. In examining how and why the events in this particular case occurred, the first area for analysis is to determine the extent that Adult A was subjected to abusive, coercive or controlling behaviour in her previous relationships and whether there is any evidence that this led to her taking her own life.
     2. As part of the review process the panel considered whether Adult A was exposed to domestic abuse during her childhood. There is nothing recorded in agency records or information gained from friends and relatives that would suggest that she was exposed to violence or abuse.
     3. The first recorded domestic abuse incident was recorded by the Police in 2009. At this time Adult A was in a relationship with Adult D, during which time there were a number of non-crime domestics. Agency records show that Adult A intermittently returned to Adult D when other relationships had failed.
     4. In 2012 Adult A commenced a relationship with Adult E and there were two MARAC meetings in respect of that relationship.
     5. 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 was built around substance abuse with Adult A being totally dependent upon Adult B to feed her addiction. From the information gained from professionals and Adult A’s family it would appear that Adult B enjoyed the power that he exerted over Adult A and the fact that he could manipulate and control her. On one occasion Adult A disclosed to the psychiatric liaison service that Adult B controlled her via her drug habit.
     6. Adult A had a history of failing to make complaints to the police about those partners that abused her (2009 she did not make two assault complaints against Adult D) due to fear of further abuse and the level of control that they had over her. On speaking to her support worker from Addaction it was clear that agencies went to great lengths to try and persuade her to report abuse. Addaction would seek to persuade Adult A to make a complaint and when she agreed they would contact local police officers and make arrangements to transport her to them. Whilst the final preparations were being made Adult A would then state that she didn’t want to follow it through. 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.
     7. Adult A did make statements to police whilst in relationships with Adult E in 2012 but the two assault reports did not result in a conviction. When she was assaulted by Adult D in 2015, she did provide a statement against him but later withdrew her support. Adult A’s level of cooperation however deteriorated when she commenced her relationship with Adult B and as a result of the control that he had over her she frequently failed to engage (due to the level of abuse and exploitation that she was suffering and the effect that drugs were having on her life), or she would lie about the injuries that she had sustained. This was seen when police domestic violence officer’s attended hospital 01.02.2017 to speak to Adult A when she attended hospital with stab injuries. On this occasion she did not disclose anything to the police instead stating that the injuries were self-inflicted. On the 05.02.2017 Adult A disclosed to her mother that she had been assaulted on the 01.02.2017, but when the police attended she would not engage with them and would not make a complaint.
     8. In terms of the nature and level of violence in the relationship with Adult B, agency records (Police, Health, Addaction) document physical assault, sexual and emotional abuse over a number of years and this is evidenced in the chronology. 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. Professionals working in all of the agencies acknowledge that many incidents of domestic abuse go unreported and it is likely on the information available that multiple forms of abuse were taking place in the relationship[[16]](#footnote-16).
     9. Whilst Adult A would be prepared to discuss some of the abuse she was suffering on other occasions she was protective of Adult B and would defend him stating that he was ‘kind to her’. This can be a typical response from victims suffering from abuse and perpetrators will often use ‘nice behaviours’ in order to maintain control. Most abusive relationships display a distinct pattern, known as the cycle of abuse: tension building, incident (abuse occurs), honeymoon or reconciliation phase, calm (before the tensions starts again)[[17]](#footnote-17). 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.
     10. Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviourwhich takes place over time in order for one individual to exert power, control or coercion over another. The Cross-Government definition of domestic abuse and abuse[[18]](#footnote-18) outlines controlling or coercive behaviour as follows;

‘*Controlling behaviour is****:*** *a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour’.*

1. The impact of coercive control on an individual’s mental and social wellbeing is now considered to be so serious that it became an offence in law in January 2016, under the Serious Crime Act 2015.
2. The components of coercive control can include behavioural traits such as:

* Deliberate use of alternative moods.
* Excessive jealousy and possessiveness.
* Isolation-preventing partner from seeing family or friends.
* Control of the partner’s money.
* Control over what the partner wears, who they see, where they go, what they think.

1. Adult B was possessive and professionals state that he appeared to enjoy the power and control that he had over Adult A. On many occasions Adult B would try and attend meetings or was present during phone calls and this undoubtedly had an effect on Adult A’s ability to think for herself or come forward and speak openly with professionals. Adult B was demonstrating all the behavioural traits of an intimate terrorist[[19]](#footnote-19).
2. 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. On the 13.10.2016 Adult A presented to PLS stating that she was experiencing heroin withdrawal and had run away from her partner (Adult B) who she advised was a drug dealer and whom she had been with for a year. Health staff asked Adult A a number of questions about domestic abuse[[20]](#footnote-20). On this occasion Adult A stated that Adult B had been increasing the amount of heroin that she was using and that she believed that this was an attempt to trap her. Adult A explained that Adult B was injecting her up to thirty times per day and that he had increased her heroin use to £70 - £80 per day. On that occasion Adult A also reported that recently, a group of people (she did not state who they were) ‘put something inside me (a drug that was) like superglue’. She went on to state she had been covered in faeces by a group of people and washed off with baby oil to remove finger prints. She did not consent to this and stated this was done by her ex-partner (assumed by the author to mean Adult B). When asked why this had occurred Adult A’s only explanation as ‘he’s a psychopath’. She also described how Adult B would put faeces all over her and in to her vagina although the reasons for this were unclear.
3. In light of the emerging information that was being disclosed by agencies following their contact with Adult A the Police became increasingly concerned about the risks posed by Adult B. The Police together with the other agencies recognised that the standard multi agency methods of helping a victim to leave were not working. Adult B had demonstrated all of the traits of an ‘intimate terrorist[[21]](#footnote-21).
4. In terms of other types of abuse that was occurring in the relationship there were indications in the information held by agencies that Adult A was also suffering from economic abuse at the hands of Adult B (report from Devon and Cornwall Housing – 07/10/15). Adult A had a history of being unable to manage her money (as detailed in the chronology) and was receiving debt advice (19/08/15). Due to the level of exploitation that she suffered and her vulnerability through mental health and substance abuse her ability to effectively manage her money would have also been compounded by the fact that she had drug debts that she would have had to pay back. The level of financial control that Adult B had over Adult A is not clear but her ability to fund her addictions would have meant that her freedom of choice and ability to pay for basic essentials would have been severely curtailed and she would have had to have relied on others for support. This reliance on others would have also increased her vulnerability to being exploited.
5. All of the domestic violence incidents had been risk assessed utilising the DASH[[22]](#footnote-22) checklist. The purpose of the checklist is to give a consistent and practical tool to practitioners working with victims of domestic abuse to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage the risk. The DASH process is not a predictive process and there is no accurate procedure to calculate or foresee which cases will result in homicide or further assault or harm. The risk identification and assessments in this case were based on the model and involved structured professional judgement. The DASH model structures and informs decisions that are made by officers and other professionals who are trained in its use. The assessment of risk is often very complicated and can only be based on the information that is provided by the victim at the time that it is completed. The model is nationally recognised and used widely across all agencies.
6. The Police IMR has identified that there was an appropriate response to the domestic abuse reports made in relation to Adult A and DASH risk assessmentswere completed in line with policy (D034[[23]](#footnote-23)).
7. In this case Adult A had been involved in domestic incidents with a number of different partners. All of the incidents had been assessed to an appropriate level and it was clear that officers recognised the relevant risk factors as a number of the incidents had been graded as high. In relation to these specific incidents the assessments had resulted in escalation and a co-ordinated response by agencies.
8. 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. The extent of intervention that was put into place was documented in agency records and verified from the discussions held with professionals. This level of action was not however comprehensively recorded in the minutes of MARAC meetings which were variable in their content. MARAC minutes need to comprehensively document the risks considered and the action taken. These meetings are now recorded and therefore this issue has been resolved.
9. In this case the Police also faced difficult decisions, as Adult A did not wish to engage with the criminal justice process. There was evidence within the Police IMR that clearly showed that officers did look at alternative options to deal with Adult B and the concerns that had been raised. This was also confirmed by speaking to the police representatives on the panel. As a consequence of that risk Adult B was nominated as a DASSP. The DASSP was initiated to identify criminality and increase opportunities for targeted intervention. Consideration was also given for civil orders (20/09/2017) and a Domestic Violence Prevention Order (DVPO) (01/02/2015). In relation to the DVPO it is a police decision to apply for the order rather than the victim. These options were discussed with Adult A however she did not support them and therefore they could not be progressed.
10. Police had also considered the option to seek a victimless prosecution in this case. For the Police to progress such an option they needed to have sufficient evidence in order for a court to be able to convict the perpetrator. If the victim (as in this case) does not provide that evidence or allow Police to obtain potential corroborating evidence then the matter often cannot be progressed. In their IMR the Police have also highlighted that in such cases they also need to consider the potential criminal justice outcome. In this case there was belief that a prosecution would not have ensued was based on the evidence that was available at the time and by pursuing such a course of action could have placed Adult A at more risk of harm. Police had considered that an unsuccessful victimless prosecution may have also further undermined Adult A’s faith in the police. Concerns were raised that had they pursued such a course of action and had failed to take into account Adult A’s wishes then she may not have engaged with them again and this would have limited future opportunities to safeguard her. Where victims have capacity to make decisions then agencies must balance the need to respect their wishes and the reasons for it against risk. There also needs to be recognition and balance against the fear that victims have and that people may not be making informed choices out of free will. This would appear to have occurred in this case.
11. What is clear is that Adult B would appear to have 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. This would not be unusual behaviour for a domestic abuse victim due to the fear of further abuse and exploitation.
12. Despite repeated attempts to secure sufficient evidence to prosecute Adult B in relation to the information that Adult A had disclosed 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.
13. In terms of safety planning there was clear documented evidence that there was a co-ordinated approach across agencies led by Addaction. Adult A was offered support from IDVA’s and following an allegation of rape, an Independent Sexual Violence Advocate (ISVA’s). Adult A was also signposted to available support agencies. Adult A was also offered and provided with a Home Office alarm and other preventative measures such as Cocoon Watch[[24]](#footnote-24) was put into place. Adult A was provided with three separate safe contact mobile phones by Addaction but records state that she either lost or sold them for drug money. This resulted in Addaction eventually having to refuse to provide another phone to her.
14. At case review meetings and interviews, professionals discussed the option of refuge for Adult A. There is limited refuge provision in Cornwall for those with mental health or addiction issues and many staff when questioned as part of the Review were unaware of what was actually available for those with complex needs.
15. Adult A’s housing provider was seen as a main point of contact for her (together with Addaction -paragraph 15.6). Those working for the organisation worked with her to support her needs and address any welfare issues as they identified them. There was evidence of good information sharing between them and other agencies to manage risk. Those managing her case were flexible in their approach and due to her vulnerability worked hard with other agencies to keep her housed. Intervention by Sanctuary[[25]](#footnote-25) was also considered in order to protect Adult A. Sanctuary had conducted assessments at Adult A’s home address but the intervention options that they could consider were restricted as she would continually let her partners and others into the address despite the risks that they posed.
16. Adult A’s GP had become aware of Adult A’s disclosures of domestic abuse from other agencies including CFT, ambulance service and police. Adult A did not directly disclose any abuse to any of the GP practice staff and she didn’t present with unexplained injuries. The disclosures that were shared with the GP practice were however not explored further with Adult A at appointments. This could have been a missed opportunity to have engaged further with Adult A in an attempt to illicit more information or to encourage her to report matters.
17. There was clear evidence that CFT’s staff were aware of Adult A’s ‘chaotic lifestyle’ and also of Adult B’s controlling nature towards her. Whilst not recorded in her health record at the time, one of the PLS staff involved in the first assessment made by the service (13.10.2016) recalled to the CFT IMR author that they had previous knowledge of Adult B (from a previous role with Cornwall Drug and Alcohol Team – CDAT) and knew that he had been involved in abusive relationships with other young women. This contributed to staff taking the disclosers that were made by Adult A as serious. On that particular occasion the CFT IMR writer identified that staff did not appear to have triggered any further action in addition to signposting Adult A to REACH[[26]](#footnote-26). This would appear to have been an individual oversight.
18. There were many examples of staff showing sensitivity towards Adult A’s situation and presentation e.g. EIT assessment appointments were not sent to Adult A’s address but were co-ordinated through Addaction. Her Addaction worker and on occasions her housing support worker were also in attendance for some CFT planned assessment appointments. Unfortunately Adult A only attended one of these (10.11.2017). Addaction have commented to the author that they felt that EIT went over and above what they would normally do in order to engage with Adult A.
19. All of Adult A’s assessments within CFT incorporated routine enquiry into domestic abuse. The DASH risk assessment tool was however not used by any CFT staff as part of their assessment with Adult A. It was also noted by the CFT IMR author that the PLS does not have the resource or capacity to undertake DASH risk assessments. Staff within CFT also did not consider requesting the completion of a DASH by REACH with a view to gaining an up to date assessment of risk. From the meetings held with staff it was apparent that not all of them were familiar with the DASH and therefore this needs to be addressed through further training.
20. Despite the DASH not being used It would appear from a review of Adult A’s health records and from the meetings that were held with staff that they felt confident in assessing risks of abuse. Adult A’s disclosures were recorded and incorporated into her overall clinical risk rating. Disclosures and risks were shared with other agencies known to be working with Adult A (GP and Addaction).
21. 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 (with the exception of 1.02.2017, when she was describing visual and auditory psychotic symptoms) 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 that may have allowed CFT staff to explore other issues that were having a severe impact on Adult A’s life, although this would have depended upon her engagement.
22. 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’. This desperate act could have included taking her own life in order that she could end her cycle of abuse and exploitation (Professor Johnson 2008)[[27]](#footnote-27). 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.
23. 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[[28]](#footnote-28), 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.
24. RCHT previously had an IDVA service based at the hospital. At the time that Adult A presented this service had ceased due to a lack of funding. The Panel had discussed the impact that this would have had. Although in this case it would be impossible to have known whether such a service would have assisted with the engagement of Adult A all felt that it would have had benefits and it would have provided an opportunity to undertake a new DASH risk assessment (dependent upon Adult A’s cooperation). This service had previously been seen as best practice and a broadly similar provision is due to be reinstated in the coming months.
25. 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 actively engage with them and had eventually declined their help. Again these decisions were impacted upon by the pressures relating to her life experiences.
26. 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. 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.
27. The areas for improvement that have been highlighted in this section have been subject to recommendations as at 19.0.
28. Operational practice will be discussed in more detail at paragraph 16.10.

