Learning Lessons Review (LLR)

CASE 6/18

Adult C

Overview Report V5

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CONTENTS

1. INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

1.1. Adult C was a 30-year-old lady who died following cardiac arrest after diagnosis and treatment for pneumonia. Adult C was a longstanding alcoholic who showed some signs of wanting to reduce her alcohol consumption. Adult C was known to have been in an abusive relationship with reports of injuries from both her partner and her ex father in law as well as others. Adult C was also considered to be a perpetrator of physical violence against her partner and other adults. Adult C was known to many agencies as a result of her alcoholism and the abuse she suffered. On the date of her death, it was her partner who called an ambulance; her ex father in law was also present. They were originally arrested on suspicion of the murder of Adult C, but her death was later found to be from physical health causes. An inquest confirmed death by natural causes.

2. METHODOLOGY AND SCOPE

2.1. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR) and other reviews. Full Terms of Reference, rationale for the scope and methodology of the review etc. for this Learning Lessons Review (LLR) can be found in Appendix 1.

2.2. This review takes into account interagency involvement covering the six months prior to the date of Adult C's death. This period covers a timeframe where there is likely to be learning within contemporary systems and multiagency working as opposed to identifying learning from historical systems that may have already changed. Key background information will also form part of the review that will inform the more contemporary elements of Adult C's journey.

3. FAMILY ENGAGEMENT

3.1. A key part of undertaking a LLR is to gather the views of the family and share findings with them. Contact by letter was made with Adult C's partner and mother. No response was received from Adult C's mother. The Board Manager and the Author met with Adult C's partner (Adult 1) following the second workshop. His views have been incorporated throughout the report as appropriate.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Agencies report that Adult C had stated that she had enjoyed school and went to college to study cookery. It was whilst at college that she met her previous partner. In her interactions

with agencies, Adult C did not mention her parents.

4.2. The relationship between Adult C and her ex-partner was reportedly one where domestic abuse had been a feature. Information given to this review indicated that Adult C and her previous partner planned for a child, who was seven years old at the time of writing this report. Adult C came to the attention of services during pregnancy on a couple of occasions, having been alcohol intoxicated. After delivery, Adult C developed post-natal depression which was treated by her GP. There was ongoing children's social care involvement with the child being taken into care of the local authority. The child has resided with her birth father for over two and a half years following a period in foster care. Adult C initially had supervised contact with the child, but this was later stopped by the child's father.

4.3. Adult C's drinking continued and became problematic. Adult C was diagnosed with alcohol dependency when she was 25. The drinking and domestic abuse ultimately led to a breakdown of that relationship.

4.4. When Adult C was 28, she was allocated an Independent Sexual Violence Advocate (ISVA)[1], having been referred by a Sexual Abuse Referral Centre[2]. Assessment indicated that Adult C was struggling emotionally and that she was sofa surfing between her mother's and her mother's ex partner's home. During a Victims Right to Review meeting[3] when a prosecution was not being taken forward by the Crown Prosecution Service, Adult C showed disappointment and her drinking increased. Albeit that Adult C had been hard to engage, she disengaged further at this point leading to an eventual closure of her case by the ISVA service. During her time with the service Adult C reported that she had informed police of a separate physical assault by her ex father in law.

4.5. Adult C met her new partner (Adult 1) when she was about 29 years old. Adult 1 had been a perpetrator of domestic abuse in a previous relationship. Adult 1 was also known to be a heavy drinker and alcohol dependent. Adult 1 was known to the probation service. His history of domestic abuse created significant enough concern for him to be more recently managed

[1] Independent Sexual Violence Advisors (**ISVAs)** are trained to provide emotional and practical support to survivors of rape, sexual abuse and sexual assault who have reported to the police or are considering reporting to the police.

[2] **SARCs** (sexual assault referral centres) are specialist medical and forensic services for anyone who has been raped or sexually assaulted. They are designed to be comfortable and multi-functional, providing private space for interviews and forensic examinations, and some may also offer sexual health and counselling services. Their services are free of charge and provided to women, men, young people and children.

[3] **The Victims' Right to Review Scheme** makes it easier for victims to seek a review of a Crown Prosecution Service decision not to bring charges or to terminate all proceedings.

by the National Probation Service[4] as opposed to a Community Rehabilitation Company[5].

4.6. When Adult 1 met with the author he talked about his previous abusive relationship and the time that he spent in prison for offences related to that relationship.

4.7. Before Adult C entered into her relationship with Adult 1, her drinking and risky behaviour resulted in a referral by Police for a Multi-Agency Case Conference. At the time, these case conferences were held monthly, chaired by the community safety team, in an attempt to have multi agency plans in place for those who were vulnerable. Adult C was discussed six times within these meetings over an eighteen-month period that ended two months prior the scoping period of this review. Adult C was discussed at several meetings after her relationship with Adult 1 commenced. Due to a review of this process following learning from other reviews, these meetings no longer take place. A new process, Team Around the Individual (TATI), led by Adult Social Care that has strategic decision makers within the process has recently been introduced.

4.8. Within a very short period, violence became a feature in the new relationship. An arrest of Adult 1 and referral to the Multi Agency Risk Assessment Conference (MARAC)[6] was made within 3 months of the relationship starting. (Adult C was still subject to multi agency case conferences at this time [not to be confused with MARAC]). Adult 1 was sentenced to a 24 month Suspended Sentence Order with six-month Alcohol Treatment Requirement[7] and 25 Rehabilitation Activity Requirement days[8].

4.9. Adult C was referred to specialist domestic abuse services 1 (DA1) and 2 (DA2). DA 1 continued to offer intensive support services and refuge to Adult C; initially it had been agreed that DA2 would not offer services as DA1 was involved. Two months later though, it was considered that specialist intensive services were required, leading to a referral back to DA2 who are commissioned to provide this. It was of note that to be accepted to this intensive element of the service, a victim must be actively fleeing from an abusive partner, so

[4] **The National Probation Service** is a statutory criminal justice service that supervises high-risk offenders released into the community.

[5] After sentence, all offenders who are assessed as low or medium risk of harm by the National Probation Service are transferred to the **Community Rehabilitation Company** to manage.

[6] **MARAC** A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.

[7] **The Alcohol Treatment Requirement (ATR)** focuses on offenders who are dependent on alcohol or whose alcohol use contributes to their offending. The aim is to reduce or eliminate the offender's dependency on alcohol.

[8] **Rehabilitation Activity Requirements** (RAR) The court can sentence individuals to a maximum number of **rehabilitation activity days**, which involves the service user attending a combination of appointments and **activities** aimed at helping them avoid reoffending.

the service declined this referral.

4.10. Adult C was offered refuge accommodation on several occasions which was initially declined but then she did accept a period of five weeks in refuge two months prior to the scoping period of this review. This then enabled an acceptance by the intensive service of DA 2.

