Safeguarding Adult Review

Learning from the death of Bernadette

Independent Reviewer: Chris Hogben. (Invigor Consulting Ltd).

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1. Introduction

1.1 This safeguarding adult review, (SAR), has been commissioned by the Teeswide Safeguarding Adults Board, (TSAB), to extract the learning from the circumstances surrounding the death of Bernadette in October 2022. This case was referred to the Teeswide Safeguarding Adults Board, (TSAB), for consideration of holding a safeguarding adult review, (SAR). The referral was considered by the TSAB safeguarding adults review Sub-Group who determined that the criteria for a statutory review under section 44 of the Care Act 2014 were met. The TSAB Independent Chair subsequently endorsed this decision.

1.2 At the time of her death in October 2022, Bernadette was 32 years old white female and lived in rented accommodation with a male partner and at times, an unidentified female friend. Bernadette had a history of drug and alcohol abuse, she also suffered from depression. She had a number of physical health issues including diabetes, pains in her leg, falls and seizures.

1.3 Bernadette was known to a number of services prior to her death, this included being an open case to adult social care. Bernadette had been identified as a victim of domestic abuse and had previously been subject of the MARAC, (Multi-Agency Risk Assessment Conference), process.[1]

1.4 Under section 44 of the Care Act 2014, a Safeguarding Adult Board, (SAB), must arrange for there to be a review of a case involving an adult in its area with need of care and support, (whether or not the Local Authority has been meeting any of those needs), if:

- 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
- the adult has died,
- and the SAB knows or suspects that the death resulted from abuse or neglect, whether or not it knew about the abuse or neglect before the adult died, (the neglect includes self-neglect).

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:

i, identifying the lessons to be learned from the adult's case, and,

ii, applying those lessons to future cases.

2. Terms of Reference

2.1 To use a rapid review methodology to identify any learning, including examples of good practice, from Bernadette's case.

[1] A MARAC is a multi-agency meeting to share information on high-risk domestic abuse cases, to risk assess and to agree cross agency risk mitigation plans.

2.2 To consider the learning that emerges in light of what is understood already through national research or published SARs.

2.3 To develop a ‘questions for the board’ section which will allow key challenges for the partnership to be teased out and presented to the board for them to consider how to respond. The questions will be shaped through a co-production style of working between the independent reviewer and the Safeguarding Adult Review Governance Group.

3. Methodology

3.1 The Care Act 2014 guidance states that the process for undertaking a SAR should be determined locally according to the circumstances of an individual case, no one model will be appropriate in all cases. The focus should be on understanding what happened and why, what may need to change and potentially, answers for the family and friends of the adult who has died or been seriously abused or neglected.

3.2 TSAB have decided to use a rapid review methodology that will engage frontline practitioners and partner agency safeguarding leads. The review will be facilitated by an independent reviewer and overview report author. Chronologies collated during the initial scoping phase, together with other relevant information, were reviewed by the independent reviewer to determine the appropriate areas for enquiry. Partner agencies were then asked to review their own involvement with Bernadette, and to provide a report detailing that involvement, good practice, learning and suggested recommendations. A practitioner workshop was undertaken to focus on understanding the strengths of the current systems and seeking to identify potential areas for further improvement.

3.3 The Independent Reviewer worked with the SAR Governance Group to develop agreed multi-agency recommendations and key actions for TSAB’s consideration.

3.4 The timeline for the SAR was for the five months prior to Bernadette’s death in October 2022, although agencies provided a brief summary of any other historical information in relation to Bernadette that was relevant to the terms of reference. A key principle underpinning this SAR is the need to build on the learning from previous reviews and so the SAR methodology was adjusted accordingly.

3.5 Those agencies that Bernadette was known to were identified and were expected to engage in the SAR process, including the completion of a single agency report and participation in the practitioner workshop event.

3.6 Some agencies who did not have contact with Bernadette during the period subject of this review were not required to complete a single agency report but were invited to participate in the practitioner workshop.

3.7 It will be the responsibility of each participating agency to brief relevant managers and staff about the SAR, engaging them in the information gathering process and once completed, to brief them on the outcomes of the review.

3.8 Each agency will be asked to nominate a person to act as the single point of contact for the review and additionally, where required, a designated person to undertake the single agency report.

3.9 The workshop was structured to enable specific issues relating to Bernadette's case to be considered and then allow time for focussing on broader themes identified in the review.

3.10 An important element of the SAR is to engage with Bernadette's family, encourage their contribution to the process and then to share the findings with them prior to publication. A key worker was appointed to liaise with the family throughout the process should they wish. TSAB identified relevant family members for Bernadette and actively sought their engagement in the process.

3.11 An Independent Reviewer/Overview Report Author was been commissioned, this is Chris Hogben, Invigor Consulting Ltd, who is completely independent from all of the agencies involved in this case.

4. Key Lines of Enquiry (KLOEs)

4.1 The following KLOEs were examined as part of the review, they are not in any order of priority. Agencies completed a single agency report using an agreed template addressing each area covering good practice, learning and recommendations against each;

4.2 Multi-agency Working/Safeguarding

How well did relevant agencies work together with a specific focus on:

- How risk management and safeguarding processes were applied.
- Evidence of multi-agency co-ordination, timely information sharing, risk assessments and risk management planning.
- Leadership/ownership of issues.
- Analysing the effectiveness of responses and identify potential learning from this.

4.3 Domestic Abuse

Were practitioners' system wide able to:

- Identify domestic abuse issues.
- Have the skills and confidence to carry out risk assessments and to contribute to risk mitigation.
- Understand the appropriate referral/escalation pathways.
- Did weekend work impact on the cross-agency response?

4.4 Legal Literacy

How well did professionals understand and use relevant legislation and policy identified within this SAR, including:

- The Care Act 2014
- The Mental Capacity Act 2005, and in particular, both decisional/functional capacity and executive capacity.
- Domestic Abuse Crime and Victims Act 2004.
- Were there barriers/limitations as to how the legislation was applied and if so, why?

4.5 Barriers to Engagement

What strategies are adopted to manage the adult's reluctance to/lack of engagement with a focus on:

- Self-neglect, particularly where this relates to existing physical health concerns.
- The impact of compulsive behaviours.
- Non-engagement policy.
- Professional curiosity.

4.6 Substance Misuse

- What services were available and offered to the adult.
- If not accessed, do we understand why.
- Was dual diagnosis recognised in Bernadette's case and if so, what strategies were considered to manage these issues.

5. Family Involvement

5.1 Bernadette's Mother, agreed to meet with the independent reviewer and Bernadette's social care worker, (SCW) to provide information to support the review process and to bring Bernadette's voice to the document. Although it was clear that Bernadette's mother had limited contact with her in the years prior to her death, and specifically during the period subject to this review, she was able to provide some context and understanding of Bernadette's perspective, helping to shape the report.

6. Narrative Chronology

6.1 Bernadette-a pen picture.

Bernadette was the fifth of eight children, seven of which were birth children and one who was adopted. Bernadette struggled with her reading and writing skills and, in her mother's words, went to a special school where her behaviour deteriorated. Bernadette met her partner whilst she was about 15 years old, and within a short period of time gave birth to two children, a daughter and a son, Bernadette was unable to care for the children who were cared for by Bernadette's parents until her father died in 2013. The two children were initially placed into foster care before being cared for by their paternal grandmother where they remain today. Although Bernadette wasn't able to care for her children, those who knew her state that she

loved her children and although she had little money, she was proud to tell people that she was saving what money she could to buy them presents for birthdays and Christmas.

Bernadette's mother described her relationship with Bernadette as not being close, indeed she had only seen Bernadette occasionally in the last few years. Bernadette's mother told the independent reviewer that she wasn't aware of Bernadette's drug addiction. She had met Bernadette by chance outside a shop whilst she was walking with another daughter, at some point in 2022, and was very surprised by Bernadette's significant loss of weight.

Bernadette did not have a close relationship with her siblings either, she didn't meet any of them on a regular basis and whilst some services report Bernadette having a sister staying at her address, this is not correct as none of her siblings were residing with Bernadette. Her mother will state that if another female was staying at Bernadette's address, it must have been a female friend of hers.

Bernadette's mother also advised that she was aware of the fact that Bernadette suffered from domestic abuse from her partner. Historically, although she had seen bruising on Bernadette on occasions, Bernadette didn't disclose much to her. She would invariably deny living with her partner although Bernadette's mother did remember that at some point, Bernadette had told her that her partner kept control of her bank card.