16.4Alcohol and Drug Abuse

* + 1. The second area for analysis relates to the impact that alcohol and drugs had on Adult A’s life. Adult A’s behaviour had become increasingly difficult to manage due to the deterioration in her mental health and her intense poly-drug & alcohol misuse, and this was apparent in agency records.
    2. Adult A would regularly misuse substances and the effect on her behaviour was self-evident to both professionals and her family. From the information available it would appear that the type of substance and quantity that she would take varied considerably depending upon its availability. There is clear evidence nationally[[29]](#footnote-29) of the detrimental impact that these substances can have on the lives of individuals. Exposure to these substances also increases the risk of harm and abuse. There is research[[30]](#footnote-30) that substance abuse coupled with mental health issues also increases the risk of domestic abuse.
    3. Adult A had a history of taking a cocktail of illegal substances which included amphetamine, ecstasy, crack cocaine, heroin, ketamine, Subutex, as well as alcohol. Heroin dependence was recorded by GP services from 2008. On many occasions Adult A would take a combination of these drugs and there was evidence contained within Health records that shows that she had through the challenges in her life become extremely complacent believing that regular drugs users were not susceptible to experiencing an overdose.
    4. Throughout her journey with CFT, staff had full knowledge of Adult A’s substance misuse and addiction. There are many entries within her health records regarding the effective management of her of substance misuse and scripts, There was also evidence of staff discussing with, and encouraging Adult A to embark on residential drug detoxification programmes. Addaction have advised the author that a residential place would have been available to Adult A when she indicated that she was ready to embark on this but despite numerous attempts she felt unable to take them up the offer that they had made.
    5. 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. On 13.10.2015 Adult A told her keyworker that she had been supplying and running for a new dealer in the area of Truro to support her dependency. Drug dealers were also using her home address to supply to others.
    6. Adult A lived in social housing accommodation (Devon and Cornwall Housing) in Truro. At times Adult A did not want to live at her home address as she did not feel safe. This was due to a combination of drug induced psychosis and the threat that she possibly felt from those who frequented the property. As a consequence Adult A felt that she had no choice but to become a rough sleeper in a car park in Truro. This pattern of behaviour had been identified by the CFT, Housing and a support worker on 13.03.2017. This resulted in this staff member making a referral to CFT’s community services for a mental health assessment. This action was in line with the rough sleeping policy[[31]](#footnote-31) that was and continues to be in place within Cornwall. Additional support was also provided through her housing provider (see paragraph 16.3.7) to provide her with the reassurance and confidence to remain at the property. This included the consideration of a Home Office Alarm and CCTV at the premise, Cocoon Watch, property maintenance and regular visits by staff.
    7. 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. 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. From the information available it would appear that Adult A was totally dependent upon Adult B due to her addiction.
    8. Services acknowledged that Adult A struggled to engage them due to her chaotic lifestyle, substance misuse and 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.
    9. 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. In November 2012 Adult A went through a period where she would appear to have been illicit drug and alcohol free. In December that same year there was a reported lapse with regards to alcohol which appears to coincide with the fact that she had broken up with her boyfriend. In early 2013 records show that she had also returned to taking heroin. There was also a period of stability in her life when she met and had a relationship with Adult H. Adult A relapsed once more into her chaotic lifestyle following his death which she had struggled to cope with.
    10. There was clear evidence in the records of all agencies of effective intervention in relation to drug management, particularly Addaction. Adult A’s Addaction case worker was proactive in supporting her through the chaotic moments of her life and referring her to all relevant agencies (Boswyns[[32]](#footnote-32) 16.01.2016, CRASAC[[33]](#footnote-33), SUzie Project[[34]](#footnote-34)). This worker ensured that information was shared between services and they took the role of the lead agency, co-ordinating an effective response to meet Adult A’s needs. This help and support included trying to motivate Adult A to work towards detox and supporting her through the constant relapses into substance abuse. Proactive management included the appropriate withdrawal of her script on those occasions where she was failing to engage, actively taking her to appointments and arranging for services to be delivered at Addaction premises.
    11. Despite Adult A finding it difficult to engage with agencies on many occasions the Addaction worker continued to support her. On one occasion the case worker recalled how he and agencies had waited over an hour and half for Adult A to turn up for an appointment. On another occasion Addaction managed to secure additional funding to support Adult A with housing and other needs in order to try and stabilise her life. This level of support included daily interaction which continued up until the time of Adult A’s death. On occasions Adult A resented this level of support as she felt that it was intrusive.
    12. Addaction workers spent a great deal of time talking to Adult A about her motivation and the need to set targets to take control of her life and reduce or prevent the risk of overdose. Adult A seemed to have little appreciation about this risk and one entry stated;

*‘ADULT A advised that she had taken street bought oramorph, small amounts 3 times a month and that a friend gave it to her for nothing. ADULT A was also taking pregabalin occasionally, again for no particular reason other than her friends gave it to her and it made her feel 'pissed up'. Discussion had in regard to overdose risk of combining oramorph, methadone and heroin.[Adult A] described complacency as a reason for recommencing heroin use. She stated that the heroin was not bad quality and that she was enjoying taking it and that it relived her boredom (20/03/2015)’.*

* + 1. This Addaction key worker remained grounded throughout their interaction with Adult A and was consistently honest with her constantly re-iterating to her that death was a real possibility due to the choices that she felt that she had to make. Options in relation to care pathways were made clear to her but it remained the case that Adult A was not stable enough to complete many of the treatments that were available to her. The level of support and commitment shown by the Addaction key workers in this case was exceptional and should be seen as best practice.
    2. Adult A would also drink alcohol on a daily basis and again, like her drug habit, the volume consumed would vary considerably. Her GP records show that she had a problem with regards to alcohol from 2005. On the 13.02.2017 Adult A was seen whilst in custody and admitted that she had drank two bottles of vodka but on that occasion she denied that she was drinking regularly. On other occasions she freely admitted to drinking a litre of vodka in a day. On those occasions where Adult A committed offences of theft (i.e. 28.2.2011) she was invariably under the influence of alcohol.
    3. The combination of drug and alcohol abuse had a severe impact on Adult A’s mental and physical state and was a contributing factor to her self-neglect which will be discussed later in this report. People with substance use disorders are about six [times](http://www.psychiatrictimes.com/substance-use-disorder/link-between-substance-abuse-violence-and-suicide) more likely to take their own lives than the general population[[35]](#footnote-35). Addaction workers were fully aware of this and active risk management was evident from the IMR that was submitted and from the discussions that were had with her key worker.
    4. Adult A’s GP recognised that Adult A was very vulnerable, with multiple risks of drugs, alcohol and domestic circumstances. When asked, Adult A’s GP was not sure what else could have been put into place to protect Adult A as she was known to and had (or had been offered) support from a range of services.
  1. Adult A’s Mental Health
     1. The third area for analysis is whether Adult A was vulnerable due the decline in her mental health and her exposure to substance misuse.
     2. As previously stated Adult A had a history of substance misuse and was known to take a variety of illegal drugs. She was also known to drink alcohol on a regular basis. The Review has not been able to ascertain exactly why she started to misuse drugs and alcohol but it is clear that she had done so from a very young age.
     3. 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 and difficult to determine if the psychotic symptoms Adult A was experiencing were due to stimulant misuse or an underlying psychotic disorder. 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
     4. At a number of presentations Adult A displayed elements of paranoia and psychosis which included;
* visions of shadows;
* seeing her daughter and her dog decapitated;
* visions of her mother with her eyes gouged out;
* TV changing pictures;
* seeing her family in various states and then in coffins;
* black figures with glowing eyes that she tried to confront;
* cameras in her house watching her;
* her daughter being in a car at a petrol station and then disappearing;
* hearing a woman’s voice which was derogatory in nature but not threatening or commanding;
* hearing people in her attic.
  + 1. 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. This concern came as a result of information received from other parties (RCHT emergency department, CFT, Addaction, Police and Ambulance Service). Her GP has however stated that when she presented at the surgery (on occasions with her sister) she was never under the influence of drugs and alcohol and had capacity. Adult A was the subject of an internal safeguarding meeting within the GP surgery where her risk, presentation and safeguarding were discussed by staff. This should be seen as best practice.
    2. Her GP first prescribed anti-psychotic medication (Aripiprazole) on 20.03.2017 following advice received by Addaction’s Psychiatrist. Initially, this prescription was weekly, but was subsequently changed to fortnightly in September 2017. On 5.06.2017 Adult A spoke with the duty GP and advised that this medication was causing her to have seizures. She was invited to attend a medication review the following day but did not attend. These concerns were discussed with her on 06.07.2017 when she attended the surgery and where she was assured that this medication was unlikely to have brought on the seizures and the most likely cause was her alcohol consumption. Adult A’s mental health symptoms were seen to improve when she was taking some prophylactic anti-psychotic medication. Her commitment to taking this medication varied due to the chaotic nature of her lifestyle.
    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.
    4. Under Section 2 of the Mental Health Act 1983 a person can only be detained if:
* they have a [mental disorder](https://www.mind.org.uk/information-support/new-legal-publications/sectioning-know-your-rights/terms-you-need-to-know/#mentaldisorder).
* they need to be detained for a short time for assessment and possibly medical treatment, and
* it is necessary for their own health or safety or for the protection of other people.

