



Adult O

Date of Death: February 2020

**Safeguarding Adults Review
Domestic Homicide Review**

Independent Overview Report

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Introduction

1. In August 2020, the Newcastle Safeguarding Adults Board (NSAB) agreed to undertake a Safeguarding Adults Review (SAR) following the death of Adult O, a 39 year old white British woman with care and support needs. At the time of her death Adult O was in a relationship with a man, JC. In 2022, Adult O's family requested that her death be considered for a Domestic Homicide Review (DHR). This request was accepted by Safe Newcastle in June 2022. Therefore, this report is a joint SAR / DHR.
2. Adult O was not formally a victim of a domestic homicide. The coroner determined that her cause of death was a "blunt head injury". She was found at home in the company of JC. She had a head injury which the Hospital, in their notes, attributed to a fall. The exact circumstances of this injury are unknown, but the Home Office Pathologist undertook a post-mortem and concluded that there was no third-party involvement. Adult O's family are not in agreement with this view.
3. What is unarguable, however, is that she had experienced a long and repeating history of domestic abuse from a number of partners, in conjunction with a pattern of chronic and chaotic substance misuse. These were both significant contributory factors to the physical decline that led to her death. As a result it was agreed to review this tragedy as a joint SAR/DHR.
4. The SAB has a statutory duty to undertake SARs under section 44 of the Care Act 2014. The Community Safety Partnership (Safe Newcastle) has a statutory duty to undertake Domestic Homicide Reviews under section 9 of the Domestic Violence, Crime and Victims Act 2004.¹

A tribute from family and friends - A daughter. A sister. A friend.

5. The following pen picture of Adult O was provided by her family. It has been included without editing.

A beautiful, determined individual who in her younger life was known to many as "Princess".

Well educated, well-spoken and impeccably dressed - very particular about her appearance - she was a real head-turner and stunningly beautiful in a very natural way.

Well-travelled, having lived in many countries as a young girl and having visited many parts of the world on holidays with her parents, sister and partners, well into her late twenties.

¹ Although the circumstances of Adult O's death were not considered a homicide, a DHR is appropriate in this case because it does meet the Section 9 criteria and can take place even if a suspect is not charged with an offence or they are tried and acquitted. Overall responsibility for establishing this DHR lies with Safe Newcastle and the Chair has agreed to initiate this review.

An animal lover who from childhood wanted to rescue stray or injured animals and always tried to get them back to health, whether that be a cat, dog, bird, mouse or insect.

As a young girl she spent a few holidays on Riding Holiday breaks where she cared for, groomed and rode a horse for a week – not exactly a holiday as some would see it but she loved horses and wanted to learn how to care for them. In her teens she went on to have her own horse which was a dream come true and she adored that horse, riding around the countryside surrounding our home to galloping along the beach in Beadnell Bay or entering gala competitions. On finishing school she took Equine Studies at college and passed with flying colours, being offered a job training racehorses in the South.

A keen gym-goer, loving to keep fit she'd often be out running the streets where she lived and also enjoyed training with her sister doing exercise classes at a local gym.

She loved to holiday and visited some luxurious and far-flung places and enjoyed nothing more than sampling local culinary delights whilst travelling. A real foodie - although couldn't cook herself – she loved to dine out.

Quote from one of her closest friends:

"A natural beauty, absolutely stunning. Wore little make up and her gorgeous brown wavy hair would simply fall perfectly like a mane.

She turned heads when she walked into a room. She was funny, sweet and adored her godson.

We shared a mutual love of animals which I still carry on in memory of her, trying to care for any animal in need.

A soft soul, kind, full of life, giggly, my soul sister. I have her name tattooed on my forearm so my beautiful friend is always always by my side."

6. This description of the younger Adult O provides a striking contrast with the picture that emerged as she approached the end of her life.

Condolences

7. The Chairs of the Newcastle SAB and Safe Newcastle, as well as the Panel for this SAR/DHR, wish to express and record their condolences to Adult O's family on her sad death.

Timeframe

8. This Review concentrates on an approximately two year period from January 2018 to her death in February 2020. However, it does take a longer view where

significant information is available, e.g. regarding previous assaults and serious injuries (particularly those that might have impacted on her cognition) and in describing her ongoing pattern of substance use.

9. The length of this Review was impacted initially by being carried out as a Safeguarding Adults Review, but then following discussions with the family, they requested that a Domestic Homicide Review also be carried out. This was agreed between the Safeguarding Adults Board and Safe Newcastle, the Community Safety Partnership.

Confidentiality

10. The findings of the review are confidential. Information is available only to participating officers/professionals and their line managers. The report uses pseudonymous initials to protect the identity of the individuals involved. In the case of "Adult O" this has been agreed with the family; and, in general, this follows the practice in local Safeguarding Adult Reviews.

Nature and purpose of the Domestic Homicide Review / Safeguarding Adults Review

11. The purpose of a DHR / SAR is not to reinvestigate or to apportion blame, undertake human resource duties or establish how someone died. Its purpose is:
 - To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard victims or survivors.
 - To prepare or commission a report which brings together and analyses practice, identifies clearly what the lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
 - To improve systems, policies, procedures and practice by applying the lessons to service responses.
 - To prevent abuse, neglect, domestic violence, and homicides and improve service responses for all abuse victims, survivors and their families through improved intra- and inter-agency working.
12. There is a strong focus on understanding the underlying issues that informed agency/professionals' actions and what, if anything, prevented them from being able to properly help and protect Adult O from abuse. Further information can be found in the Safeguarding Adults Review Policy and Procedure and Safe Newcastle Domestic Homicide Reviews.
13. It is important to note that this is a combined SAR / DHR and therefore has a different focus from a DHR. It has a greater focus on the victim's difficulties and lifestyle, and domestic abuse and coercive and controlling behaviour are not always the sole focus.

Independent Review

14. Mike Ward was commissioned to write the overview report. He is independent, having never worked or lived in Newcastle. He has been the author of twenty five SARs as well as drug and alcohol death reviews and a member of a mental health homicide inquiry team. He worked in Adult Social Care for many years but in the last decade has worked mainly on developing responses to change resistant dependent drinkers and drug users. He has undertaken research and led training with Against Violence and Abuse on the role of alcohol as a contributor to domestic violence and abuse. He has undertaken the Home Office's online learning on conducting Domestic Homicide Reviews.

Methodology

15. A joint multi-agency panel of the SAB and Safe Newcastle was set up to commission the independent author and oversee the review. Initial information was sought from agencies involved with Adult O and her final partner JC. This supported the development of Terms of Reference which are included as an appendix. More detailed Information was sought from the involved agencies in the form of Individual Management Review (IMR) reports addressing the themes in the Terms of Reference. Agencies were also invited to include any other information they considered relevant. This included information from outside the time period identified.
16. The following agencies were involved in the process and in the panel:
 - Newcastle upon Tyne Hospitals NHS Foundation Trust. Lesley Sinclair
 - Department for Work and Pensions. Jackie Butson
 - Your Home Newcastle City Council Housing Provider (contact with JC). Caron Storey
 - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Jo Sharpe
 - Newcastle City Council (Adult Social Care) Jonathan Jamison and Sam Keith
 - Newcastle Safeguarding Adults Board. Claire Nixon
 - Newcastle City Council, (Community Safety Team) Joan Flood
 - Newcastle Integrated Domestic Abuse Service (NIDAS). Laura McIntyre
 - Northumbria Police. Ian Callaghan
 - North East Ambulance Service. Jane Stubbings
 - North East and North Cumbria Integrated Care Board. Dr Karen Hutchinson
 - The Probation Service (contact with JC) Paul Weatherstone.
17. There were some delays in progressing this review compared to the usual timescales. This was as a result of: the SAB receiving several SAR referrals at the same time and a decision being made to undertake multiple reviews consecutively, ensuring the best use of resources and to get the most learning; the impact of Covid-19; and the criminal and Coroner processes taking

precedence in this case. The request and agreement to progress this review as a joint SAR/DHR further delayed the commencement of the review. The Home Office was notified in July 2022 that a DHR was to be carried out.

18. An initial SAR/DHR Panel meeting was held in November 2022 to discuss the process, terms of reference and timeline of the review. IMRs were drafted and submitted. A Practitioner Reflection Day was held in April 2023 and contributed a range of thoughts and views on Adult O, JC and the individual and joint response to their needs. The Panel met three times.
19. All this information was analysed by the report writer and an initial draft of this report was produced and went to the Review Panel in June 2023. Further changes were made over the next two months, and a final draft was completed for the Panel in August 2023.

Family contact

20. An important element of any review process is contact with family. Adult O has an older sister still living in the North East; her mother sadly died during the writing of the review. These family members were instrumental in ensuring Adult O's death was reviewed as a DHR. Her sister also played a key part in the development of this review. The family have provided a pen picture of, and tribute to Adult O which is included above. The review is undoubtedly the more robust, and has a richer evidence base, as a result of their contribution and the author is grateful, in particular, for the sister's input.
21. The family were offered specialist advocacy; but this was not viewed as necessary. They received the terms of reference and met with both staff involved in the SAR/DHR and the author. They were updated regularly. Once the report was complete, Adult O's sister, was given the opportunity to privately review the draft and had the time and opportunity to comment and make amendments.

Perpetrator contact

22. Attempts were made to engage JC in the review process. A letter was sent to him explaining that the review was happening, seeking his consent for his records to be reviewed and encouraging him to make contact with the Independent Author. No reply was received to this letter.

Parallel processes

23. There were no parallel processes such as Police or Coronial inquiries that coincided with the review process itself. These had already been completed.

Terms of Reference

24. The terms of reference for this process are included in Appendix 1. These informed the development of the agency reports and the thinking about this review. However, they have not been used to structure this review because the review process opened up new learning about the themes to be prioritised in the report and how that material should be presented.

Language

25. In talking about individuals like Adult O, it is important not to use language that is victim blaming. However, it is also necessary to use language which is precisely descriptive. In this report, two terms have been used that require comment:
26. *Chaotic* – this term has been used at points to describe patterns of substance use. This is an important descriptive term because chaotic use is far more dangerous than a more regular, albeit still heavy, pattern of use. The chaotic nature of the use significantly increases the risks of overdoses, infections and possibly other problems. A “chaotic” lifestyle would be characterised by impulsivity, a lack of structure and inconsistent or contradictory approaches to the challenges of life.
27. *Clients that services find difficult to engage* – the term “difficult to engage clients” is problematic and blaming. It has been replaced with “clients that services find difficult to engage”. This maintains the emphasis on engagement as a theme without blaming the client. This report views engagement as a separate process, a necessary pre-condition for providing support or care, and believes that service providers need to have a specific focus on building engagement skills. Therefore, this precise language is important.

Equality and diversity

28. Throughout this review process the Panel has considered the issues of equality and in particular the nine protected characteristics under Section 4 of the Equality Act 2010. These are:
- Age
 - Disability
 - Gender reassignment
 - Marriage or civil partnership (in employment only)
 - Pregnancy and maternity
 - Race
 - Religion or belief
 - Sex
 - Sexual orientation
29. Section 6 of the Act states that:
- (1) A person (P) has a disability if:

- (a) P has a physical or mental impairment, and
- (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

30. None of the subjects of the review had any diagnosed physical or mental impairment which would have defined them as disabled.
31. The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol and other addictions are not, therefore, covered by the Act. However, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.
32. Adult O was a white British, heterosexual woman. She was aged 39 at her death. Of the protected characteristics disability is the most relevant. She had a range of physical and possibly mental health problems and at times received benefits reflecting this.
33. JC was a 41 year old White British heterosexual male at the time of Adult O's death. He also had mental disorders. i.e. anxiety and depression and post-traumatic stress disorder as well as alcohol use disorders.
34. There is no evidence of any negative or positive bias in the delivery of services based on any of the protected characteristics.