When asked if she had any knowledge of Bernadette's engagement with services, Bernadette's mother acknowledged that she hadn't seen Bernadette on many occasions in the last few years. She was aware that Bernadette 'didn't get much help' but Bernadette never explained to her why that was, her mother recognised that Bernadette probably didn't ask for help or attend appointments. Both her mother and her Social Care Worker clearly believe that Bernadette was ashamed of her drug addiction and that she sought to hide this from those people she came into contact with, both family members and professionals.

6.2 Background prior to relevant period.

Bernadette had extensive contact with the Police dating back to June 2006 when information was received by the police to suggest that Bernadette, then aged 9 years, was visiting the home of a known schedule 1 offender, (this is the equivalent of a registered sex offender today). In July 2005, when aged 14, Bernadette was reported as being the victim of a sexual offence although the records would suggest that although a male was arrested, no prosecution resulted from the investigation.

In July 2007, when Bernadette was 16 years old, she reported being the victim of rape by a male person known to her. Police records show that a suspect was arrested and charged to court with respect to this allegation.

The police records raise the likelihood of Bernadette suffering childhood trauma through adverse childhood experiences, (ACES)[2], in this case, trauma related to

[2] Adverse childhood experiences are traumatic events that occur before a child reaches the age of 18. ACEs include all types of abuse and neglect, including parental substance misuse, incarceration and

child sexual abuse. Research recognises the impact this can have on victim's later life experiences.

Police information describes a range of issues in Bernadette's life prior to the period subject of this review, this includes episodes of being missing from home, reports of anti-social behaviour, Bernadette being involved in the use and the unlawful supply of controlled drugs and occasions where Bernadette was suspected of involvement in other criminality, primarily theft offences.

Bernadette is also recorded as being the victim of crime allegations on thirty-three occasions, this includes being the victim of domestic abuse with both her partner and a previous partner.

Bernadette had two children, none of whom resided with her, they were under the care of Bernadette's grandmother through a special guardianship order.

When Bernadette first transferred to the local Acute Trust, she had informed staff that she was an ex intravenous drug user and that she was on a methadone programme, receiving 100mls daily. Bernadette had additionally stated that she didn't drink alcohol or take oral recreational drugs. Although the Department of Health (2017) guidance identifies that a person on a methadone programme could be tested to confirm treatment compliance and/or to monitor illicit drug use, there is no record of whether such testing took place.

Bernadette was first referred to Adult Social Care, ASC, in April 2019 when a support provider raised a safeguarding concern about financial and sexual exploitation, weight loss, drug abuse and Bernadette's health needs. This referral included concerns about Bernadette being a victim of domestic abuse. During this safeguarding enquiry process, a referral was made for a social work assessment and there was continued social care involvement from that point until Bernadette's death in October 2022. There were no further adult safeguarding referrals made with respect to Bernadette until her admission to hospital in October 2022.

Bernadette was referred to the Multi-Agency Risk Assessment Conference, (MARAC), process following the arrest of her partner in October 2018 for making threats to kill Bernadette, her partner was charged and remanded in custody to prison. Her partner was subsequently convicted of a number of offences and remained in prison until his release in July 2019. The minutes of the MARAC meeting held in November 2018 record a good attendance from relevant agencies and significant information sharing to support the risk assessment process. Whilst the risk of harm to Bernadette through domestic abuse was mitigated through the perpetrator being in prison, the meeting identified the risk through self-neglect, specifically relating to her poor management of diabetes, and her substance misuse. The minutes don't identify any agreed actions with respect to these issues.

Bernadette was subject to a further discussion at MARAC in July 2019 to consider the risk posed by her partner's release from prison. Probation Service records show

domestic abuse. They are linked to chronic health problems, substance misuse and mental illness in adolescence and adulthood.

that he was initially released as homeless, he didn't attend the homeless unit address as directed but did attend his probation Service appointment on 18 July 2019. The records suggest that he wanted to reside at a friend's address, subsequently identified as the address that Bernadette was staying at. This address was not approved and he was given a formal warning with respect to breaching the licence conditions that had been imposed on him to mitigate the threat of harm to Bernadette. Alternative emergency accommodation was arranged for him to enable additional risk management and monitoring. The review notes that he subsequently failed to comply with his licence conditions and was subject of a prison recall.

The MARAC minutes also record issues specific to Bernadette and the wider risk of harm to her. A local domestic abuse service, had reported that after an initial assessment in May 2019, Bernadette didn't access any support provided and wouldn't engage with counselling services. The Acute Trust record 2 inpatient admissions but also the fact that Bernadette did not attend her last two diabetic appointments. They also highlight an incident in April 2019 where Bernadette was brought to A&E in relation to alcohol problems but absconded prior to treatment.

ASC informed the MARAC meeting that Bernadette had informed them she was not in a relationship at that time but was staying with a male who had assaulted her, she was scared of and professionals were concerned that he may be controlling her. It is notable that ASC informed the meeting that in their view, Bernadette did not disclose information openly to practitioners. The records also show that Bernadette was open to ASC's long term intervention team.

Bernadette had contact with a substance misuse service in 2019, the Substance Misuse Service informed the MARAC meeting that Bernadette started a prescribed treatment programme in July 2019 but was still using heroin on a daily basis, they noted that she had indicated a desire to reduce her use of heroin.

The MARAC meeting records clearly identify the risks in Bernadette's case; further domestic abuse, inconsistent engagement with services, drug abuse, medical needs and it being unclear if she was selling her medication to fund her lifestyle, and the fact that her social worker hadn't actually seen her. The meeting agrees actions including a joint visit to Bernadette by ASC and the Police and that ASC should encourage Bernadette to engage with Domestic Abuse Support Services.

ASC records refer to concerns being raised about Bernadette and self-neglect behaviour in the management of her diabetes in January 2021. There are no recorded actions with respect to this concern.

6.3 The relevant period.

In May 2022 the Acute Trust, record Bernadette not attending an appointment with infectious diseases. On the same day, Bernadette also failed to attend a prescribing service appointment in relation to her having an echo cardiogram, ECG, as part of a methadone programme.

In May 2022 Bernadette's GP saw Bernadette in a face-to-face consultation, Bernadette was complaining of pain to her right side and her ribs, she had also been

vomiting. She informed the GP that she had attended A&E the previous evening but left without treatment as it was very busy and she had waited a long time. Bernadette explained that the injuries were caused through her falling down stairs. The GP advised her to go to A&E to be properly assessed but Bernadette declined, the GP proscribed Prochlorperazine 5mg tablets to be taken three times a day.

A couple of days later Bernadette failed to attend her appointment with the prescribing service for an ECG. Bernadette was collecting her methadone prescriptions regularly although she failed to attend her prescription appointment, a prescription was generated none the less to keep the patient in treatment.

In May 2022 and June 2022, the Acute Trust record Bernadette not attending two appointments with infectious diseases.

In June 2022, Bernadette met with a clinical support worker for a face-to-face review. Bernadette had her ECG, she admitted using heroin and crack cocaine. It is noted that prior to attending this appointment, Bernadette had asked for an increase in her prescription.

In 2020 the drug and alcohol service were brought into the local Council and renamed, providing support services, including outreach workers, for a range of issues, including those with substance misuse issues and domestic abuse. Although Bernadette was not in a treatment programme, she was seen by outreach workers on six occasions between May and August 2022. These meetings were face to face and usually in the homeless café. The Drug and Alcohol Service records report that on each occasion, Bernadette informed staff that she had been using crack cocaine. The records also suggest that there was no contact between the outreach staff and the social care worker to provide a coordinated approach to Bernadette's care needs.

In July 2022, ASC received a report from the 'homeless café' that Bernadette had come into their premises with broken ribs. Bernadette was spoken to by phone, stating that the injuries were sustained as a result of domestic abuse by her partner. The ASC records show that the social care worker had an appropriate discussion with Bernadette regarding accessing support services that could be offered by the commissioned domestic abuse support provider, The social care worker took Bernadette to hospital and ensured that she followed up on the case the next day. There was no risk assessment completed, no safeguarding concern raised, or consideration of the need to override Bernadette's consent based upon the assessment of risk.

Whilst social care workers will have in house training and have access to the TSAB training courses, they have not had the legal training that social workers would have as part of their university studies. They do not have specific domestic abuse risk assessment training although this is currently being commissioned based upon the initial learning from Bernadette's case.

The Acute Trust record Bernadette attending A&E department in July 2022 with injuries to her chest/abdomen that were received as a result of her being assaulted by her partner about 6 days previously. Prior to any treatment, Bernadette had left

A&E without any treatment. Bernadette was considered to have mental capacity with respect to decisions about treatment.