4.11. Adult 1 was again arrested for a further assault, but this did not proceed to trial as Adult C withdrew her allegation of assault.

4.12. This period also featured involvement from the substance misuse service who were attempting to work with Adult C to support her to reduce her drinking. Adult C had been admitted to hospital on previous occasions in order to participate in detoxification programmes. Adult C always returned to drinking.

4.13. This pre scoping period featured numerous contacts with police from Adult C and other persons known to her, with complaints of assaults and harassment, usually as a result of Adult C and on occasions others, engaged in heavy drinking. This was as well as numerous contacts related to violence within the relationship between Adult C and Adult 1.

4.14. The Local Authority Safeguarding Team received two referrals in the four months prior to the scoping period. Although Section 42 enquiries commenced on both occasions, there were delays in being able to speak to Adult C to ascertain her wishes and feelings. Ultimately Adult C stated that she did not want a safeguarding intervention and was deemed to have capacity to make this decision. It was recognised that Adult C already had the support of relevant services.

4.15. Mental Health Services also had contact from Adult C in this period requesting alcohol detoxification. As this was not a role for secondary mental health services, she was signposted elsewhere. There were several other contacts to Mental Health Services resulting in information sharing with the police via the street triage team[9].

4.16. Adult C presented at Accident and Emergency department of the Acute Hospital on numerous occasions associated with self-harm and alleged physical assault injuries but more notably alcohol related illness and seizures.

[9] **The street triage teams** work alongside local police forces to reduce the number of inappropriate detentions made under Section 136 of the Mental Health Act (MHA) and to make sure that people who need mental health treatment receive it as quickly as possible. The street triage team of mental health nurses carry out an immediate assessment to determine whether the person should be held under Section 136 of the MHA and if not, whether any follow up is needed from mental health, social or substance misuse services.

4.17. Adult C had been registered with the same GP from birth. The GP was treating her for her alcohol dependent related physical health issues as well as other conditions as required. The GP was not aware of any domestic abuse until this review was commissioned.

4.18. Adult C also came into contact with street wardens from the local authority community support teams. Their contacts were out of the scope of this review, but learning has been identified of the need to train street wardens in responding to domestic abuse incidents.

4.19. Adult C engaged very sporadically with all of the above services. It is of note, however that there is no evidence that Adult C defaulted any hospital appointments. When Adult C was in the refuge she went missing on occasions. This erratic engagement made effective support very difficult for agencies.

5. KEY PHASES

5.1. There was an extensive history with many services who engaged with this review. It is, however, the six months prior to Adult C's death that will be looked at in depth, being a period where it is believed that most systems learning will be gained. Review of systems older than six months is likely to lead to learning that has already been identified from other reviews and processes e.g. as discussed in 4.7.

5.2. The scoping period will be divided into three phases each covering two months.

Phase One – Month One and Two

5.3. During month one, Adult C attended the Accident and Emergency department with a cut to her hand. Whilst in the waiting room Adult C had a witnessed seizure. Adult C was treated for a superficial wound to the back of her left hand. The injury was reported as being sustained following a disagreement with family and friends during which a bottle had been smashed that had slightly cut her hand. Adult C subsequently cut this further with a broken piece of glass.

5.4. Adult C was referred to the Mental Health Liaison Service. It was ascertained that Adult C was reacting to social stressors, had no current active suicidal intent, and no evidence of an ongoing mental illness. The plan was to update the DA services that were working with Adult C and to share information with the GP, advising her to visit the GP within 7 days. Adult C was also provided with useful numbers to contact in a crisis.

5.5. Adult C was admitted to a ward for monitoring of further alcohol withdrawal symptoms (the cause of the seizure) and was seen by the substance misuse inpatient liaison team. Adult C indicated her desire to reduce her drinking via an inpatient detoxification. Adult C was advised that it was necessary to engage with psychosocial support for this to be successful,

based on several previously failed attempts. The worker identified that Adult C was open to the community-based substance misuse service and contacted them to update and request contact with Adult C. The inpatient liaison team signposted to DA services that Adult C was already open to; Adult C did not indicate that she had already had intensive support from these services.

5.6. The inpatient liaison team advised the ward staff of treatments that would be required if Adult C remained on the ward and also to undertake a SADQ (severity of alcohol dependence questionnaire). Adult C then discharged herself, therefore the SADQ was not completed. A discharge letter was sent to the GP with advice regarding a prescription for magnesium as this was low on review of the blood test. The pharmacy did not receive a prescription of magnesium.

5.7. Three days later, Adult C collapsed in the street reportedly having had a seizure and was conveyed to Accident and Emergency by ambulance. Adult C was treated for an opiate overdose although Adult C stated that it was an alcohol related seizure. She was admitted to a ward and persuaded to stay. Adult C was given drugs to combat alcohol withdrawal.

5.8. As per the previous admission, Adult C was assessed by psychiatric liaison team with the same outcome and actions. Adult C was also again seen by the liaison substance misuse services. This resulted in a three-way meeting following discharge, where barriers to engaging were discussed. It is of note that Adult C stated that engagement was difficult due to the level of alcohol that she was drinking and the impact that had on her memory. It was agreed that workers would text reminders of appointments. Domestic abuse was also discussed, Adult C stated that she was still with her partner who was in prison at this point (he had been remanded in custody for the assault on her). It was also later agreed to move Adult C's appointments to a different centre to make attendance easier. Despite this, Adult C then failed to attend a number of appointments over the next few weeks before finally attending at the end of month one. Adult C attended with Adult 1. (Adult 1 had been sentenced to a supervision by the Community Rehabilitation Company).

5.9. During this period, police received a call made by Adult C's ex father in law stating that Adult C had assaulted him. This was not progressed as the ex-father in law was not available at a pre-arranged appointment with police. Three further calls were made on one day midway through month two. Two were made by Adult 1 and one apparently by Adult C who later could not remember making the call. The calls appeared to be as a result of both being intoxicated and arguing. No offences were disclosed, and so no action was taken.

5.10. Adult C requested housing support from DA2 with referrals being made to a housing charity commissioned to support people to access affordable housing in the private rented sector.

5.11. Adult C was also investigated for a painful swelling in the throat that was causing her some concern. Adult C was worried that this might be cancer causing increased stress. This was later diagnosed as not cancer.

5.12. The key issues presented in this period were ongoing failure to engage effectively with DA2 or substance misuse services.

Phase Two – Month Three and Four

5.13. This period features a large increase in the number of reports to police from Adult 1 against Adult C on an almost daily basis. There was also a report from the mother of Adult C that she had telephoned and could hear an argument happening. There was another call by Adult C that there had been an assault by another female that appeared to have happened at a drinking party in another flat. The reports by Adult 1 resulted in Adult C being arrested and bailed to her ex father in law's address. Following that, further reports from Adult 1 were that Adult C was breaching her bail conditions as she was at his flat or he was with her at another address.