Chronology

35. Detailed chronologies were received from all the agencies identified in the review. These covered both Adult O and JC as well as some very limited information about other partners and associates of both individuals. These have been used to create a single chronology which has been vital in informing this report. However, the chronology runs to almost 200 pages and is therefore impossible to include in the review report itself. It is available to relevant agencies via the NSAB or Safe Newcastle.
36. A briefer summary chronology of the final two years of Adult's life and of her interactions with JC is included here. It should be noted that this is a summary of a huge range of contacts and is, therefore, not comprehensive.

Date	
January 2018	<ul style="list-style-type: none"> ▶ Has recently separated from her partner AJ. ▶ Currently on prescriptions for omeprazole, sertraline (for anxiety), thiamine (vitamin therapy). ▶ Drinking a litre of vodka per day and is engaged with alcohol and drug services. ▶ One Ambulance call out and one Hospital admission.

Date	
February 2018	<ul style="list-style-type: none"> ▶ Reviewed by the Alcohol and Drug Services. Recent heroin use reported as well as cocaine, and crack following renewing relationship with AJ. ▶ There is a Police report of a theft from Adult O by AJ but there was no further action. ▶ There is also a confused report of threatened violence by AJ over the phone. However, Adult O was intoxicated, and this did not proceed. ▶ A very aggressive and intoxicated appointment with her GP is reported.
March 2018	<ul style="list-style-type: none"> ▶ She had a fall early in the month which required some medical attention following infection.
April 2018	<ul style="list-style-type: none"> ▶ Two walk in centre appointments. ▶ Police attended when Adult O reported that a female was kicking at her front door. This seemed to be due to an earlier relationship. ▶ Hospital admission due to abdominal problems.
May 2018	<ul style="list-style-type: none"> ▶ Soft tissue infection from intravenous drug use. ▶ Hospital attendances and admission due to abdominal pain and vomiting ▶ ACE-III (cognitive test) completed in Hospital and her score is low indicating concerns. ▶ Ongoing heroin and alcohol use
June 2018	<ul style="list-style-type: none"> ▶ Concern about inflammation of arm – probably due to infection ▶ Report of crack/cocaine use ▶ Further Hospital admission ▶ Adult O reported unusual calls in the early hours of the morning when no-one speaks - she thinks it may be PW her previous ex or his new partner and has reported to Police. ▶ She reports that PW wants to renew their relationship, but she does not want this because of his past abuse of her. ▶ AJ remanded into custody
July 2018	<ul style="list-style-type: none"> ▶ One Ambulance call out and one Hospital admission. ▶ 2 Hospital attendances. ▶ Off methadone script and plan to retitrate onto substitute prescribing.
August 2018	<ul style="list-style-type: none"> ▶ On Methadone again with daily pick-up. ▶ Dating new man who she describes as her partner. ▶ Bruising to legs noted but refused fuller examination. ▶ Later in month reports “man” staying with her who owes her £700.
September 2018	<ul style="list-style-type: none"> ▶ Safeguarding concern raised – she called the Police because of “trouble” with a man and a woman who had been coming and going to her flat. She was later found in Hospital. ▶ No electricity in her flat ▶ Safeguarding concern did not progress because she was already engaging with the Crisis Team ▶ 1x further Hospital admission ▶ Reports of abusive behaviour by Adult O to taxi drivers sent to collect her ▶ Also abusive to staff because taxi did not attend ▶ Reports to emergency services that she is feeling suicidal

Date	
	<ul style="list-style-type: none"> ▶ Reports a possible burglary to the Police – her front door has been kicked in – unclear if anything has been stolen. ▶ Found by Police in street talking to herself taken for mental health assessment ▶ Further Hospital admission due to hallucinations ▶ Disclosed a historical rape from past partner PW (four years previously). She asks for no further action. ▶ Accepts referral to domestic abuse service but they could not contact her. ▶ Safeguarding concern raised.
October 2018	<ul style="list-style-type: none"> ▶ Adult Social Care (ASC) attempt contact following concern – unsuccessful. ▶ Cognitive testing undertaken – she scores below the normal score. ▶ Joins new GP practice ▶ Fails to attend work capability assessment and her ESA is ended.
November 2018	<ul style="list-style-type: none"> ▶ Hospital admission. ▶ Off methadone script again. ▶ ESA decision reversed. ▶ Tells DWP she is felling suicidal.
December 2018	<ul style="list-style-type: none"> ▶ Adult O's mother reports to Police that people are in her daughter's property. ▶ On methadone script but not engaging consistently. ▶ Possible stroke.
January 2019	<ul style="list-style-type: none"> ▶ Withdraws from methadone. ▶ Ambulance call out as a result. ▶ Hospital admission. ▶ Not complying with prescribing regime.
February 2019	<ul style="list-style-type: none"> ▶ Landlord reports abusive and drunken calls from her about the property. ▶ Ambulance callout due to heroin withdrawal. ▶ Reported as a missing person by her mother – found by Police in bed due to drink and taken to Hospital. ▶ Reports being beaten up – broken jaw and other facial injuries. Emergency housing sought. This does not seem to have been found. ▶ Aggressive behaviour to staff at Drug Service because of management of script.
March 2019	<ul style="list-style-type: none"> ▶ Seriously assaulted in her own home by a woman acquaintance over several hours. Police involved. ▶ She was treated and discharged. ▶ Safeguarding concern. ▶ Abusive to drug service staff. ▶ Reported injection of cocaine as well as heroin. ▶ Distressed phone call to the Police who took her to Hospital. ▶ Methadone restarted. ▶ Reported the theft of a phone and a bank card to the Police. She would not pursue this.
April 2019	<ul style="list-style-type: none"> ▶ Ambulance callout to a fit. Diagnosed with angina. ▶ Did not arrive at PIP assessment. ▶ PIP disallowed. ▶ Admits to carrying weapons because she feels under threat.

Date	
May 2019	<ul style="list-style-type: none"> ▶ Ongoing work with drug service.
June 2019	<ul style="list-style-type: none"> ▶ Adult O's mother reports concern about her daughter - she had not seen her for a week. ▶ Adult O reported she had deliberately cut contact with her mother. ▶ Ambulance call out due to chest pain. ▶ Admitted to Hospital with jaundice and nutritional issues. Also suicidal ideation. ▶ Discharged after stay in Hospital.
July 2019	<ul style="list-style-type: none"> ▶ Contact with ASC for personal support following Hospital discharge. ▶ One week service for support with property. ▶ Reports depression and anxiety to ASC. ▶ Declined support from carer. ▶ Admitted to Hospital with abdominal pain. Physiotherapy due to mobility concerns. ▶ Aggressive and abusive to staff on the ward and she self-discharged.
August 2019	<ul style="list-style-type: none"> ▶ Retrospective report of her being punched in the face – perpetrator is not reported. ▶ Multiple Ambulance callouts and Hospital attendances due to abdominal pain and swelling. Threatened to stab her abdomen. ▶ Attendance re overdose. ▶ Removed from Hospital due to being abusive to staff. ▶ Call by Adult O to Police because male JC is going around looking for her and she feels unsafe. ▶ Safeguarding concern because she took her mother's medication. ▶ Failed to attend DWP appointment. ▶ Currently off methadone script.
September 2019	<ul style="list-style-type: none"> ▶ Ambulance callout due to vomiting. ▶ New partner JC is seen with her. ▶ Expresses suicidal thoughts to ASC due to "no-one helping her".
October 2019	<ul style="list-style-type: none"> ▶ ED attendance with abdominal pain. ▶ Ambulance callout re liver disease. ▶ New partner present at drug and alcohol service appointment.
November 2019	<ul style="list-style-type: none"> ▶ Safeguarding concern from Police as a result of her very poor health. ▶ Call to Ambulance Service about Adult O's poor health but the male caller would not reveal his identity. No-one was at home when Ambulance arrived.
December 2019	<ul style="list-style-type: none"> ▶ Incidence of violence between Adult O and JC. She had been reported missing by mother and found at partner's address and had significant bruising. ▶ DASH completed – high risk. ▶ Safeguarding concern submitted. ▶ Adult O denied assault. ▶ Admission to Hospital when found wandering in the street with physical injuries. ▶ JC arrived in Hospital and behind a curtain a slap was heard, and Adult O was found pinned to the bed by JC. ▶ JC taken into custody but Adult O would not pursue charges.

Date	
	<ul style="list-style-type: none"> ▶ Safeguarding concern raised due to concerns by mother about whereabouts of Adult O. She was found at JC's address. She was taken to Hospital. ▶ In Hospital disclosed abuse by JC. ▶ Referral to IDVA service but unable to contact her. ▶ Reported further assault by partner while she was intoxicated but cannot recall details
January 2020	<ul style="list-style-type: none"> ▶ Reports to Police from both JC and Adult O that the other was threatening them by phone. Police check phones and no offence identified. ▶ JC and Adult O are reported to have separated. ▶ Adult O reports being bitten by a rat several times. Medical help sought. JC attended with Adult O but refused to leave when asked. ▶ Adult O reports blurred vision due to banging her head on a wall. She is aggressive to staff. ▶ Aggressive to DWP staff on phone assessment ▶ Attends A&E but makes a confused call asking the Ambulance service for a "refund" for a pizza she missed because she was taken to Hospital. Also threatened to kill herself. ▶ Safeguarding concern submitted following Hospital visit. ▶ Problems with benefits due to missed appointments. ▶ Discussed in MARAC following abuse from JC. ▶ Described at MARAC as having organ failure. ▶ Seen by Ambulance service covered in bruises – believed to be due to liver disease rather than violence. ▶ Taken to Hospital by partner because of bruising. They are intoxicated and leave without treatment. ▶ Ambulance called following vomiting red blood also heart problems. ▶ IDVA attempted contact several times. ▶ Safeguarding strategy meeting held. ▶ Admitted to Hospital due to drinking and health concerns. ▶ Domestic abuse report to Police by Adult O. JC had smashed her television.
February 2020	<ul style="list-style-type: none"> ▶ ASC attempt contact with Adult O but unsuccessful. ▶ Consideration of application for inherent jurisdiction to keep Adult O safe. ▶ JC and Adult O reported to be in ongoing relationship. ▶ Failed to attend review at Drug and Alcohol Service. ▶ Admitted to Hospital with a subdural bleed and subsequently passes away. ▶ It is unclear if the bleed and accompanying bruising is the result of violence. ▶ JC arrested in relation to her death but no further action was taken.

Description of Adult O from professionals

37. This section provides a general overview of Adult O and is based on information provided to the review by agencies and professionals who were involved with her. Her relationships and the domestic abuse she experienced is described in more detail in subsequent sections.

38. Adult O was a 39 year old White British woman who died in February 2020. She repeatedly experienced violence and domestic abuse from her male partners from at least 2007 onwards. This may also have included financial abuse.
39. She was described by professionals who knew her as very intelligent with a good sense of humour. As soon as she was sober on a ward, she would be taking care of her appearance and *“proudly walking around in her high heels and fur coat – even with hospital pyjamas”*. She was said to have loved animals and to have had aspirations to working in veterinary care.
40. In addition to the abuse she experienced, Adult O had alcohol and drug use disorders. At the time of her death she was drinking approximately 3.5 litres of cider a day (26 units). She had had a long history of heroin use for which she had received opiate substitution therapy (methadone). By her death, she was reported to have stopped using heroin but was known to occasionally use cocaine.
41. Adult O had also previously been assessed as having care and support needs as a result of physical conditions associated with a serious road accident in 2011, when she was travelling as a passenger in a car, intoxicated and not wearing a seat belt.
42. At the start of the review period, her health was already very poor. She had epilepsy, liver disease, a traumatic brain haemorrhage and a fractured cervical spine. In 2018, the Mental Health Trust noted her to be “notably underweight though clean and well-presented”. At another health assessment in December 2018 she disclosed mental health problems, musculoskeletal problems, alcohol misuse, polycystic ovaries, neck and knee pain from the car accident and a fatty liver.
43. As a result, she was a regular user of health services. In the period under review she made 30x 999 calls and 25x 111 calls. She had 17 Emergency Department presentations, 14 Hospital admissions, 5 Walk-in Centre visits and one other planned attendance at Hospital. 11 safeguarding concerns were raised regarding Adult O between 2007 and her death.
44. In 2019, Adult O was the victim of a significant assault perpetrated by a female “friend”. Hospital notes describe the seriousness of this incident: *Adult O reported an assault by a female in her own home...punched face / kicked body / bit nose / tried to strangle / used cigarettes to burn her chest / held gas lighter up close to her eye. Bruising noted to both sides of face / left thigh / anterior chest / left upper arm / bruising and swelling to jaw.*
45. Adult O also indicated to Hospital staff that the woman and her partner were financially abusing her. The perpetrator was arrested and charged with unlawful wounding and was sentenced to 19 months in prison. However, following discharge from hospital, Adult O declined most of the support, which

was offered, other than information being shared with key agencies and professionals.