At 1000 the following day, ASC receive a call from Bernadette advising that she was discharged from A&E the previous day without treatment, with painkillers, she also complained that they wouldn't call a taxi for her. Bernadette was advised to contact her GP.

The GP practice record a telephone consultation with Bernadette at 1155 the same day, she was asking for sickness medication with respect to rib injuries, again giving a history involving of falling down stairs. Bernadette was advised to go to A&E.

At 1200 the same day, Bernadette again contacted ASC, stating that the GP had advised her to go to A&E but that she felt too weak to go. Bernadette had called for an ambulance but that would be at least another hour and a half before attending. ASC staff agreed to take her to A&E.

The Acute Trust record Bernadette being treated in A&E at 1334 that day. She was found to have two undisplaced fractures to her ribs, she gave a history of domestic assault. She was provided with codeine tablets for pain relief and had consented to seeing the Trust Independent Domestic Violence Advisor, IDVA, who provided her with general safety advice. Bernadette did not consent to the A&E staff contacting the police with respect to her being a victim of domestic assault.

Later the same day, the A&E department, submitted a MARAC referral with respect to concerns about Bernadette following her attendance at their department that day, her injuries and the disclosure of domestic abuse. This referral was reviewed by Police 5 days later and determined by the reviewing officer to not meet the threshold for MARAC. The reasons recorded for this decision were:

- The couple were considered at MARAC in 2019 and have not been referred since then.
- There had been no further domestic abuse allegations reported to the police since 2019.
- If the victim accesses support from a domestic abuse support service, then they will look at all of the safeguarding measures indicated on the referral.
- Although there are factors which are indicative of a risk of harm, this is not imminent in the current circumstances. However, if circumstances change, another referral should be submitted.

This decision was supported by a manager in the domestic abuse team and includes the fact that the reported assault was a common assault, (minor/no injury) that Bernadette did not want to engage with the police but would accept domestic abuse support and that Bernadette's case had been considered at MARAC in 2018 and was no longer active, as the rationale for this. The Independent reviewer also notes that the supervising manager did not believe that the risk to the victim was imminent because the victim was staying with family and that the suspect was not aware of her location. This was based upon the information within the referral form but previous MARAC minutes and information held by other agencies may have allowed a

different conclusion to have been reached. The police records also refer to a lack of information within the referral and that this was a common theme with health-based referrals, there is also a reference to the independent MARAC chair seeking to address this. There is however, no evidence of any professional curiosity which may have led practitioners to draw a different conclusion.

In July 2022, ASC contacted Bernadette by telephone, she informed them that she had been prescribed codeine and had a scan. The domestic abuse issues were discussed and Bernadette was advised to make contact with the local domestic abuse support service. Bernadette declined, stating that she would only speak to ASC and that she was safe at home with her brother. A referral was made to a community-based project providing food parcels to vulnerable individuals.

Bernadette had a telephone appointment with her GP in August 2022, Bernadette reported having abscess/cellulitis on her back and abdomen and urinary incontinence. Bernadette stated that she was unable to provide a photograph as she didn't have a mobile phone to do this. The GP prescribed antibiotics and requested a urine sample. A face-to-face consultation was arranged for the next day but Bernadette cancelled this and failed to provide a urine sample. There is no record of safeguarding concerns being raised.

In September 2022, Bernadette again had a telephone consultation with her GP, she reported having burns on her leg that were weeping. The GP advised her to attend A&E for treatment. The GP entry states that there is no record of A&E attendance. Again, there was no record of any safeguarding concerns being raised.

In October 2022 the Acute Trust records state that Bernadette failed to attend an appointment at their infectious diseases department.

At 0528 on the day before she died, the Ambulance Service, responded to a call from Bernadette's partner initially reporting that Bernadette appeared to be suffering from low blood sugar, (hypoglycemia). This was initially graded as a category 3 call, then regraded as a category 2 call but there were no available crews to attend and, following a second call describing Bernadette as being unconscious, it was again upgraded and a priority 1 crew were subsequently dispatched, arriving on scene at 0612. On this occasion, Bernadette was treated at scene and was clinically well when the ambulance crew departed the scene. The practitioners who treated her on this first call did not report any concerns about domestic abuse nor is there any indication on the clinical assessment of any visible injuries being present.

At 1240 the same day, the ambulance service received another call from Bernadette's partner reporting that Bernadette was conscious but had a head injury, the caller reported Bernadette falling down stairs and being drowsy. It was also noted in the ambulance service records that Bernadette's partner was losing his temper with Bernadette and saying 'nasty things' to her. This was again graded as a priority 2 call and an ambulance dispatched. It arrived at scene 48 minutes after the initial emergency call was received.

The ambulance crew displayed professional curiosity, exploring the initial account given, noting a significant level of visible bruising and obtaining a lot of information

from Bernadette. There is evidence of sound information sharing between the ambulance crew and hospital staff, identifying the level of risk to Bernadette. Bernadette did not consent to information being shared with the police, the police were not informed about the allegation of assault or involved in any safety planning with respect to Bernadette's ongoing support. Whilst the issue of consent remains a challenge for practitioners, this was a missed opportunity.

The A&E staff record that Bernadette had been conveyed to their department following her experiencing low blood sugar levels, (hypoglycemic symptoms). This had been reversed through treatment by the ambulance crew whilst on route to hospital. Bernadette informed the A&E staff that she had experienced withdrawal symptoms two days previously and had been using cocaine. She self-reported 'a lot of social issues' but was reluctant to give any further details. Bernadette was observed to have bruising and swelling to her body and to her head but refused to remain in the A&E department to undergo a medical assessment and diagnostic investigation. Paramedics shared with the A&E staff that Bernadette's partner's sister had informed them that her brother had abused Bernadette. Despite attempts by the staff to engage with Bernadette, she refused any assistance, denied any abuse was taking place and left the department.

It is noted that discharge letters were sent to Bernadette's GP by the A&E department after each attendance there.

The Emergency Duty Team, EDT, received a referral with respect to Bernadette at 1839 on the evening of her attendance at A&E, this was initially received in the EDT email inbox. This inbox is not constantly monitored. The EDT report that the usual practice is that they would expect to receive a follow up call from the referrer to confirm receipt of the referral and to discuss issues of concern. In Bernadette's case, a telephone call was made by the ambulance service, with a message left asking for a call back. The EDT contacted the ambulance service by phone at 1943 that evening and was on hold for more than five minutes, there was no response so the call was terminated. The EDT risk assessment was low based on the fact that Bernadette was at hospital, a place of safety, and that the hospital had been made aware of the concerns by the ambulance crew. The usual practice would see EDT await any contact from the hospital if any action was required to support discharge planning. The social worker subsequently contacted the A&E department by phone at 2107 that evening and was informed that Bernadette was no longer there, when the social worker requested a contact number for Bernadette, they were informed that the hospital did not have one.

The EDT had no further involvement with Bernadette's case until contacted by the police following her death the following day.

The ambulance service received a final call from Bernadette's partner, on this occasion Bernadette was found to be not breathing and despite the efforts of the of the attending staff, she was not able to be resuscitated.

7. Findings and Analysis

7.1 Barriers to engagement.

The professionals who had contact with Bernadette had difficulties in engaging with her. Throughout the review period and indeed before May 2022, Bernadette had significant contact with services but on many occasions refused to provide information or provided inaccurate and misleading information to practitioners. Conversations relating to specific areas of her life, particularly with respect to family relationships, were always shut down by Bernadette, making it very challenging for those practitioners engaging with her to be professionally curious about such issues as domestic abuse. It is also noted that Bernadette declined support from services at times, such as her attendance at A&E, she would also decline to engage with the police when speaking to social care or health professionals about assaults and injuries that she had suffered.

Bernadette was the victim of sexual exploitation as a child. Adverse childhood experiences, ACEs, in this case trauma related to child sexual abuse, are recognised by researchers as significantly increasing the likelihood of leading to poor health outcomes in later adult life. This can include chronic diseases such as cancer, diabetes and heart disease, mental illness and health risk behaviours. (O'Neil et al, Adverse Childhood Experiences, 2021). In Bernadette's case, she was diabetic, she misused illicit drugs and formed at least two abusive relationships.

Bernadette had a history of contact with the police, both as a victim of crime and through her involvement in criminality, primarily theft and drug related activity. She is recorded as being the victim of crime on some thirty-three occasions, a number of these crime allegations are linked to domestic abuse, both with the partner who she was with during the period of time under review and a previous partner. Regular contact with the police, particularly in relation to her criminal activity, is likely to have created a negative perception of policing in her mind which may have influenced her willingness to report allegations of domestic abuse to Police. Bernadette had disclosed to some practitioners that she was using illicit drugs, specifically cocaine and thus actively engaging in criminal activity which may make her reluctant to engage with the Police.