5.14. Adult C had some contact with substance misuse services in this period, where she was reported on one occasion to be looking well. Adult C indicated a continued wish to reduce her alcohol consumption but attended on two occasions whilst intoxicated. Adult C reported being attacked by another female she alluded to as 'auntie'.

5.15. In her engagement with DA2 in this period, Adult C was reported to have cancelled an appointment as she had a seizure in the bath and suspected she had fractured her ribs. On advice to seek medical attention Adult C refused. On further contact following several missed appointments, Adult C explained that she had been arrested three times over the previous few weeks due to the reports by Adult 1 to the police.

5.16. At a further appointment with DA2, Adult C disclosed that it was her ex-partner (Adult 1) who had assaulted her, stating that he had strangled her until she felt dizzy. Adult C stated that one of her acquaintances had also stolen £200 from her. She declined to report the incidents to the police. Adult C failed to attend another appointment set for a week later.

Phase Three – The Last Ten Weeks

5.17. There was a continued plethora of calls from Adult 1 in this period relating to Adult C breaching her bail conditions. On one of those occasions it is clear that Adult 1 had gone to the address where Adult C was at, having earlier invited her. It appeared that this address was one that was used by a group of people as a regular drinking venue. Adult C later reported an assault by another of the associates that drank at the same address. There was a further record of a report of violence where the same associates were drinking on a bank

holiday in the same venue. Police reported all in attendance to be very drunk.

5.18. This chaotic drinking and associating with other drinkers at this address appears to have resulted in multiple arguments and calls from various people about assaults. On one occasion a caller made reference to Adult C being 'marched' to a cash machine to withdraw cash that she 'owed'. On discussion in this review there was a belief that each of the associates took it in turns to purchase alcohol for the others based on when their benefits were paid. This would have left little cash for food and other expenses.

5.19. As the reported violence and calls to police increased, Adult C attended the GP with increasing anxiety and was prescribed anti-depressants.

5.20. At the beginning of this period, the couple were again discussed at MARAC, but on this occasion, it was Adult 1 who was the victim with Adult C as the perpetrator. One of the key actions was to resolve the housing issue for Adult C supporting her to secure her own tenancy. Adult C was assessed and offered a property; the landlord then undertook credit checks and retracted the accommodation offer due to rent arrears. Adult C had also been verbally abusive and threatening to the Housing Charity. As a result of this they declined offering further support and suggested a referral to supported accommodation. This was not resolved before Adult C died. The MARAC records that police were trying to keep the couple apart by imposing stringent bail conditions that the couple should not be together. MARAC actions also note addressing alcohol issues for both parties.

5.21. It was also a feature in this period that Adult C was not getting her medication; she telephoned the GP to state that she had "not had any meds for ages, moving from place to place whilst trying to get life back together." The GP reviewed the medication and issued a prescription which was sent electronically to the pharmacy.

5.22. Adult C continued to consume large amounts of alcohol in this period and also reported to DA2 the ongoing violence resulting in various injuries from her partner and fights with others during the bank holiday period. She also stated that she had her benefits taken from her by the 'auntie'. Adult C stated that the relationship with Adult 1 was on and off.

5.23. Adult C had a couple of contacts with substance misuse services in this time when she reported the issues that she had experienced over the bank holiday as well withdrawal seizures. Adult C was advised not to stop drinking suddenly and to see her GP.

5.24. Three and a half weeks before Adult C died, DA2 discussed all of the issues of concern with Adult C and gained consent to make a safeguarding referral. There were a number of concerns related to ongoing manipulation and coercion by Adult 1, no tenancy of her own, presenting with a number of injuries, exploitation by the 'auntie', risk of criminal charges, and

that there was no change to the vulnerability of Adult C despite many support agencies involvement over several years.

5.25. Adult Social Care immediately contacted the housing charity and the police to share concerns. Police did not take any action on this information, the housing charity stated that they would discuss with DA2. DA2 have no record of receiving contact from the housing charity.

5.26. Adult Social Care safeguarding team allocated the case for assessment to the local access team with an appointment made for two weeks' time to meet up with Adult C. DA2 contacted Adult C the day before the appointment to remind her. Adult C did not arrive for this appointment. The following week, on ascertaining that Adult C had forgotten about the appointment but was still keen to be seen, an appointment was arranged the following week. Adult C died before this rearranged appointment.

5.27. Four days before the death of Adult C, she contacted the GP practice in the morning, concerned about pain in her chest which was worse on breathing. Adult C was advised to call 999 but stated she wanted to see her GP; she was advised to call 999 if symptoms got worse. Seven hours later Adult C called the GP practice again stating that she was worse, at this point she agreed to attend the surgery. The GP recognised symptoms of possible sepsis and arranged an ambulance to convey her to hospital after being persuaded not to leave the practice and to be picked up there rather than going home.

5.28. Adult C was promptly conveyed to the Acute Hospital. Once in Accident and Emergency, Adult C was diagnosed with possible chest infection, low blood potassium and pulmonary embolism (blood clot in a blood vessel of the lung). Adult C reported that she had not been taking her prescribed oral potassium supplements as she had not been able to keep food and water down, although she appeared well hydrated at that time. Adult C was administered with an anticoagulant (treatment for blood clots), prescribed oral potassium, advised to ensure adequate oral nutrition and hydration. Adult C was requested to attend Ambulatory Care at the hospital the next morning to have a computed tomography pulmonary angiography (CTPA – diagnostic scan for a pulmonary embolism) and discharged with the advice that if vomiting persisted to return to the department for intravenous potassium replacement.

5.29. The next day Adult C attended the Ambulatory Care Unit and was diagnosed with a community acquired pneumonia by a Nurse Practitioner. Adult C was prescribed a course of a combination of two oral antibiotics and a follow up review planned for in six weeks. The CTPA was not requested at this review as the x-ray showed infection and not embolism.

5.30. In the early hours of the next morning, Adult C's ex father in Law called 999 as Adult C continued to be unwell. A crew was dispatched but Adult C refused to go to hospital, stating that she was merely seeking advice. She signed the electronic record declining treatment and

was advised to see her GP later that day if she continued to feel unwell. There was no evidence that Adult C had been drinking or that there were issues related to a requirement to assess mental capacity regarding her decision to refuse treatment.

5.31. Two days later, an ambulance was again called. Adult C was coughing, struggling with her breathing and was agitated. The call advisor calmed Adult C down and ascertained, using pathways triage, that an ambulance was required within a two-hour timeslot. Three quarters of an hour later, a further phone call was made stating that Adult C was grey and then started fitting. An ambulance was immediately dispatched and arrived seven minutes later. Adult C could not be resuscitated, and death was pronounced 30 minutes later.