46. Adult O had contact with the local Mental Health Trust for both mental health problems and substance use disorders. She first had contact with Mental Health Services in 2007. After that there were occasional referrals to the Mental Health Crisis Team (2011), Psychiatric Liaison Team (2011 & 2019) and the Street Triage Team (2018 & 2019). At the start of the review period Adult O was receiving prescriptions for sertraline (for anxiety).
47. In September 2018 Adult O rang police to say she was going to kill herself by throwing herself off a bridge. Officers could not see her at the location and later found her at her home address. In October 2018, her GP notes that Adult O describes herself as having obsessive compulsive disorder because she “washes with a lot of fragranced products”.
48. However, the more significant concern was her substance use disorder. In 2008 and 2011 there were short periods when she was referred to Drug and Alcohol Services. She was again referred to them in December 2011 and remained open to the service until her death.
49. Adult O was prescribed methadone by Drug and Alcohol Services to help control her heroin use. She also reported some crack/cocaine use. Nonetheless, the practitioner’s workshop agreed that her most consistent problem was with alcohol. In January 2018, she was reported not to be taking heroin anymore but was drinking half a bottle of spirits per day (14 units). She was being prescribed thiamine (vitamin therapy used with dependent drinkers) and she was diagnosed with alcoholic liver cirrhosis and, as a result, was under palliative treatment at the time of her death.
50. A subsidiary problem was that services found her very difficult to engage into any package of treatment or care. For example, she had contact with her GP but often did not attend follow ups or respond to invitations for review after her many attendances at Accident and Emergency, the Walk In Centre or Out Of Hours GP Service. When she did present to the GP she often had multiple problems and presented a vague and difficult to follow history which made assessment difficult. At times, this was likely to be because she was under the influence of alcohol or drugs.
51. Adult O could also be very abusive or aggressive to staff, and at points this led to the termination of services, particularly health services. This pattern included being verbally aggressive on the telephone with professionals. She was also evicted from a private rental property as a result of aggression to the landlord.
52. At points, Adult O was involved with the Criminal Justice System. Between 2006 and 2020 she is recorded as the victim in 23 crimes and as a witness in relation to two of them. She was also subject to 10 arrests between 2006 and 2015. These included driving / attempting to drive a motor vehicle whilst unfit through drink, breach of the peace, criminal damage, affray, theft, and domestic

abuse assault offences. She was not charged with these offences, but she was issued with a penalty notice for theft and cautions for criminal damage, the assault offence and possession of a controlled drug with intent to supply.

Description of JC

53. JC was Adult O's partner in the last six months of her life. He is a White British man who was 41 when Adult O died. He was diagnosed with anxiety and depression in 2001 and post-traumatic stress disorder and alcohol use disorders in 2007. In 2019 he was having alcohol induced seizures and hallucinations which suggest dependent drinking. He also used cannabis and had taken multiple drug overdoses in the past.
54. Although not as acutely unwell as Adult O, JC had a significant impact on health services. During the review period, the Ambulance Service received contacts relating to JC on a total of 60 days, many of those days show multiple calls to 111 or 999. The majority of these calls were made by JC himself and a small number by either the Police or his then partner. Ambulances were dispatched on 21 occasions and additional transport was dispatched twice (e.g. a taxi). Several calls were triaged to other services such as his own GP or the Crisis Team. On occasions JC was described as agitated and abusive on calls and staff often documented that he would not listen to what was being said.
55. He had a pattern of drug seeking behaviour in which he would tell the Ambulance Service or his GP that he had lost medications and needed replacements. On one occasion in 2019, he became aggressive when he was unsuccessful; telling the receptionist: *"you are a waste of space and do nothing to help"*.
56. However, his main problem was his alcohol use disorder. This underpinned many of his engagements with health and other services. Ultimately this led to a Court imposing a six month Alcohol Treatment Requirement (Probation Order targeted at individuals who have a dependency on alcohol). However, JC did not engage with this and did not engage with any other programme of alcohol treatment.
57. JC also had mental health problems and would ring the Police with suicidal thoughts and speak with the Street Triage Mental Health Team. On two occasions he had expressed thoughts of self-harm to the Probation Service.
58. JC had a long involvement with the criminal justice system. He had had six convictions for 12 offences between 1995 through to 2019. These offences included; Breach of the Peace (1995), Theft from a Motor Vehicle (1997), Making a False Statement or Representation in Order to Obtain Benefit or Payment (2006), Assault Occasioning Actual Bodily Harm (2008), Possession of Cannabis (2015) and Failing to Surrender (2019).

59. He had had an 18 month Probation Order in 2008/2009. He next came to the attention of Probation Services in 2019 as a result of an offence of Possession of an Article with a Blade or Point in a Public Place. He was sentenced to a Suspended Sentence Order for a period of 12 months with a 6 month custodial element and an Alcohol Treatment Requirement as well as:
- Rehabilitation Activity Requirement (RAR) (20 days). This required that he participate in activity to reduce the prospect of reoffending.
 - Curfew (8 weeks) between 7pm – 6am. This required him to stay within a specified place (usually home) for a certain period and was electronically monitored.
60. JC was both aggressive to others generally and a high risk perpetrator of domestic violence specifically. He had alerts on record that he should not receive a home visit due to being “aggressive, usually intoxicated” and he was barred from one pharmacy due to abusive behaviour.
61. The Probation Service identified records of 30 domestic violence incidents of which 19 were in 2019: some of the recent incidents concerned Adult O. However, during that period he had been in a relationship with another woman, YV, and again there appears to have been violence and abuse. In October 2019 he was discussed at MARAC in the context of violence towards YV. In November 2019 there was concern about violence from JC to YV’s mother. Conversely, while he was with Adult O, JC regularly reported being a victim of harassment from YV; however although he reported this to the Police, he never supported a prosecution.

The relationship between Adult O and JC

62. *This section describes the relationship between Adult O and JC. The response from agencies is described later.*
63. The relationship between Adult O and JC lasted for no more than the six months immediately prior to Adult O’s death.
64. JC lived close to Adult O’s final home, but they seem to have met for the first time in hospital in July / August 2019. The first note in the chronology concerning both of them is in early August 2019 when the Police IMR reports that Adult O “rang police saying there is a male named JC and an unknown female who are currently going door to door in the area asking for her and this is making her feel unsafe. An officer arrived at her address. (Adult O) said she had recently moved to the address...When in hospital (recently) she met JC and they became friends. There was a window open in her flat today and she heard a voice she thought was JC and he was asking where she lived. No one was at the door and no threats were made. She did not see JC.”
65. She is first described as being in a relationship with JC in late October 2019 when the Mental Health Trust undertook a home visit to Adult O and found her *new partner JC was present...he reluctantly agreed to leave the room as he was still drinking cider 7.5% (am appt). Adult O showed them bruises on her*

arms, hands and body which she felt were a result of her liver damage but it was noted these may have been inflicted on her...an ambulance was arranged to take her to hospital and she asked JC to accompany her for this... Staff then left the property as JC was becoming a little prickly in his manner towards them...FACE Risk assessment was updated. During this period the risk of abuse from others was increased to serious apparent risk recognising she is in a relationship with JC and he has a history of domestic abuse to partners.

66. JC and Adult O appear to have had separate properties and the extent to which they cohabited is unclear. JC and Adult O were together in November 2019 because he witnessed her having a fit. As a result in mid-November he told his Probation Officer that the relationship was over because of the stress that dealing with this health crisis had on his drinking. However, he subsequently told his Probation Officer that Adult O had been with him during late November and December.
67. Adult O and JC were together around Christmas 2019 and there was an incident reported to the police of possible domestic abuse. Adult O had a pattern of bruising which was consistent with being hit but she ultimately ascribed this to fits and bruising related to liver disease. However, during a hospital admission following this incident there was another assault on Adult O by JC while she was in a hospital bed. The curtains were closed so the initial incident was not observed but slaps were heard as well as a complaint from JC. On responding, staff found Adult O pinned to the bed by JC. Staff on the ward took this incident seriously and JC was asked to leave, Police were called to speak to Adult O, a safeguarding concern was raised and this led to a MARAC referral and a discussion at a MARAC meeting in January 2020.
68. It is reported by JC that he saw Adult O on New Year's Eve and she was "nasty" to him. However, that day Adult O attended the Walk-in centre and initially reported that she had been assaulted by her partner; the details she provided subsequently played down the assault and the key outcome was referral to the Emergency Department. No specific action appears to have been taken on the violence.
69. This pattern of violence and abuse from JC towards Adult O appears to have continued until just before her death. For example, on the 2nd January 2020 an allegation was made by JC that both Adult O and her mother were threatening him. However, counter-allegations were made, and this was recorded as an incident in which JC was the perpetrator. The next day, they attended a medical appointment together. JC was asked to leave but refused and stayed.
70. In mid-January Adult O twice attended Hospital with JC. On the first occasion they were both abusive and swearing. On the second occasion the notes indicate that JC kept speaking for Adult O. When asked to let Adult O answer he became rude and was asked to sit in the waiting room; he refused and Adult O stated she wanted him to remain.
71. At the end of January, Adult O rang the police regarding her "ex-partner", saying

he had smashed her television and had sent her threatening messages and deleted contacts from her mobile phone. After this, reports of violence or abuse cease. It is unclear whether the abuse continued but this is also the point at which Adult O's health was deteriorating significantly.

Adult O's earlier relationships

72. Adult O was the victim of violence and abuse in previous relationships. She first came to the attention of Adult Social Care in October 2007 when she was admitted to hospital with bruising to her face and body, where it transpired, she was a victim of assault from her partner who had just been released from prison. It is unclear when that relationship ended.
73. Adult O was discussed in MARAC nine times between 2011-2014. (She was also discussed once in 2017 and once in 2020).
74. In late 2017 she ended a relationship with AJ, he is understood to have, at the least, financially abused her by stealing money using her bank card. In April 2018, Adult O rang the police saying there was a female kicking at her front door, she said this was the ex-partner of her current partner DL. Adult O believed the woman had come because she had found out that Adult O had spent time with her partner and his child. Police Officers attended but the woman was not there. In August 2018 Adult O was in a relationship with a new partner. He was also a heroin user, and she described him as her "bodyguard" and that she felt safe now. She denied any current abuse.
75. In September 2018, while on route to hospital with a Police Officer, Adult O disclosed a rape offence; however, she refused to provide any information around the person responsible, or dates and times. A crime was created for rape in which she disclosed that a known male engaged in sexual intercourse with her, she told him to stop during intercourse and he continued. Ultimately, she did not provide details of the person responsible or identify evidential lines of enquiry and no other action was taken.
76. She then began a relationship with PW who is also known to have assaulted her. He also tried to dissuade her from attending rehab and at one point it was suggested that PW was injecting her with heroin. This relationship was followed by that with JC.
77. However, potentially her most serious single assault was from a female associate, who inflicted very severe injuries in an unexplained attack in 2019. Adult O described the woman who assaulted her as the girlfriend of a friend that she has known for many years. Adult O disclosed that they had taken money from her bank in the past and that she also paid for the couple's food, drink and other living expenses on a daily basis.