Bernadette had been identified as a victim of domestic abuse by professionals prior to the period of time subject of this SAR. As well as evidence of physical assaults, there were also concerns raised about coercive and controlling behaviour which is a common issue in abusive relationships. As well as the fear of further physical harm, it may be that the coercive and controlling behaviour of her partner, may have influenced Bernadette's reluctance to disclose information to professionals, to engage with the police and on occasions, to provide misleading information to those practitioners seeking to provide support to her.

In Bernadette's case, she suffered from an addiction to illicit drugs, she had been on a methadone programme prior to the period under review, and remained so until her death in October 2022. She also disclosed to practitioners that she was using cocaine on a regular basis. There were also concerns about self-neglect, in particular her ability to manage her type one diabetes. Practitioners who came into

contact with Bernadette, considered her to have mental capacity and respected her decisions with respect to engaging with services.

Some Acute Trust staff linked self-neglect and diabetes, commenting that it was a common problem, staff also acknowledged that self-neglect wasn't always obvious and could be missed. Some staff were concerned that there weren't sufficient resources within A&E to manage self-neglect, although medical staff stated that they would generally admit patients if they felt that self-neglect was a significant issue. The duty under the Care Act 2014 and the option of making an adult safeguarding referral weren't identified.

Bernadette's engagement with services offered reflects a significant level of failing to attend appointments, this included her infectious disease and diabetes scheduled outpatient appointments as well as leaving A&E without being examined or receiving the appropriate treatment. Although Bernadette had a significant history with services, with concerns raised about self-neglect with respect to her diabetes, sexual exploitation, domestic abuse and on occasions, presenting with physical injuries, there is very limited evidence of professional curiosity to establish why she wasn't engaging with services or effective risk assessment/risk mitigation planning. This is perhaps reflected in July 2022 when the hospital Independent Domestic Violence Advisor, IDVA, attempted to contact Bernadette to complete a referral for outreach support, after three failed attempts to speak to Bernadette, a person known to be hard to engage with, the case was closed in line with Trust policy. As Bernadette was very difficult to engage with, particularly with respect to domestic abuse issues, the decision to utilise outreach support would appear to be good practice but to close the case after three failed telephone attempts to make contact, albeit in line with Trust policy, seems to almost contradict the need for outreach support.

The 'three strikes and you are out' approach was discussed at the workshop. Practitioners agreed that simply disengaging with adults who were hard to engage with wasn't appropriate and that more could and should have been done to engage with Bernadette. This wasn't helped by the fact that no single agency had sufficient information to understand the risks that Bernadette faced. Practitioners suggested that consideration should be given to a '3 strikes and you share' approach, particularly in cases where domestic abuse, compulsive behaviours or self-neglect are suspected.

Practitioners at the workshop raised the concern that information sharing could be difficult if the adult wasn't open to a service. The example was given that an adult being seen in the community may be given safety advice and see several outreach workers but if they are not open to services, the case worker cannot co-ordinate any information sharing.

The use of assertive outreach teams, investing time and resource to develop a 'relationship' with those individuals who do not wish to engage with services is recognised as good practice, (Preston-Shoot et al), particularly where self-neglect is an issue. In Bernadette's case, the substance user outreach team, met with Bernadette on six occasions between May and October 2022. They were able to build a level of engagement with her, providing support and advice around harm

minimization. It is also noted that the social care worker, SCW, had invested time in building a good relationship and a level of trust with Bernadette, who contacted the SCW when she needed specific support. The independent reviewer would suggest that the use of assertive outreach and the investment of time by the SCW, are examples of good practice.

The issue of consent to share safeguarding information with partner agencies is a challenging one for safeguarding professionals. Making Safeguarding Personal, MSP, is a person centred approach which means that adults are encouraged to make their own decisions and are provided with the appropriate support and information to empower them. This approach recognises that adults have a general right to independence, choice and self-determination, including control over information about themselves. Adults may choose not to consent to professionals sharing information about them with other agencies for a variety of reasons, if this is the case, their wishes should, in general, be respected. However, there are some circumstances where practitioners can reasonably override such a decision, including:

- The adult lacks capacity to make such a decision, practitioners should consider both decisional and executive capacity[3] when assessing this issue.
- Emergency or life-threatening situations may warrant the sharing of relevant information with the emergency services.
- Other people are or may be at risk, including children.
- Sharing the information could prevent a serious crime.
- A serious crime has been committed.
- The risk is unreasonably high and a duty of care needs to be considered.
- There is a court order or other legal authority for taking action without consent.

In such circumstances, practitioners should carefully record their decision-making process and where practicable, seek advice from managers and/or their legal services as appropriate. (SCIE guidance, Consent in relation to safeguarding, published in 2021).[4]

In Bernadette's case, in July and October 2022, she presented to professionals with visible injuries, those injuries in July included two fractured ribs. Following Bernadette's attendance at the A&E department in July 2022, staff completed a MARAC referral but did not inform Police of the allegation of serious domestic assault because Bernadette did not consent to them sharing information with the police. When she left A&E, Bernadette returned to her home address, an address she shared with the perpetrator of abuse, with no safety plan in place. There is no record of the decision-making process; whether any consideration was given to the reasons why Bernadette's consent may have been overridden in the circumstances. A risk assessment may have considered sharing information with the Police,

[3] Decisional capacity relates to understanding the decision in the abstract whilst executive capacity refers to the ability to put the decision into practice at the appropriate time.
[4] Social Care Institute for Excellence, SCIE, produce a range of products to support safeguarding adults under the care Act 2014. The document is at SCIE: Information Sharing

(overriding Bernadette's consent), proportionate as a serious crime had been committed, sharing information could prevent a further serious crime being committed, the risk is unreasonably high and a duty of care needs to be considered and this could be seen as an emergency situation that would warrant the sharing of information.

The circumstances are similar in October 2022 where sharing information with the police could and perhaps should have been considered. There is no record of the decision-making process other than the fact that Bernadette did not consent to information being shared with the police, there is no record of any consideration to overriding Bernadette's lack of consent.

The incidents in July and October 2022 were missed opportunities that saw Bernadette return to an environment in which she was clearly at risk of serious harm through domestic abuse and potentially self-neglect with respect to her management of her diabetes.

The issue of overriding an adult's lack of consent was a theme discussed at the workshop. Practitioners identified that it can be difficult to override an adult's lack of consent and to share information with other agencies. In Bernadette's case, the view was expressed that had information been shared against her wishes, there may have been consequences for her from the perpetrator of abuse. Any action would have to be carefully thought through to minimise any risk to Bernadette and to ensure her safety. There was also a risk of her disengaging further with services if trust is broken. It was widely recognised that it was good practice to seek an adult's consent to share information and to inform that adult if a decision to override consent was made.

Workshop attendees seemed less sure of the reasons why consent might be overridden or how confident that front line practitioners might be in making such decisions. When asked about advice and guidance, it was suggested that supervisors or legal departments may be consulted but attendees were unable to identify guidance documents that might support frontline decision making. The Independent reviewer has examined the TSAB Inter-Agency Safeguarding Adults Procedures document[5] and the TSAB Decision Support Guidance document[6] and whilst they rightly refer to seeking consent from the adult and sharing information where appropriate, there is no guidance as to when consent should be overridden. The TSAB information sharing agreement document[7] provides some guidance in terms of sharing information without consent, primarily within the context of processing data in line with GDPR. The Social Care Institute for Excellence, SCIE, guidance document provides an easier read for practitioners.

7.2 Substance Misuse

A person can be referred into a methadone programme either by their GP within a community setting or during an inpatient episode by the agencies relevant service. In

[5] Inter-Agency Safeguarding Adults Procedure
[6] Decision Support Guidance
[7] Information Sharing Agreement

the Acute Trust the relevant service is the Alcohol Care Team, ACT. Practitioners prescribing an individual's methadone programme would be guided by the drug misuse and dependence: UK guidelines on clinical management (2017), Department of Health.

When Bernadette transferred to the Acute Trust's care, she informed staff that she was an ex intravenous drug user and that she was on a methadone programme, the methadone being prescribed by a specialist clinical prescribing service. This prescribing service work to the NICE guidance which recommends the patient undertakes an echo Cardiogram, ECG, when prescribed 100 mls of methadone to ensure safe prescribing. Bernadette missed three consecutive appointments for the ECG in May 2022 before attending the fourth appointment offered in June 2022 although it is noted that this followed a request for an increase in the prescription.