Under Section 3 a person can be detained if:

* they have a [mental disorder](https://www.mind.org.uk/information-support/new-legal-publications/sectioning-know-your-rights/terms-you-need-to-know/#mentaldisorder).
* they need to be detained for your own health or safety or for the protection of other people, and
* treatment can’t be given unless the individual is detained in hospital.

Under this section a person cannot be sectioned unless the doctors also agree that [appropriate treatment](https://www.mind.org.uk/information-support/new-legal-publications/sectioning-know-your-rights/terms-you-need-to-know/#appropriate) is available for that individual.

Under Section 4 a person ‘needs to be’ detained if:

* they have a [mental disorder](https://www.mind.org.uk/information-support/new-legal-publications/sectioning-know-your-rights/terms-you-need-to-know/#mentaldisorder)
* and it is urgently necessary for that person to be admitted to hospital and detained, and
* waiting for a second doctor to confirm that the person needs to be admitted to hospital on a section 2 would cause “undesirable delay”.

Under this section a person can be sectioned by one doctor only (together with the [approved mental health professional](https://www.mind.org.uk/information-support/new-legal-pubs/sectioning-know-your-rights/terms-you-need-to-know/#AMHP)) and that person can be taken to hospital in an emergency and assessed there.

16.5.8 Those professionals working with people suffering from mental health problems often use the term “mental disorder”. The Act defines this as “any disorder or disability of mind” (section 1).

Mental disorder can include:

* any mental health problem normally diagnosed in psychiatry
* learning disabilities, if the disability makes a person act in a way which may seem abnormally aggressive" or "seriously irresponsible".
  + 1. Based on the assessments that were made in this case by the PLS, health care professionals did not find any evidence of any underlying acute mental health disorder and they concluded that Adult A’s symptoms were indicative of substance misuse or withdrawal symptoms.
    2. In this case on those occasions that Adult A presented to Health services they concluded that there was no immediate need of care and control. On each occasion that Adult A was assessed she was deemed to have capacity and therefore did not reach the thresholds laid down by the Mental Health Act. There has been nothing identified through the review process that would contradict this view.
    3. There were six referrals to PLS, two to the L&D service[[36]](#footnote-36) and six to community mental health services, including those made to EIT and re-referrals following Adult A’s non- attendance of earlier appointments. There was also one hospital in-patient admission. In addition to these two further contacts were made by phone to CFT’s out of hours mental health service, and there was one contact when Adult A walked into an ICMHT base. The assessments that were made were also informed by historical and multi-agency information. Records indicate that risks were explored by appropriately trained staff and that they were documented both in the progress notes and risk assessments. The plans that were put into place were discussed with Adult A and details were shared in writing with Adult A’s GP and in most cases with Addaction (with the exception of the third contact with PLS).
    4. Adult A was referred four times to the EIT. The aim of the service is to assess and treat people as early as possible in the course of their illness. The service treats individuals experiencing a first episode of psychosis including drug induced psychosis and manic depressive psychosis who are aged between fourteen and thirty five years. Upon receipt of the first telephone referral initiated by the CJLDS[[37]](#footnote-37) (17 February 2017), the referral was discussed by the Multi-Disciplinary Team (MDT) and further explored in conjunction with Adult A’s psychiatric assessments in view of her recent (2-3 February 2017) in-patient admission. On that occasion the referral was discharged as Adult A did not meet the criteria for the team as those that had examined her concluded that the possible psychotic symptoms were short lived and there was heroin withdrawal. In hindsight the CFT IMR writer recognised that this may have been a missed opportunity as Adult A may have engaged sooner had she been dealt with at this point.
    5. The EIT contact for Adult A in July 2017 followed a referral to the team from the Local Authority’s Safeguarding Team. This referral had initially been received by Carrick ICMHT on the 21.07.2017. Following the referral numerous attempts were made the EIT to phone Adult A on the numbers that had been provided. Despite these attempts there was no answer and the duty worker noted from her health record that Adult A was street homeless. The referral was passed to the West EIT and was triaged on 31.07.2017. Following this an appointment for Adult A’s assessment was made for 17.08.2017. The CFT IMR author noted that there was ten days between the referral from the Adult Safeguarding Service being triaged by each team and a further seventeen days before the appointment. Some of the delay between EIT triage and the scheduled appointment date appears to have been caused by EIT not being able to get hold of Addaction and Devon and Cornwall Housing by phone – six attempts made by EIT in this time frame. The IMR author identified that this delay was clearly not helpful for a client who was recognised as being at high risk to herself and from others and where ‘windows of opportunity’ with which to engage with Adult A were known by this stage to be limited.
    6. Following the second missed appointment on the 17.8.2017 a decision was made to discharge Adult A after which EIT were contacted by the Adult Safeguarding Service. On this occasion Adult Safeguarding queried that the decision to offer no further appointments was ‘leaving this very vulnerable person without anything’ and they questioned whether there was anything further that could be done to get Adult A to engage. EIT at that time stated that they intended to become involved again when Adult A was ready to engage and this was communicated to Addaction. EIT reiterated that they were committed to attend further safeguarding meetings when they were held. The CFT IMR author notes that in making their decision EIT had not considered Adult A’s capacity and ability to make choices and decisions based on free will and without the coercion/duress from Adult B, as disclosed earlier by Adult A. Again the issue of substance use became the focus along with the view that services needed to wait for the adult to be ready to engage, thus losing the safeguarding risk issues from the abuse. The author also questions whether at this point this team could have reversed the decision to discharge and offered a further appointment as part of being flexible towards a client who was known to be at high risk of abuse (neglect and domestic), very vulnerable and at risk of harm from self, although noting a number of appointments were offered which was over and above the usual operational policy.
    7. EIT offered Adult A eight appointments which she did not attend. Adult A did attend her assessment appointment on 10 November 2017.
    8. The difficulties that professionals had in this case were shown when Adult A was an informal inpatient at Longreach House (2 /3.02.2017). On this occasions Adult A had requested to leave the hospital. Discussions had taken place with Adult A to encourage her to remain on the ward over the weekend in order that she could remain in a ‘safe place’. However, this was not something that Adult A wanted to do. Health care professionals (ward consultant, nursing staff and her Addaction worker) discussed and considered various options in an attempt to keep Adult A at Longreach. By this time, the psychotic symptoms that she had been displaying two days earlier had dissipated. Health professionals at that time concluded that Adult A did have the capacity to make decisions regarding her health and well-being and that there was no legal framework (Mental Health Act, Mental Capacity Act[[38]](#footnote-38), Deprivation of Liberty[[39]](#footnote-39)) that could be applied to detain her in hospital. On this occasion Adult A left the hospital with her Addaction worker.
    9. A series of attempts had been made to assess Adult A’s mental health more fully, which had been hampered by Adult A’s level of engagement with Adult mental health services. On reflection medical staff who were seen as part of this Review have concluded that no comprehensive assessment of Adult A’s personality or mental health had taken place when she was substance free. One member of staff reflected that a detention under the Mental Health Act to enable this assessment may have been a remote option, had a full review of all the notes and circumstances been undertaken. On reflection they also concluded that practically there was limited confidence that a Mental Health Act assessment would have indicated detention or that such a detention would have been maintained long enough to be enable to a full assessment to take place. Even if Adult A had been detained under the authority of one clinician it was likely that another would have deemed her to have had capacity and therefore she would have been released.
    10. The CFT IMR’s clinical adviser has commented that ‘Adult A was a chaotic and vulnerable drug user who was potentially the subject of control and physical/emotional abuse by her partner. She appeared to have had a difficult and dysfunctional early life. She was supported by multiple agencies (Addaction/Safeguarding/EIT/CMHT) but none were able to engage with her in any sustained or meaningful manner. Clinically Adult A’s initial presentations (multiple presentations to RCH Treliske ED in the year prior to \her death) appear to be consistent with drug-induced psychotic symptoms (in the context of drug intoxication/withdrawal) which rapidly resolved when she was drug free. Latterly there was possible evidence of more persistent psychotic symptoms (i.e. derogatory voices, paranoid thoughts, visual and tactile hallucinations). However, the picture/ definitive diagnosis however remained clouded by Adult A’s persistent use of drugs and alcohol. Adult A had been prescribed antipsychotic medication (Aripiprazole) for psychotic symptoms, but had only taken them intermittently, and stopped them as she felt it had contributed to her having seizures (more likely related to alcohol withdrawal).
    11. Adult A was briefly reviewed by EIT a short time prior to her death. She again appeared to be presenting with psychotic-type symptoms but her drug screen was positive for multiple substances, including cocaine and opiates. This again made an accurate diagnosis difficult. On being questioned about her symptoms Adult A had however stated that psychotic experiences were present even when she wasn't taking any drugs. The reviewing doctor therefore recommended that a minimum of a two week drug-free period[[40]](#footnote-40) would be advised in order to get a clearer picture of her mental state (although they accepted that this may not be realistic or possible in view of her lifestyle). The reviewing doctor also planned to continue the assessment with EIT and to liaise with other involved agencies, particularly Addaction. This course of action would appear to have been appropriate in the circumstances.
    12. 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 believe that she did have an underlying psychosis which she minimised at times when it suited her (e.g. when Adult A was in Longreach there was a belief that she said that she wasn’t hearing voices so that she would be allowed to leave). Again this made an accurate diagnosis difficult.
    13. When EIT had accepted Adult A’s referral from Addaction, this service made it known that they would go the extra mile to assess Adult A’s mental state. This agency told the CFT IMR author that EIT were willing to undertake assessments at venues more convenient for Adult A such as Addaction Offices and at Adult A’s home address. This team also undertook more attempts at assessing Adult A than the team’s policy had recommended. Following the first referral, for example, this team tried five times to assess Adult A, whereas ordinarily they would discharge after two to three failed appointments. Additionally the L& D service identified that their support workers could offer support for Adult A to attend to see her GP (after encouraging Adult A to make an appointment (13.02.2017) and for the EIT assessment. Adult A would sometimes leave Treliske Hospital prior to completion of assessments by the PLS (26.01.2017, 18.8.2017). This flexibility in the delivery of service should be seen as best practice.
    14. Clinical risk including risk of domestic abuse and risk of harm from herself (including the risk of 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. Suicidal ideations were always explored with Adult A. Research[[41]](#footnote-41) evidence now clearly shows a direct link between women's experiences of domestic abuse and heightened rates of depression, trauma symptoms, and self-harm. Intimate partner violence is also seen as a significant risk factor for suicidal thoughts and behaviours[[42]](#footnote-42).
    15. CFT staff who knew Adult A were aware and had documented the high risks to her health and well-being due to drug abuse and other aspects of her lifestyle. Adult A had talked about taking her own life and there were some impulsive events recorded that had put her in danger of ending her life (i.e. jumping in front of a lorry, entering into a river to save a baby which wasn’t there). Those that dealt with however have all stated that Adult A never gave specific cause for concern that she would deliberately end her life at any of her presentations.
    16. Whilst her risk of her taking her own life was considered to be low Adult A’s clinical risk was rated as high in relation to the risk to herself and from others but this was due to the impact of drug abuse ( CFT IMR; 13.01.2016, 24.07.2017).
    17. On her last contact (10.11.2017) with CFT staff from EIT they described how Adult A did not appear to be distressed or frightened and that she had clearly indicated a willingness to attend further appointments.
    18. In summary CFT’s engagement with Adult A followed occasions when she actively sought help for her mental health or opportunistically, with consent, when presenting at Treliske Hospital, a police station and at Court. On these occasions she was provided with a service for her mental well-being (assessment including risk assessments and a ‘care plan’) along with suggested follow-up such as via her GP or Addaction. Adult A had also been provided with additional information on other support services (Out of Hours Help, Samaritans, IDVA and other domestic abuse support services).
    19. Within CFT Adult A had contact with numerous members of staff but most of them only had one contact which was often opportunistic and brief. Consequently, no single member of CFT staff had been in a position to build up any consistent therapeutic relationship or continuity of care. Staff were dependent on building up a picture of Adult A from electronic health records and information sharing between colleagues in different services or from other agencies such as Addaction. Those members of staff who did have contact with Adult A have conveyed that they often felt ‘helpless’ in terms of what support they could offer. Similarly one team leader spoke of how staff within his team wanted to ‘rescue’ Adult A although they recognised that they had to work within professional and legal frameworks.