The gendered nature of domestic abuse

78. At points JC claims that he has been the victim of domestic abuse. Nonetheless, it is important to remember that Adult O's experience of domestic violence and abuse was, and was always likely to be, worse than that of JC. Being female (and having disabilities) places her at increased risk of experiencing domestic abuse and that the abuse was more likely to go on longer, be more severe, and it may be harder for her to access support.
79. Both men and women may experience incidents of inter-personal violence and abuse, but women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to have experienced sustained physical, psychological or emotional abuse, or violence which results in injury or death. This needs to be borne in mind when considering Adult O and JC's various histories.

The intersection between alcohol and drug use disorders and domestic violence and abuse

80. Alcohol and drug use does not cause domestic abuse, but it is a contributory factor in a number of ways. It may have:
- increased the likelihood of violent and abusive behaviour on the part of the perpetrators in Adult O's life such as JC as a result, for example, of its disinhibiting effects;
 - increased the vulnerability of Adult O to such violence by making her less able to take steps to protect herself in both the short and longer term;
 - been a coping mechanism for the ongoing violence and abuse she experienced from multiple partners;
 - a means by which these partners could control Adult O as part of the abuse e.g. by supplying and encouraging drug or alcohol use.
81. The exact mechanisms that applied to Adult O are a matter for debate because the information available does not clarify this. Nonetheless, it is highly probable that most, if not all, of these factors were operating at points in her life.

Learning from Adult O

82. Adult O had two linked sets of challenges: her substance use disorder and the domestic abuse that she experienced from successive partners. However, underpinning these two issues was a more fundamental problem: the challenge of engaging her into services.
83. Adult O consistently pushed back at people and agencies who were trying to engage her into structured interventions that would have greatly improved the quality of her life. (This was also true of JC). The Primary Care IMR states that: *"During many... interactions she appeared either intoxicated, presented multiple problems or shouted at the health professional which would have made routine enquiry very difficult. When a follow up appointment to discuss issues*

in further detail was booked; she did not attend.... On 7/1/20 the practice proactively contacted Adult O to arrange an appointment to review things ...but she declined the appointment; however just over 2 hours later she rang the practice and "Started screaming down the phone..." and the receptionist had to terminate the call.

84. The Hospital Trust describe her: *"as being volatile, aggressive, and abusive to staff and had to be asked at times to lower her voice/tone, to be asked to be respectful. Security had to be called on occasion also to remove Adult O from the Department/Hospital. Adult O also on occasion was noted to threaten self-harm if unable to have the treatment..."*
85. The Mental Health Trust describe how she did not attend appointments and then was verbally aggressive when she did attend.
86. Faced with, at times, aggressive refusal of service, it is easy for agencies to simply be reactive and to respond to each new crisis but without assertively trying to change Adult O's situation. To use the language of the Mental Capacity Act, it is easy to see what is happening as Adult O making "unwise decisions" or more colloquially, making "lifestyle choices" to live like this. However, this active, if not aggressive, refusal of services may well conceal the degree of vulnerability or past trauma underpinning this behaviour and, therefore, the need for intervention.
87. Therefore, at the heart of this review is a single question: as Adult O approached the end of her life did she have the ability to keep herself safe, to keep herself physically healthy and to act in her own best interests? This question is deliberately not using the language of mental capacity. It is asking something more basic: would a reasonable person realistically believe she can protect herself from harm and care adequately for her significant health needs?
88. If the answer to that question is "no", then despite her pushing back at services, a more assertive response will be necessary to address her needs and the risks she experienced. Therefore, the review then considers how agencies can work with someone who they find difficult to engage in services. It explores a number of related themes:
- Multi-agency management
 - The need for a policy on working with clients that services find difficult to engage
 - The use of the Mental Capacity Act
 - Safeguarding
 - Other legal frameworks
89. In addition, the report considers the response to her two main challenges: her substance use disorder and the domestic abuse she experiences. Within this framework, comments are also made about the response to JC.

Professional curiosity - Can Adult O keep herself safe?

90. During the period under review, and almost certainly prior to it, Adult O appeared to be unable to protect herself from harm. She was involved in a series of relationships characterised by violence towards her, and she was unable to leave those relationships despite repeated abuse. She was also exploited financially by another couple, one of whom perpetrated a very serious, potentially life threatening, assault on her.
91. At the same time she engaged in chaotic alcohol and drug use and did not take advantage of the help that was continually on offer to her. This pattern led to serious physical decline including liver disease but also accidental harm such as the serious injuries she experienced in the 2011 car crash.
92. Professional curiosity² is required to understand what lies behind this inability to keep herself safe. Is this simply a choice or is there a more complex picture to be understood? Therefore, this review begins by exploring whether Adult O was choosing this lifestyle or was she unable to protect herself from harm. Was Adult O able to keep herself safe? Three main reasons suggest this was not the case:
- The impact of cognitive damage
 - The impact of her dependency on psychoactive substances
 - The impact of domestic abuse.

Professional curiosity - cognitive damage

93. Even with only the most cursory knowledge of Adult O's history, it would be possible to recognise that there was a high probability that she was experiencing cognitive impairment:
- She had a road traffic collision in 2011 in which she suffered serious injuries, particularly as she was not wearing a seatbelt.
 - She had been the repeated victim of domestic abuse and violence over the 13 years prior to her death.
 - She was very seriously assaulted by a female associate in 2019 – this could have been life threatening and involved blows to the head and face.
 - She was drinking at dependent levels risking alcohol related brain damage (Wernicke Korsakoff's Syndrome).
 - She was generally low weight and, therefore, probably poorly nourished which would contribute to the alcohol related brain damage.
 - She had repeated alcohol withdrawals which can contribute to cognitive damage through a process known as "kindling".³
 - She had fits during withdrawals which risk cognitive damage.
 - She may have had a stroke in December 2018.
 - She had possibly had other accidents while intoxicated, again risking head injury.

² Professional curiosity is where a practitioner explores and proactively tries to understand what is happening within a family or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value. See [202 - Professional Curiosity.pdf \(leeds.gov.uk\)](#)

³ [Kindling in Alcohol Withdrawal \(nih.gov\)](#)

94. The possibility of cognitive impairment is acknowledged at various points by professionals and steps were taken to address this, but this was still at an early stage when she died. The Acute Hospital Trust acknowledge that *“The longer-term picture would have been consideration of cognition”*. The Mental Health Trust used cognitive assessment tools and sought a review from a Psychiatrist because of her low score. In September 2018 she was described as having difficulty remembering things particularly when under stress – she couldn’t use her phone properly and forgot dates and appointments. She was screened using the Montreal Cognitive Assessment tool and scored 19. (A score of 25 points or less may indicate some degree of cognitive impairment, people with Alzheimer’s disease score an average of 16.2)
95. As a result, a Consultant Psychiatrist reviewed her and commented that she had *Multiple risk factors for poor cognition, ongoing opiate (methadone) use, alcohol dependence, history of head injury, and psychological distress/anxiety... Results of cognitive testing could be explained by multifactorial cognitive impairment, exacerbated by anxiety and psychosocial stressors. Neuropsychological assessment is unlikely to provide further detail to pinpoint the exact cause of cognitive difficulties, and given her engagement, may be counter-productive.*
96. The Psychiatrist suggested ongoing work to investigate her cognitive impairment.

Professional curiosity - dependency

97. Adult O was dependent on alcohol and, at points, opiates. The DSM 5 definition of addiction includes characteristics such as:
- Experiencing intense cravings or urges to use the substance.
 - Spending more time getting and using drugs and recovering from substance use.
 - Neglecting responsibilities...because of substance use.
 - Continuing to use even when it causes relationship problems.
 - Using substances in risky settings that put you in danger.
 - Continuing to use despite the substance causing problems to your physical and mental health.
98. These alone highlight that Adult O would have found it hard to keep herself safe while dependent on psychoactive substances. However, the Code of Practice on the Mental Capacity Act takes this a stage further. In Chapter 4.22 it comments that *for example, a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.* The Code of Practice acknowledges that people with compulsive behaviour will find it hard to maintain their safety and wellbeing. This is as likely to apply to the compulsion associated with dependency as it does to anorexia.

Professional curiosity - domestic violence and abuse

99. A third factor which raises questions about her ability to keep herself safe is her pattern of being a repeated victim of domestic violence, abuse and coercive control from successive partners. Adult O was in a number of relationships with abusive partners. She was vulnerable and it is highly likely that she was targeted by perpetrators, some of whom were repeat high risk perpetrators. Indeed, JC seems to have actively pursued her.
100. It is clear at points that her partners undermined efforts to seek help. For example, JC would not leave a treatment room while she was being treated at a Walk-in Centre. This inhibited any questioning of Adult O. A previous partner had dissuaded her from seeking residential rehabilitation.
101. It is important to try and step into Adult O's shoes. She would have seen a risk of violence not just from her partners but also from others in her world. There are occasions when she rang the Police because of a feeling of threat from other people, although Officers could not identify anyone. Indeed, she may have viewed the risk from her partners as less serious than the risk from other people. At one point, she describes a male partner as her "bodyguard". This world view became a reality in 2019 with a serious assault that could potentially have killed her. She may feel that she is trapped in a world where there is the potential of violence whichever way she turns.
102. The Alice Ruggles Domestic Homicide Review from Gateshead criticises "victim-led" responses. It suggests that simply following what the victim is saying may not protect them. It states that "while it is important to involve the victim...it is important their involvement does not ultimately dictate the approach." This suggests that in the midst of a pattern of domestic violence, the victims may not be the best judge of what will keep them safe. This may well have applied to Adult O.

Professional curiosity - fatigue and other health problems

103. In addition to these three main factors, other physical health problems may also have impacted on her ability to care for herself. She had liver disease which causes fatigue and low energy levels. She also reported significant levels of pain as a legacy of her car accident in 2011 and possibly as a result of the serious assault in 2019. Either of these factors could have hindered her ability, and her motivation, to care for herself. It is likely that there were other debilitating health factors as she neared the end of her life:
- 60-70% of dependent drinkers report depression or low mood, in part at least due to the chronic depressant effect of alcohol.⁴
 - They may have confusional states resulting from liver disease, pancreatitis or urinary tract infections.⁵
 - They may have poor sleep patterns due to excessive alcohol use (or lifestyle) which again will lead to depression, low mood and lack of energy.

⁴ Davidson K. – Diagnosis of depression in alcohol dependence – British Journal of Psychiatry (1995) 166, 199-204

⁵ E.g. <http://www.britishlivertrust.org.uk/liver-information/living-with-liver-disease/looking-after-yourself/>

- They may have poor nutrition which will increase depression.⁶

104. Irrespective of specific questions about mental capacity, professional curiosity would suggest that Adult O was unable to care for herself or protect herself. It appears very predictable that without some more structured intervention she would become more and more seriously unwell and increasingly vulnerable. At the most basic level, a professional duty of care or the need to “promote individual well-being” (as per the Care Act) would suggest that more structured action is required to keep Adult O safe.

105. The Manchester Safeguarding Partnership’s *Carers Thematic Learning Review 2021* powerfully comments on this same issue with this client group. It recognises that: *a sense that their persistent refusal of offers of care and support were perhaps too readily accepted, perceived and interpreted by practitioners as ‘non-compliance’ rather than as a form of self-neglect, which was a product of the adults’ adverse life experiences, poor quality of life and very challenging day to day living.*

106. The rest of this report considers the steps that could have been taken.

A more structured approach

107. The question for this review is: What steps could have been taken that were not taken during the last years of Adult O’s life? What could have helped protect or safeguard her?

108. In this section, the structure of interventions is considered e.g. multi-agency management, policies on non-engagement, use of the Care Act and the Mental Capacity Act. In the subsequent sections, the review considers the response to the two specific issues of alcohol and drug problems and domestic abuse. In addition, the report will look at interventions with JC.

A more structured approach - difficulty of engagement

109. Once it is recognised that Adult O’s pattern of vulnerability and non-engagement requires further intervention, it will be useful for practitioners to have structured guidance on how and where to escalate her needs. The Primary Care IMR *highlights the challenge of working with someone who struggles to engage with primary care;*” and importantly, goes on to say: *“Guidance on how this could be handled would be helpful.*

110. This is not a local issue. The Manchester Safeguarding Partnership’s *Carers Thematic Learning Review 2021*, mentioned above, identifies: *The challenges of supporting adults who do not consent to treatment or support and who are judged to have the capacity to make those decisions in an informed way...* It also recognises failures to escalate these individuals.