The Department of Health 2017 guidance states that a person on a methadone programme could be subject to testing to confirm compliance and/or monitor illicit drug use as part of their programme, this would be seen as good practice. Bernadette had a drug screen test in February 2022 which tested positive for cocaine and methadone. Records show that Bernadette admitted using illicit drugs at other prescribing appointments. There is no record of any information being shared with Bernadette's GP or other services, or of any action being taken with respect to Bernadette's use of illicit drugs.

Front line staff at a recent focus group, not specific to Bernadette's case, identified that they were confident that they knew when and how to refer patients into the ACT inpatient service where appropriate and that they did this on a regular basis, this varied from almost daily to a few times a week. The focus group did highlight the fact that a very high rate of substance misusers would decline to consent to an ACT referral. They also commented favourably on the new electronic Web ICE system which made the referral process easier to complete.

At the workshop practitioners were asked to consider the issue of substance misusers declining to consent to a referral to drug and alcohol services. They reported that they are very limited by law in what they can do when a person refuses to consent to drug and alcohol services treatment. The practitioner would need to look at the balance of risk and how you may be able to encourage engagement, in appropriate circumstances, assertive outreach options may be successful. If there were sufficient safeguarding concerns, then section 42 of the Care Act 2014 provides a formal statutory framework for agencies to work together and a duty to co-operate.

The workshop also received a presentation from the Teesside substance misuse and death prevention coordinator on the Drug and Alcohol Related Deaths, DARD, process, the independent reviewer had also met separately with the coordinator to discuss the process. It was clear that the six weekly meetings were well supported by the relevant agencies, sharing information and reviewing those deaths where drugs or alcohol were suspected of being a significant issue. The purpose of the process was to identify common themes and potential learning and would appear to be good practice. Whilst it was clearly an evolving process, and the passion and

drive of the coordinator were noted, consideration may need to be given in terms of enhancing the knowledge of the process system wide as most practitioners were not sighted on it. Whilst the DARD meetings created actions, there were no minutes for meetings and there was a limited framework for capturing and acting on learning identified during the process.

7.3 Legal Literacy and Professional Curiosity

Professional curiosity is widely recognised as helping practitioners avoid making assumptions about people's lifestyle, the decisions they make and what is important to them. In Bernadette's case, practitioners made assumptions about Bernadette's decision making without recording how addiction, domestic abuse including coercive behaviour and possibly mental health, influenced those 'choices', if they were indeed considered.

During the period under review, and before, Bernadette failed to attend appointments, was reluctant to provide information, suffered poorly explained injuries, self-neglected her diabetes, disclosed domestic abuse and would not consent to information being shared with the police. She also disclosed the fact that she was using illicit drugs. Greater use of professional curiosity may have helped professionals to better understand the impact of trauma, the issues encountered by Bernadette, the pressure she was under and perhaps most importantly, the risks she faced.

Bernadette was assumed by practitioners to have mental capacity in respect of decisions she made'. If we focus on a person's decisional capacity, we will not understand the person's ability to carry out their decision, (executive capacity), and potentially what prevents them from doing this. We will not understand why the person continues to neglect themselves, engages in risky behaviour or returns to an abusive relationship, it will also limit a practitioner's confidence in using professional curiosity and respectful challenge.

Practitioners can be fearful of limiting a person's 'right to make unwise choices' as a common misinterpretation of the Mental Capacity Act legislation. The idea that adults have 'a right to make an unwise choice' has gained currency nationally in practitioner thinking and some training. We should remember that the actual Mental Capacity Act legislation states that 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision' (Mental Capacity Act 2005). It does not afford such a right to a capacitated person. S11, Care Act 2014 sets out the duty of the local authority to assess the care and support needs of an adult if they believe that the adult is experiencing, or at risk of, abuse or neglect, this would include self-neglect.

It is also important to consider the impact that compulsive behaviours, including substance misuse, can have on a person's decision-making ability. Professor Preston-Shoot et al, in their paper 'effective work with adults who self-neglect', (2020), describe the need to include both decisional capacity and executive capacity when considering a person's mental capacity. Specifically, this means that when working with self-neglect, practitioners should not only consider the person's ability

to understand and reason through the elements of a decision in the abstract but they also need to consider the person's ability to realise when a decision needs to be put into practice and to execute it at the appropriate moment. Furthermore, when considering executive capacity, Preston-Shoot et al emphasise the fact that addiction may impair a person's executive capacity, particularly their ability to weigh and use the information. This is reinforced in case law, the judge in NHS Trust v L Ors, (2012), EWHC, found in his judgement, that compulsive behaviours may impair someone's executive capacity. Compulsive behaviours could include both substance addiction and self-neglect.

Bernadette had misused illicit drugs for a significant period of time, during the period under review, Bernadette had disclosed to the outreach team that she was using 'crack cocaine', a form of cocaine that is recognised as being highly addictive. She was in an abusive relationship with a male partner who was not only physically abusing her but believed to be displaying coercive and controlling behaviour towards her as well. There were also concerns raised about Bernadette self-neglecting, particularly in respect of her management of diabetes issues.

Practitioners assumed that she had capacity to make specific decisions with respect to not engaging with services, but practitioners could have considered the impact of compulsive behaviour, primarily drug addiction, the fear generated through coercive and controlling behaviour and the self-neglect issues when assessing Bernadette's mental capacity. She made unwise decisions in missing health related appointments, not waiting for treatment in A&E, returning to an abusive relationship with the clear risk of physical assault, using illicit drugs and not engaging with some services, including the police. Professional curiosity and a more robust application of the Mental Capacity Act may have led practitioners to draw a different conclusion.

The workshop had a robust discussion around mental capacity assessments, professional curiosity and the impact of compulsive behaviours on the executive decision function. Attendees felt that front line staff were much more aware of mental capacity in terms of decisional capacity, but recognised that the issue of executive capacity was not so well understood. This was made all the more challenging when there was a need to consider the impact of compulsive behaviours, such as substance misuse, and the influence of domestic abuse, (fear of abuse and controlling/coercive behaviour), on mental capacity, particularly executive capacity. The issue of evidence being required that the adult lacked executive capacity was also raised, that the adult would need to demonstrate that they could not put decisions into practice when appropriate. In Bernadette's case, the fact that she was abusing illicit drugs, not managing her diabetes, presenting with injuries and returning to an abusive relationship as well as not engaging with health services and was known to mislead services may have provided sufficient reason to question her executive capacity.

Practitioners at the workshop reported that front line professionals understood the need for professional curiosity, this had been supported by learning from the May

2023 learning brief, 'Professional challenge and Curiosity reviewed'[8]. It was highlighted that some staff have longer periods of engagement with adults and would therefore have greater opportunity to use professional curiosity and where appropriate, mental capacity assessments than others such as the Police and Ambulance Service. It was noted that in Bernadette's case, the second ambulance crew who dealt with her in October 2022 had identified injuries on her body and had used professional curiosity to secure relevant information from Bernadette that they then shared with A&E professionals.

7.4 Multi-Agency Working/Safeguarding

It is clear that there were examples of good practice in terms of some of the engagement that agencies had with Bernadette, this includes the investment of time to build relationships with her by ASC and the substance user outreach team. That said, although there is no doubt that practitioners sought to help Bernadette, agencies worked in silos with limited cross agency information sharing, identification and management of risk, coordination or leadership.

Bernadette had care and support needs and was certainly at risk of abuse or neglect, (self-neglect), abuse in this case would include domestic abuse, yet there were no safeguarding referrals made by practitioners between her first referral into ASC in 2019 and the referral made by the Acute Trust in October 2022. The use of a section 42 enquiry, (Care Act), could have provided a framework for cross agency information sharing, risk assessment and shared responsibility. This may have led to a more effective cross agency response to Bernadette's care and support needs.

The use of the s42 enquiry has the advantage of placing a statutory duty to cooperate on agencies and had a holistic view of the information held by different agencies been taken, the threshold for a s42 enquiry may have been deemed to have been met. The statutory guidance, DHSC chapter 14.17 states 'it should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend upon the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support'.

Determining whether self-neglect meets the criteria for a s42 enquiry is a subjective decision but where there is evidence of compulsive behaviours, one needs to consider how that will impact on the person's ability to protect themselves by controlling their behaviour. In Bernadette's case, she used 'crack cocaine', a highly addictive illicit drug and was in an abusive and potentially coercive/controlling relationship. This may have been considered to impact on her ability to protect herself from harm through either abuse or neglect and thus meet the threshold for the s42 enquiry.