* + 1. There was also evidence that overall risk had also been considered by other agencies. Adult Social Care used the Signs of Safety within Safeguarding[[43]](#footnote-43) to decide on the risk level and the IMR writer verified that this was evidenced in the adult protection initial meeting document which concluded that Adult A was a high risk. This document clearly showed the risks identified and the decision making process in this case. There were also clear goals and actions set for all agencies involved.
    2. Addaction also clearly recognised that Adult A lived a very high risk, chaotic lifestyle and appropriate risk assessments were completed in order to deal with this. Those working with Adult A on a daily basis concluded that from their perspective her death could not have been foreseen. Despite Adult A suffering from drug induced psychosis and low moods she had never expressed an intent to take her own life to those that worked closely with her. Like those working in Health, Adult A’s Addaction worker believed a far greater risk came from accidental overdose, exploitation or physical abuse.
    3. 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. The true impact of his death on Adult A’s mental health was however difficult to ascertain, although her family saw this as a significant event in her life. Agency records do not contain any specific information and it would appear that Adult A did not confide in any professional about her feelings on the matter in the weeks following his death. Addaction have stated that when they spoke to her shortly after the death of Adult G she was clearly emotional but this had then subsided after she had returned to her normal level of substance abuse. Following the death, Adult A returned to her relationship with Adult B and her life deteriorated once more into the chaos that professionals had previously seen.
    4. Addaction have also stated that Adult A had disclosed that she had thought that she had been pregnant just prior to her death. Again the impact of this on her mental health could not be ascertained and she did not disclose what her thoughts about this to professionals or her family. There was nothing recorded in the post mortem report to suggest that Adult A was in fact pregnant.
    5. On the morning of her death it is clear that Adult A had been suffering from elements of paranoia. She had left her friends address where she had stayed the night and returned to her own home. Whilst at her home address Adult A had called the police saying she could hear voices in the house. The police attended and on searching the premise 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 were attributable to her drug use. Adult A remained at home address for about thirty minutes before returning to her friends address. At about 1.30pm that same day Adult A told her friend and Adult B that she was going to see her niece and baby and she left the premise. Adult A was found hanging from a tree twenty-five minutes later by a member of the public.
    6. 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. Capacity
     1. The next area for analysis is whether Adult A had capacity to make informed decisions in her life. As stated in the previous section Adult A’s capacity to make decisions would fluctuate according to the type and amount of substances that she had taken. Whilst there is nothing to suggest, from the assessments that were made, that she did not have capacity the clarity of her decision making was undoubtedly influenced by other external factors in her life.
     2. Nationally adults who use substances are often viewed as making unwise ‘lifestyle choices’, and that there is little that professionals can do to intervene while the adult is not ready to address their addictions. Staff within agencies therefore often feel disempowered when dealing with such individuals. Services also lack sufficient resources to manage the volume of substance users that present to psychiatric liaison services in general hospitals and therefore those that are willing to address their addictions have to be prioritised. Issues regarding fluctuating capacity and mental health issues due to drug addiction and alcohol misuse, and its impact on conducting accurate mental health assessments has been the subject of national research.[[44]](#footnote-44)
     3. Issues of high risk self-neglect and the testing of a person’s capacity are often not considered to be part of the assessment that staff carry out in healthcare settings. Staff use the presumption of capacity in line with the Mental Capacity Act (MCA) and in cases such as this will they often believe that the Adult is making ‘unwise lifestyle’ choices. The Adult’s ability to verbalise that they understand what they are being asked or that they are able to convey that they do not want from a service is frequently accepted as capacity. There is emerging research from safeguarding Adult reviews (SARS) about cases of self-neglect, which indicates the need for a change in direction nationally to consider the need to consider executive capacity. The literature reveals that capacity is a complex attribute, involving not only the ability to understand the consequences of a decision but also the ability to execute the decision. Where decisional capacity is not accompanied by executive capacity, and thus overall capacity for autonomous action is impaired, ‘best interests[[45]](#footnote-45)’ intervention by professionals to safeguard wellbeing may be legitimate. The assessment of executive capacity is described as the ability to act on a decision and to manage any consequences of it[[46]](#footnote-46). There is additional challenge and complexity in relation to those Adults who also use substances and where there are circumstances of alleged abuse and exploitation.
     4. The Mental Capacity Act reiterates that the starting assumption for all professionals should always be that the person who they are dealing with has capacity. The Act further details a two-stage test of capacity:

1. Does the person have an impairment or a disturbance in the functioning, of their mind or brain? This can include, for example, conditions associated with mental illness, concussion, or symptoms of drug or alcohol abuse.

2. Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? Appropriate and practical support should be offered to achieve this before applying this stage of the test.

To be able to make a decision a person should be able to:

• Understand the decision to be made and the information provided about the decision. The consequences of making a decision must be included in the information given.

• Retain the information – a person should be able to retain the information given for long enough to make the decision. If information can only be retained for short periods of time, it should not automatically be assumed that the person lacks capacity.

• Use that information in making the decision – a person should be able to weigh up the pros and cons of making the decision.

• Communicate their decision – if a person cannot communicate their decision, the Act specifies that they should be treated as if they lack capacity. All efforts to help the person communicate their decision should be made before deciding they cannot.

* + 1. Adults A continually presented to professionals (except for her GP) under the influence of alcohol or drugs and often her disclosures and allegations were clouded by this. Adults A reaction to the alleged abuse was ‘blunted’ by the substances that she took. As a result of this abuse and her addictions Adult A also did not engage well with services and often professionals were unable to contact her, or she failed to attend appointments (08/01/2013 24/01/2013). On occasions Adult A left assessments and appointments part way through and this frustrated any attempts by professionals to work with her. All of these factors impacted on the ability for professionals to accurately assess her capacity and to consider duress and whether adult a had free will due to the controlling nature of her relationship with Adult B.
    2. A formal assessment of capacity includes assessing an individual’s ability to understand the implications of their situation, take action to protect themselves from abuse and for them to fully participate in decision making about interventions. From information in this case these points raise questions for CFT and other agencies involved in the care of Adult A and any other similar patients. In this case and in hindsight Adult A may not have been able to make choices with free will due to alleged control and coercion from Adult B. It is important to note that there is a distinction between a lack of capacity within the meaning of the Mental Capacity Act and being unable to make a decision due to undue influence, coercion or duress. As such there is an emerging practice challenge for services working with people who use substances to consider capacity through a different lens.
    3. On occasions Adult A displayed full capacity and there were moments in her life when she had attempted to take control. These moments were however limited in number due to her continued exposure to substance abuse.

16.7 Self Neglect

1. The fifth area for analysis is whether Adult A was vulnerable to self-neglect due to her declining mental health and her exposure to drug addiction. This section will also explore whether Adult A could and should have received additional support that may have addressed this condition.
2. Adult A did meet the definition of vulnerability used by statutory agencies[[47]](#footnote-47) 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.
3. 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. Agency records also clearly demonstrate that professionals were cognisant of the impact of Adult A’s chaotic lifestyle on her health. Throughout the period covered by the Review Adult A had been supported by Health professionals, including GP and mental health services, all of whom were monitoring her health and welfare.
4. 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. This included the period in her life when she had decided to sleep in a local car park rather than at her home address. Professionals were alive to this issue and continually provided advice and support to Adult A during this period. Her Addaction worker was particularly supportive during these periods in her life and the level of that support that was provided went beyond that which would normally be provided to the majority of other service users.
5. 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. All agencies through a multitude of forums were monitoring Adult A’s health and offering support where appropriate.
6. 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. This protocol is currently being reviewed and will work alongside the high risk behaviours policy which was ratified September 2018 – it is anticipated that staff will use the self-neglect policy first and when exhausted and where they have not achieved risk reduction referrals will be made into a ‘high risk panel’ for discussion and alternative action. The protocol itself is available to staff on Cornwall Councils Adult safeguarding web pages and also on CFTs electronic document library. This protocol has been frequently circulated to clinical teams within CFT and to staff within other agencies. 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.

16.8 Risk Management – Adult A

1. There were significant high risks identified in Adult A’s life and these included;

* Abuse of drugs, alcohol
* Mental Health
* Adult A underestimated her risk of harm from Adult B.
* Separation – Adult A had separated or attempted to separate from Adult B on numerous occasions.
* Pregnancy – Adult A had stated to Addaction that she was pregnant a week prior to her death.
* Controlling behaviour.
* Escalation and repeat victimisation.
* Isolation
* Sexual assault

1. These risks were known to professionals and identified in agency risk assessments. Not only have these risks been linked with increased probabilities of homicide they have also been linked with individuals taking their own lives. Studies[[48]](#footnote-48) have found that domestic abuse survivors have higher than average rates of suicidal thoughts, with as many as twenty three percent of them having attempted to take their own lives compared with three percent among populations with no prior domestic abuse exposure.
2. The review has identified that the risk management of Adult A was actively considered by Health services in relation to mental health and substance abuse. Examination of agency records has also identified that other agencies were also cognisant of the risks that Adult A was exposed to.

1. In this case there was clear evidence of fluctuating mental health, substance abuse and domestic abuse[[49]](#footnote-49). The presence of this these factors is recognised as a clear indicator of increased risk of victimisation to both children and adults.
2. In addition to Health services who were monitoring risks other agencies (Addaction, Housing, Police) were also doing likewise. Whilst each agency was looking at risks factors that were pertinent to their own organisation there was also a collective understanding of the issues that Adult A faced due to the numerous multi agency meetings that were held about her. Each agency where appropriate documented the risk factors and plans were put into place to mitigate those issues that were identified.
3. The Police continually assessed risk as part of their interaction with Adult A. The key issues for police were focused on safeguarding, domestic abuse, and criminality (with Adult A being a victim and perpetrator). Risks would appear to have been correctly considered and incidents prioritised accordingly, including attendance at reported domestic abuse incidents. Police based risk decisions on all available information. This can be seen on the 06.08.2017 when police received a call from Adult A stating that she was going to take her own life. Police made immediate enquiries in line with their response policy[[50]](#footnote-50) to locate Adult A, and she was later seen in the presence of her family. On this occasion Adult A stated that she was no longer feeling suicidal but despite this the attending officer submitted a red rated ViST[[51]](#footnote-51) in which they documented their views that “whilst Adult A is in a relationship with Adult B that he would kill her or supply the drugs that will take her life. Adult A needs support in breaking her relationship with Adult B and to start living dependently away from him”. They further state that “Adult A is saying the right things to Police such as she knows that if she stays with Adult B she will end up dead and that she does not want to be with him. She knows that she is not strong enough to him”. These risks were clearly documented and shared as part of multi-agency practice.
4. As a result of concerns such as these Adult B was made a DASSP and Adult A was referred to the MARAC process. Adult A was also supported by specialist domestic abuse officers, who are experienced and trained to deal with victims of abuse. Adult A’s case was also referred and discussed at the ‘Serious Organised Crime Group[[52]](#footnote-52)’ and raised to the local neighbourhood team. The neighbourhood crime team also sought to assist Adult A and entries detail their frustrations of about her lack of engagement;

“*There is no more we can do at this time to safeguard Adult A. She has a dedicated Addaction worker, professionals meetings have taken place, safety plans put in place at the hospital, opportunities to work with IDVA's and police about DV disclosures, individual budgets from housing and Adult social care have been utilised. At the end of the day Adult A is addicted to substances, she doesn’t want to rehabilitate herself at this time, she continues to state she loves Adult B and doesn’t want to leave him, continuing to put herself in harm’s way despite every professional telling her of the negative impact the relationship is having upon her physical and mental health.” (Police IMR -*20/08/17).