⁶ E.g. <http://www.nchpad.org/606/2558/Food~and~Your~Mood~~Nutrition~and~Mental~Health>

111. It is the view of this report, in line with the comments from Primary Care, that Adult O's pattern of non-engagement highlights the need for specific published protocols to guide professionals in dealing with client non-engagement. Adult O's case history highlights that to make such protocols useful it will need to provide guidance on:
- how to judge the level of risk or vulnerability that warrants ongoing, assertive action;
 - how to practically intervene in these situations; and
 - how to escalate these concerns and where they should be escalated to (including professional supervision).
112. This process, whether single agency or multi-agency, would also benefit from guidance on what techniques work with clients that services find hard to engage. Newcastle SAB have, following the Lee Irving SAR, agreed Eight Principles of Engagement as best practice approaches to responding to people who, for a range of reasons, may not be engaging with services. This will provide a baseline for any such work.
113. However, engagement remains an under-developed field. The SAR author looked for national guidance on this issue as part of the drafting of this report but could not find an overarching guidance document. Reports such as "The Keys to Engagement" (mental health)⁷ and "The Blue Light Project" (alcohol misuse)⁸ have addressed this issue with specific client groups but there is no single guidance document. Whether at a local or a national level, such guidance will be a vital support to those working with vulnerable clients that they find difficult to engage.

A more structured approach - Multi agency management and care coordination

114. Any response to the complex challenges presented by Adult O will require care coordination and/or multi-agency management. This is also likely to be a key part of any protocol on working with individuals that services find hard to engage.
115. Multi-agency working was a part of the response to Adult O. Communication between agencies is evidenced throughout the records. This encompasses Adult Social Care, the GP, Drug and Alcohol Services, IDVA, Police, Consultant and Acute Trust Safeguarding Team as well as JC's Probation Officer due to concerns about his previous behaviours towards another service user known to Adult Social Care.
116. Adult O was also discussed at MARAC on eleven occasions; albeit only one of which was during the review period. It is also known via the GP that both Adult O and JC were discussed in a clinical case meeting. Very near the end of her life there was a multi-agency safeguarding meeting about Adult O.

⁷ https://www.centreformentalhealth.org.uk/sites/default/files/keys_to_engagement.pdf

⁸ <https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project>

117. However, the Mental Health Trust are clear that: overall there appears to be a *lack of collaborative multi-agency working/actions aimed at protecting Adult O from harm*. The Primary Care IMR also comments that *It may have helped to develop a management strategy for both Adult O and JC via a discussion with other providers of healthcare support such as accident and emergency, walk in centres and the drug and alcohol team. There is no current forum or protocol for similar complex cases to be discussed between health practitioners in different NHS organisations*.
118. In the same way, many agencies and professionals were in contact with Adult O, yet no one person seems to have taken on a care coordination role with her.
119. Her care would have benefited from clear leadership: a care coordinator and/or multi-agency management. These two elements would have fed off each other: having a care coordinator would have supported regular multi-agency meetings, and regular meetings could equally have driven the appointment of a care coordinator.
120. Multi-agency management of Adult O would also have enabled discussion of a range of issues that were central to her care e.g. mental capacity, cognitive impairment or escalation to a more senior group. In the same way, care coordination, with a single worker taking a lead, would have supported focused discussions in those meetings.
121. This apparent gap could have been addressed in a number of ways:
- as part of a safeguarding process (following a safeguarding concern);
 - by having a clear policy on dealing with clients that services find difficult to engage;
 - by having a policy on calling a multi-agency meeting;
 - through referral to an existing multi-agency group; or
 - through individual initiative by another professional.
122. Whichever way is chosen, this is a process that would have benefited Adult O.

A more structured approach - mental capacity

123. Repeated service refusal must raise questions about mental capacity and Adult O's care raises questions at two levels:
- Was her mental capacity being appropriately considered and assessed?
 - Is the Mental Capacity Act itself appropriate to meet the needs of someone like Adult O?
124. The IMRs contain multiple references to assessments of her mental capacity. For example, the Adult Social Care IMR comments that: *Throughout this time, both known adult perpetrators were still on the scene, Adult O was deemed to have capacity and wanted the adult perpetrators to remain in her life at that time, informing that they were kind to her when they weren't drinking*.

125. The Acute Hospital Trust IMR comments that: *When Adult O wanted to self-discharge...(she) was seen by medical staff and advised that treatment being given was to protect her from brain damage secondary to alcohol excess and also to monitor her liver due to Decompensating Liver Failure. Notes indicate understanding and no concern re capacity. Adult O then self-discharged.*
126. On the other hand, the Primary Care IMR comments: *No capacity assessment is recorded in the notes of Adult O, however given the way she presented to the practice, with multiple problems, intoxicated or abusive, and did not attend any planned reviews; it is difficult to see how a formal capacity assessment could have been undertaken at any point.*
127. The Mental Health Trust IMR comments that: *Adult O was deemed to have capacity...on (four) occasions. Some of these focused on her care and treatment. However there were no formal capacity assessments at any time, and no-one appears to have challenged the view that she was deemed to have capacity. Whilst there is reference to specific decision-making capacity, there is no reference to executive functioning or executive capacity and this does not appear to have been considered at any point in time.*
128. The IMR also goes on to say that: *Adult O's long-standing history of alcohol dependence, substance misuse, cognitive functioning concerns/impairment along with mental (anxiety and low mood) and physical health concerns, along with a history of abuse and exploitation from males would have given reasonable and sufficient evidence for specific capacity assessments to have been considered and/or a clear rationale recorded as to why they were not.*
129. The Acute Hospital Trust IMR comments that: *There are parallels in this review with other recent DHRs/SARs and alcohol use, particularly the question of Mental Capacity assessment in the context of coercion and control and consideration of overall assessment of executive functioning.*
130. The application of the Mental Capacity Act to people with substance use disorders is an issue that has been explored in a growing number of Safeguarding Adult Reviews, including the Adult N SAR from Newcastle (written by the same author as this SAR). The box below quotes the Adult N SAR at length because it is equally applicable to the situation of Adult O.
131. (NB This is not an implicit criticism that these problems had not been addressed as a result of the Adult N review – Adult N actually died after Adult O. It simply underlines the need to address them.)

In making (mental capacity) assessments, it is important to remember that people who are dependent on drugs or alcohol are covered by the Mental Capacity Act. The fact that they appear to be choosing to use drugs does not mean that they are really exercising choice in that or other areas of their life.

The test of mental capacity requires proof that the person has an impairment of the mind or brain. These impairments include the symptoms of alcohol or drug use.

It also tests whether a person can: 1. understand information about the decision to be made, or 2. retain that information in their mind, or 3. use or weigh that information as part of the decision-making process, or 4. communicate their decision.

A chronic, dependent drug user might meet any of these four criteria. For example, a drug user with cognitive impairment might meet either of the first two criteria. However, with many drug users the more relevant issue may be the third criteria: can they use information in a decision-making process. The MCA Code of Practice provides a useful parallel for the situation of the dependent drug user. The Code says: a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.

This is a situation that will be commonplace with many dependent drug users: their compulsion to use drugs means that they are unable to use information that they are given about the impact of their dependency, even if they understand and retain it. The Teeswide Carol SAR talks about the need to look at a dependent drinker or drug user's "executive capacity" as well as their "decisional capacity". Can someone both take a decision and put it into effect (i.e. use the information)? This will necessitate a longer-term view when assessing capacity with someone like Adult N.

Assessing capacity in dependent drug or alcohol users is complex and should not be subject to simplistic judgements. Decisions may require time, multi-agency discussion and professional challenge.

The Code of Practice supports this stating that: Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.

In addition, it should be remembered that the Code of Practice comments that: 2.11 There may be cause for concern if somebody: repeatedly makes unwise decisions that put them at significant risk of harm or exploitation...These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation...

Even if Adult N did have the capacity to make decisions about her safety, care and treatment, the Code suggests that professionals seeing her repetitive behaviour should certainly have explored what lay behind this pattern.

132. With Adult O, all of these considerations are relevant. A series of one-off decisions about capacity may not address the presenting problems. Professionals need to step back and consider the bigger picture. They need to see that she may well be able to articulate that she can care for herself but a review of a repeated pattern of not following-up on those statements must

raise questions about her executive capacity. Could she put decisions into effect? Multi-agency management would again have provided a very good framework for considering these issues and may have supported practitioners to be more confident in using these powers and, perhaps, to undertake joint capacity assessments.

133. Near the end of her life, Adult Social Care made contact with their Legal Services to request an application to the High Court for inherent jurisdiction to be made regarding Adult O not being able to keep herself safe. The advice provided was that it was difficult to ascertain what would be asked of the court as information required needed to be clear and concise as to how they could keep Adult O safe and what the exact issues were. Adult O passed away before this could be looked into further.
134. It might also have been possible to move beyond the Mental Capacity Act and to build a case for action on the need to preserve her Article 2 rights under the Human Rights Act – the right to life? (Or indeed Article 3 – freedom from degrading treatment). This is not a widely used approach in the substance misuse field, but, in Manchester, the Substance Misuse Social Work Team is using the Human Rights Act to drive intervention with individuals where other frameworks have not proven viable. This is a route that may be worth consideration in such cases.
135. Ultimately, this does raise questions about whether the problem lies with the confidence of professionals to use the Act, or whether it is about the adequacy of the legislative framework itself. This is considered further below.

A more structured approach - safeguarding

136. The Adult Social Care IMR reports that 11 safeguarding concerns were raised about Adult O. It is stated that each one was followed up correctly with a clear outcome and reason for next steps, including no further action on some. The only exception to this is the last one that was ongoing at the time of her death.
137. Just under half of these referrals were prior to the review period. For example, in 2014, a safeguarding concern was raised by the Police due to a domestic violence incident. On this occasion there was no further action by Adult Services as other professionals were involved, e.g. an IDVA and the case was in MARAC. In 2015, an alert was made to Adult Services due to concerns about Adult O taking part in sexual activities with different men. This was viewed as a capacitated decision and no further action was taken.
138. Two further concerns were received in July and December 2017, as a result of relationships with men. One of these came from Adult O's mother, the other from the Police due to coercive control by her partner. In the latter case, the outcome was that she continued with support from alcohol and drug services and an IDVA. In one other safeguarding alert, Adult O was classed as the perpetrator and concerns were raised, because she was using her mother's medication.

139. During the review period, the Police raised five safeguarding concerns relating to concerns around her mental health, alcohol use, going missing from home and her vulnerability as a victim of domestic abuse from her partners.
140. At other points safeguarding concerns might have been raised but were not. For example, the Police did not raise concerns about incidents in June 2018 and August 2019 when she reported being under threat from other people – although it should be noted that it was not possible for the Police to corroborate these threats.
141. On one occasion, Police Officers found Adult O behaving erratically. Following advice from the Street Triage Mental Health Team, she was taken to Hospital as she was suffering with alcohol withdrawal symptoms. A safeguarding concern was considered but Adult O did not provide consent for this, and this was not overridden by the Officers in attendance. This is described by the Police IMR as a missed opportunity.
142. The Acute Hospital may also have missed opportunities to make referrals following admissions in both 2018 and 2019. Confusion as to whether the Police had submitted a concern may have led to one of these situations. More generally it is noted that, Adult O had 26 Emergency Department attendances over the 24-month period prior to her death. Adult Social Care highlight that they were not always made aware of these: although the Acute Trust state that this would only be the case if it was proportionate to do so and might not always be expected given circumstances such as Out of Hours discharges. She was flagged on the NHS system as a high-risk victim of domestic abuse but it is recognised that: *“It would have been beneficial to consult with ASC as soon as Adult O was in the hospital before she self-discharged so we could seek her views in a timelier manner and offer support before she left the hospital.”*
143. Late in 2019, a further safeguarding concern was raised due to both her general welfare and a specific domestic abuse incident. During an inpatient stay, Ward staff heard a slap and found Adult O being pinned to the bed by JC. A safeguarding adults enquiry was commenced in early 2020 and Adult O was discussed at MARAC. However, Adult O then passed away.
144. At the very least, this highlights the need for ongoing reminders of the importance of submitting safeguarding concerns and more specifically that people with substance use disorders are covered by this requirement. It is hard to say whether further action should have been taken by Adult Social Care on any one specific incident. However, the ability to use section 42 to drive a multi-agency response to a client does not seem to have been considered until the last two months of her life.