5.32. Adult 1 and Adult C's ex father in law were originally arrested on suspicion of murder; however, they were later cleared after a forensic post-mortem declared death from natural causes.

6. GOOD PRACTICE

6.1. It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. This review has identified a plethora of good practice that is discussed throughout this report.

6.2. Many agencies have responded immediately to the learning that they have identified and commenced changes as well as using this case to further system changes that were already in progress.

7. ANALYSIS

7.1. The analysis section takes a strengths-based approach identifying what went well and building a picture of areas where learning has occurred. Adult C had an extensive history of being involved with services over the previous seven years. Much of that time period covers systems that have changed as well as changed policy and legislation. The background provided to this review offers a contextual perspective but will also be drawn on where it impacts on current learning and systems. The first three sections identify learning regarding domestic abuse, alcohol dependency and physical health with the final section identifying the complexities of those three areas impacting on each other.

7.2. It is of note that Adult C died of natural causes. Those were identified as pneumonia with a secondary cause of liver problems related to alcohol consumption. Adult C did not die as a direct result of domestic abuse. She did, however, die of complications from her alcohol consumption. It should be noted, that pneumonia is a disease that can also cause death in healthy adults.

7.3. This review is therefore an opportunity to review the systems and processes that were in place to support Adult C with the complex issues that she faced rather than a review of whether her death was preventable.

Understanding and Managing Domestic Abuse

7.4. Adult C was known to have been in an abusive relationship with her ex-partner, (the father of her child). Adult C appeared to have started problematic drinking during her pregnancy and this escalated post pregnancy due to post-natal depression and difficulties around surgery she required post-delivery.

7.5. After the breakdown of that relationship Adult C then moved into another abusive relationship with a person who also had an alcohol dependency and mental health issues. In recognition of the abuse that Adult C was experiencing, there was early involvement with specialist domestic abuse services. It can be seen that domestic abuse was generally well understood by those working with Adult C with evidence of some good support for her throughout the timeframe of the review.

7.6. There was appropriate offer of refuge from DA1 and DA2 with Adult C only taking this offer on one occasion.

7.7. Adult C was first mentioned at MARAC as mentioned above in section 5. This was again good practice and in recognition of the seriousness of the abuse that Adult C was experiencing. There is, however, some learning here. The GP was not asked for any information regarding Adult C and minutes were not shared with the GP practice. The substance misuse service was only partially aware of the MARAC and did not have a good understanding of the purpose of MARAC; this organisation has made a recommendation related to the need for MARAC training.

7.8. It was generally agreed during this review that there were misconceptions as to the nature and remit of MARAC. In effect, MARAC is a risk management and safeguarding multi agency panel, which assesses and evaluates up to date information surrounding risk post incident (the incident that leads to the referral to MARAC). Agencies should not under any circumstances delay any immediate safety measures or information sharing amongst key agencies until it is heard at MARAC. A risk analysis and action plan are formulated for each MARAC case. MARAC does not continue managing or coordinating each MARAC case. It is heard initially and then discharged with an action plan. It will only be heard again in MARAC as a Repeat MARAC case, if MARAC receives a referral and it is accepted within the 12 months of the case initially been heard. Outside of the 12-month period a new MARAC referral will have to be submitted and accepted.

7.9. This was not fully understood by agencies who reported that the case was 'in MARAC' indicating and believing that there was therefore a coordinated response. There have been some significant deficiencies in the MARAC process noted locally by previous domestic homicide reviews (DHRs) and recent inspection of the local police force. This has resulted in a suite of materials and some changes to the MARAC process. This review will therefore not repeat those recommendations but will ask that the impact of those changes is assessed.

7.10. There were several issues that were not successfully addressed as part of a response to the safety of Adult C. One of these was housing. Adult C relied on others for her housing needs. She lived with Adult 1, stayed with friends who appeared to be her drinking friends and on one occasion was bailed to her ex father in law's house who had previously physically assaulted her.

7.11. The housing issues caused consternation within the review. Adult C was very close to getting a property of her own, supported by DA2. This failed for the reasons identified in section 5. There was a further referral for supported living for vulnerable women, but Adult C died before this could be progressed. DA1 and DA2 had always discussed several options for housing with Adult C but she always declined what was offered. Whilst resolving housing issues may have helped Adult C to be able to leave Adult 1 or at least give her some space when she needed to get away from Adult 1 it was acknowledged within the review that there was a strong co-dependency between Adult C and Adult 1.

7.12. Adult C was ambivalent to her housing issues on occasion but had expressed a fear of living on her own in case she had a seizure with no one there to look after her. It does not appear that Adult C's stated fear of being on her own equated to relevant thoughts by professionals about the impact this may have had on her ability to live on her own.

7.13. There were attempts made to encourage Adult C to move away from the area, making a clean break and starting again in a new area. Whilst this may have had some benefits, it also means that her support network of professionals who knew her would be lost and it is not always in the victim's best interests to move away.

7.14. The issue of the bail address not being a necessarily safe one came about because it was court bail and not police bail. The process for these is undertaken very quickly at magistrates' court the day after arrest and there is not enough time to identify any issues related to this. It is the detainee that is asked to provide a suitable bail address. There was discussion during the review related to this but there was felt to be no resolution available for these types of circumstances.

7.15. There was a discussion during the review regarding Adult C being seen as a perpetrator. At the time, this did not receive an oversight as to whether this was the best option and route to follow. There was information available that this was not the truth and that Adult C had been

subjected to a significant assault on that occasion. There was a view by some that Adult 1 was working the situation in order to maintain control and to manipulate the system so that he was viewed as a victim. DA1 refused a referral for Adult 1 as a victim because of this. This is not an unusual situation in domestic abuse, where a perpetrator will argue that an assault is violence against the perpetrator and not of a retaliatory nature. It is further manipulation and control by a perpetrator. Several research[10],[11] articles identify that in domestic abuse, some victims will retaliate but usually as a way of trying to protect themselves during an abusive act.

7.16. Retaliated violence is often seen as justified. In this case, Adult C was criminalised and was to have been tried at court for the offence but Adult 1 did not progress this. The review identified that police do not have any discretion where a crime has been committed. If they arrive at an incident and it is clear that an assault has been perpetrated and the victim is reporting it as such, then the necessary action is taken. This is so as to ensure that the law is applied equally to all alleged victims. To do otherwise may well result in the police being criticised for gender bias and also the possibility that male victims do not receive an equitable service.

7.17. Adult 1 was possibly manipulating the situation in order that he could use the bail conditions against Adult C. He also was able to exploit this and make complaints to the police when Adult C was in breach of bail conditions even when it was because he had deliberately gone to a place where she was.

7.18. There was also discussion within the review regarding the management of perpetrators as a way of reducing the risk of domestic abuse. Indeed, Adult 1 told the author that he had wished that he had been able to address his violent behaviour against women earlier.