1. Even when Adult A was dealt with as a suspect for a crime, there is documented evidence that her welfare and vulnerabilities were considered and this should be seen as best practice. Whilst in custody Adult A was the subject of safeguarding reviews. There were referrals to drug and alcohol dependency support workers, and she was seen by liaison and diversion mental health nurses and other health care professionals.
2. Although Adult A’s willingness to engage presented a significant issue for all agencies in the management of her risk there was evidence recorded within records that would indicate effective safety planning taking place (i.e. housing did not evict Adult A despite ASB and non-residence issues at her address, IDVA and Addaction making significant efforts to engage Adult A). The risks identified were managed on a multi-agency level and significantly via the MARAC process. There was also evidence that the safety plans that were initiated were discussed with family members when this was deemed to be appropriate (discussion with Adult A’s mother 12.02.2017).

16.10 Operational Practice, Policy and Procedure

* 1. The seventh area for analysis was whether professionals had a good knowledge of relevant policy and practices and whether this was reflected in operational practice. This analysis includes the knowledge and policies relating to domestic abuse.
  2. All of the agencies involved in this case had policies in place with regard to safeguarding and domestic abuse. These policies are known to staff and are available to them through internal intranet sites. Whilst policies in the main were robust the Review has highlighted a number of areas of operational practice that require additional improvement.
  3. During the period of the review there has been a significant change in the Police’s response to safeguarding. In December 2015/January 2016 the Force restructured from having a Central Referral Unit (CRU) to the implementation of a Central Safeguarding Team (CST) and a new Single Safeguarding Process (SSP). The SSP had been introduced to deliver a consistent approach to meeting the Force’s safeguarding requirements. Both Adult and children safeguarding activity and the decisions made in respect to them are coordinated through a single process to ensure that cases are comprehensively researched and risk assessed, information is shared more effectively with partner agencies, and early decisions are made to determine the most appropriate agency and response required. Key elements of the SSP include the ViST (Vulnerability identification Screening Tool) which is a risk assessment tool employed by police officers and staff to assess vulnerability and the Central Safeguarding Team (CST), which receives and processes the ViST to identify cases requiring further multi-agency assessment and intervention. The Force has also created an effective process to share information with other agencies.
  4. Prior to 2016 the existing structures and processes within the Police, in relation to safeguarding, had a lack of consistency and the effectiveness of service delivery was dependant on location. In a national context a lack of effective multi agency safeguarding has resulted in several high profile cases and public enquiries[[53]](#footnote-53) with consistent themes emerging. Each had identified shortcoming in the Police’s (and partner agencies’) ability to identify vulnerability and engage in effective multi-agency information sharing and safeguarding arrangements.
  5. The changes that have been made in relation to the Police safeguarding process was evident in their IMR in relation to the submission of ViST’s, their quality assurance and review, and the subsequent sharing of information.
  6. Policy D034 is the Devon and Cornwall policy regarding domestic violence and this policy has been changed a number of times during the timescale considered in this review. This Policy refers to the use of the DASH risk assessment tool. The DASH must be used at every domestic abuse incident. In relation to the incidents between Adult A and Adult B the DASH assessments were completed as per the Forces’ policy.
  7. The Police IMR detailed how their response had escalated over time and the number of safeguarding actions that were delivered. Adult A was the subject of safeguarding Adult enquiries, she had a police alarm installed, warnings were placed on the addresses she frequented, cocoon watch was implemented and Sanctuary assessments completed. Police Referrals had been made to alcohol and drug referral workers and information had been shared with Adult A’s GP (07/08/2017).
  8. Whilst overall there was good evidence of multi-agency working the Police identified in their IMR that they were not involved in safety planning when Adult A was discharged from Longreach (03/01/2017). This occurred despite the domestic violence officer in charge of Adult A’s case asking to be contacted when she was due to be discharged. Addaction have also stated that they felt that there was a lack of effective discharge planning on this occasion and that their concerns regarding the safety and wellbeing of Adult A were to a large extent disregarded by CFT staff. Adult A’s Addaction caseworker stated that discussion had taken place in relation to the provision of an antipsychotic medication. Adult A who appeared to have capacity stated that she did not want this at that time and Addaction staff felt that she had simply stated this in an attempt order to expediate her discharge on this occasion. Adult A left the ward with her Addaction worker who took then her back to Truro. The Addaction caseworker has stated that they were surprised that the ward did not provide Adult A with a Subutex prescription as this presented a risk for Adult A, who was unlikely to have access to any form of medication (due to it being a weekend) and that it should have been obvious that she would have turned to illicit drugs. From discussions with Addaction it would appear that whilst there are good working relationships with CFT staff they can on occasions feel as though they their views are not taken into account.
  9. Since Adult A’s death and the initiation of the DHR, CFT has undertaken two case review meetings with staff who had met Adult A. These meetings have explored key aspects of assessments and decision making around Adult A. These form part of learning from experience which will contribute to practice change in these teams and have been articulated in this review. The learning from these case review meetings have been incorporated into this report.
     1. CFT provides an out of hours service (OOH) for Adult mental health patients. This is currently provided by CFT’s Home Treatment Teams. Patients, carers or professionals can telephone the service if they have concerns in relation to their own or another person’s mental health well-being. Unless urgent, this service do not undertake or arrange patient assessments, but will provide advice as an interim, until a patient can be assessed by an appropriate department. Where a patient is on the caseload of one of CFT’s adult mental health services, there is a requirement that the OOH’s will advise that service of details of the contact to enable any follow up required.
     2. On the 18.01.2017 Adult B had contacted the OOH service regarding concerns that he had in relation to Adult A. The OOH service phoned Adult B later that same night. The member of staff did not speak with Adult A but information that was shared by Adult B regarding her was recorded within her health record (hearing voices, talking to herself, the fact that she had tried to pour a kettle of hot water over herself, and how she had tried to jump in front of a lorry). Adult B stated that Adult A needed help. This contact noted that at times Adult B was difficult to understand and he had also come across as threatening. Adult B was advised to refer Adult A to Carrick ICMHT the following day or take her to the local hospital that night if his concerns continued. The caller was aware of allegations that had been made about Adult B by Adult A from health record entries. No further action was taken by OOHs at that time. The CFT IMR author has questioned whether this response was appropriate, if viewed from a perspective of Adult B phoning in as Adult A’s carer and that he was trying to access help. This referral was identified as a window of opportunity to complete an assessment of Adult A’s psychiatric and safeguarding needs and therefore the matter should have been referred on to an appropriate service for follow up.
     3. In total Adult A was referred to EIT on four occasions. Upon receipt of the first telephone referral initiated by the CJLDS (February 2017), the referral was discussed by the MDT and at that time consideration was also to the psychiatric assessments from her recent (2-3 February 2017) in-patient admission. A decision was made to discharge the referral as Adult A did not meet the criteria for the team due to her psychotic symptoms being short lived and being associated with her heroin withdrawal. The information from the last PLS assessment the Adult A’s psychotic symptoms may not have been solely attributable to substance use; the information from the Addaction consultant who raised similar questions; and the referral to iCMHT from Addaction noting that she displayed symptoms even when not using substances were over shadowed by the substance misuse at time of this referral. Again the IMR report writer has identified that this may be a missed opportunity and that in hindsight, this may have enabled professionals to engage Adult A sooner.
     4. Two further referrals were received from CFT services (CJLDS written referral and Housing Support – telephone referral) a month later and triaged by EIT (17 March 2017) The outcome of the referral was to offer Adult A an assessment. Addaction were asked to co-ordinate the appointment. When Adult A did not attend the first and the following four alternative appointments she was discharged from the team. Adult A’s GP and Addaction were advised of this decision. The decision to discharge at this point would seem to have been appropriate. Ordinarily this team would discharge a patient after two or three missed appointments. The approach to offer more than three appointments demonstrated a willingness to engage with Adult A over and above what is expected and there was flexibility in the service. The team made it clear to Addaction that they would respond and assess when Addaction thought that it was most appropriate. This approach should be seen as best practice.
     5. CFT staff did not make any referrals to REACH or Adult Safeguarding and there was no discussion with CFTs Adult safeguarding team about Adult A’s case. When seen by PLS staff on 17.02.2017, a referral was made to the Councils Adult Safeguarding and to a medical team for self-neglect. Whilst not in the patient’s health records, these referrals were actioned. Safeguarding concerns were discussed with RCHT’s Adult safeguarding nurse, who then made a referral to the Adult Safeguarding Service[[54]](#footnote-54).
     6. Staff interviewed as part of the review process where aware of safeguarding information as they had been present at the multi-agency and internal meetings where her case had been discussed and the detail was also recorded in clinical records. This detail included the fact that an adult safeguarding referral had been made and an IDVA was supporting Adult A. This provided reassurance to staff in relation to the action that was being taken but contributed to them not progressing the matter further. This was seen as a missed opportunity to get an up to date understanding of where the safeguarding process was, and to initiate a re-assessment of the risk from domestic abuse.
     7. This review has considered what policies and procedures CFT had in place with reference to Adult safeguarding, domestic abuse, risk assessment and risk management at the time of the incident. The relevant policies and practices were in place including an Adult Safeguarding Policy which was last updated in September 2017. All CFT staff are orientated to these policies upon appointment and can access them via the Trusts intranet.
     8. In May 2014 CFT launched a Domestic Abuse Strategy which included structured implementation of Routine Enquiry (RE) into domestic abuse, reflecting statutory, Department of Health and NICE guidance. RE was introduced in CFT in 2015. Initially this practice was initiated within the PLS and was already in place in CAMHs and health visiting services. In April 2016 CFT took on adult community services previously provided by Peninsula Community Health (PCH). This was a significant change to service delivery and the consequences of prioritising this work has resulted in the roll out of routine enquiry to some departments being slower than planned. Since September 2017 Nurse consultants, senior managers and individual team managers are now responsible for the roll out of RE for their respective specialities. In this case Adult A was asked questions in line with this practice although the quality of that questioning was variable.
     9. A clinical risk assessment tool is in place in CFT and is completed for all adult mental health patients as part of initial and subsequent assessments of their mental health and well-being. This tool is held, recorded and saved within the patient’s electronic health record on RiO[[55]](#footnote-55). This tool gathers information on amongst other risks, risk of harm to self, including suicide, risk of harm from others and requires a rating based on the assessment and clinical judgement of low, medium or high risk. Following recommendations in a CFT IMR for a mental health homicide in 2014 , this risk assessment now includes questions about domestic abuse. This requires staff to ask questions about domestic abuse and where they fail to do so record the reasons why. This screen also links directly to the patient’s core assessment. This risk tool was also reviewed and updated in late 2017 to ensure that staff were not able to move past this question without answering it , as a means of reminding staff to make the enquiry. This tool was used in assessing the risks associated with Adult A’s behaviour.
     10. At the time of Adult A’s later interactions with CFT, the Trust was using the STORM risk assessment to identify those at risk of taking their own life, alongside the RiO risk assessment. The RiO risk assessment tool captures a range of risks including harm to self and others. CFT have subsequently been developing a new suicide risk assessment tool along with training for staff, which is currently being piloted. This process will assist practitioners who may be dealing with similar cases in the future.
     11. The DASH risk assessment is available for CFT staff who have attended the DASH risk assessment training day. If high risk of domestic abuse is identified staff can make a referral to First Light’s REACH[[56]](#footnote-56) service, refer direct to A MARAC and raise a safeguarding alert to safeguarding services. A safety plan template for CFT patients experiencing domestic abuse is also available on the Trust intranet safeguarding pages and also from First Light web pages should the patient not be ready or consent to a referral to REACH (Cornwall’s local domestic abuse support service). CFT’s PLS do not currently use the DASH risk assessment, due to capacity issues, however most staff have had DASH risk assessment training. The PLS team leader, interviewed as part of the review process, stated that they do use a proforma mental health assessment tool, which captures risk including risk from domestic abuse.
     12. It was apparent from interviews and discussions held with CFT staff as part of this IMR, that staff felt comfortable about making a routine enquiry into domestic abuse, recording responses and signposting their patients or clients onto agencies that could provide support, although one practitioner (bank nurse in PLS) had lack of awareness of domestic abuse support services.
     13. Despite the reassurances provided in paragraph 16.10.19 the author of the CFT IMR identified that despite several high indicators for domestic abuse being disclosed by Adult A through her journey with CFT, staff did not routinely seek further advice from CFT’s Adult Safeguarding Team, directly refer Adult A to Cornwall’s REACH service or to the local authority Adult Safeguarding Service until 17.02.2017. On this occasion a staff member from PLS discussed their concerns with RCHT’s Adult Safeguarding Nurse, which then prompted a safeguarding referral to the Adult Safeguarding Service. From discussing this issue through with staff it was apparent that although policy is in place they were otherwise influenced by a range of factors (such as Adult A’s primary presentation being related to requests for drugs and withdrawal) and reassured by the knowledge that an IDVA, Addaction and Adult safeguarding referral had been already made and that Adult A was receiving support from a whole range of services.
     14. As in this case people with drug and alcohol problems can often find it difficult to engage with services and will due to their lifestyle persistently self-discharge and therefore any treatment pathway must include consideration of assertive outreach services. In this case this pattern of behaviour was evident and Addaction have highlighted that Adult A needed to be assertively followed up in the community. Both staff from CFT and Addaction have identified that a joint understanding and joint working between Addaction and community based adult mental health services could be improved for patients with alcohol or substance misuse and who are experiencing mental health problems. A shared treatment pathway could be developed and it is noted that this was a recommendation from a previous DHR.
     15. Locally all agencies have been involved in developing and implementing a Dual Diagnosis strategy. The purpose of this strategy is to assist delivery and experience of integrated and inclusive service delivery for people with co-existing mental health and substance misuse problems, and their associated complex needs through consistently collaborative working. In order to achieve this a new steering group was established in November 2018 to bring together representatives from the main commissioned services to better understand and respond to the needs of those with complex needs who often fall between commissioned service provision. This is a positive step forward and should be seen as best practice.
     16. CFT staff who attended one of the case review meetings for this IMR were asked if they had considered modern slavery[[57]](#footnote-57) as part of the domestic abuse that Adult A was disclosing. Professionals had not considered this at the time. An attendee who had compiled a report for the Coroner following Adult A’s death has since reflected that having analysed her health records and domestic abuse disclosures that elements of modern slavery were evident in the relationship with Adult B. These elements were;
* Adult B controlling Adult A’s movements and travel.
* Adult A being under the control and influence of Adult B
* Adult B speaking on Adult A’s behalf
* Possibility of Adult A having to pay off drugs debts to Adult B.
* Drug dealing for Adult B through fear of violence and intimidation.