The adequacy of existing legal frameworks

145. Adult O highlights problems with the existing legal frameworks for managing people with chronic alcohol and drug use disorders. Both the Care

Act and the Mental Capacity Act highlight the importance of individual's having the right to self-determine, e.g.:

- The importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being; (Care Act)
- The importance of the individual participating as fully as possible in decisions (Care Act)
- A person is not to be treated as unable to make a decision merely because she makes an unwise decision. (MCA)

146. However, this prioritisation is very challenging to negotiate when someone's substance use disorder and related choices constantly place them at very serious risk of harm; and, moreover, when they appear to be repeatedly choosing to return to that lifestyle (and repeatedly articulating that choice). It is also at variance with the emphasis in the Alice Ruggles DHR on professionals not simply being led by the client's apparent wishes when working with a victim of domestic abuse.

147. The challenges posed by this situation are even greater when one turns to the guidance on the legislation:

- The Code of Practice on the MCA mentions alcohol just three times.
- The Guidance on the Care Act mentions alcohol just twice.

148. Practitioners are working in the absence of any clear statutory guidance on how to negotiate the type of challenges posed by Adult O. This is not an isolated issue, 25% of SARs feature people with significant alcohol problems.⁹ This does raise the question of whether England needs a new legislative framework for managing chronic dependent drinkers?

149. Other countries do have legislation which is specific to this client group and allows the compelled, protective, detention of dependent drinkers like Adult O. In some jurisdictions this is called "civil commitment" (e.g. USA).^{10 11 12} Indeed Article 5 of the European Convention on Human Rights specifically recognises this possibility.¹³ Such legislation might have provided a framework within which Adult O's needs could have been managed.

150. Three options exist for addressing this gap:

- Revised guidance / code of practice or specific guidance as per the CQC guidance on the Mental Health Act & Eating Disorders
- Revisions to the existing legislation

⁹ Preston-Shoot M. et al. - National SAR Analysis: April 2017-March 2019 – LGA / ADSS (2020)

¹⁰ http://www.emcdda.europa.eu/attachements.cfm/att_142550_EN_SE-NR2010.pdf

¹¹

http://www.legislation.govt.nz/act/public/2017/0004/latest/DLM6609057.html?search=ts_act%40bill%40regulation%40deemedreg_substance+addiction_resel_25_a&p=1

¹²

<http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf>

¹³ Article 5 of the *European Convention on Human Rights* (the *Right to liberty and security*) states that:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

- New legislation as per other countries
151. In the short term, it is most realistic to look for a change to the guidance on the legislation. In particular, clarification about how the Mental Capacity Act and the Care Act should be applied to this client group including case study examples. This would cover issues such as “executive capacity” or how the self-neglect provisions of the Care Act apply to dependent drinkers.
152. The Safeguarding Adults Board or Safe Newcastle may want to consider lobbying, at the least, for better guidance on how to use the existing legislation most effectively with this client group or even renewed legislation.

Alcohol and drug use disorders

Alcohol and drug use disorders - community interventions

153. Adult O received a good level of care from the local Alcohol and Drug Services. She was engaged with them almost continuously from 2012 onwards and the services did not close her case when faced with her challenging presentation e.g.:
- Difficulty of engagement.
 - The difficult task of managing a methadone script being taken by a chaotic dependent drinker – a combination with a heightened risk of overdose.
 - Her aggression towards staff which, at one point, required a change of worker.
 - Associated dangers which required two workers in some situations.
154. Her needs were assessed as complex; as a result, Adult O had a Mental Health Trust worker who managed complex cases (lower-risk cases were managed by their voluntary sector partner). She was also discussed at the Addictions Complex Case meetings (e.g. in August 2019.)
155. In addition, Adult O encountered the Alcohol Liaison Nurse Specialists in the Acute Hospital, and they followed the agreed Alcohol Care Pathway.
156. As has been said, she appears to have had a good response from Alcohol and Drug Services; nonetheless two other pathways were feasible for managing her substance use disorders.

Alcohol and drug use disorders - residential rehabilitation

157. At the Practitioners event, it was agreed that the ideal care pathway for Adult O would have been inpatient detoxification followed by a period of residential rehabilitation. This would have enabled:
- A time away from her abusive situation in a protected environment
 - A chance to properly assess her cognitive impairment and build any necessary rehabilitative programme
 - A chance to address her substance use disorders and consider her relationships.

158. This approach was considered with Adult O. In 2011 The Drug and Alcohol Services twice recommended: *“a residential rehabilitation placement to work with Adult O on her drinking, as she had indicated that she would like to reduce the need and wanted to eventually seek paid employment, she favoured a day placement instead and would not agree to residential rehab.”* In particular, it was recognised at the time that she wished to remain in contact with her then partner, PW, who tried to dissuade her from attending rehab. Ultimately, professionals felt that *“Adult O put barriers in place to jeopardise any sort of rehab.”* It is hard to determine whether her decision not to proceed was hers or whether she was dissuaded by her partner.
159. Adult O would probably have found a residential rehabilitation programme challenging at any point in her last decade. However, the review considers that, given the range of possible care packages, this would have been the best option for her.
160. This is a theme pursued by this author in a previous SAR in Newcastle (Adult N). What was said in that context is worth repeating because it applies equally to Adult O:
161. *Dame Carol Black’s Review of drugs part two: prevention, treatment, and recovery (states): Local commissioning of inpatient detoxification and residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs. Local commissioning of such high-cost but low-volume services should be replaced with a regional or sub-regional approach.*
162. *This is not an easy option. Adult N is very likely to have rejected any such offer. Moreover, it may not have succeeded even if she had agreed to attend a rehab. Detoxing Adult N was likely to be complex. It is also probable that there would have been problems finding an appropriate placement. However, in a very difficult and “stuck” situation it may have offered a route forward and Dame Carol Black’s report highlights the importance of considering this approach with people with complex needs.*
163. *Access to residential rehabilitation may not have been the panacea that would have solved Adult N’s problems. However, it is important that:*
- such a route should have been considered by staff working with her;*
 - efforts should have been made to “sell” this approach to her by all professionals;*
 - funding should have been available via commissioners for this approach without unreasonable barriers if she expressed interest in this option;*
 - commissioners should support and encourage the development of residential facilities that will work with more complex substance use disorders including those with cognitive impairment.*
164. This same statement is equally applicable to Adult O.

Alcohol and drug use disorders - assertive outreach

165. In the absence of a residential placement but also as a way of encouraging her to engage with such a placement, Adult O could have benefited from an assertive outreach approach. This would have attempted to build a relationship with her in order to understand what lay behind her challenging presentation, to stabilise the situation and to encourage her to move forward. This links to, and supports the need for, professional curiosity and care coordination.
166. An assertive outreach approach is built on the recognition that with complex clients such as Adult O, agencies are going to need to sustain the relationship rather than expecting her to be able to do that. This will require an approach that is:
- Assertive – using home visits
 - Focused on building a relationship
 - Flexible – client focused – looking at what the client wants
 - Holistic – looking at the whole person
 - Coordinated – linking with other agencies
 - Persistent and consistent.
167. Once professionals had a better understanding of what was behind this pattern of non-engagement, they could have begun to think about ways in which her needs could be better addressed. This might have ranged from helping with meal preparation, an outreach worker being present at appointments with her, the use of motivational interviewing and on to a better understanding of how the Mental Capacity Act could be used.
168. The Adult Social Care IMR focuses on assertive outreach and comments that: *“it isn’t a service that ...is in place in Newcastle.”* It goes on to reflect that: *“Although it would have been useful to have one person/team have full oversight of meeting with Adult O, I am not sure she would have engaged any better, as the Adult Perpetrator was still trying to discourage her from abstaining from alcohol...If an Assertive Outreach team had been in place however, they may have been able to build a rapport with her family to try and work more closely with them with planning long term support for Adult O.”*
169. Nothing suggests that assertive outreach would have been an easy option with Adult O. The Acute Hospital Trust IMR suggests that an assertive outreach had previously existed locally, and that Adult O had at one time been a client of that service. Someone who worked with her in that service described Adult O as an individual who: *only would let professionals go so far in their enquiries and no further, could seem scared at times, which may then translate to finding difficulty engaging.*
170. Nonetheless, given the complexity of her situation, an approach built on assertive outreach followed ideally by support to move into a residential rehabilitation placement would appear to have been the model care pathway for her.

Responses to domestic violence and abuse

This section separately considers the work done with Adult O as the victim of abuse and JC as the perpetrator of abuse.

Responses to domestic violence and abuse - Adult O

171. According to her family, Adult O was the victim of violence and abuse from most of her male partners for at least 13 years. During the review period she was in at least two and possibly three intimate partner relationships which were violent and abusive. This review does not have sufficient information to analyse the steps taken to protect Adult O in any but the last of these relationships – that with JC.
172. However, it should be noted that within the review's time frame, the Independent Sexual Violence Adviser (ISVA) Service received a referral (September 2018), related to a disclosure from Adult O regarding a historic rape by her ex-partner. The ISVA had a conversation with Adult O via telephone and support was offered but declined.
173. The relationship between Adult O and JC was relatively short-lived. The relationship appears to have started in August or September 2019. It is also unclear how much time they spent together – both maintained separate addresses. At one point JC appeared to have ended the relationship.
174. At the same period, for many agencies, the main concern about JC and domestic violence was his previous relationship with YV. Although it seems clear that this relationship had ended, JC made frequent reports to the Police that he was being threatened and harassed by YV. Again this review cannot focus on that relationship. However, it is highlighted to provide a picture of how the situation would have appeared at the time rather than with the clarity of hindsight.
175. Steps were taken to address the domestic violence and abuse that Adult O experienced from JC.
- In late December 2019, the IDVA Service received a high risk domestic abuse referral from the Police. Adult O was the victim and JC the perpetrator.
 - She was discussed in MARAC in January 2020 in connection with JC. (MARAC notes indicate that Adult O had been discussed with two previous partners.)
 - Adult O was flagged on the Hospital and the Ambulance Service systems as a victim of domestic violence.
 - One of Adult O's workers in the Mental Health Trust / Alcohol and Drug Service is described as *"alert to any abuse...referencing Adult O's history of domestically abusive relationships, enquiring into her then relationship status, highlighting the positives that occurred when she was not in a relationship, discussing the case in supervision, and attempts being made to speak with the IDVA."*

- At the end of January 2020, the IDVA Service received a notification from Northumbria Police of a medium risk domestic abuse referral for Adult O. It was reported that there had been an incident which involved JC damaging Adult O's television and making threats towards her.
- The IDVA had phone and email contact with Adult Social Care and the Police and attended a Safeguarding Strategy Meeting which discussed her vulnerability to domestic abuse at the end of January 2020.
- Between the end of December and her death, the IDVA made eight unsuccessful attempts at telephone contact. The phone often diverted to voicemail and, for her safety, no messages were left.

176. In terms of action not taken, the Police highlight that key learning from this review was that a disclosure under the 'Right To Know' part of the Domestic Violence Disclosure Scheme, also known as Clare's Law¹⁴, was not made. There was a history of violence from JC to partners and a history of Adult O being the victim of violence. The Police IMR highlights that this could have been discussed by officers when they were aware Adult O was in a new relationship with JC (and other previous partners). This was a missed opportunity; however, her family do not believe that this would have had an impact on Adult O's decisions. This view was also shared by professionals in the Practitioners' Workshop.