7.19. Adult 1 as a perpetrator was subject to the sanctions identified in Section 5. There were also other options open to the police to use Domestic Violence Prevention Notifications and Orders[12] to provide sanctions that would keep the couple apart in the immediate aftermath of incidents. The police indicated in their Agency Review Report that this had also been a

[10] Swan S.C. (2008) A Review of Research on Women's Use of Violence with Male Intimate Partners Violence Vict. 2008 ; 23(3): 301–314. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2968709/pdf/nihms244725.pdf

[11] Who is Doing What to Whom? Determining the Core Aggressor in Relationships Where Domestic Violence Exists. https://www.speakcdn.com/assets/2497/who_is_doing_what_to_whom.pdf

[12] **Domestic Violence Protection Orders (DVPOs) and Domestic Violence Protection Notices (DVPNs**) were rolled out from 8 March 2014. DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions….. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575363/DVPO_guidance_FINAL_3.pdf

subject of criticism in a recent inspection and as such is subject to improvement.

7.20. The local area introduced a multi-agency police led initiative of Multi Agency Tasking and Coordination (MATAC) at around the time of the scoping period of this review. MATAC is a process to ensure that agencies work in partnership to engage serial domestic abuse perpetrators in support, take enforcement action where required and to protect vulnerable and intimidated victims.

7.21. Adult 1 was not referred to MATAC as he and Adult C were already listed several times at MARAC. The local protocol advises against the perpetrator being listed at both to avoid the risk of duplication and/or gaps. The One Minute guide to MATAC[13] for professionals does not make this clear and needs clarifying.

7.22. Notwithstanding the attempts made by all services involved to support Adult C to keep herself safe from the domestic abuse that she experienced from her partner, Adult 1 told the author that he did not believe that anything could have kept them apart. Adult 1 stated that he believed that the violence was 98% down to him. He stated that whatever sanctions were in place, they both contacted each other. That included when he was on remand (Adult 1 stated that Adult C's number was on his approved list of phone numbers), when Adult C was in refuge and when she was subject to bail conditions. Adult 1 told the author that he did agree that they were completely co-dependant and that this was not healthy. Adult 1 stated that this insight has come from undertaking a perpetrator programme recently. Adult 1 said that he wished that he had been able to do this when he had been in prison previously. Adult 1 talked about his violence and how he now reflected on what had happened. For the moment, Adult 1 stated that he did not want to be in another relationship.

7.23. This would suggest that the professional efforts to keep Adult C safe were always likely to fail and leads to consideration and implications for multi-agency working discussed later.

[13] https://middlesbrough.gov.uk/sites/default/files/One-Minute-Guide-10-MATAC.pdf

Learning Point 1: MARAC is a response to domestic abuse incidents and not an ongoing plan for protections. It does not replace effective multi agency working. MARAC does not provide a key worker role.
Learning Point 2: Addressing housing needs is an important part of planning for protection from domestic abuse.
Learning Point 3: Understanding and assessing perceived retaliatory violence may protect from further controlling behaviour from perpetrators.
Learning Point 4: Use of civil orders and processes to manage perpetrators is an important part of protection of victims.
Learning Point 5: Understanding and working with co-dependent couples requires different approaches
Learning Point 6: GPs are the central hub for all health-related information and therefore their information for MARAC and knowledge of a person subject to MARAC is an important element of providing holistic and safe care.
Learning Point 7: Information for professionals can be improved by providing clarity as to which process is relevant in any given case.

Understanding and Managing Alcohol Dependency

7.24. There was early recognition and diagnosis of the alcohol dependency with substance misuse services offering expertise and support tailored to the needs of Adult C, with changes being made to an appointment centre for ease of access. This review identified this as good practice and in response to Adult C's stated barriers to attendance.

7.25. Adult C had been alcohol dependent over several years. This impacted on her physical health with evidence of withdrawal seizures, deranged liver function, fatty liver and, vitamin and mineral deficiencies. It is also known that long term alcohol dependency can cause other physical health issues and has an effect on the body's immune system[14]. The cited research indicates alcohol dependent individuals are especially at risk from pneumonia with increased morbidity in this group of people.

7.26. Adult C saw her GP regularly who made appropriate referrals for alcohol dependency and its physical health impacts. Knowing these impacts did not lead to agencies having a conversation with the GP regarding concerns for her health. Psychiatric liaison assessments and hospital discharge letters were sent to the GP, but the GP had no multi agency engagement.

[14] Trevejo-Nunez, Giraldina et al. (2015) "Alcohol Use As a Risk Factor in Infections and Healing: A Clinician's Perspective." *Alcohol research : current reviews* vol. 37,2 (2015): 177-84. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4590615/

7.27. Section 5 indicates how spasmodic Adult C's engagement with agencies was. On many occasions she was deemed and assessed as required by the Mental Capacity Act (2005), to have the Mental Capacity to make decisions, despite the fact that on many of those occasions she was under the influence of alcohol or intoxicated.

7.28. Professionals did not show a general understanding of the impact of alcohol on decision making. More specifically, whether Adult C had the ability to use and weigh information regarding her decisions regarding ability to keep herself safe or if she was able to display executive capacity to actually carry out the decisions that she had previously agreed to. Not only does recent consumption of alcohol affect decision making and leads to fluctuating capacity, but it is also known that alcohol dependency leads to changes in the brain that can lead to issues and affect mental capacity. Many neuropsychological studies have repeatedly highlighted that alcohol dependence is associated with impaired executive functioning, including working memory, planning, and flexibility[15]. Whilst that may have an impact on attending appointments and the ability to engage effectively with services, when that is combined with domestic abuse impacts, it can be seen that mental capacity is possibly severely impacted.

7.29. Professionals have a general understanding of application of the Mental Capacity Act, however, when it is being assessed as part of such complex circumstances, there is very little guidance available. Use of legal advice and the Court of Protection were not considered or discussed in the case of Adult C.

7.30. Adult C was also associating with, not only her partner who was a problem drinker, but with other people who were also drinkers. They engaged in drinking parties and there appeared to be an expectation that income/benefits that funded drinking were shared. It is not known how exploited Adult C was in this regard. Professionals did not appear to explore this further. This was likely to mean that breaking away and changing that drinking pattern would be even more difficult than for an individual drinker.

7.31. When Adult 1 met with the author he had a very different view of Adult C's drinking. His belief was that she was not dependant on alcohol although he stated that he was. Adult 1 said that Adult C only drank when he did and did not appear to have a need to drink in the way that he did. This review acknowledges that the medical evidence indicated otherwise. Adult 1 is now trying to address his alcohol issues and has distanced himself from the group that he and Adult C used to associate with.