The barriers to Adult A reporting this type of abuse and to receiving support are similar to those experienced by all domestic abuse survivors. For many survivors there are concerns about retaliation by their abusers and dependency on them in terms of finance and, as in this case, for drugs. There can also be a mistrust of the criminal justice system and the abuse being normalised. The use of modern slavery and human trafficking legislation in cases such as this is becoming more widespread and is now taught as part of the Health Intercollegiate document[[58]](#footnote-58).

* + 1. Adult A was not on the case load of Carrick Integrated Community Mental Health Team (ICMHT), but there were three contacts (one face to face and two referrals) where brief assessments of Adult A’s presentation had taken place. Adult A’s GP has however expressed frustration with adult community mental health services, feeling that GP’s are often ‘fobbed off’ in relation to those individuals who have complex needs (CFT IMR). In cases involving people like Adult A they are often re-directed to addiction support services rather than having an opportunity of being assessed by a mental health practitioner. There is an opportunity for GP’s to raise with mental health staff issues of concern at a liaison meeting in relation to complex cases. It is not known if there was any discussion about Adult A although there is confirmation that some GP/mental health liaison meetings did take place.
    2. In relation to Adult Social Care appropriate referrals were made to the agency in 2015 and following discussion with those already supporting Adult A the case was closed as it was identified that Adult A was engaging with Addaction services. A further input was initiated in February 2017 when concerns were raised by RCHT regarding the impact of ongoing drug use, self-neglect and alleged abuse by her partner. On the 27.03.2017 a multi-agency meeting was held and a range of support options were considered. Again it was identified that numerous support agencies were involved with Adult A and therefore an Adult Social Services Assessment was not required at that time. The safeguarding concern was closed and this was in line with policy and the rationale would appear to have been appropriate.
    3. The IMR from Adult Social Care identified that the six key principles of safeguarding were evidenced throughout the case, ( i.e. partnership working was demonstrated through the regular meetings with the main agencies involved) and that the approach that was taken with regards to preventative action was proactive in its attempt to minimise the risk of harm.
    4. Case notes and documents within Adult Social Care show evidence of appropriate use of policy and practice and that these procedures were adequate. The IMR writer did however identify a number of delays in the completion of safeguarding meetings within agreed timescales. The reason recorded for this was ‘staff shortages’. Delays of this nature should however be reviewed and appropriate action taken by Adult services to ensure that other service users are not impacted upon in the future. On reviewing this issue the IMR writer concluded that there did not seem to be any evidence to show that this delay impacted on the situation of Adult A.
    5. Whilst reviewing this case the Adult Social Care IMR writer identified that case recording within the service was also weak. They identified that there were gaps in recording on case notes which meant that additional searching was required to identify relevant documents. They IMR writer concluded that whilst there was a great deal of information held it was not easy to find and referencing in case notes to specific documents would ensure that professionals have a comprehensive overview of a case.
    6. In relation to best practice Adult Social Care have now introduced a monthly self-neglect audit for managers to oversee cases where individuals are difficult to engage with. This meeting is held between a service manager and a risk manager in each locality and is a forum where cases are discussed and actions fed back to frontline professionals to help with service delivery. Such an audit would identify and review cases such as Adult A’s.
    7. Cornwall Adult Social Care have implemented a High Risk Behaviour Policy (September 2018). This policy was not introduced in response to this particular case but as guidance to professionals when dealing with people with high risk behaviours such as those in Adult A’s situation. Again this is a useful tool for frontline staff and if used consistently could assist with cases similar to this one.
    8. The author of the CFT IMR also questioned whether no psychiatric follow for Adult A was appropriate after she was discharged from Longreach. This was particularly relevant given the knowledge around Adult A’s overall risk and vulnerabilities at this time. Upon reflection, although there were no current signs of mental illness while on the ward, there was an emerging picture of possible non substance induced psychosis and psychotic phenomena which may have led to her stabbing herself in the abdomen. The IMR writer concludes that this was a missed opportunity to assess Adult A.
    9. On reviewing all of the material it is apparent that Adult A’s story regrading self-harm had changed and the earlier PLS assessment (immediately prior to admission) which assessed “that she may have symptoms of psychosis which are not believed to be substance induced. She is distressed and has become suicidal as a result of these symptoms and has no support” was not considered. The Addaction consultant had also stated that it was unclear as to whether Adult A‘s symptoms were related to substance abuse and that she simply ‘blips into psychosis’. These assessments were not given the weight they deserved. This was again seen as a missed opportunity to undertake an extended assessment in her home environment ‘given the risks disclosed and the seriousness either way of the wound to her abdomen’.
    10. Both CFT staff and Addaction have spoken to the author about the difficulties presented to each organisation now that CFT focuses on mental illness and Addaction on the substance misuse. The situation was different five years ago when there was a Cornwall Drug and Alcohol Team (CDAT), which had expertise on both mental health and addiction in one team and had a joint assertive outreach approach. CFT also identified that there was less mental health expertise in Addaction, meaning an increased number of referrals to community mental health teams. Addaction staff were and continue to be frustrated when referrals are not accepted, due to clients’ problems not being severe enough to meet the criteria to access mental health services.
    11. Addaction also spoke of their concerns that they were carrying more of the risk for clients who were not being accepted onto CFT caseloads due to their addiction. When spoken too by the Panel Adult A’s case worker has stated that they felt a huge burden of responsibility about being nominated as the lead agency. There was almost an assumption by all agencies concerned that the risks posed by Adult A could be effectively co-ordinated and managed by Addaction. Whilst there were numerous multi agency meetings there would appear to have been no consideration about the impact on the case worker or the agency. Adult A’s GP has also stated that it was difficult to tell who was the main lead agency for Adult A. In a case where the risks are considered so high consideration must be given to a statutory organisation taking the lead role. Either way the decision as to why an agency should take the lead should be clearly discussed, constantly reviewed and the outcomes documented.
    12. Addaction are working with local mental health services to improve referral routes. Addaction are also liaising with mental health services to try and ensure that an ‘escalation process’ is put in place so that high risk clients don’t get screened out.
    13. Panel members have identified that there is a ‘hub’ being developed on site at RCHT which will co-locate the services already sited at RCHT, this will provide the opportunity to host services such as CAMHS, Drug and Alcohol Services, Perinatal Mental Health, the Police and Independent Domestic Violence Advocates (IDVA) in the same building. The aim of this hub will be to improve joint working and provide early support to people who present in crisis. The teams will then support safety planning and onward referrals and signposting to relevant community services.
    14. Agencies involved in this case also questioned whether there was more of a role for women’s refuges in cases like this. The existing women’s refuges in Cornwall do not take women who are addicted to substances, and there are limited alternatives available to safeguard such individuals This causes problems for operational staff and therefore the provision of such services should be reviewed.
    15. Those working on the Review have identified that in this case multi agency working was progressed on many occasions, not as a result of policy, but through informal contacts and networks that have been established between professionals in Cornwall. Whilst this is admirable and assists in developing responsive and flexible services agencies must be cognisant that staff are working in this way in order to meet perceived deficiencies in service. Effective supervision is therefore vital in order to ensure that such deficiencies are identified and where appropriate are addressed. In this case the areas that have been identified have resulted in recommendations.
    16. The perception of life style choice and capacity for substance users may be an area for national and local multi-agency work to challenge and develop practitioner skills and knowledge around exploitation, modern slavery, lack of executive functioning.
    17. All of the professionals involved in this case agreed on the benefits of taking a multi-agency approach and strategy when dealing with Adult A. There was an acknowledgement that no single agency could meet her needs alone.
    18. As a result of cases such as this Cornwall Council are looking at introducing a ‘whole systems’ approach to support people with complex and multiple needs (Complex Needs Model). This approach ensures that services are integrated around the needs of the person, improving individual outcomes whilst also ensuring best use of resources. The model recognises that ‘there are challenges in relation to increases in complexity with growing numbers of people experiencing alcohol and other drug dependence, homelessness, offending and poor mental health as a result of changes in welfare reform, under-funding and increasing health inequalities.’ The adoption of this model should be seen as good practice.