177. It was also noted that neither a Domestic Violence Protection Notice, nor a Domestic Violence Protection Order was issued or sought.¹⁵ The family did question this gap in the process. This theme was raised at the Practitioners' Workshop and the gap was recognised. It was suggested that because this relationship was relatively recent, some people involved may not have been aware of the need for this step.

178. A more specific concern, and one raised by the family, is the apparent lack of action as a result of the MARAC meeting in January 2020. The notes on this meeting appear limited and the family report that this information gap was highlighted at the Coroner's Inquest. The chronology states that "*Adult O discussed at MARAC. IDVA actions – continue attempting contact with Adult O.*" This was a step that had already been taken with Adult O, and as stated above, had yielded no results. The chronology then acknowledges that the "*MARAC minutes do not record whether alternative ways to establish contact were explored*".

179. The family are concerned that, given Adult O's frailty, her long history of being a victim of violence and above all the evident challenges of trying to engage her, no further action was identified by the MARAC meeting.

180. A very specific problem in Adult O's relationship with JC is that at points she attended medical appointments with him, and he refused to leave the consultation room – possibly out of concern about what she might divulge. This

¹⁴ [Domestic Violence Disclosure Scheme factsheet - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85442/DVDS_Factsheet.pdf)

¹⁵ [Domestic Violence Protection Notices \(DVPNs\) and Domestic Violence Protection Orders \(DVPOs\) guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/85442/DVPOs_guidance.pdf)

problem was exacerbated by Adult O indicating that she was happy for him to stay. This closed down a real opportunity to explore what was happening.

181. It is hard to be prescriptive about how this should be addressed because services have such different settings and resources e.g. a Hospital may have security personnel, a small charity will not. However, each agency should have an agreed procedure for handling this situation without putting staff and clients at risk.
182. One of the IMRs is very open in its analysis of their staff's engagement with the domestic violence and abuse. It highlights both positive practice (included above) but also concerns about a lack of follow-up enquiry and *concerned curiosity about Adult O's relationship status particularly when she had informed staff there was a male on the scene. Reports of injuries/concerns were not followed up despite her known vulnerability to abuse. Incidents/concerns appeared to have been considered in one moment in time, and various reported/known risk indicators do not appear to have been joined up longitudinally, which could potentially have offered another perspective and identified some safeguarding actions.*
183. The IMR concludes that: *"it was felt staff either did not think it was their responsibility and/or assumed that it was for other agencies to respond to or had already. Some of the recordings captured around Adult O's capacity and understanding of risks noted she had capacity to understand these, and this could also have influenced staff's decision not to pursue any concern further."*
184. Although these comments are specific to one agency, they are probably applicable, particularly that about *concerned curiosity*, to many of the agencies involved in her care. However, the relative brevity of the relationship makes it hard to be specific about this.

Responses to domestic violence and abuse - Responding to JC's history of domestic violence

185. It was widely known that JC was a perpetrator of domestic abuse. Therefore, action was also required to address his history of domestic violence and abuse.
186. One approach might have been a referral to the MATAC (Multi Agency Tasking and Coordination) process. This identifies individuals who serially perpetrate domestic abuse; i.e. those who have committed more than one domestic abuse incident against two or more different victims and attempts to address their domestic abuse. The review sought information on whether any of Adult O's partners had come to the attention of the process.
187. It was reported that her two previous partners would not have been appropriate for MATAC because there were limited reported incidents in the

previous two year period or only one victim attached to them (both key criteria). This meant their scores were very low on the system used to assess individuals.

188. However, it was recognised that JC did have a positive score and that this was increasing in January / February 2020. He was reviewed for the MATAC on 18th Feb 2020 but not accepted into the process as recent incidents in which he was a suspect were classed as standard risk. It would have been helpful for JC to have entered the MATAC process or some other perpetrator scheme. However, by February 2020 this process would have probably been too late to have had any impact on Adult O.

189. This raises the question of whether new or alternative interventions are required with perpetrators. Structured responses to perpetrators of domestic violence remain at an early stage of development. The Government only published its *Standards for Domestic Abuse Perpetrator Interventions* in January 2023, so this is an emerging field of work.

190. A strategic review of response to perpetrators across the Northumbria Police force area has been carried out by the Violence Reduction Unit (VRU) in the Office of the Police and Crime Commissioner during 2022. This produced a series of recommendations around early intervention, workforce development, training and the need for the commissioning of a broader range of perpetrator interventions with integrated support services for partners and ex-partners. Further work was carried out in 2023 to develop an outcomes framework for domestic abuse perpetrator interventions and referral pathways across the region. This work had identified gaps in provision in Newcastle which is currently being addressed through commissioning.

191. The agency who had the most consistent and intensive contact with JC was the Probation Service. Their IMR is commendably honest about identifying failings in addressing JC's pattern of domestic abuse. It also highlights more generally that HM Inspectorate of Probation conducted an inspection of the local Community Rehabilitation Company services in 2018 and domestic abuse practice was assessed to be insufficient. The inspection concluded that there was insufficient attention paid to actual or potential victims in almost two-thirds of relevant cases that were reviewed.

192. The detailed analysis provided by the Probation Service could fill two pages of this Review; that would probably place a disproportionate emphasis on the role of Probation in this tragedy. However, their review identifies a number of areas for improvement:

- The use of the 'Domestic Violence Perpetrator' flag.
- A lack of focus upon domestic abuse throughout the management of JC's case.
- Police call out enquiries to JC were not conducted at regular intervals throughout the duration of the Order.
- A lack of planned and structured work on his Rehabilitation Activity Requirement.
- The OASys assessment contained only very brief information and lacked analysis relating to domestic abuse.

- The lack of acknowledgement of domestic abuse also meant that a Spousal Assault Risk Assessment was not triggered within OASys.
- The Risk of Serious Harm Screening did not capture the relevant risks of the case.
- A lack of professional curiosity throughout the case.
- Supervision did not identify and challenge these gaps.
- Practice did not change as new facts about the relationship emerged (e.g. the assault in Hospital in December 2019)

193. The IMR concludes that there was: *“significant lack of focus on domestic related offending. This resulted in an assessment that was insufficient in its analysis and lacked a robust risk management plan to monitor and manage potential risks and / or address domestic related offending behaviour through planned and structured work. In addition, there was a lack of professional curiosity executed throughout the management of the case.”* These are powerful comments on the Service’s practice, but it is also commendable that they have been so clear-sighted and honest about them.

JC – wider comments

194. JC cannot be seen solely in the context of his pattern of domestic abuse. He was a man with his own needs including health, mental health and alcohol use disorders. These have been described above. This report is not going to apply the same depth of analysis to service responses to JC’s needs as was applied to Adult O.
195. Nonetheless, JC presented with a chronic alcohol use disorder and chaotic behaviour and like Adult O would have benefited from some of the same therapeutic interventions suggested for her i.e.:
- residential rehabilitation &
 - assertive outreach.
196. Each of these would require a robust risk assessment to determine their safety and appropriateness.
197. In addition, a multi-agency management framework focused on managing his chronic alcohol use and his multiple service use could have benefited him, as could a care-coordination approach.
198. For some people with substance use disorders, the introduction to therapeutic processes is via the criminal justice system and this can help initiate change. JC received an Alcohol Treatment Requirement (a probation order with a condition of alcohol treatment) as part of his sentence in 2019. The Probation IMR is again rigorous in its analysis of the application of this order. It comments that: *“In terms of the ATR, his attendance and engagement with this requirement were inadequately recorded and there was limited evidence of liaison with the alcohol misuse service provider.”* This represents a missed opportunity to address JC’s alcohol use disorder.

Key Learning Points

199. Many agencies made efforts to help Adult O. There is no sense that she experienced professional neglect or specific prejudicial attitudes. Practitioners who encountered her appear to have tried to help her within the framework of their particular discipline. However, a different approach was required to keep Adult O safe.
200. Adult O experienced a number of factors that were impacting on her ability to care for herself and keep herself safe – possible problems with cognition, the compulsion associated with dependency, the wider health impacts of alcohol and the impact of domestic abuse. As a result, services found it very difficult to engage her in a constructive programme of care. She required a more assertive and collaborative approach from services, including a more confident use of legal powers such as the Mental Capacity Act.
201. None of these more assertive approaches could or would have been used unless she was identified as someone who needed more intensive work to engage her. At one level, identification is simple, Adult O's needs are visible in plain sight. But the needs tend to be visible to one agency at a time, the Hospital, Primary Care, Police, or Alcohol and Drug Services. What is required is a mechanism whereby an individual agency can flag her as someone requiring more intensive, multi-agency intervention.
202. This can have two elements:
- A policy or procedure guiding the management and escalation clients that agencies find difficult to engage like Adult O (and possibly JC)
 - A clear multi-agency framework for the management of these individuals supported by care coordination.
203. This review suggests that the response to clients that services find difficult to engage will be strengthened by the development of a local policy or procedure which guides professionals on how to work with such clients. This should build on Newcastle SAB's existing Eight Principles of Engagement. It should include comment on the level of risk that requires a more assertive approach and identify the need to escalate the more vulnerable, hard to engage clients, to a local multi-agency forum for joint management.
204. Multi-agency structures do exist in Newcastle. A safeguarding process itself could fit that requirement if there are concerns about abuse, neglect or self-neglect. As in any other area, there is a MARAC as well as other multi-agency risk management groups. However, lessons from SARs and DHRS as well as practice in other parts of the country suggest that these structures do not work particularly well for people with substance use disorders who actively push back at help. For example, her family are concerned that, given Adult O's frailty, her long history of being a victim of violence and abuse and above all the evident challenges of trying to engage her, no further action is

identified from the MARAC meeting in January other than repeated attempts to contact her by phone.

205. Therefore, local commissioners and strategic leads may wish to consider setting up a multi-agency group to manage chronic dependent substance users like Adult O and JC. The Northumberland Blue Light operational group, of which the local Mental Health Trust is already a part, offers one model. This group brings together key agencies such as Police, Housing, Anti-Social Behaviour Teams, Mental Health, Hospital and others together with the Specialist Alcohol Services. This will enable the identification of the most challenging clients and the development of consistent, jointly owned interventions. This initiative was developed in partnership with the former Public Health England and won a Royal Society for Public Health Healthier Lifestyles Award and A Guardian Public Health & Wellbeing Award.
206. Adult O could and should have been protected via legal frameworks such as the Care Act or the Mental Capacity Act.
207. Adult O was subject to six safeguarding referrals during the period of the review. All but the last of these enquiries was reported to be completed and closed appropriately. Nonetheless, Adult O died. The addition of the escalation policy and structure highlighted above may well enhance this pathway. It was also noted, at points, that agencies failed to submit safeguarding concerns when this would clearly have been appropriate.
208. More importantly, Adult O's care highlights that practitioners continue to struggle to use the Mental Capacity Act in ways that will better protect people with repetitive and compulsive behaviours. The focus on "decision specific" assessments means that practitioners did not follow the advice in paragraph 4.30 of the 2007 Code of Practice that suggest that in taking a capacity decision: *Information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else.* In other words, past decisions, for example to protect oneself, which have not then been executed, can form part of a current assessment. The Code of Practice acknowledges that practitioners need to look up from the immediate context and take a longer term view when assessing capacity.
209. National concern about such situations has led to an increasing emphasis on considering executive capacity. In assessing capacity with vulnerable and self-neglecting individuals like Adult O it is important to consider executive function. The Teeswide Carol SAR talks about the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *take* a decision and *put it into effect* (i.e. use the information)? This will again necessitate a longer-term view when assessing capacity. Repeated refusals of care should have raised questions about Adult O's ability to execute decisions. The new draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function as well as considering repeated failed decisions when assessing capacity.