[8] Professional Challenge and Curiosity Learning Briefing

There were a number of occasions between 2019 and October 2022 where Bernadette came into contact with professionals who had concerns about Bernadette's drug addiction, poor management of diabetes, inconsistent engagement with services and vulnerability to domestic abuse but there were no safeguarding referrals made during that period until October 2022. The single agency reports do not provide any rationale for this, which may suggest that risk assessments weren't completed, cross agency information sharing wasn't effective and practitioners didn't identify that Bernadette was an adult with care and support needs, was at risk of abuse/neglect, including self-neglect, and that safeguarding measures could and perhaps should have been considered.

This was discussed with attendees at the workshop who reported that a considerable amount of work had been invested in the Tees area in relation to self-neglect following learning from previous SARs. There was a good level of confidence that front line practitioners, particularly across Health and ASC, would identify self-neglect, indeed it was recognised that it was the ambulance services' highest referral category and that A&E tended to over report self-neglect concerns. It was noted that in Bernadette's case, professionals weren't in possession of enough information to identify the significant level of risk she faced. The Acute Trust weren't sighted on the hypo glycaemia issues, A&E wouldn't have seen the records relating to missed diabetes appointments, other professionals wouldn't have been aware of the controlling/coercive domestic abuse. At the workshop practitioners agreed that understanding the whole 'picture' would have led to safeguarding referrals being made in Bernadette's case. This was clearly a missed opportunity.

7.5 Domestic Abuse

Bernadette had a significant history of domestic abuse, not only with her existing partner but with a previous partner as well, whilst not all of the allegations relate to domestic abuse, it is noted that the police records suggest that Bernadette was a crime victim on thirty-three occasions during her lifetime, and this figure would only reflect those occasions where the police were notified of such incidents.

Bernadette was referred to the MARAC in 2018 and discussed further in July 2019, (at the time of her partner's release from prison). The cross-agency attendance at these meetings was good, the minutes suggest that there was a good level of information sharing and the record clearly identifies the risks in Bernadette's case, this includes the wider risks around drug abuse, self-neglect and poor engagement with services. It is also notable that ASC report in the meeting that Bernadette did not openly disclose information to practitioners, this might be considered to reflect a greater need for professional curiosity when dealing with Bernadette looking forward. The referral to MARAC, the good attendance and effective information sharing would be seen as good practice.

The Probation Service records show that Bernadette's partner was subject to licence conditions on his release from prison and that reasonable steps were taken to ensure compliance. Prisoners being released as homeless is a common issue and, in this case, when it was clear that Bernadette's partner was not staying at an approved address, appropriate action was taken; he was warned about breaching

his licence conditions and emergency accommodation was arranged. The records highlight the fact that further none compliance resulted in a prison recall which is good practice.

The minutes of the 2018 meeting rightly assess the risk of domestic abuse as mitigated in the short term as the perpetrator was in prison. However, they identify the wider risks to Bernadette through self-neglect through her diabetes management, drug abuse and lack of engagement with services, yet the minutes don't appear to identify any agreed actions with respect to these issues. The 2019 minutes record a number of actions, including that the Police and ASC conduct a joint visit to Bernadette, there is no record as to whether this action was carried out, certainly there was no safeguarding referral made as a result.

In May 2022, Bernadette had a face-to-face consultation with her GP, complaining of pain to her right side and her ribs, she had also been vomiting. She informed the GP that she had attended A&E the previous evening but had left prior to any treatment. Laura explained that the injuries were caused by falling down stairs. The GP advised Bernadette to go to A&E and prescribed Prochlorperazine tablets but despite Bernadette having a history of domestic abuse, the GP did not identify any additional risk to Bernadette and it would appear that no referral was considered.

In July 2022, Bernadette disclosed that she had been assaulted by an 'ex-partner' and was taken to A&E by the SCW from ASC, unfortunately she left prior to receiving treatment. The following day, Bernadette contacted ASC, stating that she had been discharged from A&E with painkillers but was in pain. She was advised to contact her GP which she did. It is noted that in a telephone call to the GP, Bernadette again suggested her injuries had been as a result of falling down the stairs and was advised to go to A&E.

ASC conveyed Bernadette to A&E where it was determined she had two fractured ribs and gave a history of the injuries being caused by domestic abuse. She was also seen by the hospital IDVA, (Independent Domestic Violence Advisor), and provided with what has been described as general safety advice. Bernadette was then discharged back to the address she shared with the perpetrator of physical and coercive domestic abuse. It is clear that the A&E staff used a degree of professional curiosity in their dealings with Bernadette, obtaining information from Bernadette who disclosed the abuse albeit blaming an ex-partner. Bernadette would not consent to the A&E staff contacting the police with respect to this serious assault, there is no recorded evidence of any consideration to overriding this lack of consent in line with guidance or any risk assessment/safety planning. The A&E staff subsequently submitted a MARAC referral form which is noted as good practice.

Although the MARAC referral form was submitted to Police, it wasn't reviewed by the Police until 5 days later, the reasons for the delay aren't recorded although two of these days were a weekend. The Police reviewing officer determined that the referral didn't meet the threshold for MARAC, the reasons given being:

- The couple were considered at MARAC in 2019 and have not been referred since.

- There have been no further domestic abuse allegations reported to the police since 2019.
- If the victim accesses support from a domestic abuse support service, then they will look at the safeguarding measures indicated on the referral form.
- Although there are factors which indicate harm, this is not imminent in the current circumstances, however, if circumstances change, another referral should be submitted.

It is difficult not to conclude that the MARAC referral in July 2022 was a significant missed opportunity for a cross agency response to effectively intervene to safeguard Bernadette. It is clear from various agency's contact with Bernadette that she wouldn't consent to practitioners sharing information with the police, that her engagement with professionals was inconsistent and she also denied being the victim of abuse on occasions, particularly where there was a lack of professional curiosity on the part of practitioners involved. It is therefore unsurprising that there have not been further domestic abuse allegations made to the police or further MARAC referrals made. Had the reviewing officer used an element of professional curiosity, there was information available, both from partner agencies and through the previous MARAC minutes, that may have heightened concerns.

There is a history of domestic abuse, including physical injuries, on this occasion the fracturing of two ribs, a serious assault, committed by a perpetrator that Bernadette was living with and had returned to in July 2022. The MARAC referral refers to injuries being sustained but doesn't record details of what they were. To enable an effective risk assessment, and to understand the seriousness of the assault, enquiries should have been made to establish the extent of the injuries, this would have identified that this was a serious assault and enabled a more effective risk assessment to have been conducted.

Bernadette had a long, documented history of not engaging with services, of being a victim of domestic abuse and living with the perpetrator of this abuse. This information was available to the MARAC review officer through the previous MARAC minutes. A decision to rely on Bernadette to engage with domestic abuse support services and for them to put adequate safeguarding measures in place for Bernadette as a single agency, seems a less than robust response in these circumstances. The July 2022 MARAC referral document refers to Bernadette consenting to a referral to domestic abuse support services, there is no record of which agency would make the referral, there is no evidence of a referral being made.

It is good practice that the decision making of practitioners is reviewed by supervisors but again this would appear to be a further missed opportunity, when a manager provides their supervisory review. The manager describes this assault as a common assault, (minor or no injury) which is clearly wrong. The MARAC referral form makes references to injuries sustained albeit, there is no detail of the injuries described on the form. The hospital records clearly describe two fractured ribs which would amount to an offence of 'grievous bodily harm'. The Independent reviewer also notes that the supervising manager did not believe that the risk to the victim was imminent because the victim was staying with family and that the suspect was not

aware of her location. This was based upon the information within the referral form but previous MARAC minutes and information held by other agencies may have allowed a different conclusion to have been reached. It is likely that a degree of professional curiosity would have identified the significant and potentially imminent risk of harm to Bernadette and enabled a more co-ordinated and effective response.

The Police made reference to a MARAC pilot and changes to working practices/training for practitioners, this will include work to improve the standard of referrals made. It is noted that the MARAC meetings will also increase in frequency, enabling a prompter meeting and increasing capacity.

The ambulance service had contact with Bernadette twice on the day before she died. On the first occasion, there is no recorded evidence that would cause a concern with respect to domestic abuse. The second call resulted in the ambulance staff identifying significant bruising and using professional curiosity to obtain a lot of information relating to domestic abuse. There was then sound evidence of information sharing with the hospital staff, enabling a shared understanding of the risk to Bernadette. Despite the efforts of staff to counsel Bernadette, she refused further assistance and left the hospital. Although there is evidence of effective information sharing between health agencies, including discharge letters being sent to the GP, no information was passed to the police.