16.11 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. Since 2016 with the introduction of ViST’s has provided officers with a method of identifying safeguarding issues, that previously would have remained unreported, and provides a process to raise concerns with partner agencies. In this case there is clear evidence of information being shared with partner agencies with good working and in this case between Police, Addaction, Health and IDVA’s.
  3. The Police also have a process which automatically creates and shares an email of the DASH forms that have been completed in the previous twenty four hours with the local domestic abuse service. This enables services to respond quickly to such incidents and co-ordinate approaches. Again this should be seen as good practice.
  4. The lack of consent of Adult A in this case did mean that some information has not shared by Police after incidents. These incidents were assessed by the Central Safeguarding Team (CST) and the rational for not sharing the information was recorded on IT systems. In the main the rationale of not sharing information was that Adult A had not provided consent and other agencies where already dealing with her for the issue that had been raised. The decision making behind the sharing of information on the 22.04.2016 was however a good example of where the CST intervened following a decision being made by frontline staff not to share information. On reviewing the risk information was appropriately shared without Adult A’s consent to allow safety planning to be considered. This demonstrates that quality assurance and supervision practices are in place and in the main are effective.
  5. Conversely however on the 16.06.2017 Police officers attended Adult A’s home address following an incident that had been reported by her neighbour. Following the incident the officers attending submitted a ViST highlighting her vulnerability. This information was reviewed by the CST who concluded that the information would not be shared with other agencies as no specific vulnerabilities were identified. On this occasion the information should have been shared in view of Adult A’s history. As stated on the majority of occasions that rationale for not sharing information was correct. On reviewing this incident it would appear that this was an individual omission and therefore this has not resulted in a specific recommendation.
  6. Within records there is evidence of information being shared with Adult A’s GP in relation to concerns about her drug addiction and her exposure to domestic abuse. This included Housing, Police, Addaction and IDVA services. Information from Health Care professionals who were working in those custody settings that dealt with Adult A was also effectively shared with her GP.
  7. Throughout the case notes held by agencies it was apparent that family members including Adult A’s mother and sisters had consistent concerns about her welfare. CFT had two contacts with friends/family members regarding Adult A. The first was on 11 December 2016, when one of Adult A’s sisters, concerned for her welfare took her to Treliske Hospital. On this occasion Adult A’s primary presentation was recorded as consistent with substance misuse and Adult A was signposted to Addaction. A copy of the letter detailing contact was provided to Adult A’s GP and Addaction which again demonstrates good interaction with primary care services. On this occasion Adult A’s sister was unhappy with the outcome of the assessment and she was signposted to the PALs service should she wish to complain. PALs have no record of any complaints relating to Adult A.
  8. From a review of Adult A’s health records and from meetings with staff there appears to have been regular and detailed information shared by CFT staff with those agencies known to be in contact with Adult A. These were most notably Addaction, Adult Safeguarding (6 March & 17 August 2017) and her GP. As a minimum this information was shared in a letter i.e. following Adult A’s first attendance at the PLS at Treliske on 16 October 2017. On other occasions there was full disclosure of information.
  9. A further example of effective communication and information sharing was demonstrated between CFT’s EIT service and Addaction when organising appointments for Adult A at Addaction’s offices and the support of Addaction to get Adult A to the appointment (March to November 2017). At these appointments CFT, Addaction and Devon and Cornwall Housing Association would exchange information verbally to ensure that each agency was aware of the wider picture of Adult A’s circumstances. This again should be considered as good practice.
  10. There were however, missed opportunities for sharing information with agencies. On 7.11.2017, Adult A had attended the emergency department having overdosed on alcohol and ‘spice’. The CFT IMR author identified that this was three days before her assessment with CFT’s EIT and according to the information that was reviewed it would appear that this information was not shared with other relevant agencies.
  11. Adult A’s GP has also stated that information sharing and contact could be improved with Addaction. The GP stated that that in respect of his own surgery there was a requirement to clearly articulate the level of concerns that they may have regarding risks to patients with Addaction.

* 1. Similarly Adult A presented herself at one of CFT’s ICMHT offices on 14.10.2016. On that occasion she had no appointment and presented in crisis. Whilst her mental well-being was reviewed, and practical advice was given to her (signposting to other agencies) there was little further exploration on what was causing her distress. The staff member who dealt with this incident recalled that they had been called out of clinic to respond to Adult A and that they had not had the opportunity to comprehensively review all her recent contact with services. They also stated that they were not aware of the disclosures that she had made about domestic abuse although they had been advised by staff of the recent mental health assessment and outcome. This staff member has reflected on this and comments that had he known about this detail it may have prompted other options for referral or discussion.
  2. Adult A also disclosed domestic abuse when she was an in-patient (2-3.02.2017). On exploring this further with CFT staff at the case review meetings it was apparent that Adult A’s addiction and mental health examination became the focus of CFT’s interventions with Adult A rather than domestic abuse. It is noted that the time of her admission may have made it impractical to do so (lateness of hour) however staff failed to pick up on the information that Adult A had shared with them throughout her admission.
  3. The CFT IMR had also identified that at one of Adult A’s assessments, which had been conducted on the 11.12.2016 by mental health services, no consideration had been given to discussing concerns with Adult safeguarding services.
  4. On reviewing all of the information that has been made available to the review it would appear that it was not the case that staff were unwilling to share information but instead that they were overly confident that Adult A was already being supported by relevant agencies. In all safeguarding cases, especially where there is a recognised high risk, then all relevant information should be continually shared in accordance with established protocols.
  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. Adult A’s case was appropriately escalated to team leaders on several occasions due to the risks posed by her partners and the chaotic lifestyle she was leading. Managers were also engaged at the appropriate times and this ensured that relevant decisions were made, one example of this being the transfer of Adult A’s case to the complex needs team within CFT due to escalating risk.
3. A review of Adult A’s health records indicates that practitioners working with or trying to engage with Adult A made use of colleagues and managers when assessing Adult A’s mental health. The electronic health record including clinical risk assessments were also well maintained to enable colleagues or managers to share information between colleagues, teams and managers within CFT’s Adult Mental Health services. This was evidenced on the 13.3.2017 when the EIT team leader was briefed on Adult A’s situation and circumstances. This led to her case being escalated and discussed at weekly MDT meetings.
4. CFT staff attending the case review meetings for this IMR spoke of being aware of Adult A being open to safeguarding (from March 2017 onwards) and of Addaction being the lead agency. There may have been an opportunity to review safeguarding action and gain advice and supervision had CFTs Adult safeguarding team been contacted to discuss the recurring presentations and disclosures. One practitioner from PLS did discuss Adult A’s presentation and disclosures with RCHT’s Safeguarding Team (17th February 2017), which led to a referral to Adult social care. Contact with CFT’s safeguarding team would have prompted staff and managers to consider the multi-agency self-neglect protocol and risk management meetings, which may have provided an earlier opportunity to clarify risks and share information and generate a multi-agency plan. The lack of contact with the CFT safeguarding team should have been picked up through effective supervision practices in the clinical teams.
5. The Review has identified that there are implications for management and supervision around cases of substance misuse, self-neglect and consideration of capacity. There are also implications in respect of the use of SAB multi agency self- neglect protocol (currently under review) and use of the new SAB multi agency ‘high Risk Behaviours protocol when this is introduced shortly. This will include the effective dissemination of information, training and quality assurance measures to ensure that staff are following the agreed processes.

16.13 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.
2. In relation to the Police the Force continues to work towards improving the response to domestic violence Incidents and as part of the Force domestic improvement plan there is a recommendation to ensure that one hundred per cent of all police officers are DASH trained. The progress towards this action is reviewed on a regular basis.
3. The DASH process is the subject of frequent reviews at a national level and the Force is waiting for the release of a new risk assessment that is being trialled by the College of Policing. When this assessment is released then the Force intends to review its training strategy to ensure effective implementation to frontline officers.
4. In addition to the domestic abuse training that has been delivered in the Force all officers have been trained in the single safeguarding process which covers vulnerability in children and adults and the ViST process. E Learning training in relation to stalking and harassment, abusive relationships and specialist training for domestic violence protection notice and order process has also been available to officers.
5. Relevant workers from Adult Social Care had completed domestic abuse and adult safeguarding training and this is available on an ongoing basis across the department. There has also been joint training across the partnership on aspects of self-neglect and other areas of concern such as high risk drug abuse.
6. CFT’s mandatory training is undertaken at induction and annually by all its staff and this includes adult safeguarding. The training module for adult safeguarding is delivered through a full day on induction for all front line staff followed up by e-learning which includes types of abuse including domestic abuse. There is also an additional e-module on domestic abuse and all front line staff are expected to complete this. Every three years CFT frontline staff are required to undertake an adult safeguarding refresher course.
7. The CFT’s adult safeguarding lead has developed a short training package for managers to present to their teams about the using RE in their respective services.
8. CFT staff also attend class room based training on both Adult Safeguarding and domestic abuse. This training encourages staff to seek advice from and make referrals to First Light’s Risk Evaluation and Co - ordination Hub (REACH), domestic abuse services and CFT’s Adult safeguarding team.
9. All staff who were involved in Adult A’s care have completed mandatory training on Adult safeguarding and domestic abuse. Those who were interviewed were aware of their safeguarding responsibilities and what to do should they have a safeguarding concern. Some staff were aware of MARAC, but not overly familiar with its remit or how to refer. As identified in this Review on occasions staff failed to make such referrals and therefore these processes will need to be reemphasised through an internal communication strategy.
10. All staff who were involved in Adult A’s care within the CFT had completed mandatory training on Adult safeguarding.
11. The CFT IMR author has ascertained from Adult A’s health records and from meetings with staff, that despite several high risk flags for domestic abuse being disclosed by Adult A through her journey with CFT, staff did not seek further advice from CFT’s Adult Safeguarding Team, directly refer Adult A to Cornwall’s REACH service, refer Adult A to the Councils Adult Safeguarding Service or consider whether a referral to MARAC with a request for a DASH risk assessment was required. Opportunities to improve operational practice and knowledge have therefore been made in relation to the DASH process, the ‘high risk behaviours policy’ and the ‘self-neglect, rough sleepers and hoarding protocol’ have been identified and these have been reflected in the recommendations that have been made at section 19.0 in this report.