[15] Brevers, Damien et al. "Impaired decision-making under risk in individuals with alcohol dependence." *Alcoholism, clinical and experimental research* vol. 38,7 (2014): 1924-31. doi:10.1111/acer.12447 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4115290/pdf/nihms587887.pdf

7.32. The issues highlighted above have been raised in an analysis of alcohol related SARs[16], one of which was a previous SAR for Teeswide Safeguarding Adult Board.

7.33. The learning from these alcohol related SAR cases were significant and there are many parallels to this case, therefore the learning and findings are similar. TSAB have recently received a presentation from the author of that report and were asked to consider what needed to change locally. In light of this TSAB will be asked to formally review the learning and apply it locally in respect of this case (see recommendations).

Learning Point 8: The effect of alcohol dependency on decision making requires careful consideration especially when assessing mental capacity and understanding whether a person can really assert choice with significant addiction.
Learning Point 9: It is important for all services to be cognisant of physical health conditions and treatments in order to support compliance with medication.
Learning Point 10: Understanding barriers to change may be important in assessing resistance.

Management and coordination of community acquired pneumonia in alcohol dependent adults

7.34. When Adult C developed chest symptoms, she contacted her GP. The GP surgery accommodated her request to be seen at the surgery. The GP surgery worked well to persuade Adult C that she needed immediate hospital treatment.

7.35. When Adult C was seen at hospital that day and the following day, she was seen, diagnosed and treated appropriately as an adult with community acquired pneumonia (CAP). There is a multitude of research regarding the increased risk of CAP in this group as well as indicators of a higher mortality rate from CAP in this group.

7.36. Adult C's treatment was undertaken in line with NICE Guidance[17] by a Specialist Nurse Practitioner in consultation with a specialist consultant.

7.37. Other agencies knew of Adult C's sporadic engagement in treatment plans and interventions and there was also evidence of some non-compliance with drug treatments. Adult C had a very chaotic lifestyle. It is of note however, that Adult C always attended her hospital appointments with no recorded evidence of defaulted appointments. Adult 1 told the author

[16] Alcohol Change UK (2019) : Learning from tragedies An analysis of alcohol-related Safeguarding Adult Reviews published in 2017 July 2019
https://alcoholchange.org.uk/publication/learning-from-tragedies-an-analysis-of-alcohol-related-safeguarding-adult-reviews-published-in-2017

[17] Pneumonia in adults: diagnosis and management. Clinical guideline [CG191] Published date: December 2014 Last updated: September 2019.https://www.nice.org.uk/guidance/cg191

that he always made sure Adult C attended her health appointments.

7.38. When her condition worsened a couple of days later, Adult C refused hospital admission and was deemed to have capacity to do so; assessment of capacity in this situation, as discussed previously was unlikely to have been straightforward.

7.39. There was debate during the review regarding why Adult C may have chosen to not go to hospital. Although the reason cannot be known, there were thoughts that maybe she had not realised how serious pneumonia can be. The ambulance crew had not found her to be extremely unwell and she had been seen by the nurse specialist 17 hours earlier.

7.40. When the author met with Adult 1, he indicated that he had not known about the call to the ambulance two days before she died. In response to asking about the possible reasons that Adult C would have refused to go to hospital, Adult 1 thought that she may have been scared. Adult 1 informed the author that a friend of Adult C's had recently died from pneumonia and was in his thirties. Adult 1 stated that Adult C knew that she could be at risk of dying from pneumonia. Adult 1 stated that he had tried to reassure her that she would not die.

Learning Point 11: Use of clinical pathways for treatment is a useful tool to aid effective management of physical health conditions in those who are alcohol dependent and live in complex circumstances
Learning Point 12: Pneumonia is a serious condition that can result in death even in healthy adults. It is important that professionals convey to the person the urgency of seeking help if a person's condition causes them concern.

Multi agency working and communication.

7.41. This case has highlighted the need for effective communication and multi-agency working. It is discussed above how there are significant complexities in working with those who are alcohol dependent and are victims of domestic abuse. The risks are significant and interventions that are likely to lead to positive outcomes are challenging. Several research studies and guidance [18], [19] have indicated that when these two situations occur together, professionals can find that the need for specialist intervention and advice is vital. In the case of Adult C, she was open to services that could support her in both of these issues. It was a feature, though, that these services did not really work together effectively. The substance misuse service had little understanding of how MARAC worked and did not make repeated referrals as required believing that Adult C was already known to MARAC. Neither substance

[18] https://alcoholchange.org.uk/blog/2019/alcohol-and-intimate-partner-violence
[17]Ward, M. et al 2016 Domestic abuse and change resistant drinkers: preventing and reducing the harm Learning lessons from Domestic Homicide Reviews
https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

misuse services nor domestic abuse services had any contact with the GP.

7.42. It would appear therefore that domestic abuse, alcohol dependence and chronic health problems were all being managed in parallel lines rather than in a coordinated manner with each cognisant of the others plans. Adult 1 told the author that it was very difficult for Adult C to keep appointments as they were constant with some on the same day as others. Adult 1 indicated that she would sometimes come out of an appointment and go straight to get a drink. There were some positive elements of trying to have an improved approach e.g. when the alcohol worker arranged a joint appointment at a convenient venue for Adult C. This type of approach was not sustained and was not used as a model moving forward.

7.43. Adult C did show some insight into the reasons why she did not engage well during a conversation with substance misuse services. It was apparent that many of the services that Adult C needed, had criteria that she was required to meet. The real barriers to her engagement and improving outcomes may well have been the service requirements were not ones that someone with the complex needs of Adult C could easily achieve. The coercion, control and power imbalance of domestic abuse alongside her having little agency[20] and control of her situation due to alcohol dependency required a more assertive outreach approach to support Adult C to engage and address these issues.

7.44. Improvements made to MARAC locally, may well offer a more effective route for multi-agency working for those who are victims of domestic abuse.

7.45. Whilst there were safeguarding referrals made and these were responded to, Adult C refused intervention or sporadic engagement led to delays with needs assessments. Latterly, the safeguarding referral was not progressed as there was a need to assess Adult C directly; she died before this could happen.

7.46. Adults who have care and support needs, who are alcohol dependent and victims of domestic abuse, can come under the care required under the Care Act Section 42 under several categories of abuse. Whilst issues addressed earlier in this report provide an explanation as to why Adult C did not engage with Adult Social Care, a TATI approach would have led to a better understanding of the needs that she had leading Adult Social Care to see a role for them in a wider safeguarding response much earlier. These issues were also picked up in the SAR Alcohol Change UK Report referenced previously.

7.47. The new TATI process has now been introduced. At the time of writing this report, the first two meetings have shown to be positive. This model has been developed locally and provides

[20] In social science, **agency** is defined as the capacity of individuals to act independently and to **make** their own free choices. Those not able to exercise **agency** due to other influences struggle to bring their influence to bear on what they can control.

a more holistic and collaborative model providing an overview and understanding of what each individual agency knows and is undertaking. Problem solving is enabled more effectively when agencies with different specialisms come together.