The Emergency Duty Team, EDT, received a safeguarding referral with respect to Bernadette at 1839 on the evening of the day before she died, this was initially received in the EDT email inbox. This inbox is not continuously monitored. The EDT report that they would usually expect to get a follow up call from the referrer, in line with working practice, but this didn't happen in this case. The EDT attempted to contact the ambulance service by phone at 1943 but were unable to get an answer. As Bernadette was believed to be in hospital, the risk assessment was low. The EDT subsequently contacted the hospital at 2107 the same day to be informed that Bernadette had already left. There were no risk assessments, safety planning or further referrals made.

The engagement with Bernadette at this time was a further opportunity missed to intervene positively to mitigate the risks she faced. The identification of bruising, the professional curiosity to seek more information and then sharing it with the hospital would be good practice. Unfortunately, there were then missed opportunities to share information with the police and make a MARAC referral based on available information. It is clear that practitioners struggled with the issue of overriding the need for a patient's consent in the appropriate circumstances, which is a common theme throughout Bernadette's care, a better understanding of when and why such consent could or should be overridden may provide practitioners the confidence to act decisively where legitimately required.

It is noted that focus group discussions, (not connected to this review), within the A&E department and a back of house ward, identified a varying level of confidence in being able to identify signs of domestic abuse and then being able to escalate concerns effectively. The staff also reported that there were varying degrees of skill

and competence in carrying out risk assessments, completing DASH assessments[9] and making MARAC referrals, this was in part due to some staff not having received the relevant training and, in some cases, staff simply not being experienced in dealing with such matters.

In terms of out of hours services, practitioners felt that guidance and support was significantly reduced in some areas compared to weekday working hours. Some services, Police, ambulance and A&E provided a reasonably consistent level of service out of hours, including at the weekend. Other services and support functions were reduced at the weekends or simply unavailable; the EDT provide an out of hours service for social care, dealing with immediate safeguarding issues but there was a lack of clarity amongst practitioners in terms of the referral process. The EDT have an email inbox but this is not constantly monitored, specifically when the duty social worker is 'out of office' dealing with a safeguarding referral. The designated telephone number can be diverted to the social worker's mobile phone so EDT expect referrers to back up an emailed referral with a phone call. The TSAB website only has a telephone number for the EDT with no email address. The workshop accepted that there needed to be clarity around the EDT referral process and what practitioners can expect from the EDT role.

Health practitioners at the workshop expressed a view that weekend working impacted on the cross-agency response through increased workloads within A&E, a lack of IDVA and safeguarding team support, (both work weekday office hours), and reduced access to and support from, external agencies.

[9] The DASH risk assessment is the accepted risk assessment tool used by the police and partner agencies when identifying and assessing the risk to victims of domestic abuse.

8. Conclusions and Questions for the Board

8.1 The terms of reference require the reviewer to consider:

- How well did relevant agencies work together to safeguard the adult?
- Were practitioners' system wide able to identify domestic abuse issues and respond appropriately to mitigate risk? Did weekend work impact on the cross-agency response?
- How well did professionals understand and apply relevant legislation and policy identified in this SAR?
- What strategies were adopted to manage the adult's reluctance to engage with services?
- What services were available and offered to the adult, and if not accessed, do we understand why?

8.2 It is important to reflect on the fact that Bernadette died prior to the latest learning briefs on Mental Capacity and professional curiosity, and the TSAB decision support guidance were published.

8.3 The professionals who had contact with Bernadette had difficulties in engaging with her. Bernadette had significant contact with services but on many occasions, she refused to provide information or provided inaccurate and misleading information to practitioners, particularly with respect to relationships and family members. Practitioners found it challenging to be professionally curious about issues Bernadette faced, particularly where concerns related to domestic abuse. Bernadette would also decline support or treatment, this included visits to A&E, she also regularly failed to attend appointments.

8.4 Bernadette had a history of involvement with the police, both as a victim of crime and through her involvement in criminality, regular contact with the police, particularly through her criminality, may have created a negative perception of policing in her mind and may have influenced her willingness to engage with Police with respect to domestic abuse issues. Bernadette had been identified as a victim of domestic abuse prior to the period of her life subject to this review. As well as the fear of further physical harm, it may have been the coercive and controlling behaviour of her partner that may have influenced Bernadette's reluctance to disclose information to professionals, to engage with the police and on occasions, to provide misleading information to those practitioners trying to provide support to her.

8.5 Bernadette's engagement with services offered reflects a significant level of failing to attend appointments as well as leaving A&E without being examined or receiving the appropriate treatment. Although Bernadette had a history with services that included concerns raised about self-neglect, primarily related to her diabetes, sexual exploitation, substance misuse, domestic abuse and on occasions, presenting with physical injuries, there is limited evidence of professional curiosity to establish why she wasn't engaging with services or of effective risk assessment/risk mitigation planning. This is reflected in the decision made in July 2022, following three failed attempts by the hospital IDVA to contact Bernadette, the case was closed in line with Trust policy, despite the fact that Bernadette was known to be very

difficult to engage with, particularly with respect to domestic abuse issues. Workshop practitioners suggested that a ‘three strikes and you share’ approach might be more appropriate.

8.6 The use of assertive outreach teams, investing time and resource to enhance engagement with those adults who do not readily engage with services is recognised as good practice, this is supported by relevant research. The Substance user outreach team met with Bernadette on six occasions within the period under review although different outreach workers attended the meetings on most occasions which makes relationship building more challenging. It is also clear that there was limited co-ordination or information sharing surrounding the use of the outreach team with Bernadette, the outreach team focusing on harm reduction advice but unless the adult is open to other services, the case worker cannot co-ordinate information sharing.

8.7 Question for the board- Do the board have clarity with respect to the outreach services available across the system and would a more integrated provision ensure that these services are effective and responsive to the themes raised in the review?

8.8 The assessment of mental capacity, particularly in cases where the adult is difficult to engage with and where compulsive behaviours were identified was a significant issue in this review. Bernadette was assumed by practitioners to have mental capacity in respect of decisions she made, these decisions, however unwise, were then respected. As discussed at 7.3 of this report, the focus was on Bernadette’s decisional capacity, there is no recorded consideration of her executive capacity. Yes, she may have been able to reason through elements of a decision in the abstract, but did she have the ability to execute that decision at the appropriate moment?

8.9 Bernadette had misused illicit drugs for a significant period of time, during the period under review, she had disclosed to the outreach worker that she was using the highly addictive ‘crack cocaine’. She was known to be in an abusive relationship with a male partner who was not only physically abusing her, but was also believed to be coercive and controlling. There were also concerns raised about self-neglect, particularly with respect to her diabetes management. She made unwise decisions in failing to attend appointments, not waiting for treatment in A&E, her engagement with services was poor and wouldn’t consent to information being shared, particularly with the police. Greater use of professional curiosity and a more robust mental capacity assessment that considered the impact of compulsive behaviour and wider influences, may have led practitioners to draw a different conclusion about her executive capacity.

8.10 The workshop attendees discussed mental capacity assessments, the use of professional curiosity and the impact of compulsive behaviours on the executive decision function. Attendees believed that front line staff were much more aware of mental capacity in terms of decisional capacity, but recognised that the issue of executive capacity was not so well understood. This was all the more challenging for staff when there was a need to consider the impact of compulsive behaviours such

as substance misuse and the influence of domestic abuse on mental capacity, particularly executive capacity. In Bernadette's case, it was accepted that there were sufficient grounds to have questioned her ability to put decisions into practice at the appropriate moment.

8.11 Question for the board- What measures can the board take to support practitioners in working with executive capacity? Should partners commission additional training and guidance for front line staff on this issue?

8.12 It is clear that there were examples of good practice in terms of some of the engagement that services had with Bernadette, this includes the investment of time to build relationships with her by ASC and the outreach team. That said, although practitioners sought to help Bernadette, agencies worked in silos with limited cross agency information sharing, identification and management of risk, co-ordination or leadership.

8.13 Bernadette had care and support needs and was certainly at risk of abuse and/or neglect, yet there were no safeguarding referrals made by practitioners between her first referral into ASC in 2019 and the Acute Trust's referral in October 2022. The single agency reports do not provide any rationale for this which may suggest that risk assessments weren't completed, cross agency information sharing wasn't effective and that practitioners didn't identify the need to make a safeguarding referral in Bernadette's case. This was certainly a missed opportunity.

8.14 The workshop attendees reported that there was a good level of confidence that front line practitioners would identify self-neglect, particularly those across Health and ASC. It was noted that in Bernadette's case, no single agency was in possession of enough information to identify the significant level of risk that she faced. It was agreed that understanding the holistic picture would have led to safeguarding referrals being made.