210. Ultimately, the challenges of using existing legal frameworks with people like Adult O do raise questions about the adequacy of the legislation for this client group. Those who commission and plan the development of Alcohol Treatment Services may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group; or new legislation to better meet their needs.
211. All of the above provide a framework within which a more assertive response could have been delivered to Adult O. However, the question remains as to what services are practically going to do differently with her. The two central themes in Adult O's life are domestic abuse and her substance use disorder. This review has considered responses to both of these elements.
212. Adult O used both alcohol and opiates; it was acknowledged by both family and practitioners that her most consistent problem was her dependency on alcohol. There was strong agreement that the best package of care for her would have been a detoxification followed by a period in residential rehabilitation. This would have provided time to stabilise her health, assess her cognition and help her to reconsider her current situation. This was offered to her on at least two occasions. She did not take up this offer and it is acknowledged that at most times during the review period she would have rejected it. However, it is important that efforts are made to "sell" the benefits of this option to her and, if she agrees, that the opportunity is there for her to move swiftly into rehabilitation.
213. In the absence of residential care, the next best approach is one built on assertive outreach. With individuals like Adult O, it is unrealistic to wait for her to be "ready to change". She needs a practitioner who has a specific focus on relationship building and working with her intensively to reduce harm and motivate change. Frontline Alcohol and Drug Services should have the commissioned capacity to undertake assertive outreach with the most challenging individuals. The existing service in Northumberland may offer a model.
214. This report has not provided the same depth of analysis of JC's care needs, but it is likely that many of the above comments apply to his needs e.g. having a focus on clients that services find difficult to engage, the need for residential care and the benefits of an assertive outreach approach. The key area of difference is obviously the response to the domestic abuse.
215. Adult O's relationship with JC was relatively short-lived. It may have lasted no more than six months and was really only obvious to professionals from about three to four months before her death. Nonetheless, steps were taken to address the abuse she suffered. She was referred to MARAC at the end of December 2019 and was discussed at the group in January 2020. Even before the MARAC, an IDVA was trying to make contact with her. At the MARAC, it was agreed that efforts should continue to be made by the IDVA.

216. However, there are also questions about the efforts made to address the domestic abuse. The repeated failure of the IDVA to be able to make contact with Adult O, does suggest that alternative strategies were required. This review has already addressed the need for policies and procedures to develop work with people with substance use disorders that services find difficult to engage and these principles also apply to addressing the domestic abuse.
217. It is also noted that no consideration was given to the “Right to Know” part of the Domestic Violence Disclosure Scheme (also known as “Clare’s Law”) or a Domestic Violence Protection Notice / Order. Both practitioners and the family were agreed that a disclosure about JC’s past history was unlikely to have impacted on Adult O. Nonetheless this should have been a consideration. A DVPN / DVPO was felt by the family to be more relevant and could also have been considered. Again, it is uncertain whether this would have had an impact on the relationship.
218. A very specific problem in Adult O’s relationship with JC is that at points she attended medical appointments with him, and he refused to leave the consultation room, thereby closing down the opportunities to talk about abuse. Agencies need to have an agreed procedure for handling this situation without putting staff and clients at risk.
219. More generally, both Adult O and JC highlight the importance of professional curiosity. It is impossible to say what the impact of earlier identification of Adult O’s new relationship with JC would have been, but it was clearly desirable that efforts to intervene began as swiftly as possible.
220. The review has also explored the response to JC as a perpetrator of violence and abuse. The key agency in this context was the Probation Service. Probation’s IMR provides a very thorough and honest analysis of the general need to improve the response to domestic abuse and the specific need to improve the response to JC. This summary will not repeat that detail, but it does highlight the need for ongoing work to ensure the Probation Service’s response to domestic abuse is being improved.
221. The review has also highlighted the lack of other means for addressing JC’s ongoing and repeated pattern of perpetrating domestic abuse against female partners. The only structured approach was a referral to MATAC; however, he did not meet the criteria until the very end of Adult O’s life. This may raise the question of whether new or alternative interventions are required with perpetrators.
222. Structured responses to perpetrators of domestic violence remain at an early stage of development. The Government only published its *Standards for Domestic Abuse Perpetrator Interventions* in January 2023, so this is an emerging field of work.
223. A strategic review of response to perpetrators across the Northumbria Police force area has been carried out by the Violence Reduction Unit in the Office of the Police and Crime Commissioner during 2022. This work had

identified gaps in provision in Newcastle which is currently being addressed through commissioning.

Good practice

224. The focus of this section is on good practice with Adult O. However, it is also worth noting the openness of local agencies during the review process. In particular the Mental Health Trust and the Probation Service IMRs offered analyses which were rigorously honest about practice and how it could be improved.

225. Within the work with Adult O there were examples of good practice. The following stand out in the chronology:

- On one occasion Police officers encountered Adult O with a pattern of bruising, which she initially said was from fits related to her alcohol dependency. However, officers revisited her later and gave her the opportunity to disclose an assault, – which she did.
- On two occasions Ambulance Service Call Handlers were concerned about the content of calls from Adult O – one that was disrupted by a male partner and one that was ended by Adult O despite health concerns. Further clinical follow-up was initiated by the Call Handlers.
- The Alcohol and Drug Service continued to support Adult O for eight years despite the challenges she presented, including at times, aggressive behaviour to staff.

Recommendations

Working with individuals that services find hard to engage

Recommendation 1 – Newcastle SAB should lead the development of local procedures that build on the SAB's existing Eight Principles and which guide professionals on how to respond to individuals requiring safeguarding but who they find difficult to engage. (These protocols could equally apply to vulnerable clients outside of the safeguarding context). These procedures should include:

- a structure for determining the level of vulnerability associated with a client, which will then guide the level of persistence that is used to follow-up these clients;
- escalation pathways.

Recommendation 2 – Newcastle SAB should ensure that the procedures include the need to escalate vulnerable clients that services find difficult, to a local multi-agency forum for joint management. The SAB should ensure that the importance of escalating concerns about more vulnerable clients to multi-agency agency management frameworks is cascaded as widely as possible through their own and partner agencies' communication systems.

Recommendation 3 – Newcastle SAB should ensure that there is ongoing training and messaging about the need to raise safeguarding concerns about vulnerable individuals with substance use disorders.

Working with substance use disorders

Recommendation 4 – Public Health Commissioners who commission and plan the development of Alcohol Treatment Services need to ensure that frontline staff consider residential rehabilitation as an option for clients and that it can be accessed without undue barriers. In particular, a smooth pathway from inpatient detoxification to residential rehabilitation should be possible for complex clients.

Recommendation 5 – Public Health Commissioners should ensure that frontline alcohol services have the commissioned capacity to undertake assertive outreach with the most challenging chronic dependent drinkers and drug users.

Recommendation 6 – Local commissioners and strategic leads should ensure that people with complex substance use disorders can be escalated to a multi-agency framework for joint management. This might be a separate group or could be part of the structure set out in Recommendation 2.

Tackling domestic abuse

Recommendation 7 – Safe Newcastle should work with the Police to ensure that the Police are considering the ‘Right To Know’ part of the Domestic Violence Disclosure Scheme, also known as “Clare’s Law”, and that DVPOs/DVPNs are being regularly considered and used when appropriate.

Recommendation 8 - Safe Newcastle should work with health services and other partners to ensure that relevant agencies have an agreed procedure in place, without putting staff and clients at risk, for handling situations where partners or family members of a patient/client refuse to leave the patient/client alone in a consultation room with a professional, thereby closing down the opportunities to ask about abuse.

Recommendation 9 - Safe Newcastle working with the Newcastle Domestic Abuse Local Partnership Board) should (i) benchmark itself against the recommendations set out in the VRU strategic review of responses to domestic abuse perpetrators across Northumbria, and (ii) consider the findings of the VRU commissioned work that has mapped perpetrator interventions and pathways, with specific regard to the findings for Newcastle. This work should be done with a view to identifying actions needed to address gaps and enhance the strategic and operational response to perpetrators.

Recommendation 10 - Safe Newcastle working with the Newcastle Domestic Abuse Local Partnership Board should ensure that any new primary, secondary or tertiary interventions commissioned should be developed in-line with the new Northumbria Outcomes Framework commissioned by the VRU, which should have clear referral pathways and a clear set of outcomes and measures that can demonstrate impact on reducing perpetration and underlying causes of domestic abuse.

Recommendation 11 – Safe Newcastle should work with the Probation Service to review their ongoing work to improve responses to perpetrators of domestic abuse engaged with Probation.

Recommendation 12 – Safe Newcastle should review responses to clients like Adult O who are known to not engage with services or support, to ensure that MARAC

actions reflect challenges to engagement, and that MARAC partners have a practice of working together to identify actions that will support opportunities for engagement.

National

Recommendation 13 – Those who commission and plan the development of alcohol and drug treatment services may wish to consider lobbying national government directly, or via the SAB Chairs Network, for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group; or new legislation to better meet their needs.

Dissemination

226. The report will be shared with the following:

- Adult O's family
- Newcastle Safeguarding Adults Board
- Newcastle Community Safety Partnership
- Newcastle Domestic Abuse Local Partnership Board
- All agencies contributing to the review
- Northumbria Police and Crime Commissioner
- Domestic Abuse Commissioner

Appendix 1

Terms of Reference

At a panel meeting in November 2022, the following key issues were agreed as being important and which should be considered within the Domestic Homicide Review - Safeguarding Adults Review:

Identifying abuse

- What indicators of abuse, including coercive and controlling behaviour, did your agency have that could have identified Adult O as a victim and what was your response?
- Were there opportunities for professionals to routinely enquire regarding domestic abuse with Adult O? Did those enquiries take place, if not, why?

Risk Assessment and risk management

- What were the relevant points or opportunities for risk assessment and decision making in this case in relation to Adult O and or her partner/ex-partner? Were risk assessment and risk management processes for domestic abuse victims or perpetrators correctly used in this case?
- Do the assessments and decisions appear to have been reached in an informed and professional way?
- Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with? Were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?
- Was the case viewed as complex or challenging by those involved at the time? Were escalation processes followed, including the involvement of senior managers and other agencies?
- Did agencies work together sufficiently to protect Adult O?

Mental Capacity and decision-making

- Was the Mental Capacity Act used sufficiently and appropriately with Adult O?
- What consideration was given to the impact of the cognitive impairment Adult O may have received as a result of the road traffic accident and other assaults?
- What consideration was given to the impact that control and coercion might be having an impact on Adult O's decision-making?

Risks from others

- What knowledge did your agency have that indicated that Adult O's partners/ex-partners might be a perpetrator of domestic abuse and what was the response?

- Were her partner/ ex-partners subject to MAPPA¹⁶, MATAC¹⁷ or any other perpetrator intervention programme? Were there any injunctions or protection orders in place?

Making Safeguarding Personal, family and community involvement

- When, and in what way, were Adult O's (or where appropriate, her family's) wishes, feelings and views ascertained, considered and acted upon?
- What knowledge or concerns did family and friends and community have about the abuse of Adult O and did they know how to act on them?

Policy and procedures

- Were single and multi-agency policies and procedures, including safeguarding adults, the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?
- Did the agency have policies and procedures in place relating to domestic abuse?

Mental health and addiction

- What knowledge did your agency have of any alcohol, drug, gambling, addictions or mental health issues in respect of Adult O or her partner/ ex-partners? What services did your agency provide in response to these issues?

Barriers to accessing support

- Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Adult O (and her partner/ ex-partners) or on your agency's ability to work effectively with other agencies?
- What was your agency's knowledge of any barriers faced by Adult O that might have prevented her reporting domestic abuse and what did it do to overcome them?
- How did your agency take account of any ethnic, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Adult O?
- Is there indication that Adult O was disadvantaged because of her drug and alcohol use – was she prevented from accessing services, care, treatment or justice?
- To what extent did assertive outreach feature in the support and care offered to Adult O? Would Adult O have benefitted from more assertive interventions?

Learning and good practice

- What are the lessons from this case for the way in which your agency works to protect adults at risk and victims/survivors of domestic abuse?
- Please comment on any aspects of the case or the agency involvement that are examples of outstanding or innovative practice.

¹⁶ MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).

¹⁷ MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse

- Does the learning from this review appear in other Safeguarding Adult Reviews or Domestic Homicide Reviews undertaken by the Newcastle Safeguarding Adults Board or Safe Newcastle?
- Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?