7.48. This approach may have led to better understanding of the following issues in Adult C's case :

- Non engagement with services
- Management of chronic health problems and medication compliance
- The victim/perpetrator dilemma and power base being exerted
- Exploitation of finances and associated drinking partners
- Resolution of housing issues
- MARAC

7.49. Where a person is being discussed in TATI and MARAC meetings it is important that both reference the other to avoid duplication or gaps. However, as MARAC may only consist of one meeting regarding a person, TATI will be the ongoing coordination process that will need to take MARAC actions into account.

7.50. It was of note that there was no involvement from senior managers in this case. Multi agency working gives rise to a collective discussion and decisions to escalate and include senior managers where risk is feeling unmanageable by frontline workers. It is of note that the TATI model is led by senior management in Adult Social Care in order that the oversight of complex cases is integrated into the meetings.

7.51. Whilst the TATI model (and similar in other Teeswide areas) addresses those with complex needs where risk is escalating, this does not meet the need for a more integrated approach at a lower level or where risk is more manageable. For those with mental health needs that meet the Care Programme Approach[21] criteria, there is a solution utilising the multi-agency element of this with the identified care coordinator to provide a key worker role. This would not be the case for adults like Adult C who did not have enduring mental health illness or needs.

7.52. In the area where Adult C lived and received services, there is a new commissioning model proposed. The integrated service model for vulnerable people is being developed to bring services together so that a coordinated response can be utilised for people like Adult C who have complex needs. The model has set outcomes that will remove the risk of duplication of services, multiple assessments and managing disengagement. The model is set to provide an assertive outreach team offering intensive support for the most at risk and vulnerable to

[21] The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs. http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx.

overcome barriers that may have previously prevented access to services for those people.

7.53. There would still be a pathway to refer to TATI where risk was escalating, thereby providing a complete pathway for managing people in vulnerable circumstances who were at risk, where a Section 42 enquiry is not an appropriate way forward. It is of note that the commissioning model and TATI does not preclude those that are subject to a Section 42 enquiry but is not a criteria for inclusion.

7.54. How the needs of vulnerable adults with complex needs that fall below the threshold for TATI (or similar) are met in other localities of the Teeswide area will be an issue for TSAB to consider.

Learning Point 13: Effective MARACs provide a platform for sharing information and effective interventions.
Learning Point 14: The Team Around the Individual is a useful process in managing and supporting people who are change resistant drinkers who are also victims of domestic abuse.
Learning Point 15: Commissioning the right services to address complex drinking and domestic abuse cases, albeit resource intensive, may provide long-term benefits.

8. CONCLUSION

8.1. This review has acknowledged the complex set of circumstances that Adult C faced daily in keeping herself safe. This not only included safety from abuse and exploitation but also safe from the physical health complications of her lifestyle.

8.2. Adult C's capacity to change and keep safe was severely affected by several factors:

- by the power and controlling relationship that she was in
- her alcohol dependency
- her physical health condition/s
- the trauma of previous experiences
- the associates who she drank with
- the lack of suitable housing

8.3. Adult C's situation was by no means unique; much of the literature review undertaken for this LLR highlights similar situations with well researched recommendations already being suggested. A DHR locally as well as the 2019 Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) Peel inspection[22] of the Police has also highlighted required

[22] **Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services** (HMICFRS) inspects and reports to the public and their elected representatives on how well the police do their job. The purpose is to promote improvements in policing and keep everyone safe. HMICFRS provide authoritative information to allow the public to compare the performance of their police

improvements in MARAC and associated processes with improvement plans in place.

8.4. This review has highlighted the complexity of assessing, managing interventions and improving outcomes for people who are victims of domestic abuse and alcohol dependant who are change resistant, especially where the perpetrator/s and friends are also problem drinkers.

8.5. This review found no gaps in service delivery to Adult C. All the commissioned and statutory services that should have been engaged were actively seeking to improve outcomes for her using tried and tested models. Services signposted to other services as necessary and made appropriate referrals. The disclosure from Adult 1 that nothing that professionals tried would have kept them apart is testament to the difficulties faced by professionals.

8.6. Some agencies have recognised where they could make improvements and have made single agency recommendations to improve their own practices e.g. the substance misuse service have recommended increased MARAC training for staff and the Clinical Commissioning Group have recognised the need for GPs to be more aware of MARAC from this and other reviews (including MARAC minutes being shared to enable awareness of patients who are known victims of domestic abuse and flagging on systems). The process by which this can happen is subject to recommendation in this review.

8.7. Whilst there is a process identified such as the TATI that could be beneficial in future cases in the locality, people with these needs and issues require more of an assertive outreach approach.

8.8. Approaches of that nature are labour intensive and are often for one specific issue e.g. domestic abuse, mental health. What is required is a more eclectic service that is able to support people with multiple needs, whose lifestyles are likely to lead to tragic outcomes unless intervention approaches can be person tailored rather than service specific.

8.9. In such cases, alcohol, domestic abuse and health services need to work more closely together to align their approaches, each cognisant of the other's plans and goals. Improving outcomes for domestic abuse victims will not be possible without improving outcomes for alcohol addiction.

8.10. The new integrated vulnerability service delivery model that is proposed for the area, if it is introduced in the way proposed, will meet much of the needs of the population with issues

force against others. Evidence is used to drive improvements in the services provided and to highlight good practice. HMICFRS report annually on their effectiveness, efficiency and legitimacy via our PEEL assessments.

such as Adult C's, therefore the future of this model will require close observation by TSAB to assure itself that vulnerable people have a more effective joined up service.

8.11. With many new systems in place to support and engage Adults like Adult C, TSAB's role will be to receive assurance as to how effective these are and to ensure that agencies avoid complacency that the new systems will be a whole answer. With systems in place, it is reliant on those working within the systems to know of them and to understand their criteria and use if they are to be effective.

9. RECOMMENDATIONS

9.1. The findings identified above have been included in learning points throughout this report and lead to recommendations for improvement.

9.2. The improvements required from the learning in this case are already largely known to the TSAB through previous reviews and other reports. Where recommendations have already been made these will need monitoring.

9.3. Where agencies have made their own recommendations in their Agency Review Reports, TSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

9.4. The following multi agency recommendations are made to the TSAB as a result of the learning in this case:

1. The Safeguarding System

TSAB should review the effectiveness of the Team Around the Individual approach for cases of domestic abuse and alcohol dependence by means of audit and appreciative enquiry to understand impacts. All relevant partners must be included in the process. Audit must assess interface between MARAC and TATI.