17.0 Conclusions

1. The content of this section seeks to bring together an overview of main issues identified, and conclusions drawn from them which will translate into the detailing of learning in the next section.
2. Adult A was extremely vulnerable and led a chaotic lifestyle which was driven by her addictions to drugs and alcohol. As a result of this lifestyle she was drawn into low level criminality in order to fund her addictions. On a daily basis and due to the pressures relating to her life experiences Adult A would take a cocktail of drugs. Those that supported her were continually concerned that she would die as a result of an overdose. Adult A’s GP, health services and Addaction all worked together to manage her complex poly-substance misuse. Addaction were identified as the lead agency in coordinating support to Adult A and they had actively supported her on a daily basis.
3. Adult A would often present to agencies in crisis and suffered from what professionals believed to be drug induced psychosis. Adult A would often hear voices and hallucinate but attempts to effectively diagnose an underlying mental health condition were continually frustrated by her lack of engagement with services and ongoing substance use. Much of this behaviour was driven by the exploitation and abuse that she suffered. 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.
4. In this case the professionals concluded that there did not appear to be any justification for the use of detention at any stage of her 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 in line with national guidance and policy. There were no obvious clinical shortcomings/failings in this case.
5. 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 and emotionally abuse 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.
6. Despite the chaotic nature of her lifestyle Adult A’s family had remained supportive and had often offered help and support. They often felt frustrated that agencies had an inability to make her attend appointments. Her family had become increasingly worried about the influence and detrimental effect that Adult B had on her life but despite their efforts they too could not persuade Adult A to end the relationship.
7. From an early stage in her life Adult A had been supported by specialist services who had attempted to manage her addictions and support her through times of crisis. This level of support continued into her Adult life. Agencies had tried to engage and help Adult A but her lifestyle choices, sporadic engagement and lack of motivation for change (possibly due to being under duress from her partner) made it almost impossible for this to occur.
8. 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.
9. 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.
10. 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.
11. 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 may need to think more laterally when undertaking assessments in order to make informed judgements about treatment and care. In this case it cannot be stated with any certainty and these possible interventions are complex and would have required cooperation from Adult A in being assessed, along with the opportunity to undertake such assessments.

17.12 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.

17.13 Adult A had to cope with a daily struggle with drug, alcohol and domestic 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[[59]](#footnote-59).

18.0 Learning

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

18.2 The learning opportunities identified in this case are listed by number and these correspond with the recommendations in section 19.0.

Single Agency

* 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[[60]](#footnote-60) 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.

19.0 Recommendation

* 1. This section of the Overview Report sets out the recommendations made by the DHR panel and includes the recommendations made in each of the IMR reports.
  2. The DHR panel therefore offers the following overarching recommendations for local action:

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 Adult Social Care.

* 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. (*Completed).*

* 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

[Adult A’s] 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 (*Completed).*

* 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.

Glossary

AAFDA - Advocacy After Fatal Domestic Abuse.

A&E - Accident and Emergency.

CCG - Clinical Commissioning Group.

CFT - Cornwall Foundation Trust.

CDAT - Cornwall Drug and Alcohol Team.

CJLDS - Criminal Justice Liaison and Diversion Service.

CMHT - Community Mental Health Trust.

CRASAC- Cornwall Rape and Sexual Abuse Centre.

CSP - Community Safety Partnership.

CST - Central Safeguarding Team.

CYPS - Children and Young Person Services.

DASH - Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment.

DASSP – Domestic Abuse Serious and Serial Perpetrator.

DHR - Domestic Homicide Review.

DVPO - Domestic Violence Protection Order.

DVO - Domestic violence Officer.

ED - Emergency Department.

GP - General Practitioner.

GSC - Government Security Classifications.

HCP - Health Care Professional.

ICMHT – Integrated Community Mental Health Teams.

IIDVA - Independent Domestic Abuse Adviser.

IMR - Independent Management Review.

IOPC - Independent Office for Police Conduct.

ISVA - Independent Sexual Violence Advocate.

L&D - Learning and Diversion service.

MARAC - Multi Agency Risk Assessment Conference.

MCA - Mental Capacity Act.

MDT- Multi Disciplinary Team.

MHT - Mental Health Team.

NHSE - National Health Service England.

OOH - Out of Hours.

PCT- Primary Care Trust.

PLS - Psychiatric Liaison Service.

RCHT - Royal Cornwall Hospitals Trust.

RE - Routine enquiry.

REACH - Risk Evaluation and Co-ordination Hub.

SAB - Safeguarding Adult Board.

SAR- Safeguarding Adult Review.

SIO - Senior Investigating Officer.

SI -   Serious Incident.

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1. Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016 [↑](#footnote-ref-1)
2. The Care Act 2015. The Care Act replaced ‘No Secrets’ and the terminology used in the Care Act is adult with care and support needs / an adult at risk, who as a result of their care and support needs cannot protect themselves from abuse / risk of abuse/ effects of abuse (Adult As vulnerabilities were increased due to her chaotic lifestyle and her inability to engage with services to get maximum benefit from help on offer which is detailed later in this report). [↑](#footnote-ref-2)
3. A MARAC is a meeting held by professionals to discuss victims at high risk of murder or serious harm. A domestic abuse specialist (IDVA) police, children’s social services, health and other relevant agencies attend the meeting. Information is shared at the meeting in order to address the risks that are identified. The meeting is confidential. [↑](#footnote-ref-3)
4. DASSP- Process to identify serious perpetrators of domestic abuse and take proactive action against them. [↑](#footnote-ref-4)
5. It could not be ascertained whether Adult A would let Adult E into the premise willingly or that there was an element of fear, coercion and/or control. [↑](#footnote-ref-5)
6. K9 Crusaders – Dog welfare charity. [↑](#footnote-ref-6)
7. Life skills team – Team that provides advice and support in matters such as debt management. [↑](#footnote-ref-7)
8. Resource [↑](#footnote-ref-8)
9. Central Safeguarding Team- police team that process safeguarding inquiries. [↑](#footnote-ref-9)
10. Appropriate adults are called to the police station as an important safeguard, providing independent support to detainees who are: aged under 17, or maybe mentally disordered or mentally vulnerable. [↑](#footnote-ref-10)
11. Criminal Justice Liaison and Diversion Service. [↑](#footnote-ref-11)
12. Waves is a confidential counselling and outreach service provided by specialist trained counsellors [↑](#footnote-ref-12)
13. Independent Futures (or i-futures) is a company, within Devon & Cornwall Housing group, that brings together all of the services focused on supporting people to live independent lives. [↑](#footnote-ref-13)
14. Non crime domestic- a domestic abuse incident that has been reported to the Police but that does not reach the threshold for recording it as a crime. [↑](#footnote-ref-14)
15. This service aims to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. [↑](#footnote-ref-15)
16. On average victim’s experience fifty incidents of abuse before getting effective help (Safe Lives ;2018) [↑](#footnote-ref-16)
17. Mills, LG (2008) [↑](#footnote-ref-17)
18. Domestic abuse; Home Office (2016) [↑](#footnote-ref-18)
19. Johnson, M (2010) [↑](#footnote-ref-19)
20. This practice is called routine enquiry or RE. [↑](#footnote-ref-20)
21. Intimate terrorism is the use of physical abuse plus a broad range of tactics designed to get and keep control over the other person in the relationship MP Johnson (2010). [↑](#footnote-ref-21)
22. Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH, 2009) Risk Identification and Assessment. [↑](#footnote-ref-22)
23. Devon and Cornwall Police’s Domestic Abuse Policy. [↑](#footnote-ref-23)
24. Cocoon Watch- A option used to protect domestic abuse victims where neighbours are asked to monitor incidents at the victims home address and to report matters of concern. [↑](#footnote-ref-24)
25. Sanctuary – Supported Living Arrangements. [↑](#footnote-ref-25)
26. REACH (Risk Evaluation and Co-ordination Hub). This service offers advice and support to victims and survivors of domestic abuse. [↑](#footnote-ref-26)
27. The typologies identified by Johnson are included in CFT’s domestic abuse training. [↑](#footnote-ref-27)
28. [↑](#footnote-ref-28)
29. *Schumacher et al (2001)*  [↑](#footnote-ref-29)
30. *Brecklin (2002), Bennett & Williams (2003).*  [↑](#footnote-ref-30)
31. Rough Sleeping Policy implemented to provide a co-ordinated multi agency response to the issue of rough sleeping. [↑](#footnote-ref-31)
32. Drug and Alcohol treatment centre. [↑](#footnote-ref-32)
33. Cornwall Rape and sexual Abuse Centre. [↑](#footnote-ref-33)
34. Project dedicated to providing support to survivors of domestic abuse. [↑](#footnote-ref-34)
35. Psychology Today 2014 [↑](#footnote-ref-35)
36. This service aims to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. [↑](#footnote-ref-36)
37. There were three presentations to Criminal Justice Liaison and Diversion Scheme (13.02.2017, 3-9. 03.2017,30..03.2017). [↑](#footnote-ref-37)
38. The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The MCA is designed to protect and restore power to those vulnerable people who lack capacity. [↑](#footnote-ref-38)
39. The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity **Act** allows restraint and restrictions to be used – but only if they are in a person's best interests. These are called the Deprivation of Liberty Safeguards. [↑](#footnote-ref-39)
40. An Addaction professional have stated that this is a common misconception by Mental Health (MH) workers. It is not necessary to have a period “drug and alcohol free” before assessment can be made, but it does require the individual to be sober enough to undertake an assessment. Historically, drug and alcohol use has been given as a reason for exclusion from MH assessment or treatment. This does not comply with national guidance. However, MH services clearly demonstrated their commitment in this case, so the issue is one of training for MH professionals. [↑](#footnote-ref-40)
41. Boyle A (2006) [↑](#footnote-ref-41)
42. [McLaughlin](https://www.sciencedirect.com/science/article/pii/S0272735812001158#!). J; [O'Carroll](https://www.sciencedirect.com/science/article/pii/S0272735812001158#!). RE; [O'Connor](https://www.sciencedirect.com/science/article/pii/S0272735812001158#!). RC (2012). [↑](#footnote-ref-42)
43. The Signs of Safety is an innovative strengths-based, safety-organised approach to child protection casework. [↑](#footnote-ref-43)
44. *Sakar, J (2008); Community Care (2008)* [↑](#footnote-ref-44)
45. Best interests principle. ... If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests**.** [↑](#footnote-ref-45)
46. Braye et al Self-neglect and Adult safeguarding: findings from research SCIE 2011. [↑](#footnote-ref-46)
47. *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-47)
48. Aitken, R & Munro, V.E (2018), DomesticShelter.Org (2016). [↑](#footnote-ref-48)
49. *(Brandon et al:2012)* [↑](#footnote-ref-49)
50. Policy D52 relates to Police response and attendance at incidents. [↑](#footnote-ref-50)
51. ViST- Vulnerability Screening tool used by the police to identify safeguarding concerns. [↑](#footnote-ref-51)
52. Safer Cornwall is a well-established community safety partnership (CSP) which is well placed to lead on the strategic coordination of activity in relation to serious and organised crime. This partnership has a statutory duty to: reduce reoffending; tackle crime and disorder; anti- social behaviour; alcohol and substance misuse; and any other behaviour which has a negative effect on the local environment. The Serious and Organised Crime Group is a Multi-agency forum established to look at pursue, protect, prevent and prepare opportunities in relation to this type of criminality. [↑](#footnote-ref-52)
53. Serious Case Reviews; NSPCC (2018) [↑](#footnote-ref-53)
54. Cornwall Council has an Adult social Care team who help adults with social care needs find care and support so they can live as independently as possible in their own homes. This includes older people, people with physical disabilities or learning disabilities, and mental health service users. [↑](#footnote-ref-54)
55. RiO is an electronic records management system used by CFT. [↑](#footnote-ref-55)
56. Risk Evaluation And Co-ordination Hub. [↑](#footnote-ref-56)
57. Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. [↑](#footnote-ref-57)
58. Adult Safeguarding: Roles and Competencies for Health Care Staff (2019) [↑](#footnote-ref-58)
59. A ‘desperate act of resistance’- [↑](#footnote-ref-59)
60. Safeguarding Adult Board. [↑](#footnote-ref-60)