8.15 The use of the section 42 enquiry places a duty of the relevant agencies to co-operate and would ensure that information was effectively shared, a lead agency would likely be identified and a more co-ordinated response to Bernadette's needs put in place. It is also worthy of note that the section 42 framework would also enable the section 68 duty to appoint an independent advocate, if deemed appropriate, that may have assisted Bernadette to engage more effectively with safeguarding decision making.

8.16 Question for the board- Is the board confident that practitioners understand how to apply the section 42 criteria in cases involving self-neglect, substance misuse and domestic abuse? What measures could the board take to improve the consistency and quality of section 42 referrals system wide?

8.17 The DARD process was identified as potential good practice in terms of seeking to identify themes and learning from drug and alcohol related deaths. The six weekly meetings are well supported by the relevant agencies who appear to share information to support assessment and decision making. Whilst it was recognised that this was an evolving process, it was evident that the workshop attendees had

limited or no knowledge of the process and that there was no clear framework to capture and share learning system wide.

8.18 Question for the board- Is the board satisfied that practitioners are sighted on the DARD process and that there is an appropriate framework in place to capture and disseminate learning identified within it?

8.19 Bernadette had a significant, documented history of domestic abuse, had been referred to MARAC in 2018 and then further discussed at a meeting in 2019. The MARAC meetings in 2018 and 2019 were well attended and, with good information sharing, the risks that Bernadette faced were identified.

8.20 In May 2022, the GP had a face-to-face meeting with Bernadette who was complaining of pain to her right side and to her ribs, explaining that the injuries were caused by falling down the stairs. Despite a history of domestic abuse, there is no risk identified or referral made.

8.21 In July 2022 Bernadette spoke to her GP by phone, complaining of injuries to her ribs, again suggesting that they had been caused by a fall downstairs. Bernadette was subsequently taken to A&E by her social care worker where she disclosed that the injuries were due to domestic abuse. Although the A&E staff used professional curiosity to obtain the disclosure of domestic abuse, Bernadette would not give consent to them contacting the police regarding this serious assault, (fractured ribs). There is no recorded evidence of any consideration to overriding the lack of consent or any form of risk management/safety planning on discharge other than some general safety advice from the hospital Independent Domestic Violence Advisor, IDVA. It is noted that the hospital staff subsequently submit a MARAC referral which in its own right, would be recognised as good practice.

8.22 The issue of consent to share information with other safeguarding agencies was a significant barrier to identifying and mitigating the risks Bernadette faced. This was a theme discussed at the workshop with practitioners identifying that it can be difficult to override an adult's lack of consent, that there may be consequences for Bernadette from the perpetrator of abuse, that good practice to seek the adult's consent to share information and that sharing without consent would break the level trust established.

8.23 Attendees seemed less sure of the reasons why consent might be overridden or how confident that front line practitioners might be in making such decisions. When asked about advice and guidance, it was suggested that supervisors or legal departments may be consulted but attendees were unable to identify guidance documents that might support front line decision making. The independent reviewer has examined the TSAB Inter-Agency Safeguarding Adults Procedures and the TSAB Decision Support Guidance document, whilst they rightly refer to seeking consent from the adult, and sharing information where appropriate, there is no guidance as to when consent should be overridden. The TSAB information sharing agreement document provides some guidance in terms of sharing information without consent but primarily from the context of processing data in line with GDPR.

The Social Care Institute for Excellence, SCIE, guidance document provides a more effective and easier read for practitioners.

8.24 Although the MARAC referral was submitted in July 2022, it wasn't reviewed by the police for five days. The police reviewing officer determined that the referral did not meet the threshold for MARAC, the reasons being covered at 7.5 within this report. The decision is then reviewed by a manager who supports the original decision. It is good practice for supervisors to be reviewing such decisions but unfortunately the decision making is based on incorrect information with no evidence of any professional curiosity. The police had access to Bernadette's significant domestic abuse history and the wider concerns through the previous MARAC meeting minutes. Partner agencies also held significant information that would have supported a more effective risk assessment to have been completed and to enable a risk mitigation plan to have been implemented. This was a significant missed opportunity to have identified and intervened in, the risk Bernadette faced.

8.25 The review has also considered the impact of weekend working on the response to Bernadette's safeguarding concern raised in October 2022. The Emergency Duty Team, EDT, received a safeguarding referral at 1839 on the day before she died, this was initially received in the EDT email inbox but this is not continuously monitored. The EDT report that they would expect to get a follow up phone call from the referrer, in line with working practice but this didn't happen in Bernadette's case. The EDT staff were unable to make contact with the ambulance service by phone but believing that Bernadette was still in hospital, they assessed the risk as low. By the time they discussed the referral with the hospital, Bernadette had already left, there were no risk assessments, safety planning or further referrals made.

8.26 The workshop attendees felt that some agencies, the Police, ambulance service and A&E provide a reasonably consistent level of service out of hours, including at the weekend, whilst other services were reduced at the weekends or simply unavailable. The EDT provide an out of hours safeguarding service but there was a lack of clarity amongst practitioners in relation to the referral process. Health colleagues identified that as well as increased workloads for A&E at the weekend, many specialist services weren't available, the lack of an IDVA or safeguarding support being key examples.

8.27 Question for the board- Is the board assured that front line practitioners have the ability and confidence to identify domestic abuse issues and to make the appropriate referrals?

8.28 Question for the board- Is the board satisfied that the TSAB guidance documents are suitably robust with respect to when and how to override an adult's consent when practitioners are dealing with high-risk safeguarding issues?

8.29 Question for the board- Is the board confident that the MARAC process is suitably robust, that referrals are of a suitable quality in terms of information

provided and that decision makers use professional curiosity to ensure those at risk are appropriately safeguarded?

8.30 Question for the board- There is an identified gap in the provision of services at weekends with respect to responding to adults at risk of abuse, how can the board address this?

9. Appendices

Appendix 1 – Questions for the Board (Summary)

Question No.	Issue	
1.	Barriers to engagement.	Do the board have clarity with respect to the outreach services available across the system and would a more integrated provision ensure that these services are effective and responsive to the themes raised in the review?
2.	Executive capacity.	What measures can the board take to support practitioners in working with executive capacity? Should partners commission additional training and guidance for front line staff on this issue?
3.	Section 42 Care Act 2014.	Is the board confident that practitioners understand how to apply the section 42 criteria in cases involving self-neglect, substance misuse and domestic abuse? What measures could the board take to improve the consistency and quality of section 42 referrals system wide?
4.	DARD process.	Is the board satisfied that practitioners are sighted on the DARD process and that there is an appropriate framework in place to capture and disseminate learning identified within it?
5.	Domestic abuse.	Is the board assured that front line practitioners have the ability and confidence to identify domestic abuse issues and to make the appropriate referrals?
6.	Domestic abuse.	Is the board satisfied that the TSAB guidance documents are suitably robust with respect to when and how to override an adult's consent when practitioners are dealing with high-risk safeguarding issues?
7.	MARAC process.	Is the board confident that the MARAC process is suitably robust, that referrals are of a suitable quality in terms of information provided and that decision makers use professional curiosity to ensure those at risk are appropriately safeguarded?
8.	Weekend working.	There is an identified gap in the provision of services at weekends with respect to responding to adults at risk of abuse, how can the board address this?

Appendix 2 - Project Plan Dates

1.	Review of initial chronology/material by independent chair.	26/04/2023
2.	Initial planning meeting.	27/04/2023
3.	Scoping meeting, (existing SAR Sub-Group date), TOR agreed and individual agency reports requested. (40 minutes required).	14/06/2023
4.	Agencies to submit individual agency reports, (6 weeks to complete).	28/07/2023
5.	Independent Reviewer to review single agency reports, seek clarification if required---key themes/questions to be developed for Practitioner's workshop.	22/08/2023
6.	Agenda and key questions circulated to workshop attendees.	23/08/2023
7.	Meeting with Laura's family.	30/08/2023
8.	Practitioner Workshop.	31/08/2023
9.	First draft report, (v1), to workshop attendees and Panel members. (Two weeks to draft).	18/09/2023
10.	Feedback from workshop attendees. (One week).	25/09/2023
11.	Draft report, v1.2, to Panel members.	27/09/2023
12.	Panel meeting, (existing SAR Sub-Group date).	04/10/2023
13.	Independent Reviewer to prepare draft v2 following feedback.	19/10/2023
14.	Draft Overview report, v2, to Panel.	20/10/2023
15.	Panel meeting, (existing SAR Sub-Group date), to finalise report, learning briefing and develop recommendations.	08/11/2023
16.	Final report signed off through internal governance arrangements.	22/11/2023
17.	Final report and learning briefing circulated to Board members.	06/12/2023
18.	Final report and learning briefing to Board.	13/12/2023