2. Alcohol Dependency with combined Domestic abuse

a. TSAB must review the recommendations made in the Alcohol Change UK analysis of SARS. TSAB must undertake a gap analysis of current practice against the following recommendations. Analysis must include assessment against the vulnerability model proposed to the locality but consider how this will be met for other parts of the Teeswide area following this LLR.

- Local authorities should ensure that vulnerable adults with alcohol problems are actively supported to engage with services and should support services to adapt so that they can better serve these adults. In particular, there should be support for multi-agency systems that can

coordinate assertive outreach and view the task of generating positive engagements as an important action in its own right.

- All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatizing drinkers.

- Significantly greater investment is needed in alcohol treatment services, with much of that investment funding service models like 'assertive outreach' which support the most at-risk and vulnerable individuals.

- [The Mental Capacity Act 2005 Code of Practice should be amended to include] specific guidance for working with individuals with alcohol misuse or dependence, especially when they are likely to have complex needs.

- [National] guidance should be produced on applying the Mental Capacity Act (2005) to people with fluctuating capacity due to alcohol misuse.

b. TSAB should seek assurance from the Police and Crime Commissioner's Office of the effectiveness of the improvements in MARAC and domestic abuse services made as a result of DHR 1 in Middlesbrough. Evidence from audit and appreciative enquiry will provide evidence of system improvement.

c. TSAB should ask that the One Minute Guide related to MATAC is updated to include that perpetrators would not be listed at MATAC and MARAC.

d. TSAB should task CCGs to work with the MARAC Chair to identify resolutions to moving towards GPs being routinely asked for and providing information pre-MARAC and receiving minutes post MARAC meetings.

e. TSAB must work with other relevant strategic partnerships to be assured that commissioners and providers are developing evidenced based pathways for working with domestic abuse and change resistant drinkers that will be relevant locally e.g. akin to the Blue Light Project (see below)

   Ward, M. et al 2016 Domestic abuse and change resistant drinkers: preventing and reducing the harm Learning lessons from Domestic Homicide Reviews https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

3. TSAB must produce a briefing related to all learning points from this LLR.

Appendix One Terms of Reference (REDACTED)

Learning Lessons Review
Case 6/18
Adult C
Terms of Reference and Scope

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and TSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

Adult C was a 30-year-old lady who died following cardiac arrest after diagnosis and treatment for pneumonia. Adult C was a longstanding alcoholic who showed some signs of wanting to reduce her alcohol consumption. Adult C was known to have been in an abusive relationship with many reports of injuries from both her partner and her ex father in law as well as others. Adult C was also considered to be a perpetrator of physical violence against her partner and other adults. Adult C was known to many agencies as a result of her alcoholism and the abuse she suffered. On

the date of her death, it was her partner who called an ambulance; her ex father in law was also present. They were originally arrested for the murder of Adult C, but her death was later deemed to be from physical health causes. An inquest is open and ongoing.

3. Decision to hold a Learning Lessons Review

The Safeguarding Adults Review Sub Group of the Safeguarding Adults Board met on 15th May 2019. It was agreed that the criteria for a Safeguarding Adults Review were not met and made a recommendation to the TSAB Independent Chair that there was likely to be learning in the way that agencies worked together to safeguard Adult C and recommended a Learning Lessons Review. The Independent Chair endorsed this decision.

4. Scope

The review will cover a period **six months prior to death.** Key background information will also form part of the review that will inform the more contemporary elements of Adult C's journey.

5. Method

In determining the methodology to be used for this Learning Lessons Review the TSAB considered the Care Act 2014 Statutory Guidance which states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

TSAB chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a Learning and Reflection Workshop to review all of the material and identify key themes and learning. A Review workshop will take place to review the first draft of the overview report.

6. Key Lines of Enquiry to be addressed

As well as broader analysis provided within the Agency Review Reports the following case specific key lines of enquiry will be addressed.

6.1. Assessment

What assessment did your agency undertake of Adult C's holistic needs, inclusive of physical and mental health? How robust was this? How did this inform care planning and interventions?
Please provide analysis of what assessment policies and frameworks were in use and identify any gaps in policy and/or practice.

6.2. Mental Capacity

What did your agency understand of Adult C's decisional capacity at various points in the timeline for this review? What evidence is there regarding the considerations given to the impact of alcohol and domestic abuse on decision making. Please give examples of how this was understood. Please provide thorough analysis of application of the Mental Capacity Act.

6.3. **Managing Risk of Domestic Abuse**

How did your agency engage in responding to the ongoing domestic abuse that Adult C was subject to? What was your agency's involvement in MARAC meetings? Analyse effectiveness of plans and responses and suggest learning from this.

6.4. **Management of Perpetrators**

What was your understanding of prevention measures in place to manage the risk from identified perpetrators? Please analyse the effectiveness of the system to manage perpetrators of domestic abuse in this case. Please include when Adult C was considered a perpetrator.

6.5. Effectiveness of the Safeguarding System

How were safeguarding processes applied? What was your agency's involvement in the safeguarding processes? Please include referrals, strategy meetings and closures. Provide evidence and discuss this against expected safeguarding processes.

6.6. Family Involvement

How did your agency engage with Adult C's family? What did you understand of the relationship between Adult C and family? How were they included in plans and assessments?

6.7. Documentation

Please identify if documentation was in line with agency requirements. If not, please analyse why this might be.

6.8. Good Practice

Please identify examples of good practice from your agency and others.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Learning Lessons Review is **Karen Rees.**

8. Organisations to be involved with the review:

- CCG for the GP Practice

- Substance misuse services
- Police
- Domestic Abuse Service 1
- Local Council
- Domestic Abuse Service 2
- Ambulance Service
- Hospital NHS Foundation Trust
- Mental Health NHS Foundation Trust

9. Family Involvement

A key part of undertaking Learning Lessons Review is to gather the views of the family and share findings with them prior to finalisation of the report. Adult C's ex-partner and family will be contacted to inform them of the review and invite them to meet with the author.

10. Project Plan dates:

		Date
1.	Scoping Meeting (Governance Group)	26/09/2019
2.	Terms of Reference updated	As above
3.	Agency Authors' Briefing	As above
4.	Agency Review Reports submitted	08/11/2019
5.	Review of Reports by Independent Author	8-10/11/2019
6.	Distribution of Reports to all Learning & Reflection Workshop attendees	11/11/2019
7.	Learning and Reflection Workshop (Full Day)	27/11/2019
8.	First Draft Overview Report to all attendees	06/01/2020
9.	Learning and Reflection Review Workshop	14/01/2020
10.	V2 Overview report circulated to workshop attendees	22/01/2020
11.	Comments on V2	05/02/2020
12	V3 to SAR/Governance Sub Group	12/02/2020
13	SAR / Governance Sub-Group to agree workable achievable recommendations and agree report prior to presentation at Board.	27/02/2020
14	Presentation to TSAB Meeting	23/04/2020